

# Confronting the Fear Factor:

## The Coverage/Access Disparity in Universal Health Care

by Mark E. Litow

Since their introduction following World War II, single-payer health care systems and universally mandated health care systems have stumbled, but in their pratfalls are many lessons that apply to the universal health care proposals currently on the table in the United States. The critical and often-overlooked point is that universal coverage does not guarantee that individuals will receive needed care—In many cases guaranteed access to care is a false promise or available only on a delayed timetable. A more feasible alternative lies in providing a safety net for citizens who truly need care and financial support with an appropriate system of checks and balances—without disrupting the economic and actuarial fundamental principles of supply and demand and risk classification.

**F**ear is a powerful driver of human behavior. Today in the United States when it comes to health care and the future, individuals fear being uninsured, underinsured or unable to afford large copayments or cost sharing. Given that many people are unemployed or have part-time employment, are unable to afford health care coverage or are trapped in undesirable jobs simply for the insurance, their fears are real.

The numbers reflect the pain: Over the last several decades, health care costs generally have risen in the 8% to 9% range per year, while incomes are up only 5% or 6% per year.<sup>1</sup> While they may have initially absorbed those increases, more and more individuals can no longer cover the spread. Some estimates put the total uninsured population at 46 million,<sup>2</sup> which translates to perhaps 70 million or more people not insured at some point during a calendar year.

That's why it's understandable that many embrace health care policies that provide universal coverage; the promise that everyone receives some type of pub-

lic or private coverage is alluring. Politicians are responding to these fears by introducing health care coverage solutions—including recently-publicized efforts in California and Massachusetts. While some of these new alternatives are not single-payer systems yet, they are following a path that will likely lead them into a Medicaid or Medicare look-alike in the United States, or down the somewhat different paths of other countries worldwide, whether a U.K., Canadian, Japanese or Chinese type of model. In all these cases, cost is controlled at the expense of access to quality health care, with decisions on such access coming under the province of the government instead of the family.

The trajectory of these single-payer programs—or the universally mandated predecessors—is extraordinarily complex, both economically and politically. Needless to say, all these points are critical as federal and state governments revisit health care delivery and funding, a focus heightened by President Bush's recent State of the Union health care insurance plan.

The tough bottom line, though, is that however well-intended, universally mandated care programs

appear destined to inevitably morph into single-payer systems, with governments taking on and carrying this mammoth financial burden. This article looks at single-payer systems generally, including some of the features of the emerging Massachusetts-California-style proposals as well as offering an alternative option: a balance between public and private funding that relies on a safety net approach only for those in need.

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To understand today's health care environment, it's instructive to look at:

- How other countries with single-payer systems have fared and what they now face, including much different economies and demographics
- Why mandated universal coverage, nonsingle-payer systems have already morphed—or are likely to transition into single-payer systems
- The importance of fundamentals—checks and balances and basic economic principles
- The evolution of single-payer systems in the United States itself—notably the Medicaid and Medicare programs, which date back to the 1960s, and the “War on Poverty” that began during the Lyndon Johnson administration.

## THE WORLD EXPERIENCE

Following World War II, a handful of countries launched universal health care initiatives, with most being single-payer government systems. While there are many types of single-payer systems, they all suffer from the same malady: They work well for a while—

and a “while” can be decades—but they ultimately stumble and fail.

From the citizen's perspective, all's well when health care can be delivered acutely. Whether the doctor is setting a broken bone, performing a surgical procedure or tending some other acute condition, the patient can expect some closure. But with a growing aging population and the looming cost implications of chronic conditions, systems can deteriorate fast. Costs spiral and soar; tax money simply isn't available to pay providers and to handle the ever-increasing care requirements and costs.

Citizens increasingly use the system, and the system isn't built to withstand the strain. Why? Because single-payer systems do not have built-in incentives to control costs. The great equalizer—market competition—is not present. There's no authority yelling “whoa” because the authority and the payer are one and the same.

The classic short-term and shortsighted response then is for the governments to turn to coercion to control the rising costs—through either price controls and/or budget caps. Again providers cut back in order to make ends meet. As a result, queues for patient care develop, especially for costly procedures such as heart bypass surgery. When they can't get the care they need at home, patients run for the borders, to countries where the procedures are available through private insurance/payments or for affordable out-of-pocket payments. Unfortunately, these private pay patients are the same ones the system needs in order to balance out costs.

In the meantime, the national system is supporting more and more patients who are sicker longer. Ultimately these systems collapse and nothing works, with no providers and no access to health care in either a timely or quality fashion.

As demographics shift and populations become older, the tension is amplified. This is surely the case in Japan and in other countries with falling birth rates and aging populations. By contrast, Mexico has a young and growing population along with an expanding economy, and thus can absorb current health care spending (a parallel with the United States in the post-World War II period).

## WHAT ABOUT UNIVERSALLY MANDATED SYSTEMS?

As a supposed alternative to single-payer systems, others have tried mandates that force everyone to participate in the system. In these efforts, some or all of these features generally exist:

- Those who do not participate still are required to

pay into the system through a penalty that is set by law. These are frequently referred to as play-or-pay provisions.

- To ensure that the less healthy are subsidized, insurers are generally required to issue a policy to any person or group that desires coverage; premium ranges are restricted so that healthier individuals or groups pay considerably more than their cost would suggest.
- Some mandated coverage has extensive benefits while still offering significant options.

In these scenarios, as have occurred in the states of Vermont, New Jersey and New York, and in other countries such as South Africa, the results have been spiraling costs. In an attempt to control these costs, these jurisdictions then put in place additional mandates that place more limits on the system and move it ever closer to the default of a single-payer system.

## BACK TO FUNDAMENTALS

What's missing in all these national health care scenarios is recognition of fundamental economic and actuarial principles, including:

- **Laws of supply and demand.** The price controls and budget caps leave providers with several options: (a) They increase services where reimbursements are acceptable to them and limit or eliminate services where they are not; (b) they adjust prices for services not subject to the controls; (c) they change billing practices to increase revenue; or (d) they withdraw their services, unable to keep their doors open.
- **Requirements for checks and balances.** Because there are no counterbalances with these government systems, costs initially soar out of control as increasing numbers of citizens use—and often overuse—the system. Ultimately, to control costs, the government initiates price controls or budget caps, which create queues for care as dictated by the government. There's no accountability of the universal system or the single-payer system to other government or public authority, and thus no incentive (or fear of ramifications) to drive responsible cost-containment or improve access to quality care.
- **Risk classification and actuarial principles.** Public planners and politicians ignore risk classification considerations, wrongly believing that everybody—from providers to citizens—will participate in the health care system as desired, and that they will participate for the good of society. It doesn't require an actuarial analysis to show that people act in their own interest. This self-interest seg-

ments the system into dramatically different groups, with different interests and drivers. The result is that people or groups make different choices (selection), which creates higher participation by less healthy and/or low-income participants and lower participation by healthier and/or higher-income participants. (As detailed below, this is especially true with the “play-or-pay” systems and those that limit underwriting and risk rating to a substantial degree, as have passed or are being considered in Massachusetts, California and elsewhere.)

Not surprisingly, some of the early national single-payer systems—the United Kingdom and Canada come to mind—are now considering private payer solutions, at least partially and/or in smaller jurisdictions.

## THE U.S. STORY

Although the United States might be considered an uncoordinated, mixed (or even hodgepodge) health care system, the nation has compelling experience with taxpayer-funded single-payer systems in its Medicaid and Medicare systems. Both were launched as simple concepts in the 1960s: Medicaid as part of the war on poverty and Medicare in response to workers who, upon retirement, found that their employers no longer covered their health care expenses. (Those workers heretofore wrongly assumed that health care was “free” because their employers had quietly paid for it.)

Now these systems are experiencing the classic death spiral: Because of the forces described above, Medicaid—administered through the states—generally reimburses providers about 50% of what com-

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## BASIC DISTINCTIONS

In the fierce blizzard that is today's health care debate, it's easy to lose sight of the distinctions between the various types of programs. Importantly, universal care and single-payer systems are not synonymous, nor are universal care and universal access. Here are the basics:

**Single-payer system**—The government both pays for and insures health care and may also be a major provider of care—but not necessarily. There also may, or may not, be other payers and insurers. (The U.S. Medicaid and Medicare programs are examples of single-payer systems.)

**Universal care**—By law, everyone receives health care, but delivery of that care varies—either through a totally private system, a single-payer system or a mix of public and private systems. (Canada, for example, is a universal care and single-payer system, with the government picking up the tab; however, the Canadian system is now failing to provide universal access as the population ages and queues for care develop.)

**Universal access**—A more general concept, universal access means that all citizens have access to health care. The United States today is close to universal access, as even the uninsured must be cared for by hospital emergency rooms. (Of course, this is in sharp contrast to poorer countries, where governments can barely provide clean water and sanitation, let alone health care for the needy.)

mercial markets do. With Medicare for seniors, the payment is about 60%. With both these programs, however, because the services are perceived as “free,” the usage is generally at least 50% greater than that experienced by the general population after adjustment for age and health status. In 2006, Medicare and Medicaid each spent close to \$8,000 per eligible individual, while those with commercial coverage in the under-age-65 market averaged roughly \$3,500.<sup>3</sup>

With such discrepancies, the big health care squeeze is on, manifested in the following symptoms:

- **Access denied.** Both Medicaid and to a lesser extent Medicare recipients protest that they cannot find doctors to treat them, particularly in high-cost regions or where there are few doctors. And there's a mean hook: With Medicaid, reimbursements can be so low that physicians won't accept them; patients defer care until absolutely necessary, then visit expensive emergency rooms where they end up being admitted to receive the necessary tests. The result is high utilization, high costs and a population that often does not receive affordable, timely care (and instead receives expensive, untimely care). Fortunately for most individuals, the United States still has the best access to care, but that is in danger. As Medicaid and Medicare are demonstrating, universal coverage does not guarantee access to health care. With the aging of these systems, along with the aging of the participants, access to care diminishes.
- **Cost-shifting.** The above disparity between public and private reimbursements results in dramatic cost-shifting, with private payers subsidizing the public system through their own insurance bills (in addition to their tax contributions).
- **Unequal treatment.** Because of how these pro-

grams were initially conceived, some patients who need and deserve care don't receive it. Others receive help from systems like Medicare when they do not need it financially. (Even Medicaid, designed for the poor, now covers some individuals who could provide their own care.)

- **System overuse.** The mistaken belief that a single-payer system is “free”—and even a “right”—has fueled health care usage. The twist is that the influx of guaranteed Medicare dollars has expanded the U.S. health care infrastructure over the last 40 years (although much of it is aimed at sustaining those most-expensive last years of life).

## PLAY OR PAY

Predictably, the United States, in responding to its fears, is turning to some of the same bailout approaches that were tried and failed in Europe and elsewhere. While this article is not meant to dissect any particular health care proposal, it is wise to consider the “play-or-pay” provisions included in plans in Massachusetts and, more recently, in California. Play or pay requires that either employers provide health care insurance, or they pay a flat rate and participate in the new state system.

Unfortunately, this play-or-pay ultimatum ignores human behavior and the actuarial reality of adverse selection. Actuaries know that requiring everyone to pay the same amount for a totally different product or service ends up in disaster. This approach doesn't allow for any choices or segmentation of the participants. Those who pay but get little out of the system quickly scramble for better options (or for ways to circumvent the system, even opting to cross state

lines). Those who devour services suck all the oxygen from the system. As with Medicaid/Medicare, adversely selected heavy users create soaring costs that again get shifted to private payer/taxpayers.

Technically, and for the sake of argument, it's probably possible to create a single-payer system that works, but it would require attention to adverse selection and economic principles. Participation would be mandated and choices would have to be limited and balanced to allow for the various populations including—just as simple examples—four distinct “buckets” segmenting people into sick/healthy and poor/wealthy.

## SAFETY NET APPROACH

Fortunately, there is light at the end of the tunnel. Where these universal coverage efforts go wrong is by extending a good thing—the safety net—too broadly. A safety net system provides protection and care for those who cannot afford it or who can't help themselves due to physical disability or mental inabilities.

Providing the safety net is what matters, and there are ways to do it besides universal, single-payer coverage. This entails balancing public and private pay systems. Likewise, planners must truly identify the various groups who need (and do *not* need) this safety net coverage and develop ways to pay for this more targeted care, taking into consideration the country's economy and medical infrastructure.

Placing everyone into either a universal care or a single-payer system or some combination of the two

may be politically convenient, but it generally creates an unsustainable system similar to a Ponzi scheme. In such, people in the front of the queue receive a large benefit for little cost while those later arrivals farther down the queue end up paying more in a system that spirals further out of control over time. This is not the answer.

Instead, viable alternatives would seem more likely to exist with the creation of a sustainable safety net that will work for all generations now and into the future. This means a system that is not overly generous upfront and has the built-in flexibility to change with the times. The time to search for such a system is now, not after the health care system collapses under the guise of providing universal coverage, which we already know results in large doses of adverse selection and other insidious side effects.

Now is the time for the United States to draw upon best experiences and best practices from around the world to create a safety net health care system that benefits all our citizens. ◀

## Endnotes

1. U.S. Bureau of the Census. *Statistical Abstract of the United States*. [www.census.gov/prod/www/statistical-abstract.html](http://www.census.gov/prod/www/statistical-abstract.html).
2. U.S. Bureau of the Census. “Income Climbs, Poverty Stabilizes, Uninsured Rate Increases,” press release, 29 August 2006. [www.census.gov/Press-Release/www/releases/archives/income\\_wealth/007419.html](http://www.census.gov/Press-Release/www/releases/archives/income_wealth/007419.html).
3. M. Litow, unpublished data. This number was derived from a Milliman model, using data from the *Statistical Abstract of the United States*.

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