Reconsidering
national health insurance

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In 1971 Martin Feldstein published an article in this journal entitled "A New Approach to National Health Insurance." In it, Feldstein proposed that the government provide every household with major risk health insurance (MRI). Under MRI, every household would have an income-related ceiling on its annual medical financial burden; MRI would thus achieve universal income-related catastrophic protection. At the same time, prior to reaching its out-of-pocket ceiling, every household would pay at least a fraction of any medical bill, so each consumer of medical care would have an incentive to be cost-conscious.

Some observers might contend that, whatever the merits of MRI, events have passed it by, and two decades of developments in the U.S. health sector have rendered it irrelevant. In truth, however, these very developments have shown the wisdom of the MRI strategy, which is now more relevant and desirable than ever.

Today, many conservatives oppose any government initiative concerning health insurance, and many liberals advocate mandated private health insurance with specific provisions.
Conservatives seek to limit government regulation of medical providers and liberals hope to assure universal access to medical care without financial hardship. I will attempt to explain why both are mistaken: their strategies will not achieve their objectives. Instead, an income-related MRI is the best way both to limit government regulation of medical providers and to achieve universal access without financial hardship.

**Feldstein’s 1971 article**

Feldstein began his 1971 article by stating that we should judge any system of health insurance according to whether it prevents deprivation of care, prevents financial hardship, keeps costs down through consumer cost-consciousness, avoids a large tax increase, is easily administered, and is generally acceptable. He then applied these six criteria to the then-existing system, to subsidy-credit plans that would help low-income households buy private insurance, to uniform comprehensive health insurance, and to his MRI proposal.

According to Feldstein’s six criteria, the 1971 system did not work well. The system provided too much insurance for average hospital bills, but too little insurance for very large medical bills. A sizable number of households were deprived of care due to an inability to pay, while others obtained care only at the cost of severe financial hardship. Yet because private insurance, Medicare, or Medicaid paid virtually all of the typical hospital bill, many consumers of hospital care had no incentive to care about costs. Doctors and hospitals therefore felt little pressure to keep costs down. Nevertheless, even households with nearly complete insurance for normal hospital stays were vulnerable to severe financial hardship from an unusually long stay.

Subsidy-credit plans fared little better under Feldstein’s analysis. They would make some households able to afford needed care, but they would do nothing to remedy the basic shortcoming of the current system: excessive insurance for normal hospital episodes and inadequate protection against large medical bills.

Feldstein then turned to uniform comprehensive health insurance. In today’s political environment, it may be difficult to recall that the AFL-CIO’s Health Security bill, sponsored by Senator Kennedy, was regarded as a serious contender. Under Health Security, the federal government would have raised enough tax revenue to pay the entire medical bill of every household. This
plan would have prevented deprivation of care and financial hardship, but it would obviously have required a large tax increase. Less obviously, its method of controlling costs by regulating providers of medical care was seriously flawed.

Feldstein conceded that regulation of providers might keep costs down, but he emphasized that completely insured consumers would have no reason to be cost-conscious. Everywhere else in the economy, each consumer weighs the cost of a good or service against its benefit as he judges it. In this way, consumer preferences help guide resource allocation and avoid waste in the economy. Feldstein explained that the failure to let consumer preferences guide resource allocation is a basic flaw in the regulatory approach to cost control:

Detailed controls, fee schedules, and limits on hospital charges might, of course, prevent rising costs.... [But] such controls would not achieve, and might actually work against, an efficient use of health resources. They would certainly require a large number of arbitrary policy decisions.... Such arbitrary decisions pose a more serious problem than may be generally recognized: What is a "reasonable" level of hospital daily cost? At what rate should hospitals improve facilities, add staff, raise the level of amenities? How many beds should there be per thousand population? How much should different medical specialists earn? These are not technical questions that can be answered "objectively" if only enough research were done—they involve tastes and value judgments about the relative desirability of different goods and services.

Feldstein then presented his MRI proposal. The government would provide every household with an income-related ceiling on its annual medical financial burden. Prior to reaching that ceiling, each household would bear a fraction of any medical cost it incurred. Once the household reached its ceiling, the government would pay all of any additional medical bill incurred that year. Feldstein suggested that most households have a ceiling of 10 percent of income.

In the simplest version of MRI, each family would be fully responsible for its medical bill up to its ceiling. A family with an income of $6,000 in 1971, for example, would have paid the first $600 of medical expenses, and the government would have paid all additional medical bills. But the simplest version of MRI has an important disadvantage. The family's "ceiling medical bill"—the figure at which the family's annual medical bills reach their MRI ceiling—is too low; the family with an income of $6,000 would have an incentive to care about cost only for the first $600 of its
annual medical bill. A solution to this problem, as Feldstein pointed out, is to increase the ceiling medical bill through co-insurance—the sharing of cost between the family and the government. The family with $6,000 of income, for example, might be responsible for half of its annual medical bill until the bill reached $1,200 and its burden reached $600. The government would then pay all of any additional bills so that the family’s burden would again be limited to 10 percent of its income. But now the family would have an incentive to care about cost for the first $1,200 of its annual medical bill. So the ceiling medical bill would be 20 percent of income while the out-of-pocket ceiling would remain 10 percent of income.

MRI is designed to strike an optimal compromise between two conflicting objectives: giving each household an incentive to be cost-conscious, and reducing its financial risk from a medical problem. MRI concentrates on the incentive when the family’s financial burden is tolerable, but switches to risk reduction when the family’s burden threatens to become intolerable. According to Feldstein:

Major risk insurance is the most important type of health care insurance for the government to provide. It concentrates government effort on those families for whom medical expenses would create financial hardship or prevent appropriate care.

Feldstein explained that MRI would fare extremely well according to his criteria. It would prevent deprivation of care and financial hardship. It would make most consumers of medical care cost-conscious so that consumers would regulate themselves, as they do everywhere else in the economy, and thereby eliminate the need for government regulation of medical providers. In contrast to Health Security, “the cost to taxpayers for an MRI program would not be large relative to the benefits conferred,” because many households would pay an important fraction of their own medical bills.

It is important to emphasize that Feldstein’s MRI would cover the same services as comprehensive insurance. The difference concerns consumer cost-sharing. Feldstein emphasized the importance of removing the bias in favor of hospital inpatient care by applying the same patient cost-sharing to outpatient and inpatient care.
Why government must provide MRI

Feldstein took for granted that MRI should be provided by the government, not by private companies. Developments over the last two decades, however, require a reexamination of this key feature of MRI, because first conservatives, then liberals, have adopted the position that most health insurance should be provided by private insurers.

In 1971 the AFL-CIO, Senator Kennedy, and most liberals supported government health insurance. The Nixon administration, however, proposed instead that government require employers to buy their employees private health insurance that met certain standards; the government specified, for instance, a dollar ceiling on households' out-of-pocket burdens. It is important to note that the ceiling did not vary with household income. By proposing MRI, Feldstein implicitly rejected the idea of mandated private insurance, though he unfortunately did not address it explicitly in his article.

As the 1970s continued, liberals became discouraged about the possibility of enacting a large tax increase to pay the medical bills of most households. The Carter administration proposed essentially the Nixon administration's approach of mandated private insurance, while the AFL-CIO and Senator Kennedy endorsed a mandated approach with no patient cost-sharing. By the end of the 1970s, liberals were the primary advocates of mandated private insurance, and most conservatives were opposing any federal initiative concerning health insurance. Today, few liberals or conservatives openly support government provision of any kind of health insurance for the majority of households.

It is important, then, to understand why an acceptable MRI must be provided by government. As Feldstein recognized, a key feature of MRI is that it relates each household's maximum out-of-pocket burden to the household's income. A uniform dollar ceiling for all households cannot achieve a central goal of MRI: prevention of both deprivation of care and financial hardship. For example, $3,000 may be a tolerable burden for a household whose income is $60,000, but intolerable for a household whose income is $20,000.

I would go further than Feldstein in arguing that the consumer cost-sharing rate, as well as the ceiling, must be related to income. I would suggest a schedule like the following:
<table>
<thead>
<tr>
<th>Household income</th>
<th>Ceiling (percent of income)</th>
<th>Cost-sharing rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20,000</td>
<td>$1,200 (6 percent)</td>
<td>10 percent</td>
</tr>
<tr>
<td>$60,000</td>
<td>$4,800 (8 percent)</td>
<td>30 percent</td>
</tr>
<tr>
<td>$100,000</td>
<td>$10,000 (10 percent)</td>
<td>50 percent</td>
</tr>
</tbody>
</table>

A $20,000 household would pay 10 percent of any medical bill until its annual medical bill reached $12,000. But a $100,000 household would pay 50 percent of any medical bill until its annual medical bill reached $20,000.

Scaling the cost-sharing rate to household income helps to achieve two of Feldstein’s criteria simultaneously: preventing deprivation of care and avoiding a large tax increase. A uniform low cost-sharing rate would enable low-income households to afford necessary care but would entail a large tax increase. A uniform high cost-sharing rate would limit the tax increase but deprive low-income households of needed care. Only by varying the cost-sharing rate with income can both objectives be met.

Another advantage of relating the consumer cost-sharing rate to household income is that doing so reduces the fraction of households that will reach the free-care range. In our example, the $20,000 household has an incentive to care about cost until its annual medical bill reaches $12,000. But if its cost-sharing rate were 50 percent instead of 10 percent, it would reach the free-care range when its annual bill reached only $2,400.

Even with income-related cost sharing, it is true that some households will reach the free-care range. But many of these “catastrophic” patients and their doctors may still weigh cost. At the time that medical decisions are made, neither the patient nor his doctor is likely to know whether the free-care range has yet been attained. Few patients and doctors will keep a running total of the patient’s annual medical bills. In practice, risk-averse patients and doctors will probably find it prudent to assume that cost sharing still applies. Doctors who become accustomed to cost-sharing patients are unlikely to alter their medical decisions for the small fraction of patients who may have reached the free-care range.

Thus income-relating is crucial to both the fairness and the effectiveness of consumer cost-sharing. Yet private insurers cannot administer income-related cost sharing, because they are unable to obtain the necessary household income data. It is true that an employer might provide data on the compensation of each employee, but the employer does not have data on the full income
of the employee's household. What private insurer, competing for business, would ask customers to turn over tax returns? It should not be surprising that patient cost-sharing under private insurance is virtually never related to income.

The government, of course, has the tax-return data. Under MRI, the government would contract with private insurers to process bills, as is the case under Medicare. Using the preceding year's tax returns, the government would supply the bill processors with each household's cost-sharing rate and ceiling for that year. As agents for the government, the processors would pay medical bills and then bill households for their required share.

**Protecting consumer cost-sharing under MRI**

A central aim of MRI is to restore consumer cost-consciousness. It is important to understand that the aim is not to keep costs down per se. There is no more reason to focus on cost reduction in the health sector than on cost reduction in any other sector. The aim is to induce the optimal level of cost growth.

First, in every sector, each producer should feel pressure to operate efficiently—to produce a given quantity and quality at minimum cost. Second, we want producers to raise cost and improve quality if and only if consumers value the improvement in quality more than its cost. And third, we want consumers to refrain from consuming a good or service when they do not judge its benefit to be worth its cost. In most other sectors, consumer cost-bearing achieves all three of these objectives without government regulation. The resulting rate of sector cost growth, whether fast or slow, is socially optimal. Complete consumer cost-bearing would be unacceptable in medical care, but income-related consumer cost-sharing strikes a nice compromise between providing protection and preserving consumer cost-consciousness.

But what's to prevent households from buying private insurance to cover their share of the MRI's cost sharing, thereby eliminating their incentive to care about costs? This, after all, is what the majority of elderly people have done under Medicare. In contrast to MRI, however, Medicare has never provided an income-related ceiling, so many retirees have sought private insurance to protect themselves. Feldstein believed that given the MRI income-related ceiling, most households would find additional private insurance not worth its cost—especially if the current tax subsidy to private
insurance were eliminated, so that all employee compensation—whether in the form of health insurance or cash wage—was taxed.

But consumer cost-sharing under MRI can be fully protected with one further simple provision: permit households to use either MRI or private insurance to help pay each medical bill, but not both. With this provision, it is doubtful that many households would decide to pay high premiums for private insurance with no cost sharing when they were automatically covered by MRI.

**Coverage and financing**

A universal income-related MRI would cover the entire population, including the poor and the elderly. It would therefore replace Medicaid and Medicare. Every household would be required to file an annual tax return to establish its cost-sharing rate and ceiling for the coming year. Many citizens might instinctively prefer to preserve Medicare and to limit MRI’s coverage to the non-elderly. The developments in Medicare over the past two decades, however, show that it is crucial to replace Medicare with income-related MRI.

Medicare has been the perfect example of poorly designed insurance: it provides excessive coverage for normal hospital stays and too little coverage for large medical bills. For hospital care, Medicare entails a deductible (usually surpassed in the first day) and complete insurance through day sixty, but significant cost sharing beyond that; physician care entails 20-percent cost sharing without limit. With no out-of-pocket ceiling on hospital or physician care, many elderly sensibly obtained “medigap” coverage—private insurance to eliminate most of the Medicare cost sharing. With most cost sharing eliminated, cost growth was rapid, and regulation was imposed in the 1980s to curtail it. Much of the demand for medical care comes from elderly people, and demographic projections indicate that this share will grow in the next few decades. If the elderly are exempt from income-related consumer cost-sharing, then medical providers will probably need to be regulated even if MRI is enacted for the rest of the population.

The disadvantage of treating the elderly separately was well illustrated by the recent revolt against the Medicare Catastrophic Coverage Act of 1988. The revolt had nothing to do with the Act’s out-of-pocket ceiling, which remains popular. But most of the burden of financing the ceiling was placed on the affluent elderly, rather than being distributed over the entire population. The afflu-
ent elderly objected. Their revolt illustrated vividly what many recent studies have made clear: the elderly are a diverse group with respect to both income and health. This diversity strengthens the case for replacing Medicare with MRI.

Would consumer cost-sharing work?

Many remain skeptical about the impact of consumer cost-sharing, despite an impressive set of econometric studies and controlled experiments that support the potency of cost sharing for medical care. This skepticism is often based on a misunderstanding about how cost sharing is supposed to work. The skeptic often believes that cost-sharing advocates expect patients to shop around for hospitals, carefully comparing prices before selecting one. As the heart-attack victim, barely conscious, is carried out on a stretcher, he whispers: "What are they charging?"

If the cost-sharing strategy depended on such behavior, this skepticism would be understandable. Cost sharing can succeed only if doctors, when making decisions, tend to take into account the financial impact of the decisions on their patients. After the introduction of MRI, doctors would soon recognize that most of their patients had a new attitude toward costs. Doctors now know that their patients would want them to disregard hospital costs. Under MRI the average patient would still prefer more costly care if the additional quality were worth the out-of-pocket expense, but he would want his physician to economize whenever possible.

At the time of the decision to enter a hospital, the average patient would probably simply acquiesce in his physician's decisions. Two months later, however, when the recuperating patient received his bill and estimated the fraction that he must pay, he might review his doctor's choices. Was the tenth day really necessary? Was hospital A, the most costly in the area, really best for his problem? Why did he need test Z? Because the patient must pay a fraction of the bill, doctors would begin to receive feedback from patients.

Doctors who take the trust relationship seriously would try to reduce wasteful expenditure. Other doctors, out of self-interest, would seek to minimize complaints by saving their patients money whenever possible without loss of quality, and by letting their patients know that they were doing so.

The average doctor would develop a new attitude toward hospital services. Since physicians could choose among hospitals competing
for their patients, hospitals would be pressured to economize and to raise costs if and only if quality improvements justified doing so. As in most other sectors of the economy, a minority of astute consumers, who carefully weigh price against quality, can make the difference between profit and loss. The same competitive pressure that promotes the optimal mix of quality and cost in other industries would now bear on the hospital sector.

When regulation rather than cost sharing limits costs, no mechanism induces the consumer to reveal the urgency of his preference. The physician, as an advocate for his patient, will tend to describe any service as essential, even if it is merely beneficial. If regulation is strong enough to limit cost growth, some patients will be deprived of service that they urgently prefer. If hospital capacity is constrained by budget-limit regulation, for example, some people may be forced to wait for admission, although they highly value a quick treatment of their problem. A regulator—rather than the patient and his doctor—will decide whether the case is urgent and therefore deserves first priority for admission.

Consider the goal of achieving the right length of hospital stays for patients. With complete insurance and no regulation, the average stay would no doubt be excessive, because doctors and patients would regard each additional day as free. Under cost sharing, if patient and physician still regarded the extra day as necessary, the physician would prescribe it. Otherwise, the physician would discharge the patient. Under MRI, the out-of-pocket cost induces the consumer to reveal the urgency of his preference, while enabling families to afford needed medical services.

The crucial advantage of cost sharing over regulation, therefore, is not that it slows cost growth but rather that it is more sensitive to the preferences of individual patients. Under cost sharing, each patient and his physician retain the freedom to decide what they regard as necessary and urgent. Hospitals will be free to respond fully to the demands of patients and doctors, so that each can obtain whatever service he desires as quickly as he desires it.

Finally, cost sharing gives each patient firmer control over his own medical care. Free medical care is not really free, for it requires every individual consumer to give up some control and power. If patients do not pay for the services that they use, then their demands for more services are not credible; “the system” must therefore make decisions for the patient. But if the patient pays some of the cost of everything that he orders, then his
demands become credible and the system can respond to them without worrying that they are frivolous and wasteful.

There are at least four reasons why the private-insurance sector has failed to introduce significant consumer cost-sharing for hospital care. First, the tax subsidy encourages employee compensation to be channeled into high-premium, low-cost-sharing insurance policies. Second, employers often subsidize employees when they choose a high-premium option. Third, employees are probably reluctant to risk policies with cost sharing for fear that the promised out-of-pocket ceilings contain hidden loopholes. Fourth, many employees, unions, and even employers probably believe that cost sharing, unscaled to household income, is unfair and should not be selected.

The absence of consumer cost-sharing generated rapid growth in health-care costs and created intense pressure on the federal government to do something to contain Medicare expenditures. In 1982 the Reagan administration, though generally hostile to government regulation of private producers, accepted hospital-rate regulation. Under the diagnosis related group (DRG) system, all hospital Medicare cases are classified into 468 categories, and each case is reimbursed at a rate fixed in advance, regardless of the actual cost. With physician costs for Medicare growing rapidly, in 1985 Congress established the Physician Payment Review Commission (PPRC) to consider options for a Medicare physician-fee schedule. The Bush administration will almost surely accept a Medicare fee schedule in the near future.

But regulation will not end there. Rate regulation has in fact reduced hospital-cost growth and average length of stay, and fee regulation will no doubt reduce physician-cost growth. Using the incorrect criterion of cost-growth reduction, advocates of regulation will claim success. Naturally, they will argue that these successful techniques should be applied to the non-elderly population and to health services not currently regulated. Excessive cost growth and abuses in unregulated services will give their arguments force. It is almost certain that regulation will spread gradually to most of the health sector as long as there is little consumer cost-sharing for medical care.

The only way to reverse this regulatory advance is to restore consumer cost-sharing; the only way to make cost sharing acceptable to the public is to relate it to incomes; and the only way to have income-related cost sharing is through government MRI.