

FOUR

BOOK REVIEW OF LAURENCE J. KOTLIKOFF'S THE HEALTH CARE FIX: UNIVERSAL INSURANCE FOR ALL AMERICANS

(MIT Press, 2007)

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INTRODUCTION

With the 2008 race for the White House in full swing and the economy in danger of sliding into recession, “change” is the watchword of nearly every candidate for the Oval Office. It has now been fourteen years since the last major discussion on universal health care took place in the halls of government—a discussion that ended in abject failure.

Health care spending continues to rise dramatically: per capita spending on health care in the United States has risen from \$3,469 in 1993 to \$7,026 in 2006. Over the same period, spending as a percentage of Gross Domestic Product (GDP) increased from 5.2 percent to 16 percent. Today we spend more than \$2 trillion dollars as a nation on health care, and we are projected to double that amount by 2016 under the current systems (Kaiser Commission on Medicaid and the Uninsured 2007; U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services 2007). Meanwhile, forty-seven million Americans have no health insurance, up from about 40 million when the Clinton plan failed to achieve passage in 1994 (U.S. Census Bureau 2006). The need for health care reform is apparent.

In *The Healthcare Fix: Universal Insurance for All Americans* (MIT Press, 2007), Boston University economist Laurence J. Kotlikoff argues that the United States government is facing bankruptcy largely due to the runaway costs of Medicare and Medicaid. The case he makes is both unique and convincing. Other arguments for change have focused on aging baby boomers, human rights, social costs of the uninsured, and controlling medical inflation. Kotlikoff, on the other hand, bases his analysis on the fiscal gap confronting the government, data that he says has been largely suppressed by both the current Bush administration and the previous administration under Bill Clinton. He projects the difference between anticipated fiscal obligations and projected revenue to be as much as \$70 trillion or 56 percent more than the 2002 projections commissioned by the then Treasury Secretary Paul O'Neill.

Many claim that Americans already have universal access to health care. In the sense that emergency treatment is available, often through county hospitals, this is true. However, those without health insurance may have to rely on high-cost emergency room treatment for the majority of their care. This means that routine, preventative intervention is ignored, allowing for the possibility of more severe problems once treatment is finally sought. Kotlikoff notes that hospitals increasingly are requiring uninsured patients to charge their medical expenses to high-interest credit cards, which, in many cases, they are unable to pay later. What Kotlikoff fails to mention is that these charges are most frequently made at the top-dollar price of the hospital rather than at the much lower negotiated pricing structure offered to HMOs and insurance companies, increasing the debt accrued by patients (Anderson 2007).

KOTLIKOFF'S PROPOSAL: THE MEDICAL SECURITY SYSTEM

Kotlikoff proposes a single-payer system as a solution to the current health care crisis. The traditional "single-payer" approach is one under which the federal government pays the direct costs of health care, utilizing either general funds or a special payroll tax to finance the benefits. Unlike the traditional notion of "single-payer," however, Kotlikoff's solution calls for the federal government to pay the premiums through the existing private insurer system. Kotlikoff argues that his Medical Security System (MSS) is a simple, but powerful, fix for the looming crisis. Kotlikoff's proposal, while potentially more attractive than the traditional single-payer approach to the powerful insurance lobby who spent millions to defeat the Clinton plan, falls short of providing a comprehensive approach that will actually solve the impending crisis that he predicts.

Kotlikoff's proposal comprises three elements: (1) provision of a federally-funded annual voucher to every American for the purchase of a basic healthcare plan; (2) increased voucher amounts for those with pre-existing conditions; and (3) government setting of the overall budget for vouchers based on what the government can afford to pay. The government would decide the basic benefits to be covered under the plan. Insurers would be free to offer rebates to consumers based on whether they take higher deductibles or other incentives to reduce benefit outlay. They could also offer extra benefits and coverage for premiums paid above the voucher amount.

The definition of a policy problem is critical to evaluation of whether the policy proposal advances the situation toward a solution. In the case of health care, the problems are many, but

Kotlikoff's plan focuses on the looming fiscal problems that the government will face if change is not forthcoming. If cost were the only component of the health care problem, the MSS proposal may pass muster. Unfortunately, there are several other problems inherent in the health care arena, which are not addressed fully in the MSS proposal. These problems may best be illuminated by examining the equitability, economic feasibility, and political viability of the plan.

Equitability

Given that every American would have basic medical benefit coverage, Kotlikoff's plan passes the equitability test. But the assumption that insurers would readily accept the voucher amount as payment, especially in the case of higher-risk customers, seems less likely than Kotlikoff contends. His assumption is based in his brief discussion of adverse selection—the likelihood of those who know they are more likely to incur major expenses to purchase more comprehensive policies. Universal coverage does have the potential to eliminate adverse selection. However, possession of a higher voucher amount would be a giveaway to the insurer that the risk, though conceivably not revealed to the insurer, is higher than the risk of a consumer with a lower voucher amount. The plan has no apparent guarantee that higher-risk consumers would be able to obtain private coverage. Under the current system, which the proposal seeks to maintain, insurers are regulated at the state level. Absent inclusion of federal legislation restricting insurers from discriminating against higher-risk applicants, it is likely that insurers would continue current practices of selecting lower-risk applicants. This bias would be compounded in the event that the voucher amounts set by the government were insufficient to cover the expenses of providing the benefits. Including a non-discrimination provision has been proposed by others making the case for universal coverage. However, such a provision is not likely to be well-received by the insurance lobby, and may therefore threaten the political viability of any such proposal.

Economic Feasibility

As for economic feasibility, the MSS plan calls for the government to decide what the total budget will be for health care vouchers. It further implies that percentage increases in the annual budget would be no more than the percentage increase in per capita income as measured by the Gross Domestic Product. Though not explicit in the brief proposal, one can infer that the distribution of the total national health budget, in the form of vouchers, would be determined by some sort of ranking system based on individual health status, and the overall budget would be split among the citizenry accordingly. Whether such a split would result in voucher payments sufficient to actually pay the annual cost of the basic benefit plan is, at the least, unclear in the proposed plan. Unquestionably, the government's ability to set the national health budget could help to solve the fiscal gap problem that is the focus of Kotlikoff's proposal. There is no guarantee, however, that politicians would have the political will to restrict the budget in such a way as to actually achieve the reductions in or elimination of the fiscal gap as Kotlikoff envisions.

In addition to the uncertainty regarding the economic feasibility of MSS, there is the question of revenue sources to pay for the vouchers under the plan. Kotlikoff relies on two sources of funding: current total government expenditures in the forms of Medicare and Medicaid direct payments and the revenue regained by eliminating the tax subsidy to employer-provided health insurance. He contends that these two sources would likely provide sufficient

funds to pay for most, if not all, of the cost of the vouchers. Though he offers rich economic evidence in his more extensive argument as to why the current system cannot be allowed to continue, he does not offer any concrete evidence to support his contention that the MSS plan will be sufficiently funded using the aforementioned sources.

Additionally, Kotlikoff's proposal is relatively inadequate with respect to controlling the rapid rise in medical costs, another component of economic feasibility. In his lengthy statement about the problems with the current system, Kotlikoff makes a compelling argument against Medicare and many private insurers' current fee-for-service arrangements. Kotlikoff, conversely, does not describe how these arrangements would differ under his proposal. Rather, in a very brief section on the reduction of health care costs, he contends that administrative savings, stemming from a government-determined universal and electronic claims processing system, will be a cost-saving measure. He fails to consider the costs of administering the voucher program. Because the MSS plan requires experience rating, the government will have to collect and process massive health care data on each participant. This task, alone, would equate to formidable administrative costs under MSS, having the potential to wipe out any anticipated savings from the reduced administrative burden under the new claims system. Kotlikoff also makes a one-sentence reference to the need for malpractice reform to limit payouts and, thereby, reduce the costly use of defensive medicine. Such a major component of cost reductions deserves more explanation, which would strengthen his overall case.

The economic feasibility of the MSS plan must also be examined from the individual level. One might conclude from Kotlikoff's own argument that the aging baby-boomer generation would require, on average, much larger vouchers than younger citizens. In this sense, the elderly and the seriously ill would continue to consume the larger share of the national health budget. However, only basic benefits—as defined by the government itself—would be required under the plans. Insurers would be free to offer private-pay major medical coverage to those wishing more comprehensive coverage. By Kotlikoff's own admission, this would reopen the system to the adverse selection problem previously mentioned. Whether those who currently have either government or employer-provided major medical coverage would consent to paying for "gap" plans, especially with post-tax dollars, is questionable and unaddressed in the MSS proposal.

Political Viability

The current American political system is largely controlled by special interest groups and corporate lobbies. Within this context, the political viability of the MSS plan is highly uncertain. To Kotlikoff's credit, he acknowledges the potential for his MSS plan to be perceived as politically naïve. One pre-publication reviewer contended that the voucher-centered approach would be unacceptable to Democrats while the centralization of power and information at the hands of government would be problematic for Republicans. Kotlikoff, however, dismisses this objection. In response to the Democratic point, he remarks that labeling the payments as "vouchers" is semantic only and that semantics must give way to sound policy. In this regard, he compounds his perceived naiveté and passes up the opportunity to address the Democratic point with a solid argument. Given the relative importance of the terms in which political discourse is framed, semantics cannot be so easily dismissed (Lakoff 2004). As for the potential Republican objection, Kotlikoff contends that the government has already been collecting such information

on Medicare and Medicaid recipients without any lapse in confidentiality. To the extent that he is correct about this, it may be that Republicans will not object on this basis. However, a problem may arise in permitting the government to set both the premium and benefits schedules (at least for the basic benefits); such is likely to be viewed by Republicans as excessive government interference in the marketplace. If these were the only areas in which the plan was politically naïve, Kotlikoff might well be correct in his defenses to the objections. However, the political viability question is far more complex than a simple overview of political party philosophy and so requires more attention.

Kotlikoff maintains that the current anxiety surrounding health care is so high that individuals currently covered under Medicare or employer-provided insurance would willingly give up their current plans in return for the lifelong guarantee of health care coverage. As outlined, the MSS plan would replace Medicare and Medicaid with a voucher-based payment system for basic benefits. Medicare recipients, however, currently receive much more than basic benefits. Rather than embrace the proposal, the powerful elderly lobby would likely reject the MSS wholesale. Likewise, the fifty-six percent of Americans covered by employer-provided healthcare insurance may be hesitant to give up their plans if they perceive their current benefits as more generous than what they would receive under the MSS proposal.

Certainly, Kotlikoff's MSS proposal has appeal to some sectors. Corporations would no longer have responsibility for covering ever-increasing health care costs. The uninsured would likely be very pleased to have at least basic benefits covered. The proposal does not eliminate private-sector insurance companies in any way, and, in fact, may even increase premium income. How insurers would react to increased benefit liabilities under the proposal, however, is less certain. Having no control over the basic benefits decided annually by the government or the premiums to be charged based on the voucher system is likely to raise serious concerns in the powerful insurance lobby—who were among the major opponents of the Clinton reform plan, spending many millions to ensure its defeat. The plan makes no mention of how “basic” the “basic benefits” would be. If, as seems likely, the basic benefits represent a significant reduction from the benefits of current employer-sponsored or government plans, persons presently covered under those plans are going to find the MSS plan less than desirable.

CONCLUSION

Kotlikoff's compelling argument for change in the health care financing system is important. His MSS plan has the appeal of maintaining much of the current system. The plan's simplicity is appealing as well. Unfortunately, if it were proposed in its present form, the current political system, especially with continued pressure from corporate lobbyists and special interest groups, is likely to complicate the plan greatly. The legislative process simply will not permit such a “simple” approach to go forward unchanged.

Americans are facing an unfathomable fiscal crisis. With a projected fiscal gap in current dollars of \$70 trillion by 2050 and an already mounting national debt of \$9 trillion, there is no question that measures must be taken to address this crisis. Kotlikoff makes this clear. Although his solution is not complete, his book may provide additional impetus to find new proposals to address this mounting gap. In raising the fiscal gap concerns alone, the book is worth reading.

Without serious attention to the ongoing spiral of medical inflation, however, and given the potential shortfalls of the MSS plan, the likelihood of averting the fiscal crisis in the manner suggested by Kotlikoff is anything but definitive.

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