



THE CASE FOR A **Two-Tier Health System**

BY JONATHAN GRUBER

THESE ARE EXCITING TIMES for those who want to fundamentally reform the U.S. health care system by establishing universal health care coverage. There are sizeable Democratic majorities in both houses of Congress and a Democratic president who made universal coverage a central pledge of his campaign. Indeed, Senators Baucus and Kennedy are hard at work on universal coverage legislation, and Senators Wyden and Bennett have already submitted a bipartisan bill that would accomplish that goal.

But while Democrats (and some Republicans) have long agreed on fundamental health reform centered on universal insurance coverage, that is where the agreement ends. There are a wide variety of reform models, and a number of different ways to get to universal coverage. Many argue that the only logical approach to such reform is a single-payer system, as in Canada, where one monopoly government insurer provides coverage for the entire population. Every resident of Canada is entitled to a uniform package of insurance benefits with limited patient cost-sharing. This approach has a number of major efficiency advantages, including lower administrative costs and maximum bargaining power for the insurer (the government) in negotiations with providers, which keep medical costs much lower than in the United States. It also may lead to much more equalized outcomes of the health care system than does a piecemeal system of insurance.

At the same time, such an approach is highly unlikely to succeed in the United States for two reasons. First, it would displace the majority of insured Americans who are largely satisfied with the health insurance they receive from their employers. Second, it would require nationalizing an industry, private health insurance, with more than \$500 billion in revenues per year. These barriers are not likely to be overcome in the foreseeable future.

For this reason, policymakers have been turning to a new model that I label “incremental universalism”: moving to universal health insurance coverage by building on the existing system of (largely employer-based) private health insurance and filling in the cracks through which the uninsured are likely to fall. The example most commonly used to illustrate this model is the ambitious health reform that began in late 2006 in the state of Massachusetts. This plan had several key features: heavily subsidized insurance for low-income residents that is very comprehensive (with limited copayments and no deductibles); market reform for other residents so that everyone else in the uninsured and small-group insurance markets purchase through a pooled market where prices cannot vary by health (and only in a limited way by age); and an individual mandate that imposes large fines on residents who do not have health insurance coverage unless they meet a set of narrow exemption guidelines (exempting about 15 percent of the uninsured on income grounds).

This plan leaves intact the employer-based system for firms with more than 50 employees. Most of the insurance coverage in the state continues to be provided via this employer-based model. It is perhaps for this reason that the plan was able to pass.

Thus far, the plan has been quite successful, with the most recent estimate reporting an uninsurance rate of only 2.6 percent, by far the lowest in the nation and perhaps as close to

universal coverage as is feasible in the United States. Costs have been high, but in line with projections of about \$1 billion for fiscal year 2009. This implies a cost of about \$2,000 per newly insured person, which is very low by the standard of other options for increasing health insurance coverage.

Universal Coverage and Inequality

Single-payer and “incremental universalism” are just two examples of models that can lead the United States to universal health insurance coverage. Yet these two models, as well as other alternatives, can have very different implications for the *inequality* of health outcomes in our society. Indeed, the primary concern for advocates of universal coverage should be this level of inequality. For the most advantaged members of society today, both health care and health outcomes are excellent; for example, the white infant mortality rate in the United States is comparable to rates in other developed nations. The fundamental problem with the U.S. health system, and the one reflected in our poor international comparisons, is the terrible outcomes of the most disadvantaged members of society: the black infant mortality rate in the United States is twice the white rate, and is higher than the rates in either Barbados or Malaysia.

In this essay, I step back to discuss the determinants of health inequality and how it plays into the structure of universal coverage. Health status inequality in any nation will be the product of several factors. The first, and most important, is inequality in non-medical factors. This ranges from nutrition to exercise to smoking to safety, and is largely beyond the influence of the medical system. These non-medical sources of inequality should be the primary focus of any campaign to reduce health disparities. Perhaps the single best source of improvement in the health of Americans over the past 50 years has been the reduction in cigarette smoking, and a serious gun control policy might do as much or more for the health of Americans as any expansion of insurance coverage. Although these issues around non-medical inequality are both important and fascinating, they are beyond the purview of this article.

Of the remaining health inequality that is amenable to medical intervention, the three factors that matter are uniformity of *coverage*, uniformity of *access*, and uniformity of *quality*. By uniformity of coverage, I mean uniformity in the comprehensiveness with which medical care is covered by insurance, and the costs that individuals have to pay out of pocket to use that care. By uniformity of access I mean uniformity in the availability of nearby physicians and hospital care. And by uniformity of quality I mean uniformity in the skill level of the providers to which individuals have access.

In practice, it is infeasible to achieve perfect uniformity along all three of these dimensions. Consider uniformity of access. Given the enormous differences in population density in

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countries such as the United States, it would be incredibly inefficient to guarantee every citizen a physician within 5 miles of his or her home, or even perhaps within 25 miles.

Minimum Standards

So the question becomes: What should developed nations strive for as standards in these areas? I believe that the right approach is to move toward an explicit two-tier medical system, whereby society sets minimum standards in each of these areas, but then allows individuals to buy higher coverage, access, or quality using their own resources. In fact, such is the approach used by most single-payer nations that have an explicit national health program: They allow individuals to buy extra insurance or care using their own funds.

But this is not the approach currently used in the United States. There are no explicit standards for what constitutes minimum acceptable standards for coverage, access, and quality. As a result, we have many individuals falling below any reasonable acceptable minimum in each category, while most others end up subsidized to levels well above such minima. This extremely unequal patchwork system must be reformed. At the same time, it is fiscally impossible to bring every American up to the highest standard of coverage, access, and quality. Therefore, the question becomes: What is an acceptable minimum standard that can form the basis for a two-tier system?

The best example of this issue is the generosity of insurance coverage. Forty-seven million Americans have no health insurance coverage, and that figure is only going to grow due to recent economic hardships. Yet the vast majority of the remaining Americans actually have *too much* insurance coverage, in that they are induced to use medical care beyond the point where it is cost effective. This is clear from the famous RAND Health Insurance Experiment of the 1970s. In this experiment, individuals were randomly assigned to plans with more or less individual cost-sharing; some received health care for free, while others had to pay 95 percent of the costs up to an out-of-pocket limit that was roughly \$5,000 in today's dollars. As one might expect, the individuals who were less comprehensively covered used less health care; for example, those for whom health care was free used 50 percent more care than those who had to pay 95 percent of the costs. What was more surprising was that, on average, they were in no worse health. That is, the marginal health care utilization that was induced by more generous insurance coverage did not improve health.

Why do individuals typically have insurance coverage that covers care that does not seem to improve health? There are a variety of reasons, but one is that the government subsidizes them to do so. Individuals who receive their health insurance through their employers pay taxes on their wages but not on the value of their health insurance. This tax subsidy, which amounts to foregone revenues to the government of over \$250 billion/year (making it the third largest health care program in the United States), induces individuals to purchase excessively generous insurance coverage.

Given these facts, how should health insurance coverage be reformed to increase equality in a fiscally responsible manner? First and foremost, all citizens must be guaranteed some form of insurance coverage. But that base level should be no more generous than is

necessary to produce health efficiently. This would be achieved by a plan that made individuals pay their up-front costs of health care, but with an out-of-pocket maximum that is income-related so no family is bankrupted by their health care needs.

At the same time, the government should allow individuals who wish to purchase more generous coverage to do so. Without this “escape mechanism,” there will be enormous pressure to continually ratchet upward the generosity of the base level to meet the needs of higher-income individuals who prefer, and can afford, to be over-insured. However, a key change must be to end government subsidies to insurance coverage that are above that base level: If higher-income individuals want to buy more generous coverage, they should be allowed to, but not with government-subsidized dollars. Such a two-tier system can then ensure that all have cost-effective insurance coverage, while also reducing government expenditures on health care.

Another example of an explicit two-tier approach is with respect to quality of care. As researchers at Dartmouth and elsewhere have emphasized, there are enormous discrepancies in the quality of care that is delivered around the United States. For example, sensible preventive measures, such as the use of beta blockers after a heart attack, are ignored by a sizeable share of primary care doctors and specialists around the nation.

A clear move toward equality in health would be to both penalize poor-quality care and reward high-quality care through reimbursement incentives. Once again, society must address the key question of a minimum level of quality that it is willing to accept for all citizens. Having defined that, both public and private insurers need to pay providers only if they meet those minimum standards. Such “pay for performance” measures are slowly being adopted in the United States, but in a haphazard way. Once again, however, insurance plans may adopt higher standards for quality and charge more as a result. Individuals who want to pay more for such plans should not be restricted from doing so, but should not be subsidized in any way for those purchases.

In summary, the United States could move to a health care system that is much more equal—but it is impossible, and impractical, to demand perfect equality of health outcomes, or even of health insurance inputs. Rather than hold out for perfect equality, the focus of action should be in two areas. The first is defining a universally accepted minimum, then ensuring that all citizens receive that minimum, be it with respect to health insurance generosity, quality of care, or other features. The second is to allow individuals to purchase above that minimum—but not to subsidize such purchases through the government. Any public resources devoted to this problem should be devoted to financing an acceptable minimum, not to promoting choices beyond that level.

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