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"Medicover": A Proposal for National Health Insurance

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"MEDICOVER": A PROPOSAL FOR NATIONAL HEALTH INSURANCE

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INTRODUCTION

On October 28, 2006, a group of health policy experts participated in a workshop at Case Western Reserve University School of Law to design a program to provide affordable health insurance for all Americans. The result was "Medicover."

The discussion proceeded from seven working assumptions:

1. All Americans must have access to affordable health insurance.
2. The private sector by itself cannot provide this.
3. Nor can the states.
4. The more the government restricts private choice, the less likely that a health insurance program will be adopted.
5. People dislike creating new bureaucracies.
6. The most efficient administrative system for health insurance is Medicare.
7. Any new program administered by Medicare must not interfere with the existing Medicare program.

The result was a program with the following key features:

1. Congress should create and Medicare should administer a new federal health insurance program.
2. Health insurance under the program should be available to anyone who wants or needs it.

[†] The workshop was made possible by the generosity of Peter Weinberger, a member of the firm of Spangenberg, Shibley & Liber LLP and a graduate of Case Western Reserve University School of Law, and by his fundraising efforts, which led to support from the law firms of Baker Hostetler and Porter Wright Morris & Arthur LLP. Additional funding was provided by the School of Law through the Law-Medicine Center, which hosted the workshop. The author would like to thank Gary Broadbent for his research assistance.

3. While the new program should be administered by Medicare, it should not reduce the benefits of or the funding for the current Medicare program.
4. The new program should be voluntary.
5. The new program should provide an adequate package of basic benefits.
6. The new program should employ best practices to keep costs down.
7. Those who can afford it should pay premiums, based on ability to pay.
8. Those who cannot afford to pay full premiums should be subsidized by the government.
9. States should be permitted to enroll their Medicaid beneficiaries in the program upon payment of suitable premiums.
10. Employers should be permitted to enroll employees in the program upon payment of suitable premiums.
11. Since the new program would be administered by Medicare and would provide health insurance coverage, its name would be "Medicover."

This Article provides a description of the events leading up to the workshop, the discussion that took place, and the proposal that emerged. The proposal is intended to be a discussion document rather than a final product. It needs greater detail, a clearer sense of its costs and financing mechanisms, and input from stakeholders. Nevertheless, the workshop participants believe that Medicover may be a viable option for helping to solve the current health care crisis.

I. THE CURRENT HEALTH CARE CRISIS

One of the gravest crises facing the United States today is the state of our health care system. The facts are not in dispute: The price of health care is increasing at almost three times the rate of inflation.[1] Nearly 46 million Americans are uninsured, an increase of 6 million since 2000.[2] Fewer employers, the source of health insurance for most Americans, are offering it to their employees.[3] An additional 16

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[1] *See* Cynthia Smith et al., *Trends, National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending*, 25 HEALTH AFF. 186, 186, 193 (2006).

[2] CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004 16 (2005), *available at* http://www.census.gov/prod/2005pubs/p60-229.pdf.

[3] *See* Sherry A. Glied & Phyllis C. Borzi, *The Current State of Employment-*

million Americans are considered "underinsured" based on their high out-of-pocket expenses relative to their incomes.[4] "[T]wo of five Americans—insured and uninsured alike—have trouble paying their medical bills or have accrued [significant] medical debt."[5] People who lack adequate health insurance have difficulty managing chronic conditions and are much less likely to get preventive care. When they do receive care, it is frequently in the emergency room, the most expensive form of primary care. Lack of health insurance leads to an estimated 18,000 excess deaths each year.[6] In addition, the impact of this situation reaches far beyond the circumstances of any individual family: a recent Commonwealth Fund study estimates that health problems among working-age Americans and their families cost an estimated $260 billion in lost productivity each year.[7]

At the same time, the United States is the only industrialized country that lacks a comprehensive national health insurance program. This demonstrates that providing affordable access to an adequate package of health care benefits clearly is feasible. Jost's article offers a number of explanations for why the U.S. has not followed the path of the rest of the world:

> Explanations tend to focus on five factors, each of which seems to play a role, though commentators disagree on their relative importance: U.S. political institutions; the U.S. social culture and character; a weak left and the limited strength of unions in the U.S.; the political power of provider and insurer interest groups; and the strength of path dependency.[8]

Based Health Coverage, 32 J.L. MED. & ETHICS 404 (2004).

[4] Cathy Schoen et al., *Insured But Not Protected: How Many Adults Are Underinsured?*, HEALTH AFF., June 14, 2005, http://content.healthaffairs.org/cgi/content/long/hlthaff.w5.289/DC1; *see also* SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, GAPS IN HEALTH INSURANCE: AN ALL-AMERICAN PROBLEM 15, 20 (2006), *available at* http://www.cmwf.org/usr_doc/Collins_gapshltins_920.pdf (twenty-eight percent of all working-age adults reported being underinsured in 2005).

[5] THE COMMONWEALTH FUND, HEALTH INSURANCE: AN OVERVIEW, http://www.cmwf.org/General/General_show.htm?doc_id=318887 (last visited Mar. 13, 2007); *see also* MICHELLE M. DOTY ET AL., THE COMMONWEALTH FUND, SEEING RED: AMERICANS DRIVEN INTO DEBT BY MEDICAL BILLS 3 (2005), *available at* http://www.cmwf.org/usr_doc/837_Doty_seeing_red_medical_debt.pdf.

[6] INSTITUTE OF MEDICINE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 163 (2002).

[7] KAREN DAVIS ET AL., THE COMMONWEALTH FUND, HEALTH AND PRODUCTIVITY AMONG U.S. WORKERS 4 (2005), *available at* http://www.cmwf.org/usr_doc/856_Davis_hlt_productivity_USworkers.pdf.

[8] Timothy Stoltzfus Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED. & ETHICS 433, 437 (2004).

Perhaps it would be desirable if these factors did not exist. But the U.S. cannot solve its health care crisis by pretending that they do not.

These realities impose a number of constraints on the possible solutions. A single-payer system is likely to be the cheapest and the most equitable, which is why it is the model for most of the rest of the world. But the private health insurance industry, which wields enormous political power, is no more likely to allow itself to be eradicated now than during the Clinton health reform initiative of the early 1990s. Some large employers, moreover, believe that they can obtain a better deal on group health benefits from private insurers than from the government. Americans do not seem willing to deny themselves the right to purchase health care on the private market. Consequently, any proposal for solving the insurance crisis must accommodate private insurance. Finally, Americans hate being forced to do things by the government. They prefer to govern their own lives, even if the decisions they make prove unwise or cause them harm.

These attitudes not only doom the creation of a single-payer system, but also most proposals for government-run national health insurance. Several Democrats have urged adoption of "Medicare-for-All," which would eliminate private health insurance and require everyone to enroll in Medicare.[9] In August of 2006, Congressman Stark introduced a bill to establish "Americare," which would require all Americans to purchase a health insurance plan approved by the government.[10] Neither of these proposals stands much chance of being adopted. Massachusetts recently passed a law creating a program to insure all state residents. Governor Schwartzenegger has proposed a similar plan for California.[11] The details of these programs have yet to be worked out, and it is not clear if they will survive the need for various restrictions and financing charges. In any event, the wide disparities in state resources mean that many states will be unable to afford a comparable system. Unless the nation is prepared to accept a patchwork of state-by-state health insurance plans with significantly different degrees of coverage, including some states that have no programs at all beyond Medicaid, state action is not the solution.

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[9] United States National Health Insurance Act, H.R. 676, 109th Cong. (2005); *see also* Robert Pear, *The Health Care Debate: The Legislation; Bill Passed by Panel Would Open Medicare to Millions of Uninsured People*, N.Y. TIMES, July 1, 1994, at A12.

[10] AmeriCare Health Care Act of 2006, H.R. 5886, 109th Cong. (2006).

[11] Press Release, Governor of California, Gov. Schwarzenegger Tackles California's Broken Health Care System, Proposes Comprehensive Plan to Help All Californians (Jan. 8, 2007), *available at* http://gov.ca.gov/index.php?/press-release/5057/.

A uniquely American approach might be to rely on the private sector to solve the crisis. But the private sector has tried without success to do this for the past fifty years. Community-rated, not-for-profit hospital and physician plans that emerged in the 1930s could not compete with commercial, for-profit companies, which led to fragmentary rather than population-wide insurance delivered at high administrative cost. Employer-based group insurance filled the breach in many cases but has become so expensive that it is being offered by fewer and fewer firms, while small employers and self-employed individuals are priced out of the health insurance market unless their risk factors make them unlikely to require health care in the first place. In the 1980s and '90s, the private sector experimented with managed care to restrain spending, which essentially shifted insurance risk from insurers to providers. This failed when health care professionals and their patients resisted attempts by managed care plans to place them in an adversarial relationship in order to constrain the consumption of health care services. The latest effort by the private sector is "consumer-driven health care." The theory is that health care costs can be controlled by making "consumers," *i.e.*, patients, pay a significant portion of their health care expenses, thereby giving them an incentive to be frugal. This is merely another attempt by third-party payers to shift risk away from themselves, with the bizarre twist that it is now the patients themselves, rather than insurers, employers, or health care professionals, who are expected to make wise purchasing decisions. Yet, no one has explained how patients—especially those who are seriously ill—have the knowledge, expertise, time, and emotional fortitude to make such choices, and the result is bound to be a health policy disaster. The only explanation offered by the private sector for this succession of failures is goverment interference: If its hands had not been tied by government regulation, the market would have been more successful. But in this, market proponents make the same error as advocates of a single-payer system—the nation is no more likely to eliminate public constraints on the private sector than it is to eliminate the private sector itself.

Against this backdrop, the options for effective change are limited, but they do exist. What is necessary is a voluntary, federally-run program that assures patients an adequate package of affordable health care services, keeps administrative costs low, and controls costs without making physicians adversaries toward their patients.

This rules out one often-made suggestion: that the federal employee health insurance program be made available to persons who are not federal employees. This program is not run by the federal government but by private insurance companies such as Blue Cross/Blue Shield. It does not provide an adequate package of services, and the

scope of coverage is constantly shrinking. It does not effectively control its costs, despite utilizing a full range of cost control techniques. Consequently, premiums are constantly rising.

One option would be to create a new government bureaucracy to administer this program. This was the thrust of the Clinton health reform initiative. It planned to establish an extensive set of new agencies at both the state and federal level. This feature was seized upon by opponents, chiefly the private health insurance industry, as too much government and was one of the main reasons the initiative failed. People do not like big bureaucracies, and they especially do not like to create new ones.

Fortunately, there is no need to. Unquestionably, the best-run insurance program in the country is Medicare. Its administrative costs are the lowest, averaging approximately three to six percent, as compared with an average of twelve to thirteen percent for private plans.[12] Its beneficiaries are generally highly satisfied with how it functions. The only significant administrative problems with Medicare have occurred in connection with the new Part D drug plan, and this is due to Congress's misguided attempt to delegate the bulk of the administrative responsibilities to private insurers.

The workshop, therefore, concentrated on designing a new, federal health program open to all Americans and administered by Medicare.

II. WORKSHOP PARTICIPANTS

In addition to myself, the following experts participated in the workshop:

- Timothy S. Jost, Robert L. Willet Family Professor of Law, Washington and Lee University School of Law.[13]

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[12] JEFF LEMIEUX, CTR. FOR POLICY & RESEARCH, AM.'S HEALTH INS. PLANS, PERSPECTIVE: ADMINISTRATIVE COSTS OF PRIVATE HEALTH INSURANCE PLANS, http://www.ahipresearch.org/pdfs/Administrative_Costs_030705.pdf (last visited Mar. 14, 2007) (noting that Medicare's low administrative costs of three to six percent may not be comparable to the private sector for various reasons, including the fact that the administrative costs do not include the cost of capital to service Medicare, which alone might increase the actual cost by about seven percent).

[13] Professor Jost was named Willett Professor of Law in 2001. Earlier, he was Newton D. Baker, Baker & Hostetler Chair of Law and Professor at the College of Medicine and Public Health at Ohio State University. From 1987 through 1992, he was a member of the Ohio State Medical Board. He is an expert on comparative health law and author of numerous articles and books, including: TIMOTHY STOLTZFUS JOST, HEALTH CARE COVERAGE DETERMINATIONS: AN INTERNATIONAL COMPARATIVE STUDY (2004), Timothy Stoltzfus Jost, *Our Broken Health Care System and How to*

- Theodore Marmor, Ph.D., Professor of Public Policy and Management, Professor of Political Science, Yale University.[14]

- Marilyn Moon, Ph.D., Vice President and Director of the Health Program, American Institutes for Research.[15]

- J.B. Silvers, Ph.D., Elizabeth M. & William C. Treuhaft Professor of Health Systems Management, Professor, Banking and Finance, Weatherhead School of Management, Case Western Reserve University.[16]

Fix It, 41 Wake Forest L. Rev. 537 (2006), and Timothy Stoltzfus Jost, *Why Can't We Do What They Do? National Health Reform Abroad,* 32 J.L. MED. & ETHICS 433 (2004).

[14] Professor Marmor's scholarship focuses on welfare state politics and policy in North America and Western Europe, with emphasis on major spending programs. He authored THEODORE R. MARMOR, THE POLITICS OF MEDICARE (Aldine Transaction, 2d ed., 2000) and, with Mashaw and Harvey, THEODORE R. MARMOR ET AL., AMERICA'S MISUNDERSTOOD WELFARE STATE: PERSISTENT MYTHS, ENDURING REALITIES (1990). Author or co-author of eleven books, Professor Marmor has published over a hundred articles in scholarly journals. Professor Marmor began his career as a special assistant to Wilbur Cohen (Secretary of HEW) in the 1960s. He was Associate Dean of Minnesota's School of Public Affairs, on the University of Chicago faculty, the head of Yale's Center for Health Services, a member of President Carter's Commission on the National Agenda for the 1980s, and a senior social policy advisor to Walter Mondale during the 1984 Presidential campaign. Professor Marmor received his Bachelor's Degree from Harvard College in 1960 and his Ph.D. from Harvard University in 1966.

[15] Marilyn Moon is a nationally-known expert on Medicare. She has also served as a Senior Fellow at the Urban Institute and as a public trustee for the Social Security and Medicare trust funds. Dr. Moon has written extensively on health policy, both for the elderly and the population in general, and on social insurance issues. Her most recent book, MARILYN MOON, MEDICARE: A POLICY PRIMER (2006), was published by the Urban Institute Press in 2006. From 1993 to 2000, Moon also wrote a periodic column for the Washington Post on health reform and health coverage issues. She has served on a number of boards for non-profit organizations and is currently President of the board of the Medicare Rights Center and is a board member for the National Academy of Social Insurance. She is a member of the Institute of Medicine of the National Academy of Sciences. Dr. Moon earned a Ph.D. in economics from the University of Wisconsin—Madison, where her work focused on the health and economic status of the elderly. Previously, she has been an associate professor of economics at the University of Wisconsin-Milwaukee, a senior analyst at the Congressional Budget Office, and the founding Director of the Public Policy Institute of the American Association of Retired Persons.

[16] J.B. Silvers has been on the Weatherhead faculty since 1979. He is also Professor of Epidemiology & Biostatistics at Case Western Reserve University School of Medicine. Professor Silvers teaches health finance, strategic financial management and value creation, and health policy and management decisions. His research focuses on health finance/insurance, pharmaconomics, mergers, and public

- Joseph White, Ph.D., Chair, Department of Political Science, Luxenberg Family Professor of Public Policy, Director of the Center for Policy Studies, Case Western Reserve University.[17]

III. ACHIEVING THE GOALS OF A MEDICOVER PROGRAM

The two days of discussion during the workshop centered on a number of key issues. What benefits should Medicover provide? Should the program impose the same limits on benefits as the Medicare program? If not, what effect would this have on Medicare itself? What would Medicover cost, and how would it be financed? How would the program control costs? How serious a problem would be posed by adverse selection, and how can it be prevented? Could Medicover compete effectively with private insurers? How should Medicover relate to employer-based health insurance? To Medicaid? What political realities would confront a Medicover proposal, and is it politically feasible?

Given the limited amount of time available during the workshop, few of the issues can be said to have been discussed fully, much less resolved. What follows is a summary of the discussion. Numbers in parentheses are references to pages of the official transcript of the

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policy. His book chapter, *The Role of the Capital Markets in Restructuring Health Care*, appeared in PETER J. HAMMER ET AL., UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE 156 (2003). He is the author of numerous scholarly articles on business and epidemiology. Professor Silvers received his B.S in Engineering (1965) and his M.S.I.A. (1966) from Purdue University. In 1971, he earned a Ph.D. from Stanford University. He serves on a number of boards for medical organizations, including the Joint Commission on Accreditation of Healthcare Organizations (Oakbrook Terrace, Illinois).

[17] Dr. Joseph White received his A.B. from the University of Chicago and M.A. and Ph.D. from the University of California, Berkeley. Dr. White's research has focused on American federal budget politics and policies; health care finance policy and politics; and "reform" of Social Security and Medicare. Among his books are JOSEPH WHITE, FALSE ALARM: WHY THE GREATEST THREAT TO SOCIAL SECURITY AND MEDICARE IS THE CAMPAIGN TO "SAVE" THEM (2001) and JOSEPH WHITE, COMPETING SOLUTIONS: AMERICAN HEALTH CARE PROPOSALS AND INTERNATIONAL EXPERIENCE (1995). He authored the entry on *National Health Care & Insurance Systems* in the INTERNATIONAL ENCYCLOPEDIA OF THE SOCIAL & BEHAVIORAL SCIENCES 10299-10303 (2001) and the entry on *The Cost of Health Care in Western Countries* in EDWARD J. BENZ, OXFORD TEXTBOOK OF MEDICINE (4th ed. 2003).

Also participating in the workshop was William J. Scanlon, Ph.D., Senior Policy Advisor, Health Policy R&D, who provided an introductory presentation on financing and cost issues and contributed to the discussion based on his experience with Medicare administration and payment policies.

workshop proceedings. The final section of this report identifies the numerous questions that remain.

One aspect of the workshop is striking, however. Relatively little concern was expressed about how Medicover would be financed and whether the nation could afford its price tag. In part, this is attributable to the preliminary nature of the proposal and the time limitations of the workshop. But more fundamentally, it reflects a consensus among the participants that the time is long past for this country to provide affordable health insurance for all. If every other advanced country can afford do so, so can we, the wealthiest country of all. Surely difficult questions remain about the extent to which employers would be expected to finance premiums for employees, how much individuals would be required to contribute on behalf of themselves and their families, and the nature and size of any necessary tax increases. One way or another, answers to these questions must be found. To some extent, as Professor Jost explained during the workshop, they can be gleaned from the experience of other countries. But the question can no longer be *whether* we can afford a national health insurance alternative. The only question now must be *how*.

A. What Benefits Should Medicover Provide?

One of the key features identified in advance for the Medicover program is that it "should provide an adequate package of basic benefits." Mindful of cost concerns, some health policymakers have advocated the creation of an inexpensive, bare-bones health insurance option for the uninsured. But the solution to the health insurance crisis should not be to create more people who are under-insured. The goal of Medicover should be to meet the needs of both the uninsured and the underinsured. The workshop agreed that a meaningful health insurance alternative must provide a comprehensive benefits package, including inpatient and outpatient care, physician and ancillary services, drugs and durable medical equipment, and home and hospice care.

Another issue tackled by the workshop participants was the need for Medicover to place a cap on individual out-of-pocket spending—often referred to as a "catastrophic cap" since it is likely to be triggered by an expensive, catastrophic episode of illness. Medicare has no such cap. Due to deductibles, co-insurance, co-payments, premiums, and lifetime limits, the average Medicare beneficiary currently pays about forty-five percent of his or her health care costs out-of-pocket (207). The closest thing to caps under Medicare is the ability to deduct health care expenditures from federal income taxes if they exceed seven and a half percent of adjusted gross income and to qualify

for Medicaid once the individual has exhausted virtually all of his or her assets. Many Medicare beneficiaries become impoverished as a result. In contrast, the German system pays all health care costs once individual spending exceeds two percent of income. The workshop participants did not specify what the Medicover cap should be but agreed that one was necessary.

There was considerable discussion about whether or not to include Part C of Medicare in Medicover. Part C, originally called Medicare+Choice and now "Medicare Advantage," was added in 1997 as an effort to privatize Medicare by permitting beneficiaries to contract with private health insurance plans for their Medicare benefits. Part C authorizes both managed care plans and private versions of the traditional Medicare fee-for-service approach. The workshop participants strongly felt that Part C should not be included in Medicover because its plans fail to achieve the administrative savings of the Medicare program itself (409).

Finally, the workshop participants mentioned the need to consider whether Medicover would provide long-term care (nursing home) benefits but did not discuss the issue in detail (412).

B. What Would Medicover Cost?

As noted above, there was relatively little concern about whether Medicover would be affordable. Nor did the workshop make a serious attempt to calculate how much the program would cost. One participant estimated its cost at between $40 and $70 billion a year, but only if all current expenditures for the uninsured, including the money spent on community health clinics and uncompensated care, and the funds that providers recoup by shifting the costs of the uninsured to the insured, could be captured and the funds added to the Medicover budget. But the participants acknowledged that this would be extremely difficult to achieve (425-26). One heartening point about costs was the observation that public programs already provided coverage for the most expensive patient population, namely, Medicare beneficiaries (291). This segment of the population accounts for seventeen percent of total health care spending.[18]

C. How Would Medicover Contain Costs?

A key feature of Medicover would be the use of "best practices" to control costs. The workshop participants agreed that Medicover

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[18] THE HENRY J. KAISER FAMILY FOUND., MEDICARE: MEDICARE SPENDING AND FINANCING (2005), *available at* http://www.kff.org/medicare/upload/7305.pdf.

needed to do a better job of containing costs than Medicare, but time constraints did not permit an extensive discussion of what cost controls should be employed. Participants noted the need for limitations on both the price and the volume (or "intensity") of services, since, as the experience with Medicare's efforts to restrain physician payments has shown, fee limits alone cannot check spending (412). An additional type of cost control would be restrictions on Medicover expenditures, such as annual global budgets for providers or payment adjustments based on targeted rates of growth. There was also discussion of the need for limitations on coverage, including requiring that new, costly technologies demonstrate not only that they are safer or more effective than existing alternatives, but that they are more cost-effective, that is, that they are the least expensive means to achieve a desired outcome. Moreover, unlike Part D, the new Medicare drug benefit, Medicover should have the authority to negotiate prices with drug manufacturers, which most likely would require use of a drug formulary to limit access to drugs whose manufacturers refused to give the program a sufficient discount on price.

D. How Would Medicover Be Financed?

The workshop addressed a number of elements of Medicover financing. Individuals would pay premiums on the basis of ability to pay (421). Premiums would be subsidized for those who could not afford to pay the full premium but effectively also for those who were ill or at high risk of illness and who, therefore, could not afford to pay the high premiums that they would be charged by private insurers (257). There was considerable debate about whether premiums should be set according to a person's income or some other measure, such as wealth (252). The former is administratively simpler but less progressive, favoring persons with large amounts of non-income-generating assets. It was noted that both Medicaid and Part D of Medicare employ asset tests (394). One option is to place a ceiling on how much income or wealth would be counted for purposes of calculating Medicover premiums, similar to the cap on income for paying FICA taxes (260).

There was interest in the capitalized system used in Germany, in which an individual's premiums are placed in an interest-bearing account so that they decline over time. If individuals were required to pay deductibles, co-payments, or co-insurance, these should be assessed on a lump-sum basis rather than piecemeal for each type of care, as under Medicare, and the amount of cost sharing should vary on the basis of the patient's ability-to-pay (423-24). There was discus-

sion of the problem of insuring illegal aliens, but no solution offered (387).

E. Adverse Selection

One of the most troublesome threats to a voluntary program like Medicover is adverse selection. This occurs when individuals refrain from purchasing insurance until they are ill and then drop it once they recover. It also occurs when individuals or firms drop private insurance in order to take advantage of premium subsidies under the public program. The more this occurs, the more those paying full premiums under Medicover will be persons requiring health care and the less it will be healthy individuals whose premiums can help pay for that care. Adverse selection is a dynamic effect in that premiums increase as the proportion of enrollees who require health care increases, which in turn drives up premiums even further. This phenomenon, known as the insurance death spiral, ultimately destroys the insurance plan because insureds pay for their care in full.

Medicover will face this threat so long as enrollment is voluntary. Healthy individuals either will not purchase health insurance at all or will obtain more favorable rates from private plans. The only people who will enroll in Medicover are those who cannot afford private insurance or who would have to pay more for private insurance than for Medicover.

The classic solution to the problem of adverse selection is to require everyone to be insured under the program, but this violates the basic objective that Medicover should be voluntary. So does the partial response of requiring everyone to have some form of health insurance. One other approach is to make people help finance Medicover whether or not they enroll. Enrollment in Medicover would remain voluntary but paying for it would not. This is similar to the Australian system (235). Another alternative is the German system of capitalized premiums, mentioned earlier, where the longer individuals delay enrolling, the higher their premiums will be. In order to discourage people from enrolling in Medicover when they need health care and then dis-enrolling when they become well, Medicover could also emulate the German system, which prevents persons from re-enrolling in the public health insurance program once they leave it (199).

Another problem created by making Medicover voluntary is the risk that lower-wage employers who previously helped pay for health insurance for their employees will cease to do so in the expectation that their employees will obtain subsidized coverage under Medicover. This may be less of a problem in the future as fewer low-wage employers provide health insurance to their employees, but it will still

be a threat. The solution again is either to make employers pay for Medicover whether or not they provide it to their employees or at least to require some payment by employers who drop private insurance once Medicover becomes available.

On the other hand, the workshop participants acknowledged that it is difficult, if not impossible, to predict the amount of adverse selection that would occur or its impact on the financial viability of a Medicover program. The workshop participants, therefore, decided that, rather than establish mechanisms in advance to deal with adverse selection that might turn out not to be a serious problem, it made more sense to require the program to monitor the problem and take steps to reduce it in the future if they became necessary (401).

F. Cherry-Picking

Another basic premise of Medicover is that it would provide an alternative to, rather than a replacement for, private health insurance. This leaves the private sector free to "cherry-pick," that is, to offer low-cost plans to healthy segments of the population, thereby drawing these groups away from the Medicover pool of insureds. In a sense, this makes Medicover a high-risk pool, insuring those who are not sufficiently profitable for the private sector.

The workshop participants had no problem with the private sector selling supplemental insurance to Medicover enrollees for items and services that Medicover did not cover and, since Medicover itself presumably would pay for all medically necessary care, participants saw no need for the premiums for these policies to be subsidized for those less able to pay (416). However, it might be necessary for the government to limit and standardize the supplemental policies that could be sold to prevent the confusion and duplication of coverage that characterized the market for Medigap policies prior to government intervention (415).

One way to deal with cherry-picking would be to require private plans to help finance Medicover. Another approach, which was part of the Clinton reform proposal, would be to subsidize private plans in return for insuring higher-risk individuals. As in the case of adverse selection, however, the degree and effect of cherry-picking cannot be ascertained in advance. It is quite possible that enough people will enroll in Medicover that it would have enough purchasing power to compete effectively with smaller private plans by negotiating price discounts from providers. Therefore, the participants agreed that Medicover should monitor cherry-picking and only adopt mechanisms to deal with it if it became problematic.

G. Employers

Employers would be permitted to buy Medicover for their employees. There was extensive discussion of how to calculate employer premiums. Experience-rating was rejected on the basis that it would discourage employers from hiring employees with disabilities or other high-risk factors (383). But participants thought that rates could vary according to the sex and age of employees and the type of industry. If an employer provided Medicover, it would have to cover all employees (402). Employees could be required to pay a portion of the premiums by having it deducted from their wages (271). The workshop considered, but did not resolve, whether Medicover should employ a play-or-pay type of mandate in which employers who did not enroll their employees would have pay a Medicover tax to help finance Medicover.

H. Medicare

A core objective of Medicover is that it is not seen as a threat to the current Medicare program, lest it excite opposition from powerful lobbying groups representing seniors. Accordingly, the financing for Medicover should not come from resources that are necessary to sustain Medicare. As the workshop unfolded, however, it became clear that a number of recommendations were being put forward that would render Medicover more generous in certain respects than Medicare (415 ff.). These included placing a limit on the amount of out-of-pocket expenditures by enrollees and subsidizing enrollees who could not afford to fully pay deductibles, co-payments, and co-insurance. Ideally, these features would be added to Medicare. But the participants were cognizant that budget concerns might make that unrealistic, in which case Medicover would face pressure to abandon these features despite their desirability.

I. Medicaid

States should be permitted to terminate their Medicaid programs in favor of enrolling Medicaid-eligibles in Medicover. In that case, the state would transfer its Medicaid budget to the Medicover program, while the federal government would transfer to Medicover what it would have contributed to pay for the former state program.

J. Political Realities

No health reform proposal is a good proposal if it does not stand a chance of being adopted. The Medicover proposal contains a number of features that some might not regard as ideal, such as being volun-

tary and not being accompanied by an individual or employer health insurance mandate. Medicover is not a single-payer system. It is an incremental change. At best, it will not solve the entire problem posed by the lack of universal health insurance.

These ostensible shortcomings are part of the proposal for a reason, however. They are intended to give the proposal a chance at life. At the least, the workshop participants felt that the proposal deserves to be developed further and to play a role in the growing national debate that will culminate in calls for action during coming presidential elections.

The workshop was heartened by the lessons from abroad. Medicover has analogues throughout the world. Typically, countries have moved toward universal health insurance incrementally, and, characteristically, they have relied on a combination of public and private insurance in doing so.

The concluding session of the workshop explored the political landscape for health insurance reform and how Medicover would fare in the political arena. One source of opposition is bound to be the drug industry, which will feel threatened by the prospect of lower drug prices as the result of Medicover's negotiating strength. Yet it is likely that by the time Congress addresses Medicover, Medicare itself will have been given the authority to negotiate drug prices under Part D. The major opposition to Medicover would come from the private health insurance industry and from market advocates who reject government as the solution to the health insurance crisis. One of the key objectives of making Medicover voluntary is to blunt the objections of private insurers. Medicover will not force anyone to abandon private insurance and, unless it turns out to be necessary down the road, will not interfere in any way with the ability of private insurers to offer better terms to segments of the population at lower risk for ill health. Those who promote competition as the way to restrain prices can consider Medicover as a means of injecting a dose of real competition into the health care system. If private insurers compete effectively, they will continue to thrive. However, it will be clear to the private sector that Medicover may grow sufficiently large that it gains far greater bargaining power than individual private insurers. Eventually Medicover may "crowd out" much of the private insurance sector. Opposition from that sector may be somewhat weakened by some of Medicover's features, but it will still be fierce.

It is critical, therefore, that the Medicover proposal garners the support of interest groups powerful enough to offset its opponents. Unfortunately, those who would most benefit from such a program—the un- and under-insured—lack an organized political voice. The one exception is self-employed individuals, who wield influence through

various independent and small business trade associations (447). Support for Medicover may come from unions, who may see it as a partial solution to the loss of employment-based health benefits (446). Organized social progressives would be supportive if they were willing to set aside their preference for more comprehensive change. Fiscal conservative groups might get behind the proposal if they felt that it would help rein in health care spending (349). Other potential key allies are health care providers. The question is whether they would be frightened off by Medicover's cost controls or would see the program as a source of greater revenues by financing access to health care for patients who do not now receive adequate services or cannot pay for them (307).

A final key source of support for Medicover, however, could be large employers (343). They might endorse the program if they viewed it as a cost-effective method of promoting a healthy workforce and as the best way to avoid more draconian insurance mandates. It, therefore, is critical that large employers be part of the coalition that designs and backs the proposal.

IV. WHERE TO GO FROM HERE

The October 2006 workshop was only the first step in what has to be an extended process. It has produced the bare bones of a proposal, to which critical details must now be added. Among the details are such central features as how Medicover would be financed, how it would control spending, and how much it can be expected to cost.

It is also noteworthy that the workshop presenters were all health policy experts rather than stakeholder representatives. None were physicians, hospital administrators, or health insurers (although one person, J.B. Silvers, had previously served as the chief executive of a managed care plan). There were no business owners, union officials, or corporate officers. These stakeholders now need to be brought into the process so that their suggestions are considered and their objections noted and, ideally, addressed.

The next steps, thus, are clear: to continue to flesh out the Medicover program and to present a more complete plan to a convocation of key constituents. In the meantime, you can play a role by directing any comments or suggestions to me at The Law-Medicine Center, Case Western Reserve University School of Law, 11075 East Boulevard, Cleveland, Ohio 44106, or e-mail me at mjm10@case.edu.