

Are We Headed Toward Socialized Medicine?

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April 16, 2008



Overview

Goals of paper

- assess the claim that health reform proposals will lead us to “government run” health care or “socialized medicine.”
- attempt to classify health systems by extent of government role and come to working definition of socialized medicine
- examine how different proposals, with different levels of government involvement, affect choice, costs, access, quality

Conclusions

- Most assertions that the U.S. is headed to socialized medicine are exaggerated and out of date and, more importantly, not helpful
- Most proposals have significant, though different, roles for government in financing and regulating health care
- Limits on choice, access and quality can occur in government run plans, largely because of inadequate funding, but these issues also can arise in market oriented plans

A Classification System

1. Fully Public – government finances care and provides services
2. Public Contract/Providers – government contracts with and pays private providers
3. Public Contract/Private Insurers – government contracts with insurers who compete for enrollees and pay for services
4. Private Insurers/Private Providers – business and individuals contract with insurers who contract with and pay providers

The U.S. System Today

1. Fully Public – the VA
2. Public Contract/Providers – fee for service
Medicare and Medicaid
3. Public Contract/Private Insurers – Medicare
Advantage, Medicaid for families, SCHIP
4. Private Insurer/Private Provider – most of U.S.
health system

Government Financing and Regulation

Financing –

- Medicare (42m) and Medicaid (43m)
 - FEHBP (9m)
 - VA, active duty military (4m)
 - Tax subsidies
 - employer exclusion (165m)
 - self employed (3m)
- * All but 5% of U.S. population with insurance receives government assistance, either directly or through tax subsidies

Regulation –

- generally to increase the pooling of risk

Health Reform Would Change Public And Private Responsibilities

- Mainstream Democratic Proposals –
 - models II and III
 - would increase government financing and regulation – but would not be government run systems
- Kucinich style plans – little appeal at national level
- Republican proposals – model IV
 - would increase subsidies to allow purchase in individual insurance markets
 - considerable redistribution of income
 - reduce market regulation
 - significant role for Medicare and Medicaid

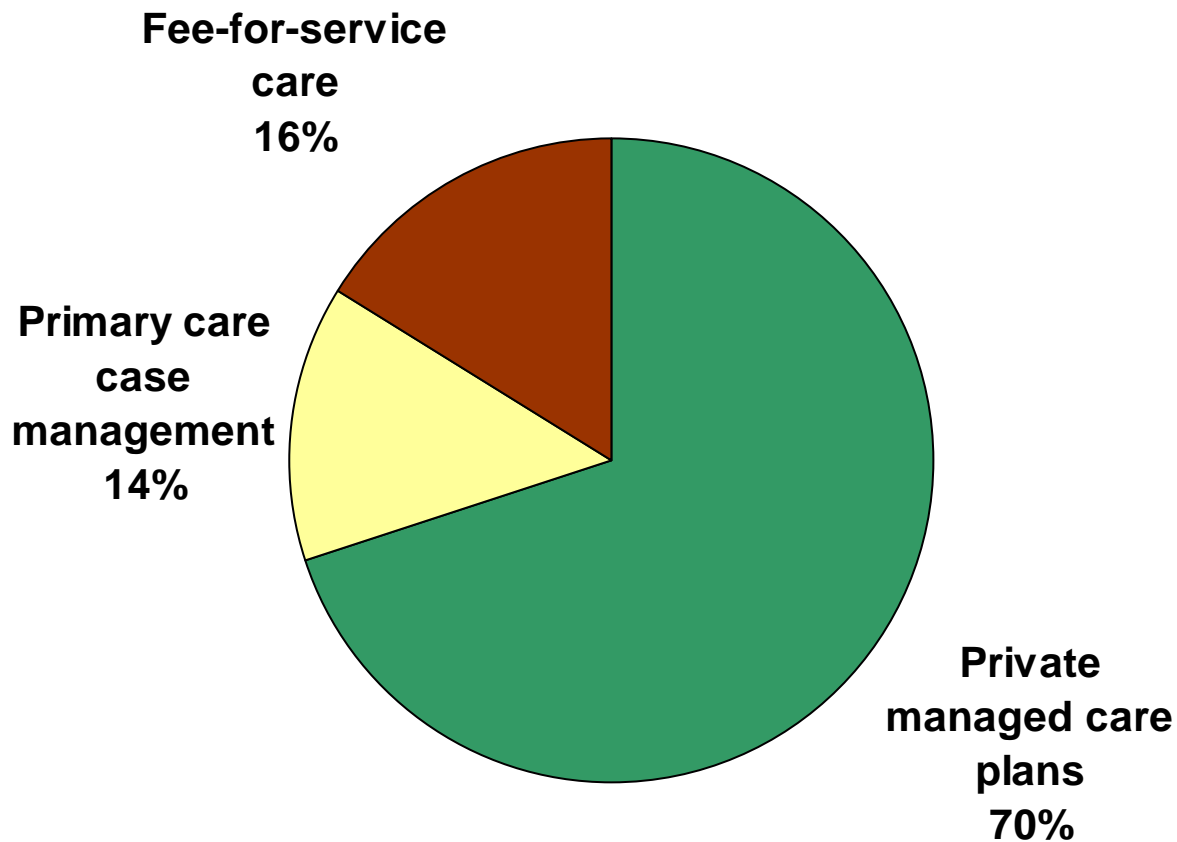
Concerns About Government Role

- Absence of choice
 - “a patient should always be able to spend his own money on the health care services he desires. Yet that freedom is often threatened or denied when government tries to provide universal health insurance coverage...” K.M. Brown (Cato), 2007.
- Poor quality and access – rationing, waiting lists
 - “government-run health care” leads to “rationing, inefficiency, and long waiting lines.” President Bush, 2007.
- Centralized decision-making means errors can have more serious consequences

SCHIP Reauthorization

- Model III: Public contract/private insurer
- Pluralistic decision-making structure
 - State – substantial flexibility, more than Medicaid
 - Private insurers
- No dominant role – SCHIP would cover less than 10% of all children in 2012

Children Enrolled In SCHIP, By Type Of Coverage: 2005



Source: McInerney 2007.

SCHIP: Choice And Access

- Employer-sponsored insurance (ESI) today
 - 49% of workers offered ESI have a choice of >1 plan
 - Below \$20,000 in income, only 37% have choice
- SCHIP – choice of private plans available in:
 - 15 of 24 Medicaid/SCHIP programs
 - 17 of 28 SCHIP stand-alone programs
- SCHIP greatly improved access to care for previously uninsured children
- SCHIP vs. private coverage (low-income)
 - Primary care: equal or better access
 - Specialty care: low reimbursement can create access barriers

Main Proposals From Democratic Candidates (like Mass plan)

- Health insurance exchange – new option to choose among competing private plans
 - Some proposals include public plan
 - Diverse cost-sharing and provider networks
- Subsidies for low-income enrollees
- Individual and employer mandate – varies by proposal

These Are Not Socialized Systems

- Model III: Public contract/private insurer
 - Private insurers, private providers
 - Exception: public plan as competitor
- Pluralistic decision-making structure
 - Private insurers – key role
 - Consumer choices shape coverage

Choice, Quality And Access

- Health insurance exchanges provide choice among competing health plans
 - “making consumer choice and ownership of health insurance the fundamental organizing principle of a state’s health system.” Haislmaier (Heritage) 2007.
- Some loss of choice for a minority of people
 - Employers may lose the choice not to subsidize their workers’ health coverage
 - Individuals may lose the choice to be uninsured
- Market mechanisms should improve quality and access, but problems can exist if under funded

Single-payer Proposals

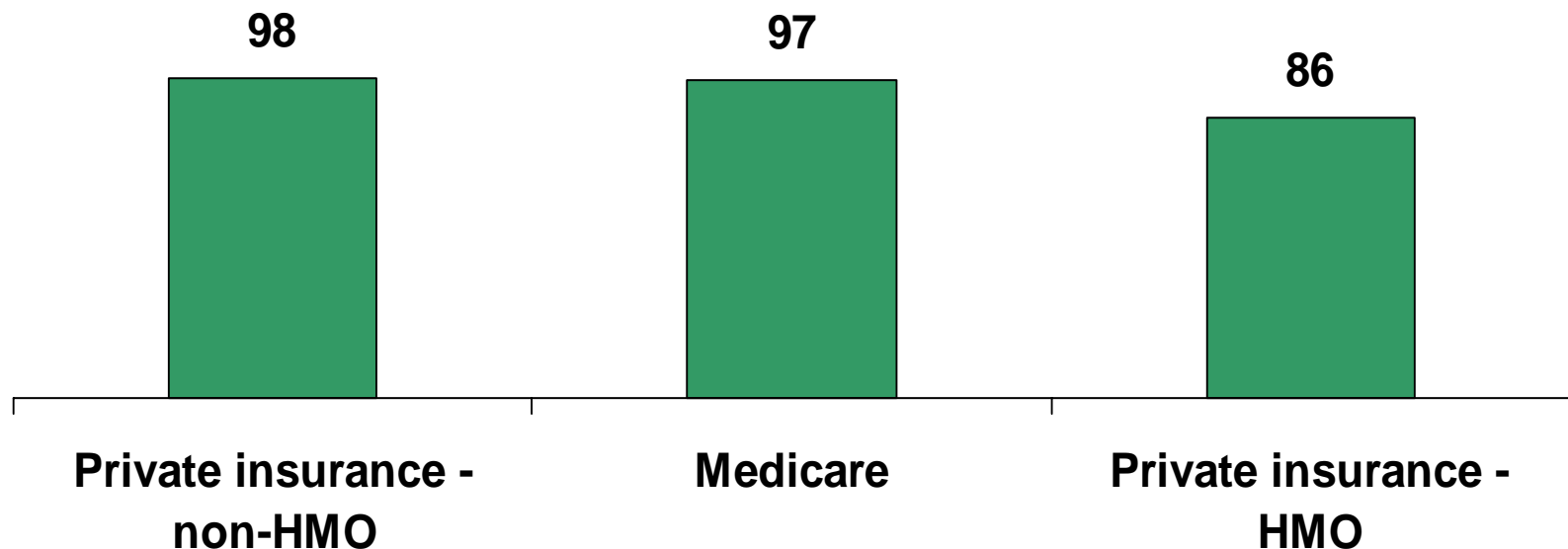
- Medicare expands to cover all non-elderly
 - More benefits than the elderly now receive
- Usually funded by payroll tax
- Other systems of coverage
 - In some versions, employers can opt out
 - In other versions (e.g., Kucinich):
 - No other coverage can duplicate publicly provided benefits
 - Public sector controls capital investment
 - All health care becomes non-profit

Government-run Health Care?

- Technically, no
 - Model II: public contract/private providers
- As a practical matter:
 - The degree of government control can be so great that the policy becomes the functional equivalent of socialized medicine
 - Consumers cannot seek and providers cannot furnish meaningful care outside the public system

Medicare Provides Significant Choice Among Providers

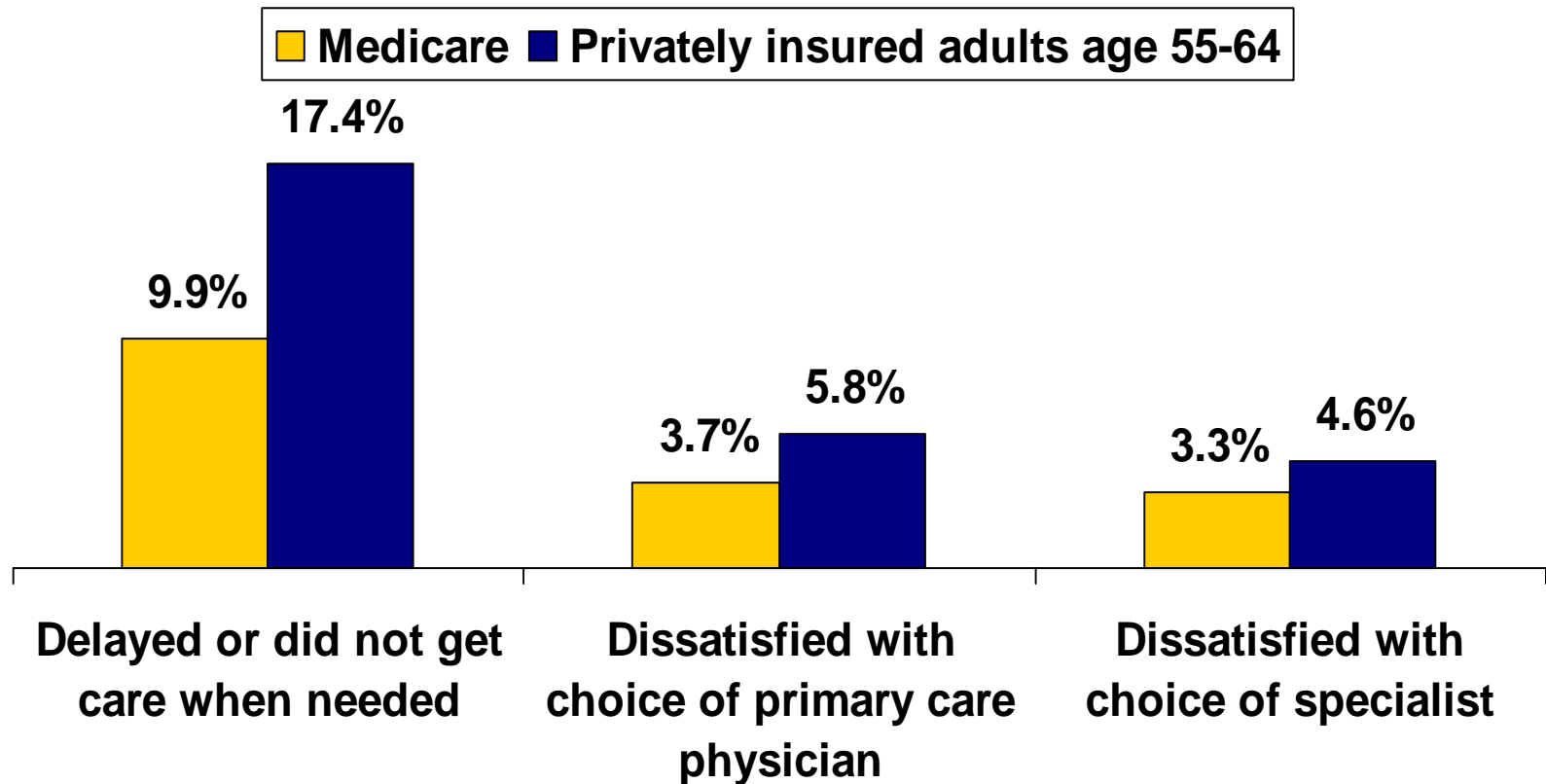
Percentage of physicians accepting new patients with various forms of insurance: 2006



Source: MedPAC 2007.



Percentage Reporting Various Problems with Care, Medicare Enrollees vs. Privately Insured Adults Age 55–64: 2003



Source: Trude and Ginsburg 2005.



More Market-oriented Proposals

- President Bush, Senator McCain, and others
- Common elements
 - Eliminate open-ended tax preference for ESI
 - Provide fixed-value tax deduction or refundable, advanceable tax credit usable for either ESI or non-group plans
 - Less regulation of non-group market – plans can be bought interstate

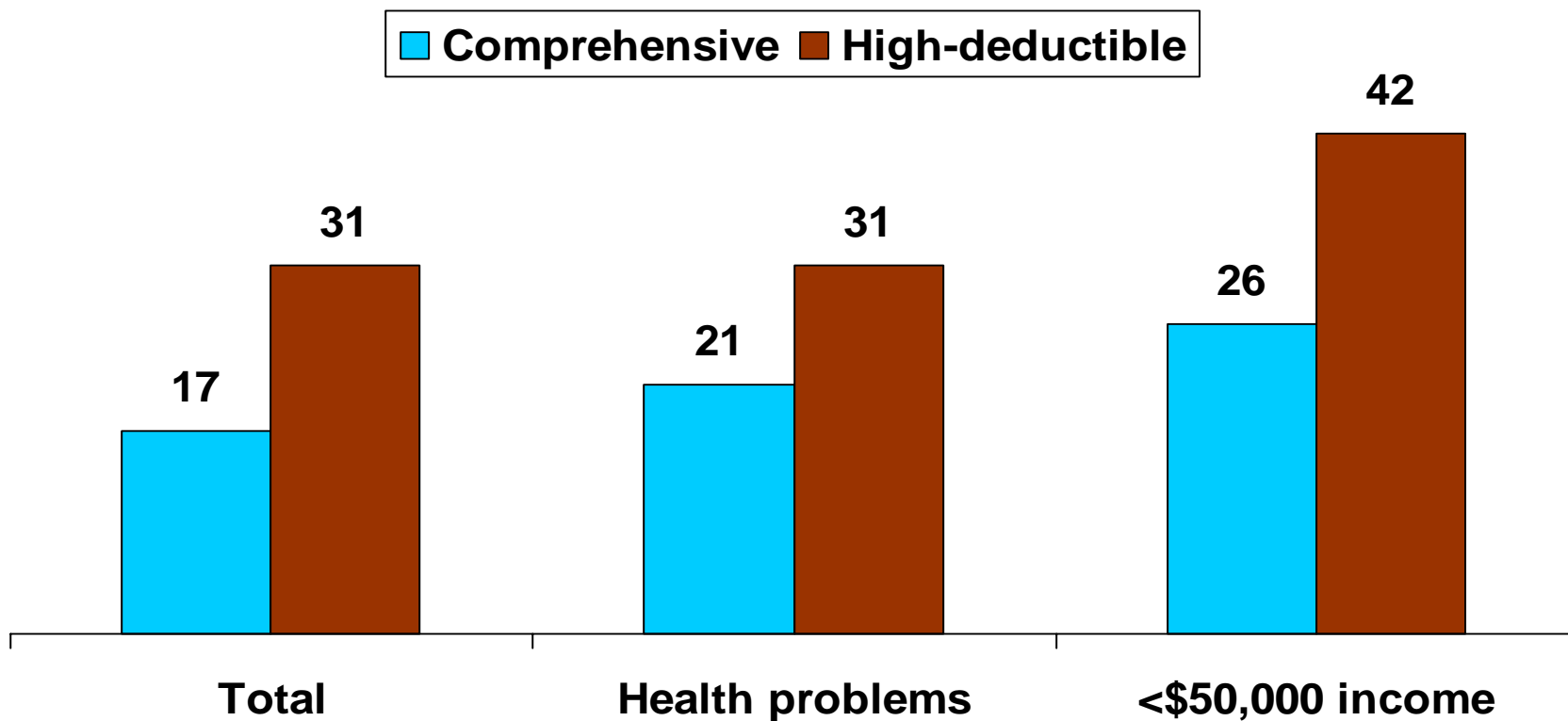
Not Pure Free-market Health Care

- Current government roles remain (albeit with changes):
 - Medicare and Medicaid;
 - Medical research;
 - Drug safety; etc.
- Active government
 - Massive redistribution of income if employer exclusion is replaced with a refundable tax credit
 - Using tax law to engineer a major shift from ESI to non-group coverage

Access and Quality

- Depending on policy design, some people may be unable to buy non-group coverage that provides affordable access to care
 - Low-income people, if credits are too small
 - Older adults and people with health problems, if the non-group market remains largely unregulated
- High-deductible plans can make essential care unaffordable for some people – e.g., low income, health problems

Percentage Of Adults Who Delayed Or Avoided Getting Care Because Of Cost, By Type Of Coverage: 2005



Source: Fronstin and Collins 2005. Notes: (1) High-deductible plans have deductibles of at least \$1,000 and \$2,000 per individual and family. (2) People with health problems either self-report poor or fair health or have been diagnosed with a chronic illness.



Regardless Of Public Sector Role

- Inadequate funding causes access problems
 - Medicaid/SCHIP – low reimbursement rates, limited provider participation
 - Tax credits – small size, low take-up, limited access to care
- In a sound policy framework, adequate funding can provide good access
 - Medicare
 - Most ESI

Conclusion

- No proposal being taken seriously embodies either government-run or free-market health care. Each such plan falls on a continuum between these extremes.
- Neither SCHIP reauthorization nor most Democratic presidential proposals involve “socialized medicine.” Such proposals generally expand choice and private coverage.
- Market-oriented proposals can create access and quality problems for people who are low-income or have health conditions.
- The key issue in reform is, not government’s size, but each proposal’s effect on uninsurance, cost, quality, access, and choice.