

# Economic Investigations

Investigation #5: Health Care:  
Who Should Pay the Cost?



*There Is More to the Story*



Junior Achievement®





# Economic Investigations: There Is More to the Story

“Economic Investigations: There Is More to the Story” was a National Science Foundation funded project, which began in September 2003. The Social Science Education Consortium (SSEC) of Boulder, Colorado, was the grantee agency. James Davis, Executive Director of the SSEC, was the project director, and Donald Wentworth, Professor Emeritus of Pacific Lutheran University, was project co-director.

The overall project goal was to help students achieve a deeper understanding of puzzling economics questions so they could explain and provide thorough, supported, and justifiable accounts of economic phenomena, facts, and data. Three objectives guided project development:

- Create a classroom laboratory orientation for the investigations similar to those students would encounter in a laboratory science course.
- Develop quantitative skills in students—more so than they would acquire in a standard high school economics course.
- Focus the investigations on intriguing economics questions to spark student and teacher interest.

## The Investigations

Twelve investigations were created by teams of economics curriculum materials developers and high school economics teachers. The titles of each investigation identify its content area followed by the main question addressed in the investigation. The investigation titles are:

### Microeconomic Investigations

1. Women’s Wages: Do Women Earn Less Money Than Men?
2. Organ Transplants: Where Are the Missing Kidneys?
3. Minimum Wage: Does Raising the Rate Help Younger Workers?
4. Poverty: How Can a Family Be in Poverty and Not Be Poor?
5. Health Care: Who Should Pay the Cost?

### Macroeconomic Investigations

6. Performance of the National Economy: How Do We Measure the Economy’s Health?
7. Inflation: Are Higher Prices the Only Problem?
8. Employment and Unemployment: How Can Both Rates Rise at the Same Time?
9. Fiscal Policy: Can Congress Diagnose and Treat an Ailing Economy?
10. Monetary Policy: Can the Federal Reserve Diagnose and Treat an Ailing Economy?

### International Investigations

11. African-U.S. Trade: What’s in It for Africa?
12. Imports: Does American Employment Decline Because of International Trade?



## Investigation and Field Test Results

The investigations were field-tested by high school teachers in the spring semesters of 2004 and 2006. Field test locations included Jefferson County Colorado; Milwaukee, Wisconsin; Sioux Falls, South Dakota; Scottsdale/Mesa, Arizona; and Plano, Texas. Based on this field test, the investigations were found to promote deeper student understanding of economic issues through the use of effective instructional methods. Students acknowledged that they learned a great deal from the investigations and teachers stated they would recommend the investigations to other teachers.

## Cooperative Publishing Agreement

The Social Science Education Consortium has transferred the copyright of these investigations to JA Worldwide. JA Worldwide is making them available to teachers by posting them on the JA Worldwide website ([www.ja.org](http://www.ja.org)) and distributing them in CD-ROM format. The investigations also will be posted on the SSEC website ([www.socialscience-ed.org](http://www.socialscience-ed.org)). Ultimately, the investigations will support the revised Junior Achievement high school program, JA Economics.

## Authorship and Consultants

The project was fortunate to have an excellent group of authors and consultants. These individuals are listed below.

### Colorado Development Team

Laura Burrow, Jefferson County Public Schools  
James Davis, Social Science Education Consortium  
Lewis Karstenson, University of Nevada, Las Vegas

### Washington Development Team

Penny Brunken, Sioux Falls (SD) Public Schools  
Donald Wentworth, Professor Emeritus, Pacific Lutheran University


### Wisconsin Development Team

Thomas Fugate, Homestead High School, Mequon, WI  
Mark Schug, University of Wisconsin-Milwaukee

The economics consultant to the project was Norris Peterson, Professor of Economics, Pacific Lutheran University, Tacoma, Washington.

The project evaluator was William Walstad, Professor of Economics, University of Nebraska, Lincoln.

Nancy Baldrice, Excelsior, Minnesota, served in an editorial and desktop-publishing capacity on the project.



## Field-Test Teachers

Below are the teachers who completed field tests during the second year of the project.

### Arizona

Amy Willis, coordinator, Arizona Council of Economic Education  
Dan Korzec, St. Johns High School, St. Johns, AZ  
Bridget Olson, Mesa High School, Mesa, AZ  
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John Kessler, Goodyear, AZ

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Tracey Boychuk, Pomona High School, Arvada, CO  
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### South Dakota

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Jeanette Remily, Britton-Hecla High School, Britton, SD  
Kellie Schultz, Washington High School, Sioux Falls, SD  
Erika Vont, Akron-Westfield High School, Akron, IA


### Texas

Julie Meek, Plano East Senior High School, Plano, TX

### Wisconsin

Tom Fugate, Homestead High School, Mequon, WI  
Mark Cywinski, Brown Deer High School, Brown Deer, WI  
Andy Bosley, Homestead High School, Mequon, WI

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**Investigation # 5:**  
**Health Care:**  
**Who Should Pay the Cost?**

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## Investigation #5: Health Care: Who Should Pay the Cost?

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### Introduction

Medical care in the United States is arguably the best in the world. Yet, increasing costs of both health care and health insurance are making the nation's excellent care less accessible to millions of Americans. Despite that in 2004 the United States devoted 16 percent of its Gross Domestic Product to health care, 23 of the 26 Organization for Economic Cooperation and Development (OECD) countries had lower infant mortality rates, and 17 had higher life expectancies than the United States.

In the United States, the provision of health care evolved over the last century as a mix of employment-based health insurance and government-provided safety nets (Medicare for the elderly and Medicaid for the poor). Most observers would agree that, given the above statistics and the fact that in 2003 almost 44 million Americans were uninsured, the system is terribly flawed. Yet, there is much disagreement as to how to fix the problems. Should there be a greater emphasis on market solutions or on government solutions?

### Student Comprehension

This investigation helps students explore the issues surrounding the provision of health care in the United States, including the following:

- How is health care currently financed in the United States?
- What is behind the high and rapidly growing cost of health care?
- Is health care a private or public good?
- What are possible market solutions to the problems with health care? What are the costs and benefits of those solutions?
- What are possible government solutions? What are the costs and benefits?

### Concepts

Cost  
Benefit  
Public Good  
Private Good  
Supply  
Demand  
Market



## Objectives

After completing this lesson, students will be able to

- explain the basics of the current system of health care provision in the United States;
- list several causes of the high and growing cost of health care;
- explain the limitations of reliance on employer-provided health insurance;
- discuss the public and private good aspects of health care; and
- evaluate the costs and benefits of solutions to the rising costs of, and limited access to health care.

## Economic Principles

The nature of the health care market differs from conventional markets for many reasons. The reliance on employment-based insurance, established early in the twentieth century and codified in post-World War II legislation, put in place a system that inserts a third party (the insurance provider) between the consumer (patients) and the supplier (the health care industry). As a result, market equilibrium price is distorted, because consumers do not directly pay the total cost and, thus, have less incentive to find the lowest cost care. Further, suppliers of health care have several incentives to supply many costly services.

The market is also complicated because consumers are less informed than suppliers. As a result, consumers tend to over-consume health care. On the supply side, many argue that as providers fear potential malpractice suits, they practice “defensive medicine,” prescribing more tests and treatments than may be necessary in order to avoid lawsuits. This leads to a situation of over-supply. Both situations contribute to the increased use, and increased cost, of health care.

## Investigation


### Description

This investigation begins with an attitudinal survey regarding students’ opinions of U.S. health care. Following the survey, students engage in a true/false reality check concerning health care accessibility, cost, right versus privilege, and options for change.

Students then examine, through a reading, the evolution of health-care financing in the United States. They also explore the current situation of how health care is financed and what problems exist in cost and accessibility.

The final activity focuses on four policy positions concerning health care reform. Small groups of students are assigned a policy position. The groups conduct an Internet search to expand their knowledge of the policy position. In a “health care summit,” each group presents its case for its assigned policy position.

**Time Required:** 120 minutes



**Technology:** It is strongly suggested that small groups of students use the Internet (hopefully in a computer lab) to add to their information on their assigned health care policy position.

General Health Care and Health Insurance Sites:

[www.cdc.gov](http://www.cdc.gov) – Centers for Disease Control and Prevention

[www.whitehouse.gov/fsbr/health.html](http://www.whitehouse.gov/fsbr/health.html) – National Center for Health Statistics

[www.ahcpr.gov](http://www.ahcpr.gov) – Agency for Healthcare Research and Quality

[www.dol.gov/ebsa](http://www.dol.gov/ebsa) – Employee Benefits Security Administration

[www.hschange.org](http://www.hschange.org) – Center for Studying Health System Change

Market Solutions Sites:

[www.ncpa.org](http://www.ncpa.org) – National Center for Policy Analysis

[www.galen.org](http://www.galen.org) – Galen Institute

[www.cato.org](http://www.cato.org) – The Cato Institute: Public Policy Analysis

Government Solutions Sites:

[www.pnhp.org](http://www.pnhp.org) – Physicians for a National Health Program

[www.uhcan.org](http://www.uhcan.org) – Universal Health Care Action Network

**Materials:**

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Activity #1	Perceptions of United States Health Care
Visual #1	United States Health Care System: A Reality Check
Visual #2	Health Care Spending Per Capita – 2002 (Selected Countries)
Visual #3	Infant Mortality & Life Expectancy (Selected Countries)
Visual #4	Uninsured Americans and Their Work Status
Visual #5	Increases in Health Insurance Premiums – 1996-2003
Reading #1	The State of Health Care in the United States
Student Handout	Internet Site Information Sheet
Policy Position #1	Health Savings Accounts (HSAs)
Policy Position #2	National Health Insurance
Policy Position #3	Contribution Health Plans
Policy Position #4	Incremental Expansion of Medicare and Other Government-Paid Programs





## Procedure

1. Tell students that this investigation will examine the current state of the health care system in the United States, perceived flaws in the system, and how the system may be reformed. Announce that students will have an opportunity to research on the Internet health care reform options. (Hopefully, you will be able to arrange for students to use a computer lab to conduct Internet searches.)
2. Distribute **Activity #1 – Perceptions of United States Health Care** and have students complete it. Assign two students to tally the responses and report the results. You may wish to debrief the results by asking students why they indicated agreement or disagreement with the statements.
3. Display **Visual #1 – United States Health Care System: A Reality Check** and ask for a show of hands on whether students think the four statements are true or false. Note the results.
4. Debrief the results of **Visual #1** by showing **Visuals #2–#5**. Here are brief responses to the items in Visual #1:

- Item 1: Per capita spending is arrived at by dividing the total population into the total amount of health care spending. Clearly, per capita spending for health care in the United States far outstrips per capita spending in the other countries listed. **(False)**
- Item 2: Of the countries listed, the United States has the second-highest infant mortality rate. The United States ranks about in the middle of the countries listed in terms of life expectancy. **(True and False)**
- Item 3: Seventy percent of uninsured non-elderly Americans work full time and 12 percent work part time. **(False)**
- Item 4: Health insurance premiums have increased each year since 1996. Perhaps most alarming is the double-digit increases in 2001, 2002, and 2003. **(False)**

5. Copy and distribute **Reading #1 – The State of Health Care in the United States**. Here are five questions related to the reading you may wish to ask the class:
  - What is meant by an employment-based insurance program?
  - What are some benefits of employment-based insurance coverage?
  - What are some drawbacks to employment-based insurance coverage?
  - In what ways is health care a public good?
  - In what ways is it a private good?



6. Form eight small groups of students, and distribute the four policy positions so at least two groups address each position. Provide the groups with the Internet site information sheet and give them time to investigate additional information on their policy positions. Prior to doing this, announce that each group will be responsible for advocating its policy position in a “health care summit.” You will need to set the date and time for the summit.
7. Announce that each group will have four minutes at the summit to present its strongest possible statement on each policy position.
8. Performance Assessment: You may wish to use the following rubric to assess each group’s summit presentation:
  - Analysis**
    - 4 points – Thorough analysis of the position, including the private or public nature of the position*
    - 3 points – Mostly complete analysis
    - 2 points – Partially complete analysis
    - 1 point – Incomplete analysis
  - Policy Implications**
    - 4 points – Outstanding policy presentation that considers benefits and drawbacks of the recommended policy*
    - 3 points – Very good policy presentation
    - 2 points – Acceptable policy presentation
    - 1 point – Weak and inadequately presented policy presentation
9. To bring closure to this investigation, revisit **Activity #1 – Perceptions of United States Health Care** and have students complete it. Compare the results with the initial use of this activity.

## **Perceptions of United States Health Care**

*Directions: To the left of each statement below indicate whether you agree (A), disagree (D), or are undecided (U) about the statement.*

- \_\_\_ 1. Americans pay too much for health care.
- \_\_\_ 2. Everyone should have access to the same level of health care a millionaire receives.
- \_\_\_ 3. Access to health care is a “right” and should not be limited by one’s ability to pay.
- \_\_\_ 4. Health care should be allocated in the same way as CDs and automobiles. Those who can pay for the goods get them.
- \_\_\_ 5. While I don’t want to pay higher health care costs, I don’t want a system that restricts my access to care or my ability to choose.





## **United States Health Care System:** **A Reality Check**

Are the statements below true or false?

1. Americans spend about the same on health care as people in other industrialized countries.
2. Americans generally are healthier than citizens in other industrialized countries.
3. Most of the 43.6 million uninsured Americans are unemployed.
4. Americans' spending on employer-sponsored health care coverage has been lower than the average rate of inflation and the average increase in workers' wages during the period 1996-2003.



## Health Care Spending Per Capita–2002 (Selected Countries)

<i>Country</i>	<i>Per Capita Spending (U.S. Dollars)</i>
Australia	\$2,504
Canada	\$2,931
France	\$2,736
Germany	\$2,817
Italy	\$2,166
Korea	\$ 931
Mexico	\$ 553
Spain	\$1,646
United States	\$5,267

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\*Source: *OECD Health Data, 2004, 1st Edition*

## Infant Mortality & Life Expectancy (Selected Countries)

Country	Infant Mortality Rates (2000)*	Life Expectancy at Birth (1999)	
		MALE	FEMALE
Australia	5.2	76.2	81.8
Czech Republic	4.1	71.4	78.1
Denmark	5.3	74.2	79
France	4.5	75	82.5
Hungary	9.2	66.3	75.1
Japan	3.2	77.1	84
Mexico	N/A	72.8	77.3
Sweden	3.4	77	81.9
United States	7.1	73.9	79.4

*\*Per 1,000 live births*

*\*Source: OECD Health Data, 2002*



## Uninsured Americans and Their Work Status

- Number of non-elderly, uninsured Americans in 2002:  
43.6 Million

### Work Status of the Uninsured, 2001

1 full-time worker	56%
2 or more full-time workers	14%
Part-time workers	12%
Not working	18%

*\*Source: 2003 Current Population Survey*

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## Increases in Health Insurance Premiums 1996-2003

<u>Year</u>	<u>Percentage Increase</u>
1996	.8
1997	2.3
1998	4.2
1999	5.3
2000	8.2
2001	10.9
2002	12.9
2003	13.9

- Average inflation rate between 1996-2003:  
2.2%
- Average increase in workers' earnings  
between 1996-2003:  
3.1%

\*Source: Kaiser Commission on Medicaid and the Uninsured

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## **The State of Health Care in the United States**

As we enter the twenty-first century, it is easy to argue that Americans have access to the best health care in the world. Technological advances, the vast majority of which are developed in the United States, make diagnosis and treatment more effective. Life expectancies have increased, and people's lives are healthier in their later years. More and more communities now have access to sophisticated medical technology.

However, there are some disturbing trends in American health care that taint this rosy picture. Health care costs, overall, are increasing. U.S. health expenditure grew 14.6 percent in 2002 alone. That rate is expected to repeat itself over the next several years. Outpatient care and prescription drugs have led the way in cost increases, but the increased use of new technologies also contributes. Another important cause of rising costs is the aging of the American population. Older people require more – and more expensive – health care.

Higher costs of health care lead to higher insurance premiums. As a result, more employers are unwilling or unable to offer health insurance to their employees. The number of employees covered by health insurance dropped 4 percent between 2000–2004 to 60 percent. And those still offered insurance through their employment are paying higher premiums, deductibles, and co-pays. Employee-paid premiums rose about 60 percent between 2000–2004, and are expected to continue to rise more than 12 percent per year for the foreseeable future.

Fifteen percent of Americans, 43.6 million people, do not have health insurance and must either pay medical expenses themselves or rely on the health care system to absorb their costs. In turn, those who cannot pay raise costs for those who are insured. Those uninsured also are less likely to seek care and, as a result, are sicker and, thus, more costly when they do get treatment.



**How did the American health care system get where it is today?**

In 2000, 69 percent of all health insurance coverage for those under 65 was provided through employment-based programs. An employment-based program is a benefit provided to workers that allows them to obtain health insurance at no cost or reduced cost from an insurance company that has contracted with the employer. These programs generally offer lower premiums than individuals could find independently because the insurer offers group rates, thus spreading the risk.

Employment-based health insurance programs began in the early 1900s. Companies saw the programs as a means to provide non-wage benefits to employees and to improve the health and productivity of their workforce. During World War II, when the National War Labor Board enacted a wage freeze, employers expanded employment-based health insurance coverage as a way to attract and retain workers during the labor shortage of wartime.

In the 1950s post-war era, the number of employment-based programs continued to grow. In 1954, employer contributions to health plans were excluded from taxation by the federal government. Further, it was enacted that workers' health benefits were not subject to federal income or Social Security taxes, thus giving workers a tax-free benefit, preferably, in many cases, to a wage increase.

These decisions established the provision of health care coverage in the United States to be a *private good*. A private good is a good that is produced and consumed by individuals through interaction in the marketplace. This path differed from most other industrialized countries that chose to treat health care as a *public good*, one that is produced by government to provide all citizens with some form of government-based health care program.



## **Investigation #5 – Reading #1, page 3**

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The private provision of health care insurance in the U.S. was modified during the Great Society era, in 1965, with the passage of Medicare and Medicaid legislation. These programs established the provision of some health care insurance as a public good. Medicare is government-provided health insurance for Americans over 65 years old, regardless of income, and Medicaid provides health care coverage for low-income Americans. In 2000, 14 percent of all health insurance coverage in the U.S. was provided by federal and state governments.

*What effect has the current U.S. health care provision system had on the market for health care?*

The reliance on private insurance to pay for health care has led to a disconnect between buyers and sellers in the market for health care. Insurance companies act as a third party in the market, in the sense that consumers (patients) do not directly pay the cost of health care to the suppliers (doctors and hospitals).

Consumers who pay relatively small and capped costs have little incentive to seek lower prices for health care. If insurance covers the visit and the patient pays only a \$20 or so co-pay, why would the patient care what the total bill is? Many argue this leads to over-consumption of health care services. Because Americans demand so many goods and services, they drive up health care costs.

Suppliers who are paid by insurance companies often have an incentive to provide more health care than is necessary. If insurance covers a test and protects a doctor or hospital from malpractice lawsuits, why would a doctor or hospital care what the total bill is? It can be argued that this mindset leads to over-supply and helps to drive up the cost of health care.

The case can then be made that Americans consume and supply too much health care for the insured, thus driving up costs. On the other side of the coin, there are millions who have no or limited access to health care, which also drives up costs.

## **Investigation #5 – Reading #1, page 4**

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Consider a final note. Inefficiency in the current system drives up costs, as suppliers of health care attempt to deal with a large number of insurance companies, each of which has its own rules, regulations, and paperwork. An advantage is that the large number of health insurance companies offers the consumer choices. The downside is that the vast number of vendors creates unnecessary costs.

### **How can the United States reform the current health care system?**

The answer to this question depends on whether you see health care as a private or public good. Most experts agree that not all Americans will be able to have access to all the health care they want. How then should society decide? Should the decision be based on the provision of health care as a private good in the market, tempered by the laws of supply and demand? Or, should health care be a public good, provided to all by government?





## **Internet Site Information Sheet**

### **General Health Care and Health Insurance Sites:**

[www.cdc.gov](http://www.cdc.gov) – Centers for Disease Control and Prevention

[www.whitehouse.gov/fsbr/health.html](http://www.whitehouse.gov/fsbr/health.html) – National Center for Health Statistics

[www.ahrq.gov](http://www.ahrq.gov) – Agency for Healthcare Research and Quality

[www.dol.gov/ebsa](http://www.dol.gov/ebsa) – Employee Benefits Security Administration

[www.hschange.org](http://www.hschange.org) – Center for Studying Health System Change

### **Market Solutions Sites:**

[www.ncpa.org](http://www.ncpa.org) – National Center for Policy Analysis

[www.galen.org](http://www.galen.org) – Galen Institute

[www.cato.org](http://www.cato.org) – The Cato Institute: Public Policy Analysis

### **Government Solutions Sites:**

[www.pnhp.org](http://www.pnhp.org) – Physicians for a National Health Program

[www.uhcan.org](http://www.uhcan.org) – Universal Health Care Action Network



## **Health Savings Accounts (HSAs) Policy Position #1**

One private-good market approach to reforming the current health care system that became effective January 1, 2004, is the Health Savings Account, or HSA. HSAs are tax-free savings accounts that can be used to pay medical expenses. They are available to those covered by a high-deductible health insurance plan and allow individuals to contribute to a tax-sheltered savings account used exclusively for qualified health care expenses. Qualified expenses include insurance deductibles, prescriptions and over-the-counter drugs, and insurance premiums. Individuals own these savings accounts, so if they change jobs or become unemployed, the funds in the accounts are still theirs.

HSAs are coupled with low-premium, high-deductible insurance policies (at least \$2,000 for family coverage). For most employment-based insurance participants, this means their premiums are lowered dramatically, allowing them to put the money they used to pay for insurance premiums into their HSAs. When medical care is needed, the individual uses funds from the savings account to pay the cost. Insurance would not pay for any doctor visits, drugs, or other medical care until the deductible amount has been met.

The expected benefit of HSAs is to allow people to make their own choices between health care and other uses of money. It is argued that if consumers pay their own routine, basic health care costs, consumer involvement in health care decisions will increase, resulting in greater awareness of and concern about prices. And this, it is believed, will lead to lower costs, as consumers shop for lower prices in the market. Consumers also may demand fewer services when they are paying for them. This action could drive down the cost of medical care, as well.

Some arguments against HSAs are that the accounts potentially could split the pool of insured people into two camps: (1) affluent workers who can afford to sock away pre-tax dollars and healthy people who can risk reduced coverage in one camp, and (2) poorer and sicker people in the other. Others argue that if one is not a good saver, there's no requirement to put money into the savings account. The person may come out short if his or her expenses exceed the balance in the account and the deductible has not yet been met.





## **National Health Insurance** **Policy Position #2**

The most sweeping change to health care in the United States would be to adopt a system of national health insurance (NHI). With such a system, the federal government would be the single payer for health care, providing a basic package of health care financed by taxes. The proposal is to establish a publicly funded, privately provided health care system. This is not socialized medicine; doctors and other health care providers would not be government employees. Rather, the government would be billed for medical services provided by private suppliers.

Proponents of national health insurance argue that a single-payer system would dramatically reduce costs. As opposed to the current system that includes more than 1,500 private insurance companies and plans, a single-payer system would lower administrative costs. Today, 25 percent of every dollar spent on health care goes to billing, marketing, and other administrative costs. One source estimates that a national health insurance program could save approximately \$150 billion on paperwork alone.

NHI also is the most direct way to provide coverage for all citizens. One supporter, Dr. Marcia Angell of the *New England Journal of Medicine*, argues that health care ought to be a public good. According to Angell, “It’s something that a decent society supplies to everyone.” And by making health care accessible to all, there would be lowered costs. Today, many uninsured postpone seeking health care until they are really sick and require more expensive care. Often, the uninsured get relatively routine care at expensive emergency care facilities.

To those who say that NHI would raise taxes, supporters argue that health care expenses currently are paid through premiums, deductibles, and co-payments. It would more efficient and less expensive to pay for it through taxes.



Further, a single-payer system separates health care coverage from employment. This would benefit workers who then could change jobs without fear of losing insurance. It also would benefit the millions of workers whose companies don't or can't afford to provide health insurance. Such a system would benefit employers, as well, removing the costs and administrative headaches of providing employee insurance. Wages would be more likely to increase, as employers shifted funds away from insurance benefits. Finally, this system might reverse the trend of companies hiring part-time and temporary workers to avoid paying insurance benefits.

Supporters of NHI admit there may be delays for some elective procedures, a situation often seen with Canada's single-payer system. Dr. Angell argues, however, "If you have an elective procedure in Canada, let's say a knee replacement ... you might have to wait four months. If you're an American with private insurance, you might have to wait two days. If you're an American who doesn't have insurance, you'll wait forever. So which is better, four months or two days or never for your knee replacement?"

Other arguments against national health insurance include the assertion that the system is not likely to control costs, as private providers, doctors and others can still maintain their fees despite government regulations. Also, the case can be made that government, by definition, is inefficient. Witness the Department of Defense and its cost overruns.



## **Contribution Health Plans Policy Position #3**

A defined-contribution health care plan is a reform of employment-based health benefits intended to expand consumer choice and increase competition in the health insurance industry. These plans give employees a fixed dollar contribution they may use on a variety of different health insurance options. Under the defined-contribution approach, the employer would agree to provide a specific amount of money to the employee toward the purchase of health coverage from any source agreed upon by the employer and employee.

Under the current employment-based health coverage system, the employer usually makes the decision about which insurance company to contract, based solely on cost. The result is that the employer offers employees one, maybe two, health insurance options, creating a one-size-fits-all plan.

Supporters of defined-contribution plans assert that more choice would provide flexibility and lower costs. Employees could find a plan that better fits their family needs in term of premiums and deductibles. If an employees became dissatisfied with a plan, they could vote with their wallets and change companies. This would increase competition between insurance providers and result in lower costs. Insurance companies then would have a real incentive to provide a better product. It also is argued that making the consumer, not the employer, responsible for choosing a plan would make consumers more cost-conscious.

Another benefit of defined-contribution health plans is that, since the individual contracts with the insurance provider, coverage would be portable and move with the employee from job to job. This system would reduce expenses for employers, administration of health benefits.





Opponents of defined-contribution plans argue that the plans favor healthier individuals. If someone is considered a high-risk individual because of previous medical conditions, shopping for his or her own policy could be expensive and beyond the contribution provided by the employer. Further, opponents ask, as an employer caps increases to their contributions, would employees be forced to pay more and more of their own money as insurance premiums continued to climb? Finally, research into existing defined-contribution plans shows that those employees who favor the system tend to be wealthier and possess the sophistication and education to make wise insurance decisions.



*Incremental Expansion of Medicare  
and Other Government-Paid Programs*  
**Policy Position #4**

This position is a compromise proposal between a public-good and private-good approach. It attempts to deal with increasing access to health care coverage for selected populations by extending government-provided health insurance to targeted groups of Americans. The groups most frequently mentioned are children and citizens between the ages of 55 and 65, (the age at which citizens qualify for Medicare benefits). It can be argued that, in this way, the country could incrementally move toward a national health insurance program.

The two groups targeted typically are two groups who are likely to be uninsured. A benefit of this proposal would be that children of the uninsured would be covered. This group has been growing in numbers in recent years, as fewer parents are covered by employment-based insurance or can afford the coverage offered. It is argued that the increased health of America's youth would contribute to healthier adults.

The older Americans mentioned are at a distinct disadvantage when trying to get insurance on their own when they are not covered by an employer. Their age makes them higher- risk candidates and, thus, increases their cost of coverage. Proposals for this group vary from providing full Medicare coverage to allowing them to buy into the Medicare system.

Supporters of incrementally expanded government health insurance argue that the current federal program, Medicare, is very efficient. Dr. Marcia Angell of the *New England Journal of Medicine* states, "The overhead of Medicare is 1 percent. The overhead of the private insurance industry is roughly 20 percent. That's profits and administrative costs."

Opponents of expanded government-provided health coverage argue that taxes would most likely increase. The government is naturally inefficient, and it makes more sense to provide insurance to these groups through tax credits, so they can purchase their own insurance.

