10. A MORE EQUITABLE AND EFFICIENT APPROACH TO INSURING THE UNINSURABLE

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1. INTRODUCTION

Employer provided health insurance is largely the result of historical accident in the United States. In the face of wage and price controls enforced by the government during World War II, employers used health care coverage (among other in-kind benefits) as a second-best channel to attract workers in a particularly tight labor market. This vestige of government intervention likely endures due to health insurance's favorable tax treatment, as it remains one of the few benefits that goes untaxed for the employee and serves as a deduction for the employer.

This tying of insurance to employment generates a number of distortions in the labor market. However, it does provide an especially valuable benefit to individuals with conditions that generate relatively high expected health costs. By pooling these individuals with other employees facing relatively low expected costs, the high-cost individuals are cross-subsidized by their fellow workers. Although such a scenario generates efficiency distortions, other normative considerations, such as fairness or some other element of social justice, may lead society to decide that the efficiency losses are worth bearing. Policy makers may decide that it is reasonable to induce the relatively healthy to pick up some of the tab for the relatively unhealthy as part of the social safety net. Further, on pragmatic grounds, a policy decision may be made that it is better to make it easier for the high-cost individuals to obtain coverage; this would avoid situations in which these individuals would forego early health care, which ultimately would lead to larger costs, likely to be borne by the public, in the future, when the high-cost individuals would qualify for Medicare.

In this paper, we argue that although concern for individuals with relatively high expected health care costs may justify significant cross-subsidization on normative grounds, it makes sense as a matter of fairness and in terms of minimizing attendant efficiency losses to sever the employment link, enacting a program through which cross-subsidization occurs within society more generally.

Although we provide more detail below, our proposal is fairly simple. Policy makers determine the baseline level of coverage to be required as well as some income-based affordability metric. Individuals would then be required to demonstrate that they have coverage meeting or exceeding the chosen baseline or else provide evidence that they obtained multiple price quotes from different

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insurers that exceed the affordability index implied by their income level. Individuals doing the latter would receive federally provided insurance for the appropriate income-adjusted price. Competition among insurers in such a system is likely to push toward accurate pricing of an individual's risk, and it allows for a broadening of the risk pool. Further, it spreads the burden of cross-subsidization more equally across taxpayers and rids the system of the labor market inefficiencies created through tax advantaged employer provided health insurance.

In Section 2, we briefly review the literature on labor market distortions related to health insurance benefits. In Section 3, we provide a short discussion of how many individuals are likely to be "uninsurable" in an insurance market in which coverage is not tied to a person's employer. Section 4 lays out our proposal, including a discussion of the determinants of health insurance affordability and our pricing mechanism. Section 5 discusses the necessary federalization of Medicaid and the abolishment of state-level insurance mandates that accompanies our proposal. Section 6 examines the experience of other countries to shed light on the efficacy of our proposal, and Section 7 concludes.

2. DISTORTIONS IN THE EMPLOYER BASED SYSTEM

Tying health insurance to employment has the potential to generate multiple distortions in the labor market. Gruber and Madrian review the empirical literature on these distortions. They find that there is almost unanimous agreement across studies using different identification strategies and different data that the bundling of health insurance with employment leads individuals to delay their retirement on average. Namely, individuals whose employers provide insurance during the term of employment but not after retirement continue working longer than those whose employers continue coverage into retirement. This effect is statistically and economically significant, with some estimates suggesting a differential as large as two years.[1]

There is also some evidence that employment-based insurance reduces job mobility as individuals who otherwise may wish to change employers are reluctant to do so for fear of not being able to secure comparable coverage from a new employer. Various identification strategies have been employed to examine this issue, and while the evidence is mixed, the studies employing more credible identification strategies show that the lock-in effect may be substantial. Several studies published after the Gruber and Madrian review, including Adams[2] and

1. Gruber, Jonathan, and Brigitte Madrian. 2002. "Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature." *NBER Working Paper:* 8817.

2. Adams, Scott. 2004. "Employer-Provided Health Insurance and Job Change." *Contemporary Economic Policy*, 22(3): 357–369.

Bansak and Raphael[3] continue to find at least some evidence of health insurance related job lock in.

Gruber and Madrian note that there are very few estimates of the welfare effects of these labor market distortions in the literature. Examining various approaches, they place the upper bound of the welfare costs of decreased mobility at somewhere between nine and thirty billion annually, but they suggest these estimates are very crude. Essentially no work has been done on the welfare effects of insurance induced labor market distortions other than the lock in effects.[4]

3. INSURABILITY IN THE INDIVIDUAL MARKET

Despite the distortions discussed above, a number of individuals have pointed out that tying insurance to employment has the benefit of limiting adverse selection problems, as relatively healthy individuals are not generally induced to drop out of the risk pool when they effectively cross-subsidize their relatively unhealthy co-workers. These commentators suggest that because job choice is multidimensional and individual employees likely enjoy some surplus along those various dimensions, the relatively small cost of the cross-subsidy does not appear to induce individuals to sort very strongly along health cost dimensions across firms. Further, the tax subsidy might mitigate the incentive for healthy individuals to switch or decline coverage in the face of this cross subsidy. Although there are some partial counter-examples[5], this view is fairly prominent among health economists.

The presumption behind this view is that if this employer-based pooling did not exist, high-cost individuals would have difficulty obtaining insurance in the non-group market. Although historical estimates place the fraction of Americans who are "uninsurable" around 1 percent[6], subsequent investigation suggests

3. Bansak, Cynthia, and Steven Raphael. 2005. "The State Children's Health Insurance Program and Job Mobility." Working paper.

4. Note that at the upper end of this estimate, the improvement in welfare from eliminating just this lock-in effect is comparable to at least some estimates of the cost of insuring the uninsured. *See*, for example,Hadley, Jack, and John Holahan. 2003. "Covering The Uninsured: How Much Would It Cost?" *Health Affairs*, Jan-Jun;Suppl Web Exclusives:W3-250-65.

5. See, for example, Altman, Daniel, David Cutler, and Richard Zeckhauser. 1998. "Adverse Selection and Adverse Retention." *American Economic Review*, 88(2): 122–126 and Cutler, David, and Richard Zeckhauser. 1998. "Adverse Selection in Health Insurance." *Frontiers in Health Policy Research*, vol. 1, Alan Garber, ed., MIT Press: 1-31.

6. Laudicina, Susan. 1988. "State Health Risk Pools: Insuring the 'Uninsurable.'" *Health Affairs*, 7(4): 97–104.

that the actual number is much higher[7]. Further, even if some moderate to high-cost individuals are not uninsurable in a formal sense, they may be able to acquire coverage in the non-group market that is deemed inadequate or too expensive according to a social or political consensus. A number of states have adopted community rating laws and/or guaranteed issue and renewal laws in an effort to avoid these problems in the non-group market, but many of these attempts have not been successful in generating a robust individual market. Arguably, the presence of better employer-based insurance options can lead to an adverse retention problem for individual plans in states with these laws[8], although evidence on this is mixed[9].

However, even if these kinds of policies could be effective in bolstering the non-group insurance market, the mobility distortions discussed above might simply be moved to the residence, as opposed to the employer level. Further, there is a distinct possibility that state-to-state heterogeneity in terms of these policies could generate adverse selection/retention problems as well.

Further, from a normative stand point, if society determines that high-cost individuals deserve assistance, either directly through tax credits or state-provided subsidies or indirectly through state-wide cross subsidies among insured individuals, there is no particularly good reason to restrict this subsidization to occurring within the state's boundaries (much less within a firm's boundaries). It is not clear why it should be the case that low-cost individuals (or taxpayers generally) should subsidize a high-cost individual in their state, but low-cost individuals in a bordering state have no obligation to subsidize that individual.

Standard principles of federalism fall short of justifying this state-based subsidization. Given the common view of health care as a primary good, there is little reason to be concerned with heterogeneity in voter preferences across state lines regarding what should and should not be covered. Basing coverage decisions on these divergent preferences is likely to worsen the geographic health disparities many people already find lamentable. Further, differential provision across states could affect residential choices in a way that is problematic with relatively generous states attracting a disproportionate number of high-cost individuals. Lastly, as discussed more fully below, perverse incentives are generated by a fragmented system in which early life health care for those receiving subsidies, when health capital is built up and when preventive care may have the

7. Pollitz, Karen, and Richard Sorian. 2002. "Ensuring Health Security: Is the Individual Market Ready for Prime Time?" *Health Affairs*, W372–376.

8. See, for example, Monheit, Alan, Joel Cantor, Margaret Koller, and Kimberly Fox. 2004. "Community Rating and Sustainable Individual Health Insurance Markets: Trends in the New Jersey Individual Health Coverage Program." *Health Affairs*, 23(4): 167–175.

9. See, for example, Buchmueller, Thomas, and John DiNardo. 2002. "Did Community Rating Induce an Adverse Selection Death Spiral?" *American Economic Review*, 92(1): 280–294.

most efficacy, is governed by state interests, whereas the benefits of that care accrue to the federal Medicare system.

4. EXPANDING THE POOL

It makes little sense on efficiency or equity grounds to maintain the tax distortions that support the employer based health insurance system in the United States. If it is desirable to cross-subsidize high-cost individuals, there is no strong reason to operationalize those subsidies through the employment channel. Our proposal is to move individuals requiring these subsidies to a broad-based pool financed through the federal tax system. Such a program would eliminate the labor market distortions discussed above, and carrying out the program at the federal level avoids the problems associated with state-based policies. Our proposal differs from a fully nationalized health insurance program in that it only includes individuals who cannot find affordable coverage in the private market. A hybrid system like this at least partially retains the positive aspects of competition among insurers, allowing for innovation in the market, and, as described below, it harnesses the market's pricing mechanism to determine who needs the public insurance.

4.a Means Tested Care

Defining affordability with respect to heath insurance is largely a normative or political question. Bundorf and Pauly examine a number of different potential standards for affordability and provide estimates of how many individuals would be unable to afford coverage under each definition.[10] Determining what constitutes requisite coverage is likewise outside of the analytical sphere. However, once those normative issues are decided, presumably through political means, taking into account the relative value of preventive care and taking the current commitments to fund coverage for the elderly as given, federal legislators and regulators can develop a schedule of income-adjusted thresholds above which coverage will be deemed as unaffordable for the individual. The individual, as described below, will then be required to either procure private coverage meeting or exceeding the set minimum or, in the event he or she is unable to find private coverage for less than the threshold cost (and unwilling to pay the above-threshold prices he or she is quoted), the individual will enter the public insurance program, paying (presumably through the existing tax system) a sum equal to the threshold amount.

10. Bundorf, Kate, and Mark Pauly. 2006. "Is Health Insurance Affordable for the Uninsured?" *Journal of Health Economics*, 25(4): 650–673.

4.b Ensuring Correct Pricing

To qualify for the public coverage, an individual would need to provide evidence that he or she received multiple quotes from private insurers for the minimum coverage that exceeded his or her threshold. Market forces would induce insurers to compete both on the margins of administrative costs and pricing accuracy. Maintaining this reliance on market pricing mechanisms relieves the federal program from making individual decisions regarding who receives public coverage. Further, relative to a fully public insurance system, the potential remains for private innovations in terms of administrative practices, pricing models, and customer service. Additionally, relative to the fully public system, individuals in the private system retain a large degree of choice across insurers.

If there are concerns that insurance markets might collectively over-price individuals representing negligible profit margins to avoid covering these individuals, federal regulators could monitor insurer pricing decisions using cost data from the public program. Namely, by comparing actual expenditures for individuals priced out of the private market with the price quotes they procured from private insurers, federal regulators could identify insurers that systematically misprice certain types of individuals at the aggregate level in order to remove them from the private risk pools. By using fines and other sanctions, federal regulators could mitigate the potential for this possibility.

4.c Other Strategic Concerns

Another concern with respect to our proposal is that insurers will forego preventive treatments that could be cost justified over the patient's (non-Medicare) life horizon but are not profitable on a short term basis. In such a situation, the insurer will have an incentive to quote a relatively low current premium that does not reflect the cost of the preventive care only to raise the cost once the subsequent health problem develops. At this point the customer is more likely to fall under the public system as the price rises above the government set income threshold.

There exist both market and mandate-based solutions to this strategic concern. From the market perspective, if the public system is made to be undesirable along amenity/luxury dimensions (e.g., limited provider choice, longer wait times, less attractive hospital facilities such as non-private rooms, etc.), consumers will prefer to remain in the private system, making insurers who provide preventive care more attractive. To remedy the short-term vs. long-term incongruity of preventive care, insurers would find it profitable to enter into long-term policies with their customers, in much the same way that the term life insurance market operates today.[11]

11. Presumably, like in the term life insurance market, providers would perform examinations of customers before entering into the contract, allowing for more accurate pricing.

Alternately, the government could simply include the cost-justified preventive treatments in the baseline coverage it requires. For cost-effective preventive care that only generates health improvements in old age, after Medicare kicks in, this option becomes especially important. As discussed below, this concern arises even among those individuals currently enrolled in Medicaid.

5. GAINS FROM UN-FRAGMENTING PUBLIC HEALTH INSURANCE

Insurers in the current U.S. system potentially face large difficulties in terms of internalizing the benefits of preventive care.[12] For many maladies, the benefits of prevention only occur fairly late in life when Medicare would reap the reduced costs due to measures undertaken years before. Further, even in those instances where cost savings arise before the individual becomes Medicare-eligible, an insurer faces uncertainty as to whether the individual will still be a customer or not. Both of these forces push against insurers investing in preventive care on the margin.

Especially in the case of diabetes, but perhaps more generally as well, these issues may be even more acute among the poor who potentially have the weakest incentives to engage in prevention on their own due to high subjective discount rates, health knowledge deficits, or other obstacles to successful health management. However, because of the fragmented public health insurance system in this country, state Medicaid programs have little incentive to invest in preventive care when the benefits of that care are likely to accrue to the federal Medicare program. Although perhaps some of these incentive problems can be mitigated through federal directives and differential matching formulas within the Medicaid system, these seem like relatively poor policy tools relative to an un-fragmented/integrated public insurance program. Perhaps this is why state Medicaid programs fare relatively poorly in studies examining the degree to which enrollees receive preventive care.[13]

As implied above, integrating the poor and elderly public health systems will require standardizing what counts as standard or covered care. This would represent a departure from the current Medicaid system which can (and does)

With the rapidly declining costs of DNA mapping (see Pollack 2008), such examinations will become increasingly cost-effective.

12. See the discussion in the context of diabetes coverage in Klick, Jonathan, and Thomas Stratmann. 2007. "Diabetes Treatments and Moral Hazard." *Journal of Law and Economics*, 50(3): 519–538 or more generally in Avraham, Ronen, and K.A.D. Camara. 2007. "The Tragedy of the Human Commons." *Cardozo Law Review*, 29(2): 479–511.

13. See, for example, Armour, Brian, and Melinda Pitts. 2005. "The Quality of Preventive and Diagnostic Medical Care: Why Do Southern States Underperform?" *Federal Reserve Bank of Atlanta Economic Review*, 90(1): 59–67.

provide very divergent coverage from state to state.[14] Such standardization may improve social welfare as care dollars can be moved from relatively low marginal benefit uses to higher marginal benefit uses. Further, it almost surely would represent an improvement in equity, as the location of an individual is presumably morally irrelevant to the question of how much care he or she should receive. This standardization is also a practical requirement for the program as laid out above, given the requirement that a standard coverage package be defined. Eliminating the patchwork of state-level care mandates could also generate savings for private insurers as well as they would no longer need to master fifty different sets of regulations regarding what must be covered and at what terms.

6. EVIDENCE FROM OTHER COUNTRIES

Countries' methods of providing health care services differ in a myriad of ways. Governments often run hospitals and clinics and employ health care providers within the civil service. Often there is a "private" sector operating parallel to the government system. In other countries the hospitals and providers are private in the sense that they are not part of the civil service paid by the government directly. Yet even in these systems the government's role in financing the health care system is large. Given the role governments generally play in financing health care, even in those countries in which the provision of health care is ostensibly private, it is misleading in the extreme to speak of a "free market" in heath care.

Even with that important caveat there are important differences in the way countries finance health care that provide some insights into our proposal. In essence most countries with a private provision of health care services have some sort of mandate that individuals purchase insurance. They further provide a subsidy of some sort to individuals who are unable to pay for the mandated coverage. Interestingly, the subsidy is typically linked to an income or age threshold. In a typical scheme those individuals with income below a certain level are eligible for government assistance in purchasing health insurance, as are retired persons. Rarely is the subsidy tied to health risk. Although the price of private insurance is often risk-rated, governments rarely provide a larger subsidy to those who have greater risk of costly medical care.

The heart of our proposal is to shift the means test for public assistance away from an income-means test and toward a health-risk test. One might argue that the public subsidy systems currently have such a test. Age and income are important predictors of health risk. In the United States Medicaid provides insurance for low-income individuals whereas Medicare provides it for the elderly.

14. *See*, for example, Greve, Michael, and Jinney Smith. 2003. "What Goes Up May Not Go Down: State Medicaid Decisions in Times of Plenty." AEI Papers and Studies.

The problem is that age and income are imperfect predictors of health costs.[15] Some individuals with relatively high income but chronic conditions do not receive health insurance in the United States whereas those with very low health risk but low income are covered. Aside from the obvious equity considerations of such an arrangement, it creates a system in which private health insurance providers will compete on price, benefits, and the composition of the risk pool. With a regulated price and a requirement to offer the same benefits to all policy holders, removing high-risk individuals is perhaps the lowest cost margin on which to compete.

This problem has been addressed is several different ways in different countries. In particular we focus on three systems: the Netherlands, Chile, and Germany. The Netherlands and Germany have public funding for private health insurance. Although both have extensive public clinics and hospitals, there is a large private sector providing health services. Chile, by contrast, has a public health insurance system operating parallel to a smaller private health care system. In all three cases, risk of the insurance pool for the public system is determined by income and age. Importantly, all three mandate coverage. In particular we are interested in how these systems manage to include all individuals in the system of insurance, the adverse selection problems they face, and the lessons offered to the United States by each.

6.a Germany

Health care in Germany is financed by a combination of required health insurance, contributions for general tax revenues, private health insurance, and copayments by the individual. The financing of health care in Germany begins with a mandated membership in one of the "sickness funds." Contributions to these funds are required for those earning below a certain level. The sickness funds system is financed by employee and employer contributions and the contribution rate is determined only by income and is not risk adjusted. Although, in theory, sickness funds can set their own contribution rates, there appears to be very little difference in contribution rates. In addition, the funds are open to all and all offer similar benefits. Contribution level to a sickness fund does not determine benefits.

The ability of German health care consumers to choose a sickness fund is relatively recent. Since 1995, Germans can choose from over four hundred sickness funds and all must accept any application. Consumers have the freedom to change once a year or when they move to a new employer. Even this level of choice has produced different cost levels. It is clear, according to the Organisation for Economic Co-operation and Development (OECD) that some funds have

15. *See* Newhouse, J. P., 1994 "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs*, Spring: 132–146.

attracted higher risk populations given different costs associated with funds. The use of co-payments has risen recently as well. A number of Germans buy supplementary health insurance to cover these co-payments, dental visits, and to receive treatment in greater privacy.

Most relevant to our proposal, Germany allows high-income earners to opt out of the sickness fund by purchasing private insurance. About one in three eligible for private insurance opts out.[16] In general, these individuals are treated in the same hospitals and clinics as those on the public system, and private insurance seems largely to provide access to top specialists as well as coverage for those who work or travel extensively outside of German.

6.b The Netherlands

Provision of health care in the Netherlands is closer to our proposal. The OECD describes Holland as one of the few countries where private health insurance plays a significant role in principal coverage. In the Netherlands, as in Germany and Chile, everyone is covered by a mandate to buy insurance and those earning less than a certain threshold must purchase it from the government. There is no opt in or out except that people in the Dutch public insurance system (sickness funds) can buy supplemental insurance. Prior to the late 1980s, sickness fund participation was voluntary, which resulted in healthy individuals departing the sickness funds for private insurance. This adverse selection led the Dutch government to end the voluntary opt-out for those earning less than a specified income level.

Currently about thirty one percent of the population is covered by private insurance and is not eligible for public insurance. As in Germany, contracts with private insurance are annual and must be renewed if the enrollee wishes to continue coverage. Employers in the Netherlands also play a significant role in offering private health insurance and financing it for employees by providing contributions on behalf of employees.

Almost everyone in the public system (ninety three percent in 2000) purchases supplemental coverage. Although there is no opting out of the sickness fund coverage, the vast majority of the Dutch have some form of private insurance. These insurers, whether offering supplemental or full private coverage, are generally not-for-profit companies and are fewer in number than the German system.[17]

The proportion of the population in sickness funds, and hence private insurance, has been extremely stable for a number of years with two-thirds of the population (those with the lowest income) insured by the sickness funds. In part this is because the government provision of a subsidy and the mandate to be in

16. In 2000 about 7.4 million Germans had private insurance.

17. In 2002, forty-seven companies offered coverage with the largest controlling 15 percent of market.

the sickness fund are tied to an income threshold designed to keep the proportions constant. Everyone in the sickness fund receives a subsidy toward their compulsory health insurance premium. The subsidy is paid by mandatory income-dependent contributions collected as taxes. The subsidies are to some extent risk adjusted. Specifically the subsidy is designed to equal the risk of the person's "risk group" minus approximately ten percent, which the individual pays to the sickness fund of his or her choice.

6.c Chile

Prior to 1981, all workers in Chile contributed to a compulsory public health system—Fonasa. The system was publicly administered, and the care was provided by government employees. The system was not typically used by high-income individuals. After 1981, Chile instituted a health care mandate under which anyone who opted for the private system—Isapres—was exempt from the requirement to pay into the public system. Currently all workers must contribute seven percent of their wage or pension (although, in the case of the Isapres, they can contribute more) to either the Fonasa or Isapres. In the case of the public system, there is a maximum compulsory contribution. Workers who opt out of the public system can choose one of ten plans but most purchase health insurance. Currently, the private system covers sixteen percent of the population, although that number has been falling in recent years. One important difference between the Chilean and the German or Dutch models discussed above is that opting out in Chile is not directly tied to income.

Even within the public system there is some choice. The public system offers two options. The first allows patients to choose their provider with the patient paying a co-payment. Alternatively, patients can choose to use the state-owned hospital system where there is no co-pay. The public system is not fully funded by contributions for workers. Fisher (2004) suggests that this is largely due to the system's coverage of the indigent population. In 2003 it received fifty four percent of its revenues for the government.

The private system, by contrast, risk-rates the price charged to participants. Fisher reports that these premiums are typically greater than the seven percent contribution for the private system. Like the public system, the private plans also have HMOs and choice options and typically both have a co-payment or, more typically, reimbursement does not cover the full cost of treatment. In total, a participant in a private plan typically has about sixty eight percent of his or her medical bills covered (Fisher, 2004). One further important difference between the Chilean model and the Dutch and German models is that private health insurers are typically for-profit.

Although opting out of the public system is not specifically tied to income in Chile, the private system is typically too expensive for low-income Chileans. Fisher finds that 3.1 percent of the lowest income quartile is in the private system, while fifty four percent of highest income quartile is in the private system.

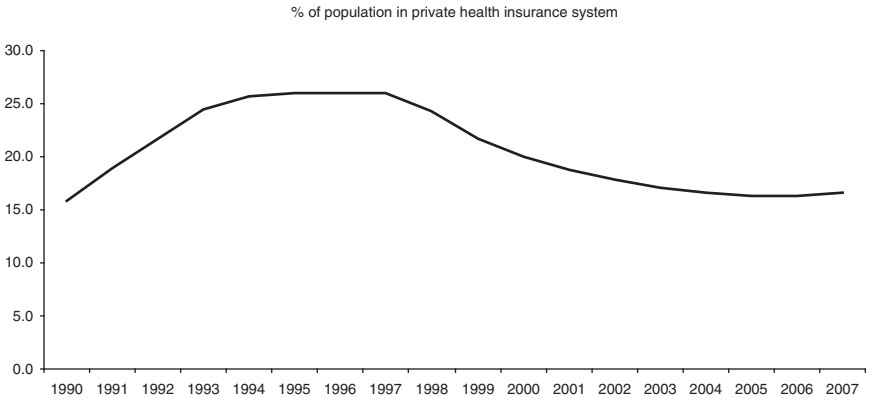

FIGURE 1 PRIVATE INSURANCE SHARE IN CHILE

Another difference between the Chilean system and those of the Dutch and Germans is that the number of enrollees has been declining since 1997. As the figure below shows, the percentage of the population in the private system has stabilized in recent years but has fallen from its high of twenty five percent.

The exact reasons for the decline are unclear, but Fisher and others posit that it is due to increased unemployment in Chile as well as increased funding for the public system. In addition, rising health care costs, caused by increasing cost of treatment, have made the public system, with its flat premium, based on seven percent of income, more attractive. A final reason appears to be a reduction in adverse selection. In recent years, the Chilean government has made it more difficult to switch into the public system if an individual becomes ill. This has reduced the number of private policies without catastrophic coverage and raised the price of private insurance. There is some evidence that private plans without catastrophic coverage were purchased by individuals who intended to use the public system if they became gravely ill.[18]

Cream skimming by private insurers and adverse selection by participants still remains. The price structure of the private plans also contributes to the problem. When an individual becomes ill, the private premium can rise while the public premium remains constant or may even fall if the illness reduces income. Currently, private plans must offer a policy renewal to an existing member, but price is unregulated. Sapelli and Torche find that private insurance is more likely for younger individuals, those with higher income and poorer health status but

18. *See* Fisher, Ronald, Pablo Gonzalez and Pablo Serra (2006) "Does Competition in Privatized Social Services Work? The Chilean Experience." *World Development*, 34(4): 647–664.

lower risk based on public information.[19] This suggests that there is adverse selection in both directions. Private plans want to get rid of high-risk individuals, and those with poor health, who can afford it, are opting into the private system.

One of the main criticisms of the Chilean model is that it is not equitable. The private system is much more expensive than the public system, with per beneficiary cost almost 60 percent greater than public care. It is unclear why. One possibility is that the public system may be more efficient, but, given that the public system provides very different types of treatment than the private system, it is hard to draw any conclusions. For example, Fisher notes that 65 percent of all births in the private system are cesarean sections, whereas the corresponding rate is far lower in the public system.

Aggregate level evidence suggests that inequality as measured by the relationship between income and contact with the health system is far smaller than many allege.[20] Consider a simple regression that estimates the relationship between income and contact with the health system. A larger positive coefficient on income in this regression indicates that higher-income individuals are more likely to have contact with the health system controlling for a variety of other factors such as age, sex, and health status. In Chile, Sapelli and Sapelli and Torche find a negative coefficient on income indicating that lower-income individuals are more likely to have contact with the health system (either public or private).[21] Only at the highest quartile of income does access and expenditure diverge. How much inequality does this generate? Sapelli find that the Chilean system is about as equal as the typical European system.[22] He concludes that the system has less inequality than the Netherlands, Spain, and the UK.

19. Sapelli, Claudio (2004) "Risk segmentation and equity in the Chilean mandatory health insurance system," *Social Science and Medicine*, 58:259–265. Sapelli, C. and A. Torche (2000) The Mandatory Health Insurance System in Chile: Explaining the Choice between Public and Private Insurance. *International Journal of Health Economics and Finance*.

20. *See*, for example, Wagstaff, A. and E. Van Doorslaer (1993). "Equity in the finance of health care: methods and findings." *Equity in the Finance and Delivery of Health Care: An International Perspective. Commission of the European Communities Health Service Research Series*, 8:20–48.

21. Sapelli, Claudio (2004) "Risk segmentation and equity in the Chilean mandatory health insurance system," *Social Science and Medicine*, 58:259–265 and Sapelli, C. and A. Torche (2000) The Mandatory Health Insurance System in Chile: Explaining the Choice between Public and Private Insurance. *International Journal of Health Economics and Finance*.

22. Sapelli, Claudio (2004) "Risk segmentation and equity in the Chilean mandatory health insurance system," *Social Science and Medicine*, 58:259–265

7. CONCLUSION

In this short proposal, we lay out an argument for providing an alternative to employer-based health insurance pooling for high-cost individuals. By developing a federal-level program for individuals deemed to not be able to afford standard care in the private non-group market, the burden of cross-subsidizing these individuals will be borne for broadly leading to a more equitable system. From a cost perspective, unbundling employment and health care insurance may generate efficiency gains as labor market distortions arising from the current system are remedied. Also, un-fragmenting the state and federal level Medicaid and Medicare systems could potentially allow for the better internalization of the benefits from preventive care among the relatively poor and unhealthy.