Ends and Means in Health Insurance Policy

by Bruce C. Vladeck

As the ratio of discussion and analysis to actual health policy change continues to grow, we seem increasingly at risk of running afoul of two of the most dangerous, and closely related, confusions in rhetoric: the one between means and ends, on the one hand, and the confusion between is and ought to be, on the other. *Covering America: Real Remedies for the Uninsured* is itself not immune from these problems, which is especially distressing given the amount of thought, effort, concern, and real goodwill that went into its production. One hesitates to criticize by name any of the 20 contributors, who certainly cannot be faulted for a lack of seriousness, sincerity, or sophistication—but individual criticism is largely beside the point. While there are many important and substantive differences among them, all of the chapters in *Covering America* occupy space within the same intellectual and political construct. And that framework, I would suggest, is very much a reflection of the problems of ends and means and is and ought to be.

In this paper, I try to identify and explore the three principal shortcomings of that framework—the confusion between means and ends in the discussion of health insurance; the confusion between means and ends in the discussion of incrementalism; and the confusion between is and ought to be in the discussion of health care costs and markets—and try to identify some of the consequences. In fairness to the spirit of the enterprise, however, I think it would be inappropriate to engage solely in criticism. Therefore, I will try to suggest some alternate ways of thinking about things that might be more conducive to moving policy in the direction everyone says they want to go—or, alternatively, to smoking out some of the profound conflicts and fundamental disagreements that the current discourse conceals, and that in fact may constitute more significant barriers to policy change than any shortcomings of the analytic process.

My own view is that, when real, non-incremental change, good or bad, comes to American health policy, it will do so as a result of a process in which analytic discourse will be largely irrelevant—in which, indeed, the process and products of analytic discourse become a weapon in the fight against change. Such a view, of course, exposes its proponent to accusations of anti-intellectual nihilism, to which I can respond only by reference to the historical record, and by re-emphasizing the difference between means and ends.

Means and Ends in Health Insurance

In the very first sentence of their chapter, Wicks, Meyer, and Silow-Carroll write,

> No Americans should be denied access to needed medical care because they lack health insurance coverage, and no health care providers should go unpaid because they treat people who lack the means to pay for care. This proposition is the guiding principle underlying the proposal for universal health coverage that we develop in this paper.

This is a worthy principle, and one to which I certainly subscribe, as I am sure do all the authors in *Covering America.* But then, like the other authors, Wicks, Meyer, and Silow-Carroll proceed to devote most of their discussion to health *insurance,* not access to health care.

It is easy to confuse the two. The syllogism is pretty straightforward: in the contemporary United States, health insurance coverage is generally a necessary, if not always sufficient, condition for access to the kind of "mainstream" health care that most of us expect. The evidence is overwhelming that individuals without health insurance have less access, and less satisfactory access, to the health care system than the rest of us, a particularly important point to make in the current political climate, in which the notion that "no one in America is denied access to medical care" has taken on considerable currency, although it is demonstrably untrue. Most of those without insurance are, in Uwe Reinhardt's particularly apposite phrase, "beggars at the health care feast," a phenomenon that few would condone openly.

But not all health insurance is the same. And not everyone with health insurance has "the means to pay for care" as a result. Indeed, as several of the authors in *Covering America* do acknowledge, a growing number of Americans have health insurance that is inadequate as a tool for insuring the means to pay for care. More important, most of the contributors would encourage the proliferation of health insurance policies that would increase the numbers of Americans who had nominal health insurance, but lacked the ability to afford services they need.

The underlying problem, of course, is that health "insurance" is at least partially a misnomer. One could spend a lot of time in the debate over whether health insurance is insurance at all, but the ways in which it differs from property and casualty or automobile or life insurance are particularly important for the issues at hand. Since Kenneth Arrow, health economists have tended to focus on the extent to which insured events in health care take place at the discretion of the insured—a concern that I think is much overrated, and that has contributed significantly to the confusion about health insurance—and the extent to which "moral hazard" exists. But even more important is the fundamental fact that insured events happen quite often. The average American with health insurance has more than four covered physician visits a year, along with claims for prescription drugs and other services.

Much of what consumers want from their health insurance is precisely what economists do not want them to have: protection from out-of-pocket costs at the point of service and decoupling of financial and clinical transactions. We used to call some of what we now lump under "health insurance" "health care prepayment plans," and that is what health insurance represents for many consumers. Policy makers keep trying to shift coverage from the front end to the back end, but actual consumers keep buying more front-end coverage than would be rational if they were primarily interested in buying insurance.

More important than prepayment as a unique characteristic of health insurance is the extent to which such insurance is redistributive. It redistributes resources from the healthy to the sick. Most of the authors in *Covering America* seek to maintain or expand insurance pools such as those provided by most large employers to avoid the complex risk-adjustment methods that must be adopted otherwise to prevent risk selection from overwhelming the redistributive power of health insurance.

The simple arithmetic requires such redistribution. If the purpose of health "insurance" in a society like ours is to assure, or help assure, that people will have the necessary financial resources to pay for necessary medical care when they get sick, then the brute fact is that the cost of treatment for one serious illness can easily exceed the total gross annual income of an average household. And the probability of encountering such expenses is not randomly distributed among the population, but not distributed in entirely predictable ways either: healthy 30-year-olds get hit by cars and develop cancers, but at a much lower rate than 60-year-olds or 80-year-olds. So most of the authors in *Covering America* require community rating of insurance pools to ensure that the health insurance market does not work like a real insurance market, by concealing subsidies from the healthy to the sick. And as several contributors note, the practical and political advantages of maintaining a system of employer-based health insurance are counterbalanced by the fact that working people are systematically healthier than are non-workers.

This would not be such a big deal if it were not for the fact that the risks of needing expensive medical care are distributed not just by demographic characteristics, but by income as well. The less income one has, the more likely one is to be sick (which is cause and which is effect is an interesting but insoluble question). At the same time—in an often overlooked obvious point—the less income one has, the less one has to spend either on purchasing health insurance or paying out-of-pocket costs. So if health insurance is to be an effective means toward the end of access to medical care, it has to subsidize people of modest incomes quite extensively. Doing so, however, costs a lot of money, since even without the tax exclusion, people with more money will continue to demand extensive insurance. As a result, many of the contributors to *Covering America* end up recommending subsidization of moderate-income people at a level that provides them the opportunity to obtain health insurance that almost certainly will be inadequate to provide them with access to mainstream health care. This is not just a theoretical assertion: in multiple-choice, defined-contribution employer plans in both the public and private sectors, there is a powerful correlation between income and plan choice, and unless health insurance prices have absolutely no economic meaning, this means that lower-income employees are getting less valuable health insurance, even though they are more likely to need it.

For very low-income people, we know very clearly that copayments deter medically necessary outpatient utilization. The effective prohibition on copayments for most services is what makes Medicaid so unusual in American health care, and is why folks like Feder et al. cling so desperately to preserving Medicaid as a means of assuring access to care for low-income people. But in this and other ways, Medicaid thus really is not insurance at all; it is a mechanism to funnel money to providers of service on behalf of people with effectively no disposable income of their own. Of course, just because Medicaid is not really health insurance does not mean that it actually guarantees access: while Medicaid beneficiaries, in general, have significantly better access to needed medical care than do the uninsured, their access is often inferior to that of more affluent people with private insurance.

The ultimate confusion between means and ends in the discussion of health insurance is reflected in the growing number of proposals—including several in *Covering America*—to encourage bare-bones, high-deductible policies exempt from mandatory coverage laws. Since such policies presumably will be much cheaper than most of what is now on the market, it would require substantially less subsidy to expand the number of nominally insured people. Widespread adoption of such policies also would be a financial boon to providers who give expensive services in emergency situations, who presumably would be paid something for some cases for which they now are not paid at all. But such widespread adoption could also significantly increase the number of people with health insurance without increasing access to most needed care.

Means and Ends in Political Strategy

In describing the process through which the papers in *Covering America* were developed, Elliot Wicks explains, "Although political feasibility is important, we wanted authors to consider approaches that involve fundamental reform . . . . Writers were told not to assume the present political climate." It appears that almost all of them ignored that advice. Either explicitly or implicitly, *all* of the authors talk about incrementalism as a political necessity, and all describe what are essentially incremental strategies.

In the political science literature in which the term, "incremental," originated, there are in fact two senses in which the concept is used. The first is descriptive (incrementalism as an "is"), a way of characterizing the processes through which social policy in the United States generally is made. The Madisonian division of powers, it is argued, along with the naturally pragmatic, non-ideological character of American culture, produce political processes that normally solve problems a little piece at a time. The evolution of the Social Security System, including its Medicare component, generally is adduced as the prototypical example. In the history of American

social policy, incrementalism is an observable empirical fact—though not an unvarying one.

But there is also a normative ("ought to be") theory of incrementalism, which advances it as a cognitive strategy in a world full of unknowns and unintended effects. In this guise, incrementalism is a way of coping with uncertainty and minimizing adverse consequences. In his essay, Mark Pauly explicitly adopts the latter strategy, but most of the other authors in *Covering America* argue that their proposals are inherently incrementalist, not because that is optimal, but because they have no other choice. We cannot get to universal coverage in one fell swoop, it appears; the most we can hope for in the foreseeable future is limited, incremental change. Given the consequences for real people of not having health insurance, it is irresponsible to hold out for utopian change when incrementalism offers the most realistic hope of actually accomplishing something.

That argument is fundamentally a tactical argument, a statement about ends and means. We know where we want to get, and incrementalism will get us there.

But that argument may be wrong, and I believe it is. We have been pursuing incrementalist strategies for expanding health care coverage for more than 20 years now, and the number of uninsured people has increased dramatically during that period. We are now approaching an economic period during which some of the more direct results of incremental strategies—such as the non-entitlement status of State Children's Health Insurance Program (S-CHIP) eligibility and the expensiveness of COBRA (Consolidated Omnibus Budget Reconciliation Act)—are likely to accelerate the process of health insurance loss. And just because a single example of non-incrementalist policy effort, the Clinton administration's Health Security Act, failed dramatically does not imply that incrementalist efforts have not failed as well.

In my own view, the lessons of the Reagan Revolution of 1981 and the Contract with America Congress of 1995–96 are that non-incrementalist strategies may be much more effective: even if the changes they produce are fundamentally incremental, change does occur, and in the direction the proponents of the non-incremental strategies desire. We may be re-learning the same lessons now. If you really want to change social policy in this country, it may be that you have to take advantage of a post-election honeymoon, regardless of how broad or narrow the electoral outcome actually was, to go for broke. There may be subsequent political penalties for overreaching, but in the meantime, one may get closer to one's goals. We are no closer to universal insurance today than we were 20 years ago, but during that time we have abolished the statutory commitment to full employment, federal efforts at school desegregation, and entitlements to cash assistance for single mothers.

The point, though, is that these are, or should be, fundamentally tactical arguments, arguments about means, not ends. It may well be that the only way to bring about even incremental change in the right direction is to advocate for non-incremental change. Effective political rhetoric, and effective political strategies, may require depiction of a preferred end-state that may never be attainable, but that at least can serve to define the goals of policy change, and provide a metric by which to evaluate that change. You can't always get what you want, but if you do try (to ask for all you want), you may just get what you need.

Is and Ought to Be in Health Insurance

By my count, half the contributors to *Covering America* had some involvement with creation of the Clinton administration's health reform proposal, as did I. I thus found it particularly astonishing that no fewer than five of the proposals therein involved purchasing pools or insurance exchanges—although I hasten to note that there was not a one-to-one correlation between Health Security Act alumni and pool advocates. As best I can tell, insurance exchanges are what we used to call health insurance purchasing cooperatives (HIPCs), and then, thanks to the White House spinmasters, "health alliances." No feature of the Health Security Act evoked more ridicule, mockery, or disdain. One might even suggest that the political unattractiveness of health

alliances contributed to the non-incremental policy changes of the Contract with America.

Whatever the political implications, the issue is that real health insurance markets refuse to behave like perfect theoretical markets, and real health insurance consumers refuse to behave like abstract consumers, and health policy analysts continue to devote enormous time and effort to trying to make reality look more like theory. The analytic means—the application of theoretical constructs to assist in the description and comprehension of empirical phenomena—thus becomes an end in itself.

In most cases, the relative risk characteristics of an insured population are a far more powerful predictor of actual claims expense than anything one can do about policy design. Thus, unless health insurers are especially dumb (a possibility that should not be rejected out of hand, at least as a broad generalization) or altruistic to a theory-defying degree, they will do everything they can to maximize their ability to select risk. Community rating can dampen some of these behaviors a little, and risk adjustment can level the playing field after the fact, but creating a totally artificial market may be necessary. That is especially the case if one's objective is not to eliminate risk selection but to manipulate it, so that the extent of subsidies to relatively high-risk individuals and households can be minimized and, optimally, concealed.

In a few instances, involving enormous effort and considerable investment, insurance exchanges or similar pooling devices have been able to provide a small number of small businesses with access to group insurance in a form that would not otherwise have been available to them. But, as several of the contributors to *Covering America* note, voluntary insurance exchanges suffer from the generic problem that firms that are good risks—and can demonstrate to insurers that they are good risks—have little incentive to participate over time, thus making likely, in the absence of significant subsidy, the kind of self-reinforcing "death spiral" that has afflicted so many of the individual high-risk pools established by the states.

One can design all sorts of facilities to counteract some of the inefficiencies and inequities in the small-group health insurance market, although just how far that would get us in increasing the number of insured people is a very good question. The underlying problem, however, is more systemic. Most of the authors in *Covering America* seek to transform individual American households into consumers of health insurance. The rhetoric is that doing so will give people more choice and permit insurance plans to be tailored more closely to individual preferences.

In fact, the devolution of choice to individuals serves two other, more important, compelling purposes: first, it helps to conceal the already accelerating shift of health care costs from employers and other third parties to individual households by creating the impression that maintaining current levels of coverage is a whimsical luxury for which families should pay a punitive amount. Second, by fragmenting the purchasing power of consumers, it moves the health insurance market closer to the theoretical model of neoclassical microeconomics, which is easier to talk and make assertions about.

The problem with this line of reasoning is that most individuals want no part of being health insurance consumers, and their wariness may be quite rational. A recent Commonwealth Fund survey reinforced the long-standing findings of other public opinion research that people prefer employer-provided health insurance largely because they have more confidence in their employers' ability to deal with health insurers than in their own. Data collected about Medicare beneficiaries since the advent of The Balanced Budget Act are hardly very encouraging about the ability or enthusiasm of most beneficiaries for even a very highly structured choice process, and health insurance has a higher salience for Medicare beneficiaries than for younger people. In addition, Medicare beneficiaries have far more time on their hands.

Of course, there will always be some people who prefer to have greater opportunities for choice in purchasing health insurance; one suspects that the proportion is significantly higher among academics, especially social scientists, than any other group in the population, but empirical data are scanty on this topic. And it is probably a good idea to give them

opportunities to exercise that choice, as long as we can prevent the tail from wagging the dog. But there are good reasons why individual health insurance has never accounted for more than a small fraction of the basic health insurance market in this or other countries—although it may be quite functional in a choice-driven, supplemental market that serves primarily to offer an escape valve for the more affluent. For the average consumer, though, the information and transactional costs of health insurance purchasing may far outweigh the benefits of individually tailored policies, even if one can effectively prevent the choice process from becoming an opportunity for risk selection.

In another instance of preferring theory over reality, almost every contributor to *Covering America* suggests, implicitly or explicitly, that competition among health plans is a necessary vehicle to control health care costs, especially because of the political unacceptability of direct government constraints on prices or expenditures. The rejection of government-administered cost containment represents, of course, another instance of converting the empirical, contemporary "is" into an analytic "ought to be," but we certainly have a considerable body of evidence to suggest that greater competition in health care, as a means to control costs over time, simply does not work. It may work for a very short period, or it may appear to work if people confuse the operations of the underwriting cycle for more substantive secular change, but competition among health plans, or among providers, whatever its other merits may be, does not save money over time.

In response to evidence about the absence of any clear-cut link between competition and efficiency in health care, competition proponents tend to cite either so-called design flaws in public policy or political backlash against, say, successful managed care efforts. But those are just another way of saying that, if reality fails to conform to theory, reality must be changed.

Formulating Alternatives

If the ends—the goals—of health policy should be to ensure access to needed health care for all individuals in this society, regardless of their economic circumstances, and if health insurance provides at least a partial means to that end, then there may be some other ways of thinking about some of these issues that will be of some help in moving forward. I propose to accomplish significant change—in incremental steps, but quite non-incremental in total—by proposing a non-incremental idea.

To start with, incrementalist efforts to solve the problems of the uninsured continually run into a particular difficulty: however many individuals become newly insured as a result of those efforts, others (perhaps even greater numbers) are losing insurance at the same time. We keep struggling to fill a glass that has a major hole in the bottom. Apart from the fact that, during any given period, many people are losing their health insurance, this also means that many of the still-insured face considerable anxiety or even "job lock" for fear of losing coverage, while the simple churning of so many households into and out of the system also creates enormous administrative and organizational costs for all concerned.

But if everyone ought to have health insurance, and it is hard to keep finding new ways to supply it to the uninsured, we might think about approaching the problem by starting with the proposition that *no one should lose* insurance. We should quickly adopt the absolute principle that, once a household has health insurance, it keeps it forever (or at least for as long as the household continues to exist). When people change jobs, or relocate, or experience changes in family status, they should keep the health insurance they already have until they get something new.

The unseemly haste with which employers, affinity groups, Taft-Hartley plans, and Medicaid agencies discontinue coverage for people the moment their status changes (or in the case of at least some Medicaid agencies, when their status does not change but the bureaucratic hurdles for continuing enrollment are not surmounted) arises, of course, from their concern about the financial liability they will experience for people for whom they are no longer responsible. But any policy that works to reduce the number of uninsured will surely

require a new set of public subsidies. We just need to think about targeting those subsidies to help people *keep* insurance, rather than *regain* it.

The basic structural mechanisms for implementing this approach *already exist.* People who lose jobs with large and medium-size employers are eligible for COBRA, for which administrative mechanisms are in place; developing methods to extend or socialize those mechanisms for smaller employers should be relatively straightforward. Federal law requires every state Medicaid agency to maintain a subrogation unit to collect from workers' compensation and auto insurance carriers, and to cross-match enrollment tapes with employment data. Finding out, with a high degree of confidence, who gets new health insurance is not extremely difficult; getting the right subsidies to the right places will be more complicated. But allocating the costs of maintaining insurance between government and individual households could be accommodated easily through the tax system.

My own instinct would be as follows: every household that legally qualifies as non-tax-filing, and has no health insurance of at least some minimum quality, gets a full subsidy either to keep a previous policy or to receive Medicaid or S-CHIP. Whether the household keeps the previous policy or receives Medicaid should be determined entirely by which is cheaper, for equivalent benefit packages. All households that file returns should be assessed a surtax of some fixed percentage of adjusted gross income. This surtax would fund a sizable proportion of the cost of the new government subsidies embodied in this proposal. Additional funding may need to come from general revenues or other means if the surtax is not sufficient to cover program costs. All current deductions and exclusions for health insurance and health services should remain, and the employee share of premiums for employer-provided insurance should be fully deductible, regardless of itemization. In that way, we can subsidize health insurance for the more affluent segment of the population just as we now do, through the income tax system (without running quite as much new revenue through the federal government), while continuing to provide employers with an incentive to offer health insurance, with the concomitant efficiencies of large-group plans. When individuals' job or family status changes, if they do not immediately receive new insurance from a new employer or new family, payment of COBRA will be automatic, with the relative split between public subsidy and individual contribution tied to income.

In essence, everyone's health insurance would be financed by a combination of private funds—from individual households or on behalf of individual households by employers who provide compensation in the form of health insurance rather than wages—and public subsidy, *as is now the case for everyone except some fraction of the people who are unfortunate enough to be forced to buy individual policies.* As people have noted for years, a subsidy is a subsidy, whether it takes the form of a Medicaid benefit or a tax expenditure for employment-based health insurance. The difference is, under this proposal, potential loss of health insurance would trigger a new subsidy, tied to the household's annual income determined as is now the case after the end of the year, and equally available for public and private insurance.

Since the policy goal is to provide everyone with access to health care, we should be prepared to pay now and collect later, particularly since so small a fraction of health insurance in contemporary America involves assumption of real insurance risk by intermediaries or insurance companies. Cash flow might become a problem for some of the smaller players in the system, but it would not cost very much, comparatively speaking, to subsidize appropriate working capital loans.

Over time, the administrative complexities and horizontal inequities arising from perpetuation of an unsatisfactory, pre-existing status quo might create considerable pressure for still further changes in the system. Adjustments would need to be made for firms that go out of business or drop their health insurance coverage altogether. It might become necessary to find a more sophisticated and equitable risk adjuster for COBRA than simply paying 102 percent of the average premium. If the ultimate goal of policy is kept clearly in focus, then we might respond to some of the costs and irritations arising

from cumulative incremental change by finally adopting some non-incremental improvements.

All we need to apply these principles—along with some additional subsidy to individuals who have had no insurance at all for a while—is the necessary political will and a rather substantial amount of money. Covering all of the uninsured is going to cost a lot, and I personally believe it is important not to repeat the Clinton administration's mistake and attempt to sidestep or finesse the issue of costs.

While in a more perfect world it certainly would be possible to finance care for all of the currently uninsured in America by simply eliminating a fraction of the waste and inefficiency in the current system for the insured, we do not seem to know how to do that, and even if we could make the system a whole lot more efficient, we do not have very good mechanisms for capturing and reallocating the savings. On the other hand, political and economic events of the last several years have reminded us how essentially wealthy this nation is, and how the ability to afford even tens of billions of dollars a year in additional public expenditures is a matter of political choice, not economic constraint. My particular proposal imposes the greatest cost on upper-income taxpayers while providing the greatest benefits to lower-income taxpayers, which is a conscious policy choice.

By my back-of-the-envelope calculations, full implementation of this particular proposal would reduce the number of uninsured by at least half within two years. I believe that is at least as fast as any of the proposals in *Covering America,* and much faster than anything now being discussed in Washington. Increasing enrollment of Medicaid- and S-CHIP-eligible children, and expanding coverage to their parents, would cover some of the remainder. For everyone else, I would personally favor Jacob Hacker's enhanced Medicare proposal, at least in part, since they all will eventually become Medicare beneficiaries anyway.

Non-incremental expenditures require non-incremental politics. And while most of the political and opinion elites seem to favor incremental change that clings to the center of perceived public opinion or policy choices, one certainly could argue that the most effective advocates in the American political system over the last several decades have been those who rejected that approach. Ironically, given our notions of "radicalism" and "conservatism," it has been those on the right who have been least tolerant and least accepting of consensual, incrementalist politics, and I think it is very hard to argue against the belief that they have been astonishingly successful on matters of economic and social welfare policy, and only slightly less successful on so-called social issues. Indeed, given the divergence in tactical orientations between proponents and opponents of dramatically expanding government subsidies to permit greater access to health insurance, the more practical political bet will be that we move backward rather than forward in the immediate future. The alternative most grounded in recent political experience, I believe, would be for those who believe in universal coverage to demand the whole ball of wax.

Postscript: A Word from Our Sponsors

For good reasons, most of the contributors to *Covering America* have relatively little to say about Medicare beneficiaries. People over age 65, along with recipients of Social Security Disability Income and those with end-stage renal disease are, after all, the only categories of Americans with universal health insurance coverage. But those, such as Hacker and Wicks, Meyer, and Silow-Carroll, who would extend Medicare coverage to others in the population acknowledge that, in doing so, it should be necessary as well to improve the existing Medicare benefits package.

If our criterion, again, is improved access to needed medical care, then Medicare as it is now constituted increasingly fails that test for a growing proportion of its beneficiaries. On average, it now covers barely half of the total health care expenses of the people it covers, and its generosity of coverage compares unfavorably to almost every other health insurance policy now available in the market. An ever-growing number of beneficiaries go without needed services because of economic barriers.

If we are going to move to universal insurance as a mechanism for universal access, then, taking the

existing Medicare program for granted is inadequate. We need to bring its coverage up to par, beginning, at a minimum, with a decent prescription drug benefit and some limitation on total out-of-pocket liabilities for beneficiaries. Doing so, of course, would be very expensive, and the resources available for insurance expansion are presumably finite in the short run. But if we are going to reject incrementalism as a goal, and perhaps as a tactic as well, then the simple fact is that equity demands that everyone be covered, and that those with the greatest health care needs be covered at least as well as the rest of us. A society this wealthy really can afford both. In fact, I would personally argue, it is hard to see how, ethically, we could afford to do one but not the other.

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Vladeck

Commentary Abstract

Bruce Vladeck provides a general critique of the reform proposals in the first volume in this series. He argues that too many of the authors have falsely assumed that access to the kind of insurance they propose will ensure access to adequate health care. He suggests that the authors may be incorrect in concluding that the only way to achieve universal coverage is through incremental steps toward that goal. He criticizes the proposals for trying to create health insurance markets like those of economic theory in spite of the evidence that this is inconsistent with consumer preferences and probably will not work. He closes by offering the outlines of a reform he favors based on the principle that no one, once covered, should lose health insurance.

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