Decentralizing Tragic Choices:

Pooling Health Risks with Health Unions

By K. K. FUNG*

ABSTRACT. Pooling health risks through insurance has led to cost explosion because centralized third-party payers cannot deny even cost ineffective treatment for life-and-death cases without arousing a sense of tragedy and inviting legal challenges. If the same total health budget is distributed equally on a per capita basis, funding decisions for treatment can then be voted on in a decentralized manner. Because unfunded treatment would be a result of majority choice and not bureaucratic decision, both a sense of tragedy and legal challenges can be avoided. Health unions that serve as fund-raising agencies and consumer advocates can coordinate such voting.

I

Centralized Versus Decentralized Tragic Choices in Health Care

LIFE-AND-DEATH DECISIONS AROUSE a sense of tragedy because there are conflicts in ethical principles. Specifically, compassion requires us to regard all human lives as priceless and to preserve them at all cost. But utilitarianism dictates that scarce resources be allocated to achieve the greatest good. Hence, life-and-death human needs must be prioritized. When some lives must be given up in favor of others, such choices are regarded as tragic. This sense of tragedy, however, can vary depending on how tragic choices are made. For example, most people would be resigned to an aggregate tragic outcome if it were a result of impersonal interactions of individual decisions. But if the same outcome were a result of a centralized decision, most people would be repelled by it (Calabresi and Bobbitt, 1978). This is so because in centralized decision making, the conflicts between ethical principles are highly visible and often explicit. In impersonal interactions

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of independent decisions, these conflicts are hidden and anonymous. As a result, people are resigned to seemingly random results of uncoordinated innocent choices.

In health financing, however, this insight for avoiding a sense of tragedy is ignored. Health insurers deal with tragic life-and-death health choices by pooling premiums into their centralized coffers. This centralized mode of decision making has engendered a profound sense of tragedy when funding for life-and-death treatments is denied.

Although treatment decisions are recommended by individual physicians and desired by individual patients, health insurers ultimately approve or disapprove these recommendations or desires. Paradoxically, this concentration of power in the hands of insurers weakens their power for rational but unpopular funding decisions. Because resources are pooled into the hands of insurers, their deep pockets invite political, moral, and legal challenges. If health dollars were decentralized to the hands of health consumers who must independently decide on whether to fund specific life-and-death cases, their decisions wouldn't be easily subject to political and legal challenges. But can decentralized health-financing work?

This paper analyzes the unique moral hazards of health insurance and suggests an alternative institution to pool health risks by separating the fund pooling function from the fund allocation function. For ease of exposition, this paper defines *health insurance* as any health plan that pools resources up front and centralizes funding decisions on health needs. Thus, health insurance encompasses private health plans as well as Medicare and Medicaid.

II

Unique Moral Hazards in Health Insurance

HEALTH INSURANCE POOLS HEALTH RISKS by converting unpredictable medical expenses into a fixed health insurance premium. In spite of its prevalence, health insurance is fraught with unique moral hazards not found in other kinds of insurance.

In most insurance, the covered loss is determined when the covered event occurs. For example, if an auto collision occurs, the damage to the car is determined at the same time and cannot be altered easily by the wishes of the insured. The covered loss will be either the repair cost or the

replacement value of the car, whichever is less. So most of the risk that can be affected by the behavior of the insured is before the fact.

In health insurance, the insured can also affect the risk of loss after the fact. For example, if the insured develops a bad liver, the loss is determined largely by the wishes of the insured. The loss will vary considerably depending on what expensive treatments are available and which of these treatments the insured wishes for, subject to the lifetime coverage cap. Furthermore, the insurer is no longer free to offer a replacement value to the insured instead of the more expensive treatment. In any case, there is no replacement value for a human life comparable to that for an automobile. As long as a treatment can promise a reasonable chance for temporary improvement, it can be demanded by the insured. Thus, the risk is no longer just how likely a liver turns bad, but also how likely the insured patient insists on specific liver treatments. Not only is the insurance pool held hostage by the wishes of the patient, it is also held hostage by what expensive treatments medical research can come up with (Weisbrod, 1991: 523–52).

III

Health Insurance as an Overexploited Commons

THESE UNIQUE MORAL HAZARDS of health insurance result from the existence of a pool of resources to which the insured have unassigned claims. Because exclusive claims have not been assigned, the pooled resources are subject to competitive capture by contributors. Whoever can demonstrate the most persistent claims ends up receiving the resources. In other words, a pooled fund is like the medieval commons. Neighboring farmers have unlimited access to the commons for cattle grazing. There is no reason for individual farmers to restrain the number of their cattle grazing in the commons since their self-restraint would only leave more room for their neighbors' cattle. Finally, collective over-grazing destroys the common pasture (Hardin, 1968).

In a pooled fund, a sign of imminent collapse is the uncontrolled ballooning of its budget. Over the past two decades, the growth rate of America's health spending has been twice the growth rate of its gross national product (GNP) (Goodman and Musgrave, 1992: 75). Currently, health spending represents about 15 percent of the GNP, higher than any other

country in the world. Between 1960 and 1994, per capita health costs leaped by 400 percent in inflation-adjusted terms (Carolan and Keating, December 10, 1996: A35).

This ballooning budget has been fueled by the availability of expensive technologies (such as open-heart surgery, intensive care units, long-term renal dialysis, and organ transplantation) and the growth of major medical coverage. The absence of any effective means to deny access to these expensive treatments has concentrated health spending on a small group of people. In 1987, the top 1 percent health-care spenders in the United States accounted for 30 percent of total health spending. In 1963, before the expensive treatments and major medical coverage were available, the comparable figure was only 17 percent (Berk and Monheit, 1992: 146).

The massive shift from fee-for-service indemnity plans to capitation managed-care plans has slowed down the cost explosion in recent years. The cost of employer-sponsored health benefits (per employee), which had been increasing by between 8 and 17 percent per year during the 1988–1993 period, increased by just 1.1, 2.1, and 2.5 percent in 1994, 1995 and 1996 respectively (*Foster Higgins, 1994, 1995, 1996*). But the built-in capitation incentives for managed-care plans to reduce routine waste and inefficiency have done nothing to stop the unique moral hazards of health insurance. The efforts of managed-care plans to deny coverage of expensive treatments have led to adverse judicial decisions and costly government treatment mandates that threaten to more than offset any realized or potential gains from reducing routine waste and inefficiencies (see Section XII, part A, below).

IV

The Rule of Rescue in the Allocation of Pooled Resources

UNLIKE A MEDIEVAL COMMONS WITH UNRESTRICTED access, the pooled fund in health insurance does have gatekeepers. But the gatekeepers are no matches for the *rule of rescue.* This rule requires that we not stand idly by when an identified person's life is visibly threatened if effective rescue measures are available (Jonsen, 1986: 172–174). This rule is particularly difficult to ignore when the funding decision is centralized. Centralized decision-making exposes irresolvable conflicts between the ethical prin-

ciples of compassion and utilitarianism and provides a visible focal point for public outrage when funding for life-and-death needs is denied.

An increasing variety of rescue measures has added to this difficulty. The ability of modern medical technology to turn acute illnesses into chronic illnesses is legendary. A panoply of new procedures and products, from magnetic resonance imaging (MRI) to bone-marrow transplant, has come on line in the last couple of decades. And each of these procedures costs from $1000 to more than $100,000.

The rule of rescue is ineffective by itself unless it is enforced effectively. Enforcement consists of a three-step process. First, sanctifying the rule of rescue. The goal of sanctification is to confer the status of political correctness. Once this status is achieved, the full force of social conformity can be brought to bear on dissenting opinions. Second, exposing dissension from the rule. Open ballots in legislative chambers and media coverage put dissenters in the most unfavorable spotlight. Dissenters are then forced to falsify their preferences and go with the flow of public opinions. Third, passing the buck. When the private cost (of dissension) to one's career exceeds the private cost of increased contribution, there is no point to go against the tide. This three-step process has effectively brought about many of the legislated mandates for expensive and sometimes unproven treatments (see *e.g.,* Holoweiko, 1995: 171–182).

V

Separating Fund Pooling from Fund Allocation

BECAUSE THE PRIVATE COST OF DISSENSION always exceeds the private cost of additional contribution to the pooled fund, there does not seem to be any effective control over the size of the pool. But this impasse exists only because the separable functions of pooling funds and allocating funds are lumped together. When these functions are lumped together, a centralized agency is responsible for both pooling funds and allocating them. If there is a new cause to be funded, it is much easier for the centralized agency to pool more funds from the disorganized general public than to divert funds from established causes within the pool. But if the centralized agency were only responsible for recruiting contributors while contributors were actually responsible for allocating their share of the funds in the pool, the centralized agency would then be relieved of the need to defend allocation

of funds among causes within the pool. Because funding decisions had been decentralized to individual contributors, special interests for new causes would have to dilute their lobbying efforts among the many contributors to the pool. And when increasing total funding to the pool could no longer guarantee increased funding to the new causes, the pressure to increase funding to the pool would be reduced.

Separating the fund pooling function from the fund allocation function is most appropriate for health care. Unlike other merit goods requiring pooled funding, the needs for health care are random and non-uniform. In health financing, the government should only guarantee that every potential user of health care has the means to contribute to a pooled fund but let contributors decide which pools to join and what treatments they want to fund within their chosen pools. Specifically, the national budget for health care from all sources could be divided equally among all U.S. residents who then choose what treatments they want to fund. Since the decentralized resources must be used for health care, there will be enough pooled resources for expensive treatments. And since individuals can vote their opinions in private, there is no need to falsify their preferences just to be politically correct. In addition, when there is no need for legislators to create individual health-care mandates, they don't have to falsify their preferences either. Instead, their job is simply to decide on the size of the overall budget. Without the drama of specific rescues, it is unlikely that much more additional funding will be forthcoming. An overall funding cap tying the national health budget to the gross domestic product (GDP) can then be established. The health budget will grow, but no faster than the growth rate of GDP.

VI

Decentralizing Tragic Choices through Health Unions

WITH AN EQUAL AMOUNT OF HEALTH DOLLARS, health consumers can pool their risks by joining health unions. *Health unions* are fund-raising organizations for members with similar treatment philosophy. Unlike health insurers who collect premiums up front, health unions simply channel funds raised from the healthy to the medically needy members. Although health unions are not allowed to exclude any applicant on the basis of their treatment philosophy or pre-existing conditions, members of the same union

tend to share the same treatment philosophy (see Section VIII, "Adverse Selection," below).

Under the veil of ignorance, individual health consumers who do not know in advance what diseases they might have would have much less difficulty in arriving at a tradeoff between the long and complex factors involved in measuring health benefits and comparing interpersonal health utility. Or if the difficulty is not reduced, individuals' trade-off decisions are at least less subject to political and legal challenges. On the other hand, health insurers are vulnerable targets of lawsuits. Even if the suits were unsuccessful, insurers would still be reluctant to publicize the basis upon which the tradeoff had been made. Instead, some subterfuge reasons would have to be used to justify its decision (cf., Tullock, 1979: 267–279).

Individual consumers making the tradeoff also do not have to worry about setting a precedent. They can change their mind about future tradeoffs depending on changing circumstances. It is the impersonal and independent votes of anonymous individual consumers that determine what the tradeoff should be. An insurer, on the other hand, does not enjoy the protection of impersonality and anonymity. Instead, it must be stuck with a bad precedent and apply it uniformly for a long period of time.

Providing equal means to join health unions of different treatment philosophy will decentralize decision making over life-and-death choices. The impersonal votes of independent consumers will approximate the anonymous interactions of market choices. The verdicts of the market are more incontrovertible and thus less tragic than the perceived arbitrary decisions of insurance bureaucrats. Hence the superiority of health unions over health insurance in pooling life-and-death risks.

VII

How Do Health Unions Work?

A. Budget Allocation

ARMED WITH AN EQUAL ANNUAL health budget, health consumers exercise their choice of health care through membership in health unions that match their treatment philosophy. Regardless of which health unions they choose, they will have to live with the following rules:

- Two-thirds of each resident's health dollars must be set aside for risk pooling in their chosen health unions. Members can choose

what treatments to fund for themselves and fellow members, but not whether to fund any treatment at all. Any surplus in this account from one year will go to a reserve fund for future risk-pooling health needs.

- Once two-thirds of the health dollars are set aside for risk pooling, access to them is restricted even to the individual owners. In other words, they cannot tap them at will for small expenses. Access to their own risk-pooling funds will be permitted only if the expenses for each treatment episode exceed their annual personal health budget and additional funds from other members have to be raised.
- Minor health expenses will be paid out of their one-third of the health budget reserved for personal use. If they are careless with this personal health budget, additional expenditures for each treatment episode that do not exceed their annual personal health budget will have to come out of their non-health dollar budget. And if these services are expensive and require fund pooling from other members, these benefits will be subject to veto by other members who may not share the same treatment preferences. Any surplus up to 10 percent of the personal health budget will be carried over for future personal health needs. The remainder of the surplus, if any, will be transferred to the risk-pooling account.

B. Responding to Appeals

MEMBERS WILL RECEIVE FUND-RAISING appeals from their health unions whenever major medical needs of fellow members arise. Since most treatments are routine and non-controversial, members of health unions can simply authorize their health unions to automatically deduct their fair share of contributions to routine treatments. In fact, health unions recruit members by identifying only a few controversial treatment areas in which members can express their treatment preferences. Once their preferences are known, they will see appeals only when there are exceptionally meritorious cases under their excluded categories and exceptionally egregious cases under their included categories. Union officials will cast a proxy vote for members if no responses are received by the specified deadline. Members will see only a monthly statement of itemized withdrawals and the balance in their health-dollar accounts. These simple procedures will help reduce the number of appeals to a manageable volume.

C. Holding Members Accountable

TO ENSURE THAT MEMBERS OF HEALTH UNIONS do not base their funding decisions on prejudicial criteria, the following guidelines can be imposed:

- *Antidiscrimination:* Fund-raising appeals cannot contain information on race, religion, or ethnicity.
- *Patient consent:* Members needing help should be allowed to amend the language and content of the fund-raising appeal prepared by union administrators.
- *Arbitration:* Disagreement on the language and content of fund-raising appeals will be arbitrated by an independent panel whose findings will be binding.
- *No net loss:* Members needing fatal help but who could not raise enough money will receive no less than their net contributions to other members in the past.
- *Community interests:* Contributions to health-related community interests should be compulsory for every health union member. These interests include funding for training of student doctors, technology assessment of new medical treatments, and maintenance of union administration.

D. Cost Savings through Utilization Information

TO GUIDE MEMBERS' RESPONSES to fund-pooling appeals, health unions can publish consumer reports on the cost effectiveness of current and new medical treatments. Subject to members' approval, health unions may also put a limit on what percentage of the risk-pooling funds that can be devoted to high-cost low-yield procedures. Within this limit, members can choose which particularly meritorious cases to fund.

Since health unions are primarily information-clearing centers, they can deliver substantial savings from their computerized treatment history database. With the buying power of its members, health unions can require physicians to directly enter patient records and billing information into health unions' computers. Its members can also directly report treatment outcome to the health union. With this database, health unions would be able to evaluate which provider gives the best value for a given disease. They can also demand satisfaction-guaranteed contracts from providers. These guarantees would reduce provider incentives to shift cost among themselves by skimping promised treatment.

VIII

Adverse Selection–Which Health Unions to Join?

BECAUSE HEALTH INSURERS NEED to adjust their premiums according to the health status of the insured and cannot opportunistically adjust their coverage for the insured after the policy is issued, they are constantly faced with the problem of preventing a concentration of bad risks. The problem of adverse selection is most serious if insurance is not compulsory. People who are healthy would be reluctant to buy health insurance. On the other hand, people with pre-existing conditions would want to conceal their medical conditions in the hope of avoiding rejection or higher premiums.

Under health unions, membership is compulsory. The question is not whether to join but which union to join. Because no consumers can be kept out of any health union, the chance of having unions segregated by medical needs is very low. For example, there is no point for sickly consumers needing expensive treatments to be concentrated in the same pool. They may be very sympathetic to their fellow members' needs, but they would not have the health dollars of the healthy to help out. Similarly, healthy consumers may want to keep their health dollars to themselves, but since they cannot keep out the sickly, they have to fund some expensive treatments of the needy. Over time, this self-selection process will result in financially viable health unions, each of which is only selectively generous with a very narrow range of expensive treatments.

Because the only way to control adverse selection of the insured is to restrict or exclude coverage of pre-existing conditions, health insurance offers little portability of health benefits from one insurer to another. Employees who become ill with a major medical condition find it difficult to change employers without losing coverage for their pre-existing conditions, even after their medical conditions have been stabilized.

Since health unions need not be regionally based (cf., Emanuel's community-based health programs, 1991: 178–194), employees who change employers can stay with the same health union. If health consumers change health unions, their transaction history will simply be transferred to their new health unions. Members who have been net donors will add resources to their new health unions. Members who have been net recipients will still have to depend on charitable donations from members of their new unions. To discourage opportunistic migration between unions, health

unions may favor in descending order the following categories of members when funding needs arise: a) old members who have been net donors; b) old members who have been net recipients; c) new members who have been net donors in their old unions and d) new members who have been net recipients in their old unions.

IX

Funding Equal Access

GIVING ALL RESIDENTS EQUAL HEALTH dollars raises two critical issues: first, the issue of equity and second, the issue of affordability.

A. Is Equal Access Fair?

EQUAL ACCESS SOUNDS LIKE A RADICAL DEPARTURE from our present apparently very unequal coverage. Currently, 18 percent of the non-elderly, or 41 million people, lack health insurance of any kind (EBRI, 1994). Even among those who have employer-provided health insurance, the coverage varies widely.

But access to health care is more evenly distributed than the health coverage indicates. First, state and local governments, plus medicaid, provide for the indigent, as do charitable organizations. Second, even for-profit providers can subsidize some care by shifting cost from those who are not covered or less covered to those who are covered or better covered. Third, in a third-party payment system such as health insurance, only those who are ill, and not those most adequately covered, receive health care. Fourth, those who are most adequately covered do not even have any say in what treatments to fund and who gets what treatment. Instead, the third-party payers centralize all funding decisions.

The idea of equal access by itself is simply to let all potential health consumers have an equal say on how a given national health budget is to be distributed among those who actually need health care. If no one knows in advance who is going to become ill, wouldn't equal access be the most equitable way to go (Rawls, 1971: 136–142)?

Under equal access, those who are currently most adequately covered and seldom get sick actually will have more say under health unions than under health insurance. Those who are chronically ill needing expensive treatments will have less say under health unions than under health insurance. And those who receive as much health benefits as their health budget

would buy will have as much say as under health insurance. Thus, equal access will move our health-care system away from the tyranny of the few needing very expensive treatments with little net social benefits to a majority rule by those who need care only occasionally.

B. Can We Afford Equal Access?

THE IDEA OF HEALTH UNIONS is to make the resolution of value conflicts easier and more defensible. But unless there is a ceiling to annual per capita health dollars, there is no need to make any tragic choices. Therefore, to contain health cost explosion, we must cap the national health budget to a fixed percentage of the gross domestic product and tie its growth rate to the growth rate of the GDP. The national per capita health budget is then simply this total national health budget cap divided by the total number of U.S. residents of all ages. The national standard household health budget is simply the per capita budget multiplied by the number of people in the household.

If we have been able to afford a health budget that has been increasing above the growth rate of the GDP, we can certainly afford a health budget that grows no faster than the GDP.

C. Transition from Current Arrangements

CURRENTLY, HEALTH DOLLARS for covered employees are directly channeled into the hands of insurers by employers without any input from employees. Employees have no say over what benefits are covered or how much their total compensation should go to health benefits. They may not like their health premiums going to fund a third coronary bypass for the same patient in their insurance pool, but they can't veto it.

If funding decisions for life-and-death cases are to be decided on by health consumers, they must first have control over their own health dollars. The only way to do it is to convert their in-kind health benefits into cash payments and deposit them into their health-dollar accounts. To ensure equal votes for everybody, something like the following can be done:

Guarantee an equal per capita amount of dedicated health dollars to all residents regardless of their income, employment, or age. The source of the dollars funding this guarantee, however, does vary with income, employment and age.

First, health benefits are untied from employment. Instead of receiving tax-exempt health benefits, employees' cash income is increased by a dollar-for-dollar conversion of these health benefits. Out of this bigger pay-

check, a sum equal to the employees' standard household health budget is withheld and deposited into individual health-dollar accounts to be used for health care only. These dedicated health dollars are tax-exempt. If the converted health benefits exceed this sum, the excess is taxed as ordinary cash income.

For employees whose current employer-paid health benefits fall short of their standard household health budget but whose income is above the medicaid-eligible level, additional tax incentives are offered. Specifically, the government offers dollar-for-dollar matching of additional deposits into their health-dollar accounts that exceed, say, 14 percent of their income. This matching will stop when the standard household health budget is reached. Any employee deposits within this budget are tax-exempt.

Second, medicaid is abolished. For households whose income is low enough for medicaid benefits, the current government budget for medicaid is converted into health dollars on a per household basis and deposited into medicaid recipients' health-dollar accounts. If the amount is less than the standard household health budget, additional government funding makes up the shortfall.

Third, medicare is abolished and the medicare tax is channeled into the health-dollar funds. People over 65 years get their lifetime contribution to medicare repaid with interest, and if not employed, they will contribute up to 14 percent of their above-poverty income. This contribution is tax-exempt and matching funds from the government make up any shortfall.

In summary, the need for additional taxes to fund the global health budget is very minimal. The leakage of health funding through higher cash income to those with above average health coverage will be more or less offset by the extra tax on these extra incomes, additional contributions from the non-elderly whose incomes are above the poverty level, and additional contributions from the well-to-do elderly who are now enjoying medicare benefits at very low insurance premiums. In fact, if the global budget is tied to a lower constant percentage of the GDP, the need for extra taxes can be done away with.

The general idea of health unions is not to increase health access by increasing the funding but by redistributing the health dollars of the current national health budget.

X

A Recap: Why Are Health Unions Better Than Health Insurance?

TO SUMMARIZE, HEALTH UNIONS have many unique advantages that health insurance does not have. They are as follows:

- *Decentralized tragic choices:* Life-and-death decisions arouse a sense of tragedy because there are conflicts in ethical principles. This sense of tragedy, however, can vary depending on how the tragic choices are made. In centralized decision making such as under health insurance, the conflicts between ethical principles are highly visible and often explicit. Denial of funding for life-and-death cases is viewed as more tragic. In impersonal interactions of independent decisions such as under health unions, these conflicts are hidden and anonymous. As a result, people are resigned to seemingly random results of uncoordinated innocent choices.
- *Interpersonal comparison of utility:* A centralized funding agency also has insurmountable difficulty in comparing interpersonal health utility. An explicit uniform tradeoff for all the insured among the many relevant factors, even if possible, is even harder to defend. On the other hand, individual consumers can freely take into account a broad range of utilitarian factors to arrive at a unique tradeoff.
- *Flexibility:* Individual consumers making the tradeoff also do not have to worry about setting a precedent. They can change their mind about the tradeoff depending on changing circumstances. An insurer, on the other hand, does not enjoy the protection of impersonality and anonymity. Instead, it must be stuck with a bad precedent and apply it uniformly.
- *Diversity:* Letting health consumers decide what treatments to fund for themselves and fellow members in their health unions reduces unnecessary disagreement on treatment limits. Not only might the overall treatment philosophy differ among health unions, members within a health union might differ on whether or how much to fund in any particular fund-raising appeal (cf., with Emanuel's commonality requirement in community health programs, 1991: 179–183). On the other hand, a uniform benefits package under health insurance requires the insured to subsidize all treatments in the package whether they agree with them or not.

- *No more free rides:* Health unions effectively get rid of free rides from both users of health care and potential contributors to pooled health funds. Free rides from users' desires for unlimited funding are curtailed because their desires must now be subject to other members' veto. Free rides from potential contributors' desires to abstain from contributing are curtailed because their non-participation would not increase their risk-pooling health benefits or augment their non-health budget (Rice, 1997: 383–426).
- *Balance between choice and means:* Health unions give equal means to health consumers to exercise their health choices for themselves and fellow members. If some treatments are denied, it is not because of unequal means, but because of low treatment priority jointly determined in a decentralized and informed way. In other words, some health needs are not met not because of collective inability to pay but because the marginal benefits of these needs are judged to be less than the cost of meeting these needs (Rice, 1997: 383–426).
- *Balance between consumer freedom and treatment limits:* The personal portion of the individual health budget allows consumers to exercise consumer sovereignty over minor medical expenses. This matches the consumer freedom offered by medical savings accounts. But unlike the catastrophic insurance under medical savings accounts with insurer-determined and legally vulnerable treatment limits, health unions have enforceable member-determined treatments limits (Bond et al., 1996: 78–83).
- *Balance between "exit" and "voice":* Health unions combine benefits from the economic model of "exit" and the political model of "voice." When consumers choose among health care providers with their personal health budget, they express their disapproval with "exit." But since transfer of membership among health unions entails loss of seniority access to pooled funds, members are motivated to exercise their "voice" within their current health unions for operational improvement (Hirschman, 1970: 21–43; Emanuel and Emanuel, 1997: 147–184).
- *Open membership:* Because health insurers need to adjust their premiums according to the health status of the insured, they are constantly faced with the problem of preventing a concentration of bad risk. With

compulsory membership under health unions, good risk cannot stay out of the risk pool, and bad risk must take care to spread themselves among those health unions that are sympathetic to their health needs.

- *Informed participation:* Because members determine whether and how much to fund their fellow members' health needs, they must be better informed about the cost effectiveness and the larger social and genetic implications of certain treatments. Health unions will conduct research and disseminate their findings to their members much like the Consumer Union does for other consumer products. Since health unions are primarily information-clearing centers, all the cost savings that a computerized medical database can deliver to health maintenance organizations (HMOs) can also be harvested by health unions.
- *Global budget cap:* Unlike health insurance, which allows for subsequent premium increase if spending in the past year exceeds the collected premiums, health unions must live within the means of their members under a global cap tied to the national income. The only time the global budget can be increased is when the national income increases. In other words, treatment limits must adjust to the fixed health budget under health unions instead of the health budget adjusting to the actual treatments received as under health insurance.
- *Political and legal immunity:* Unlike health insurers with centralized resources, health unions do not have deep pockets that invite political and legal challenges. Just as individuals with little means are less likely to be sued, health unions are less likely to be sued because they simply raise funds for major medical treatments. They have no power to compel members to pay any legal damages.

XI

Illustrations of Funding Scenarios

TO ILLUSTRATE HOW HEALTH UNIONS WORK for individual members, let us use the examples of four members with different health needs:

- *Tony Smith, age 30, single, employed, healthy with no disability:* The only health care Tony needs is routine dental hygiene and vision checkup. His personal health dollar account has more than enough balance to take care of these small health care expenses. And because the scope of qualified health care services has been considerably ex-

panded by his health union compared to pre-health-union days, he can use his accumulated personal health dollars for preventive health care. Tony is free to go to any health care providers he chooses. To help him choose providers, his health union has collected evaluations on providers who have been patronized by fellow members. Tony allows his health union to automatically deduct funds from his risk-pooling account for routine and proven treatment. He would not fund heroic treatment for preemies or the terminally ill, organ transplants for under-age patients, or nursing homes unless there were extenuating circumstances. Tony is much happier now than he was in the old days when he had no say over how much of his pay raise should go to fund health insurance premiums and where his health dollars should go.

- *Mrs. Valerie Doe, age 85, widowed with two married children, suffering from advanced Alzheimer's disease:* Valerie's health union cannot raise enough funds to send her to a nursing home and her children are unable to take care of her on a full-time basis. Her power-of-attorney for health care decides, with the approval of her children, to arrange for her a dignified exit. Her will specifies that the present value of her projected stream of guaranteed health dollars (had she chosen a slow death instead) be donated to the Alzheimer's Disease Research Fund.
- *Mark Lee, age 20, single, restaurant waiter, waiting for a kidney transplant while undergoing regular kidney dialysis:* Before health unions, Mark had no health insurance. His employer did not provide it and he earned too much to qualify for medicaid. Now that he is a member of a health union with an equal amount of health dollars as other members, he can raise funds for a kidney transplant. But Mark comes from a family with hereditary kidney problems. To entice those members who would not fund treatment for young patients with expensive hereditary diseases for fear of enlarging the pool of defective genes, Mark offers to give up his reproductive right.
- *Mary Black-White, age 40, single, suffering from advanced AIDS:* Mary needs a daily dose of three kinds of protease inhibitors to suppress the HIV in her blood. But this regimen of medications costs $7,500 a year, fully one-quarter of her annual income. Her health union reserves one fifth of its risk-pooling funds for expensive treatment that will not provide

a cure but can prolong life for a few years. Mary must compete with other members who require such treatment for the limited amount of funds. In the past, members of her health union have tended to prefer funding AIDS patients in their prime and who are not users of intravenous drugs.

XII

Anticipated Objections

A. What Is Wrong with HMOs?

MOST HEALTH-CARE REFORM PROPOSALS assume that routine waste and inefficiency are the most important cost drivers. If this assumption were true, then eliminating routine waste and inefficiency would lead to a one-time cost reduction. There is strong empirical evidence, as well as theoretical reasons to believe that the capitation arrangement under health maintenance organizations (HMOs) is an effective method for eliminating routine waste and inefficiency compared with traditional fee-for-service arrangements. Indeed, the massive shift from fee-for-service indemnity plans to capitation managed-care plans has slowed down the cost explosion in recent years. The cost of employer-sponsored health benefits (per employee), which had been increasing by between 8 and 17 percent per year during the 1988–1993 period, increased by just 1.1, 2.1, and 2.5 percent in 1994, 1995 and 1996, respectively (*Foster Higgins, 1994, 1995, 1996*).

This temporary respite from cost explosion may be ending. In 1996, for the first time in the 11 years of the Foster Higgins survey, the percentage of workers in traditional HMOs did not rise, remaining at 27 percent. Meanwhile, the more costly point-of-service (POS) plans grew to cover 19 percent of workers, up five percentage points. Many HMOs bid aggressively to win new members over the past two years just as medical costs were beginning to rise. That led to a decline in their profits and stock prices. But HMOs are now under less price pressure as mergers reduce some of the competition. In addition, health providers are continuing to consolidate, which gives them more bargaining clout with managed-care plans (*Foster Higgins, 1996*). Foundation Health (a large HMO in Rancho Cordova, California) has been putting through rate increases of 2 percent to 3 percent for big plans and 5 percent to 6 percent for smaller groups (Winslow, January 2, 1997: B1).

More ominously, the efforts of managed-care plans to deny coverage of

expensive treatments have led to costly government treatment mandates and adverse judicial decisions. For example:

- In September 1994, the U.S. Office of Personnel Management ordered all 350 health plans covering 9 million federal employees, retirees, and dependents to start paying for bone-marrow transplant (ABMT) in breast cancer—without raising premiums—or risk losing the government's business (Holoweiko, 1995: 171–182).
- In response to the HCFA's mandate that states cover three protease inhibitors recently approved by the FDA for HIV/AIDS patients, Tennessee officials ordered its TennCare (Tennessee's medicaid HMO) plans to cover these drugs within its current capitation rates (*Physician Manager*, July 26, 1996: 1055–1603).

These mandates are big budget-busters. A bone-marrow transplant can easily cost more than $100,000 (Anders, January 17, 1995: B1). And combining new protease inhibitors with older AIDS drugs can cost $12,000 a year (McGinley, January 24, 1997: B2).

Adverse judicial decisions can be just as costly. Worse still, there is no telling when the judiciary might re-interpret existing legislation that was never intended to confer such benefits. The most significant judicial decisions are the ones created under the Americans with Disabilities Act (ADA). The ADA was primarily intended to protect the jobs of disabled employees who can perform their job duties, not people claiming they cannot work because of disabilities. But,

- In 1995, the Eighth U.S. Circuit Court of Appeals in St. Louis ordered a company to enroll a breast-cancer patient in an experimental-treatment program because its health plan excluded the expensive treatment for some types of cancer in violation of the ADA (*Henderson v. Bodine Aluminum, Inc.*, 70 F. 3d 958, 1995).

This and similar decisions (Nason, 1995) effectively held that the prohibition of discrimination under the ADA superseded the Employee Retirement Income Security Act (ERISA), 1974, shield. Federal courts have long used this shield to enforce employer-sponsored health plans that exclude coverage of any kind if the claim is based on an employee's rights under the federal pension law.

The ERISA shield has also preempted state mandates and litigants suing

employers and employer-sponsored health plans from punitive and many compensatory damages in state courts. But this protection was also taken away by the Third U.S. Circuit Appeals Court in *Dukes v. U.S. Healthcare.* The court ruled that ERISA did not preempt the malpractice claim against the HMO concerned and remanded the case to state court because the HMO was not itself an ERISA plan (*Dukes v. U.S. Healthcare, Inc.*, 57 F. 3d 350, 1990).

These government mandates and judicial decisions can easily offset any realized and potential cost savings from the capitation insurance system of HMOs. More political and legal challenges can be expected as HMOs increasingly cover older and sicker patients. This managed-care "backlash" shows that HMOs' centralized coffers will continue to invite political and legal challenges. And HMOs will not be able to squeeze significant cost savings out of denying expensive treatments to marginal cases. But it is exactly the proliferation of high-cost, low-yield treatments that accounted for the high concentration of health expenditures on the top 2 percent of health spenders (41 percent in 1987, Berk and Monheit, 1992: 146). If HMOs are then forced to pinch pennies from low-cost high-yield procedures to stay profitable, the general quality of health care will surely decline.

Even if HMOs could occasionally get away with denying treatments to some marginal cases, the explicit rules that are needed to deny treatments to these cases consistently would add to the sense of tragedy by exposing the inherent conflict of values.

B. Are Health Unions Too Radical?

HEALTH UNIONS MAY SOUND LIKE A radical departure from health insurance, but some elements of them are widely practiced in America today. For example, raising funds for organ transplantation is quite common. But the appeal to the public's raw emotion of saving a life can often bias contributors toward medical procedures and hardship cases with very low net benefits. Raising funds for organ transplants may capture the technical aspect of funding major medical procedures in health unions, but it does not have the broad implications of risk pooling that health unions have. In fund raising for organ transplants, fund contributors cannot expect return favors from fund recipients or from fellow fund contributors. It is strictly a one-way transfer of health resources from fund contributors to fund recipients.

C. Are Private Preferences Really That Different from Public Preferences?

THE IDEA OF HEALTH UNIONS ASSUMES that health consumers' private preferences for treatment funding are very different from the actual funding patterns arising from current health insurance plans. And that if these preferences are allowed to be expressed freely, a different funding pattern would ensue. There are strong reasons to believe that health unions allows freer expression of private preferences.

First, the more health unions there are with different treatment philosophies that health consumers can choose from, the closer their final choices will be to their true preferences.

Second, the degree of anonymity offered to health-dollar voters in health unions reduces their need for preference falsification. Preference falsification is common when voters must openly state their positions. The fear of being seen as politically incorrect and the fear of potential retribution often bias their votes toward the politically correct position (Kuran, 1995). For example, it would be politically difficult for any legislator to vote against extending medicare coverage to kidney dialysis after the dramatic demonstration of the procedure in a congressional committee hearing in 1972.

In addition to allowing freer expression of private preferences, health unions may actually help change consumer preferences.

First, the need to live within the limited resources of a risk pool forces health union members to seriously prioritize their treatment preferences. If they spend too much on high-cost low-yield treatments, they will have to forgo low-cost high-yield treatments. The global cap on health budget makes it impossible to free ride on the public purse.

Second, voters may be more willing to be decisive if they know that hopelessly ill patients who are denied funding can resort to dignified exit in government funded dignified-exit clinics (Fung, 1993).

Third, the discouragement of legislated and judicial interventions in funding decisions takes away powerful rallying points for political correctness. As a result, diverse preferences can be formed on the basis of personal conviction.

D. What If Nobody Wants to Fund X Treatment?

IT IS POSSIBLE THAT SOME DISEASES are so socially stigmatized that undertreatment may occur due to insufficient donations. Social stigmatization, however, is often a result of organized ignorance based on the need for political correctness. Our current stigmatization of HIV-related diseases is

largely a result of government refusal to fund public awareness and preventive programs. Health unions are under no such pressure to be politically correct. Their members will be better informed about the nature of the disease and the efficacy of various preventive measures and treatment regimes. Insufficient donations for treatment may still occur, but they will be based on informed judgment, not organized ignorance. Donations for bold preventive measures, however, should be much more generous than funding under the current system.

E. Health Unions Deluxe?

EQUAL ACCESS GUARANTEES that all residents have at least adequate equal means to buy health care. But what if some residents want to have more health access than this per capita health dollar budget?

Since health unions must open their membership to all, there is not much point for some members to put more health dollars into their union-accessible accounts. If some members want to spend more on themselves, they just have to pay the extra bills out of their own pockets without the benefit of tax exemption. They could, of course, form their own private clubs to pool their resources, in addition to their mandatory risk pooling in health unions. But the resources that can be commanded by these private clubs are unlikely to be large enough to threaten the viability of health unions.

F. Health Unions and Their Members Can Also Be Sued?

EVEN THOUGH TRIAL LAWYERS don't usually file suits on contingency-fee basis unless there is a deep pocket to pay punitive damages, might some "public-interest" lawyers still try to undermine health unions on some legal grounds? To avoid these occurrences, it may be necessary to grant immunity to individual health consumers from creative extension of "Good Samaritan laws" for withholding funding from some treatment. Similarly, health-union administrators should not be held liable for violating the privacy rights of needy members in fund-raising appeals.

XIII

Summary and Conclusion

HEALTH INSURANCE HAS FAILED to contain health costs because its centralized decisions over what treatments to cover can be easily challenged. This challenge is more and more aggressive as medical advances keep raising health consumers' expectations but succeed only in converting acute illnesses into chronic illnesses.

To contain health costs without arousing a sense of tragedy, decisions on what treatments to cover must be exercised by individual health consumers. In order that each health consumer has equal say on what treatment to fund, the total health budget should be redistributed on an equal per capita basis. These dedicated health dollars will be controlled by individual health consumers. To pool risks in case of major health needs, consumers will join health unions that coordinate fundraising from members of similar treatment philosophy. Since there is no centralized pool of funds or centralized decision making, collective decisions cannot be easily challenged.

The advantage of decentralized health dollars is that no one set of treatment preferences need apply to everybody. Even though there is a global budget cap, there would be no rigid limit to what new treatment can be tried as long as enough donations are forthcoming. More importantly, because funding decisions are made by individuals according to their own conviction, the drama of value conflicts will no longer be played out on a collective stage. The collective sense of tragedy can thus be avoided.

The government's role will be limited. Apart from redistributing the global health budget, it can provide health services with community impact, such as immunization and quarantines. It can also legalize dignified exit to reduce the pain and suffering of hopelessly ill patients who are denied sufficient health-dollar funding.

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