CRITICAL ISSUES

Revised Edition

A National Health System for America

edited by
Stuart M. Butler
and
Edmund F. Haislmaier

The

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INTRODUCTION

America's health care system is on the critical list and needs intensive care. Despite public and private expenditures of an estimated $541 billion in 1988, or more than 11 percent of gross national product, the system does not deliver the services that Americans expect. A recent poll found that 89 percent of all Americans believe the U.S. system needs fundamental changes -- only 10 percent say it works "pretty well." Millions of retirees, for example, live in fear that a long spell in a nursing home will wipe out their entire life savings and drive them onto welfare. As many as 37 million Americans lack health insurance, playing Russian roulette every day with their health. For poor and elderly Americans who are eligible for government programs, spiraling health care costs threaten cutbacks in benefits. And working Americans with company health coverage are faced with a possible end to benefits they had taken for granted, because health cost inflation has driven most employers to make major revisions in coverage.

Pressure has been mounting in Congress for action to bridge the gaps in the system. Just last year, legislation was enacted to extend unlimited "catastrophic" protection to the elderly by extending the Medicare system. Already, the elderly are complaining loudly that the price tag for that protection is far too high, yet the legislation does not eliminate the specter of runaway nursing home costs. Legislation also is being considered to force employers to pay for basic medical insurance for employees and their families. And other laws and regulations are being readied in an attempt to slow down the rise in health care costs.

The danger in these efforts is that they would simply add new programs to a system that is inherently unsound and increasingly unworkable. The likely result would be only marginal reductions in the

gaps within the system in return for a boost in underlying health cost inflation. This in turn would trigger more controls and rationing and further reduce the quality of care for many Americans.

Because of its fundamental flaws, the gaps in the existing health care system can never be closed at acceptable cost without structural changes. To design the necessary reforms, policy makers first must appreciate how the current system originated, and they must understand the economic and political forces that are a product of that historical development.

As *Chapter 1* of this study explains, today's basic system evolved not in response to the needs of consumers, but according to the marketing and professional objectives of suppliers of health care. This has led to a distorted system of private insurance that provides generous routine coverage, yet little protection for catastrophic costs, and public sector programs that until recently have been virtually an open cash register for the health care industry. The results of such a system could have been predicted: health care costs in recent years have been rising twice as fast as general inflation. Reinforced by perverse incentives in the tax code, these basic features have produced a system that is saturated with both inflationary pressures and glaring gaps in coverage.

With such an unsound foundation on which to build, responding to the understandable concerns of Americans merely by adding new programs invites costly failure. Mandating employers to provide coverage, for instance, would force businesses to shoulder the system's inflationary pressures, triggering an escalation in payroll costs that would lead to cost-saving worker layoffs. Similarly, piling on new Medicare programs without structural reform would further weaken the finances of the program, threatening huge tax increases or eventual reductions in benefits.

Nor does the answer lie in trying to curb price rises through price controls and regulations. Whether they be gasoline controls during the Arab oil embargoes or rent control in New York City, price controls cause distortions, misallocation, and shortages. The recent U.S. experience with health cost controls is no different from previous ill-considered attempts to suppress inflationary pressures – controls spawn harmful side effects for consumers.

Major reform proposals in recent years exhibit two broad defects. Either they ignore the structural flaws of the current system and advocate major expansions of government activity, or they urge a

radical overhaul based on taxpayer-financed national health models or on universal social insurance. As *Chapter 2* explains, such changes would merely replace one set of inherent problems with another.

The conservative contribution to the health care debate has been confined largely to criticizing liberal proposals. As *Chapter 2* notes, this not only gives conservatives a reputation of insensitivity, but it also denies ordinary Americans the opportunity to evaluate a market-based proposal that might cure current deficiencies without creating new ones. It is this lack of a comprehensive alternative that has caused many Americans to be attracted to the liberals' health care agenda.

This study attempts to fill that void. It offers a strategy to make adequate health care available at acceptable cost to every American within a framework where strong market incentives operate to give the widest possible degree of choice and the best possible value per dollar for both patients and taxpayers.

The key element in this reform strategy, as *Chapter 3* stresses, is to address the core defects of the current system by turning today's quasi-market health care system into a true market system. Just as a strong, growing, and enterprising economy is needed as the base on which to construct programs to help the poor, so an efficient, competitive health system that well serves the majority of Americans must be the starting point for special strategies to care for the particular needs of smaller groups, such as the elderly, the poor, and the chronically ill. *Chapters 2* and *3* describe the basic elements of a reformed system. These include a major revision of the tax treatment of health care costs that removes the current perverse incentives for patients and providers. Included too is a compact between government and citizens: a commitment by government to provide aid to any family genuinely unable to afford adequate health care; a legal obligation on all families to obtain a minimum level of protection against health care costs.

Having outlined a fundamental overhaul of the basic system, the other chapters in this study turn to the needs of specific groups. *Chapter 4* lays out a health care reform package for the elderly, designed to assuage the concerns of retirees without bankrupting the Treasury. Its main components: a radical reform of Medicare, constructing a program based on vouchers and tax-free savings accounts; incentives for workers to purchase insurance to protect themselves from medical and

nursing home costs when they retire; and a reform of Medicaid to create a government-funded, long-term care program specifically designed to meet the needs of the elderly poor.

Chapter 5 focuses on other special groups ill-served by the current system – the poor and the chronically ill. This chapter reviews the innovations sparked at the state level by changes in the Medicaid system during the Reagan Administration. It notes that state demonstration projects have built up a valuable bank of experience indicating that state governments are the key to designing public-private partnerships to serve the poor efficiently and to address the problem of affordable insurance for those Americans most prone to high medical bills.

Many Americans understandably feel there is something fundamentally wrong when, in a country as rich as the U.S., there are so many citizens who lack access to affordable health care. With U.S. spending on health, as a proportion of gross national product, exceeding that of virtually every other country, most Americans also are understandably frustrated that Congress seems unable to design policies to steer those health care dollars into a satisfactory system. As this study makes clear, only a far-reaching set of market-based reforms, accompanied by a strong campaign to explain the reforms to the American people, will end that frustration and cure the ills of America's health care system. With such reforms in place, the U.S. can create a system that will be the model for the entire industrialized world.

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Chapter 1

Why America's Health Care System Is In Trouble

Edmund F. Haislmaier

There is growing concern in America that the nation's health care system needs intensive care. The most obvious problems are the rapid escalation in the cost of medical care and, in part as a result of such high costs, the fact that many Americans effectively are denied access to necessary medical treatment. In response, Congress and many state legislatures are considering proposals to close gaps in the system. Lawmakers are looking for ways to finance the increased need for long-term care among the elderly; they are considering programs to provide coverage to millions of younger Americans currently without health insurance; they are trying to alleviate a shortage of nurses; they are exploring policies to expand medical services for the poor; and they are trying to respond to new health care demands generated by the spread of AIDS.

Lawmakers have tried in recent years, through various cost control measures, to curb the rising cost of government health programs such as Medicare and Medicaid. They also have encouraged, or even imposed, price control measures in the private sector. At the same time, private employers and insurance companies have introduced a wide variety of initiatives to limit health care costs affecting private insurance plans. Yet this strategy has raised the concern that cost controls

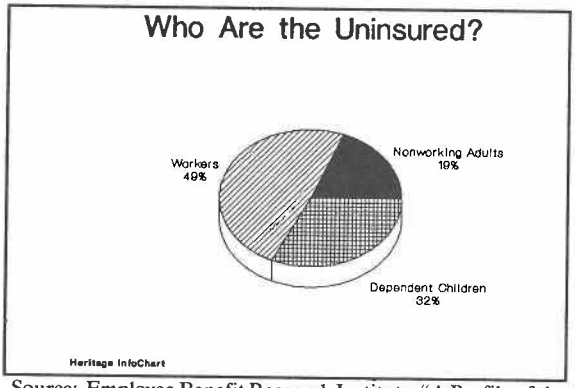
may be adversely affecting the quality and availability of patient care. And questions of declining quality are not being raised just about cost control programs in government-funded Medicare and Medicaid. There is also concern that private cost control efforts, such as the widespread use of prepaid Health Maintenance Organizations (HMOs), may be reducing the quality of care available to many private patients.

Yet amid all these problems, few would challenge the assertion that American medical care and technology are the best in the world. In fact, some critics argue that U.S. medical technology is too good and that the only way to restrain costs is by rationing expensive state-of-the-art procedures and equipment. They argue that society simply cannot afford the continued demand for more and better medical care.

While the alarmists are only a small minority, it is nonetheless clear that growing dissatisfaction with the current system is increasing the pressure on Congress to "do something." But lawmakers have been frustrated repeatedly in their search for solutions to health care problems. Time and again, they have found that a solution to one problem simply aggravates a related problem or spawns some new concern. Examples:

♦♦ Of the approximately 37 million Americans without health insurance, over two-thirds are workers or their dependents. Most of these working families lack coverage because they or their employers cannot afford it or because they choose to save money by taking the risk of going

Chart 1



Source: Employee Benefit Research Institute, "A Profile of the Nonelderly Population Without Health Insurance," Issue Brief No. 66, May 1987. Based on tabulation of the Census Bureau's March 1986 Current Population Survey.

without insurance. Yet most of these uninsured workers spend hundreds of dollars a year purchasing health care for the elderly through the Medicare payroll tax. But if Congress were to let these workers spend their money on their own health care, where would it get the money to meet the needs of the elderly? Worse still, the demand for health care among the elderly is growing, and Medicare is running out of funds to pay for it. If Congress decides to increase the payroll tax to cover the rising costs of Medicare, it will leave workers with even less to spend on their own health care, and it will increase the number of workers without any health insurance.

♦ ♦ Proposals have been advanced for using Medicaid to subsidize the purchase of health insurance for low-income workers either by allowing these workers to "buy into" Medicaid or by using Medicaid funds in the form of vouchers to subsidize the purchase of private insurance by these workers. Several states have introduced such programs or are considering them (see *Chapter 5*). Yet one-third of all federal and state Medicaid spending, about $20 billion a year, now goes to pay for nursing home care for the elderly, and many of these destitute retirees were in the middle class until long-term care costs drove them into poverty, forcing Medicaid to pick up the costs. With the aging of America's population, such pressures on Medicaid will increase. In the absence of new ways to pay for the long-term care of middle-class senior citizens, there will be less and less Medicaid money available to help young, low-wage workers.

Lawmakers are faced with these frustrating dilemmas because such problems as uninsurance and long-term care are in fact only the symptoms of much deeper flaws in America's health care financing structure. Because of this structural deficiency, trying to solve individual problems without changing the system's basic design inevitably will fail. Grafting new programs onto the diseased stock will only compound the crisis.

To achieve effective health care reform, lawmakers must redesign the underlying policies and programs of the current system. The vital first step in this process must be to review the origins of those policies and programs. By doing so, it is possible to determine why they developed they way they did, and thus, to understand the political and economic forces influencing the current system. Carrying out this

exercise enables policy makers to propose reforms to address these forces, permitting a sound strategy to be devised to reform today's health care system for all Americans.

HEALTH CARE BEFORE THE 1930s

Unlike publicly financed health care systems in European countries, the way Americans pay for health care is more the result of historical accident than political design. Today's financing system essentially evolved during the past century in response to various incentives and changing circumstances. The factors having the greatest influence on the course of its development were changes in economic conditions, social trends, government policies, and advances in medical science. Medical technology in many ways has played the biggest role in shaping both America's health care delivery system and the corresponding financing structure of private insurance and government programs. Most of the common medical practices and products Americans now take for granted were developed or discovered only during the past century. Indeed much of it is the result of advances made in just the past 50 years. And unlike technological advances in many fields, improvements in medical technology resulted in major new public policies designed specifically to spread their benefits throughout the population.

It was not until the 1880s that scientists conclusively demonstrated that diseases are caused by germs. During most of the 19th century, dirt and "bad air" were thought to be responsible. At that time, hospitals were used almost exclusively by the poor; most other Americans were cared for at home. Perhaps not surprisingly, therefore, prior to the development of antiseptics and heat sterilization in the 1880s and 1890s, most Americans believed – correctly – that it was far safer to be treated outside of a hospital than in one.

The acceptance of the germ theory of disease in the late 19th century was just the beginning of a revolution in medical science and of a significant change in public attitudes toward health care. Most dramatic was the change in public attitudes toward hospitals.

Americans no longer viewed them as places housing the sick poor, but as "medical workshops" – the primary facilities for meeting the health needs of the general population.[1]

The resulting growth in the number of hospitals was staggering. In 1873, there were only 149 hospitals in the U.S. In just 50 years, by 1923, the number had soared to 6,830.[2] Since then, hospitals have dominated the American health care delivery system.

As America entered the 20th century, the questions of how to improve public health and how to extend to all Americans the new benefits of medical science became more important. Most of the improvements in sanitation during the 19th century were the result of efforts by state and local governments. Most of the new hospitals built between 1890 and 1920 were financed in much the same way or by religious organizations and charities. But as hospitals became seen as institutions to care for the whole population, and not just the poor, the issue became one of how to fund a dramatic increase in the number of hospitals, doctors, and nurses.

In Europe the answer was to turn to national government, where "social insurance" and "national health care" systems were launched. Similar arrangements were proposed in the U.S., but they failed to win wide support for several different reasons. One was that Americans were inclined to view public health measures as the responsibility of state and local governments, rather than of the national government. Another was that the European idea of a national health system was the product of socialist politicians; this sparked suspicion in Congress.

Although Americans rejected a tax-financed national health system, they did not turn immediately to private insurance. Between 1900 and 1930, various employers, unions, and fraternal groups developed health insurance plans, but they were not widespread. Americans before 1930 typically paid for over 80 percent to 90 percent of their medical expenses out of their own pockets. While some of the remainder was paid for through private insurance, most of it was provided as publicly or privately financed charity care.

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1 Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), pp. 145-179.

2 U.S. Department of Commerce, Bureau of the Census, *Historical Statistics of the United States*, Volume 1, p. 78; and *Concise Dictionary of American History* (New York: Charles Scribner's Sons, 1983), pp. 468-469.

THE 1930s AND 1940s: CREATING A HEALTH CARE FINANCING SYSTEM

If America's health care delivery system has its roots in the advances in medical science at the turn of the century, its health care financing system stems largely from the Great Depression and World War II.[3]

By 1930, the physical infrastructure of today's health care delivery system was solidly in place. The U.S. in 1930 had as many or more medical, nursing, and dental schools and hospitals and hospital beds per unit of population as it has today. Only the number of physicians, nurses, and dentists has grown at a faster rate than the general population since then.[4] The Great Depression, however, threatened to undermine the expansion of health care facilities and personnel. Many Americans had severe trouble paying for the medical care they needed. While doctors could try to make allowances for patients in financial straits, hospitals, with their higher fixed costs had much less flexibility. As a result, hospitals turned to insurance plans as a way to guarantee a steady cash flow by spreading the financial risk more widely.

The Growth of Hospital Plans

The first effective hospital plan was introduced in 1929 at Baylor University Hospital in Dallas, Texas, to serve a group of 1,500 schoolteachers. Under the plan, a subscriber paid the set fee of $6 per year. In return, Baylor agreed to provide up to 21 days of hospital care. The subscribers benefited because the plan limited the potential cost of their individual hospital care by spreading the risk among them while allowing them to pay for it in a predictable manner. The hospital, in

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3 For more detailed descriptions of the development of health insurance in the U.S. and the impact of the Depression and World War II on health care financing, see: Starr, *op. cit.*, pp. 200-209, 240-242, 290-320; also, Congressional Research Service, Library of Congress, *Health Insurance and the Uninsured: Background Data and Analysis*, pp. 14-18; and Peter Temin, "An Economic History of American Hospitals," in H. E. Frech, III, ed., *Health Care in America: The Political Economy of Hospitals and Health Insurance* (San Francisco: Pacific Research Institute for Public Policy, 1988), pp. 75-92.

4 *Historical Statistics of the United States*, *op. cit.*, pp. 8, 75-76, 78-79 and corresponding tables in U.S. Department of Commerce, Bureau of the Census, *Statistical Abstract of the United States*, editions 100 through 108.

turn, benefited because the plan guaranteed it a predictable income, regardless of how many services it provided or which subscribers it served.

The idea caught on, and other hospitals set up similar plans. Soon, groups of nonprofit hospitals in several cities organized multiple hospital insurance plans. Under these arrangements, participating hospitals in an area agreed to provide specified services to subscribers in that area. This had the advantage of giving subscribers a choice of medical care providers. As a result, these plans attracted more subscribers and the income of participating hospitals became more predictable. This nonprofit multiple hospital plan served as a model for Blue Cross, first established in 1932 in Sacramento, California.

These hospital plans changed the concept of insurance in a way that had an enormous impact on the American health care system. Unlike other forms of insurance, such as home or auto protection, the primary purpose of these hospital plans was not to protect consumers from large, unforeseen expenses, but rather to keep certain providers – in this case hospitals – in business by guaranteeing them a regular income. While these plans benefited consumers by giving them a predictable method of paying for most medical care, some of their features worked against consumers' other interests. In particular:

The plans focused on "front-end" coverage. They paid for initial hospitalization and then terminated coverage after a specified number of days. These plans thus guaranteed hospitals a basic income level, but exposed seriously ill patients to high out-of-pocket costs. This became an increasingly serious problem as advances in medical science resulted in more lengthy and expensive treatments for previously untreatable conditions.

The plans reinforced the public notion of hospitals as the primary providers of medical care. To afford the cost of medical care, Americans would purchase a hospital plan; and for medical care to be paid for by such a plan, the subscriber had to be treated in a hospital. This was the first step in the U.S. medical care system bias toward specified providers or services. Over time, the question of "what will the plan pay for?" superseded the question of "what treatment offers the optimum cost and effectiveness?"

The plans established a method for paying health insurance benefits that was different from the way benefits were paid under other forms of insurance. Instead of providing "indemnity coverage" these

hospital plans paid "service benefits." Under indemnity plans, such as automobile insurance, the policyholder or his heirs is directly reimbursed a specified amount to compensate for his loss. The policyholder then uses those funds to repair the loss. For example, if a person with an auto insurance policy has his car completely wrecked, his insurance will pay an amount equal to the value of the car. The policyholder then decides if he wants to buy a new car of equal value, buy a better car and pay the additional cost out of his own pocket, or buy a less expensive car and keep some of the insurance money.

Under a service benefits policy, by contrast, the insurance covers certain, specified services, whatever their cost might be. This would be like an auto insurance company writing a policy that would pay, in the event of a wreck, for any kind of new car or for whatever it might cost to repair the old one. Under a service benefit policy, the policyholder thus has little incentive to get the best value for the money, and the service provider has every incentive to increase the cost of his services or to continue recommending additional services of only marginal benefit.

Basing medical insurance on service benefits made good sense to most Americans, however. If they were injured or fell ill, they wanted insurance that would pay for them to be treated or cured, not insurance that would merely provide them with a certain amount of money to help defray treatment costs. But this form of insurance also served the interests of the hospitals as service providers, since the cost of a service was not an important issue to a patient covered by a plan. Any unnecessary increases in the price or quantity of services, of course, hurt consumers in the long run by forcing them to pay higher premiums.

This creation of a provider-oriented, rather than consumer-oriented, system of health insurance was one of the most important and lasting effects of the Great Depression. It continues to form the heart of America's health care financing system and the core of its problems.

In the mid-1930s, in an effort to encourage financial stability and to protect the consumer's interests, some state insurance commissions tried to subject multiple hospital plans to the same regulations governing other types of insurance. In particular, they wanted to require these new plans to maintain reserve funds – that is, to set aside a portion of their premium revenues to cover unexpectedly large claims. In response, hospitals and doctors, working with the American Hospital Association (AHA) and American Medical Association (AMA)

promoted state legislation to exempt Blue Cross plans from normal insurance regulations. In exchange, Blue Cross plans were required to serve the entire community by providing insurance to anyone who wanted it and charging rates that were affordable to lower-income people. Blue Cross plans also received federal tax exemption as charitable organizations.

In keeping with their traditional methods, commercial insurers offered indemnity insurance coverage against hospital expenses; often they covered expenses not paid for in Blue Cross plans, such as outpatient physician services and prescription drugs. Of course, health care providers had a strong incentive to prefer service benefit plans, especially ones that they themselves operated. So in response to the expansion of commercial health insurance, and often with the assistance of the Blue Cross plans, doctors established Blue Shield plans to cover physician services.

The combination of negotiated rates with providers and the exemption from taxes and large reserve funds gave the Blue Cross and Blue Shield plans enormous financial advantages over other insurers. As a result they were soon able to dominate American health insurance. Of the total population with hospital insurance in 1940, half were covered by Blue Cross, and until the 1980s, Blue Cross and Blue Shield never held less than 40 percent of the entire health insurance market.[5]

Because of their size and advantages, "the Blues" soon forced their competitors among the commercial insurance companies to adopt the same basic structure in their benefit plans. Doctors were reimbursed either according to a negotiated schedule of fees or on the basis of what insurers considered to be "reasonable and customary" charges. In the case of hospitals, reimbursement was on a "cost-plus" basis. For doctors this meant that they would be paid whatever they charged, provided it was generally comparable to the fees charged by other doctors in their locality. For hospitals, cost-plus reimbursement meant that the insurer paid the hospital a percentage of its costs, according to the percentage of policyholders using the hospital's services, plus an additional percentage of the hospital's working and equity capital.

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5 Health Insurance Association of America, *Sourcebook of Health Insurance Data, 1984-1985*, Tables 1.2, 1.3, 1.4, and 1.5.

The basic effect of this was to create a perverse incentive for hospitals to increase costs. Under a cost-plus system, increased costs mean increased income for a hospital, while reduced costs means lower income. The more a hospital expanded its facilities, equipment, or services, the more revenue it received, regardless of the demand for those items.[6]

The Growth of Employer-Paid Plans

The other major development in health care financing during this period was the growth of employer-purchased health insurance. During World War II, the large number of men serving in the armed forces meant U.S. employers faced a tight labor market. Wartime wage and price controls prevented employers from raising salaries to attract workers. Employers turned instead to noncash benefits, particularly health benefits, as a backdoor way of offering employees additional compensation.

At the same time, the Internal Revenue Service ruled that the purchase of health insurance for workers was a legitimate cost of doing business and could be deducted from taxable business income. The IRS also ruled that workers did not have to include the value of health insurance benefits in calculating their taxable income. This, in effect, made employer-provided health insurance a giant tax dodge and very appealing to both workers and employers. Unions gained even more leverage to demand employer-provided health insurance when the National Labor Relations Board (NRLB) ruled in 1948 that such benefits were a legitimate subject of collective bargaining. This further accelerated the spread of company plans after World War II, even though the initial incentive of wage controls had by then been removed.

In the fifteen years between the start of the Great Depression and the end of World War II, therefore, an entirely new system for financing health care was created in the U.S. It is a system characterized by provider-oriented insurance plans and by tax incentives that encourage

6 For a more detailed analysis of cost-plus reimbursement and the role of Blue Cross and Blue Shield, see John Goodman and Gerald Musgrave, "The Changing Market for Health Insurance: Opting Out of the Cost-Plus System," National Center for Policy Analysis, Dallas, Policy Report Number 118, September 1985.

workers to obtain health benefits through their employers. The combined influence of these two factors has had a lasting impact on American health care.

These factors have distorted health care coverage significantly and, consequently, the health care delivery system. Specifically, they have encouraged front-end coverage and acute-care treatment, particularly as provided in a hospital.

The Defects of Front-End, Acute-Care Coverage

Insurance policies emphasizing front-end coverage pay for routine services or the initial costs of a service, but not later, heavier expenses. A policyholder, of course, is more likely to spend five days in a hospital than, say, 35 days and is more likely to need stitches for a laceration than an appendix removal. As such, inexpensive coverage for limited services might seem most attractive. The problem is that those poorly served by front-end coverage are those who need help the most – those with unexpectedly serious illnesses leading to very high medical bills. By leaving policyholders vulnerable to catastrophic losses, while covering inexpensive routine costs, front-end health insurance operates contrary to all other forms of insurance.

A bias toward the treatment of acute medical conditions, meaning illnesses that can be cured by specific treatments, also tends to favor the interests of hospitals and doctors over those of patients. Under an acute-care policy, the more treatment a doctor provides, the more money he receives. While it is true that the patient benefits from the treatment, a patient would be both physically and financially better off if, for instance, he had the incentive to take actions to prevent or avoid illnesses and their costs. Furthermore, under front-end plans, doctors are encouraged to prescribe additional treatments up to the limit of the patient's insurance coverage, even though these treatments may improve the patient's health or well-being only marginally.

The equivalent of front-end, acute care health insurance would be an auto insurance policy that paid, say, for the first $500 annually of labor and replacement parts for accidents or mechanical breakdowns with the auto mechanic allowed to determine what work should be done. Under such a policy, the average car owner would have most of his repairs paid for in return for his premium. But he has little incentive

to question the cost of minor repairs or to spend money on proper preventive maintenance not included in the plan, such as having the wheels aligned or the oil changed regularly.

At the same time, if he needs the engine rebuilt or extensive body work following a major accident, he would have to pay much of the cost out of his own pocket. Such a policy would be very expensive, since most car owners spend several hundred dollars on minor repairs and replacement parts every year, while only a few have serious accidents or breakdowns costing more than $500 to fix.

How Perverse Tax Incentives Compound the Problem

The reason why few Americans would purchase this kind of insurance policy for their automobile, yet millions of them purchase such policies for their health care, is simply that the tax code encourages the latter coverage. Since the money an employer spends on purchasing health insurance for a worker is excluded from taxable income, without limit, the worker typically views health insurance plans merely as tax-free compensation – rather than as real insurance. Thus workers tend to favor coverage that pays for the medical care they are most likely to need in the near future. Such a health insurance policy frees up the worker's taxable cash income for discretionary expenses.

The result is insurance that is no longer used to spread risks, but to avoid taxes on income for routine, minor medical costs. This, in turn establishes a set of perverse incentives encouraging both health care price inflation and increased demands for medical services.

With patients no longer paying directly for the more common services, normal incentives to question the cost of those services disappear. Instead, patients actually have an incentive to demand more expensive services. At the same time, doctors and hospitals lose the normal financial incentive to deliver efficient, cost-effective care, and instead, are encouraged to increase the price and the quantity of their services.

In short, America entered the postwar era with a new health care financing system, largely the result of historical accident, that could not have been better designed to be both inadequate and inflationary. This structure of insurance and tax incentives also reinforced the existing technological biases favoring acute-care, hospital-based medicine.

In the 1940s, hospitalization was synonymous with serious illness, and insurance that covered the first 30 days of hospital care was *de facto* catastrophic coverage. There was little that doctors could do for most patients with chronic or degenerative conditions, and with the exception of serious mental illness, such patients usually were cared for at home by relatives. But medical science was undergoing a second revolution, brought about by the discovery of penicillin and sulfa drugs, capable of killing bacterial infections inside the body.[7] Suddenly, doctors could cure a whole range of illnesses where previously they could only treat the symptoms or alleviate suffering. Such advances also meant surgeons no longer had to weigh the benefits of surgery against the likelihood of a patient contracting a potentially fatal postoperative infection. The availability of new drugs to kill postoperative infections meant that, instead of limiting themselves to the most extreme, life-threatening cases, surgeons could safely treat a broader range of patients with bolder and more innovative procedures.

By the end of the 1940s, therefore, the public perception of American health care was of a system in which doctors were the people who "fixed" health problems and hospitals were the places where those "repairs" were performed. And most important, in the context of today's problems, Americans increasingly expected insurers, employers, or government to pay the bills.

THE 1950s AND 1960s: THE RISE OF THIRD-PARTY PAYMENTS

The dominant characteristic of American health care in the 1950s and 1960s was the rapid growth of the "third-party" payment system, under which transactions between physician and patient are paid for by a third party—an insurance company or the government. The share of personal health costs paid for by governments and private insurance almost doubled between 1950 and 1970. In 1950, these third-party payments accounted for 34 percent of all personal health care spending; by 1960 that figure had risen to 45 percent; and by 1970, to 62 percent.[8]

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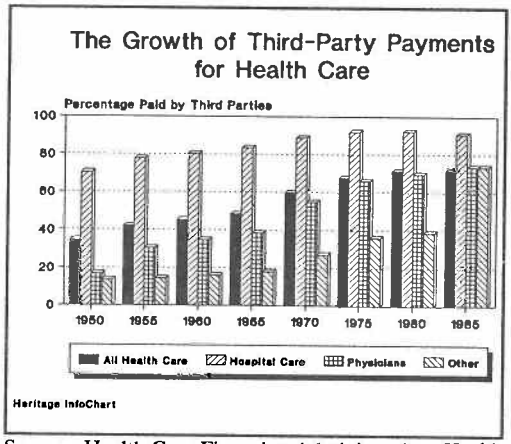
7 For a good description of the impact these discoveries had on the medical profession, see Frank D. Campion, *The AMA and U.S. Health Policy Since 1940* (Chicago: Chicago Review Press, 1984), pp. 11-29.

8 Health Care Financing Administration, *Health Care Financing Review*, September 1982, p. 23.

In addition to the rapid expansion of the third-party financing system, private health insurance continued to undergo another significant structural change that has contributed to the gaps in coverage in today's system. This important change was the development by commercial insurers of the practice of "experience rating" the health insurance plans of different employers.

Chart 2



Source: Health Care Financing Administration, *Health Care Financing Review*, September 1982, pp. 23-26 and Fall 1986, pp. 16-18.

Normally, insurance companies use some form of "community rating" system to calculate a basic premium. Under a community rating system, the premium reflects the average frequency and cost of claims among all the policyholders in a given area. For example, a company offering auto insurance in Illinois would probably charge drivers in Chicago a higher basic premium than it would charge those in Peoria. This is because Chicago drivers statistically are more likely to have accidents, and car repairs are more expensive in Chicago.

Under an experience rating system, however, the cost of the premium depends on the actual experience of the individual policyholder, based on the frequency and size of the claims he files. In the case of most auto insurance today, companies use a mix of these two systems. They calculate basic premiums according to a community rating system and then charge extra for insuring policy holders with bad driving records.

Commercial insurers initially turned to experience rating employer health insurance plans as a way to compete with Blue Cross and Blue Shield. Because they were exempt from taxes and reserve requirements, the Blues had a competitive advantage over commercial in-

surers. But the Blues often were required by regulation to use a community rating system. The commercial insurers responded by selling insurance to employers with relatively healthy, low-risk employees – and thus a better experience rating – at cheaper rates than Blue Cross and Blue Shield. The Blues in turn responded by pressing successfully for permission to institute a modified community rating to reflect experience.

Experience rating has contributed considerably to current problems in the system. Under an experience rating system, the risk pool that an insurance company uses to calculate premiums for group plans tends to be limited to those working for a single employer. This is in contrast to the larger, community-wide risk pools used in calculating policies for auto, life, homeowners, or other forms of insurance. As a result, smaller companies that have fewer employees over whom to spread costs generally must pay more for insurance than larger ones. In addition, small companies may face larger increases in their premiums, or possibly even the cancelling of their insurance, if just one employee incurs unusually high medical expenses. Not surprisingly, today over 65 percent of all workers without health insurance are in businesses with 25 or fewer employees.[9]

The Creation of Medicare and Medicaid

While employer-provided health insurance grew steadily in scope and coverage in the 1950s and 1960s, political pressures also built for a larger government role as a third-party insurer. By the late 1950s, it was clear that the unemployed and retired elderly were not benefiting from the expansion of employer-provided insurance.

Even the American Medical Association (AMA) and other staunch defenders of private health care agreed that the government should in some way help meet the health care needs of the elderly and the poor. Where they differed from the advocates of national health insurance was in the means to accomplish this. The AMA favored decentralized, state-administered programs, based on need, which preserved the autonomy of doctors and hospitals. National health insurance advo-

9 Employee Benefit Research Institute, "A Profile of the Nonelderly Population without Health Insurance," Issue Brief Number 66, May 1987, p. 5.

cates in Congress, the labor unions, and the Social Security bureaucracy favored a federal program, available to the entire elderly population, regardless of income. After a long and bruising legislative battle, the result was the enactment in 1965 of Medicare and Medicaid.[10]

In its final form, the Medicare legislation was a composite of the positions of the AMA and the advocates of national health insurance. The largest segment of the legislation, Medicare Part A, essentially was a scaled-down version of the universal social insurance scheme advocated by proponents of national health insurance. The other element, Medicare Part B, was a voluntary program to cover physician services, paid for by a mixture of premiums and general federal revenues. Medicaid was based on the alternative originally sponsored by the AMA. It paid for medical care for the poor, regardless of age, financed by a combination of matching federal and state funds and administered by the states.

With the enactment of Medicare and Medicaid in 1965, the third-party payment system completely dominated American health care. Virtually all Americans now were covered either by private health insurance or public programs for most of the costs of their hospital care and basic physician services. But the legislation also effectively cemented into place a government version of the private health care financing system created between 1930 and 1945, complete with defects and biases.

First, the provider-oriented reimbursement policies of private insurance were replicated in Medicare, and by many states in Medicaid. Hospitals were allowed to charge Medicare for the "reasonable cost" of treating patients, and doctors were reimbursed for their "reasonable and customary" fees. These policies in private insurance already had made the system inflationary; their adoption by Medicare intensified the trend.

Second, because the medical care provided to beneficiaries under Medicare and Medicaid was either free or greatly subsidized, and premiums were nonexistent (Medicaid) or unrelated to individual or group usage (Medicare), beneficiaries had virtually no incentive to

10 For an interesting examination of the politics behind the enactment of Medicare and Medicaid, see Campion, *op. cit.*, pp. 253-283.

question costs and every incentive to demand more services. Even the few restraints that still remained in the private sector were completely absent in these new government programs.

Third, Medicare's benefit structure favored the same kind of acute-care, front-end coverage as private insurance. Under Part A hospital insurance, the patient was to be charged a deductible equal to the average cost of a single day in a hospital, but he paid nothing more for the first 60 days of hospital care. Patients were then required to pay an increasing share of costs, known as coinsurance, for hospital stays beyond 60 days. This meant that seriously ill patients faced rapidly decreasing coverage. At the same time, what little nursing home coverage Medicare did provide was limited to short stays in a skilled nursing facility for patients recuperating from acute treatments in a hospital. Thus, what would soon become a growing need for long-term care for the elderly was completely ignored.

THE SYSTEM TODAY: COST EXPLOSION AND GAPS

Thanks to the dynamics of the system created since the 1930s, the dominant characteristic of American health care today is massive inflation and gaps in coverage. After 1965, health care costs began to grow rapidly. In one important respect the higher general inflation rates of the 1970s reinforced defects in the health care financing system. Because tax brackets were not fully indexed until 1985, wage increases to keep pace with soaring prices meant workers were pushed into higher tax brackets, leaving them with a real decrease in disposable income.

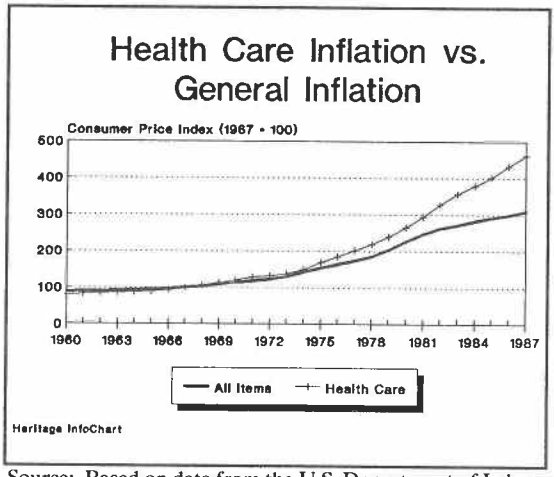
Under these circumstances, front-end health insurance provided by firms became a particularly attractive way for employees to receive nontaxable income. This led companies and unions to agree to insurance coverage for more and more routine health costs rather than adding the equivalent dollars to paychecks. For example, between 1970 and 1980 the number of Americans with insurance coverage for dental expenses jumped from 12 million to 80 million.[11]

At the same time, government and business leaders belatedly became alarmed as the costs of both private insurance and government health programs ballooned. Corporate executives saw health costs

11 Health Insurance Association of America, *op. cit.*, Table 1.8.

becoming their largest and most rapidly increasing business cost. A survey of *Fortune* 500 companies and the nation's 250 largest nonindustrial firms finds that "From 1981 to 1983, the average rate of increase of health insurance premiums was a staggering 20 percent." Total health care costs for those firms, on the average, amounted to 24 percent of after-tax corporate profits.[12]

Chart 3



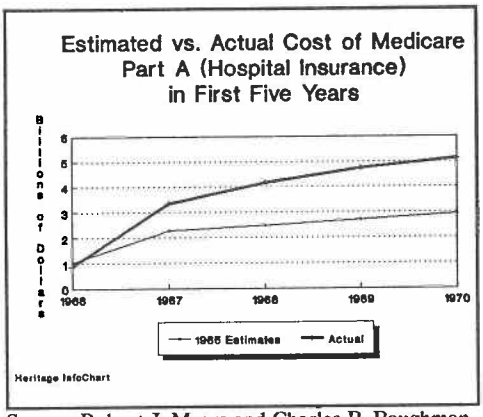
Source: Based on data from the U.S. Department of Labor.

The experience of the Caterpillar Tractor Company typifies the impact of escalating health care costs on corporate America. In 1973, Caterpillar spent $35 million on health care for its U.S. employees. By 1977, the company's annual health care bill was nearly $100 million, and by 1982, it was over $155 million. In less than a decade, employee health care costs at Caterpillar had jumped by 343 percent. Even in constant dollars to adjust for general inflation, the real growth in the company's health care spending was a staggering 104 percent in just nine years.[13]

12 Regina E. Herzlinger and Jeffrey Schwartz, "How Companies Tackle Health Care Costs: Part I," *Harvard Business Review*, July-August 1985, p. 69.

13 Patricia W. Samors and Sean Sullivan, "Health Care Cost Containment through Private Sector Initiatives," in Jack A. Meyer, ed., *Market Reforms in Health Care* (Washington, D.C.: American Enterprise Institute, 1983), p. 144.

Chart 4



Source: Robert J. Myers and Charles B. Baughman, *History of Cost Estimates for Hospital Insurance*, Social Security Administration, U.S. Department of Health, Education and Welfare, Actuarial Study Number 61, December 1966, p. 48, and Health Care Financing Administration, U.S. Department of Health and Human Services, *Health Care Financing Program Statistics: Medicare and Medicaid Data*

The situation in Medicare and Medicaid was even more alarming. By 1970, only five years after their creation, spending for the two programs was outstripping all previous projections.[14] And the worst was to come. In constant dollars, the cost of Medicaid in 1985 was more than three times what it was in 1970, and the cost of Medicare had almost quadrupled during the same period (see chart 5).

THE GOVERNMENT'S RESPONSE: REGULATION AND PRICE CONTROLS

Confronted with this health care cost crisis, Congress had two alternatives. It either could remove the perverse incentives encouraging excessive and inefficient health care spending, or it could attempt to smother the effects of those incentives with new government regulations, like trying to stop a kettle from boiling by clamping down on the lid. Congress chose the latter.

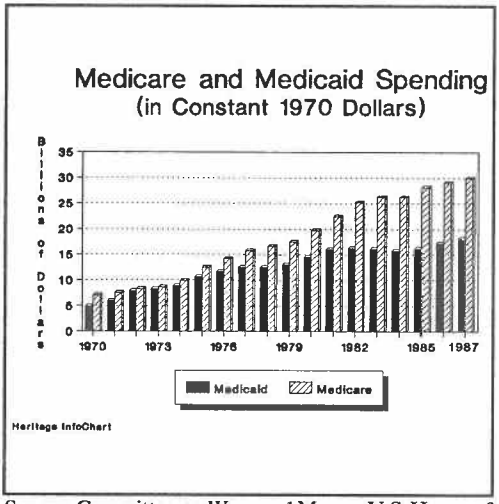
As a result, the primary thrust of health care legislation and regulation affecting the public sector since the 1970s has been to hold down prices and restrict the freedom of physicians to prescribe procedures.

14 Campion, *op. cit.*, notes a February 1970 staff report to the Senate Finance Committee which bluntly stated at that time, "The Medicare and Medicaid programs are in serious financial trouble."

Just about untouched, however, have been the underlying incentives behind this adverse behavior while providers have been given no incentives to be efficient and innovative.

To a lesser extent, cost control strategies also have been used in an effort to restrict the ability of patients to overutilize medical services. But this, too, has been attempted without removing the underlying incentives encouraging such behavior and without giving patients incentives to question the need and cost of their medical care. Cost control efforts have focused more on providers than consumers, however, because blaming greedy doctors and hospitals for all of the problems is easier and politically more appealing.

Chart 5



Source: Committee on Ways and Means, U.S. House of Representatives, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, 1989 edition, March 15, 1989, pp. 152, 1139-1140.

Encouraging HMOs

The first initiative designed to control provider costs was the Health Maintenance Organization Act of 1973, which encouraged the development of Health Maintenance Organizations (HMOs) as an alternative to traditional insurance plans.[15] In an HMO, physicians are salaried employees of an organization that provides its subscribers with medical care, as needed, for a prepaid fixed fee. HMO managers have an incentive to keep the organization profitable by requiring doctors

15 See Campion, *op. cit.*, pp. 339-344, and Congressional Research Service, *op. cit.*, pp. 16-17.

to be careful about costs and by limiting the freedom of patients to demand unnecessary services or, in many cases, to choose a particular doctor. They also have the incentive to keep subscribers as healthy as possible, usually by focusing on lower cost preventive medicine.

There were several obstacles to the creation of HMOs prior to the 1970s. First, neither physicians nor patients generally liked the idea of losing their independence by joining an HMO or other prepaid plan. Second, many states had physician-backed laws that either directly prohibited what was called the "corporate practice of medicine" or placed heavy financial requirements on HMOs, such as maintaining large reserve funds. Third, it was difficult to obtain the necessary investment capital to establish HMOs. Investors were afraid HMOs would not attract enough subscribers to make them profitable or would need to charge uncompetitive premiums to cover their higher operations costs and potential losses.

The 1973 federal HMO Act changed this situation by preempting state laws inhibiting the development of HMOs and by providing HMOs with federal grants and loans as start-up capital. The act also took a major step toward federal regulation of employee benefit plans, by requiring all companies with 25 or more employees to offer an HMO plan to their workers if a qualified HMO was operating in the area and was interested in offering coverage. These changes, combined with the increased concerns among employers about rising health care costs, spurred the growth of HMOs from 26 plans with about 3 million subscribers nationwide in the early 1970s to nearly 700 plans with 28 million enrollees in 1987.[16]

Restricting Hospital Construction

The second major legislation designed to control health care costs was the 1974 National Planning and Resources Development Act. Its objective was to prevent the duplication or overexpansion of health care facilities by establishing a system for planning and certifying the need for new or expanded facilities or major equipment before they could be built or purchased. The legislation established a confusing, three-tiered bureaucracy of national, state, and local planning agencies – with disastrous results. The various agencies quickly became mired

16 Campion, *op. cit.*, p. 344, and Congressional Research Service, *op. cit.*, p. 17.

in pork-barrel politics and paperwork. The program was such a disaster that by 1981, when the Reagan Administration asked Congress to phase it out, even some of its original sponsors supported its elimination.[17]

Regulating Insurance

Another law passed in 1974 has had a major impact on America's health care financing system, even though it was designed to address a completely different set of problems. The Employee Income and Retirement Security Act (ERISA) was intended to correct problems and abuses in employer-sponsored pension plans.

Under ERISA, the federal government assumed responsibility for regulating employer-provided pension and welfare benefit plans, such as health care, unemployment, and severance benefits, and it preempted state laws governing such plans. States still were allowed to regulate insurance companies, but if an employer decided to self-insure (to pay for its workers' health benefits directly without purchasing insurance), it was governed by ERISA and did not have to meet state insurance requirements.[18]

ERISA prompted a set of opposite but mutually reinforcing responses by state governments and employers. If a state legislature decided that health plans in its state should include coverage for specific services, for example psychiatric treatments, the legislature could not require employers to provide coverage; it could only require insurance companies to include the coverage in their policies. Employers wishing to avoid state regulations, including coverage requirements, thus could obtain an exemption by self-insuring and thereby subjecting themselves only to federal regulation under ERISA.

Under pressure from health care providers and advocates seeking coverage for various diseases, a rising number of states have enacted

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17 Campion, *op. cit.*, pp. 344-348.

18 For an outline of the provisions and effects of ERISA and related court cases, see Congressional Research Service, *op. cit.*, pp. 77-86.

mandated benefit laws requiring insurance companies to pay for specific medical services. In 1973 there were only 93 state-mandated benefit laws in the entire country; today there are 726.[19] The effect of these laws has been to guarantee markets for the favored health care providers with predictable results: an increase in the number of providers offering the favored service, an increase in the use of these services by policyholders, and an increase in the fees charged by the providers of mandated services.

These perverse effects are evident in a typical example: coverage for chiropractic services, now mandatory in 34 states. Before the mandates, insurance companies either did not cover chiropractic services at all, or offered coverage as an option for an additional premium charge. This meant that chiropractors had to keep their fees low to attract patients away from full-service general practitioners who were providing similar services covered by insurance. But with coverage mandated, chiropractors could raise their fees to the same level, or even above, those of general practitioners without fear of losing their patients. This, in turn, encouraged more chiropractors to set up practices in states that mandated coverage. Moreover, requiring insurance coverage for certain services encourages consumers to use more of them. Patients already seeing a chiropractor are inclined to visit him more frequently, while those who previously had decided the benefits were not worth the cost are now more likely to use the service since it

19 Greg Scandlen, "The Changing Environment of Mandated Benefits," Employee Benefit Research Institute, Employee Benefit Notes, June 1987, p. 8, and tabulations from the December 1988 compilation of State Mandated Health Insurance Laws, prepared by the State Services Department of the Blue Cross and Blue Shield Association.

is "free" or "low cost." This situation is not, of course, unique to chiropractors. Studies show mandated benefit laws consistently result in the same set of adverse consequences.[20]

Understandably, the growing number of mandated benefit laws has encouraged employers to avoid these costly regulations by self-insuring. Surveys showed that by 1979 some 19 percent of companies with 100 employees or more were self-insured, and by 1987 the share had risen to 40 percent.[21] These mandated health benefit laws further discourage small companies from providing health benefits since they do not have large enough cash flow to consider self-insurance. So they are stuck with the options of either increasingly regulated and expensive traditional insurance or no insurance at all.[22]

Controlling Medicare Treatment Costs

The most recent major congressional effort at health care cost control was a provision of the 1983 Social Security legislation that established a prospective payment system (PPS) for hospital reimbursement in Medicare. Under this system, Medicare establishes a fixed schedule of fees that it pays hospitals for the treatment of each of 475 diagnostic related groups (DRGs) of illnesses. If the actual cost to the hospital is less than the DRG fee, it keeps the difference; if more, it absorbs the loss. The objective was to spur price consciousness and competition among hospitals.

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20 A number of studies of the effects of specific state-mandated health insurance benefits have been conducted in recent years, particularly by various state Blue Cross and Blue Shield organizations. In addition, since 1984, nine states, Arizona, Florida, Hawaii, Nebraska, Oregon, Pennsylvania, Rhode Island, Washington, and Wisconsin, have passed laws requiring evaluations of their existing mandated benefit laws.

21 Congressional Research Service, *op. cit.*, p. 85. Data taken from the Hay/Huggins Benefits Reports.

22 For a good study of the effects of mandated insurance benefits on small businesses and their contribution to the problem of uninsurance, see John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, Dallas, Policy Report Number 134, November 1988.

The results have been disappointing. While almost any reform would have been better than the previous open-ended reimbursement system, which invited physicians and hospitals to charge as much as they could for treating a patient, PPS suffers from the same defects and failures experienced by price control systems throughout history – perverse incentives for suppliers leading to shortages and misallocations.

This is clear from the PPS track record to date. Like all price controls, PPS simply encourages the health industry to shift costs to activities not covered by the controls. Thus, while the PPS has substantially slowed the growth of Medicare hospital reimbursements, Medicare's physician reimbursements, which are not subject to the PPS, continue to grow at double digit rates.[23]

There is mounting concern, moreover, that hospitals are "dumping" higher cost patients by transferring them or discharging them early. This is because, when the potential cost of treating a patient with a difficult or complicated case exceeds Medicare's fixed payment, the hospital has a powerful incentive to limit the treatment provided to the patient or to send him elsewhere. These fears were confirmed by a July 1988 report of the Health and Human Services Department Inspector General's office, which estimated that there were over 540,000 cases each year of Medicare patients receiving poor quality care.[24]

PRIVATE SECTOR COST CONTROL EFFORTS

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23 Based on computations using data from: Committee on Ways and Means, U.S. House of Representatives, *Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*, 1989 edition, March 15, 1989, p. 152. In the five years since the introduction of PPS, the average annual rates of growth in Medicare spending have been 6.5 percent for the Hospital Insurance program and 13.8 percent for the Supplemental Medical Insurance program.

24 Office of the Inspector General, Department of Health and Human Services, *National DRG Validation Study: Quality of Patient Care in Hospitals,* July 1988. Based on a review and analysis of 7,050 cases selected through statistical sampling, the study found a 6.6 percent overall rate of poor quality care. This rate applied to the 8.28 million cases of disease during the period covered by the study yields an estimated 546,480 cases of poor quality care.

A wide variety of private sector cost control efforts also have been put into place, as employers face mounting health care costs.[25] Not only have corporations embraced alternative delivery systems, such as HMOs, but they also have forced insurance companies to abandon their provider-oriented reimbursement methods and to reverse the practice of first dollar coverage by requiring policyholders to pay a larger share of their premiums and more of their direct costs through higher deductibles and coinsurance.

Cost control measures undertaken by corporations typically involve such changes as switching to an HMO or other managed care plans and the introduction of direct company control of existing health benefit plans. Many companies also choose self-insurance, as a way of avoiding state mandated benefits or, particularly in the case of large firms, of controlling administrative and claim costs by auditing claims. An outgrowth of managed care and self-insuring has been the introduction in many companies of precertification and second opinion programs for nonemergency surgery.

Another common cost control strategy has been to increase employee cost sharing through various combinations of increased deductibles and coinsurance – requiring employees to pay a larger share of their health insurance premium. In some cases, deductibles and coinsurance are structured to encourage workers to chose lower cost treatment options. A common example of this approach is for a company to change its plan by imposing coinsurance for hospital stays while eliminating coinsurance for outpatient surgery.

Some very large corporations offer flexible benefit or "cafeteria" plans to their employees. This concept was developed in 1974 by the TRW Corporation. Under a cafeteria plan, workers are allowed to

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25 For case studies of the different approaches used by employers to control health care costs, see Samors and Sullivan, *op. cit.*, pp. 144-159, and Sara S. Bachman, David Pomeranz, and Eileen J. Tell, "Making Employers Smart Buyers of Health Care, *Business and Health*, September 1987, pp. 28-34.

choose from among a set of company approved insurance plans and HMOs. Employees who choose less expensive plans are allowed to select additional, nonhealth benefits, such as extra vacation, retirement annuities, or education. In some cases, workers are allowed to take savings in the form of increased cash wages.[26]

A few companies have experimented with cash incentives. These generally take the form of a fixed bonus awarded at the end of the year to employees who stay healthy and do not use their health insurance. In a similar vein, some employers, such as the Chrysler Corporation, offer workers cash incentives for spotting overcharges on their medical bills.[27]

The most recent trend in corporate health care cost control is the widespread introduction of employee "wellness" programs. The objective is to increase productivity while reducing medical costs and absenteeism by helping employees stay healthy. Corporations open exercise facilities and provide health education classes for their workers. Education programs typically include nutrition, weight control, stress management, and help in giving up smoking. Some firms go further by having employees fill out questionnaires on their personal and family medical history and life style. The questionnaires are evaluated, and each worker is given an assessment of his personal risk of incurring major illnesses in the future, together with specific advice on how to reduce those risks.[28]

With several years experience of corporate cost control programs now available, one basic principle is beginning to emerge: while almost any kind of cost control program offers at least some savings, the most effective way to reduce overcharging and overutilization is by increasing the cost to the beneficiary. The meaning: the greatest savings are achieved when patients are required to pay a larger share of their health bills out-of-pocket through deductibles and coinsurance.

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26 Samors and Sullivan, *op. cit.*, pp. 144-145.

27 Joseph A. Califano, Jr., *America's Health Care Revolution: Who Lives? Who Dies? Who Pays?* (New York: Random House, 1986), pp. 22-23. In Chapter 2, pp. 11-36, Califano provides a sobering, though at times humorous, account of how the various interests and perverse incentives discussed in this chapter led to enormous and uncontrolled health care costs at Chrysler and what the company tried to do in the early 1980s to control those costs.

28 Samors and Sullivan, *op. cit.*, pp. 148-149, and Howard P. Greenwald, "Getting the Most Out of Health Promotion," *Business and Health*, September 1987, pp. 40-42.

While this seems common sense, there is a major obstacle preventing the further expansion of patient cost sharing in employer-provided health insurance. Employers competing for workers in today's tight labor market are very sensitive to any differences between the benefits they and their competitors offer. Reinforcing this is the continued tax-free nature of health benefits, while deductibles, coinsurance, or premium contributions must be made by employees with after-tax dollars. Moreover, in unionized industries any change in employee benefits involves extensive labor-management negotiations. Thus while increasing patient cost sharing is the most effective health care cost control method, it also turns out to be the last resort, and even when introduced, usually is limited.

LESSONS FOR REFORM

Despite government and private sector efforts, health care costs continue to escalate. This is because health care cost control efforts do not remove the underlying perverse incentives that discourage cost consciousness and encourage overutilization. Nor do these cost control programs offer incentives to support positive behavior. Rather, their effect is to punish consumers and providers for the very behavior that is induced by the basic structure of the system. Excluding employer-provided health insurance from taxation or heavily subsidizing health care through government programs encourages patients to consume more medical services and ignore the cost of those services. Then cost control programs turn around and punish these same consumers for engaging in such behavior, for example by forcing them to obtain care only from specified providers.

Perhaps worst of all, if a consumer is cost conscious he is not rewarded. Any money a consumer saves by acting as a prudent, economical buyer of health care does not end up in his pocket. Instead, the savings goes back to the employer or government program that provides the consumer's health benefits.

Naturally, consumers resent the imposition of cost control measures that limit their choices; consumers thus resist them. Having been promised benefits by the government or their employer, they tend to view those plan providers as going back on their word when they

impose cost controls. The situation is rather like the parent who gives a teenage child unrestricted use of a credit card and then "grounds" the teenager for not making prudent purchases.

The effect of recent cost control efforts has been to reduce the rates of health care spending and inflation only marginally, while adding enormously to red tape. Indeed, since 1980, the rise in average health care costs consistently has been twice the annual, general inflation rate. This means that the problem is inherent in the system's basic structure.

Thus while America continues to lead the world in the development of new medical technology, its system for financing health care is in serious trouble and urgently needs reform. The magnitude of the task should not be underestimated; neither, however, should policy makers despair of achieving the goal of universal access to quality health care at reasonable cost. Effective, lasting reforms are possible, but only if policy makers learn from the lessons of the past.

The 60-year history of the development of organized health care financing in America shows that grafting new programs and policies onto a flawed system results in costly, adverse consequences. Thus, policy makers should recognize that, if reform proposals take the existing system as a given and then attempt to modify it to meet new problems, they will prove as inadequate as reforms have in the past. Genuine and lasting reform can only be achieved by reexamining the fundamental premises on which the entire system is built. In short, policy makers must take the radical step of rethinking the basic question – "How should Americans pay for their health care?"

In designing a new health care financing system, policy makers should keep in mind the following features of the current system:

1) The system as currently structured is bound to be expensive and inflationary.

The cumulative effect of 60 years of health care policies and practices has been to encourage systematically undesirable behavior on the part of both consumers and providers. Consumers have been encouraged to think that their health care is paid for by someone else and not to consider the cost or need for that care. At the same time, providers have been encouraged to expand their services and increase their charges. Only when these underlying dynamics are reversed, and

both consumers and providers are directly and personally rewarded for purchasing or providing cost-effective, quality health care, will health care spending and inflation be brought under control.

Present cost control efforts can achieve only limited results because of a simple but almost completely ignored fact – they do not directly benefit the consumers and providers who make basic health care decisions. When providers and consumers make costly decisions under the third-party payment system, the government or the employer pays the bills. Under what might be called third-party cost control, the government or the employer pockets the savings, while consumers and providers bear the burdens. Consumers or providers ultimately might reap the savings, but the immediate impact of controls is painful. If doctors and patients are to be expected to make prudent choices, the rewards and penalties associated with their actions must be obvious and short-term and tied directly to the specific decisions they make.

2) The troubling gaps in today's system also are the product of basic structural flaws.

Much of the current debate over health care issues centers on the concern that a growing number of Americans do not have access to the care they need, usually because they lack adequate insurance. Example: In the late 1970s, the trend toward increasing numbers of Americans being covered by either private insurance or government programs reversed itself; since 1979, the number of uninsured Americans has been steadily growing. It is estimated that there are now 37 million Americans who lack health insurance.[29] These uninsured are not all unemployed poor people. Roughly half are workers, and almost another third are the dependents of workers. Another troubling gap is the growing number of elderly individuals who need some kind of long-term nursing care services. Medicare normally does not cover these services, and only 2 percent of the entire elderly population has private insurance coverage to meet this need.

Current proposals to address the problem of uninsurance would either expand government programs or mandate all employers to provide their workers with health insurance coverage. Yet the problem

29 U.S. Department of Commerce, Bureau of the Census, *Current Population Survey*, March 1987.

is a direct result of soaring medical costs, triggered by the structural flaws of the system. As these costs continue to drive up the price of health insurance, fewer employers and workers can afford coverage. If lawmakers simply mandate health insurance or expand government programs without restructuring the system to remove the incentives for cost escalation, they will only compound the problem. The cost of health insurance will continue to soar, and businesses will face mounting costs.

The response of firms will be to cut labor costs in other ways, most likely by slowing wage increases or by cutting their labor force. Thus if insurance is made mandatory, a growing number of today's workers not only will fail to receive insurance coverage but will also lose their jobs. And if government programs are expanded to cover the uninsured, the federal government will be forced to spend ever increasing amounts each year just to cover the currently uninsured population. At the same time, rising health care costs will continue to add to the ranks of the uninsured, necessitating even more government spending.

In the case of long-term care for the elderly, the problem is that during their working lives these Americans were encouraged by tax incentives to purchase insurance for even the most minor items of immediate medical care, while discouraged from protecting themselves against long-term care costs when they retired. Without new incentives encouraging today's workers and the newly retired individuals immediately to purchase private long-term care insurance, the cost of a new government program to cover long-term care quickly would balloon to an enormous and unsupportable size.

Clearly, Congress cannot simply ignore these gaps in the system. What is crucial, however, is that lawmakers adopt solutions that deal with the sources of the problems, not short-term bandaid solutions that will add to the underlying problems.

3) The current system fails to adapt to new technology and changing demands.

Soaring medical costs and gaps in coverage may be the most pressing problems triggered by perverse incentives in the system, but they are by no means the only problems in American health care. The design of the system also restricts its ability to take full advantage of the potential of some new technologies for delivering existing services in a more

efficient and cost effective manner. At the same time, the system is ill-prepared to meet the challenge of financing the new demands and new services generated by other technologies.

The origin of these problems reaches back to the turn of the century, when an acute-care, hospital-based model of health care delivery first began to dominate the system. This meant that hospitals received an ever larger share of health care resources at the expense of encouraging less costly or more efficient outpatient and preventive care. Since then, developments in private insurance and government programs have reinforced this pattern. The creators of Medicare and Medicaid unwittingly entrenched these biases by structuring those programs to pay primarily for hospital care.

Since the mid-1960s, medical care increasingly has moved away from hospitals at both ends of the spectrum. Acute conditions that once required hospitalization can now be treated in doctors offices, at surgical centers, or with prescription drugs. Meanwhile, patients with chronic or degenerative conditions can now receive more intensive care for longer periods of time at home or in a nursing home. New technologies have decreased the risks involved in many treatments, rendering simple and routine many procedures that once were difficult or complex. They also have provided cures for previously untreatable conditions or prolonged the lives and reduced the suffering of patients whose condition is still incurable.

But the structure for financing health care has failed to adapt to these changes. The third-party payment system continues to spend vast amounts of money on acute-care treatments that are increasingly a common consumer commodity. Yet private insurance and government programs are only now beginning to address the rapidly growing need for coverage of long-term care and catastrophic acute-care expenses. In those instances where health care spending can most easily be controlled, the structural defects of the system mean there are still few incentives for patients to question costs or for doctors to use technology to provide efficient and economical treatments. But in those cases where the treatments are intensive or prolonged and the costs are enormous, patients now find themselves without the protection they need.

The impact of the system's failure to adapt to changing technology and demands is most readily apparent in the problems now plaguing Medicaid. Originally created as a program to finance basic health care

services for the poor, Medicaid in recent years has become a program for financing care for Americans driven into poverty by high medical expenses. By default, Medicaid has become the payor of last resort for America's health care bills. Over one-third of all Medicaid money is now spent on nursing home care, largely for middle class retirees who have depleted their assets and income and are left enough to qualify for the program.

Without major reforms, this situation will only become worse. The projected growth in the elderly population will increase the demand for nursing care. At the same time, the need for catastrophic acute or long-term care is increasingly a problem for the young as much as the old. The costs of caring for younger patients with severe disabilities or terminal illnesses like AIDS or degenerative neuromuscular diseases can far outstrip those for a retiree spending the last months of his or her life in a nursing home. Having exhausted their resources and run out of other options, more of these younger patients are ending up on Medicaid rolls. In the end, everyone loses: Middle-class patients are unnecessarily driven into poverty, while fewer of the poor are able to receive the care that Medicaid was originally designed to provide them.

As current problems such as health care inflation, uninsurance, and lack of coverage for long-term care grow and multiply, it is becoming increasingly clear that something is seriously wrong with the basic structure of America's health care financing system. It is no longer a question of whether the system should be reformed. Rather, it is a question of how to reform it.

Chapter 2

A Framework for Reform

Stuart M. Butler

The deficiencies of America's health care system are inherent in its very design and structure, which, as *Chapter 1* explains, are the result of policies and trends spanning more than 60 years. Thus if the ailments of the system are to be cured, the root causes must be addressed. Simply adding new programs or introducing another layer of control will fail to correct the underlying problems.

Reform must create a health care system that satisfies the demands and priorities of the American people and does so in a way that encourages the health care market to adjust to the choices of consumers rather than frustrating the operation of markets. The current crisis in large part stems from the failure of lawmakers to view the system as a market.

Liberals have resisted the use of market mechanisms in their efforts to devise a comprehensive health care system for Americans. But while conservatives advocate the use of markets, they too share the blame for today's problems. They so far have refused to recognize that some form of comprehensive health care system in America is politically inevitable, given the rising tide of pressure from groups short-changed by the current system. Refusing to recognize this, conservative lawmakers generally have confined themselves to trying to block popular liberal proposals to extend a flawed system, rather than offering their own plan for a new and comprehensive system that corrects those flaws

by introducing beneficial incentives. By playing only a narrow defensive role, conservatives have incurred the anger of Americans by slowing the introduction of liberal programs, while failing to offer a responsible alternative.

A responsible reform must achieve the broad health care objectives of the American people in a manner that cures the structural problems of the current system. As such, it must reach three goals:

Goal #1: A reformed U.S. health care system must give all Americans access to adequate health care services.

America's current health care system contains unacceptable gaps in coverage. A reformed system must bridge these gaps.

Goal #2: A reformed U.S. health care system must contain market-based incentives to moderate costs.

Today's system is riddled with perverse incentives for rapid cost escalation. Congress has tried to staunch this by introducing ineffective and damaging price controls. Needed instead is a system that uses competition and price incentives to reduce inflationary pressures.

Goal #3: While prices must be used to encourage the efficient use of health care resources, a reformed system must ensure that families do not suffer catastrophic financial losses because of ill health.

The current system protects most Americans from most routine medical costs but leaves them unprotected against heavy costs. A reformed system must focus on catastrophic protection.

Achieving these goals requires a fundamental change in the thrust of U.S. health care policy. As *Chapter 1* notes, the traditional policy approach has been to graft new programs and requirements onto a system that is inherently unsound. In the public sector, Congress has been expanding Medicare for the elderly, yet it has not solved the shortcomings of the social insurance model. Similarly, Congress has debated adding new federal programs to expand Medicaid without exploring ways to deal with the program's soaring costs. At the same time, lawmakers seem far more intent on mandating that employers provide health coverage than on correcting the perverse incentives in the tax and regulatory treatment of health insurance that make it unaffordable for some workers.

Some members of Congress, such as Senator Edward Kennedy, the Massachusetts Democrat, have traveled beyond America's borders to explore foreign health care systems as a model for restructuring the current U.S. health care system. These lawmakers recognize correctly that, if the system in this country is to achieve the goals desired by most Americans, it will require some fundamental changes. They note that the U.S. is unique among major industrialized countries in lacking a national health system, in the sense of a system in which government is directly involved in financing or delivering health care services for virtually the entire population.

The trouble is that these putative reformers in most instances have been unjustifiably impressed by the attractive features of foreign systems but have paid insufficient attention to their serious shortcomings. Indeed, an examination of systems abroad suggests that the best road to reform in the U.S. would be to focus on correcting the incentives and regulation of America's essentially private system of health care delivery and not to adopt a new system based on models drawn from such countries as Britain, Sweden, or Canada.

HEALTH CARE SYSTEMS IN OTHER COUNTRIES

In most countries the government plays a far larger role in the financing and delivery of health care services than in the U.S. Yet there is no universal model which has been adopted abroad. Rather, a wide variety of systems exists, many of them incorporating the private sector within a government-designed framework. These foreign systems fall into two broad categories:[30]

1) National health systems

A national health system is characterized by universal coverage for all citizens, as a legislated right, financed through general tax revenues, with government control or ownership of hospitals and with physicians employed either directly by the government or working under contract to the government.

30 For a review of health systems abroad, see Marshall W. Raffel, ed., *Comparative Health Systems* (University Park, Pennsylvania: Pennsylvania State University Press, 1984).

Example: Great Britain

The British National Health Service (NHS) was created in 1948 as the Free World's first comprehensive government health care system. Its architect, the economist Lord Beveridge, declared that the system would provide every citizen, rich or poor, with equal access to "whatever medical treatment he requires, in whatever form he requires." With about 1 million employees, including over 50,000 physicians, it is one of the world's largest employers.

The British system provides "cradle to grave" health services for its citizens. Britons have access to a general practitioner – although not necessarily one of their choosing – at no charge and can obtain prescription drugs at a nominal cost of less than $4, although 80 percent of the population is exempt even from that charge. There are no hospital or physician charges for tests or in-hospital treatment. The system is financed primarily through general tax revenues, although a very small contribution is made through payroll taxes and by private patients who pay fees for the use of NHS hospital facilities under the supervision of their own private physician.

The national government owns and operates over 2,000 hospitals and directly employs most hospital staff, although some hospital physicians, like most general practitioners and dentists, combine NHS work with private practice.

Although all citizens are eligible for NHS services, about 10 percent of medical care in Britain is financed and delivered through the private sector. Individuals choose private insurance or direct payment generally to obtain benefits not available from the NHS, including choice of physician and immediate access to a hospital for nonemergency surgery.

Example: Sweden

Despite a population only one-seventh that of Britain, the Swedish health system employs about one-third as many workers as Britain's NHS, or about 7.5 percent of all Swedish employees. Like Britain, Sweden provides a universal government health care system, mainly run by local county councils. The councils own Sweden's public sector hospitals and, as a group, negotiate salaries with physicians, nurses,

and ancillary workers. About 5 percent of the physicians are in private practice, mainly in the cities, and they account for about 20 percent of ambulatory medical care.

Nearly all the financing for the Swedish system comes from payroll taxes or general taxes. Patient charges, however, are high compared with most European countries. There is a charge of approximately $8.50 for each of the first 15 visits to a doctor, a $10 charge for drugs, and a daily hospital fee of $8.50.

2) Social insurance systems

Social insurance systems are characterized by universal or near universal service financed through compulsory employer and individual contributions. These contributions pay for a system that is organized through nonprofit insurance funds. The government may own some hospitals and employ some medical staff, but generally it does not dominate the medical industry.

Example: West Germany

The West German health system is a refinement of a compulsory social insurance system first developed in 1883 by Chancellor Otto von Bismarck. It is the world's oldest health insurance system. All but the 2 percent of West Germans who are privately insured are enrolled in the system. Matching contributions from employers and employees are channeled to about 1,400 "sickness funds," or nonprofit insurance companies, to which Germans must belong. Each sickness fund sets its own rate, which is collected as a tax on earnings up to a certain annually adjusted level, known as the "wage base." The average tax rate is 13 percent, split between the employer and employee. Dependents of an insured individual are automatically enrolled. The unemployed also are enrolled, with premiums paid on their behalf by the government. The patient is not charged for visits to a physician, but does pay just over $1 for prescriptions and just over $3 per day for a hospital stay.

Hospitals and physicians must negotiate fees with the sickness funds. General practitioners and other office-based physicians, for instance, are grouped in regional Associations of Insurance Doctors (AIDs). In exchange for agreed services, based on a minimum established by law, each sickness fund pays the local AID a certain amount, and the AID distributes this money according to a fee schedule agreed

by the members of the AID. Patients have free choice among the physicians that agree to treat sickness fund patients – about 90 percent of general practitioners.

Payments to hospitals take two forms. The West German federal government regulates the daily charges that hospitals can bill the sickness funds for treating patients. In addition, federal, state, and local authorities reimburse hospitals for the cost of construction and for their equipment.

Example: Canada

Since 1971, all of Canada's provinces have provided universal hospital and physician insurance. The federal government contributes approximately 50 percent of the cost (more in the poorer provinces), and the provinces are responsible for the rest. Health care funding is channeled through provincial health care programs, in some cases administered by single corporations. Canadians have free choice of hospitals and doctors and pay virtually nothing directly. Private health insurance is also available, but private insurance companies are barred by federal law from offering services that compete with the comprehensive provincial plans.

In some provinces a mixture of income and sales taxes pays for the provincial portion, but in Alberta and Ontario (Canada's most populous province) the system is based on social insurance principles, and residents are required to pay premiums, usually deducted from payroll checks. In Ontario, about 70 percent of the population pays premiums directly or indirectly through their employers. Residents over age 65 receive services without paying premiums, as do individuals and families without sufficient resources. Total premiums contribute about 20 percent of the health insurance budget.

The vast majority of hospital beds in Canada are in private institutions. The insurance program in each province reimburses hospitals on the basis of their operating costs. A calculation is made of the likely utilization rate in the area, and the acceptable total cost of services is determined by a rate-setting body in each province, usually appointed by the minister of health, with a major role in selection played by the insurance plan. Hospitals are permitted to charge special fees directly

to patients for special services (such as a private room). The capital expenditures of hospitals are financed by government grants or raised privately.

Fee-for-service is the dominant form of payment to physicians, both for hospital and office services, although some hospital doctors are paid a salary. But fees are fixed. All physicians are reimbursed according to a fee schedule for services, which is negotiated with the provincial medical associations.

IMPLICATIONS FOR AMERICA

Some proponents of expanded U.S. government programs point to certain statistics, such as infant mortality rates, to argue that national health services or social insurance programs lead to improved health among the population. But comparing the effectiveness of health care systems is a notoriously risky exercise. Explains Professor Uwe Reinhardt of the Woodrow Wilson School at Princeton University:

> Unfortunately, these crude indicators tell us little about the relative efficacy of different health systems, because these health-status indicators are shaped by many socio-economic and demographic factors completely outside the control of the health system proper. It would therefore be neither meaningful nor fair to read into such crude numbers shortcomings of the American health system per se.[31]

Nevertheless, two things become clear in any international comparison of health systems in the developed countries. The first is that the universal, tax-financed systems tend to be very popular with voters. Only after a decade as Prime Minister has Britain's Margaret Thatcher felt able even to propose significant reforms to introduce more competition and private medicine into the NHS. The popularity of the system makes structural reforms a very dangerous political exercise. A

31 Uwe E. Reinhardt, Ph.D., "Health Care Expenditures in Other Countries," statement presented to the Subcommittee on Education and Health, Joint Economic Committee of the U.S. Congress, May 3, 1987.

poll in June 1988, for instance, found 64 percent of Britons rating the NHS as "good," with only 15 percent rating it "poor." The poll also found that 64 percent favor "total state [central government] funding" for the service, in contrast to only 2 percent favoring "mainly or solely" private funding for health.[32] A poll in Canada in 1984 found similar strong support for the provincial systems, with 81 percent of respondents declaring they were "very" or "quite" satisfied with the plans.[33]

The second characteristic, paradoxically, is that, for all the popular support for these systems among their citizenry, there is widespread bitter criticism by patients. Many of the problems they encounter would horrify most Americans. The patients apparently assume that the deficiencies are the result of insufficient government spending and not of the inherent characteristics of the systems they admire. Yet the flaws are endemic; this should give pause to those U.S. lawmakers who believe that simply adopting the British or Canadian models would lead to a major improvement.

The underlying cause of problems associated with social insurance and national health systems is, ironically, the same as that driving up the costs of the U.S. system: the fact that patients make little or no contribution to the cost of their care.

In the U.S., as *Chapter 1* explains, this "zero price" policy has led to high demand for medical services, regardless of need, efficacy, or costs, resulting in rapidly escalating and seemingly uncontrollable private and public health budgets. But in countries where budgets are determined by the political process, and thus must compete directly with other political choices, the high demand for services outstrips the supply of funds, resulting in chronic shortages, deficiencies, and rationing of medical services and supplies.

While this conflict among government spending priorities is a well-known chronic feature of health care policy in Britain, it is also the case in other countries with government-financed systems. Goran Lennmaker, health care expert for Sweden's opposition *Moderata Samlingspartiet* (Moderate Party), notes that constant hospital bed shortages in his country are due to the fact that,

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32 Poll by Market & Opinion Research International Ltd., quoted in *The New York Times*, August 7, 1988.

33 Quoted in John K. Iglehart, "Canada's Health Care System" (part 1), *The New England Journal of Medicine*, September 18, 1986, p. 781.

> ...the government has monopolized the health care, and that makes it hard to get the expansion we should have had....In other countries, and especially the U.S., patient demand directs the outcome. In Sweden there are commissions and central decisions about how to allocate resources...and that is why we fall behind.[34]

A 1986 study of the Canadian system in the *New England Journal of Medicine* found similar structural problems, noting that the policy of protecting patients from paying any portion of their bill has led to "no limits on patient demand, no system wide controls on provider volume, and an emphasis on the provision of more expensive care in the hospital, rather than – when medically appropriate – in lower cost settings."[35] The author, John Inglehart, quotes one of Canada's best-known health economists, Robert G. Evans, who characterizes the Canadian system as follows:

> Increasingly, Canada is running into the contradiction that was built into the health insurance plan at its creation. By that I mean that there is a basic conflict in a policy that says government must control its budget, health care must be universally available, physicians must retain their professional autonomy, and consumers must have free choice of providers.[36]

Every economist knows that, when prices are kept artificially low, consumer demand rises rapidly. There are only two ways to prevent such a system leading to program bankruptcy or massive tax increases. One is to control the prices charged to the government by health care providers. The other is to impose rationing, thereby denying the ideal of free access to health care. All the systems utilizing social insurance or direct government provision have in various degrees resorted to both of these practices.

Britain imposed income controls on medical staff from the inception of the NHS. Those controls have kept down the budget – indeed Britain spends less on health as a proportion of gross national product than

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34 Quoted in Annika Schildt, "In Sweden, Equality is Tinged With Inefficiency," *The Washington Post* (Health Section), August 16, 1988, p. 8.

35 Inglehart, *op. cit.*, Part 1, p. 203.

36 *Ibid.*, p. 203.

any other major Western country. But government controls have meant continuous complaints over pay by all sections of the medical profession, leading to very high rates of emigration by physicians and frequent strikes and other protest actions by medical personnel and ancillary workers. Britain, in fact, has one of the lowest rates of physicians per unit of population of any Western industrialized country. The rate would be even worse were it not for the immigration by doctors from Third World countries, where salaries are even lower.

With growing tensions between the medical profession and the government, other countries have been forced down the same road of price and income controls. Canada, for instance, has resorted to increasingly stringent controls over physician fees to keep costs within budget. Until 1984, some provinces allowed physicians to "extra bill" patients above the agreed fee schedule, as a safety valve in periods of tight control. But a 1984 federal law cut federal assistance to provinces that permitted extra billings. The move was bitterly fought and denounced by physicians, and in Ontario it triggered a 25-day strike by doctors, the longest strike in the history of Canada's health system. Such fee controls and moves in some provinces to regulate the distribution of doctors by restricting the number eligible to receive insurance payments in certain locations have angered Canadian physicians.

Direct rationing is another staple feature of health care in most countries. American officials and experts inspecting national health systems abroad invariably are impressed by tours of state-of-the-art equipment and by the elimination of financial worries for patients. What they do not see are the endemic shortages and misallocations that result from rationing policies designed to keep the demand for services under control.

Rationing exists everywhere in government-financed health systems. In the more recent universal systems, rationing is less obvious, as one might expect, but it is growing. In Canada, for example, shortages of new equipment, the deterioration of existing facilities, and waiting lists are intensifying. New and expensive technology is less available to patients in Canada than in the U.S. The entire province of Newfoundland, for instance, with a population of 579,000, has just one CAT

scanner.[37] And John Inglehart, in his study, finds that "the physical plants of Canadian hospitals – particularly the teaching institutions – are nearing obsolescence."[38]

The emergence of long waiting lists for medical care in Canada is particularly troublesome to patients and physicians alike, since it represents the denial of the ideal of national health care and is a particularly brutal way of keeping down demand. While acutely ill patients get priority, Canadians with debilitating yet nonemergency conditions are learning to wait in line. In Ottawa, a heart patient can expect to wait for four months for a coronary bypass operation.[39] In Vancouver, reports one doctor, the wait for a routine neurological examination is one to three months, a cataract operation may involve a nine-month wait, and corneal transplant surgery can involve a delay of as much as four years. Such waiting periods are not merely inconvenient, they can lead to significantly increased risk. Indeed, says the doctor, "The risk of dying on the waiting list for cardiac surgery is greater than the actual operative risk."[40]

Rationing by waiting list is an even stronger feature of fully nationalized health systems. In Sweden, a recent government commission on coronary care found that Swedes can wait up to eleven months for a diagnostic heart X-ray, and up to another eight months for essential heart surgery.[41] A research cardiologist, Steffan Ahnve, calculates that at least 1,000 Swedes die each year for lack of heart treatment. He bases the calculation on what he calls the "invisible" waiting list of "those who ought to be treated but don't even come up on the waiting list because it is so tight that we constantly have to prioritize."[42]

Britain imposes the most extreme rationing by waiting list. Currently about 680,000 Britons are on the waiting list for "elective" surgery (which in Britain merely means nonemergency). Government figures indicate that 25 percent of those on the list will be kept waiting for over

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37 Michael A. Walker, "Neighborly Advice on Health Care," *The Wall Street Journal*, June 8, 1988.

38 Inglehart, *op. cit.*, (part 1), p. 203.

39 Michael Malloy, "Health, Canadian Style," *The Wall Street Journal* (special section on health), April 22, 1988.

40 Letter to the Editor from Bill W. Weaver M.D., *The New York Times*, May 31, 1988.

41 Schildt, *op. cit.*

42 *Ibid.*

a year. Even urgent cases can mean a wait of well over a year for major eye or orthopedic surgery, and patients with debilitating heart problems can wait several months for a hospital bed. Even getting an appointment for nonemergency outpatient care or tests can mean a wait of several months. In some areas of Britain, a women receiving an initial positive test in a pap smear to detect cervical cancer can be forced to wait a further two months before a follow-up test is conducted to confirm the diagnosis.

Long waiting periods and other forms of rationing can be devastating, even fatal, for patients. Britain was the first country in Europe to establish a kidney-failure program, yet today kidney dialysis is less available to Britons than to citizens of any other country in Europe with the exception of Finland. Moreover, in practice, dialysis simply is not available to patients older than 55. The Kidney Patient Association estimates that 1,500 Britons die each year for lack of treatment.[43]

LESSONS FOR THE UNITED STATES

It is inconceivable that Americans would accept the waiting lists and other shortcomings of such systems as Britain's National Health System. Most Americans surely would balk at the problems now emerging in Canada's system. These problems are remarkably consistent across national borders. This is not surprising. They are the direct result of the economics of any health system based on social insurance or direct government funding.

The shortcomings of such government systems can, in fact, be seen already in America's Medicare and Veterans Administration (VA) health programs, the first organized on social insurance principles, the second on the British model of direct government provision. As *Chapter 5* explains, the U.S. until recently has avoided facing the demand/budget conflict by making Medicare a strict entitlement and simply spending whatever is required to pay for services after imposing premiums and copayments. But changing demographics and runaway costs have forced Congress to impose price controls on Medicare payments to hospitals, leading to limitations on hospital care for the elderly.

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43 Amity Schlaes, "Market Tests Britain's Health System," *The Wall Street Journal,* January 27, 1988.

In the Veteran's Administration, with its own separate system of hospitals and physicians, the problems are more like those of Britain – chronic misallocation of resources and poor quality patient care. This situation in the VA is made easier only by the availability of alternative private insurance and hospitals for veterans unwilling to accept the deficiencies of the VA system.

The features of government-operated and social insurance health programs at home and abroad should cause lawmakers to pause long and hard before pressing for similar systems in this country. Such systems lead inevitably to price and budget controls, and this in turn leads to arbitrary or bureaucratic rationing. There appears to be no escape from that result in any country. Only the degree of the problem differs.

Nevertheless, government-funded and managed systems remain popular. To some degree, as in the case of Britain, this may be because most citizens have never known any alternative, and thus, have a distorted impression of the largely private system in the U.S. Horror stories of uninsured foreign tourists in the U.S. running up enormous hospital bills are routine grist for the British tabloids. But another aspect of the popularity of the National Health System among Britons, which should be understood by American conservatives, is that most people in Western industrialized countries are prepared to accept many serious shortcomings in a system if it can deliver health care to everyone – even poor health care – without level of income being a barrier to access.

Conservatives too should recognize that the pressure for national health systems comes from Americans wanting the same thing: adequate care for everyone, regardless of income. Rather than denying that Americans are demanding this, conservatives should recognize that, unless they develop a comprehensive system that still maintains the choice and quality that Americans have grown to expect, the political process eventually will create a nationwide system plagued by the defects of the national systems abroad.

CREATING A NEW HEALTH CARE SYSTEM FOR AMERICANS

By modifying the existing system, the U.S. can develop a new health care system that will achieve the stated but unfulfilled goals of health care systems overseas – choice, access, and economy. Needed for this is a framework that works with, not against, basic economic forces. To be effective, the alternative framework must be built on the foundation of consumer choice – the most efficient and effective regulator of price and supply in any market, including the health care market. Public policies, regulations, and programs thus must be reformed to create an incentive structure that encourages consumers to question the need and the cost of the health care that they purchase, yet does not prevent them from obtaining needed care because of its expense.

The fundamental error of America's current health care system, in both the public and the private sector, is the assumption that health care is one area of economic activity where consumer choice and the efficient operation of markets is impossible. Policy makers agree that in theory markets are the best way of serving individuals while limiting costs, but they tend to argue that health care is an exception and is not an area where markets can function.[44] This contention rests on three allegations:

Allegation # 1: Consumers of health care have insufficient expertise to make wise choices.

Some proponents of federal health programs maintain that medical care is too technical a service for most Americans to understand. Because they cannot make sensible choices, the argument continues, a market cannot function for health care. Only a trained expert, it is said, can judge whether the cost of a given medical service is reasonable and the procedure necessary. Consequently the only way to control health care costs, it is argued, is for experts in government, corporations, or insurance companies to set prices in advance or carefully audit the costs after services are provided.

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44 For a good examination of the arguments for and against the anticompetitive nature of the health care market, see: Rita Ricardo-Campbell, *The Economics and Politics of Health Care* (Chapel Hill, North Carolina: The University of North Carolina Press, 1982), pp. 90-135.

Allegation # 2: Even informed consumers often do not have the time to choose carefully.

The need for medical care often is impossible to predict, and the needs may arise so suddenly that the consumer does not have time make an informed choice among the services and costs of different providers. A pedestrian knocked down by a truck, or a businessman suffering a heart attack, has no time to consult the price lists of competing hospitals.

Allegation # 3: Consumers cannot avoid or plan for health care costs.

Budgeting for medical costs differs greatly from planning to buy a new car or stereo. Typically, health care purchases cannot be delayed until funds are available. An individual either needs medical service or does not, and if he needs it, he has little choice over quantity or type.

Most policy makers accept the validity of these three allegations and conclude that they rule out the use of markets as the primary mechanism around which to construct a health care system. Yet although the charges appear plausible, they are not unique to medical care, and by no means, rule out markets. In fact, all specialized services in some key aspects are "unique," and just because consumers may lack a basic understanding of some professions does not prevent them from contracting for the services of, say, tax accountants, lawyers, or auto mechanics.

Consumers have ways of compensating for their lack of specialized knowledge. Normally, a consumer determines the general type of service needed or wanted. He may, for instance, conclude that he needs a mechanic to repair the transmission of his car. He then selects a specific provider based on recommendations from friends or an automobile association, or he may consult a consumers' magazine. And because he is paying for the service, this consumer has an incentive to question different mechanics regarding their estimated fees and reasons for recommending specific courses of action. Thus even without detailed knowledge of the services he needs, the consumer still can make informed decisions about the actions he should take.

While the stakes may be higher with medical services, the process itself is not fundamentally different. An individual begins by determining the kind of doctor he needs – perhaps an allergist or a general

practitioner. Next he may ask friends, relatives, or other doctors for specific recommendations. If one doctor says he needs an operation, his insurance company might require him to obtain a second opinion. In practice, a market of sorts already functions regarding the quality of medical services in America. The only element missing from the normal process of the market is cost comparison.

In a medical emergency, of course, there is no time for a consumer to do comparison shopping; but even here a consumer market can function. Genuine emergencies are routinely accommodated by insurance, and consumers can draw on expert advice in making health insurance decisions – just as a homeowner or car owner takes steps to shop around for insurance. Moreover, just as auto emergencies are a small element in most American's repair bills, medical emergencies comprise a relatively small share of a consumer's potential demand for health services. At most, only 15 percent of all medical care is of an emergency nature.[45] And even for the most critical nonemergency conditions, it is often possible to delay treatment at least long enough for a second opinion on the best course of treatment.

Thus although the need for medical care can be both unpredictable and expensive, markets still can function. Indeed, major medical care is very well suited to properly constructed insurance, while most common health expenses, such as regular checkups, dental care, and treatment for minor infections or injuries, are usually as affordable as other household expenses. The first step in reforming the U.S. health care system is to recognize that markets can operate effectively. Once this is understood, it is then possible to design policies that would increase consumer power within a more competitive health care industry, while ensuring that cost is not a barrier to access.

Given the lessons of foreign countries and a careful analysis of the failings of the current U.S. system, the key elements of a consumer-oriented, market-based, comprehensive American health system would include:

45 *Ibid.*, p. 93.

Element #1: Every resident of the U.S. must, by law, be enrolled in an adequate health care plan to cover major health care costs.

This requirement would imply a compact between the U.S. government and its citizens: in return for the government's accepting an obligation to devise a market-based system guaranteeing access to care and protecting all families from financial distress due to the cost of an illness, each individual must agree to obtain a minimum level of protection. This means that, while government would take on the obligation to find ways of guaranteeing care for those Americans unable to obtain protection in the market, perhaps because of chronic health problems or lack of income, Americans with sufficient means would no longer be able to be "free riders" on society by avoiding sensible health insurance expenditures and relying on others to pay for care in an emergency or in retirement.

Under this arrangement, all households would be required to protect themselves from major medical costs by purchasing health insurance or enrolling in a prepaid health plan. The degree of financial protection can be debated, but the principle of mandatory family protection is central to a universal health care system in America.

Help would be provided in two ways. First, the tax code would be amended, as *Chapter 3* describes, to give tax relief to individual purchasers of health insurance or prepaid plans and to provide tax credits for out-of-pocket expenses. Second, government would aid those who, because of income or medical condition, find the cost of protection to be an unreasonable burden. Such aid could take the form of vouchers for purchasing insurance or state-managed systems as described in *Chapter 5*.

The requirement to obtain basic insurance would have to be enforced. The easiest way to monitor compliance might be for households to furnish proof of insurance when they file their tax returns. If a family were to cancel its insurance, the insurer would be required to notify the government. If the family did not enroll in another plan before the first insurance coverage lapsed and did not provide evidence of financial problems, a fine might be imposed.

Element #2: For working Americans, obtaining health care protection must be a family responsibility.

The obligation for health care protection must be on the individual or head of household, rather than on an employer -- even if collective bargaining leads to many large employers agreeing to make payments on behalf of employees. There are several reasons for this. For one thing, relying on employer-provided plans as the basic system would limit freedom of choice and lead to "common denominator" coverage that may be inefficient. Employees must be free to join a company plan but not financially penalized if they choose an alternative. For another thing, families and individuals must be able to tailor their health insurance coverage to suit their own particular needs. In addition, mandating employee health benefits places enormous and costly administrative burdens on small companies; this is a major reason why so many workers in small firms lack insurance. Mandating that employers rather than individuals obtain coverage thus would lead to job losses and encourage firms to avoid hiring workers with potentially high medical bills.

Element #3: The government's proper role is to monitor the health market, subsidize needy individuals to allow them to obtain sufficient services, and encourage competition.

The government should not operate a social insurance system. This merely invites all the problems of a politicized bureaucratic monopoly. Government's proper role is three-fold. First, it should establish basic regulations to ensure that all plans comply with the broad objectives of the national system. Second, it should provide financial support for the poor and chronically sick to ensure that they can obtain adequate protection. In limited instances, this might be done by the government acting as a "surrogate consumer," buying into private plans on behalf of special groups. And third, it should develop a system of incentives and reasonable requirements to intensify competition in the health industry and to ensure that Americans have proper health care protection.

Government also can work with private institutions to devise strategies to deliver health care services more efficiently to groups served least well by the health care market, such as the indigent and

the chronically ill. By allowing states to propose demonstration projects, for instance, the public agencies may be able to use private markets to reduce the cost of assisting the poor.

By designing policies based on these three elements, America could achieve the objectives of a comprehensive health system without the problems of today's expensive and incomplete system. By establishing clear obligations and guaranteeing assistance to those who cannot meet that obligation, the nation could design a system that serves all but does not allow some to avoid sensible planning by relying on the taxes or goodwill of others. And by unleashing the creative and efficient power of the competitive marketplace, America could avoid the dismal bureaucratic rationing of other countries.

In short, by changing basic regulations and incentives to energize competition and make consumers more cost conscious, while restructuring financial support and introducing reasonable requirements that Americans purchase basic catastrophic coverage, it is possible for America to create a health system that is the envy of the world.

Chapter 3

Health Care for Workers and Their Families

Edmund F. Haislmaier

As outlined in *Chapter 1*, America's health care system today suffers from several decades of policies designed to favor health care providers and insurers rather than patients. As *Chapter 1* explains, the current debate over cost control is little more than a struggle between the competing interests of providers and insurers. Ignored are the interests and needs of the consumer.

Providers, of course, need to be compensated for their services and therefore have legitimate interests in the structure of the system. Similarly, if employers, insurance companies, and governments agencies are expected to pay most of the bills, they too have a legitimate interest in how the money is spent. But ultimately, it is the patient/consumer, not the provider or third-party payer, who uses health care services, and it is the patient for whom the system should be designed.

It is not sufficient simply to say that the consumer must come first. It is also necessary to determine for which group of consumers the basic structure of the system should be geared. A temptation for reformers is to alter the entire structure of a system so that it meets the needs of a minority of "hard cases." Moved by compassion, reformers reason that, if a system is rebuilt to serve the needs of these cases, then it also will work well for everyone else. In fact, the opposite is more often the

case. Systems designed to fit the needs of a minority of individuals can be so distorted that these systems work neither for the minority nor the majority. The best approach is to first make sure that the basic system is responsive to the needs of the majority and then to devise policies that enable the disadvantaged to share in the benefits of that system.

The difference between the two approaches to reform can be seen in the U.S. experience in another area of social policy – housing. Some cities, such as New York, have tried to address the special needs of a minority of their residents by enacting policies, such as rent controls, which have changed the basic structure of the entire housing market. The effect of this has been to undermine the system's ability to serve the majority and minority alike. The results: a decline in the number of units available to all income groups; exorbitant rents for non-rent-controlled apartments; and a shortage of housing for the poor – the very group the policy was intended to assist.

In contrast, the concept of housing vouchers is based on the understanding that a freely operating housing market best provides affordable housing to middle- and upper-income consumers and best responds to new demands for more housing. Further, it recognizes that the reason that the poor often cannot obtain adequate housing is not because of some inherent failure in the system, but because they have insufficient means to pay the market price for such housing. Vouchers are a simple means of overcoming this problem without undermining or distorting the system that works well for the majority.

It is this kind of approach – establishing a system that works well for the majority and then adding components to allow minority access to that system – that should be the strategy behind reforming the basic structure of America's health care system.

Unlike housing, America's basic health care system does not even serve the majority very well. Rapid escalation in the cost of medical care is symptomatic of a health care system with chronic problems. Thus if the special needs of specific groups of Americans are to be addressed, it first will be necessary to make the system more responsive to the needs of all Americans. This can be done by subjecting a larger share of the medical marketplace to the demands, restraints, and incentives of consumer choice, exercised by typical Americans. Only after such basic reform, and when the system is operating smoothly for most people, will government be able efficiently to "buy into" the system on behalf of the poor and chronically ill without undermining

the ability of the system to serve the majority. *Chapters 4 and 5* will detail the methods by which the government most effectively can meet the health care needs of two specific groups with special needs: the elderly and the poor.

CHANGING THE TAX TREATMENT OF HEALTH CARE

Lawmakers and officials should begin the process of health care reform by restructuring tax policies related to health expenditures. As *Chapter 1* explains, existing tax policies are most responsible for the system's problems and failures.

While, at one time, the longstanding policy of excluding the value of employer-provided health insurance from tax liability expanded access to health care, today it is a major cause of the inflation afflicting the system. This tax policy encourages Americans to think that their health care is paid for by someone else. As such, they lack the normal incentives to question the need for care or the prices charged for it. Unintentionally, tax policies have removed this key stimulus to the efficient operation of the health care market. New regulations or government programs will compound these problems. What is needed is to reintroduce market incentives by changing the tax code.

Tax-free, employer-provided health insurance diminishes the worker's awareness of how he is adversely affected by increased health insurance costs. In reality, the money that an employer spends on buying health insurance for a worker is part of the worker's wages. But because the value of these benefits is not even listed on his paycheck, the worker has little concern or interest in their cost. Furthermore, even if a worker is aware of the cost of his health insurance, he has no incentive to economize because saving money on his health care does not leave him with more cash to spend on something else. As a result, few workers see these employee benefits as anything more than a tax shelter for routine medical expenses. Gone, in other words, is both the normal consumer's attention to cost and his interest in obtaining the best combination of services and protection for each dollar. Employer-provided benefits also shield the worker from the reality that higher premiums result directly from the lack of concern over the cost and quantity of the medical services received.

Soaring medical costs will only be brought under control when Americans are encouraged to be more prudent consumers of health

care. The essential first step is to eliminate the tax exclusion of employer-provided health insurance and treat these benefits as the rest of a worker's cash income is treated. This would give workers an incentive to seek lower cost medical care or insurance by allowing them to pocket any resulting savings.

This concept is not new. Conservative and liberal scholars and lawmakers have advanced it in the past.[46]

But it always has provoked strong political opposition. The reason for this is that although over the long term workers would benefit from significant reductions in the cost of their health care, the immediate result would be an unwelcome increase in their tax bill. Understandably, therefore, workers and their unions have been the fiercest critics of the concept. But even employers facing spiraling health costs have been cool to it, fearing that the response from labor would be to demand additional income to compensate for the tax change.

A New Tax Strategy for Health Care

The way to avoid the political opposition to eliminating the tax exclusion for employer-provided health insurance would be to offset it with expanded tax deductions or tax credits in the personal income tax code for health insurance purchased directly by workers for themselves and their families. As explained in Chapter 2, workers would be required by law to obtain adequate insurance to cover major – or "catastrophic" – family medical bills.

By purchasing their insurance themselves, instead of having their employers do it for them, Americans would become more sensitive to the cost of their health insurance. This, in turn, would encourage them to avoid unnecessary or overpriced medical services that would increase their premiums. However, consumers would be even more

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46 See: Mancur Olson, ed., *A New Approach to the Economics of Health Care* (Washington, D.C.: American Enterprise Institute, 1981); Deborah J. Chollet, ed., *Employer-Provided Health Benefits: Coverage, Provisions, and Policy Issues* (Washington, D.C.: Employee Benefit Research Institute, 1984); Jack A. Meyer, ed., *Market Reforms in Health Care: Current Issues, New Directions, Strategic Decisions* (Washington, D.C.: American Enterprise Institute, 1983); Dallas L. Salisbury, ed., *Why Tax Employee Benefits?* (Washington, D.C.: Employee Benefit Research Institute, 1984); Alain Enthoven, "Health Tax Policy Mismatch," *Health Affairs*, Winter 1985, pp. 5-14; Howard R. Bloch and Roger L. Papp, "Subsidized Health Care and Consumer Choice," *The Journal of Social Political and Economic Studies*, Spring 1985, pp. 103-117.

conscious of the need and cost of their health care if they purchased more medical services directly out-of-pocket instead of through insurance. The more common medical goods and services purchased directly by Americans, the greater the consumer pressure exerted on providers to deliver quality care at reasonable prices. Ideally, consumers should purchase as much as possible of their routine medical care out-of-pocket and use health insurance only to cover very expensive and unpredictable illnesses. This would make health insurance function more like other forms of insurance such as auto or homeowner's insurance. It would also considerably reduce the cost of health insurance policies.

Therefore, the best tax policy would be one that encouraged Americans both to purchase common medical services out-of-pocket and to buy insurance coverage for expensive, unpredictable illnesses. This could be achieved by replacing the tax exclusion of employer-provided health insurance with a system of health care tax credits in the personal income tax code. These tax credits should be designed to favor out-of-pocket health care purchases over the purchase of health insurance. They should also be "refundable," meaning that, if a family's income tax liability was less than the value of the credit, the family would receive money back from the government. In effect, the government would be giving back some of the payroll taxes it collected from the family. This would enable lower-income families, who pay substantial payroll taxes but little or nothing in income taxes, to receive the same tax relief as more affluent families. These tax credits could be structured as follows:

Taxpayers could be provided with, say, a basic 20 percent tax credit for money spent on health insurance premiums and a 30 percent tax credit for out-of-pocket medical expenses. To give more relief to individuals and families with high medical costs, larger credits could be given for medical bills that exceeded a certain percentage of family income. For example, an additional credit of 50 percent could be provided for out-of-pocket expenses exceeding 5 percent of family income, and a 75 percent tax credit for out-of-pocket medical expenses above, say, 10 percent of income. This would provide increasing tax relief as health care expenditures consumed a higher proportion of family income. Tax deductions, by contrast, give more tax relief to higher earners in higher tax brackets. Such sliding scale credits would be a fair and efficient way of adjusting for differences in income and

health status among the population. Thus the lower a family's income and the higher its medical bills, the sooner it would receive tax relief and the greater that relief would be.

To aid those with the greatest need for help with large medical bills, taxpayers could take these credits for money spent on the medical expenses of needy relatives without having to meet the dependent support test. Under current law, this test requires that, before a taxpayer can claim a personal exemption, deduction, or credit for a dependent, he must demonstrate that he provided at least 50 percent of that dependent's total annual support. This reform would waive this dependent support test, so that taxpayers could claim deductions or credits for money spent on the health care of relatives carried as dependents on their health insurance policies.

This would encourage families to assume more of the health care costs for medically or financially needy relatives, particularly the elderly, the disabled, the unemployed, and low-wage workers. Families thus would become the second line of defense against high medical costs – behind insurance but ahead of the government.

This would be particularly helpful in meeting the need for long-term care service and insurance for the elderly. It also would allow parents to help their young adult children obtain health insurance or pay directly for basic medical care. Many currently uninsured workers, in fact, are young Americans.[47] Under today's system, they often cannot continue to be covered under their parents' insurance. Yet they are in low-paying, entry-level jobs where employers cannot afford to provide insurance. Waiving the dependent support test also would provide more flexibility to the parents of disabled children in meeting their medical needs. In the case of the elderly and disabled, it could also reduce the demand for public financing of necessary services.

Reforming health care tax policy in this manner should be politically attractive. While it will alter dramatically the structure of health care tax policy, it will preserve the basic principles of U.S. health policy: that access to care is a desirable social good and that to ensure access, government does not tax the money citizens use to purchase that care. Under this reform, Americans would receive roughly the same level of

47 "A Profile of the Nonelderly Population Without Health Insurance," Employee Benefit Research Institute *Issue Brief* No.66, May 1987.

tax relief for their medical expenses that they do now. The new credits, moreover, would be designed to meet the most common health care expenses, just as employer-provided insurance does. The big difference is that consumers would be paying directly for their common medical expenses, and therefore, would become very aware of the need and cost of those services.

Under the current tax exclusion for employer-provided health insurance, each dollar that a corporation spends on health care provides the worker with tax relief of at least 30 cents. Thus the worker, indirectly through his employer, pays only 70 cents for each dollar of medical care. Replacing this with a 30 percent tax credit for out-of-pocket expenses would not change the actual subsidy for purchasing health care. It would change, however, how the consumer views that subsidy. Instead of thinking only about the 30 cents he is saving in taxes, he would think too about the 70 cents he must spend directly out of his pocket to purchase the service. The total tax relief, in dollars saved, may be identical, but because he is paying bills and insurance directly, he has a vastly greater incentive to seek the best value for his money. The result: replacing the tax exclusion with a tax credit would change the consumer's attitude toward health care costs and thus change how he chooses and uses health services.

Normal market functions would return to health care. Consumers would react to market prices, forcing providers to offer quality services at competitive prices. This, in turn, would restrain health care inflation. There are other benefits to using tax credits to encourage consumers to purchase more of their health care directly out-of-pocket. The more that quantity, quality and prices in the health care market are regulated by consumer choices, the less the need for regulation by government, employers, and insurance companies. This results in less paperwork, bureaucracy, and frustration for both patients and health care providers.

In those cases where a third party, like Medicare or Medicaid, would still pay the bills, market prices can become the guide for determining appropriate reimbursements for providers. One of the biggest problems currently facing third-party payers is how to determine what they should pay for treatments, particularly outpatient physician services that are difficult to monitor. Generally, third-party payers base their reimbursements on some calculation of average prices in a specific region or on prices charged in previous years and adjusted for

inflation. In this way, they seek to offer physicians enough to provide adequate services, but not the right to charge whatever they want. In effect they try to second guess the market. The problem is that they are trying to do this in the absence of a true, consumer driven market.

Indeed, after several decades of policies that discourage consumer cost consciousness, it is unlikely that any of the market prices used by third-party payers are an accurate reflection of supply and demand. Further exacerbating the problem of distorted medical prices has been the introduction of a host of new medical technologies and procedures into a system that has no market mechanism for establishing their true value relative to existing treatments. Thus, while providers in other areas of the economy use new technologies to lower costs and prices, in medicine, the introduction of a new technology almost always results in higher costs.

When prices are determined by Americans exercising consumer choice in a freely functioning market, government would need only to address the question of how to provide the disadvantaged with the extra funds they require to purchase medical care. At least for the more common, low-cost services, the government would no more set the appropriate prices for medical care paid for by Medicaid than it would set the prices for food purchased by the poor with food stamps.

Finally, by encouraging consumers to purchase routine health care services out-of-pocket, health insurance companies would have incentives to concentrate on providing policies more suited to the natural function of insurance – coverage for unlikely but very expensive occurrences.

OBJECTIONS TO THE REFORM

Despite these benefits, a number of objections may be raised to the proposed reform. Among the most likely:

Objection #1: The tax changes would set an undesirable precedent for taxing other employer-provided fringe benefits.

Proposals to limit or remove the tax incentives for employer-provided health insurance are seen by many workers and union officials as a wedge leading to the taxation of all fringe benefits. The premise of this fear, however, is flawed. Tax relief for health care costs still would be available. The only significant difference is that it would be granted

directly to the employee, rather than indirectly through the employer, and could be adjusted to the income and medical situation of the worker and his family. In effect, health insurance would cease to be an employer-provided benefit. Instead it would be a commodity that government encourages individuals and families to purchase, just as the tax deduction for mortgage interest encourages them to purchase homes.

Objection #2: Some employers currently providing their workers with health insurance might take advantage of these changes to reduce the total package of remuneration for their workers.

If the government encourages workers to purchase medical care and health insurance on their own by providing credits in the personal income tax code, some employers might simply drop coverage for their employees and pocket the savings. This would decrease the workers' real income. Although unions no doubt would block such action in unionized firms, nonunion workers could be vulnerable.

This problem could be avoided by legislation requiring employers to distribute among their employees the money they now spend on health insurance. While the federal government generally should not interfere in management-employee bargaining, this requirement would affect only the transition period when the new policy is introduced. By ensuring that workers did not suffer a loss in total remuneration, potential worker opposition to the whole package of changes would be reduced. Once the health benefit/income transfer was completed, workers and employers could, of course, negotiate a new arrangement. For instance, the employees might negotiate some new fringe benefit, such as extra vacation. They also might negotiate an arrangement with the employer to pool the extra funds and have the employer negotiate with insurance companies as a broker on their behalf. This would be similar to the way some employers helped their workers obtain health insurance before the 1930s.

Thus employees' concerns can be addressed by the simple requirement that the employee must not be worse off as a result of the change. Yet the requirement leaves employer and employee free to negotiate any permanent change they wish in the way income is distributed to workers.

Objection #3: Insurance policies purchased individually by families would be much more expensive than group insurance.

This objection is based on the argument that insurance companies incur higher costs in marketing policies and paying claims when they sell them on an individual basis. While this is correct in a narrow sense, it overlooks three important points.

First, if consumers paid directly for more of their common medical care, the insurance policies they purchased would be less costly than current policies – covering only the more expensive, but much less likely, medical services. This would reduce the cost of health insurance by eliminating not only the substantial sums paid out in benefits for a multitude of small claims, but also the attendant administrative costs of processing those claims.

Second, most workers still would be able to purchase insurance through their employer by pooling their money through a voluntary payroll deduction discussed above. As in any other cooperative purchasing arrangement, some of the savings of bulk purchases would be passed on to each individual.

Third, and most important, if individual consumers purchased insurance directly, insurers would be forced to calculate their premiums using larger risk pools. Many policy makers believe erroneously that current group health insurance policies reduce costs by spreading risks among a large number of subscribers. In fact, the opposite is true. Under existing group health insurance policies, the risk pool an insurer uses to calculate premiums is limited to a relatively small number of people – usually those working for a single employer. In contrast, policies for auto, life, homeowner, or virtually any other kind of insurance are based on larger risk pools. Thus, the artificially limited risk pools in existing group health insurance drive up the cost of many plans.

This is apparent most vividly in the case of small businesses. The owner or employees of a small business typically can purchase affordable auto, life, or fire insurance at rates comparable to any other firm. But because a small company has fewer employees in its group, it must pay much more per worker for health insurance than a larger company. Small companies also face larger increases in their premiums, or possibly even the cancellation of their insurance, if just one employee incurs unusually high medical expenses.

With individual families purchasing health insurance, premiums would be based on large demographic groups, as is the case with other forms of insurance. This change would be of major benefit to workers in small firms and would eliminate one of the major factors contributing to the current problem of uninsurance.

Objection #4: Insurance premiums would be unaffordable for high-risk families.

This objection also would become less valid if insurance policies were restructured to eliminate or reduce coverage for routine services. While high-risk families have a greater probability of needing expensive treatments, the real difference in the cost of insuring them actually comes from their propensity for needing a greater volume of routine services. Under the proposal outlined above, high-risk families would receive more tax relief than healthier individuals for their greater out-of-pocket medical costs. And while high-risk families still would pay somewhat higher insurance premiums than healthier individuals, the cost difference for catastrophic health insurance would not be as great as it is for more comprehensive policies.

Objection #5: By being forced to pay routine medical bills out of pocket, consumers would be discouraged from purchasing necessary care.

This objection gets to the heart of the inherent conflict in American attitudes toward health care. On the one hand, there is a clear social consensus supporting equal access to health care. On the other, there is a widespread belief that health care should cost less. In the past, U.S. health care system policy has been biased in the direction of assuring equal access, regardless of cost. While the reforms outlined in this chapter are not designed to correct this bias completely, they do introduce much greater emphasis on market-based cost control for more routine health care services. Moreover, there is a clear and growing trend in medical technology toward less invasive, less complex, and less expensive treatments for a greater number of medical conditions.

As a greater portion of medical care becomes a common consumer commodity, it becomes possible to subject more of that medical care to the normal demands, incentives, and restraints of the market place

without jeopardizing access. Studies based on the Rand Health Insurance Experiment[48] provide evidence that increasing consumer cost sharing for more common medical services does not lead to patients foregoing medical care because of its expense.[49] For example, one study found that the use of hospital emergency department care by individuals with plans that required them to pay part of the bill was 40 percent less than the use by individuals whose insurance paid the entire bill. The difference in utilization between the two groups was greatest for less severe conditions, such as minor lacerations, where outpatient ambulatory care was available as an alternative.

This supports the contention that, when patients pay more of their own bills, they choose the cheaper alternative among different providers offering essentially the same services. Even more important, the study found that, after three years participation in the experiment, there was no evidence to indicate that individuals in the plans with higher cost sharing had delayed seeking treatment for their medical conditions because of expense and allowed minor conditions to become more serious.[50]

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48 Between 1974 and 1982, the federal government sponsored through the Rand Corporation of Santa Monica, California, one of the world's leading research institutes, a randomized, controlled trial of different kinds of health insurance coverage. This trial became known as the Rand Health Insurance Experiment. The purpose of the experiment was to determine the potential effects of beneficiary cost sharing in health insurance on the demand for medical care, the quality of care, and the health status of participants. A statistical cross-sample of American families were enrolled in the experiment and then randomly assigned to a variety of health insurance plans with different benefits and levels of cost sharing. The families were then studied over a period of years to determine what effects the different health insurance plans had on their consumption of medical care and their health status.

49 R. Burciaga Valdez, Robert H. Brook, William H. Rogers, John E. Ware, Jr., Emmett B. Keeler, Cathy A. Sherbourne, Kathleen N. Lohr, George A. Goldberg, Patricia Camp, Joseph P. Newhouse, "Consequences of Cost-Sharing for Children's Health," *Pediatrics*, May 1985, pp. 952-961. Kevin F. O'Grady, Willard G. Manning, Joseph P. Newhouse, and Robert H. Brook, "The Impact of Cost-Sharing on Emergency Department Use," *The New England Journal of Medicine*, August 22, 1985, pp. 484-490.

50 O'Grady, *et al.*, *op. cit.*

Objection #6: Some consumers would neglect to purchase insurance for large unforeseen medical expenses.

While this would be a legitimate objection to a proposal that only altered the tax treatment of insurance, it is avoided by the requirement, proposed in *Chapter 2*, that all working Americans purchase catastrophic health insurance for themselves and their families. This requirement would be similar to current laws in many jurisdictions requiring auto owners to have liability insurance.

For both political and economic reasons, the tax changes outlined in this chapter must form the centerpiece of any health care reform legislation. The inclusion of politically popular tax credits is essential to gaining broad popular support for other elements of the reform package. At the same time, these tax policies would introduce effective consumer choice as the primary mechanism for forcing providers to offer quality services at competitive prices, thereby bringing health care inflation under control. They also would provide the incentives needed to restructure health insurance to give Americans improved protection from catastrophic medical expenses.

In turn, reducing health care inflation and restructuring health insurance to focus on catastrophic coverage are essential preconditions for the successful reform of government programs, enabling them better to address the needs of disadvantaged members of society. If the basic health care system is more responsive to the needs of the majority of working Americans and their families, who enjoy average health and resources, government will find that it can buy into that system, on behalf of the disadvantaged without also buying into a system beset by runaway costs.

Chapter 4

Health Care and the Elderly

By Peter J. Ferrara

The elderly need and use medical services more than any other group of Americans. Often with a fixed income and a limited ability to earn more, they are especially vulnerable to rapidly rising medical and catastrophic health care expenses. The middle-class elderly fear particularly that the high costs of treating a severe or chronic illness could wipe out their life savings.

Like several other countries, as *Chapter 2* notes, the United States has adopted a social insurance approach, in the form of Medicare, to deal with these fears of the elderly. But this social insurance approach does not solve the problem of high medical costs for America's elderly. They pay as much or more of their income for medical care as they did before Medicare was adopted.[51] At the same time, the quality of care, in many respects, is deteriorating under federal cost control regulations. Medicare is still badly underfunded over the long run, and it will require huge payroll and income tax increases to maintain promised benefits. Workers already face heavy payroll tax burdens to pay for

51 See, for example, Harvard Medicare Project, Division of Health Policy Research and Education, Center for Health Policy and Management, *Medicare: Coming of Age* (Cambridge, Massachusetts, 1986), p. 1; Aldona Robbins and William E. Hurwitz, "Catastrophic Insurance is Bad Medicine," Institute for Research on the Economics of Taxation, *Economic Policy Bulletin* No. 26, 1987, p. 5.

Medicare, which is consuming ever larger amounts of federal revenues. Expanding Medicare to cover additional costs, such as that of nursing home care, would aggravate the system's problems.

America deserves a system that enables all of its elderly citizens to obtain essential quality medical care without great financial hardship. To accomplish this, a new approach is needed, based on competition, market incentives, and greater consumer choice.

THE PROBLEMS OF MEDICARE

Medicare is divided into two components: Part A, Hospital Insurance (HI); and Part B, Supplemental Medical Insurance (SMI).

Part A pays primarily for hospital care and services. It is financed by a payroll tax of 2.9 percent, split between employer and employee, on wages up to a maximum of $48,000 in 1989 (this maximum is indexed to increase each year with average earnings).

Part B pays primarily for doctor's services in and out of hospitals. About 25 percent of Part B expenses are financed by a regularly increased monthly premium payable by each elderly beneficiary. For 1989 this premium is $31.90. General revenues finance the remaining 75 percent of Part B expenditures.

Based on the federal government's most recent projections, Medicare Part A will run short of funds to pay promised benefits between the years 2000 and 2005. Under the government's most widely cited intermediate projections, paying all the program's promised benefits by the time today's young workers retire will require the total Medicare payroll tax to more than double, from today's 2.9 percent to 6.5 percent.[52] Under the so-called pessimistic projections, paying all the benefits promised these workers would require the Medicare payroll tax to increase to 13.1 percent, more than the current payroll tax for Social Security retirement, survivors, and disability programs.[53]

This is just for Part A. The long-term projections for Medicare Part B are equally bleak. General revenue contributions to Medicare Part B may have to increase by 100 percent to 300 percent in real terms to pay all promised benefits when today's young workers retire. With

52 *1988 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*, Washington D.C., May 1, 1988, Appendix F (hereinafter "OASDI Trustees' Report").

53 *Ibid.*

current general revenue contributions at about $25 billion per year, this means that paying all promised benefits to today's young workers would require a total annual general revenue contribution to Part B equivalent to $50 to $100 billion in today's dollars. In addition, annual Medicare premiums paid by the elderly would have to increase by between 100 percent to 300 percent in real terms. This means an elderly couple would have to pay total monthly premiums equivalent to between $125 and $250 in today's dollars, or $1,500 to $3,000 per year.

Payroll taxes on today's workers already are extremely high. Total Social Security and Medicare payroll taxes for an individual worker, including the employer's share, will be as high as $7,209.60 in 1989. This compares with a maximum total payroll tax of $348 in 1965, $189 in 1958, and $60 in 1949. For most workers, the total employer/employee payroll tax is more than the worker pays in federal income tax. Indeed, by fiscal 1990, total payroll tax revenues are projected to equal about 80 percent of total personal income tax revenue.[54]

These payroll taxes inflict an enormous burden on low-income workers. A married worker with two children earning wages of $10,000 in 1989 – below the official poverty line – will pay $751 in payroll taxes this year. The additional $751 paid by his employer effectively comes out of the worker's wages as well. This means a total payroll tax burden for the year of $1,502 on this low-income worker's yearly earnings.

While the payroll tax is especially burdensome for low-income workers, it hits all employment. The tax discourages employers from hiring workers and discourages workers from working extra hours. The overall result is fewer jobs and reduced economic growth. Taxing employment, as the payroll tax does, simply means there is less of it. One recent study estimates that the payroll tax rate increases scheduled from 1988 to 1990 will eliminate 500,000 jobs and ultimately reduce gross national product by $25 billion per year.[55]

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54 Office of Management and Budget, Executive Office of the President, *Budget of the United States Government, 1988*, Historical Tables (January 1988), Tables 2.1 and 2.4.

55 Aldona Robbins and Gary Robbins, "The Effect of the 1988 and 1990 Social Security Tax Increases," Institute for Research on the Economics of Taxation, Economic Report No. 39, February 3, 1988.

The elderly, too, face a heavy Medicare tax burden. Under the 1988 Medicare catastrophic legislation, the elderly are now paying a surcharge of 15 percent, on top of their income taxes, to finance expanded Medicare benefits. By 1993, the surcharge will climb to 28 percent, raising the income tax payments of those over 65 by more than one-fourth.[56] After 1993, the surcharge is indexed and will continue escalating to keep pace with program costs.

This new income tax surcharge imposes a harsh, discriminatory tax burden on the elderly, raising their marginal tax rates well above those for other Americans. This surcharge will be added to the monthly Medicare premiums, which already are a heavy burden for many retirees. The Congressional Budget Office projects that in 1993 more than 40 percent of the elderly will pay, on the average, an additional $500 a person, or $1,000 a couple, in this new tax.[57]

While cost to the elderly of their Medicare coverage is going up, the quality of care they receive in certain respects seems to be going down, because of Medicare cost control regulations. In 1983, Congress adopted the Prospective Payment System (PPS) for Medicare. This system classifies all illnesses requiring hospital treatment into 475 categories (called Diagnostic Related Groups, or DRGs), and sets the amount it will pay under Medicare in each locality for treatment of the illness in each category. The set fees are supposed to be based on an average of local hospital charges for each illness. If the hospital can treat the patient for less than the set fee, it can keep the difference. If the treatment costs more, however, the hospital cannot collect the extra charges from the patient and must absorb the loss.

While this system has put a small dent in Medicare cost increases, new, perverse incentives have been created. In particular, hospitals have the incentive to process and discharge patients as quickly as possible, with the minimum of services and treatment, to keep costs down. Even if patients want to pay more for less hurried service and more careful and thorough care, they are prohibited from doing so. Indeed, once the patient enters the hospital under PPS, the hospital automatically receives a flat fee from the federal government and thereafter faces the same economic incentives in treating the patient

56 Public Law 100-360.

57 Congressional Budget Office, "The Medicare Catastrophic Coverage Act of 1988," Staff Working Paper, October 1988, p. 8..

as it would if it were providing charity. Any expense the hospital incurs for treatment in effect comes out of its own pocket. Media reports and congressional hearings have in fact already begun to investigate complaints of unduly early hospital discharges, the "dumping" of costly patients into public hospitals, and other forms of inadequate treatment attributable to the new payment system.[58]

For those hospitals whose legitimate, unavoidable costs are above the PPS payments set by the government, the system effectively operates like price controls. And typical of price controls, PPS payment ceilings make treating some patients uneconomic, leading to a reduction in the supply or quality of care under Medicare. This curtailment of service, however, is likely to be just the first step toward rationing health care for the elderly, if the current system continues unreformed. Indeed, those supporting a large government role in health care financing in the U.S. already have begun advocating systematic health care rationing for the elderly to contain costs.[59]

The elderly also find that Medicare fails to protect them from many potentially ruinous medical expenses, despite the program's high benefit costs. For medical care outside hospitals, Medicare sets the maximum amounts it will pay, and when doctors charge more, the

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58 See *The Effects of PPS on Quality of Care for Medicare Patients*, Hearings Before the Special Committee on Aging, 99th Cong., 2nd Sess. (1986); *Quality of Care Under Medicare's Prospective Payment System*, Hearings Before the Special Senate Committee on Aging, 99th Cong., 2nd Sess (1985); *Impact of Medicare's Prospective Payment System on Quality of Care Received by Medicare Beneficiaries*, Staff of the Special Committee on Aging, 99th Cong., 2nd Sess. (1985); Robbins and Hurwitz, *op. cit.*, pp. 3-4.

59 See, for example, Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society* (New York: Simon and Schuster, 1987).

elderly themselves are responsible for paying the difference directly. In 1988, only 37 percent of doctors agreed not to charge any of their Medicare patients more than the government-established rates.[60]

Medicare also pays little for long-term care in nursing homes or other settings, and the program provides no coverage for dental care, hearing aids, eyeglasses, walking aids and similar items. These uncovered costs must be paid by the elderly themselves in addition to the program's deductible and coinsurance fees. Medicare, in fact, currently pays less than half of the medical expenses of retirees.[61]

The catastrophic health legislation, enacted in 1988, added Medicare coverage for extended hospital stays and drug expenses. This, however, does not change the financial equation significantly because the costs of the benefits under that bill were imposed on the elderly themselves through higher Medicare premiums and taxes.

Medicare, in fact, contributes heavily to its own runaway costs, as *Chapter 1* explains, because of its payment structure. To the extent that the government pays the bills through Medicare, both the patient and doctor tend to lose their concern for moderating treatment costs, because the patient is not paying directly. Hence in the case of physician services not provided in hospitals under PPS restrictions, marginally useful but costly services, tests, or treatments tend to be prescribed. Doctors lack any incentive to devise and adopt the most cost-efficient medical treatment. Indeed, they will make more by adopting more costly procedures. Not surprisingly, the cost of those procedures not covered by the PPS system have climbed faster. While Medicare spending for hospital care increased by 3.8 percent in 1988,

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60 These doctors are called "participating physicians." A non-participating physician may choose to limit his fees to the Medicare rate on a case-by-case basis. In 1988, doctors limited their charges to the Medicare rate in 76 percent of all cases. See Committee on Ways and Means, U.S. House of Representatives, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, 1989 edition, March 15, 1989, pp. 393-395.

61 Statement of Nancy M. Gordon, Assistant Director of Human Resources and Community Development, Congressional Budget Office, before the House Subcommittee on Health and the Environment, Committee on Energy and Commerce (March 26, 1986), p. 13; Waldo and Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the U.S.: 1977-1984," *Health Care Financing Review*, Fall 1987.

spending for outpatient physician services jumped 13.3 percent.[62] The resulting expense adds to the program's high tax burden and severe long-term financing problems. Medicare consequently not only fails to address the problem of rapidly rising health costs, it is a major source of the problem.

COMPOUNDING MEDICARE'S FINANCING PROBLEMS

Despite the failure of the social insurance approach, some lawmakers argue that it should be extended to address additional health care problems. There is growing pressure, for example, for the government to pay for the nursing home and home health care expenses of every American over 65—even millionaires—through a universal social insurance program financed by increased payroll tax rates and possibly other taxes.

Such a program would aggravate the problems of the current system seriously. If the government were to pay nursing home expenses without regard to financial need, many more Americans would likely enter nursing homes, sharply increasing the program's costs. While advocates of home health care benefits argue that such benefits could save government funds by allowing the elderly to be cared for at home rather than in expensive nursing homes, studies show that such savings are unlikely to result. A recent study by the Institute for Research on Poverty at the University of Wisconsin, done for the National Center for Health Services Research, concludes that few people who would otherwise be in nursing homes would end up staying in their own homes with home health care. Any savings that might result from this, says the study, would be more than offset by greatly increased government spending on home health care for those individuals who would remain at home even if the government did not pay for home care.[63]

In addition, only 26 percent of the disabled elderly now receiving care outside nursing homes receive professional, paid home health

62 Committee on Ways and Means, *op. cit.*, p. 152.

63 Peter Kemper, Robert Applebaum and Margaret Harrigan, "A Systematic Comparison of Community Care Demonstrations," Institute for Research on Poverty, June 1987.

care, and only 5 percent use full-time professional care.[64] Moreover, home health care basically involves such personal services as cooking, feeding, bathing, dressing, and housecleaning, which today are provided by family and friends for most of the elderly. A universal program to pay for these services inevitably would prompt paid professionals to displace this private informal care and induce many more of the elderly to seek these highly attractive services, once again sharply raising costs.

Total nursing home expenses in the U.S. already are nearing $50 billion per year; home health expenditures run an additional $10 billion annually.[65] Considering the massive increase in utilization that likely would result, a universal system could cost the Treasury as much as $80 billion per year.

THE PRINCIPLES OF REFORM

Despite the problems of Medicare and the potential cost of expanding the social insurance system for such additional coverage as nursing home care, Americans understandably want action to address the mounting financial problems of many elderly afflicted with infirmity or ill health. For this, another major expansion of social insurance is not needed. Indeed, it would fail. The solution instead is a comprehensive approach based on the following central principles:

1) The government should help those Americans without sufficient resources to pay for essential health or nursing services and to ensure that all elderly are guaranteed necessary care.

2) Medical care for the elderly must be high quality. Health care rationing through waiting lists or the denial of services should be rejected.

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64 Robert Maxwell, Statement of the American Association of Retired Persons on Long-Term Care Financing, before the Senate Finance Committee, Subcommittee on Health, June 12, 1987, p. 1.

65 General Accounting Office, "Long-Term Care Insurance: Coverage Varies in a Widely Developing Market" (Washington, D.C., 1986), p. 10. Total expenditures for professional home health care were $9 billion in 1985. Task Force on Long-Term Health Care Policies, *Report to Congress and the Secretary*, U.S. Department of Health and Human Services, September 21, 1987, p. 19.

3) Health care costs must be contained by increased competition of health services through expanded consumer choice and control and increased market incentives for consumers and providers of medical care.

Based on these principles, the goal of better health care for the elderly can be achieved through a five-point program of reform. This program would address the fundamental defects of the existing system and create a comprehensive system of medical and long-term care for America's elderly.

Reform #1: Abolish Medicare taxes and premiums on the elderly.

The Medicare Part B premium on retirees has soared in recent years and is now $27.90 a month. The 1988 catastrophic legislation adds a further $4 a month, bringing the 1989 premium to $31.90 a month or $382 a year for each beneficiary. Both the old and new components of the Part B premium are projected to increase even further in future years; the combined premium is likely to reach $1,200 per year for each elderly couple by 1993. This year, each elderly taxpayer will also pay an income tax surcharge of 15 percent for catastrophic protection under Medicare, raising his or her income tax bill by this percentage. This surcharge is scheduled to increase each year with program costs. It will reach 28 percent by 1993, continuing to grow thereafter. Thus, instead of removing the financial burden of health care, Medicare itself is becoming a burden on the elderly through these taxes and premiums.

Not surprisingly, retirees are becoming concerned at the cost of Medicare coverage, and there is mounting criticism of the tax surcharge to pay for catastrophic coverage. Yet these premiums and surcharges will continue to rise until the program itself is reformed. The first step toward this would be to repeal the new income tax surcharge on the elderly, together with all the burdensome Medicare monthly premiums.

Of course, eliminating the taxes and premiums now paid by the elderly would leave Medicare with less money to pay benefits. This revenue loss could be offset by readjusting Medicare coinsurance and deductibles to give better protection from the cost of major illnesses, while requiring the elderly to pay more out of pocket for routine medical services. In addition to the current annual inpatient hospital deductible of $560, a coinsurance rate of 10 percent should be charged

for all hospital care provided to beneficiaries under Part A. The annual Part B deductible should be increased to $900, and the current Part B coinsurance rate of 20 percent should continue to apply above that deductible.

The resulting Medicare savings through this new set of deductibles and coinsurance would be sufficient to finance the extended hospital care, the new drug benefit, and the expansion of the Medicaid buy-in[66] to more low-income retirees, all of which are contained in the 1988 catastrophic legislation, without having to impose either taxes or premiums on the elderly. Were Congress to eliminate the new drug coverage as well – since most of the elderly neither need nor want it – this proposed new set of deductibles and coinsurance could be lowered.

While the overall effect of this restructuring would be to shift back to retirees some of the health care costs now covered by Medicare, the elderly would still benefit from these changes. In return for major tax relief and the elimination of the entire Part B premium, the middle - and upper-class elderly would bear greater responsibility for more of their routine medical costs. This means that each of them would pay only for those routine medical services he or she needed. They would not be paying through premiums or taxes for unnecessary costs charged to Medicare by other beneficiaries. As in private health insurance, Medicare coverage for routine services encourages beneficiaries to demand more of those services, even if they are only of marginal benefit. At the same time, it removes the normal incentives for providers to be efficient and hold down costs. The result is that all beneficiaries are forced to pay ever greater premiums for unnecessary or overpriced services.

Under these reforms, the elderly would have an incentive, because of the higher deductible and copayments, to save on routine medical costs by avoiding unnecessary treatment or services and by seeking out

66 The term "Medicaid buy-in" refers to the fact that state Medicaid programs "buy into" Medicare on behalf of the poor elderly by enrolling them in Medicare's voluntary Part B program and paying the Part B premium for them. The state Medicaid programs also pay any Medicare deductibles or coinsurance charged to poor elderly individuals covered by the "buy-in." One of the provisions of the 1988 Medicare catastrophic legislation is to require all state Medicaid programs to expand this "buy-in" to cover all elderly individuals with incomes at or below the federal poverty standard by 1993. The state Medicaid programs receive matching funds from the federal government.

the lowest costs. At the same time, Medicare would continue to provide all of the elderly with expanded protection against financially catastrophic hospital and doctor bills for serious illnesses. While these changes would be budget neutral and thus not increase the total share of retirees' health care paid for by the government, they would make Medicare more like true insurance. This would help restrain the present rapid growth in Medicare spending while giving the elderly more appropriate protection against high medical costs.

Eliminating the surtax contained in the 1988 catastrophic legislation would have the added benefit of removing a heavy penalty on retirees who chose to continue working or who saved for their own retirement. Taxing middle- and upper-income retirees at higher rates will only encourage or even force them to become more dependent on government programs such as Social Security and Medicare, thus generating new pressures for increased spending on those programs.

The poor elderly would not be affected by these changes, since any deductibles on coinsurance charged to them would still be paid for them by Medicaid. As for the middle- and upper-class elderly, they would be free either to pay the deductibles and coinsurance out of pocket or to purchase private insurance or coverage by a Health Maintenance Organization (HMO) against some or all of these routine expenses.

These steps would help to reduce the cost of medical care. Cost consciousness by patients would discourage physicians from prescribing tests and procedures with only marginal value. It would also force providers of services to compete more aggressively for patient dollars.

Reform #2: Cover the long-term care expenses of those in need by restructuring Medicaid.

Medicare provides little coverage for long-term care either in a nursing home or in the patient's own home. Yet nursing home care can be extremely costly, averaging around $2,000 per month for a resident. In the case of home health care, Medicare covers true medical care provided in the home, but it does not cover personal services such as cooking, housecleaning, dressing, feeding, and bathing.

Government should pay for the essential long-term care expenses of those Americans who do not have the resources to meet this cost or

who cannot pay for it without great hardship. This will ensure that all those who need long-term care will be able to obtain it, and it will end the financial fears of those with modest incomes.

Federal and state governments currently spend over $20 billion per year for nursing home care, primarily through Medicaid. A retiree receiving Medicaid nursing home assistance is expected to contribute his or her available income and resources to the nursing home expenses, excluding a small personal needs allowance, a small amount of savings, a home of any value, a car, and other personal belongings. This is a reasonable policy, since the nursing home provides for the patient's basic needs such as food and shelter and, in the case of single patients, since no one else is dependent on the income or savings. Moreover, it is reasonable to expect Americans who can contribute to their own expenses to do so before the taxpayers are asked to pick up the bill.

Prior to recent legislation, the real problems with this policy occurred in cases where a nursing home patient had a healthy spouse still living in the community. In order to obtain Medicaid assistance for the spouse in a nursing home, the couple had to spend their joint income and savings on nursing home care until they were poor enough to qualify for Medicaid. As a result this policy unfairly and needlessly impoverished the noninstitutionalized spouses of nursing home patients.

The 1988 catastrophic legislation greatly alleviated this situation by allowing a healthy spouse to keep more of the couple's joint income and assets. By 1992, when these provisions are fully in effect, a non-institutionalized spouse will be allowed to keep an annual income of about $14,000 in today's dollars. He or she will also be able to keep 50 percent of the couple's savings, with a minimum of $12,000 and a maximum of $60,000, as well as their home and car. States are further allowed to raise the minimum amount of savings the healthy spouse can keep as high as $60,000. Any income or assets above these limits must still be used to help pay the costs of nursing home care for the institutionalized spouse. These provisions allow healthy spouses to avoid impoverishment, while still requiring more affluent elderly individuals with a spouse in a nursing home to pay for part of the costs of their care.

The next reform should be to remove this long-term care assistance from Medicaid and instead provide it through a separate program entirely dedicated to meeting the long-term care needs of the elderly

poor. Medicaid was originally designed to provide basic health care services to the nonelderly poor. It was not designed to pay for long-term care for the low-income elderly, though it has been forced by circumstances to assume this responsibility. Separating these two very different functions into different programs would allow the federal and state governments to more effectively address the needs of each group.

A separate long-term care program should have more flexibility in providing long-term care services to the poor elderly. In addition to paying for nursing home care, it should also, whenever possible, pay for home care for individuals who would otherwise have to be cared for in a nursing home at much greater expense to the government. In the case of such individuals, this would mean paying part-time caregivers to help them with personal services such as cooking, cleaning, bathing, and dressing. However, for the more affluent elderly, such personal care would continue to be provided by family and friends. As part of this reform, Congress also should reevaluate the Medicare program to ensure that it offers the same coverage for genuine medical services provided in the home as it does for medical services outside the home.

The new long-term care program should be a joint federal/state enterprise, like Medicaid and most programs of assistance for the needy. Adopting the new program as described above would result in no significant increase in federal spending, but it would use existing Medicaid funds more efficiently.

Reform #3: Encourage the purchase of long-term care insurance.

If retirees lacking the funds to pay for essential long-term care services are cared for by the government, the remaining problem involves the elderly who have substantial resources but are by no means rich. The issue here is not access to needed care, which is assured, but how to protect their resources from being ravaged by high nursing home costs. It is these middle-class Americans who are most concerned about long-term care costs, since they are protected neither by great wealth nor by government aid.

This is not really a health policy issue, however, but an estate-planning matter, which can be addressed more appropriately through private sector insurance and similar financial mechanisms. Almost by definition, such retirees have the means to pay for insurance to cover

heavy long-term care costs, and they can use some of their saved resources to pay for insurance to protect the rest. The government's role should be to promote widespread use of long-term care insurance and other private financing mechanisms for those who have significant resources. The federal government should take the following specific steps to advance this policy:

♦ ♦ **Improve the data base for users.** Many insurers are still reluctant to promote long-term care insurance aggressively because they lack the actuarial data needed to estimate the potential cost of claims. The federal government could undertake a thorough study, in conjunction with the insurance industry, to develop national and regional data on the degree to which the elderly at different ages use nursing homes, the length of stays, how coverage of nursing home costs affects utilization, and similar matters.

♦ ♦ **Reform the taxation of private policies.** The favorable tax treatment of life insurance should be extended to long-term care insurance. This means that income earned on the investment reserves of insurance policies for long-term care would no longer be subject to tax. In addition, benefits paid by such policies would not be subject to tax.

♦ ♦ **Provide tax relief for long-term health care costs.** Expenses for long-term care should be eligible for the same personal income tax credits proposed in *Chapter 3* for medical costs. That is, a 30 percent tax credit for out-of-pocket expenses and a 20 percent tax credit for premium payments for long-term care insurance. In addition, younger taxpayers would be able to receive these tax credits for money they spend on purchasing long-term care services or insurance for elderly relatives. They would be able to do this without having to meet the dependent support test, which now requires them to provide 50 percent or more of a relative's total support before they can claim the relative as a dependent and receive credits or deductions for his or her health care expenses. This would provide much needed relief to those American families facing high nursing home or home care bills.

♦ ♦ **Include long-term care insurance in "cafeteria" plans.** In the absence of the health care tax reforms outlined in *Chapter 3*, federal tax law should be changed to allow employers to offer long-term care insurance as one choice under cafeteria employee benefit plans. These are fringe benefit plans where each worker is allowed to choose from a range of offered options those benefits that best suit his needs and

preferences. Current law does not allow long-term insurance to be included as a benefit that employers can offer in such tax-free cafeteria plans.

♦ ♦ **Reverse DEFRA restrictions.** Under the Deficit Reduction Act of 1983 (DEFRA), Congress eliminated most tax deductions and exemptions for the money contributed by employers to retirement medical benefit plans and the money earned by investing the reserve funds of those plans, including plans which provide long-term care coverage. Without such deductions and exemptions, private employers are far less inclined to provide long-term care benefits. In the absence of more comprehensive health care tax reform, this tax policy should be reversed. Employers should be allowed full deductions and exemptions for contributions and returns to reserves for employee retirement health benefit plans that include long-term care benefits, just as employers are allowed deductions and exemptions for contributions and returns to retirement pension reserves.

♦ ♦ **Allow Americans to use their retirement funds to purchase long-term care insurance.** Workers and retirees should be allowed to use funds in pension plans, 401(K) plans, Individual Retirement Accounts (IRAs), and other retirement plans to make tax-free purchases of long-term care insurance. Similarly, employers should be allowed to use excess reserves in overfunded pension plans to fund long-term care health insurance benefits for their employees in retirement. This would provide a tax incentive for the purchase of long-term care policies.

♦ ♦ **Encourage the conversion of life insurance policies into long-term care insurance policies.** Families buy life insurance to protect themselves against the loss of earning capacity during working years. Such protection generally is not needed to the same extent in retirement, when income usually is no longer dependent on the employment of the head of household. With high nursing home costs posing a far greater danger than death or the loss of the ability to work, it would make sense for life insurance companies to offer policies that gradually reduce the benefits payable at death and phase in benefits payable for long-term care. While there are no restrictions on such conversions under current law, insurers are not inclined to offer such policies because of insufficient demand. The government should encourage Americans to request such convertible life insurance policies by publicizing the concept.

♦ ♦ **Promote home equity conversion.** The government also should encourage the development of financial instruments to enable the elderly to use the equity in their home to finance long-term care insurance or services. Under a "reverse annuity mortgage," the elderly homeowner would not receive a lump sum loan secured by his equity, but instead would receive a monthly payment from a finance company. The growing debt that this would created would be secured by the equity. The monthly income received could pay for long-term care insurance premiums. The accumulated debt, of course, would be paid when the home was sold – usually as part of the estate when the retiree and spouse have died. Under another arrangement, known as "sale leaseback," the elderly homeowner sells the home with the unlimited right to rent back the property for life at a predetermined rate. The sale proceeds then could be used to fund long-term care directly or through insurance. About three-fourths of the elderly own their homes; the median equity is around $60,000.[67]

Such reverse mortgage plans are available in various parts of the country, where state law permits them. The federal government recently has given such plans a considerable boost by providing federal insurance for these loans and by allowing the Federal Home Loan Mortgage Corporation (Freddie Mac) and the Federal National Mortgage Association (Fannie Mae) to purchase such loans for the secondary market. This makes the plans more secure and thus far more attractive to mortgage companies. The federal government should continue to promote equity conversion and should undertake a publicity campaign to encourage the elderly to explore this option for paying long-term costs.

67 The median home equity for persons 65 and over in 1984 was $46,200 according to the U.S. Bureau of the Census, *Household Wealth and Asset Ownership* (Washington, D.C., U.S. Government Printing Office, 1986). Today, four years later, this figure has likely grown to around $60,000 given housing value appreciation, but Census Bureau figures are not available.

Reform #4: Introduce Medicare vouchers.

The fourth major element of reform would be to spur more competition within Medicare. As *Chapter 1* explains, the lack of competition encourages cost escalation and a misallocation of resources. In any market, competition among providers is best achieved by giving customers the freedom and incentive to choose between suppliers of services. The best method of introducing competition in Medicare would be to provide retirees with Medicare vouchers.

The typical voucher would be equal in value to the average amount spent by the government on each Medicare beneficiary.[68] These vouchers would be used to purchase private health insurance coverage or other health plans, replacing the current system in which Medicare itself is the insurer. The vouchers also could be used to pay hospitals and physicians directly. In this way, Medicare benefits would be obtained through a private insurance company, an HMO, or other prepayment plan. If the private plan provided a minimum set of benefits for less cost than the current arrangement, the Medicare beneficiary would be able to pocket the difference in cash. Alternatively, retirees might use their entire voucher to purchase private coverage that offered more benefits than Medicare. Indeed, retirees could choose to pay higher premiums than the level paid by their vouchers to buy even more extensive coverage, perhaps for long-term care or other desirable benefits. To reduce the problem of "adverse selection," where insurers avoid enrolling potentially high-cost subscribers, insurance companies could be required to enroll every applicant.

Retirees would be allowed to choose coverage with very high deductibles, perhaps up to $10,000 per year, leaving them directly responsible for expenses up to the deductible amount. Such coverage would be far less expensive, and retirees could then keep the savings themselves.

Retirees should be allowed to place any savings from Medicare vouchers into special Individual Retirement Accounts (IRAs) where the return would be tax free. Withdrawals from these IRAs would be

68 As more of the elderly opted for vouchers, those remaining in Medicare would be less representative of the elderly population, and the Medicare voucher amount might have to be recalculated in a different fashion. But any new index should be devised to maintain the current relative value of Medicare benefits over time.

included in taxable income, unless used for medical or nursing expenses, in which case they would be tax free. Retirees always would have the choice, however, of refusing the vouchers and retaining current coverage under Medicare, if they felt the private alternatives were not as good.

Companies seeking to offer private coverage under the voucher plan would apply to the Department of Health and Human Services for approval. HHS would send annually to each retiree an explanation of the Medicare voucher system and a description of each of the approved private plan alternatives available in his area. If a retiree wanted to exercise the voucher option, he would simply send back a reply form identifying the private plan chosen. HHS then would notify the private plan. This would allow the private plans to be offered with a minimum of solicitation and selling costs, although direct solicitation would not be prohibited. Social Security offices would provide information and assistance to the elderly concerning the voucher and private plan alternatives.

The private plans would be required to accept at their set market rates anyone who chose them within 30 days of the mailing of the annual notice. In addition, they would be prohibited from canceling coverage for anyone choosing them under the voucher option. This is necessary to prevent companies from systematically turning down high-risk customers, thereby skimming the cream of the voucher market. However, private plans would not be required to accept an applicant who had already begun treatment for a specific illness costing more than the deductible under the plan. Such persons would have to stay with their current plans, whether Medicare or a previously chosen private plan, until the treatment was over (unless they had chosen a private plan with a higher deductible than the expected cost of the treatment).[69] This is

69 Because of this requirement, seriously sick patients under Medicare would not be able to switch to a private insurer. These patients, however, would cost Medicare much more than the average beneficiary, and Medicare expenditures would rise as a result, since the program would still be paying the average cost per beneficiary for everyone else through the vouchers. The added cost to Medicare could be recouped, however, by charging the private insurers a fee for each voucher recipient they covered, sufficient to offset the added cost to Medicare caused by retention of the high-cost patients. Alternatively, the amount of the vouchers could simply be reduced directly by this fee amount. Either way, extra costs to Medicare caused by an adverse selection would be entirely avoided.

necessary to stop retirees enrolling in lower-cost plans with relatively high deductibles and then switching to a plan with more generous benefits if a major illness strikes – increasing the financial risk of the latter plans.

Vouchers would open the health care system to competition in place of the current Medicare monopoly. Competing plans would strive to keep costs down and provide better benefits, service and care.The incentive structure in health care for the elderly would be revolutionized. Beneficiaries would have the incentive to shop vigorously for the lowest-cost coverage for a given pattern of benefits, since they could keep the savings in cash or use it to buy better benefits. This in turn would give strong incentives to competing alternative plans to keep costs down. The competition and new incentives thus would work powerfully to counter today's rapidly rising health costs.

By contrast, the current system provides little incentive for retirees to seek the most economical range of services. Worse still, the price controls imposed by the Prospective Payment System give service providers an incentive to reduce the quality of care to keep costs down.

Vouchers also would help to keep costs down by stimulating innovation. The numerous alternative plans would try different approaches, and those that were successful would tend to be adopted throughout the system.

Medicare vouchers also would give the elderly freedom of choice. Within limits, retirees could choose the package of benefits and costs that best suited their needs and preferences. The system would have new flexibility and diversity, as all retirees would not be forced into the same single plan as under Medicare. Rather, different retirees could each choose the specific plans and benefit packages they preferred.[70]

Reform #5: Introduce Health Care Savings Accounts

The final component of reform should be incentives to encourage Americans to save during their working years to defray out-of-pocket health care expenses during their retirement, thereby shifting more of the financing of retirement health benefits into the private market. To accomplish this, today's workers and their employers should be al-

70 For a discussion of Medicare vouchers, see Randall R. Bovberg, "Vouchers for Medicare: The Impossible Dream," Urban Institute, Washington, D.C., December 1987.

lowed to contribute to private savings and insurance accounts to supplement, and even substitute for, future Medicare benefits. Legislation introduced in the House by a bipartisan group of 40 legislators, led by Representative French Slaughter, the Virginia Republican, offers a concrete plan for accomplishing this goal.

The Slaughter bill would allow workers and their employers to contribute to individual Health Care Savings Accounts (HCSAs) for each worker, up to the amount of employer/employee Medicare payroll taxes for that worker. Contributors would receive an income tax credit equal to 60 percent of the amounts paid into the accounts. The contributions and investment returns would accumulate tax free until retirement. To the extent that the worker chose this option during working years, a higher Medicare deductible would apply to that worker in retirement, leaving him responsible for payment of more of his initial medical costs each year. The retired worker then would use the HCSA funds to purchase insurance covering medical expenses in retirement or to pay such expenses directly.

The legislation is so designed that workers would be likely to accumulate more than enough in their accounts by retirement to cover private insurance for the increased deductibles. They then could use the excess for long-term care or other expenses not covered by Medicare or to supplement their retirement income. In addition, if a retiree were to spend less than a specified proportion of HCSA funds on medical expenses each year, he could withdraw the difference at the end of the year to be used for any purpose.

Those who exercise the HCSA option could still choose vouchers for their remaining Medicare benefits in retirement. The voucher amount simply would be reduced according to the extent they exercised the HCSA option, with the accumulated HCSA funds then making up the difference. Besides shifting the insurance function to the private sector, as do vouchers, HCSAs make the financing of such insurance private as well.

Workers and employers who contributed to HCSAs would continue to pay their Medicare payroll taxes in full. The income tax credits for HCSA contributions, however, would offset these taxes, in effect giving workers their tax money back to the extent they chose to rely on their private HCSA funds rather than on Medicare. Since the credits would

be taken against income taxes rather than payroll taxes, Medicare payroll tax revenues would not be reduced and hence the Medicare trust fund would not be depleted.

The HCSA option would sharply reduce, and potentially eliminate altogether, Medicare's long-term financing problems. The reason: while Medicare payroll tax revenues would be maintained under the proposal, the larger deductibles paid by those retirees choosing to exercise the HCSA option would cut the program's expenditures over the long run. With revenues maintained and expenditures reduced, the long-term Medicare financing gap would shrink.

The HCSAs also would introduce additional competition and incentives to complement those introduced by Medicare vouchers. The private plans, through HCSAs and vouchers, would eliminate the worst economic features of the Medicare monopoly. They would hold down costs and improve benefits. At the same time, HCSAs would give retirees a strong new incentive to avoid unnecessary or overly expensive services and to seek out the lowest-cost private plans, since this would allow them to conserve HCSA funds for other benefits and cash withdrawals. All the advantages of vouchers resulting from increased competition, stronger incentives, and wider freedom of choice would be reinforced with HCSAs.

The elderly face real and mounting health care problems in the form of rapidly rising health costs, inadequate coverage for important health services, and a collapsing Medicare financing system that is undermining the quality of their care and imposing a growing taxation burden. These problems cannot be resolved by a further extension of the failed social insurance approach. Indeed, such an extension would only make these problems worse.

A completely new approach is needed. It must be based on competition, market incentives, and consumer choice. The five-point program of reform outlined would address each of the major problems in health care for the elderly. It would reduce the tax burden on the elderly while relieving the long-term Medicare financing crisis. It would create powerful new competition and incentives to counter rapidly rising health care costs, while improving service and quality. It would give the elderly the freedom to choose the benefits they wanted in varying

packages to suit their personal needs and preferences. It would allow them to accumulate substantial savings to meet retirement health care needs. It would give them protection against long-term care expenses and other health costs not covered by Medicare.

And unlike the social insurance approach, it would do this within a framework that introduced strong incentives for the most economical use of health care resources.

Chapter 5

Health Care for the Poor, Unemployed and High-Risk

Terree P. Wasley

The medical care received by millions of low-income Americans is delivered through a patchwork of federal and state government programs. The principal programs serving the poor and unemployed include Medicare, Medicaid, and other smaller federal and state medical care programs. Medicare is funded through payroll taxes, premiums, and general revenues of the federal government. While Medicare is primarily a program for providing health care to the elderly, regardless of income, it also covers over three million non-elderly disabled individuals. The Health Care Financing Administration, an agency within the U.S. Department of Health and Human Services (HHS), administers Medicare and also directs the Medicaid program, which provides grants to states to deliver medical services to the poor and the "medically needy," defined as Americans with chronic health problems. Medicaid is by far the largest health program for the poor. It extended health care services to more than 23 million

recipients in 1988 at a cost of $54.7 billion, $30.4 billion of which was paid by the federal government with the remaining $24.3 billion paid by the states.[71]

Smaller federal programs providing health care services to the needy include the Community Health Centers program, the Migrant Health Centers program, the Indian Health Service, the National Health Service Corps, Maternal and Child Health Block Grant program, the Preventive Health and Health Services Block Grant program, and the Alcohol, Drug Abuse, and Mental Health Block Grant program.

Thirty-two states have programs for the medically needy. These programs permit states to help those who have incurred relatively large medical bills and meet certain criteria. Other state programs include the medical indigency programs, which provide coverage for certain low-income individuals not eligible for Medicaid, programs for specific medical conditions, and state catastrophic expense programs.

Because the system is a complex array of different programs with differing eligibility rules, many Americans slip through this medical "safety net." These include mothers who receive no prenatal care, needy individuals with life-threatening diseases, and elderly patients who are shunted from hospitals to nursing homes because the cost of their condition is not adequately covered by Medicare.

Like most other federally supported programs, medical services for the poor and unemployed have come under the shadow of the federal deficit. The result has been a tightening in eligibility and a resistance by lawmakers to create new programs or pay for additional medical services. Yet attempts to control spending through more effective targeting have been blunted by the remorseless rise in medical costs discussed in *Chapter 1*. Spiraling medical costs strain government health care programs. In the decade between 1978 and 1988, Medicare spending jumped from $25.2 billion to $87.6 billion, a growth in constant dollars of 99 percent. At the same time, total Medicaid program expenses rose from $18.9 billion in 1978 to $54.7 billion in 1988, a 65 percent increase in constant dollars.[72]

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71 Committee on Ways and Means, U.S. House of Representatives, *Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*, 1989 edition, March 15, 1989, pp. 1140-1141.

72 *Ibid.*, pp. 152, 1139-1140.

In addition to the direct impact of medical costs on programs designed for the poor, the health safety net has been weakened indirectly because of general efforts by government agencies, businesses, and hospitals to control health care costs. Traditionally, many doctors and hospitals have given free or below-cost treatment to the indigent and covered this cost by charging more to patients able to pay more. Similarly, indigent patients not eligible for programs were, effectively, subsidized by "padded" bills for patients covered by Medicaid. But the adoption of cost control efforts, such as prospective payment and capitation, by Medicare and by state Medicaid programs, together with employers exerting greater pressure on hospitals to limit their charges to private group-insured patients, have increased the indigent care problem. Under a prospective payment system, hospital payments are fixed in advance, and based on the average cost for each procedure. As noted in *Chapter 4*, this has had the unintended consequence of encouraging hospitals to "dump" – that is, discharge early or send to another hospital – government-insured patients with costly or complicated illnesses. In addition, closer scrutiny by insurers and businesses of the hospital bills of their private patients prevents hospitals from charging more to privately insured patients to finance indigent care. In 1986, hospitals provided more than $8 billion in such uncompensated care.[73]

During the past decade,Medicaid increasingly has shouldered the cost of long-term care for the elderly, currently amounting to 50 percent of total Medicaid costs.[74] As this burden has grown, the share of nonelderly Americans below the poverty line covered by Medicaid

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73 Deborah J. Chollet, Ph.D., "Financing Indigent Health Care," *The Changing Health Care Market* (Washington, D.C.: Employee Benefits Research Institute, 1987), p. 185.

74 American Hospital Association, "Medicaid Options: State Opportunities and Strategies for Expanding Eligibility," a report by the Special Commission for Care for the Indigent, 1987.

has fallen from 65 percent in 1976 to less than 40 percent today. Poor women and children have been hit hardest by more restrictive income eligibility rules in recent years, which have not kept pace with inflation. In 1986, the average state income cutoff for Medicaid coverage was 48 percent of the federal poverty level, compared with 71 percent in 1975.

In addition to the poor, the unemployed make up a significant number of Americans beyond the health safety net. Although federal and state continuation laws[75] offer some assistance to short-term unemployed, the long-term unemployed generally are not covered unless they fall below the Medicaid threshold. Also excluded from the safety net are many high-risk Americans. They usually cannot purchase private health insurance because of their history of serious illness, and yet they are not poor enough to be eligible for government assistance. In many cases, they eventually become eligible for government help because their out-of-pocket medical bills drive them into poverty.

As a result of rapidly rising health care costs, moreover, a growing number of working Americans are unable to afford health insurance. Half of these workers are under age 30, many are in low-paying, entry-level jobs where the cost of insuring them would raise their effective compensation level above the value of their services. The irony is that between 1982 and 1985, during a period of rapid economic growth and job creation, the number of Americans without insurance coverage from any source – private or public – increased nearly 15 percent to nearly 35 million.[76] It is estimated that this figure now stands at 37 million.

In 1988, Congress expanded the Medicare program to include complete coverage for extended hospital stays and a new prescription drug benefit for the elderly. Congress is now considering legislation to create a new federally funded long-term care program for the elderly, as well as bills to expand prenatal coverage for poor mothers and require

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75 Continuation laws require employers to offer continued access to former employees and/or dependents of employees to group health care coverage. Length of coverage depends on the circumstances surrounding job termination or other events making the employee or dependent ineligible for continued participation in the plan. For example, often when employees shift from working full time to working part time, they lose their health insurance coverage. In other cases, dependents lose health insurance coverage when the worker dies, when spouses divorce, or when a dependent child becomes an adult.

76 Chollet, *op. cit.*, p. 189.

employers to provide health insurance to all their workers. These changes would add to the crazy quilt of programs stitched together since the early 1960s in an attempt to provide health care for those who need it and cannot afford it. With increasing numbers of poor and unemployed falling through the gaps in this system, comprehensive reform is necessary.

States have been exploring ways to improve health care services to the poor and other Americans without insurance coverage, while experimenting with ways to control costs. Though not all of these innovations have been successful, they have built a body of experience and information on which to base reform, and they suggest ways in which the federal system can address the problems of the poor, high-risk Americans, and unemployed.

The federal and state governments should build on these initiatives by taking further steps to eliminate the confusion, bureaucracy, and rigidity currently afflicting health care programs for the poor. In particular, states should be given more flexibility in redesigning their programs to encourage greater competition among health care providers and expanded consumer choice.

THE 1980S: A DECADE OF CHANGE FOR THE MEDICAID PROGRAM

Medicaid is a joint federal-state program administered by the states under federal guidelines. The state share of the total cost is based on state per capita income. The federal contribution to total Medicaid spending varies between 50 percent and 83 percent; the nationwide average is 55.5 percent. In 1988, the total federal share was $30.4 billion, and the total paid by states was $24.3 billion.

Eligibility for Medicaid benefits extends to certain categories of low-income persons who are eligible for cash assistance under the Aid to Families with Dependent Children (AFDC) program. States set the income levels for AFDC eligibility; as such, Medicaid eligibility varies among the states. Most recipients of Supplemental Security Income (SSI), a federal program for the aged poor, blind, and disabled also are eligible for Medicaid. In addition, states have the option of providing coverage to the medically needy who, depending on their income and assets, may or may not be eligible for AFDC, SSI, or other cash assistance programs on which Medicaid eligibility is normally based.

In addition, the 1988 welfare reform legislation allows welfare recipients who obtain a job to continue their Medicaid eligibility for one year.

Since 1981, tighter federal Medicaid eligibility rules have reduced the number of Americans covered. The 1981 Omnibus Budget Reconciliation Act (OBRA) included changes in the AFDC program, that in turn reduced Medicaid eligibility. A General Accounting Office (GAO) study estimated that 493,000 families had their AFDC coverage eliminated as a result of changes brought about by OBRA.[77] Most of those dropped were working people who became ineligible for Medicaid when they lost AFDC.

Another factor reducing the number of Americans served by Medicaid is that many states do not adjust their AFDC income levels completely for inflation. From 1970 to 1987, for instance, state AFDC benefits levels for a family of four, in constant dollars, failed to keep up with inflation in all but California, Maine, and Wisconsin. The nationwide median decline in benefits levels for the same period was 33 percent.[78]

Recent federal legislation, however, has expanded Medicaid benefits to new groups. One well-publicized provision of the 1988 catastrophic health insurance legislation permits a married couple to retain more income and assets than currently allowed when Medicaid takes over paying the nursing home bill for one of the spouses. Less-noticed provisions in the legislation require states to extend at least some Medicaid coverage to elderly individuals, pregnant women, and infants up to age one in families with incomes below the federal poverty threshold. And, states also are now required to continue Medicaid coverage for low-income families leaving welfare for jobs.

Such expansions, however, generally have been offset in recent years by the combination of tightened eligibility rules. This has led to a reduction in the average qualifying level of income for AFDC from 71 percent of the federal poverty standard in 1975 to 48 percent by 1986.[79]

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77 "An Evaluation of the 1981 AFDC Changes: Initial Analyses" (Washington, D.C.: U.S. General Accounting Office, April 2, 1984).

78 Program data, Committee on Ways and Means, U.S. House of Representatives, March 6, 1987.

79 Rick Curtis, "The Role of State Governments in Assuring Access to Care," *Inquiry*, Fall 1986, p. 297.

And because AFDC eligibility has been reduced and state qualifying income standards have eroded, the proportion of lower-income Americans who qualify for Medicaid coverage has fallen. By 1987, only 41.3 percent of the nonelderly population with incomes below the federal poverty standard qualified for Medicaid.

In a positive step, the 1981 Omnibus Budget Reconciliation Act (OBRA) included regulatory changes that gave states expanded flexibility to experiment in their Medicaid programs. Most states have restructured services and eligibility criteria or have introduced payment methods that changed the incentives for health care providers.[80] States now can use competitive bidding arrangements to purchase services and medical devices. States also can suspend a physician's participation in Medicaid if his services do not meet recognized standards of care. And beneficiaries found to overuse expensive services may be required to use a specific provider selected for them.

States also may request waivers from federal requirements, allowing them to manage their Medicaid programs more cost effectively. For instance, states may require beneficiaries to receive their medical care only from specific cost-effective providers and allow beneficiaries to share in savings resulting from their use of more cost-effective care. States also can enroll Medicaid beneficiaries in prepaid plans, such as Health Maintenance Organizations (HMOs), instead of relying solely on generally more expensive fee-for-service arrangements. Local jurisdictions may act as central brokers in helping beneficiaries choose from competing health care plans. Medicaid reimbursement for home - and community-based services is also authorized for beneficiaries who are otherwise eligible for admission to long-term care institutions. During 1982, more than two-thirds of the states applied for federal waivers to provide home-and community-based long-term care services for the elderly and disabled or to direct Medicaid clients to more cost-effective health care providers through the use of selective contracting, primary care case management networks, brokering arrangements, or HMOs.[81]

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80 American Enterprise Institute Studies in Health Policy, "The Health Policy Agenda: Some Critical Questions," Washington, D.C., 1985, p. 38.

81 Intergovernmental Health Policy Project, "Recent and Proposed Changes in State Medicaid Programs: A 50 State Survey" (Washington, D.C.: George Washington University, December 1983).

Moving away from the virtually uncontrolled fee-for-service payment structure and toward managed systems of care has allowed states to shop around as purchasers to control costs and improve access to good quality, comprehensive medical services. Since 1981, many states, with the cooperation of the Department of Health and Human Services' Health Care Financing Administration (HCFA), have launched health care demonstration projects, risk pools, and other alternatives to traditional Medicaid programs.[82] Typically in this trial-and-error innovation and improvement, some projects have cut costs and improved care, while others have failed and been discontinued. All have taught valuable lessons to aid the redesign of a health care policy for lower-income Americans.

Example: The Monroe County MediCap Plan

In 1985, Monroe County, New York, launched a Medicaid demonstration program called MediCap, which was designed to test the effectiveness of using a capitation system to pay for health care for the poor. In capitation systems, doctors, clinics, or HMOs agree to provide basic health care services to Medicaid beneficiaries in return for a fixed fee paid to them in advance. Under MediCap, all recipients of Aid to Families with Dependent Children (AFDC) and Home Relief (a New York state welfare program) were required to select a health maintenance organization (HMO) provider. By the end of the demonstration, 40,000 individuals had been enrolled. New York state reimbursed Monroe County for the program at a capitated, or per beneficiary, rate equal to 95 percent of normal fee-for-service costs. The county then developed rates for categories of eligible individuals, from which it paid the providers a slightly lower monthly capitation payment for each enrollee. The county created a separate, not-for-profit body, also called MediCap, to administer the program.

Monroe County planned eventually to enroll its entire Medicaid population in prepaid health plans through MediCap. The demonstra-

82 Risk pools are insurance pools for high-risk individuals, which provide subsidized insurance to those unable to find adequate and affordable coverage due to their mental or physical condition.

tion project was expected to run for three years, but it was discontinued in July 1987, after just two years because of several problems. Among them:

1) There was no competition caused by a lack of broad-based provider participation. Only two HMOs joined the MediCap Plan, for instance. The reason was the HMOs' concerns that their fees for each Medicaid enrollee were too low. They were particularly distressed that MediCap made no allowance for their extra administrative expenses under MediCap, and that the minimum benefits the HMOs were required to provide would prove too costly. They objected also to the extensive data collection and reporting requirements imposed by MediCap.

2) There was a limited ability for recipients to shop around for a lower-cost plan because of the lack of provider competition. Recipient options consisted only of choosing an affiliated provider within the HMO, although there was some price competition for enrollees within each HMO.

3) Providers complained that the process by which MediCap was introduced was too lengthy. There also were unanticipated problems that providers felt were not given adequate attention.

4) Providers lost money in their second year of participation, chiefly because of inadequate capitation fees for each enrollee, and because of high administrative expenses.

5) Because of these problems, the state and Monroe County failed to reach agreement on a payment rate for the program's third year. MediCap, however, offers important lessons to other states and counties. One lesson is that the state must offer enough financial incentives (adequate capitation rates, administrative requirements, and expenses) if it is to attract a variety of HMOs offering various plans to Medicaid recipients.

Example: The New Jersey Medicaid Personal Physician Plan

Launched in 1982, the New Jersey Medicaid Personal Physician Plan was a demonstration project designed to encourage Medicaid beneficiaries to obtain most of their medical care from a single doctor or clinic of their choice. Under the plan, the specific doctor or clinic selected by the beneficiary became the beneficiary's "primary care case manager." This case manager provided the beneficiary with all primary

care services, and except for emergencies, had to authorize any supplemental or specialized services provided by other doctors or hospitals. Medicaid would not reimburse services provided without such authorization from the case manager. In return, the case managers were paid a fixed amount, or capitation, in advance by Medicaid for each beneficiary. Participation in the program was voluntary for both Medicaid beneficiaries and primary care providers.

The program was designed to compensate the case manager for the primary care services he provided directly and to encourage the case manager to economize on the use of expensive referral services. The portion of the total capitation amount allocated to primary care case managers was based on normal fee-for-service costs of services delivered by primary care physicians, the cost of services from non-specialty clinics, and 75 percent of the cost of services provided in hospital emergency rooms. The objective of the program thus was to control Medicaid spending by giving primary care physicians and clinics a financial incentive to manage all of the health care provided to Medicaid beneficiaries, and thus, limit the ability of beneficiaries to obtain unnecessary or overly expensive services. This strategy was based on the understanding that, in a traditional fee-for-service system, Medicaid beneficiaries tend to use hospital emergency rooms inappropriately for routine care or to seek treatment from more than one doctor, resulting in unnecessary tests, prescriptions, and office visits. State officials believed that primary care case managers could make a profit under the plan by reducing Medicaid recipients' use of costly hospital emergency rooms and by dealing with many minor health problems themselves. Medicaid recipients were to select a case manager for six-month intervals, and the capitation rates would be adjusted for county of residence, sex, age, and eligibility category of the enrolled beneficiaries.[83]

83 The eligibility provisions for Medicaid are among the most complex of all assistance programs because of its interrelationships with Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs and the amount of flexibility accorded states through its regulations. Generally, at a minimum, states must cover all persons who receive cash payments from either the AFDC or, in most cases, the SSI program. States have the option of extending Medicaid coverage to specified groups of individuals known as the optionally categorically needy and to the medically needy.

The plan originally was to be introduced in four phases over a three-year demonstration period with each phase enrolling additional counties until the plan was operating statewide. The final phase was scheduled to begin in July 1985 but was postponed. The project's demonstration waivers from the Health Care Financing Administration expired in June 1987.

The problems of the New Jersey project stemmed from several aspects of its design. Among them:

1) The voluntary nature of the program resulted in low participation rates among both physicians and patients. A voluntary program needs a strong marketing strategy and clear incentives for both physicians and patients. If either the patients or the physicians do not believe that the voluntary program offers them a significant advantage over the existing system, few of them will choose to participate in it.

2) The small numbers of Medicaid patients in the demonstration (average number of enrollees per month was 8,400, only 1.8 percent of the total number of Medicaid eligibles) meant there was little market incentive for physicians to compete for enrollees by offering them better services. Also, because so few Medicaid beneficiaries participated, the program did little to alter the ways in which New Jersey Medicaid beneficiaries, in general, obtained health care services. A larger-scale, mandatory program would have a better chance of achieving significant cost savings.

Example: The Missouri Medicaid Prepaid Health Demonstration Project

Missouri established in 1986 a mandatory consumer-choice experiment in Kansas City. This incorporated various incentives and marketing techniques and offered a range of alternative health plans. The project sought to spur competition by allowing beneficiaries to choose among the competing plans, giving capitated payments to providers to stimulate greater efficiency, and using marketing incentives to encourage patients to take full advantage of the program. Each of the participating plans was required to offer at least a minimum benefits package for the Medicaid recipients under the prepaid arrangement. Missouri set its base rate of annual payment to health plans at approximately 90 percent of typical annual fee-for-service costs.

Enrollment in the program reached the target of 23,000 in June 1986. Demonstration waivers provided by the Health Care Financing Administration ended in December 1986, at which time the project applied for a permanent waiver, which it received.

The state contracted with five prepaid health plans and 57 physician groups for the program. Though there were problems at first, operations are now smoother. Whether patients are satisfied with the new program is still difficult to determine, although preliminary indications are favorable. A patient satisfaction questionnaire reveals that most patients are satisfied with their care. Overall, the program has been judged successful and was accepted for a permanent waiver. A significant proportion of the Medicaid population is now enrolled in prepaid health plans. Data on cost savings, however, is not yet available.

The key to the success of the Missouri demonstration project was that the state realized early in the planning stage that the cooperation of both providers and recipients would be needed for the program to work. As a result, considerable effort was devoted to educating recipients by providing them with objective and accurate information about the competing plans and special counseling to help them make their selections. Also, before the program went into effect, the state spent seventeen months working with providers to design an enrollment process and an acceptable set of administrative and management procedures. After the plan became operational, the state continued to improve recipient education programs, and state officials worked closely with providers to resolve the remaining administrative problems. As a result of these efforts, Missouri was able to encourage more providers to participate in the program, which in turn stimulated competition. The lesson for other states is that extensive planning, an active program for educating and counseling recipients, and a cooperative relationship with providers are important ingredients in creating a successful program.

Example: The Minnesota Prepaid Medicaid Demonstration

Minnesota in 1985 launched a prepaid capitation demonstration project for the eligible Medicaid population in three of its counties. In these counties, the per capita payment is based on the average fee-for-service cost per Medicaid recipient in each county. This rate is paid to competing health plans who organize to provide services to Medicaid

recipients within urban and suburban counties. A "rate-cell" approach is used to determine capitation rates. A cell is a group of beneficiaries with certain demographic and geographic characteristics. By adjusting payment rates for each cell to reflect their likely use of medical facilities, the state can reduce adverse-selection problems, that is, the situation where a provider receives a flat fee for all enrollees yet ends up generally serving patients with high medical costs. The cells adjust for age, sex, category of eligibility, county of residence, and institutional and Medicare status.

The capitation rate paid to the health plans for Medicaid beneficiaries differs according to whether the beneficiaries are eligible for Medicaid because they receive AFDC payments or because they receive SSI payments. For AFDC recipients the rate is 90 percent of their typical fee-for-service costs. For SSI recipients, the rate is 95 percent of the fee-for-service costs. The project was to continue for three years, and the federal waiver expired in December 1988; HCFA denied the state's request for an extension. But, Senator David Durenberger, the Minnesota Republican, successfully sponsored legislation allowing the program to continue until July 1990.

As with the other state demonstration plans, there were start-up problems in Minnesota. One was that giving Medicaid beneficiaries adequate information and time to select a plan slowed the pace of enrollment. But officials point out that allowing less time for choice would have resulted in confusion and resistance.

In addition, although the state has attempted to include as many Medicaid recipients as possible under the demonstration, including the aged, blind, and disabled, more than two-thirds of Medicaid expenditures, particularly those for long-term nursing home care for the elderly poor, are not subject to the capitation plan in the counties. Unless new prepayment arrangements can be developed to cover nursing home care and other services still paid for on a fee-for-service bases, Minnesota will only achieve limited overall savings in its Medicaid program.

Nevertheless, in a state where the concept of capitated payments for health services is well accepted generally, the plan has been popular with providers and patients. As enrollment increases and more experience is gained, state officials expect to see significant savings and improvements in health services.

Example: The Florida Alternative Health Plan Project

Launched in June 1982, this demonstration project was designed to test a number of methods for promoting competition among health care providers and insurers. These included competitive plans for Medicaid beneficiaries, physician case managers, prepaid community-based services for the elderly, and medical care vouchers.

The experiment with competitive plans was unsuccessful, mainly because of a lack of response from HMOs. Among the reasons cited: unduly low capitation rates, an arbitrary cap placed by the state on the number of Medicaid eligibles who could be enrolled in each county, and a high degree of turnover among the Medicaid population. The state eventually decided to contract with individual HMOs, rather than try to apply a standard contract to all. This approach is costly, requiring the state to assist HMOs with feasibility studies and to provide detailed information on the distribution of Medicaid recipients by hospital market area.

The case management models also were disappointing. The demonstration was designed to reduce the overutilization of medical services – that is, beneficiaries obtaining more medical services than they really need – and to assure that medically high-risk patients were not being denied services. But this part of the program suffered a number of administrative and legal delays. Enrollment in the frail-elderly segment of the program began in September 1987. The objective was to control nursing home costs by offering medical care and social services to those who can live independently in the community. The program is too new, however, to yield any conclusive results.

The plan for medical care vouchers was never put in place, as insurance companies would not underwrite the project. The state planned to issue vouchers to 1,000 recipients in three counties. The vouchers were to be set at 95 percent of the typical fee-for-service cost for the enrolled population, to be redeemed for the purchase of state-approved health plans offering a minimum array of services comparable to Florida Medicaid benefits. But Florida's insurance companies showed little interest, arguing that the voucher value was too low for them to provide acceptable benefits. In addition, the number of recipients for the program was too small for it to have any significant impact on health care costs and services.

Example: The Arizona Health Care Cost Containment System (AHCCCS)

Arizona for years did not enroll in the federal Medicaid program. In its place, indigent care programs were operated by the county governments. By 1980, county revenues no longer could cover the rising cost of indigent health care, and the counties felt they needed federal and state support. HCFA and state legislators agreed to a three-year demonstration project, beginning in October 1982.

The Arizona project was designed to test the effectiveness of greater competition in Medicaid. This competition included primary care physicians acting as case managers, prepaid capitated contracts, the use of nominal copayments to reduce unnecessary demand, and limited restrictions on freedom of choice of plans and providers. The program is still operating with over 100,000 eligible recipients enrolled in prepaid health plans.

AHCCCS provides public assistance medical care to Arizonans eligible for AFDC and Supplemental Security Income (SSI) payments. The federal government helps the state and counties pay premiums to HMOs to care for enrollees. These are special HMOs created specifically to serve the AHCCCS program. Unlike regular HMOs, they do not serve the general public. The aim of the program is for Arizona's poorest residents to receive good health care, yet for providers to have the incentive to economize. Nine of the state's thirteen AHCCCS HMOs made a profit last year, and studies suggest that costs are running about 10 percent lower than if Arizona were a Medicaid state.[84]

The experimental program is being expanded to provide health insurance packages for small businesses, a group that commercial insurers traditionally have considered too risky. It is estimated that 40 percent of U.S. small businesses have trouble obtaining affordable insurance for their employees. Under the arrangement, AHCCCS pools employees from a number of small businesses into a larger group and then contracts with prepaid health plans to provide coverage. Businesses with 25 or fewer employees are eligible to participate in the

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84 "Evaluation of the Arizona Health Care Cost-Containment System," a federally commissioned study by SRI International, Inc. (Menlo Park, California) June 1983-December 1988.

program. The plan went into effect in January 1988, and about four dozen companies are currently enrolled with 530 individuals members. The average company size is three to four employees. The one difficulty, according to Gale Silverstein, director of the project, is that only one AHCCCS HMO has agreed to offer coverage, but it does offer four different health care packages for members. "The AHCCCS health plans are timid about competing in the private sector," says Silverstein, "They are not used to it and are afraid of the risk. But I believe that will change as they realize the project is successful."

Arizona's officials hope that enrolling small businesses will alleviate the problem of uncompensated care for Arizona hospitals, which amounted to $150 million in 1986. Officials estimate that up to 550,000 Arizonans are in families with at least one wage earner but without health insurance. Almost a quarter of this number constitute what health experts call the "notch group." These fall under the official federal poverty level yet have income too high to qualify for AHCCCS. The current success of AHCCCS has encouraged some commercial insurers to consider offering HMO plans for the notch group and small businesses.

AHCCCS incorporated a long-term care component into demonstration in December 1988 and introduced coverage for the developmentally disabled and elderly populations in January 1989. In December 1988, HCFA granted the state a five-year extension for the AHCCCS demonstration.

General Assessment of State Demonstrations

As in most policy experiments, these state demonstration projects made possible by the 1981 federal legislation, have produced mixed results. The information that they yield, however, is very valuable.

All the demonstrations encountered some problems. Besides the usual start-up difficulties, the most serious concern, faced by most of the demonstrations, was inadequate participation by providers. This sometimes resulted in very limited choices for patients and thus little competitive incentive to keep costs down.

The lack of provider participation has several causes. The main reasons appears to be that states were too optimistic about the immediate savings that could be achieved. Because of this, states tended to set the capitation fees their programs paid to providers at too low a

rate. As a result, providers were often reluctant to join a program because they perceived the financial risks as too great. Providers also expressed disinterest in participating in programs with small enrollments, because the potential market was insufficient to warrant the administrative costs. In addition, programs with voluntary participation were not successful because of a lack of strong incentives to participate for both patients and providers. Also voluntary programs tended to suffer from adverse selection – that is, enrolling only those patients who anticipated needing substantial medical care. If the state pays providers or HMOs a fixed fee for all patients under a voluntary enrollment program, but only high-cost patients choose to enroll, the providers or HMOs face large financial losses.

Another problem is that these demonstrations are being undertaken in a volatile health services market. Many factors such as other public program reforms (especially changes in Medicare reimbursements), cost-saving initiatives in the private sector, and the growth of various types of alternative health care delivery systems have had a great impact on the demonstrations, making accurate assessments very difficult. Program managers thus have been forced to be flexible and willing to modify their programs in order to adapt to constant changes in the market.

As state demonstration programs matured, rate setting emerged as a major concern for program managers. Rate setting problems have been complicated by the effects of other health care system reforms, such as Medicare's prospective payment system and public and private competitive bidding initiatives.

Rate setting lies at the heart of government health care programs for the poor. The rate set for each enrollee determines the bottom line for the state and the health care provider. With rates set too low, providers are discouraged from joining the program, as they are very reluctant to enroll potentially high-cost individuals. With rates set too high, potential savings to the state disappear. Yet determining the ideal rate is very difficult. The pattern in the successful state demonstrations thus has been to start with a relatively simple formula and then modify as needed.

The longer that demonstration programs have been in place, the greater the attention to reviewing the use and quality of services. By the second year of operation, most programs had put in place medical and financial audits and some type of system for monitoring the quality

of care given to patients. In addition, improved patient education procedures have significantly reduced costly out-of-plan services, such as beneficiaries seeking care for minor illnesses at expensive hospital emergency rooms instead of low-cost outpatient clinics.

In general, most of the programs still in operation, whether on the basis of a demonstration status or a permanent waiver, appear to be successful in offering economical alternatives to the traditional Medicaid program. They provide recipients with quality medical care, and in the few cases where preliminary cost data is available, exhibit significant cost savings over traditional Medicaid programs.

The most important lesson from the state programs is that state governments are willing to experiment with providing health services to the poor. The diversity stemming from state initiatives appears to be a critical element in any national strategy to improve the effectiveness and efficiency of health care for the poor. Only by giving states the opportunity to try new ideas – and make mistakes – can the best techniques be developed for general use across the country.

STATE PROGRAMS FOR THE UNINSURED

While the legislative changes of 1981 enable states to experiment with demonstration projects for those Americans eligible for Medicaid, many other individuals not eligible for Medicaid lack adequate health care coverage. One large group comprises self-employed individuals and workers in small businesses. As explained in *Chapters 1 and 3*, under the current employer-provided health insurance system, insurance companies generally charge higher premiums to small businesses and self-employed workers. Very often these businesses and self-employed individuals respond by not buying coverage.

Another group that often has difficulty obtaining health insurance consists of those who for some reason – such as temporary unemployment – lose their coverage but have a preexisting health condition that causes insurance companies either to deny them new coverage or to offer it only at very high rates. Many of these individuals have sufficient income to afford to pay directly for routine health care, but large uninsured medical bills can easily drain their resources.

Many states have begun programs to address the health care needs of uninsured individuals not eligible for Medicaid. These programs conform to two broad models:

1) Those that provide health insurance coverage for persons who are uninsured because their medical history makes the premiums unaffordable.

2) Those that compensate providers who supply services to individuals who are unable to pay for those services.[85]

Programs for the Uninsured

Several states and localities have separate programs to provide medical assistance for low-income individuals who are ineligible for federal income assistance or Medicaid and for high-risk individuals unable to obtain affordable insurance. These programs generally cover basic health care expenses and catastrophic care. Alaska, Maine, Minnesota, and Rhode Island have longstanding catastrophic health insurance programs that serve primarily near-poor or middle-income residents. Oklahoma and South Dakota recently enacted similar programs.

Many of these programs use insurance risk pools. These pools for high-risk individuals provide insurance to those unable to find adequate coverage in the private market because of their mental or physical condition. Under such programs, the health status of the subscriber is eliminated as a barrier to health insurance, since subsidized low-cost insurance is available through the pool. States generally operate the pool by forming an association of all health insurance companies doing business in the state. One insurance organization normally is selected to administer the plan under specific guidelines for benefits, premiums, and deductibles.

Insurance for high-risk individuals obviously is more expensive than that for standard risks. But in a risk pool, premiums are set at a level affordable by those enrolled in the pool. This means that the enrollees pay less in premiums than the cost of the services that they use. The

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85 Much of the material presented in this section summarizes information from Deborah J. Chollet, Ph.D., "Financing Indigent Health Care," The Changing Health Care Market, EBRI-ERF Policy Forum (Washington, D.C.: Employee Benefit Research Institute, 1987) Chp. 14; and Aaron K. Trippler, *Comprehensive Health Insurance for High-Risk Individuals: A State by State Analysis* (Minneapolis: Communicating for Agriculture, 1987).

most common approach to cover the losses incurred by the pool is to require insurance companies to contribute in proportion to their share of the state health insurance market. Eleven states[86] partly offset this assessment through some form of tax credit against premium taxes or other state taxes. Thus the state taxpayers also make a contribution. Ohio pays all the pool's losses directly out of its general funds. Maine, meanwhile, taxes hospital patient revenues to raise the funds necessary to support operation of the program. The experience of most states indicates that the subsidy cost typically has been 1 percent of the total amount of premiums collected from all health insurance policies sold in those states.

Minnesota offered the first comprehensive health insurance pool for high-risk individuals in 1975. Since then, fourteen other states have added high-risk pool programs.[87] During the past three years, at least twenty additional states have considered the a high-risk pool for their citizens.[88]

The federal government also has taken an interest in promoting health insurance risk pools. Secretary of Health and Human Services Otis Bowen, in his November 1986 report to the President on health care reform, recommended that all states adopt high-risk pools to provide health insurance. Congress also has taken up the idea. Legislation either mandating or encouraging states to adopt risk pools has been introduced on several occasions since 1985, although no bill yet has been enacted.

Wisconsin has taken an additional step to make risk pools more accessible to low-income families not eligible for Medicaid, and to high-risk individuals with modest incomes. In 1985, a separate fund was created to help subsidize the premiums of individuals with an income of less than $16,500. The subsidies range from 6 percent to 30 percent of the premium in five categories of support based on the individual's income.

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86 Florida, Indiana, Iowa, Maine, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Tennessee, and Washington.

87 Connecticut, Florida, Illinois, Indiana, Iowa, Maine, Montana, Nebraska, New Mexico, North Dakota, Oregon, Tennessee, Washington, and Wisconsin.

88 These include New York, Texas, Vermont, California, Ohio, and Virginia.

Programs for Uncompensated Care

Uncompensated care is a term describing services provided by hospitals in the form of charity or those for which hospitals end up holding bad debts. The ideas being tested to deal with the uncompensated care problem include:

State Revenue Pools. This is a relatively new approach to resolving the inequitable distribution of indigent care costs among hospitals, in which the hospitals as a group effectively have state-sponsored insurance against bad debts. The idea is that no single hospital should bear a disproportionate share of the cost of uncompensated care simply because it does not turn away indigent patients or because it is located in a poor neighborhood. Several states[89] levy assessments on all hospitals to fund pools to offset the financial burden of indigent care in hard-hit hospitals. As a result, hospitals are less inclined to turn away individuals lacking the means to pay for care. Financing methods for the revenue pools include taxes on a hospital's net revenues, state general revenues, surcharges imposed on hospital charges, and levies on insurance premiums.

Rate Setting. Hospital rate setting (prospective pricing systems that apply to all providers of health care) has been viewed by some states as a way to slow hospital cost escalation and to distribute more equitably the burden of uncompensated care. It would achieve this by including, when making the rate calculations, an additional margin to cover the projected costs of uncompensated care. In recent years, commercial insurers, disappointed with the results of their own cost control efforts, have become leading advocates of state rate setting programs. In the six states with hospital rate setting programs (Connecticut, Maine, Maryland, Massachusetts, New Jersey, and New York), an allowance is made in setting each hospital's rates to help cover uncompensated care costs. In 1985, for instance, Massachusetts financed approximately $200 million in uncompensated care costs through rate setting. Since these rate setting systems regulate the amounts hospitals can charge privately insured patients, calculating an allowance in the rates to cover uncompensated care is essentially a

89 Florida, New York, South Carolina, West Virginia, and Wisconsin.

formalized, state-administered version of the old cross-subsidies, whereby hospitals overcharged their private patients to pay for care for the indigent.

COMPREHENSIVE HEALTH CARE REFORMS FOR THE INDIGENT

Medicaid is both the largest U.S. welfare program and the second largest government health care program. Any reform of Medicaid, therefore must not only improve America's health care system but also be compatible with broader reforms in the welfare system designed to reduce dependency and encourage self-sufficiency.

For over two decades, Medicaid has been the stepchild of U.S. health care policy. Even at its inception in 1965, the program was little more than an afterthought, tacked onto the Medicare legislation. At that time, the proponents of national health care wanted a federal system based on social insurance, and they thus proposed Medicare as an expansion of Social Security. As an alternative, the American Medical Association (AMA) favored a decentralized system based on financial need. The eventual political compromise was a combination of the two proposals; Medicaid essentially was the AMA's alternative.[90]

Following the creation of Medicare and Medicaid, liberals continued to press for a completely nationalized health system, while conservatives vigorously opposed such initiatives. Neither side, however, gave much thought to developing a comprehensive policy for meeting the health care needs of the poor and disadvantaged. Instead, programs to address particular groups were added to Medicaid. The result is today's patchwork of programs. The largest of these additions was the 1972 legislation extending Medicare coverage to nonelderly disabled individuals and kidney dialysis patients. Other programs were established to provide health services to migrant workers, Indians, and poor mothers and infants and to fund the treatment of mental illnesses and drug and alcohol abuse.

This patchwork has been strained severely in recent years by the absence of adequate, private sector insurance protection against the

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90 See Frank D. Campion, *The AMA and U.S. Health Policy since 1940* (Chicago: Chicago Review Press, 1984), pp. 253-283.

costs of long-term care. In response to this coverage gap, Medicaid has been forced to assume the increasing burden of the long-term care bills of millions of middle-class elderly patients driven into poverty by nursing home expenses. This has severely limited Medicaid's ability to meet the basic health care needs of the nonelderly poor.

Reforming the current system for providing health care to the poor requires three broad approaches. First, the basic economics of America's entire health care system must be reformed to encourage economical decisions, so that each dollar can provide more care. Such a general restructuring would result from the reforms detailed in *Chapter 3*. Second, the excessive burdens on Medicaid posed by the long-term care problems of elderly Americans must be eased by dealing directly with long-term care. Ways to accomplish this are proposed in *Chapter 4*. And third, steps must be taken to integrate health care programs for the poor more efficiently into the diverse structure of federal and state welfare programs.

The Reagan Administration laid much of the foundation for accomplishing such integration through its welfare reform measures. To spur innovation and experimentation in welfare policy, while increasing the self-sufficiency of the poor, the Administration reduced federal controls to encourage individual states to experiment with their welfare programs. This triggered widespread state innovation.

As part of this welfare reform strategy, the Reagan Administration took two important steps to encourage states to develop better methods of providing health care to the poor. The first was in 1981, when the Administration won passage of legislation to combine a number of small health programs into three block grant programs: the Preventive Health and Health Services Block Grant; the Alcohol, Drug Abuse, and Mental Health Block Grant; and the Maternal and Child Health Block Grant. These block grants allowed states to pool the federal money that they received for categorical grants and gave them more flexibility in designing local programs to meet the health care needs of targeted groups.

The second step was the passage of legislation in 1982 permitting states to undertake Medicaid demonstration projects that experimented with alternative methods of delivering health care to the poor. The demonstration projects that succeeded, as well as those that failed, have produced valuable insights and data for future reform.

The federal and state governments now should build on these initiatives by adopting a new strategy for providing health care to the poor and disadvantaged. This strategy must permit continuous policy innovation at the state level to test creative ideas. The federal government must grant state governments broad authority to keep changing and updating their health care programs for the poor. Such flexibility is essential if states are to devise the most effective and efficient methods of delivering health care services, and if they are to better integrate health care programs with all their welfare programs providing cash assistance, housing, and other services to the poor. The reform strategy should:

1) Separate the government's function of providing basic health care services to the poor from its function as the payer of last resort for middle-class patients with catastrophic medical bills.

These are both legitimate and necessary government functions, but they have different objectives and involve different groups. Confusing these two functions has led to inflexibility and excessive bureaucracy in programs, while stifling efforts to develop innovative ways of achieving either goal. The most obvious confusion of these functions is Medicaid's role as both a program for providing basic health services to the poor and as the payer of last resort for middle-class elderly patients in nursing homes and younger individuals with costly terminal illnesses.

Eliminating the confusion over the proper roles of government health programs should be the first order of business for federal and state policy makers seeking to improve health care services for the poor and disadvantaged. Policy makers should recognize that there are major differences between a family trapped in chronic poverty and a normally self-sufficient family suddenly faced with an overwhelming financial catastrophe. A middle-class family with major financial problems generally needs only temporary help to become self-sufficient again. In contrast, families suffering from long-term poverty need a program of sustained help that meets their basic needs while encouraging them to eventually break the cycle of dependency.

The *Chapter 4* proposal to establish a separate program for financing long-term care for the poor elderly would be a good step toward returning Medicaid to its original function of providing basic health

care services to the nonelderly poor. Similarly, tax changes to encourage the development of better catastrophic acute and long-term care insurance protection, as proposed in *Chapters 3* and *4*, together with the requirement that working Americans purchase such protection for themselves and their families, would alleviate considerably the problem of Americans being driven into poverty by high medical bills.

Even with these reforms, many Americans still would incur catastrophic medical expenses without adequate insurance to pay for them because they do not qualify for insurance or Medicaid for some reason or because they encountered an unusual set of circumstances not covered by normal insurance. To meet this need, more states should develop catastrophic, or last-resort programs for helping families threatened with financial ruin by high medical bills. Instead of forcing families into welfare dependency as a precondition to qualifying for Medicaid, these programs should try to help families maintain their independence. This would be similar to the way bankruptcy courts help debtors restructure their finances and become self-sufficient again.

Under such a program, families might become eligible for assistance when their out-of-pocket medical bills exceeded a certain percentage of their income. At that point, state officials could step in and tailor an assistance package to meet the family's particular needs. Depending on the family's circumstances, this assistance could take the form of cash grants, long-term, low-interest loans, subsidized insurance coverage, or regular visits by therapists and social workers to help the family care for a disabled individual.

2) Give states more flexibility to meet the health care needs of the poor and the disadvantaged.

Even before the structural reform of government functions are put in place, Congress should give the states more flexibility to meet the basic health care needs of the poor. This would entail several reforms. First, eligibility for Medicaid should be decoupled from eligibility for Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). The federal government instead should use a new eligibility index for Medicaid that takes into account the total cash and noncash benefits each family receives. This would tie health care assistance more accurately to real need. The formula for determining

how much the federal government funds each state's Medicaid program also should be decoupled from AFDC and SSI and allocated instead according to the new index.

Second, the federal government should refrain from using this new index to establish a fixed income level for Medicaid eligibility and then require states to provide full coverage to families with incomes below that amount. Rather, the states should be allowed to provide different amounts of assistance to different families – within a specified range on the index scale – depending on their income. In this way, states could explore ways of linking Medicaid assistance to other efforts designed to encourage welfare recipients to join the work force. States also would be able to coordinate Medicaid coverage with their other welfare programs.

Finally, all funding for smaller federal health care programs for the poor should be combined with Medicaid to create a single program. The money then should be allocated to the states on the basis of the new formula with minimal restrictions on the methods states use to deliver services.

3) Redesign Medicaid programs at the state level to build on the tax reforms proposed in *Chapters 3* and *4*.

The tax reforms proposed in *Chapters 3* and *4* are designed primarily to improve the way middle - and upper-class Americans buy medical services and health insurance in the private sector. These reforms also would enable states to purchase health care for the poor more efficiently.

First, the tax reforms would establish consumer choice as the primary mechanism for regulating health care prices, the total supply of health care goods and services, and the coverage and cost of health insurance. This would provide states a set of reliable market prices upon which to design and to measure the adequacy of, their medical care program, much as the appropriate value of Food Stamps and housing vouchers is established by consulting data on market prices for food and housing.

Second, the tax reforms proposed in *Chapter 3* are designed to offer a top-down strategy for closing coverage gaps in the health care system. For example, while the tax credits proposed in *Chapter 3* are designed primarily to assist middle-class Americans, making those credits refun-

dable would extend the benefits of health care tax relief to individuals further down the income scale, those low-wage workers who pay substantial payroll taxes but little or nothing in income taxes. These low-wage workers and their dependents account for as much as two-thirds of the uninsured population. Similarly, the exception to the dependent support test proposed in *Chapter 3* would give affluent Americans additional tax relief if they assisted their poorer relatives in purchasing health insurance or paying medical bills. The states should examine ways of complementing these tax incentives with bottom-up strategies, perhaps through a system of health care vouchers or cash assistance for low-wage workers. The amounts of voucher or cash assistance could vary according to the recipient's income with states providing a progressively smaller subsidy as a recipient's wages increased.

In addition, the tax incentives for long-term care insurance proposed in *Chapter 4*, over time, should relieve the current pressure on states to fund long-term care through Medicaid. This would free funds for states to use in providing basic medical services to the poor.

4) **Repeal state-mandated benefit laws.**

As noted in *Chapter 1*, state-mandated benefit laws often were well-intentioned but have had the perverse effect of driving up health care costs. Perhaps the most important step the states could take to improve health care immediately would be to repeal such laws. A recent study, in fact, finds that as many as one-quarter of the uninsured, or 9.3 million Americans, lack coverage because they have been priced out of the market through increases in health insurance costs attributable to state mandated benefit laws.[91]

5) **Establish insurance risk pools in every state.**

Separating health insurance from the work place would allow workers to retain the same policy when they switched or lost jobs, thereby eliminating many of the problems associated with a medically high-risk individual seeking new coverage. Under the refundable tax credit proposal, moreover, high-risk individuals would receive greater

91 John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, Policy Report No. 134, November 1988.

tax relief for their proportionally larger medical expenses. This would mean that, for some of the more affluent high-risk individuals, government help will not be necessary, while for less affluent individuals, the subsidy would be smaller than it now is in existing risk-pool programs. With this reduction in the potential case load for these pools, many more states should be inclined to work with private insurers to establish risk-pool programs.

6) Experiment with refundable deductibles in capitation plans for the poor.

Capitation plans provide regular assistance for each individual, so that they can be enrolled in a prepaid insurance plan. By contrast, traditional reimbursement programs simply pay out for each treatment. Under a refundable deductible system, a state could enroll beneficiaries in a capitation plan that included deductibles similar to those used in normal insurance. The difference would be that the state would prepay the deductible and then refund any unused portion to the beneficiary at the end of the year. Say a plan included a $250 refundable deductible. The first $250 charged to the plan by the beneficiary would be subtracted from the deductible. If the beneficiary incurred less than $250 in medical expenses during the year, he would receive the difference in cash. In this way, the poor would have some of the same incentives as middle - and upper-class Americans to avoid unnecessary or costly care.

This incentive is important because Medicaid beneficiaries tend to use excessive amounts of costly but inappropriate primary care. For instance, the poor will often use an expensive hospital emergency room rather than a family doctor or an outpatient clinic. This adds considerably to the cost of state Medicaid programs. To discourage this, it has been proposed that Medicaid patients be charged some level of deductibles or copayments.

The usual objection to such proposals is that the poor do not have the cash needed to pay deductibles, and thus the effect of the requirement would be to discourage them from seeking necessary care. A refundable deductible would meet this objection. If a Medicaid beneficiary chose to pay for minor treatment in cash, nothing would be charged against his refund. If, however, he did not have cash available, he could still get treatment and Medicaid would still pay the cost. But

because the treatment would count against his refundable deductible, he would still have some incentive to seek out more efficient providers. Such a system could significantly reduce overutilization and excessive treatment in Medicaid, allowing each dollar to provide more care to the poor. In developing such a system, states could experiment with different deductible amounts to achieve savings without discouraging necessary care.

CONCLUSION

As with all welfare reform, the keys to improving health care services for the poor are to be found in greater flexibility, decentralization, and innovation. Because the poor lack the resources to participate fully in society, they present unique challenges and problems to policy makers. No one can yet say with confidence that they have found the cure for poverty. Similarly, the other complex medical needs of the poor and the diversity of state assistance programs make it impossible for reformers to point to an ideal medical care program for the poor. Continuous experimentation is needed, and the best place to conduct the experiments is at those levels closest to the problem, the states and localities.

The reforms proposed in this chapter offer a basic framework for meeting the health care needs of the poor by encouraging such experimentation. If there is a lesson to be learned from the past six years of Medicaid demonstration projects, it is that significant improvements can be achieved in delivering services to the poor, in health care as in other areas of social policy, only when state and local governments are given the flexibility and incentive to experiment.

Chapter 6

The Political Prospects for Reform

Edmund F. Haislmaier

The reform agenda outlined in the preceding chapters is ambitious, but it is not impossible to achieve. Both lawmakers and the general public have become increasingly concerned about the state of America's health care system. This broad concern creates a political opportunity for launching a major health care reform initiative.

Despite aggressive cost control efforts in the public and private sectors, medical inflation continues unabated, and health care spending continues to soar. It is this cost problem that is mainly responsible for decreasing access to health care, particularly among the poor, the uninsured, and the elderly. At the same time, recent efforts to control health care costs have made the delivery of health care increasingly unattractive for many health care professionals, who in years past found it profitable. Health care providers, for instance, can no longer receive open-ended subsidies from such programs as Medicare and Medicaid. Instead they face ever tighter price controls and growing paperwork. Similarly, corporations are finding that even their tax breaks for employee health insurance no longer compensate for the enormous expense and problems associated with funding and managing those programs. So they are negotiating tough contracts with hospitals and doctors to keep costs down.

Not surprisingly, beneficiaries of government programs are beginning to question just how much they benefit from a system that lowers the quality of care while ignoring some of their most basic needs such as long-term care for the elderly. Even working Americans with insurance face a confusing and complicated system, as employers try to adapt health benefits to the realities of high medical costs, a more diverse work force, and changing family conditions.

Given the growing consensus that the current U.S. health care system has chronic problems and needs urgent treatment, it might be assumed that there would be little opposition to major reform. Yet three significant obstacles currently block necessary health care reforms.

The first is simply lack of vision in Congress. Lawmakers tend to approach problems one at a time, trying to devise separate, limited solutions for each situation. Sometimes the piecemeal approach can work. But the problems of America's health care system are so deep that lawmakers must exercise bold vision and mobilize broad popular support for major structural reforms.

The second obstacle is the common tendency of Americans to assume that "reform" of benefits inevitably means they will find themselves worse off. In such an essential area as health care, this fear triggers strong resistance to almost any proposal. The political success of any health care reform initiative thus hinges on the ability of its supporters to show that it will benefit virtually all Americans. Unless reformers can do this, reform proposals will fall victim to fears and institutional inertia.

The third major obstacle is the way in which Americans and their representatives think about health care. They tend to assume that the health care is not subject to the normal economic laws of competition governing the supply of goods and services. They also tend to assume that only employers or the government can fund health care services and that government must regulate services carefully. Because these and other erroneous assumptions have not been challenged seriously for several decades, they have the power of conventional wisdom. The result is that almost all new proposals in health care financing are doomed to failure because they presume that the existing system is an adequate foundation and then attempt to build additions onto it.

To be successful, then, the cause of health care reform must be championed by leaders who focus not on adding more and more

features to the existing system, but who offer Americans the bold vision of a new and better health care system and who have a strategy for anticipating and responding to the concerns their proposals will generate.

Specifically, reformers must:

1) Challenge existing assumptions.

The most basic assumptions about health care financing must be challenged. Reformers must dispute the prevailing notion that the health care market operates outside the normal laws of economics. And they must contest the assumption that current cost problems are the fault of the private sector operating in a free market with its implication that the solution is some form of national tax-financed system. Reformers must point out that, although America's health care system still is largely private, it is distorted by regulations and policies that encourage, or even compel, consumers and providers to ignore normal market signals which would produce good, affordable health care.

Reformers must emphasize that a new framework should approach health policy from the perspective of the needs of consumers or patients. They must make clear to Americans that such a framework will be based on consumer choice – the most efficient and effective regulator of any market – and that this will generate the incentives for providers to offer an adequate supply of quality services at reasonable prices. Based on this understanding, the aim of health care reform should be to construct a system that works with, not against, normal market forces. It is a system that seeks not to coerce or replace the market, but rather, to stimulate the market to achieve desirable social ends.

2) Emphasize the need for omnibus reform.

Reformers must explain to Americans that omnibus reform is needed to address the basic flaws of the health care system. Sweeping omnibus health care reform legislation should be drafted based on the new framework and policies detailed in the previous pages. This can be done either by the Bush Administration or by a coalition of Con-

gressmen. Such omnibus health care reform legislation should be publicized and promoted as the starting point for a national debate on health care.

3) Educate Americans and mobilize support.

Sponsors of the legislation, together with supporters outside government, should launch a national campaign to explain the rationale and benefits of reform and to allay the fears and reservations of different groups.

In thus selling health care reform, supporters will need to demonstrate not only how the nation as a whole will benefit from these reforms but also how specific groups will benefit. Reformers must identify individuals and groups of supporters among the general public and organize them into an effective political coalition. In essence, the proposals laid out above offer a set of benefits and trade-offs to the many, diverse groups who have a stake in the health care system. The job of reformers will be to explain to these key groups how their situation will change under the proposed reforms. Specifically:

Individuals and Families. The health care tax changes outlined in *Chapter 3* would give individuals and families greater responsibility for their own health care. These changes would put many health care decisions back in the hands of the consumers something that the complexity of the existing system has long precluded. Consumers should welcome such responsibility because it carries with it the added security of direct control over a vitally important, but often worrisome, aspect of their lives. Combined with a simpler insurance system, these features of the reform package should make it appealing to most Americans.

Consumers. A consumer-oriented approach to health care would have other major, positive social effects. Most important, it would stimulate both cost control and quality control while improving access. Consumer choice is the most powerful way to encourage providers to offer quality products or services at reasonable cost. Patients and their relatives always have the greatest interest in the quality of their care. Any economic decision, of course, involves striking a balance between cost and quality. And because the value of a service is a highly subjective concept, the consumer who is both paying for and benefiting from health care is best able to determine value for money in health care.

Thus the consumer is the best "regulator" of quality and price. Reformers must point out that the current system leads government to fix the price and amount of health care, and that a national health system would mean even more sweeping rationing. Reformers should explain that, by contrast, strengthening the incentives for consumers to question both the cost and the quality of their health care puts power back into the hands of patients.

Workers. While most workers, particularly if highly paid, would lose the tax advantages of employer-provided health care under the proposals advanced in *Chapter 3*, all workers would receive instead more favorable treatment for medical expenses on their personal income tax and better protection from large medical bills. For workers in businesses currently providing little or no health coverage, this would be a major improvement; for all workers, it would provide greater freedom of choice. It also would be a practical response to trends in the nation's work force, such as greater worker mobility, the growth of small business, and self-employment, which make tying health benefits to employment increasingly unsatisfactory. The fact that workers would be able to carry their insurance with them when they changed jobs should be especially attractive.

Unions. Unions have little to fear from the proposed reforms. In the past, unions have sought increased tax-free benefits as an attractive alternative to higher taxable cash wages. The reforms proposed here simply would remove health benefits from this equation by shifting tax relief to individual workers. Unions would lose none of their present leverage in demanding wage increases or other nonhealth benefits. In addition, requiring employers to pay workers the value of their present health benefits in cash after the transition would mean no reduction in real wages for union members. Furthermore, because unionized workers now have some of the richest health benefit plans in the country, they would see the greatest increase in their cash wages under the proposed reforms.

Businesses. Businesses would benefit by being freed from the considerable cost of providing and administering large-scale employee health plans. Even though businesses would be required to compensate their workers in cash for existing health benefits, they would be able to reduce considerably the accounting and paperwork costs involved in processing payrolls and managing benefit plans.

The Poor and Elderly. Reducing medical inflation would relieve much of the inflationary pressure on government programs for the poor and elderly, and at the same time, improve services. The restructuring of Medicare proposed in *Chapter 4* would mean that the more affluent elderly would have to pay a greater share of their own routine medical costs. But in return for this, the elderly generally would receive much better protection against catastrophic medical costs, and middle - and upper-class retirees would be relieved of the present, onerous burden of taxes and premiums. Furthermore, the combination of vouchers, lower taxes on insurance company reserve funds, and the exemption of medical expenses from the dependent support test could make long-term care insurance attractive to insurance companies and affordable for Americans. For the poor and the elderly, state experiments and Medicare vouchers would provide greater choice in obtaining medical care, reversing the current incentives for providers to lower their costs by reducing the quality of care. State risk pools and supplemental vouchers for low-income Americans would better target government assistance to those who most need help – the financially and medically needy.

Converting most government programs to vouchers would get the government out of the business of providing health insurance directly. Government is poorly equipped to act as an insurance company for two reasons. First, the premiums it sets inevitably reflect political more than actuarial considerations. Second, government lacks the necessary incentives to control payment costs and can do so only with a stultifying application of bureaucratic controls.

Insurance Companies. Although recalculating policies to accommodate the shift from employer group policies to individual and family policies initially would impose a major burden on insurance companies, health care reform would benefit insurers in several ways. First, converting current government health programs to vouchers would greatly expand the health insurance market. Second, the new system would remove many of the current incentives for legislatures to mandate coverage for specific providers and services. Third, insurers would have considerable flexibility in writing policies and increased incentives to be competitive and innovative. In particular, the elimination of many small claims and of the need to impose elaborate and expensive cost control systems on providers would help make health insurance a more profitable line of business.

Health Care Providers. Health care reform would stimulate greater competition among health care providers, such as hospitals and doctors, while at the same time allowing them greater flexibility in responding to innovations in medical technology. While some providers might view increased competition unfavorably, they would benefit by being freed from the massive regulatory oversight and paperwork burdens now imposed by Medicare, Medicaid and private insurance companies.

CONCLUSION

Americans are told by many policy makers that they need some kind of nationalized health system on the European or Canadian model. Yet those who advocate such an approach seem to do so not out of any conviction that a nationalized system is inherently desirable but out of a sense of resignation, believing that it is the only alternative to the existing dismal situation. Most of these advocates are well aware of the serious shortcomings and failures of national health systems. Nonetheless, they see such systems as at least rational and equitable alternatives to the growing problems in American health care.

These policy makers are correct to call for drastic action, but their nationalized health prescription will not cure the ailing system. They err in assuming that a nationalized system is the only alternative. For it is possible to create an affordable, high quality system through reforms that enhance competition and consumer choice and, assure access to a more efficient health care market for all Americans. It is also possible to make such reforms politically appealing.

The proposals described in these pages surely do not contain all the solutions to America's health care problems. But they do provide a workable framework for creating a comprehensive health care system that will serve all Americans.

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CRITICAL ISSUES

A National Health System for America

Many Americans understandably feel there is something fundamentally wrong when, in a country as rich as the U.S., there are millions of citizens who lack access to affordable health care. With U.S. spending on health, as a proportion of gross national product, exceeding that of virtually every other country, most Americans also are understandably frustrated that Congress seems unable to design policies to steer those health care dollars into a satisfactory system. Because of its fundamental flaws, however, the existing health care system cannot be reformed without structural changes.

In this study, Heritage Foundation health policy experts offer a strategy to make adequate health care available at acceptable cost to every American. It would use strong market incentives to give the widest possible degree of choice and the best possible value per dollar for both patients and taxpayers. The key element is to address the core defects of the current system by turning today's quasi-market health care system into a true market system. It would include a major revision of the tax treatment of health care costs that removes the current perverse incentives for patients and providers. Included too is a compact between government and citizens: a commitment by goverment to provide aid to any family genuinely unable to afford adequate health care; a legal obligation on all families to obtain a minimum level of protection against health care costs.

As this study makes clear, only a far-reaching set of market-based reforms, accompanied by a strong campaign to explain the reforms to the American people, will cure the ills of America's health care system. With such reforms in place, the U.S. can create a system that will be the model for the entire industrialized world.

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