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THE WHITE HOUSE

WASHINGTON

EXECUTIVE SUMMARY

OF THE REPORT

OF THE

WHITE HOUSE WORKING GROUP ON HEALTH POLICY AND ECONOMICS

Working Group Findings

America's health care system is the finest in the world. Further improvements should build upon the fundamental strengths of this system, such as leaving the provision and financing of most health care services to the private sector.

However, this system is also extremely expensive, and costs continue to rise rapidly.

A primary reason for the high rate of growth in health care spending is that government has failed to apply the principles of competition to this marketplace. For example:

- Government health care financing programs have been structured so that neither consumer nor provider has strong incentive for making cost-efficient decisions;
- Tax policy has given a preference for health benefits over wages, increasing the level of insurance coverage and the demand for health services; and
- Government regulation has been counterproductive and has prevented competition from restraining health care costs.

Appropriate federal government action can lead to a more efficient health care system. Such a system would rely on market forces to produce the amount of services that consumers desire to buy, at the right quality and at minimum cost.

In a time of overall budget restraint, health care spending also needs to be restrained. Therefore, any new programs should be fully financed and should not increase the budget deficit.

General Policy Recommendations:

Medicare Demonstrations: The current prospective payment system should be viewed as a transition from cost-reimbursement to a more comprehensive payment system based on competitive principles. The Administration should seek opportunities to test alternatives to the Prospective Payment System.

Medicare Catastrophic Coverage: Improvement of Medicare through addition of better catastrophic coverage should be considered carefully because of the President's long-standing commitment to catastrophic illness protection. Catastrophic coverage is basic to the idea of insurance in general. However, in light of the funding problems facing Medicare, catastrophic coverage should be evaluated much more completly, especially because of the new incentives toward shorter hospital stays under the Prospective Payment System. If it is to be added, it should be fully financed.

Medicare Payment for Capital: The current cost-reimbursement system for capital, which Medicare adopted from the private sector, no longer makes sense, especially with general excess hospital bed capacity. Capital payment should be appropriately merged with the basic payment system as soon as possible. This should be done with an understanding of the distributional effects across hospitals of the option chosen.

Medicare Payment for Medical Education: The rapidly growing numbers of physicians will shortly lead to an excess, if such is not already the case. With Medicare heading for insolvency, it is questionable whether this program should pay for educating people for careers that are financially lucrative.

Medicare Physician Payment: The Medicare system of physician payment based on usual, customary and reasonable charges no longer is appropriate. A new payment methodology needs to be devised, to become effective, if possible, after the current fee freeze expires. Consideration should be given to testing changes in physician payment through demonstrations.

Medicare Beneficiary Payment: Medicare beneficiary payment should be increased as a part of an effort to improve the solvency of the program and to constrain the use of additional services of low value to the beneficiary. Ways of selectively increasing payment by higher income beneficiaries should be examined carefully.

Uncompensated Hospital Care Costs: With growing health sector competition, especially price competition, attention is increasingly focused on uncompensated care. Congress is likely to debate the idea of an enlarged federal role in dealing with this issue.

There is already major federal financing of health care for the poor and near-poor. In a time of high budget deficits, it is difficult to consider any new program which is not fully financed. Uncompensated care is a component of a much larger issue over federal/state/local responsibilities. Because of its potential size as a fiscal problem, this issue may be the dominant federal-state issue in the coming years.

Much more study of uncompensated care in a rapidly evolving health care system is needed, to determine the dimensions of the problem, possible solutions and the level of government which should deal with it.

Medicare Hospital Insurance Trust Fund: Projections of income to and outgo from the Medicare HI Trust Fund have predicted insolvency in the next decade, followed by truly major deficits thereafter. This long-term financing problem is the major issue facing Medicare.

However, over the past months the short-term picture has brightened considerably. Trust Fund income has risen because of the improvement in the economy and additional payroll taxes. Trust Fund outgo has been below projections, due in part to the Prospective Payment System.

Therefore, decisions on steps to increase HI trust fund revenue or to change the retirement age could be delayed in order to assess better these developments. This delay should not be for more than a year or two, as the most effective changes to the system are best made gradually and may require substantial lead time. Also, the delay should not be taken as ignoring the long-term financing problem, but rather analyzing how to deal with it.

Medicaid: With very high federal budget deficits, federal Medicaid spending must be constrained, along with all other budget items. The rate of growth in Medicaid was lower after the OBRA changes, which gave the States additional incentives to control Medicaid. Federal policy should give States the incentives to control costs and the tools to achieve savings.

Long Term Care: Much more study needs to be done of long-term care, particularly as a part of larger issues: the aging of our society and the low savings rate in this country. The federal government already funds long-term care in a major way, through Medicaid and other programs. With high budget deficits and with Medicare facing insolvency, the federal government should be careful to avoid committing additional funding to long-term care, especially through the Medicare program.

Veterans Health Care: The nation has an obligation to recognize and compensate those Americans who sacrifice in military service to their country, especially when that sacrifice results in disability. The primary Federal role in veterans health care is to ensure medical care for disabilities incurred during military service, while being sensitive to needs of other veterans, who are poor, ill and without medical care alternatives. These obligations should be met within financially responsible limits, determined appropriately by the Congress and the President.

Department of Defense Health Programs: The cost of DOD health programs should be controlled because of the need for overall budget restraint in the face of high deficits. Before legislation is transmitted to the Congress, the interactions of these programs with the civilian health care system should be carefully evaluated to ensure that DOD initiatives are consistent with overall Administration health policy.

Tax Policy and Private Health Insurance: The current preference given to health benefits over wages should be altered, as a move to add greater cost-consciousness to private health insurance markets. This should help restrain overall health spending.

Such action should be taken in the context of deliberation over tax reform.

Health Care Technology: Federal government policy should foster the development and implementation of new health care technology. In general, this should be accomplished by removing unnecessary barriers, with appropriate continued regard for public health and safety.

Prevention: Prevention of disease and disability often is more cost-effective than treatment. Therefore, prevention efforts appropriate to the federal government should be given priority.

The production and dissemination of information regarding prevention is an appropriate federal role. Direct federal provision or financing of personal preventive medical care is less clearly a Federal role, and should be analyzed carefully. Any such direct services should be fully financed and should not increase the budget deficit.

July 10, 1985

THE WHITE HOUSE

WASHINGTON

February 22, 1985

MEMORANDUM FOR EDWIN MEESE III

FROM: The White House Working Group on Health Policy and Economics

SUBJECT: Report of the Working Group

Over the past nine months, this Working Group has examined in detail a range of issues in health policy and economics. This report presents our findings to date and our policy recommendations.

Background

Based on your April 19, 1984 memorandum to him on "Forward Planning on Health Policy and Economics," John A. Svahn requested that the Secretaries of the Treasury, Defense, and Health and Human Services, the Director of the Office of Management and Budget, the Chairman of the Council of Economic Advisers, the Administrator of Veterans Affairs and the Director of the Office of Science and Technology Policy name representatives to a White House Working Group on Health Policy and Economics.

The Working Group's primary objective has been to examine possible long-term structural reforms in federal programs that will ensure quality and availability of health care services at a minimum cost to the taxpayer.

We have been meeting during the preparation of the President's FY 1986 Budget, and members of the Working Group have been directly involved in the budget process. The Working Group itself, however, has focused on policy reforms beyond the Budget.

Activities

The Working Group has met 25 times. The following topics have been examined; some have been the subject of several sessions:

- Health care spending, public and private
- The Medicare program
- The Medicaid program
- Private sector health cost control activities
- Tax Policy and health spending
- Health care for veterans
- Capital and the health care system
- Catastrophic illness protection
- Long term care
- Health care technology
- Prevention
- Physician payment
- Department of Defense health activities

Report Structure

This interim report includes our findings, a historical overview, information on trends in the health sector, a summary of proposals in the FY 1986 Budget and future decisions facing the Administration. Also, we include a series of general policy recommendations which are unanimously supported by members of the Working Group.

The next steps are to refine those options outlined in this interim report which are considered most promising. The report also contains several specific recommendations on issues where the Administration must act in the near future.

William L. Roper

WILLIAM L. ROPER
Chairman

REPORT OF THE
WHITE HOUSE WORKING GROUP
ON HEALTH POLICY AND ECONOMICS

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FINDINGS

- America's health care system is the finest in the world. Further improvements should build upon the fundamental strengths of this system, such as leaving the provision and financing of most health care services to the private sector.

- However, this system is also extremely expensive, and costs continue to rise rapidly.

- A primary reason for the high rate of growth in health care spending is that government has failed to apply the principles of competition to this marketplace. For example,

  --Government health care financing programs have been structured so that neither consumer nor provider has strong incentive for making cost-efficient decisions;

  --Tax policy has given a preference for health benefits over wages, increasing the level of insurance coverage and the demand for health services; and

  --Government regulation has been counterproductive and has prevented competition from restraining health care costs.

- Appropriate federal government action can lead to a more efficient health care system. Such a system would rely on market forces to produce the amount of services that consumers desire to buy, at the right quality and at minimum cost.

- In a time of overall budget restraint, health care spending also needs to be restrained. Therefore, any new programs should be fully financed and should not increase the budget deficit.

HISTORICAL OVERVIEW

For more than a decade, the dominant health policy issue in America has been the cost of health care. The following is a discussion of how the nation and the Federal government came to spend so much in health care and of the consequences of this development.

Before Medicare and Medicaid

The American people have been concerned about the high cost of health care for a long time. In 1927, a blue ribbon panel, the Committee on the Costs of Medical Care was formed. The problem of cost was discussed in detail, without solution. But it was cost to the individual that was of concern. Cost to government or to society was not the central focus of the body.

The concern for a means for individuals to afford health care led to the establishment of the Blue Cross and Blue Shield plans in the 1930's. Plans soon spread nationwide. They were set up by hospitals to provide for the payment of their bills. In return for guaranteeing that a significant portion of the accounts receivable of a hospital would be paid, the plan was given a discount, typically of about 15 percent. Since the plan was set up by the hospitals, a central feature of the plan was "freedom of choice." This meant that an individual participant in a Blue Cross plan would have his bills paid at any hospital, without regard to price.

An often overlooked reason that hospitals and physicians promoted the development of Blue Cross and Blue Shield plans was to avoid the threat of competition from prepaid group health plans, later to be known as health maintenance organizations. The Blue Cross/Blue Shield plans were established according to principles and standards set by the American Medical Association and American Hospital Association. Those standards have profoundly shaped what public and private health insurance would and would not be ever since. One of the 1933 Blue Cross principles was that competition should be avoided, with plans including all hospitals in a community. Before the Blues were established, prepaid group plans were the dominant type of health plan. It would not be until decades later that they would again begin to challenge Blue Cross nationwide.

In fact, this principle of freedom of choice was so important to the plans that almost all states passed laws at the request of Blue Cross, prohibiting a health insurance company from negotiating with specific providers for lower charges and then directing patients to these providers. Thus a feature that was desirable to Blue Cross became mandatory for the entire industry in many states. Later, when Medicare and Medicaid were established, this same direct avoidance of price competition was further institutionalized.

Therefore the form of health insurance which has predominated in America has not been the natural result of economic forces, but rather the result of political and anti-competition activity.

A federally operated health insurance program covering the entire nation was considered by the Roosevelt Administration, but was never proposed to Congress. Such a system was endorsed by President Truman in 1945, bringing the mobilization of forces that were later to battle over the more limited Medicare program.

The vigorous and bitter lobbying campaign over Truman's 1949 proposal resulted in no action on the Administration's plan. Debate over the issue subsided for a time, and Eisenhower opposed a national plan.

In 1957, Congress first considered a bill that covered hospital and surgical costs of the aged under the Social Security retirement system. This marked the start of the campaign that led to the enactment of Medicare in 1965.

Enactment of Medicare and Medicaid

President Johnson's proposal was for hospital coverage for the elderly. Doctors' coverage was not included in an attempt to weaken the American Medical Association's charge that the bill would lead to socialized medicine.

The AMA pointed out that the bill did not provide for coverage of physicians' fees, and they offered a counter proposal "Eldercare," which called for voluntary comprehensive medical insurance for the aged. This proposal was introduced by Republicans, and it apparently prompted the supplementary plan added to the Administration's bill. This voluntary plan was called Part B of Medicare.

After extensive debate, the bill passed and was signed by President Johnson. Several months later the AMA decided not to sponsor an organized boycott of the Medicare program.

Medicaid, the second Federal health plan was enacted at the same time. Since 1950, the federal government had provided funding for medical vendor payments for persons on public assistance. In 1960, Congress established a program for aid to the "medically needy" aged, elderly persons not poor enough to qualify for old-age public assistance, but too poor to meet medical bills. Persons were eligible for the program only if their state chose to join and if they passed a means test. States were reimbursed by the Federal government for 50 to 80 percent of costs under the program, depending on each state's per capita income.

The 1965 act extended this program to families with dependent children, and the blind and the disabled. The maximum Federal share was established at 83 percent and the means test

was made more flexible. This expanded program was coupled with all other Federal public assistance medical programs in a new title of the Social Security Act, and called Medicaid.

The 1965 law, which included Medicare, Medicaid, a 7 percent across-the-board increase in Social Security benefits, and several other features, was estimated to have a first full year (1967) cost of $6.5 billion.

Implementation of Medicare and Medicaid

As noted above, great controversy surrounded the passage of Medicare. In order to minimize the very significant opposition to the proposal, the program was framed so that the principles of fee-for-service payment to physicians and freedom-of-choice of providers for beneficiaries were preserved. This had the effect of perpetuating the Blue Cross type of payment system, including cost-reimbursement of hospitals. Physician payment was based on a methodology borrowed from Blue Shield plans: "Usual, Customary and Reasonable." It allowed physicians as a group to determine their own payment levels.

In fact, administration of the payments process was contracted out to Blue Cross Association and commercial insurors nationwide. Although not as uniform, most states chose to administer their Medicaid programs in the same manner.

Continued emphasis on access

In the late 1960's, there was general discussion about the idea of extending the Medicare and Medicaid programs to produce a complete National Health Insurance (NHI) system for the nation. The overriding concern of most policy makers was assuring access to quality health care for all Americans. The proponents and opponents of NHI were essentially the same players as in the Medicare debate. The AMA again offered a more limited, voluntary NHI proposal, as it had for Medicare.

Early cost control efforts

In 1967 Congress established income standards for the States' medically needy programs under Medicaid, which eliminated State flexibility under the 1965 law to set them at any level. In 1968 the Senate held hearings on medical costs and the organization of medical care, and in 1969 on the costs of Medicare and Medicaid. Congress passed legislation that year allowing the States to cut back on their Medicaid programs to control costs, by providing fewer services than specified by the 1965 law.

Together with continued discussions on expansion of access to health care via national health insurance, steps were taken in the early 1970's to control health costs. As a part of the Economic Stabilization Program, President Nixon imposed wage-price constraints. The government controls did slow the growth

of health care costs, but after the controls were lifted in 1974, there was a new spurt of health cost inflation.

In 1972, Congress enacted specific regulatory controls on hospital costs under Medicare and Medicaid, including utilization review through the Professional Standards Review Organizations, review of proposals for new hospital beds and limits on hospital prices.

As concern over health costs grew, almost all proposals to deal with the problem were regulatory in nature. The one exception was the Nixon Administration's 1972 proposal to encourage the formation of Health Maintenance Organizations. Congress passed legislation that provided funding and other assistance for these prepaid group health plans. Experience with these plans, particularly by the Kaiser groups, was promising. By paying physicians salaries (not fee-for-service) and by negotiating for the best possible rates with hospitals (not freedom-of-choice), they were able to control their costs significantly.

Through the 1970's, the Federal program attempted to foster the growth of HMOs nationwide. Despite such help, HMOs were slow in growing, and continued to cover only a small fraction of the population. One factor limiting the growth of HMOs was that Medicare and Medicaid beneficiaries generally were not able to enroll in them. Also the federal HMO Act had many requirements of HMOs that diminished their marketability.

Health Planning

By 1974, the rising level of health costs was a major concern. Although national health insurance was said by President Nixon to be his highest domestic priority, the cost problem was a major obstacle. That year, the Administration supported and Congress passed the National Health Planning and Resource Development Act. It set up a nationwide system of local health planning under State and federal review. Although it was to have had a broad range of concerns, including development of new health resources, it soon was targeted at preventing the building of new hospital beds. A regulatory program, it was one of the major attempts to control costs in the 1970's.

Health providers quickly learned how to work within the system to use health planning to their ends. Health planning was not successful at slowing the rate of health cost inflation. In fact, health planning became an anti-competitive tool which was used to keep out potential competitors. Thus, it was worse than ineffective. Amendments to the law in 1979 removed some of the more anti-competitive features of health planning.

Cost as primary concern

In 1975, the Ford Administration announced that its worries over health care costs compelled it to shelve any plans for national health insurance. Whereas increasing access to health care had been the theme of the previous decade, the cost problem became the more pressing concern.

During this period, several States enacted legislation establishing state health cost control programs. Although they varied from state to state, most were located in the Northeast. They tended to treat hospitals like public utilities, with rates regulated by a state agency.

Early competition proposals

The predominant theme in the mid-1970's in health cost control was regulation: local, state, and federal. However, during this period several persons began speaking out on the idea that the health system was inherently inflationary, and that only by changing the incentives in the system could costs be brought under control.

In 1975, Martin Feldstein pointed to the link between the rapid growth in health insurance and increasing demand for services. He spoke of substantial evidence that patients demand more services and more expensive services when a large part of their costs are offset by insurance. He discussed the preference given health benefits under the tax code, and the distortion in allocation of resources that resulted.

The problem of cost-reimbursement of hospitals was highlighted in this period. Several observers proposed changing the system to some form of prospective payment for hospital services, with incentives for cost restraint.

Carter proposals

Beginning in 1977, the Carter Administration, led by HEW Secretary Joseph Califano, launched a series of efforts to control health care costs. These sought to direct the health planning effort into an even more regulatory program, with "guidelines" proposed for local planning agencies to use in the regulatory process.

The Hospital Cost Containment Act of 1977 was introduced, and a years-long debate insued. The plan singled out the nation's hospitals and specified limits on increases in total hospital revenue (9 percent the first year). The hospital industry sought to kill the Carter Administration bill. Organized labor supported the Carter proposal, as long as the wages of non-supervisory employees were exempt from control.

The hospital lobby advanced the idea that hospitals could, by collective action, control costs themselves, and it launched the Voluntary Effort campaign. The Senate passed the Carter proposal for hospital cost containment in late 1978, but it did not pass the House. In 1979, the House rejected the proposal by a 234-166 vote. It was opposed by the hospital lobby, the AMA, the Chamber of Commerce, the Business Roundtable, and the National Association of Manufacturers. The insurance industry, organized labor, and groups representing the elderly supported the bill.

Despite repeatedly mentioning national health insurance as a goal, President Carter put cost control ahead of NHI, and never got beyond the cost problem. He did submit legislation to Congress for a "National Health Plan," but attention was focused on the cost issue. The Voluntary Effort program continued; the rate of rise in costs slowed during 1979 and 1980. However, by 1981 it was no longer effective in restraining the ever-upward spiral in health costs, in the face of increasing inflation.

Pro-competition

Although the major health debate of the Carter years was over his revenue control bill, a growing number of persons were speaking out in favor of fundamental reform of the health care system, advocating competition to control costs.

Representative Al Ullman, Senator Richard Schweiker, Senator Dave Durenberger, and Representative Jim Jones all introduced bills in 1979 that took incremental steps in this direction. The Jones proposal also contained a provision that mandated cost sharing for employer-paid health plans.

The National Health Care Reform Act, introduced in 1980 by Representatives Richard Gephardt and David Stockman, carried the competitive approach even further. It proposed repeal of many health-related regulations to give competing delivery systems an environment in which to flourish. This proposal would have imposed new regulations in an attempt to structure competition.

With the defeat of the Carter hospital cost containment bill, the private sector began a dramatic surge in innovative efforts to control health costs. Since it was clear that the federal government was not going to solve this problem for them, business and industry became the engine for change in the health care system.

Another key development in the move toward a more competitive health care system in the 1970's was enforcement of the anti-trust statutes against some practices of health care providers. Several court rulings affirmed that these statutes applied to the learned professions. The Federal Trade Commission and the Department of Justice then acted to prevent physicians from impeding the development of health maintenance organizations

and other innovative ways of providing health care services and to end bans on advertising by physicians and other providers.

Reagan proposals

The election of Ronald Reagan heralded an increased effort to control health costs by stimulating competition in the marketplace. During 1981 and 1982, several pro-competition initiatives were debated within the Administration. Richard Schweiker, then Secretary of HHS, directed the development of a competition proposal. In the 1981 Omnibus Budget Reconciliation Act, federal Medicaid matching rates were reduced as incentives to the States to control Medicaid spending growth. The 1982 Tax Equity and Fisal Responsibility Act placed additional controls on hospital costs under Medicare. It also authorized enrollment of Medicare beneficiaries in HMOs and other competitive medical plans.

In early 1983, a set of proposals, the Health Incentives Reform program, were sent to Congress. The package addressed what the Administration saw as the underlying causes of excessive increases in health costs: the perverse incentives operating in the market for health services. Cost-based reimbursement, poorly structured cost-sharing and open-ended tax subsidies for health insurance were targeted for reform. Of the series of proposals, including reform of Medicare, Medicaid, and tax policy as it relates to private health insurance, only one element passed the Congress.

The Prospective Payment System was the most substantial change in Medicare hospital payment methodology since its inception. For the first time, hospitals were given an incentive for efficiency by being paid at a fixed price based on patient diagnosis. Implementation of this new system began in Fiscal Year 1984 and it is scheduled for full implementation by FY 87. This system is certainly an improvement over cost-reimbursement of hospitals, but to be truly competitive Medicare must encourage patients to use low cost providers of health services.

In 1985, the provision for Medicare beneficiaries to enroll in HMOs and other competitive medical plans has been implementated. In addition, the Administration has proposed expanding this opportunity through optional vouchers, but this proposal has not yet been passed.

Deregulation of the health industry has been an unmet goal of this Administration. For example, despite Administration proposals to eliminate the health planning program, Congress continues to fund it.

Consequences of change

As described above, the American health care system developed based on the principles of freedom of choice and cost reimbursement. When combined with very little out-of-pocket cost

sharing by patients, these factors led to reduced concern for cost-efficiency. Cross subsidies ensured that sufficient funding was available to cover the cost of uncompensated care, to pay for medical education and to develop and deliver an unending series of scientific breakthroughs.

Competition has produced cost-consciousness and lowered prices have reduced cross subsidies. Continued competition will force much more explicit consideration by society of how many resources to allocate to total health care, to health care for the indigent, to health research and development and to teaching of health professionals.

Conclusions

For decades the priority health policy issue was access, assuring that every American could avail himself of adequate quality health care services. As costs have risen rapidly and continuously, concern over those costs has grown, finally to overshadow access as a public issue. First attempts to control costs were regulatory in nature, but they have uniformly failed to restrain costs.

More recently the idea of fundamental reform, with market-place incentives in the system, has been growing. The enactment of the Administration's Propective Payment System for hospitals under Medicare was a first step toward such reform. Whether further changes will be made by government remains to be seen. Meanwhile the private sector is causing substantial evolution in the system. One consequence of these alterations is that many issues which have been ignored are now coming to the forefront in this changed system.

HEALTH TRENDS

A Series of Charts and Graphs

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Page 18	Graph 4: VA Administration Medical Care Graph 4A: VA Administration Medical Care (Constant 1972 Dollars)
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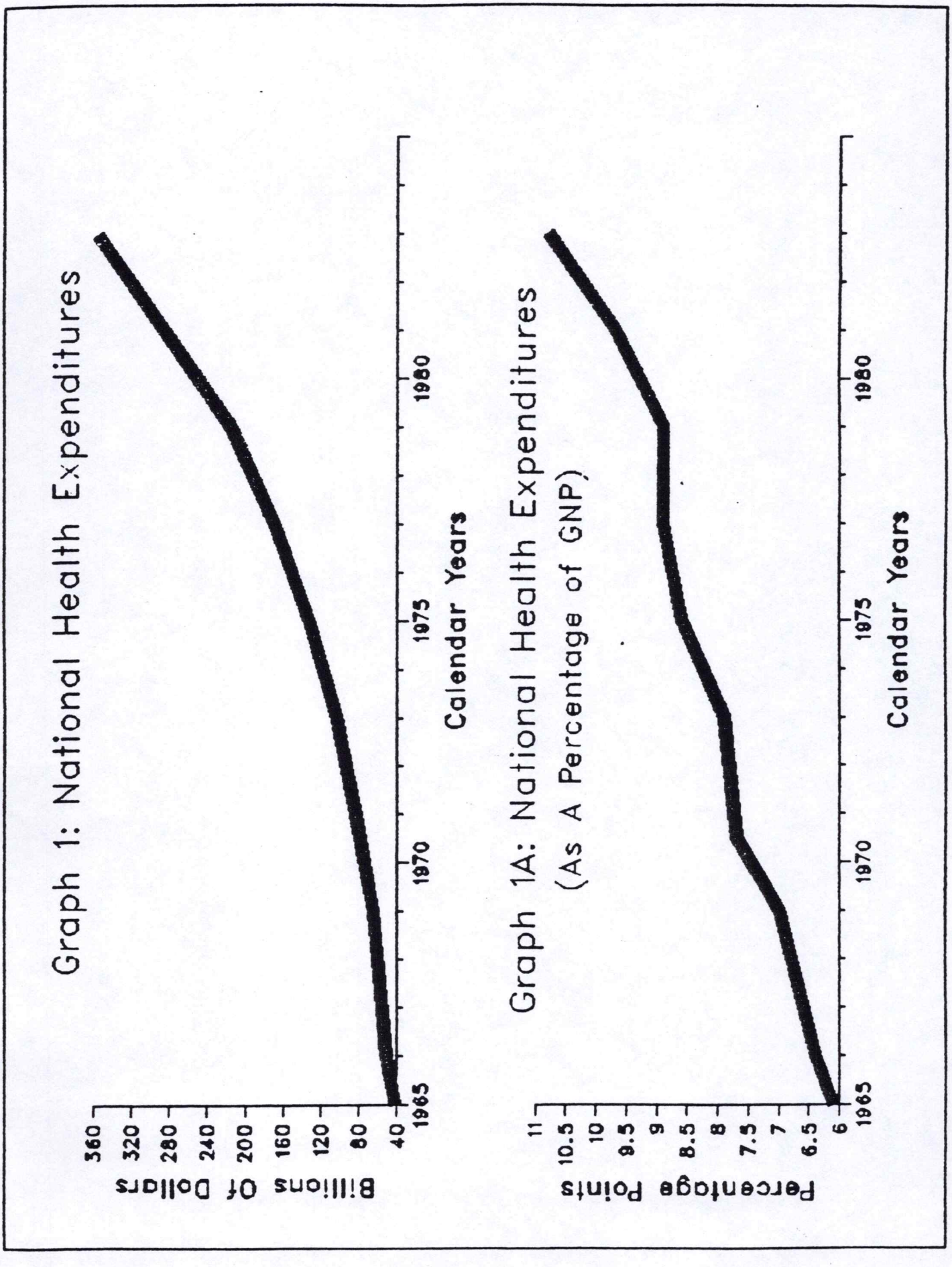
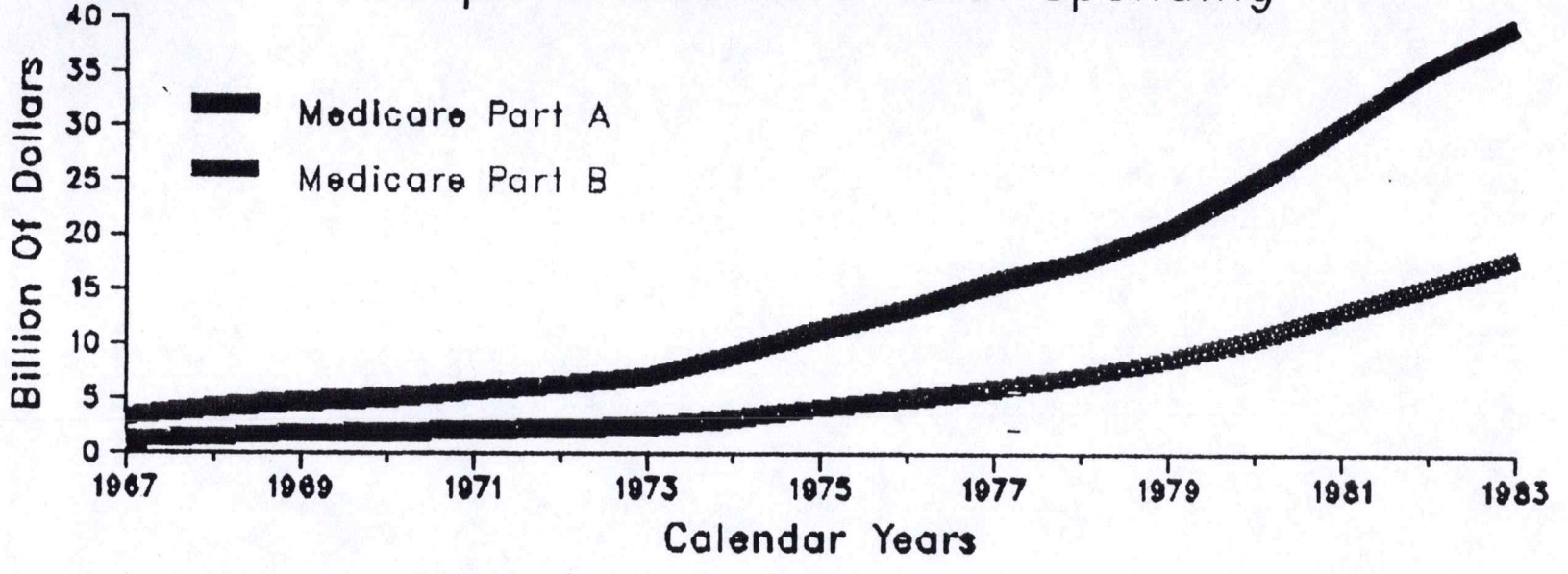
Structure of Medicare Parts A and B

	Hospital Insurance (HI) Medicare Part A	Supplementary Medical Insurance (SMI) Medicare Part B
Eligibility	Persons aged 65 or older who are eligible for OASDI or Railroad Retirement benefits; disabled persons under 65 who have been entitled to benefits for at least 24 months; and insured workers, their spouses and children with end-stage renal disease.	All persons aged 65 or older (except aliens) and all disabled persons entitled to HI are eligible to enroll in SMI.
Benefits	Pays expenses related to inpatient hospital care, skilled-nursing facilities and home health agencies.	Pays 80 percent of charges allowed for medical and related health services and supplies furnished by physicians or hospital outpatient facilities.
Financing	Employer-employee payroll tax. In 1985, combined rate will be 2.7 percent on first $38,700 in covered wages.	Premiums by enrollees, 22 percent; and general revenues, 78 percent.
Estimated Outgo		
CY 1984	$46.1 billion	$22.0 billion
FY 1985	52.0 billion	24.6 billion
Estimated Income		
CY 1984	$46.5 billion	$5.1 billion
FY 1985	51.4 billion	6.4 billion (Premiums collected from SMI enrollees.)

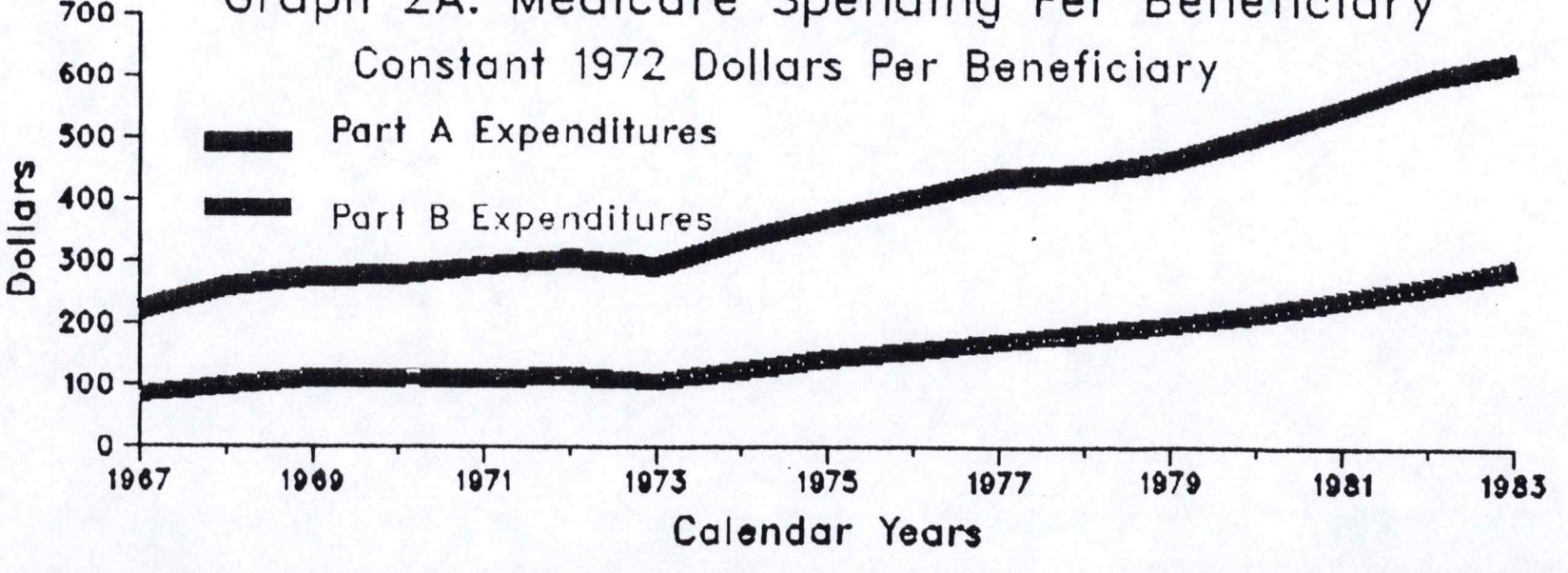

Graph 1: National Health Expenditures
Billions Of Dollars
360
320
280
240
200
160
120
80
40
1965
1970
1975
1980
Calendar Years
Graph 1A: National Health Expenditures
(As A Percentage of GNP)
Percentage Points
11
10.5
10
9.5
9
8.5
8
7.5
7
6.5
6
1965
1970
1975
1980
Calendar Years

Graph 2: Medicare Total Spending

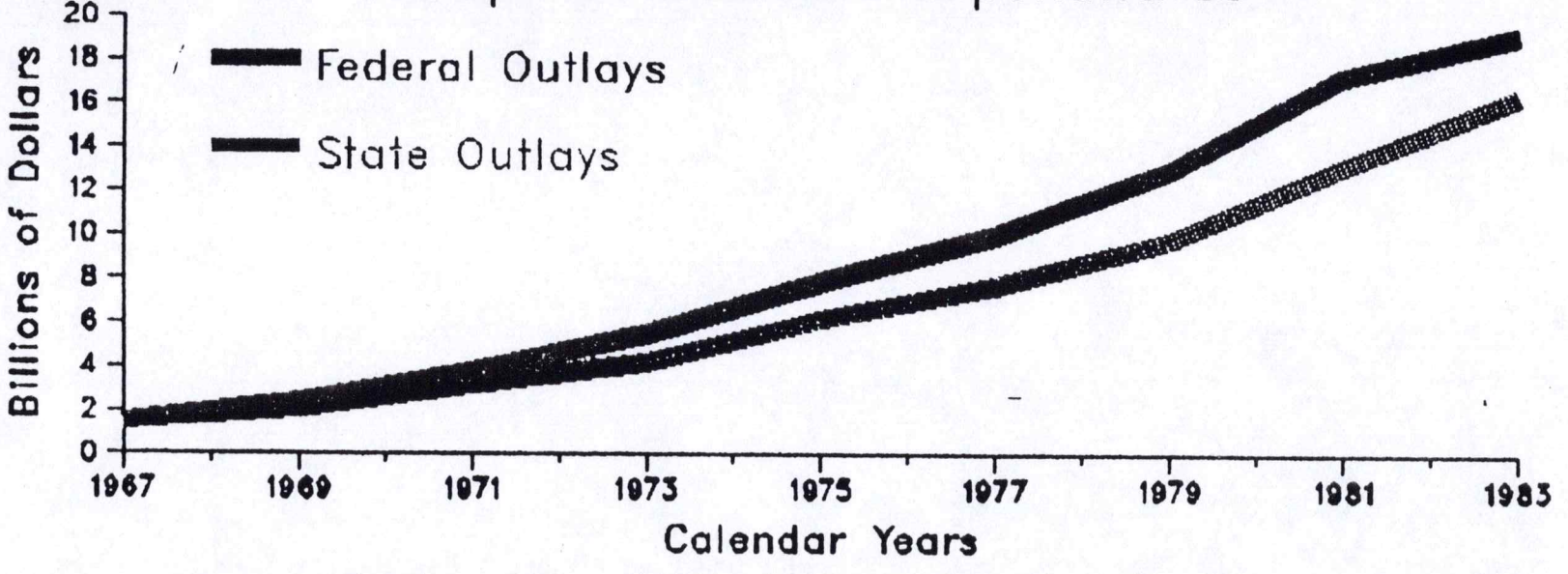


Graph 2A: Medicare Spending Per Beneficiary

Constant 1972 Dollars Per Beneficiary

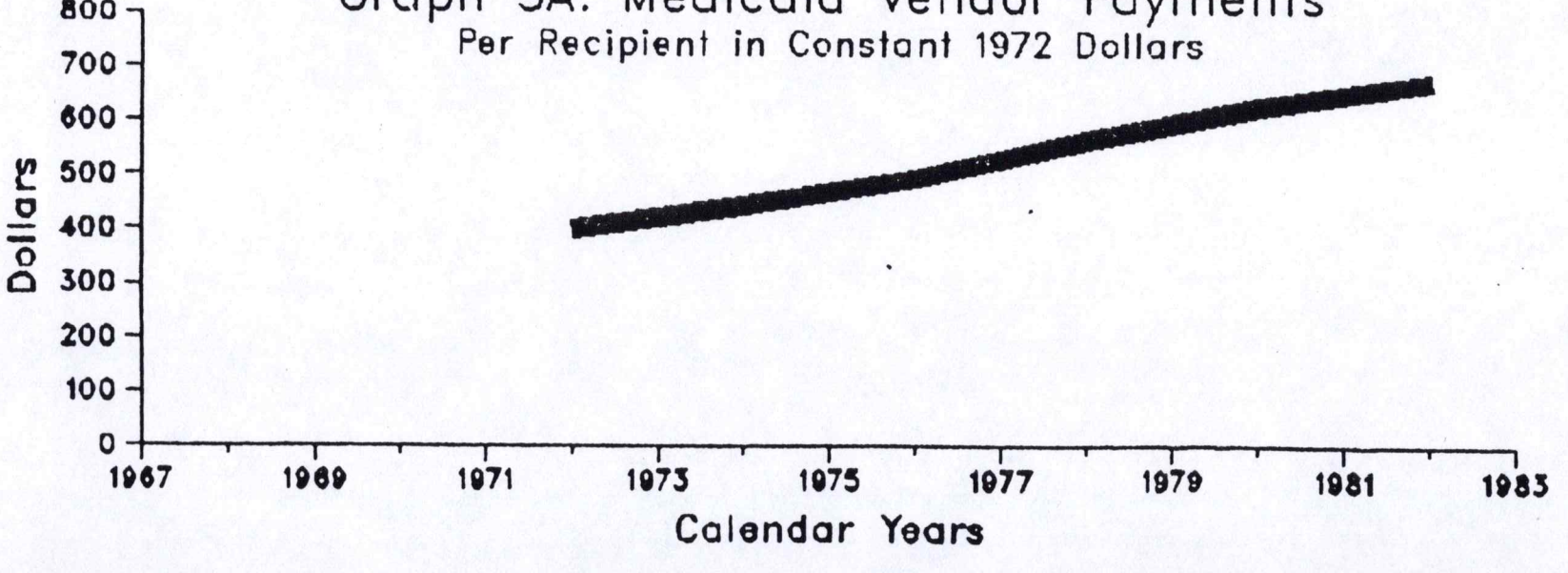


Graph 3: Medicaid Expenditures

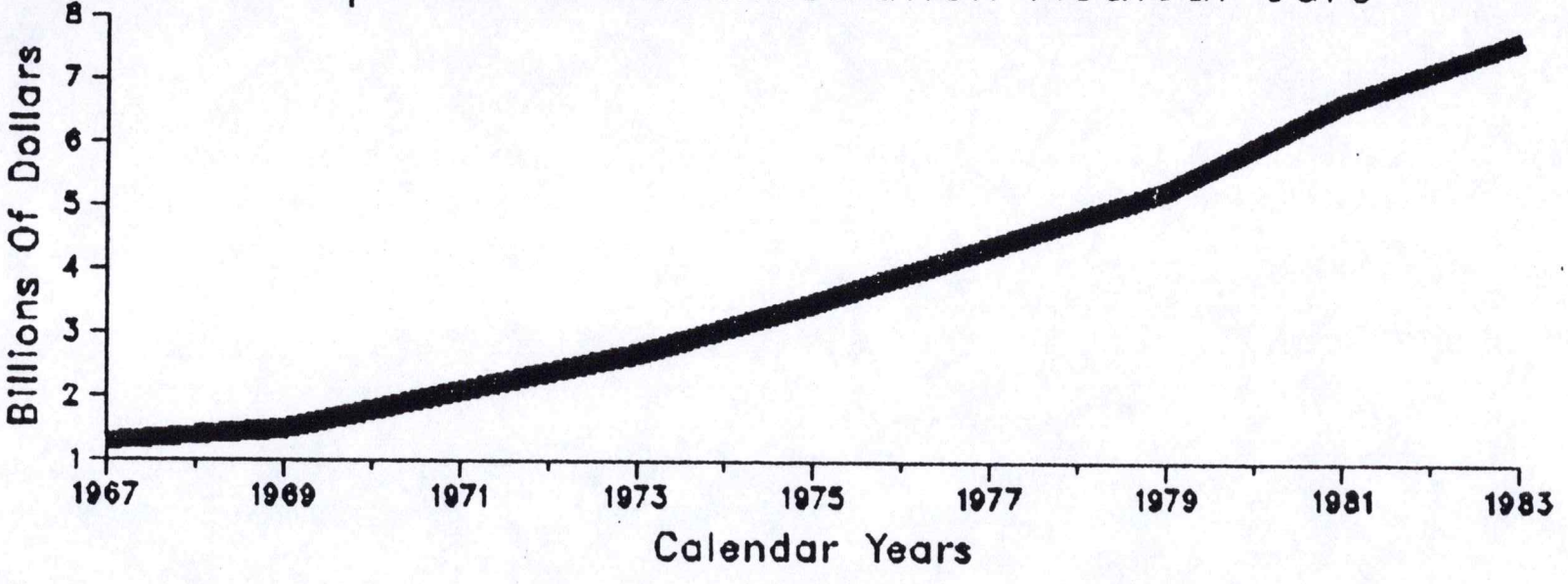


Graph 3A: Medicaid Vendor Payments

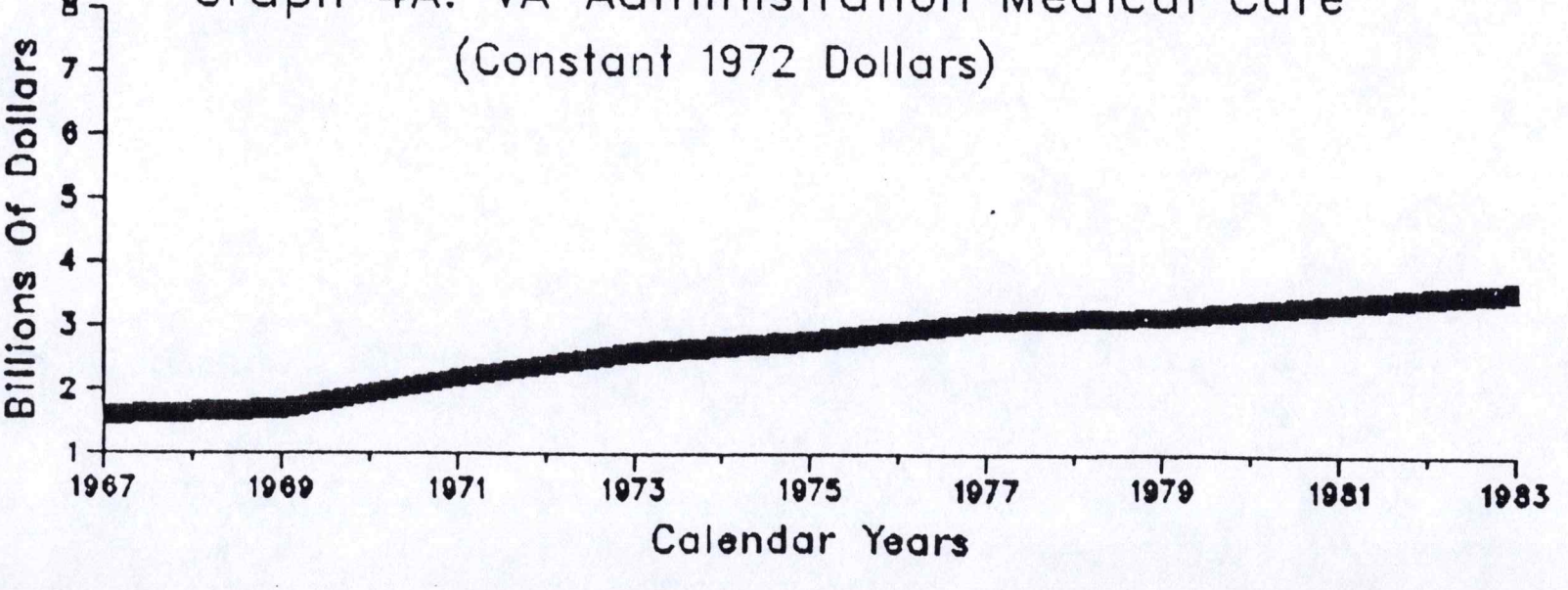
Per Recipient in Constant 1972 Dollars



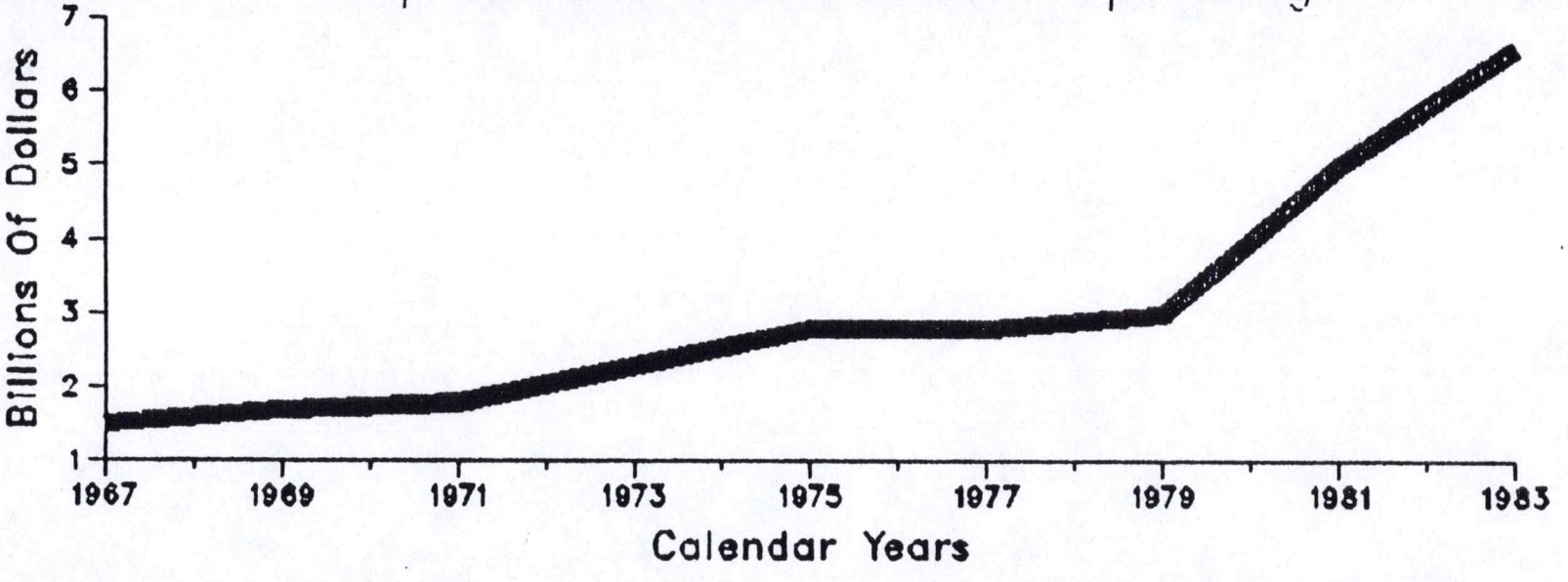
Graph 4: VA Administration Medical Care



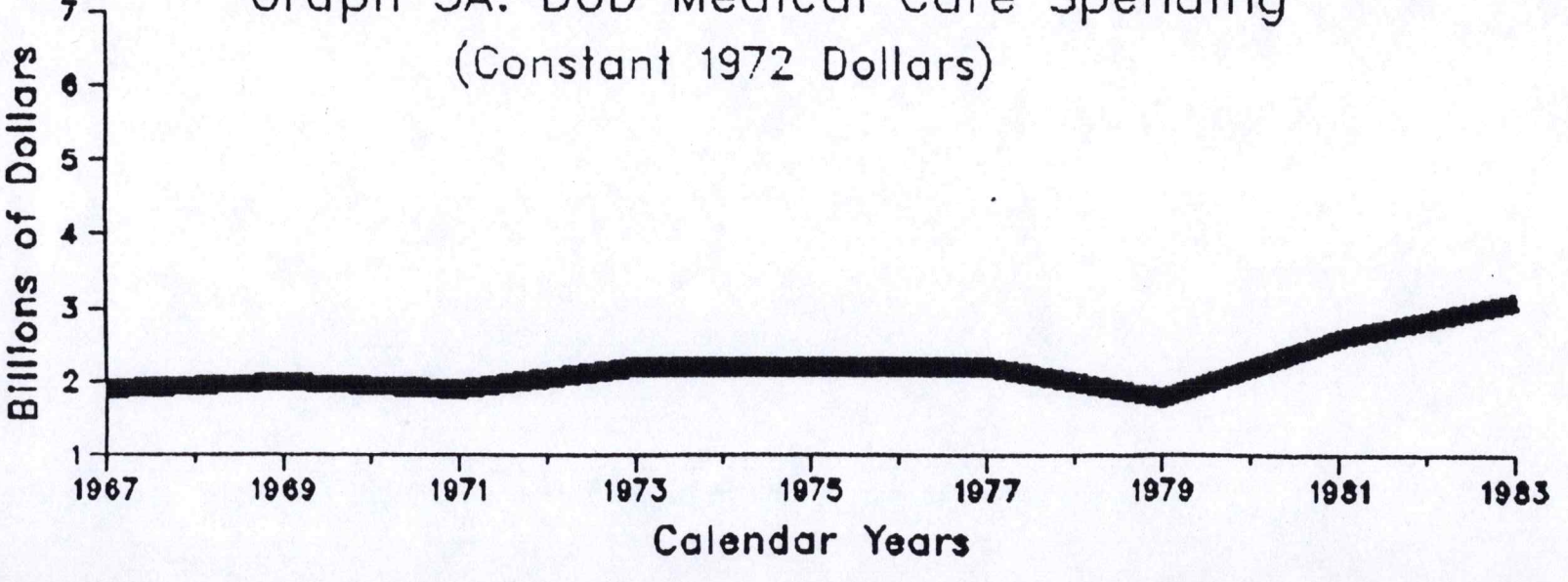
Graph 4A: VA Administration Medical Care
(Constant 1972 Dollars)



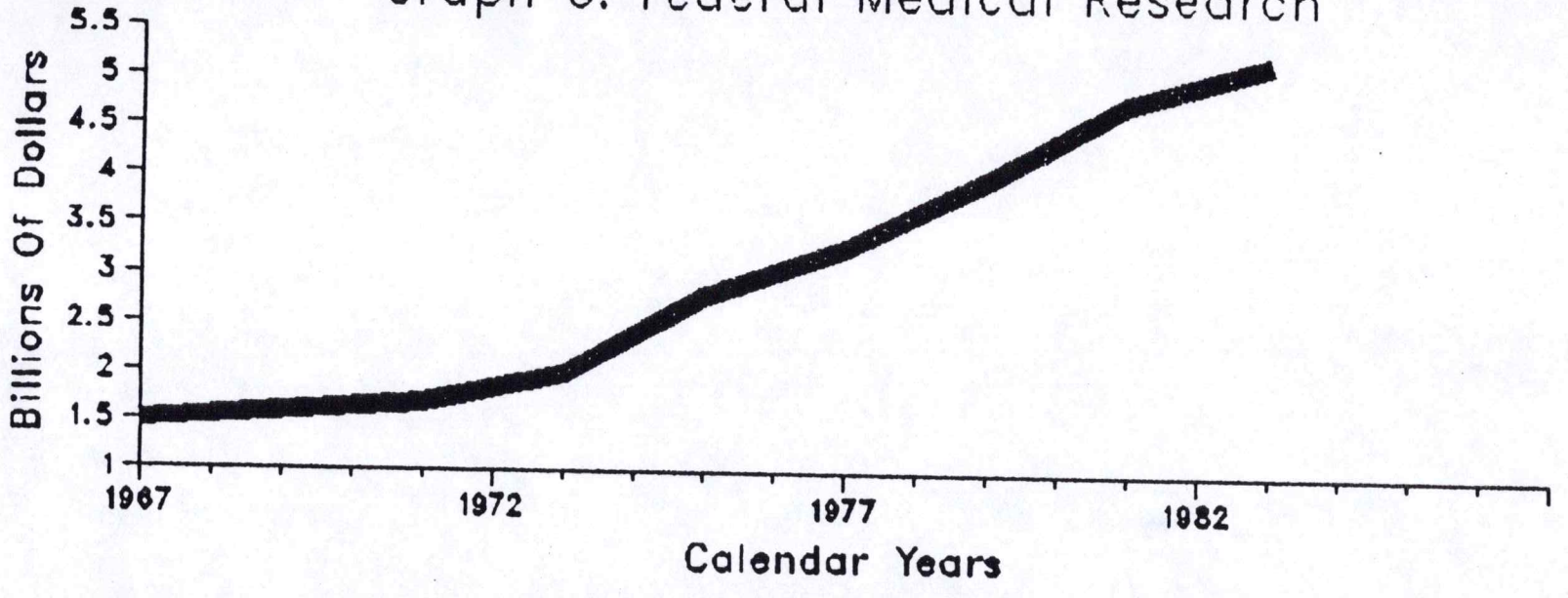
Graph 5: DoD Medical Care Spending



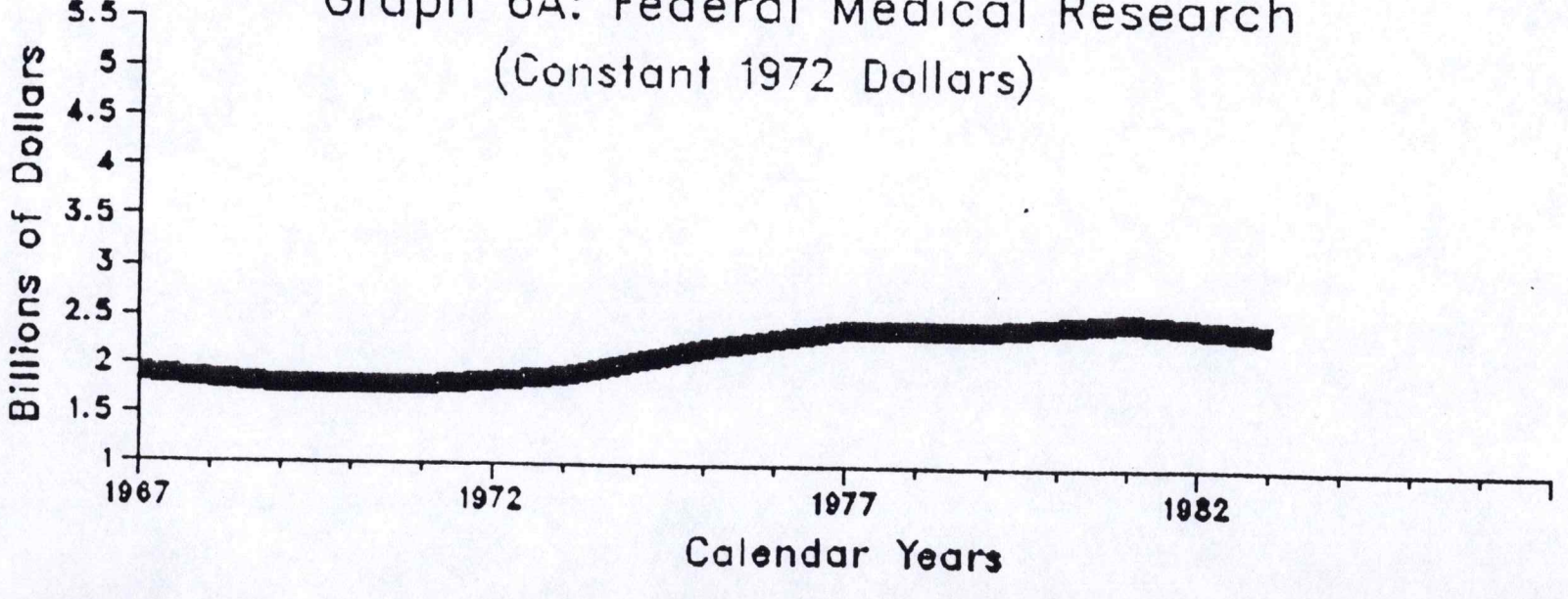
Graph 5A: DoD Medical Care Spending
(Constant 1972 Dollars)



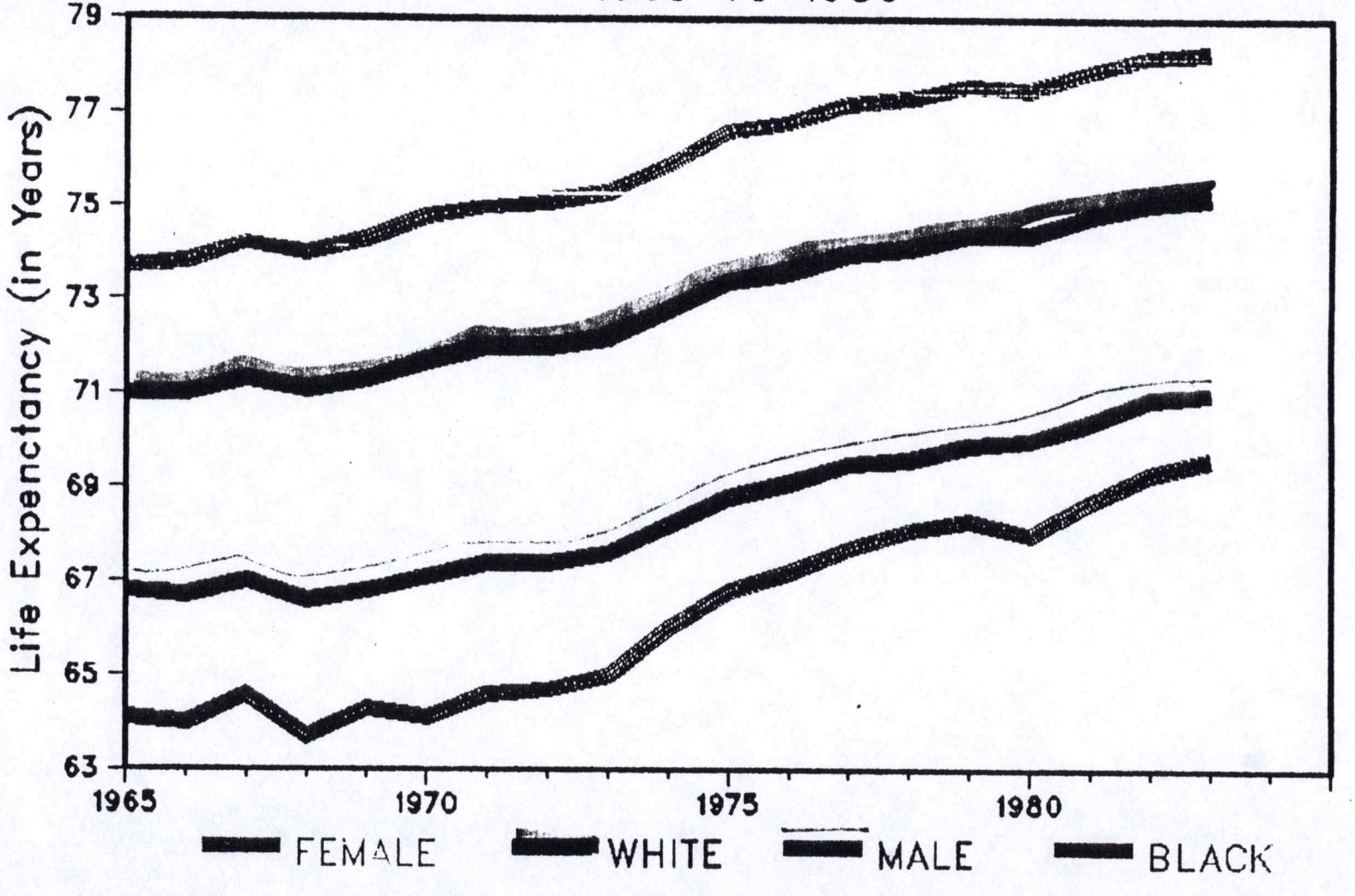
Graph 6: Federal Medical Research



Graph 6A: Federal Medical Research
(Constant 1972 Dollars)

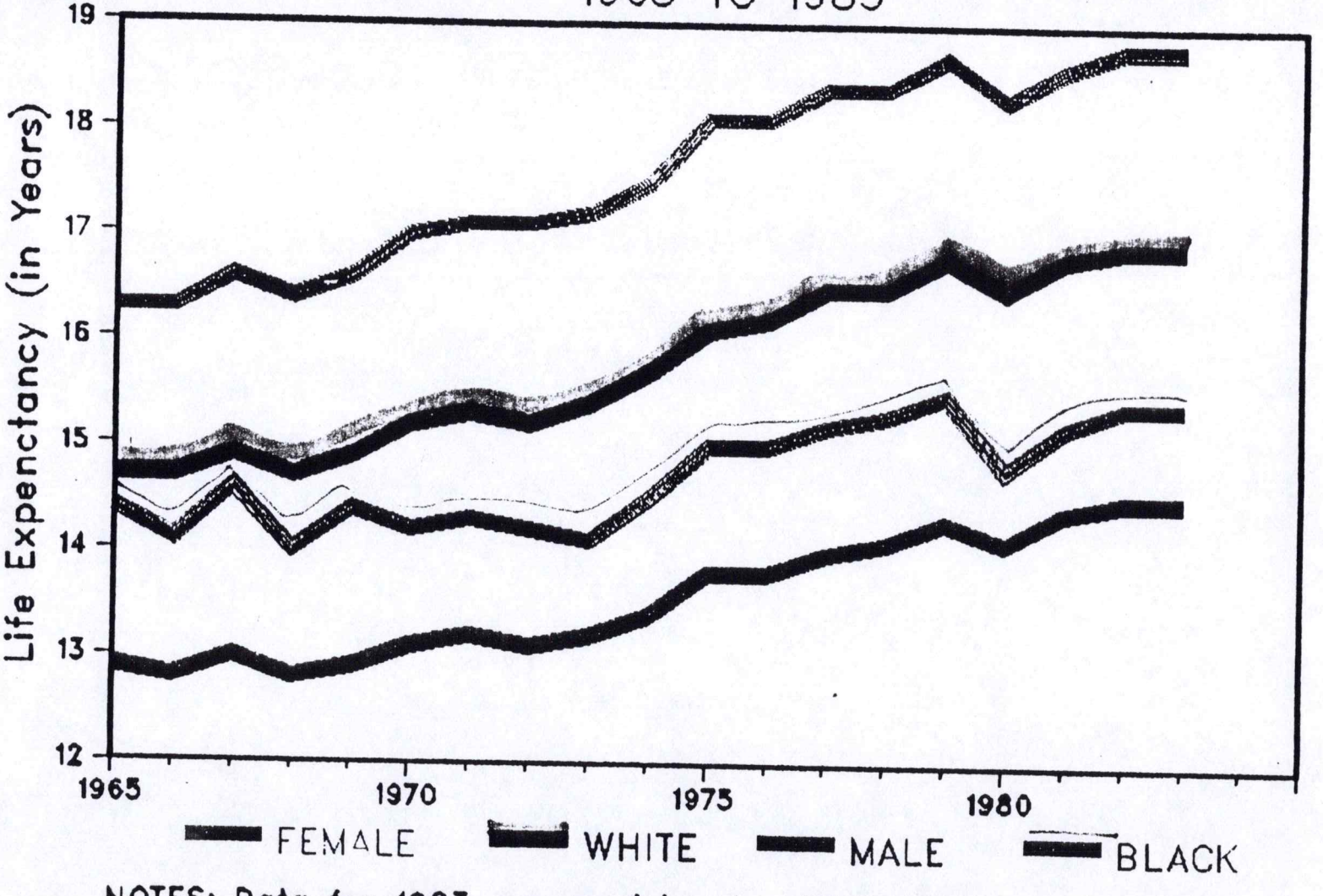


GRAPH 7: EXPECTATION OF LIFE AT BIRTH
1965 TO 1983



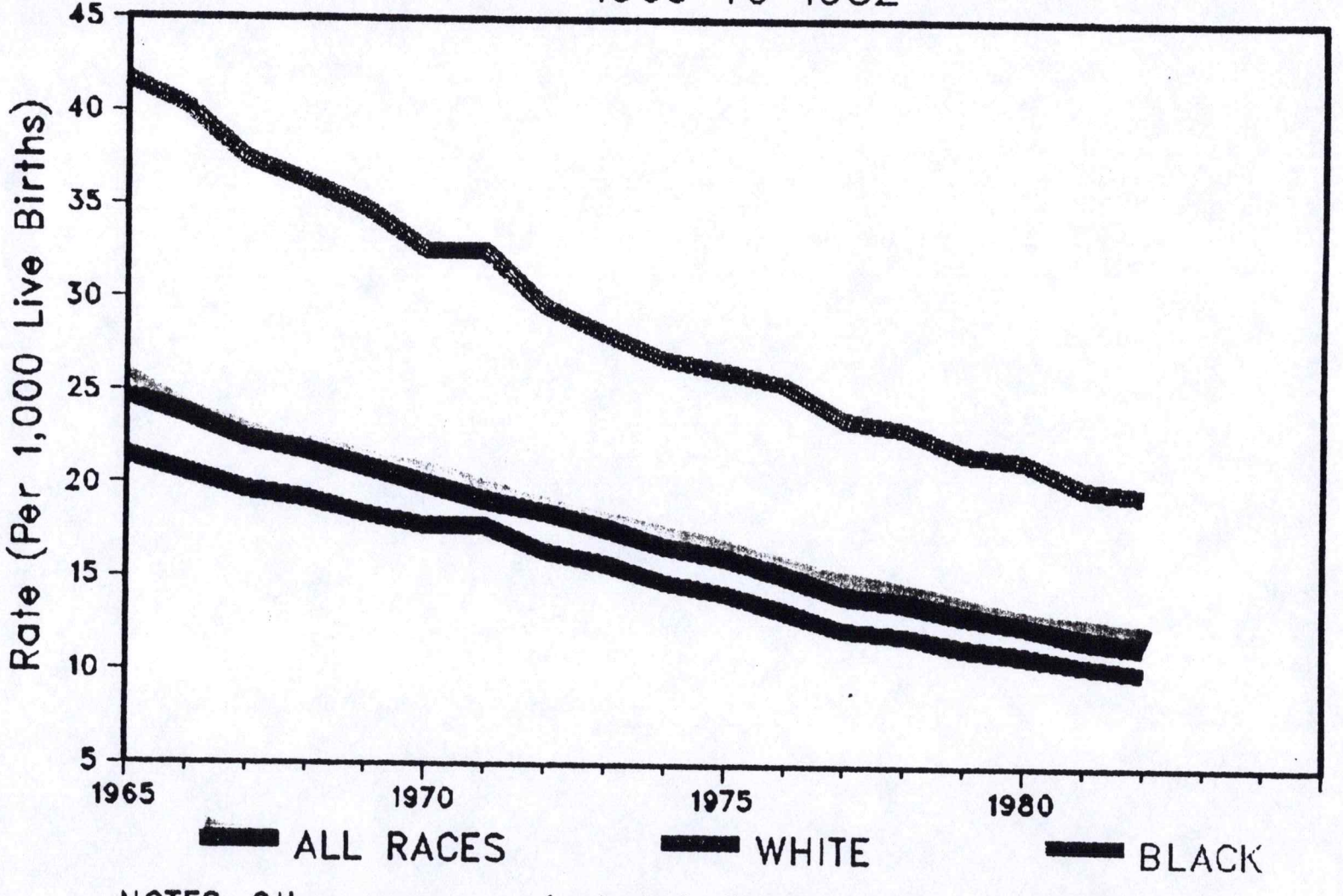
NOTES: Data for 1983 are provisional. Other races are included with Black for 1965–1969. SOURCE: National Center for Health Statistics. Monthly Vital Statistics Reports, final data.

GRAPH 8: EXPECTATION OF LIFE AT AGE 65
1965 TO 1983



NOTES: Data for 1983 are provisional. Other races are included with Black for 1965–1969. SOURCE: National Center for Health Statistics. Monthly Vital Statistics Reports, final data.

GRAPH 9: INFANT MORTALITY RATES
1965 TO 1982



NOTES: Other races are included with Black for 1965–1969.
SOURCE: National Center for Health Statistics.
Monthly Vital Statistics Reports, final data.

THE FY 1986 BUDGET AND BEYOND

The President's FY 1986 Budget contains a number of short-term health policy and economics decisions, dealing with Medicare, Medicaid, veterans medical care and other issues. Although the Working Group was focused on longer-term reform of the health care system, the budget decisions are relevant to our recommendations for the future.

The FY 1986 Budget

The President directed that a "freeze-plus" approach be used for the Budget for Fiscal Year 1986. Except for defense and social security, other items are to be frozen at the FY 1985 level or reduced or eliminated. Because health programs account for such a large share of federal spending, they figure prominently in the budget proposal.

The following are the major FY 1986 Budget proposals on items discussed by the Working Group:

- Freezing Medicare hospital prospective payment rates for one year at the FY 1985 level;
- Extending the Medicare physician fee freeze through FY 1986;
- Freezing for one year Medicare rates to other providers, such as skilled nursing facilities, home health agencies, hospices, durable medical equipment suppliers and clinical laboratories (and in some cases reforming payment systems for these providers);
- Freezing permanently Medicare direct medical education payments at the current level;
- Reducing Medicare indirect medical education payments to one-half the current law level,
- Delaying a decision on a proposal for reforming payment for capital costs under Medicare;
- Increasing the Medicare Part B premium from 25 to 35 percent of program costs for all beneficiaries by 1990;
- Indexing the Medicare Part B deductible to the Medicare Economic Index, beginning in FY 1987;
- Making Medicare the secondary payor for all working aged beneficiaries, not just those age 65-69;

- Beginning Medicare eligibility on the first of the month following the individuals 65th birthday;

- Adding a copayment for each Medicare home health visit of $4.80 in 1986 (and indexed thereafter);

- Enlarging the opportunity for Medicare beneficiaries to use voluntary vouchers to enroll in private health insurance plans;

- Reducing federal Medicaid spending by $1 billion below current law in FY 1986, and limiting increases thereafter to the increase in the medical care component of the consumer price index;

- Enhancing the flexibility of States to control Medicaid spending;

- With minor exceptions, instituting a means test for all non-service connected veterans who seek health care services at Veterans Administrations facilities; and

- Establishing reimbursement procedures for Department of Defense health programs similar to those enacted in 1983 for Medicare and allowing the federal government to seek reimbursement from private insurers for care provided to their beneficiaries in military facilities.

The Medicare changes alone produce budget savings of more than $4 billion in FY 1986, and $18.5 billion in FY 1986 through 1988.

Beyond the FY 1986 Budget

Clearly these proposals focus on short-term budget savings, not long-term health policy reform. Indeed, many are band-aids designed to allow time for more detailed policy development.

The Administration faces a series of decisions during the next months that require careful preparation if there is to be a coherent health policy for the President's second term. It is in this context that the Working Group presents our report.

The following items will require major health policy decisions:

- The report on Medicare capital payment reform, which was due to the Congress October 1, 1984;

- The report on Medicare prospective payment for skilled nursing facilities, which was due to the Congress December 31, 1984;

- The report on incorporating Medicare inpatient physician payment into the prospective payment system, due to the Congress July 1, 1985;

- Expiration of the current Medicare waivers of Massachusetts (expires September 13, 1985), New York (expires December 31, 1985) and Maryland (expires 90 days after the publication of new waiver regulations);

- Negotiations with the Congress over the specifics of the FY 1986 Budget;

- The preparation of the FY 1987 Budget; and

- The long-term funding crisis faced by Medicare.

The following options papers are designed to highlight the policy choices that will be before the Administration, and to explain the various recommendations of the Working Group on Health Policy and Economics. In addition, discussion is included of some other major issues that will be prominent in the health policy debate over the next four years.

MEDICARE DEMONSTRATIONS

Issue

Recognizing that we now have a price control system with the hospital prospective payment system (PPS), should we begin large scale Medicare payment reform demonstrations to improve Medicare and make the delivery system more competitive?

Background

When Medicare was enacted in 1965, the major goal was to buy access to hospital and physicians for beneficiaries. Retrospective cost-reimbursement was used for hospitals and the system of customary and prevailing charges based on actual physician billings was adopted for physicians. Between 1967 and 1983, total Medicare spending per beneficiary increased at rates of more than 14 percent per year. Between 1979 and 1982, Medicare physician spending increased at rates of more than 20 percent each year.

Since hospitals represent 64 percent of Medicare, the rapid growth in spending led to a number of efforts to constrain Medicare hospital reimbursements. In 1983, the hospital prospective payment system (PPS) was adopted to give hospitals incentives to render services efficiently by setting a prospective price for an entire hospital stay.

While hospital PPS is a major improvement, it does not cover spending for capital and teaching costs, and physician and hospital outpatient department services. Also, home health and skilled nursing facility services are not included. Moreover, the hospital PPS does not deal with the volume of admissions, technology or system gaming (e.g., fragmentation and readmissions). In short, the hospital PPS system does not deal with total Medicare spending for all services for all beneficiaries nor does it provide incentives for overall system efficiency.

There are several options available which could be tested as alternatives that would bring more competition, and cost-efficiency, into Medicare.

One such mechanism is capitation, i.e., paying a lump sum for all health care needs over a period of time, typically a year. Payment on a capitated basis would reverse the current incentives for more services and admissions. This could be done by contracting with a single entity, either an insuror or health care plan, on the basis of a competitive bid. This entity would then receive a capitation payment for all Medicare beneficiaries in the demonstration area and would be responsible for providing services to them.

Another alternative would be offering all beneficiaries in the demonstration area the choice of several competitive plans through the use of mandatory vouchers. Each beneficiary would have to chose one of the plans.

Preferred provider organizations, which give discounts in return for guaranteed patient volume, could be utilized in either of these two options, as the provider for all beneficiaries in a geographic area under the first option or as one of the available plans in the second option. In addition, a third alternative would use reduced beneficiary cost sharing to direct patients to preferred providers. Medicare would continue to assume all or part of the risk, but more stringent utilization review would be applied to these selected providers. This option would be an intermediate choice between full capitation and the status quo.

Yet another option would be contracting with one or more firms to contine to cover their retiring workers under their employment based plan. A capitation payment would be made on their behalf to their plan.

Another demonstration option would be structuring various Medicare benefit packages of equivalent actuarial value, but different plan design. For example, one might include more up front cost sharing but better catastrophic coverage. Offering beneficiaries a choice among the packages would give new information on just what plan design(s) beneficiaries want.

Finally, a demonstration option would be competitive bidding among providers in an area by DRG. Patients would be directed to the successful bidders based on diagnosis.

A significant problem connected with these alternatives is the allocation of beneficiaries with various risks among plans. Testing of such options on a demonstration basis would provide information on the feasibility of these alternatives for Medicare in general. In addition, further research should be done on methodologies for predicting how costs vary for Medicare enrollees.

Experience with PPS has shown that major structural reform of the Medicare payment system is best preceded by testing of the proposed new system. Demonstration projects of the magnitude and scope discussed here will require the strong support of senior level Administration officials.

General Policy Recommendations

The current prospective payment system should be viewed as a transition from cost-reimbursement to a more comprehensive payment system based on competitive principles. The Administration should seek opportunities to test alternatives to PPS.

Specific Recommendation

Because the demonstrations are critical to future Medicare policy, HHS should develop an action plan for undertaking them. The plan should be submitted for the Working Group's review not later than April 15, 1985.

MEDICARE CATASTROPHIC COVERAGE

Issue

Should the Medicare program be modified to provide better coverage for the costs of catastrophic illness?

Background

Medicare currently pays for days 2-60 in a hospital benefit period without coinsurance, after the patient pays for the first day as a deductible. Days 61-90 of a benefit period require cost sharing equal to 25% of the deductible. A patient has 60 "lifetime reserve" days which may be used at any time, but carry cost sharing equal to 50% of the deductible. Each year approximately 170,000 individuals (less than one percent of hospitalized persons) experience a spell of illness of more than sixty days and face significant hospital cost sharing. Approximately 116,000 beneficiaries have exhausted their lifetime reserve days.

Part B of Medicare pays 80 percent of the reasonable (i.e., Medicare determined) charge for covered physicians' services after an annual deductible of $75 has been met. Beneficiaries are liable for the remaining 20 percent of the reasonable charge. If the physician decides not to accept the reasonable charge as payment in full, the beneficiary must also pay the difference between the physician's actual charge and the reasonable charge. Altogether, the beneficiary's total liability for covered Part B services can be substantial.

Average health spending for an aged individual in 1984 was $4,202 of which Medicare paid 49% or $2,051. In 1977, Medicare paid only 44% of the individual's average health costs. In 1984, Medicare beneficiaries paid about 14% of income for their health care. For services covered by Medicare, the elderly pay about 29% in the form of coinsurance and deductibles. $880 (21% of the $4202) of health spending by the aged is for nursing home care. Medicaid is the primary source of public funding of nursing home services, which are frequently associated with catastrophic costs.

Analysis

Points often made about the current Medicare coinsurance structure are as follows:

- Once the Part A deductible has been met, the beneficiary does not face cost sharing until day 60. The beneficiary therefore has no incentive to reduce length of stay.

- Once sixty days of hospital benefits are used, cost sharing builds up rapidly. The sickest Medicare beneficiaries are therefore required to face the heaviest cost sharing burdens.

- Part B cost sharing is unlimited. Here again, since individuals who experience hospitalization also incur heavy Part B utilization, the sickest individuals are often asked to bear the heaviest cost sharing burdens.

There are two policy alternatives with respect to Medicare catastrophic coverage:

- Retaining current law.

  With the change to the prospective payment system for hospitals, it is not yet clear how hospitals deal with beneficiaries whose benefits are exhausted while they are in hospital. More information is needed on how current law is actually implemented under this new system with respect to catastrophic illnesses.

- Moving toward catastrophic coverage.

  In 1982, HHS proposed benefit restructuring featuring a catastrophic limit of $2,500 for both Part A and Part B covered services. In addition, there was more cost-sharing on early hospital days.

  This proposal for catastrophic coverage was dropped in favor of a proposal dealing only with Part A. It did not pass the Congress in 1983, and it was not proposed again in 1984.

  These and other options remain for catastrophic coverage under Medicare.

General Policy Recommendation

Improvement of Medicare through addition of better catastrophic coverage should be considered carefully because of the President's long-standing commitment to catastrophic illness protection. Catastrophic coverage is basic to the idea of insurance in general. However, in light of the funding problems facing Medicare, catastrophic coverage should be evaluated much more completly, especially because of the new incentives toward shorter hospital stays under PPS. If it is to be added, it should be fully financed.

Specific Recommendation

Testing of enhanced Medicare catastrophic coverage should be considered by HHS in development of the action plan for Medicare demonstrations.

MEDICARE PAYMENT FOR CAPITAL

Issue

Should Medicare continue to pay for the capital costs of hospitals under the Prospective Payment System, and if so, through what mechanism?

Background

Under Title V of the Social Security Amendments of 1983 (P.L. 98-21) Medicare reimburses hospitals for inpatient operating costs on a predetermined, specific rate for each Medicare discharge. From 1983 to October 1986, capital costs (interest, depreciation, allowable rental payments and, for investor owned facilities, return on equity) are to be a "pass through" (i.e., reimbursed on a reasonable cost basis subject to a state regulatory process). If Congress does not act by October 1986 to include capital in the Prospective Payment System, States will be required to institute a review system for all Medicare capital expenditures. FY 1985 Medicare payment for capital is estimated to be $2.9 billion.

Congress mandated that HHS study alternatives for payment for capital. This report was due to Congress in October of 1984.

The most frequently mentioned option for capital reform is a fixed percentage add-on for capital. This formula-based method would calculate the capital payment at a national average based on a ratio using total payments for operating costs as the denominator. This ratio would be multiplied by each hospital's operating payment to determine the capital payment for each hospital.

With a fixed percentage add-on, a transition period may be desirable to moderate severe shifts in levels of Medicare capital payments to individual hospitals. A transition period might be 3, 5, or 10 years and could be blended in from 0 to 100 percent of the formula each year. The length of the transition period would influence the redistribution of capital payment across hospitals.

If the capital payment is a fixed percentage add-on to the DRG operating payment, the amount of the base price and any year-to-year update are key to the amount of the capital payment.

Another alternative for capital reform is a combination, with capital pass-through for plant and fixed equipment and a DRG add-on for moveable equipment. It would distinguish among uses rather than sources of capital. Depreciation and interest on plant and fixed equipment would be paid by the current pass-through method. Moveable equipment would be subject to a formula add-on.

Yet another possibility is a capital payment determined by treating old and new capital separately. Each hospital would receive its costs for old capital and a national capital rate for new capital. These rates would be added together to arrive at the hospital's specific capital payment amount.

Medicare capital payment is likely to be actively debated in this session of Congress. The Administration's report, now months overdue, will have an impact on the course of this debate.

General Policy Recommendations

The current cost-reimbursement system for capital, which Medicare adopted from the private sector, no longer makes sense, especially with general excess hospital bed capacity. Capital payment should be appropriately merged with the basic payment system as soon as possible. This should be done with an understanding of the distributional effects across hospitals of the option chosen.

Specific Recommendation

A draft of the Congressionally mandated report on Medicare payment for capital should be submitted to the Working Group for review before its release.

MEDICARE PAYMENT FOR MEDICAL EDUCATION

Issue

Should Medicare's payment for direct and indirect medical education costs be reduced or eliminated?

Background

About 1000 Medicare-certified hospitals engage in educational activities, including training programs for interns/residents, nurses and various paramedical specialities. Both the House and Senate committee reports that accompanied the 1965 Medicare legislation stated that:

> until the community undertakes to bear such education costs in some other way, ... a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

Under reasonable cost reimbursement principles, the Medicare program paid its proportional share of these costs.

Direct medical education costs are costs of the salaries, classroom and other overhead expenses associated with educating physicians, nurses and paramedical specialties. Inpatient medical education costs in approved programs were excluded from the calculation of prospective payment rates and are currently reimbursed at 100 percent of reasonable costs; unapproved programs and teaching activities in outpatient hospital settings are reimbursed at 80 percent under Part B.

Indirect medical education costs are the additional patient care costs associated with the presence of interns and residents in a medical education program (e.g., more laboratory tests). Before PPS, no specific indirect cost adjustment was necessary since indirect costs were implicitly recognized in the reasonable cost reimbursement system.

Under PPS, indirect costs are estimated using a statistical computation that related the operating costs per case to the number of interns and residents per bed, using 1981 data. Current law provides an 11.59 percent increase in the federal portion of the PPS rate for every 0.1 increase in the ratio of interns and residents to beds.

Historically, Medicare payments for direct and indirect medical education costs have equalled 4 to 6 percent of annual expenditures from the Hospital Insurance (HI) Trust Fund. The current estimate is also within that range.

Before PPS, payments to teaching hospitals represented about 42 percent of Medicare hospital payments. Under PPS, this share has risen to 43 percent, largely as a consequence of payments to "heavy teaching" hospitals (i.e., those with an intern and resident to bed ratio of greater than 0.25).

HCFA estimates that in FY 1985, the indirect medical education adjustment requires that each hospital's federal payment per case be reduced by approximately $100 in order to pay teaching hospitals about $300 additional per case. For the 118 hospitals with the heaviest teaching load, this translates into an indirect adjustment of nearly $1,100 per case over and above their average federal DRG payment of $2,050 per case. In contrast, non-teaching hospitals would receive, on average, a federal payment of about $1,400 per case, with no adjustment for medical education.

The President's FY 1986 Budget proposes freezing Medicare direct medical education payments at the FY 1985 level, and reducing the indirect payment rate to one-half of the 11.59 percent add-on or 5.79 percent.

General Policy Recommendation

The rapidly growing numbers of physicians will shortly lead to an excess, if such is not already the case. With Medicare heading for insolvency, it is questionable whether this program should pay for educating people for careers that are financially lucrative.

Specific Recommendation

The Working Group should evaluate available data and studies now underway to determine whether additional study efforts are needed to formulate policy in this area. Longer-term policy should be developed, realizing that the FY 1986 proposals are stop-gap in nature.

MEDICARE PHYSICIAN PAYMENT

Issue

What steps should be taken to control the growth of Medicare physician payment?

Background

Physician services is the second largest component of Medicare and will account for 25 percent of the total in FY 1986 when spending is projected to be $19.8 billion. Between 1978 and 1984, Medicare physician spending increased at an annual rate of 19.6 percent, four percentage points faster than hospital spending. Approximately half of the increase was due to fee increases, another forty percent was due to utilization and intensity, while the remaining ten percent was due to growth in the enrollee population. According to mid-session projections, even with the freeze enacted in the Deficit Reduction Act, spending is projected to increase by 14.3 percent in FY 1986, faster than any other major function in the Budget.

In the original statute, Medicare physician reimbursement methodology was designed to reflect private market physician payment patterns through the adoption of the fee-for-service system based on customary, prevailing and reasonable (CPR) charges.

As an attempt to restrain the steady increases in physician spending, Congress, in 1972, created a Medicare Economic Index which limits the rate of increase in Medicare prevailing charges for physician services. The Deficit Reduction Act incorporated the first major changes in Medicare physician reimbursement since the 1972 Amendments. It mandated a 15-month freeze on Medicare customary and prevailing charge screens for physicians services and created a participating physician program. As a safeguard for beneficiaries, the statute also froze the actual charges of non-participating physicians.

The President's FY 1986 Budget proposes extending the Medicare physician fee freeze for another year.

Analysis

The current Medicare physician payment system has been criticized for a number of reasons.

- It is confusing for both beneficiaries and physicians.
- It contains no overall restraints on spending, with the result that utilization/intensity increases or changes in billing practice can offset constraints imposed on fees.

- It has resulted in geographic, specialty, and procedural payment imbalances which promote the inefficient provision and utilization of services.

- Since the Medicare Economic Index has risen more slowly than actual and customary changes, the reimbursement system is close to becoming a series of specialty-specific local fee schedules which lock in all the current imbalances.

HHS has two Congressional reports on physician reimbursement due on July 1, 1985. The first is on the advisability and feasibility of an inpatient physician DRG system. THe second will report any changes in the per capita volume or mix of physicians services that result from the freeze and will also provide specific recommendations on how to constrain physician reimbursement while protecting the beneficiary.

The Office of Technology Assessment is working on a third study, due December 31, 1985, on ways to eliminate current perceived inequities in the relative amounts paid to physicians by type of service, locality and specialty.

Alternative methodologies for physician payment under Medicare include the following:

- Inpatient physician DRGs.

  An inpatient physician DRG system would set prospective reimbursement amounts for the package of physician resources associated with each of the 467 hospital DRGs. As with the hospital DRG system, the purpose of an inpatient physician DRG system would be to give the physician (or the physician group) incentives to practice efficiently. Since physicians would be at risk for the costs of the services provided to treat a case, they would have direct financial incentives to take a broader view of the patient care process, practice more efficiently and cut back on marginal procedures.

  Inpatient physician DRGs could be set to be budget neutral or to achieve savings.

- Fee schedules.

  Under this option the Secretary would establish fee schedules for Medicare effective October 1, 1985. Initially, the fee schedules could be based on payments under the existing system (e.g., weighted average reasonable charges). They could be established to be budget neutral or could achieve the same level of savings that would be generated from extending the freeze. Fee schedules could be increased by the Economic Index in future years.

- o Capitation.

  A capitation system would control aggregate spending for both inpatient and outpatient physician services for beneficiaries. This option could be limited to physician services or it could cover the entire benefit package. It could be done through a single entity or through multiple competitive plans.

Further evaluation of these and other alternatives is needed for the Administration's report to Congress, due in July. This information will also be important in shaping the Medicare demonstrations, discussed earlier.

General Policy Recommendation

The Medicare system of physician payment based on usual, customary and reasonable charges no longer is appropriate. A new payment methodology needs to be devised, to become effective, if possible, after the current fee freeze expires. Consideration should be given to testing changes in physician payment through demonstrations.

Specific Recommendations

Because the analysis done for the Congressionally mandated Medicare physician payment report will be useful in shaping the Medicare demonstrations, HHS should brief the Working Group on the status of the report as soon as possible. A draft of the report should be submitted to the Working Group for review before its release.

MEDICARE BENEFICIARY PAYMENT

Issue

Should Medicare beneficiary payment be increased, and if so, how?

Background

Medicare beneficiaries pay for part of the cost of the program. The deductibles and copayments for Parts A and B are explained in the paper on Medicare catastrophic coverage.

In addition there is a premium for Part B. At the inception of the Medicare program, the Part B premium was designed to cover 50 percent of program costs of aged beneficiaries. However, due to premium freezes and 1972 legislation which limited the annual premium increases to the annual increase (COLA) in Social Security benefits, the share of program costs covered by premium income fell rapidly, reaching a low point of 24 percent in 1981.

- In 1982, TEFRA mandated that the premium for 1984 and 1985 be set at 25 percent of program costs for the aged.

- DEFRA extended this provision through 1987, with the limitation that the increase in the Part B premium not exceed the dollar amount of the Social Security COLA increase in the same year.

The premium is determined actuarially based on Part B costs of the aged beneficiaries. The costs associated with the disabled are not taken into account in the premium calculation. The disabled enrollees pay the same premium as the aged. However, they use considerably more benefits and as a result, the monthly premium covers only 13 percent of their actual costs.

Analysis

Medicare beneficiaries who are also covered by Medicaid have their Medicare deductibles and copayments paid by Medicaid. In addition, many other Medicare beneficiaries purchase private insurance that supplements Medicare, often referred to as "Medi-gap" insurance. As a result, 80 percent of Medicare beneficiaries do not pay deductibles and copayments out-of-pocket.

Therefore, despite evidence that modest copayments reduce unnecessary utilization without harming the health of the beneficiary, Medi-gap and Medicaid coverage insulate most Medicare beneficiaries from the impact of copayments.

Premium increases and taxation of benefits are alternatives for beneficiary payment which are currently mentioned more often than changes in the copayment schedule.

The President's FY 1986 Budget proposes increasing the Medicare Part B premium stepwise over 5 years to 35 percent of program costs for all beneficiaries. It also proposes indexing the Part B deductible, beginning in FY 1987.

Congress may respond with a Medicare proposal that involves selectively increasing payment by higher income beneficiaries. Two such alternatives are raising the Medicare Part B premium for higher income beneficiaries (e.g, to 50 percent of program costs) or taxing the Medicare benefit as income (for all beneficiaries or for those above some income threshold).

General Policy Recommendation

Medicare beneficiary payment should be increased as a part of an effort to improve the solvency of the program and to constrain the use of additional services of low value to the beneficiary. Ways of selectively increasing payment by higher income beneficiaries should be examined carefully.

Specific Recommendations

The Working Group should be prepared to analyze alternatives from the Congress for selectively increasing payment by higher income beneficiaries.

UNCOMPENSATED HOSPITAL CARE COSTS

Issue

Should the federal government play some role in financing hospitals' bad debt and/or charity care costs?

Background

In 1982, hospitals provided about $4.5B worth of bad debt care and $1.7B in charity care -- together $6.2B (about 5 percent of total charges) in "uncompensated care." This is estimated to be a 38 percent increase over 1978. These figures may not accurately differentiate between what is attributable to genuine charity care (such as is required under a Hill-Burton obligation) and uncollected bills partly due to hospitals' inadequate collection procedures.

Hospitals attempt to cross-subsidize uncompensated care by maximizing revenues from various payers. This is becoming more difficult because (a) there is increasing price competition among hospitals and not all hospitals bear an equal share of uncompensated care costs; (b) insurance purchasers (mainly employers) are less willing to reimburse on the basis of hospital charges that subsidize nonpaying patients; and (c) reimbursement rates are tightening (e.g., Medicare prospective payment).

Some hospitals are more aggressively discouraging treatment of the uninsured resulting in decreased access to care and an increased burden on public hospitals and non-profit teaching hospitals.

Most State and local governments are concerned because State statutes and constitutions hold them responsible for "indigent care" and its costs, and the courts are increasingly upholding that obligation.

Analysis

Fragmentary data show that (a) over half the uninsured are under 25 years old, almost half are in families with incomes over $15,000, and over half are employed all or part of the year; and (b) over 40 percent of the uncompensated care charges were maternity or accident-related. At one hospital, 2 percent of uncompensated care patients had unpaid bills of over $25,000 which accounted for 35 percent of the hospital's total uncompensated care.

The uncompensated care (or indigent care) burden is uneven:

	National Charges	National Uncompensated Care
Public Hospitals	18.4 percent	34.6 percent
Voluntary Hospitals	73.8 percent	60.3 percent
Investor-owned	7.8 percent	5.1 percent

Public hospitals perceive that they bear the burden of Medicaid reductions, increased coinsurance and deductibles, and laid-off workers without insurance, all resulting in high unpaid care.

States and locales are implementing solutions including:

- Insuring a larger portion of the uninsured by bringing more of the poor under Medicaid, making insurance available to the uninsured employed (e.g., multiple-employer trusts), forming local HMO-like plans for the indigent, and increasing the availability of catastrophic insurance. Most States and many locales have long had general assistance programs for the medically indigent.

- Creating funding pools. Florida imposes a surcharge on hospital revenues and redistributes funds to charity care providers. All-payer States include uncompensated care in setting the rates hospitals are paid for all directly compensated care.

- Spreading the burden by requiring all hospitals to provide a "fair share" of uncompensated or indigent care (sometimes threatening licensure, certification, certificate-of-need or other sanctions).

- Subsidizing public or contract institutions with all non-emergency care to be provided at municipal or contract hospitals supported by State and/or local tax-derived subsidies.

General Policy Recommendations

With growing health sector competition, especially price competition, attention is increasingly focused on uncompensated care. Congress is likely to debate the idea of an enlarged federal role in dealing with this issue.

There is already major federal financing of health care for the poor and near-poor. In a time of high budget deficits, it is difficult to consider any new program which is not fully financed. Uncompensated care is a component of a much larger issue over federal/state/local responsibilities. Because of its potential size as a fiscal problem, this issue may be the dominant federal-state issue in the coming years.

Much more study of uncompensated care in a rapidly evolving health care system is needed, to determine the dimensions of the problem, possible solutions and the level of government which should deal with it.

Specific Recommendations

The Working Group should evaluate available data and studies now underway to determine whether additional study efforts are needed to formulate policy in this area.

MEDICARE HOSPITAL INSURANCE TRUST FUND

Issue

What is the magnitude of the financing problem facing the Medicare Hospital Insurance Trust Fund, and how and when should it be dealt with?

Background

The Hospital Insurance (HI) program, like the rest of Social Security (OASDI or Old Age, Survivors and Disability Insurance), depends on payroll tax revenues. The HI program is running increasing deficits and its trust fund is shrinking. The Social Security Trustees, CBO, and OMB have projected depletion of the HI trust fund between 1991 and 1995 although the exact year is uncertain. More importantly, as seen in Graph 1, HI outgo is projected to exceed its income from now on, with ever-growing deficits eventually exceeding 6.5 percent of taxable payroll, or more than $350 billion annually in today's dollars by the year 2050. These estimates are conservative because they assume that hospital costs merely increase with, not faster than, general inflation after 2005 (unlike the current more rapid increases) and hospital utilization per person is assumed not to rise. Table 1 shows HI income and outgo in 1984 constant dollars and the deficit in constant dollars and as a percent of taxable payroll.

Many proposals in the President's FY 1986 budget will reduce HI outlays if enacted. Beyond these proposals, steps which could be taken to increase the long-term solvency of the HI Trust Fund include:

- Transfering the temporary OASDI surplus to HI.

  OASDI (Social Security's old age, survivors and disability programs) will run annual surpluses until 2020, with growing deficits thereafter. These surpluses could be transferred to HI (through interfund borrowing or a reallocation of tax rates) to cover HI deficits until about 2010 (see Table 2), buying extra time to make gradual changes to balance HI. After 2010, rising HI deficits would outstrip dwindling OASDI surpluses, and the combined OASDHI system deficit would grow thereafter to 9 percent of taxable payroll (see Graph 2). After 2020, OASDI would need to be repaid, but HI would be in no condition to make any repayments unless it were more than in balance.

- Generating a larger and more permanent OASDI surplus for permanent transfer to HI.

  Currently, each retiring generation receives higher initial real benefits than previous generations.

Initial benefits are the first checks received upon retirement. They are computed using wage indexes which are more generous and grow more rapidly than the price indexes used in other federal programs and for Social Security COLAs. A larger OASDI surplus could be generated by switching indexes in 1990 to slow the growth in real OASDI initial benefits so that they double rather than triple in real value over the next 75 years (see Table 3). OASDI would save 6 to 7 percent of taxable payroll (see Graph 3), or $335 billion annually, by 2060 (see Table 4). OASDI would be in perpetual surplus by 3 percent of payroll and could make a permanent transfer of that amount to HI (see Graph 4). Transferring these surpluses to HI would cover the HI deficit until 2015 and reduce the outyear HI deficits from over 6 percent to just over 3 percent of taxable payroll, a reduction of nearly one-half.

- o Earmarking tax cap revenue to HI.

The FY 1984 Budget proposed including as taxable income for the employee any contributions by the employer to an employee's health benefit plan which exceed $70 per month for an individual and $175 per month for a family. Federal income taxes collected on this fringe benefit could be earmarked for HI. This would amount to just under $12 billion by 1990 (less if tax reform reduces tax rates and less if higher exempt amounts were chosen). These revenues would equal less than 0.5 percent of taxable payroll over time, less than one-tenth of the anticipated 6 to 7 percent of payroll HI deficits in the next century.

- o Earmarking alcohol and tobacco tax revenue to HI.

The 1984 Advisory Council recommended an increase in alcohol and tobacco taxes, the increase to be earmarked to HI. By FY 1990, federal excise taxes on alcohol and tobacco might yield $14 billion. A 100 percent increase in these excise taxes would raise about $14 billion, or 0.6 percent of 1990 taxable payroll. This percent would fall as payroll tends to outstrip excise tax receipts over time unless the excise tax rates are raised periodically. Assuming such increases, these revenues would cover less than one-tenth of the projected HI deficits of 6 to 7 percent of payroll in the next century.

- o Raising the Medicare eligibility age.

The 1983 Social Security Amendments gradually raised the eligibility age for full social security retirement benefits from 65 to 67 beginning around 2000. A

similar phase-in for Medicare would ultimately reduce annual HI outgo by 0.5 to 0.6 percent of taxable payroll, less than one-tenth of projected deficits. This proposal would also lower SMI outgo. (Graph 4 illustrates the combined effects of raising the eligible age and of changing the method of calculating the initial benefit described above).

o Raising payroll taxes.

The combined employer-employee OASDHI payroll tax will be 14.1 percent on the first $38,700 of wages as of January 1, 1985. Two more increases are scheduled in 1988 and 1990 when the combined tax rate will reach 15.3 percent.

Currently, social security payroll taxes are one-third of the overall tax rate on workers. Payroll tax increases raise the cost of labor and reduce employment. Studies indicate that scheduled payroll tax increases will reduce employment by over 1.2 million jobs by 1990. If it were attempted to finance the projected deficits of nearly 9 percent of payroll in OASDHI (about 2.25 percent in OASDI and 6.55 percent in HI) by a payroll tax increase from 15 percent to nearly 25 percent of payroll, employment would fall by over 15 million jobs in the next century. Substantial revenue would be lost, and there might still be a deficit.

General Policy Recommendation

Projections of income to and outgo from the Medicare HI Trust Fund have predicted insolvency in the next decade, followed by truly major deficits thereafter. This long-term financing problem is the major issue facing Medicare.

However, over the past months the short-term picture has brightened considerably. Trust Fund income has risen because of the improvement in the economy and additional payroll taxes. Trust Fund outgo has been below projections, due in part to the Prospective Payment System.

Therefore, decisions on steps to increase HI trust fund revenue or to change the retirement age could be delayed in order to assess better these developments. This delay should not be for more than a year or two, as the most effective changes to the system are best made gradually and may require substantial lead time. Also, the delay should not be taken as ignoring the long-term financing problem, but rather analyzing how to deal with it.

Table 1

HI Income, Outgo, and Deficits in Constant 1984 Dollars
(Dollar amounts in billions)

Year	HI Outgo	HI Income	HI Deficit Amt	HI Deficit As % Tax Payroll
1984	$ 45.7	$ 43.7	$ -2.00	-0.12 %
1985	49.0	46.6	-2.37	-0.14
1986	52.5	51.4	-1.08	-0.06
1987	55.8	52.7	-3.08	-0.18
1988	59.6	54.1	-5.48	-0.30
1989	63.5	55.6	-7.91	-0.43
1990	67.7	56.9	-10.77	-0.57
1991	72.0	58.2	-13.84	-0.71
1992	76.3	59.4	-16.93	-0.85
1993	80.9	60.7	-20.23	-0.99
1994	85.6	62.1	-23.51	-1.13
1995	90.4	63.5	-26.94	-1.26
1996	95.3	64.8	-30.43	-1.39
1997	99.9	66.4	-33.55	-1.50
1998	104.9	67.8	-37.05	-1.62
1999	109.9	69.3	-40.60	-1.74
2000	114.9	71.0	-43.93	-1.83
2001	120.1	72.5	-47.57	-1.94
2002	125.0	74.1	-50.92	-2.03
2003	130.3	75.7	-54.62	-2.13
2004	135.8	77.4	-58.43	-2.23
2005	141.2	79.0	-62.17	-2.32
2006	147.0	80.6	-66.37	-2.43
2007	152.4	82.2	-70.23	-2.52
2008	159.2	83.7	-75.54	-2.66
2010	168.3	86.7	-82.11	-2.79
2015	200.9	93.5	-107.43	-3.33
2020	241.5	100.2	-141.31	-4.15
2025	291.3	107.5	-184.29	-5.04
2030	345.4	115.3	-229.61	-5.83
2035	394.7	125.3	-269.38	-6.32
2040	437.1	135.3	-301.74	-6.56
2045	474.7	146.1	-328.62	-6.61
2050	514.2	157.7	-356.49	-6.64
2055	556.8	170.6	-386.15	-6.65

Source: These figures have been derived from numbers presented in SSA Actuarial Note Number 120, "Long-range Projections of Social Security Trust Fund Operations in Dollars," May 1984. Estimates are based on Alternative II-B from the 1984 Trustees' Report.

Table 2

OASDI and HI Projected Deficits and Surpluses
in Constant 1984 Dollars based on Alternative II-B
1984 - 2055
(in billions)

Year	OASDI	HI	OASDHI
1984	$ 1.70	$ -2.00	$ -0.30
1985	6.93	-2.37	4.56
1986	8.55	-1.08	7.47
1987	9.24	-3.08	6.16
1988	22.31	-5.48	16.84
1989	24.45	-7.91	16.53
1990	30.89	-10.77	20.12
1991	32.53	-13.84	18.69
1992	33.65	-16.93	16.72
1993	35.30	-20.23	15.07
1994	39.48	-23.51	15.97
1995	43.10	-26.94	16.16
1996	47.70	-30.43	17.27
1997	53.02	-33.55	19.41
1998	57.20	-37.05	20.15
1999	60.45	-40.60	19.85
2000	63.68	-43.93	19.75
2001	66.66	-47.57	19.09
2002	69.32	-50.92	18.40
2003	71.45	-54.62	16.83
2004	73.53	-58.43	15.10
2005	75.10	-62.17	12.93
2006	75.75	-66.37	9.37
2007	75.43	-70.28	5.14
2008	74.31	-75.54	-1.23
2010	70.22	-82.11	-11.90
2015	41.57	-107.43	-65.85
2020	0.14	-141.31	-141.17
2025	-45.12	-184.29	-229.41
2030	-76.94	-229.61	-306.54
2035	-93.90	-269.33	-363.23
2040	-97.27	-301.74	-399.01
2045	-102.92	-328.62	-431.54
2050	-116.95	-356.49	-473.44
2055	-132.33	-386.15	-520.16

Source: These figures have been derived from numbers pres
in SSA Actuarial Note Number 120, "Long-range Projections of
Social Security Trust Fund Operations in Dollars," May 1984.
revenues used in deriving surpluses and deficits are from p
taxes and taxing of benefits.

Table 3

Age 65 Benefits to Married Males and Spouses by Education under Present Law and Price Indexing the Bend Points and Earnings History Beginning in 1990 (amounts expressed in 1983 dollars)

Present Law (Wage Indexing)

	College Education	High School Graduate	Less than High School
1985	$ 10992	$ 10470	$ 9414
1990	12609	12018	10665
1995	13977	13101	11519
2000	15723	14429	12732
2010	18588	16370	14541
2020	21482	18758	16649
2030	23078	20151	17886
2040	26639	23253	20639
2050	30744	26834	23817
2060	35480	30966	27485
% Increase	223 %	196 %	192 %

Price Indexing the Bend Points and Earnings History in 1990

	College Education	High School Graduate	Less than High School
1985	$ 10992	$ 10470	$ 9414
1990	12609	12013	10665
1995	13773	12906	11348
2000	14439	13259	11733
2010	15201	13229	11795
2020	16074	13723	12275
2030	16135	13559	12206
2040	17509	14631	13040
2050	19227	15845	13952
2060	21092	17137	15002
% Increase	92 %	64 %	59 %

Source: Treasury Social Security Model, using assumptions of Alternative II-B in the 1984 Social Security Trustees' Report. Benefit amounts are before-tax.

Note: The growth in real benefits for the higher wage earners is always greater than for lower wage earners. These rates of growth could be easily changed to make them more equal among workers with different levels of earnings by adjusting the marginal benefit rates in the three tiers of the benefit formula or by capping the maximum benefit.

Table 4

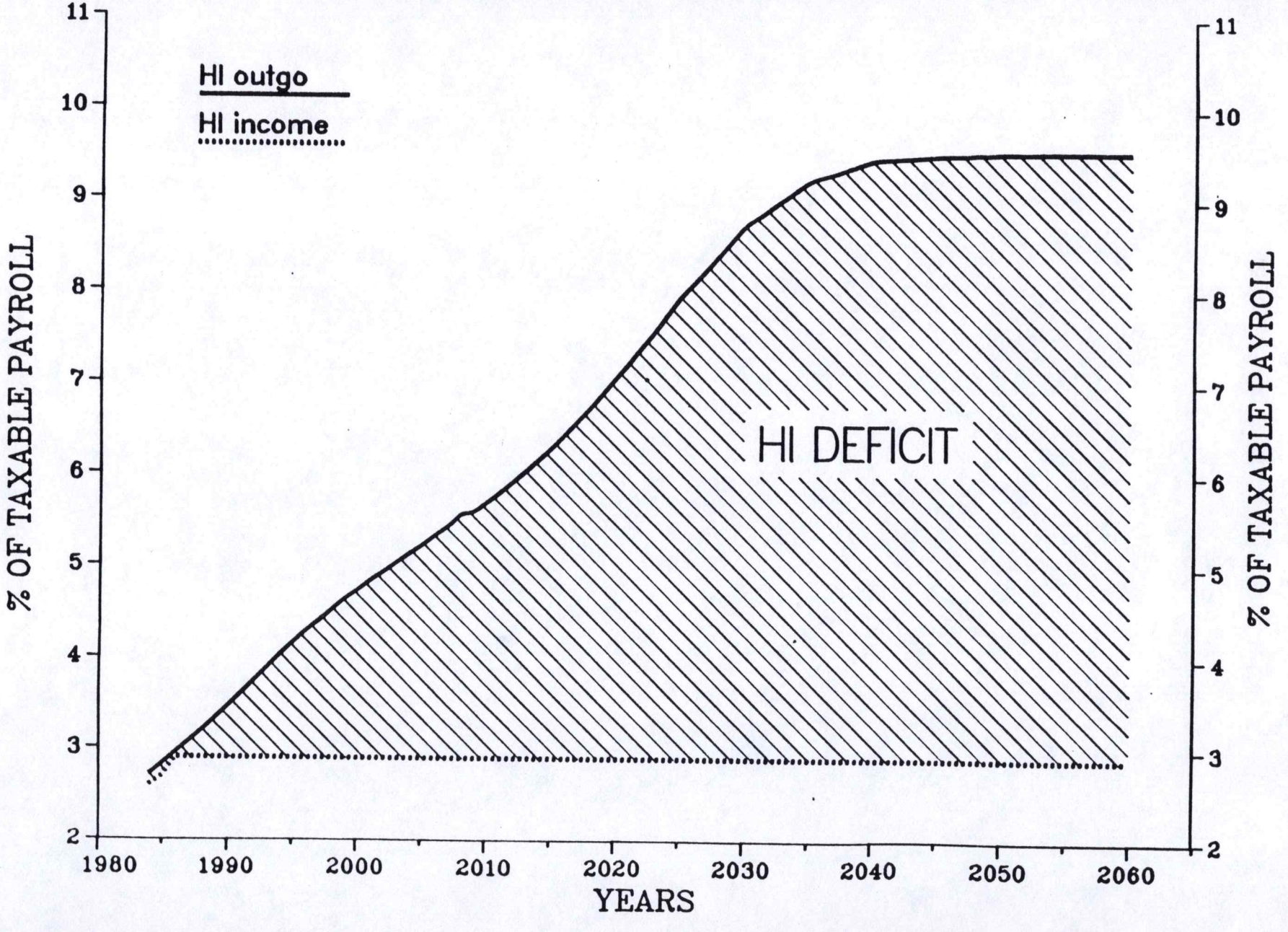
OASDI Outlays in 1984 Constant Dollars under Present Law (Wage Indexing) and Price-Indexing the Bend Points and Earnings Histories in 1990
(amounts in billions of dollars)

Year	Present Law	Price-Indexing the Bend Points	Savings	Price-Indexing the Bend Points and Earnings History	Savings
1984	$181.5	$181.5	$ --	$181.5	$ --
1985	184.3	184.3	--	184.3	--
1986	188.4	188.4	--	188.4	--
1987	193.5	193.5	--	193.5	--
1988	198.9	198.9	--	198.9	--
1989	204.0	204.0	--	204.0	--
1990	209.2	209.2	--	209.2	--
1991	213.8	213.8	--	213.8	--
1992	218.4	218.4	*	218.3	*
1993	222.9	222.8	0.1	222.7	0.2
1994	226.2	226.0	0.2	225.7	0.4
1995	228.8	228.3	0.5	227.9	0.9
1996	230.6	229.8	0.8	229.1	1.5
1997	231.7	230.4	1.2	229.3	2.3
1998	234.0	232.2	1.8	230.7	3.3
1999	237.6	235.1	2.5	233.1	4.5
2000	241.5	238.1	3.4	235.5	6.0
2001	245.5	241.2	4.4	237.9	7.7
2002	249.9	244.5	5.5	240.4	9.6
2003	254.3	248.1	6.7	243.2	11.7
2004	260.3	252.1	8.2	246.3	14.0
2005	265.3	256.5	9.8	249.6	16.7
2006	272.9	261.3	11.6	253.2	19.6
2007	280.2	266.7	13.5	257.4	22.8
2008	288.2	272.5	15.7	262.0	26.2
2010	306.0	285.3	20.7	271.9	34.1
2015	366.9	329.9	37.0	307.9	59.0
2020	440.4	382.4	58.1	351.5	89.0
2025	520.6	487.6	83.0	398.1	122.5
2030	591.3	482.5	108.8	436.4	155.0
2035	651.6	516.9	134.8	465.6	186.0
2040	700.5	539.8	160.6	484.0	215.6
2045	755.0	564.1	190.8	505.3	249.7
2050	821.3	594.5	226.8	530.9	290.4
2055	$895.1	628.6	266.5	559.7	335.4

*Indicates less than $0.1 billion.

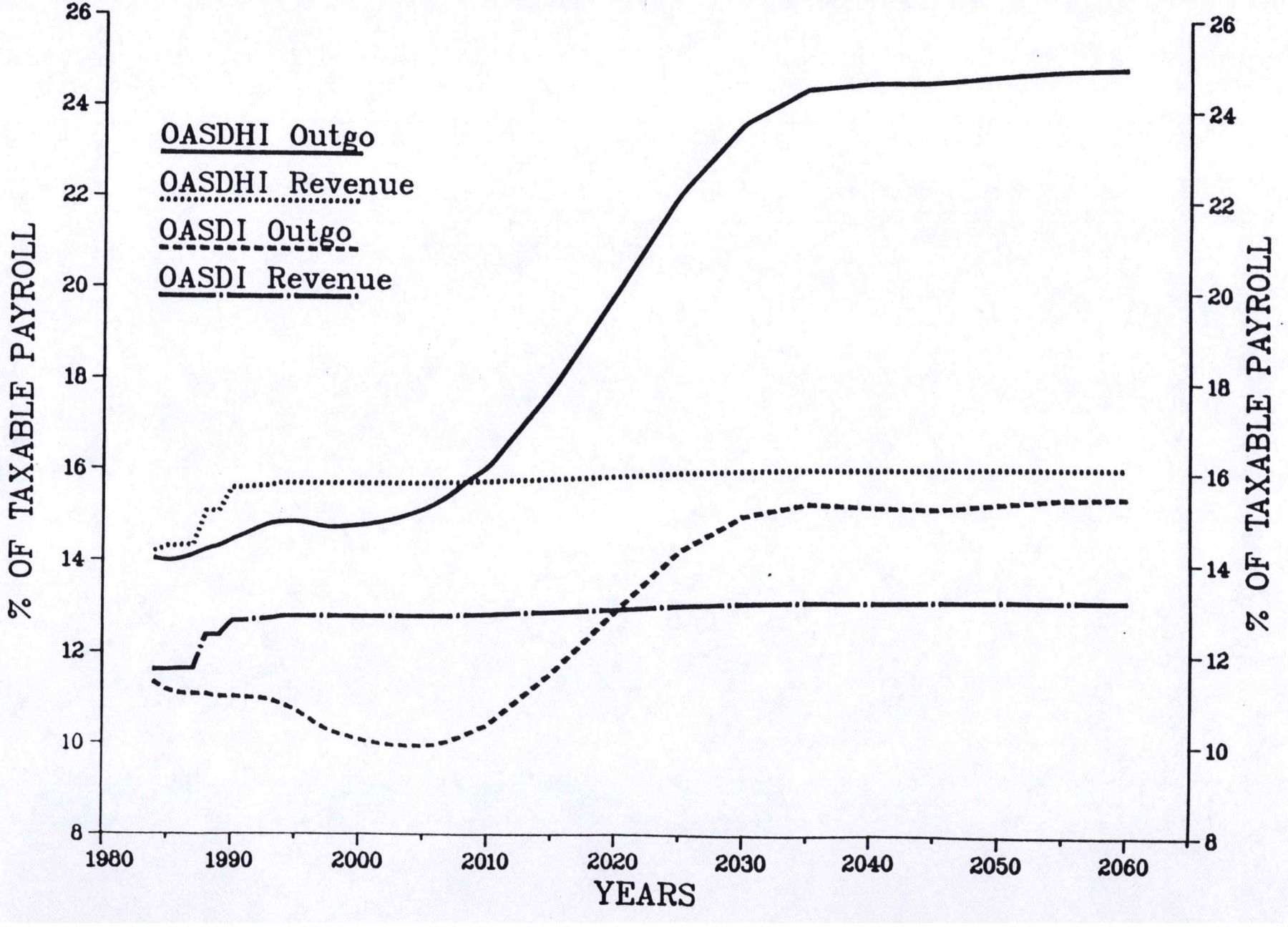
Graph 1

Hospital Insurance Income and Outgo under Present Law (1984 Alternative II–B)



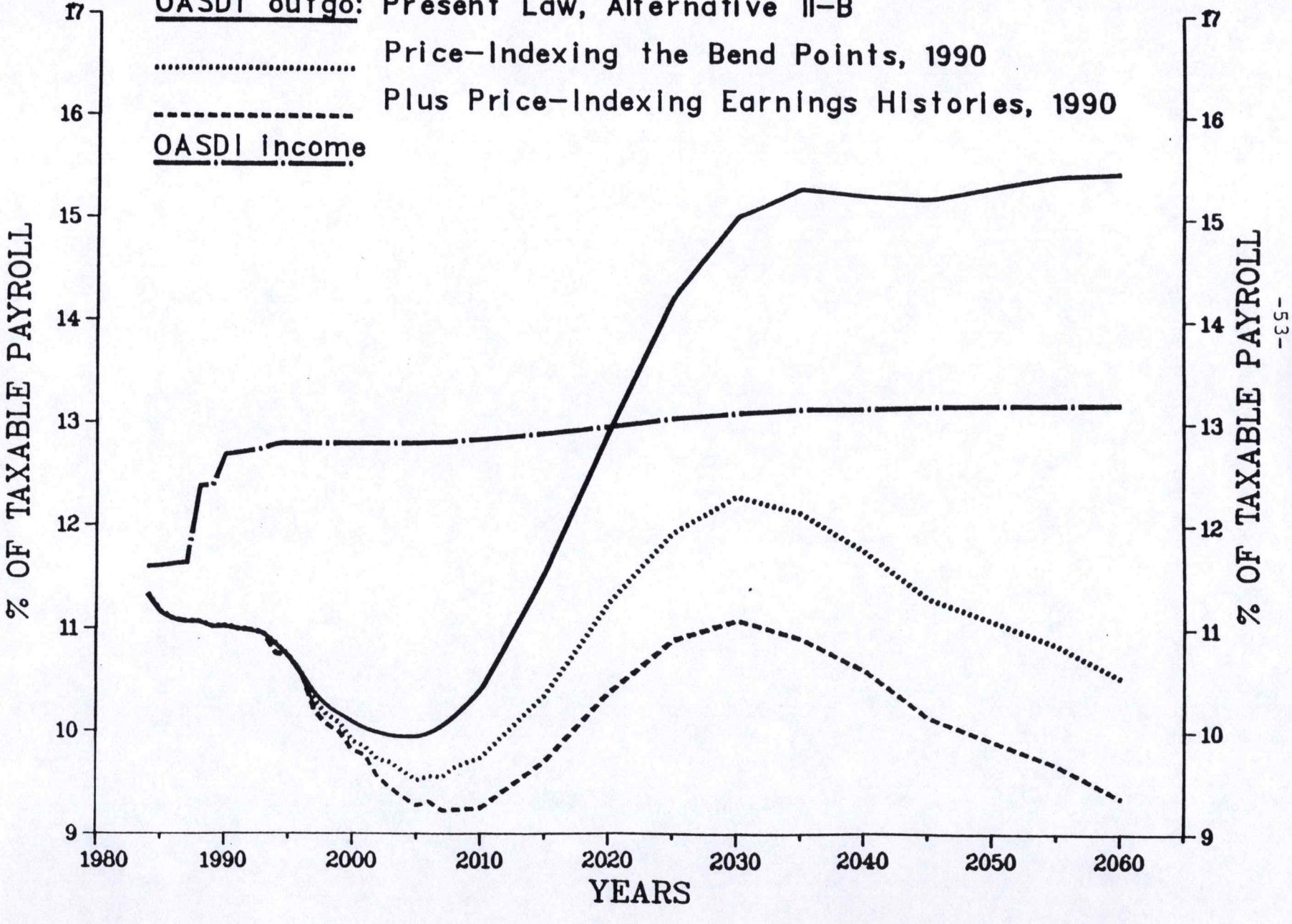
Graph 2

OASDI and OASDHI Income and Outgo under present law (1984 Alternative II–B)



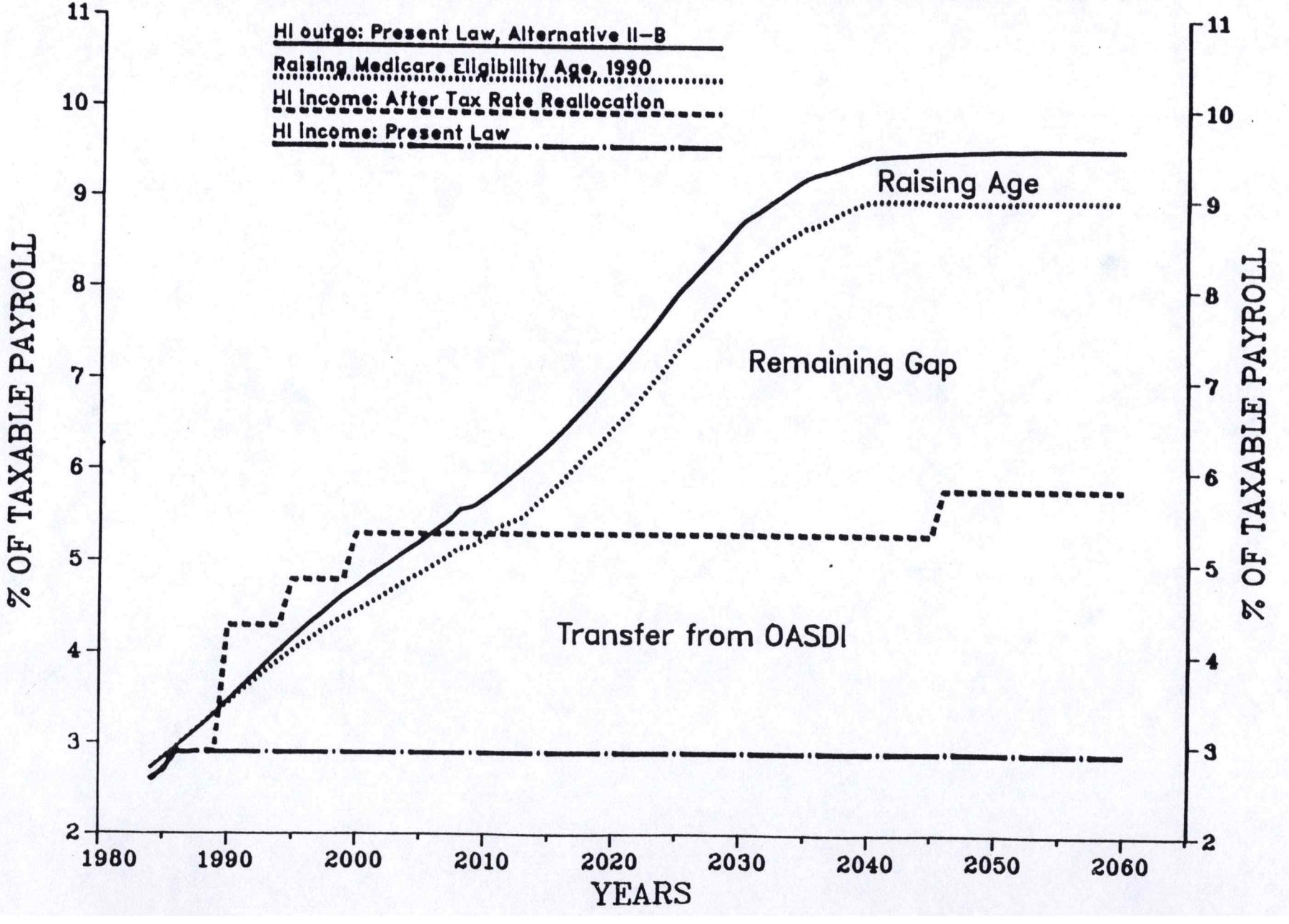
Graph 3

Additive Savings to OASDI



Graph 4

Covering the HI Deficit
(Tax Rate Reallocation and Raising Medicare Age)



MEDICAID

Issue

How should the federal share of Medicaid spending be controlled?

Background

The federal share of Medicaid program grew at a rate of 14 percent per year in the late 1970s and under 10 percent after enactment of OBRA. The States made many changes to their programs in 1981 and 1982 to control costs in response to their economic conditions, as well as the federal changes in OBRA. According to a working paper of the U.S. Treasury, the fiscal condition of the States has improved significantly. In addition, the major OBRA reduction (percentage reductions of federal matching payments) has ended. Thus, the major incentives for States to control the rate of increase in Medicaid have been removed.

The rate of increase for the Federal share of Medicaid for FY 1986 is projected to be 6 percent but average annual rates of increase for the 1987 to 1990 period under current law are projected to be 9.5 percent.

The President's FY 1986 budget proposes a $1 billion reduction in the FY 1986 base for federal Medicaid spending. In the out years, growth will be limited by the medical care component of the consumer price index. States will be given additional flexibility to control Medicaid costs. This will produce 5 year savings of $16.9 billion from current services, with average year to year increases of 5.2 percent.

General Policy Recommendation

With very high federal budget deficits, federal Medicaid spending must be constrained, along with all other budget items. The rate of growth in Medicaid was lower after the OBRA changes, which gave the States additional incentives to control Medicaid. Federal policy should give States the incentives to control costs and the tools to achieve savings.

LONG TERM CARE

Issue

What is appropriate federal government policy toward meeting the long-term care needs of the growing population of chronically impaired (and primarily elderly) persons.

Background

Long-term care refers to a range of services for individuals who are functionally limited, who are unable to carry out the tasks of daily living such as eating, dressing, shopping and cleaning without assistance over an extended period of time. These services are provided in a variety of settings -- in hospitals, in nursing homes and in a person's own residence. They can also be provided either formally -- by individuals or agencies paid for their services -- or informally -- by relatives and friends. In fact, between 60 and 80 percent of all long-term care is provided by family and friends, who are not compensated.

The knowledge that federal action could simply "buy out" the enormous amount of informal care that is now being given, and the growing awareness that the elderly as a group are relatively well off have slowed any rush to action in this area. Nevertheless, several factors combine to continue to make long-term care an important issue for public policy debate and action:

- The population most vulnerable to the chronic mental and physical conditions that require long-term care, the elderly over 75 years of age, is growing rapidly and will continue to do so for several decades.

- The Medicaid program now pays for about one-half of all nursing home expenditures in the United States and, by 1990, long-term care costs will consume up to 65 percent of the total Medicaid budget.

- Proportionately few public resources support in-home or community-based long-term care, which may be a less expensive form of care and is certainly the overwhelming preference of most consumers.

- The new Medicare prospective payment system increases the incentives of hospitals to discharge patients sooner, particularly those whose primary need is for custodial care.

- The traditional providers who anchor the long-term care system -- the family -- may experience increasing difficulty in caring for their disabled relatives because of: (1) the large proportion of women who are now in the workforce; (2) declining birth rates; (3)

the growth of single-parent families; and (4) the continuing high rate of divorce.

In FY 83, about $20 billion was spent by the public sector on long-term care related services.

- Of this amount, about $16.5 billion was spent for institutional care, and about $3.6 billion for home health and other community services.
- The Medicaid program (including federal and State shares) accounts for about 95 percent of all public nursing home expenditures and 80 percent of the total public long-term care expenditures.
- The Medicaid program paid about $16 billion for nursing home care and about $0.5 billion for home health services.
- About 60 percent of the 1.8 million nursing home residents are supported at least partially by Medicaid.
- There are at least 80 federal programs that benefit the elderly and disabled. Of these programs the most significant contributors to non-institutional long-term care services are the Social Services Block Grant Program and the Older Americans Act, which account for over $1.5 billion of community care expenditures. It is not clear, however, what proportion of these services go to persons at imminent risk of institutional placement.

Analysis

Public long-term care programs are extremely costly and if current demographic and expenditure patterns continue, tax revenues may not be able to keep pace with the need without major shifts in public priorities.

The consumer burden is also large, particularly with respect to nursing homes. Consumers pay, out of pocket, approximately one-half of the total costs of institutional care, over $12 billion in FY 80. In the more urban areas of the United States, it is not unusual to pay $2,000 to $2,500 a month for nursing home care. Many people believe that the majority of long-term nursing home residents eventually exhaust their personal resources and become eligible for Medicaid nursing home benefits.

Public long-term care financing programs have been designed toward expensive medically oriented care and institutional settings. This may be due to a variety of reasons, including that the principal financers of public long-term care were designed to provide medical rather than custodial or maintenance care.

With fixed State reimbursement rates, the quantity of nursing home beds demanded may be outstripping the supply. Anecdotal evidence indicates that, in many States, there is a lengthy waiting period to get into a nursing home, and for some publicly supported patients with heavy care needs, it is almost impossible. However, there is evidence of oversupply of beds in some areas.

Insurors have generally regarded long-term care clients as uninsurable, and thus there is currently little coverage of long-term care through private insurance. However, interest groups dealing with the elderly, providers and insurers now are working to explore ways of expanding long term care coverage.

Potential consumers are usually unaware of the risks of needing long-term care or that Medicare and most supplemental insurance policies do not cover it. Also, there have been few incentives to encourage private savings. With the significant expansion of IRAs, these incentives may have been improved.

General Policy Recommendation

Much more study needs to be done of long-term care, particularly as a part of larger issues: the aging of our society and the low savings rate in this country. The federal government already funds long-term care in a major way, through Medicaid and other programs. With high budget deficits and with Medicare facing insolvency, the federal government should be careful to avoid committing additional funding to long-term care, especially through the Medicare program.

VETERANS HEALTH CARE

Issue

What should be federal policy concerning health care for veterans?

Background

The VA health care system was created after World War I to meet the increased demand for general medical and surgical care and to provide long term care for veterans with TB, alcoholism, mental disorders and difficult physical rehabilitation problems. The largest physical expansion took place immediately following World War II to meet the needs of the returning veterans. At the same time, Congress mandated a major role for VA in medical education, to improve the quality of veteran care, and to provide a national health resource. Subsequent Congressional action created a medical research program (1947) and contingency support to the DoD health care system (1982).

Title 38, U.S. Code entitles the service-connected veteran to top priority care. Over the years, Congress has legislated making other groups eligible for care , including low income veterans, those over the age of 65, former prisoners of war, veterans exposed to Agent Orange and ionizing radiation and so forth. Priorities for admission descend from the 100 percent service-connected (SC) veteran, for SC conditions, through a complex matrix of various lower SC levels to nonservice-connected (NSC) veterans and beneficiaries of other agencies and other governments.

Post-WWII social legislation -- principally the veterans' GI Bill -- has enabled veterans to achieve incomes generally higher than the U.S. population at large. For example, the 1984 Harris survey showed the average annual income of veterans over 55 years old to be nearly $21,000; those over 65 averaged almost $19,000. Those incomes in general hold as true for younger veterans. Nevertheless, a 1979 VA survey showed that 57 percent of veterans hospitalized in VA medical centers reported incomes of less than $10,000 ($15,960 in 1984 dollars). Of veterans paying for care in private sector hospitals, only 19 percent reported incomes of less than $10,000. This survey also reported that, of those who use VA health care, 45 percent have no health insurance at all. About one-third of all veterans 65 years old or older can be described as "medically indigent." VA patients are more likely to be separated or divorced, and living alone; they experience more psychological, social, and coping problems, and they are more likely to be in need of more services than medical intervention only.

The average 1984 compensation paid to a SC veteran is $3,564 per year. The average pension for a disabled NSC veteran is $3,378 per year.

SC veterans comprised 27.2 percent of VA hospital discharges in 1979 and 29.9 percent in 1983. Outpatient workload in 1979 was 47.1 percent SC and reached 44.7 percent in 1983.

Analysis

Studies by both the VA and the Congressional Budget Office project substantial increases in current and future demand for VA health care, despite differences in basic assumptions and methodology. They show the following ranges by 1990: Hospital discharges could range from one million to 2.3 million; there could be 18.8 million to 32.1 million staff and fee outpatient visits; and there could be 46,000 - 88,000 eligible veterans who will need institutional long-term care.

The current system has the capacity to provide 55 percent to 75 percent of its treatment to veterans with no service-connected disabilities. In 1983, only 10.8 percent of care in VA hospitals was for service-connected disabilities.

The VA system treats 12 to 15 percent of the total veteran population requiring care. Forty percent of the "mandatory" groups requiring care choose to use VA hospitals, while less than 7 percent of other veterans use VA hospitals for their required care. The remainder of the veterans population obtains medical care from other sources, financed mostly by America's private insurance system and other federal programs. For all those veterans who do use VA, over half can be counted as mandatory demand on the system. The aging process will create an increase in demand for care in both the mandatory and non-mandatory groups. From 1983 to 1984, the number of veterans over the age of 65 increased by 10 percent and the VA system experienced a 7 percent increase in the number patients over 65 who received VA care.

A 1980 law requires VA to apply a means test, considering the medical expenses of many NSC veterans, to determine if they can afford the cost of care. Application of the test is limited to veterans under the age of 65.

The President's FY 1986 Budget proposes implementing a means test for non-service connected veterans regardless of age which would include the following:

--Set the income threshold at twice the VA pension level, adjusted for family size.

--Provide that veterans with incomes exceeding twice the pension level but with excessive medical costs be permitted to use the VA as a medical facility. These

veterans may be admitted to VA medical facilities after they have spent the amount of their resources that exceeds the eligibility threshold to purchase medical care in non-VA facilities.

General Policy Recommendation

The nation has an obligation to recognize and compensate those Americans who sacrifice in military service to their country, especially when that sacrifice results in disability. The primary Federal role in veterans health care is to ensure medical care for disabilities incurred during military service, while being sensitive to needs of other veterans, who are poor, ill and without medical care alternatives. These obligations should be met within financially responsible limits, determined appropriately by the Congress and the President.

DEPARTMENT OF DEFENSE HEALTH PROGRAMS

Issue

How can the cost of DoD health programs be controlled?

Background

The Department of Defense provides medical care to its beneficiaries in peacetime for two reasons: in order to utilize effectively medical resources on hand which are required for war, and as an integral part of its employee compensation package. Eligible beneficiaries of DoD medical programs include: active duty members, their dependents, retired members, their dependents, and the survivors of deceased active duty and retired members.

Medical care is provided either in a uniformed service treatment facility or in a civilian facility. The cost of care provided in civilian facilities to active duty members is paid in full directly by the parent uniformed service with annual costs exceeding $80 million. The cost of care provided in civilian facilities for all other beneficiaries is shared between the beneficiary and the government through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) with annual costs exceeding $1.4 billion. With minor exceptions, the cost of care provided in military facilities is borne by the government.

The DoD system relates to the remainder of the health care system in a number of ways, including: reimbursements in excess of $1.3 billion to civilian providers; shared graduate medical education training programs; service sharing agreements; and signed agreements with over 750 hospitals to provide approximately 70,000 beds and services during contingency operations. In terms of other federal programs, DoD and VA have some overlap regarding covered populations and DoD beneficiaries lose CHAMPUS eligibility upon becoming eligible for Medicare. In addition, the Department is required by law to consult with DHHS before issuing regulations governing DoD medical programs.

Analysis

The four major components of the DoD medical system are the Medical Departments of the Army, Navy, and Air Force, and CHAMPUS. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) is the program manager for all DoD health and medical resources. The DoD medical system consists of 161 fixed hospitals and over 310 freestanding clinics operated by the three military services and the CHAMPUS program operated by the ASD(HA). In addition, substantial resources are committed to deployable medical systems and equipment required to support the Department's readiness mission.

In Fiscal Year 1985, approximately $10 billion will be spent on DoD medical programs. Of this, $7.1 billion will go to staffing and operating military hospitals and clinics and another $1.4 billion for CHAMPUS. Some $600 million will support medical readiness requirements and another $1 billion will be roughly split between Research and Development efforts and medical military construction.

The following proposals were submitted to the Congress in the FY 1985 Budget and will be resubmitted this year:

- Item 1: Amending the law to require hospitals that participate in Medicare and participate in CHAMPUS to accept as payment in full DRG-based Medicare rates for CHAMPUS patients. First year savings: $128 million. Five year savings: $792 million.

- Item 2: Amending the law to authorize DoD to collect from private insurance companies payments for the cost of care provided in military hospitals to DoD beneficiaries who also have private insurance coverage. First year savings: $80 million. Five year savings: $1,325 million.

The following additional proposals are under consideration:

- Item 3: Amending the law to authorize DoD to designate specific health plans and payment mechanisms for beneficiaries to use in certain areas (i.e. HMOs, PPOs, other competitive plans) First year savings: $71 million. Five year savings: $1,144 million.

- Item 4: Amending the law to increase the annual CHAMPUS outpatient deductible amount from $50 for individuals and $100 for families to $100 and $200 respectively for all retirees and their dependents. First year savings: $23 million. Five year savings: $118 million.

- Item 5: Amending the law for all active duty dependents residing within military treatment facility catchment areas (40 miles) to increase the annual outpatient deductible as above and increase the outpatient coinsurance from 20 percent to 25 percent. First year savings: $14 million. Five year savings: $77 million.

- Item 6: Adding contributory dental plan for dependents of active duty members. First year cost: $105 million. Five year cost $604 million.

- Item 7: Imposing catastrophic loss limit of $1000 per year for families of active duty members and $5000 per year for families of retirees and survivors. First year cost: $27 million. Five year cost: $202 million.

Items 3, 4, and 5, would increase the workload of uniformed services facilities, which generally provide care at lower cost to the government than care purchased in the private sector, by encouraging their use over CHAMPUS. In addition, items 4 and 5, by increasing cost sharing, would bring these items more in line with most civilian plans and the FEHBP. Items 1 and 2 would produce large savings to the government with little or no cost shifting to beneficiaries. Item 7 would give protection against the fear of catastrophic illness loss.

Item 1 might encounter significant opposition from civilian hospitals and item 2 would cause a similar reaction in the health insurance industry. Item 3, 4, and 5 would be viewed by beneficiaries as an erosion of benefits and as such will be opposed.

Item 6 adds coverage that individuals otherwise might not choose to buy on their own, for costs that are largely budgetable, therefore several Working Group members are opposed to it. Several Working Group members have concerns about Item 1, which would tie CHAMPUS to DRG-based Medicare rates. While a DRG-based methodology may be desirable for CHAMPUS, Working Group members note that there are admininstrative and policy issues involved in linking the two programs.

Summary of Estimated Cost Savings
(in Millions of Dollars)

Item	First Year	Five Year
1. CHAMPUS/Medicare Link	$ 128	$ 792
2. Collect Private Insur.	80	1,325
3. Designate Certain Plans	71	1,144
4. Increase Retiree Deduct.	23	118
5. Increase Other Coinsur.	14	77
TOTALS	$ 316	$3,456

Summary of Estimated Benefit Enchancement Costs
(in Millions of Dollars)

Item	First Year	Five Year
6. Dependent Dental Plan	$ 105	$ 604
7. Catastrophic Limit	27	202
TOTALS	$ 132	$ 806

General Policy Recommendation

The cost of DOD health programs should be controlled because of the need for overall budget restraint in the face of high deficits. Before legislation is transmitted to the Congress, the interactions of these programs with the civilian health care system should be carefully evaluated to ensure that DOD initiatives are consistent with overall Administration health policy.

TAX POLICY AND PRIVATE HEALTH INSURANCE

Issue

Should employer-provided health insurance continue as an unlimited tax-free benefit to the employee?

Background

All employer contributions to health insurance plans for employees are excluded from the employees' income and wages for purposes of income and employment taxes. This tax treatment applies to all insurance coverage, including self-insured plans, regardless of cost.

Analysis

The tax-preferred status of employer-provided health insurance represents a subsidy for the purchase of insurance which has encouraged expansion of health insurance plans to include coverage for first-dollar, budgetable expenses. This has caused a significant decline in the proportion of compensation subject to tax and thus indirectly led to higher tax rates on cash wages. At the same time, expanded insurance coverage of health-related expenses has tended to insulate employees from any burden for the cost of physician and hospital services consumed. This has increased demand for such services and, thus, contributed to health care cost inflation.

Limiting the amount of income employees can receive tax-free in the form of health insurance would restore neutrality at the margin in the choice between cash and health insurance. Eliminating the bias in favor of excess insurance coverage would encourage employees to accept more efficient health insurance coverage and to be receptive to measures intended by employers to contain costs. These measures include adoption of various cost-limiting initiatives such as utilization review and second opinion on surgery, as well as introduction of preferred provider organizations, HMOs, and other competitive plan options.

The Secretary of the Treasury's tax reform plan proposes limiting tax-free health benefits at $175/month for a family and $70/month for an individual.

General Policy Recommendation

The current preference given to health benefits over wages should be altered, as a move to add greater cost-consciousness to private health insurance markets. This should help restrain overall health spending.

Such action should be taken in the context of deliberation over tax reform.

HEALTH CARE TECHNOLOGY

Issue

What should be federal government policy concerning health care technology (the drugs, devices and procedures used in medical care and the supportive systems within which they are provided)?

Background

The United States is a world leader in health care technology. While we are currently experiencing an overall trade deficit on a national basis, the medical device industry experienced a trade surplus of $1 billion last year.

In FY 1985, the federal government will spend approximately $51.7 billion on R&D. Approximately one third of that amount, or $17.9 billion will go toward non-defense R&D. Nearly one-third of this will be spent by health agencies. Hence about 10 percent of federal R&D will be health related and much of this will be devoted to technology.

The federal government's principal role in health technology has been grant support of research. However, in addition, it is involved as a major payor for technologically-based health care services, and in the development, regulation (for purposes of safety and efficacy), and transfer of technology from the public to the private sector. Efforts to bring the results of government-funded research to the market place are chiefly supported by the private sector, through further development and commercialization, and subsequent marketing activities.

The continued growth of scientific knowledge provides the basis for achieving our national goals of a strong defense, economic security, and an enhanced quality of life. A key to quality of life enhancement is the encouragement of health technologies which are directed at prevention rather than treatment.

General Policy Recommendation

Federal government policy should foster the development and implementation of new health care technology. In general, this should be accomplished by removing unnecessary barriers, with appropriate continued regard for public health and safety.

PREVENTION

Issue

What should be done by the federal government to promote prevention of disease and disability?

Background

The health of Americans is steadily improving. Since 1970, there has been a 45.5 percent drop in the death rate of infants (under one year of age), a 33.7 percent drop for children (ages 1 to 14), a 25.0 percent drop for adolescents and young adults (ages 15 to 24), a 30.8 percent drop for adults (ages 25 to 65), and a 13.5 percent drop for adults older than 65. [These figures are based on provisional death rates for 1983.]

The life expectancy for Americans is now at an all-time high of 74.7 years, up from 70.8 in 1970 and from 47 at the turn of the century.

Most of these gains have come not as a result of treatment, but from efforts to prevent diseases.

- Childhood immunization levels are now at 95 percent or higher, leading along with improved nutrition and sanitation, to the near elimination of problems like diphtheria, pertussis, polio, measles, and rubella. At the beginning of this century, infectious diseases accounted for nearly three-fourths of the deaths each year in the U.S.

- Maternal and child health efforts have fostered improved prenatal care to the point that now 76 percent of pregnant women obtain such care in the first trimester, contributing to the remarkable decline in infant mortality.

- High blood pressure control programs have led to a two-to-three-fold increase in the share of the population whose high blood pressure is controlled. These programs, along with a 25 percent reduction in adult smokers since 1965 and a major shift away from the consumption of fatty foods, have facilitated the 42 percent reduction in stroke mortality and 25 percent reduction in heart attack mortality between 1972 and 1982.

Today's leading challenges to better health for Americans are prominently rooted in lifestyle factors giving rise to chronic diseases and trauma.

- Every one of the 10 leading causes of death in the U.S. has a behavioral factor as a prominent contributor.

- It has been estimated that 50 percent of all premature deaths in the U.S. are attributable to lifestyle factors. Only about 10 percent could be addressed by our medical care system.

Analysis

A variety of opportunities exist to accelerate progress in prevention, based on current and emerging knowledge.

Because so many of our problems are derived from lifestyle factors (diet, exercise, smoking, alcohol and drug use, and safety measures), emphasis on health behavior (health promotion) is warranted.

The alcohol and tobacco tax increase, discussed in the section on the "Medicare Hospital Insurance Trust Fund," might have a healthy behavioral effect as well as raise additional revenue.

Another issue which merits examination is the growing concern over liability for vaccine injury and whether it will cause problems of inadequate supply of vaccine. This is related to the much larger medical professional liability issue that is now gaining greater attention.

General Policy Recommendation

Prevention of disease and disability often is more cost-effective than treatment. Therefore, prevention efforts appropriate to the federal government should be given priority.

The production and dissemination of information regarding prevention is an appropriate federal role. Direct federal provision or financing of personal preventive medical care is less clearly a Federal role, and should be analyzed carefully. Any such direct services should be fully financed and should not increase the budget deficit.

White House Working Group on Health Policy and Economics
1985

Recommendations and Status

ISSUE	1985 RECOMMENDATION	STATUS
Medicare demonstrations	Test alternatives to Prospective Payment System	Reagan Administration proposed Medicare voucher legislation. Congress did not act. Bush Administration budgets have not pursued voucher-type strategies, instead pursuing "managed care" as the approach to Medicare reform.
Medicare catastrophic coverage	Evaluate catastrophic coverage more completely and if implemented, fully finance	Reagan Administration made a proposal in 1987. Congress enacted a much expanded version in 1988 that was repealed in 1989.
Medicare payment for capital	Merge capital payment system with basic payment system	In February 1991 HHS proposed system of capital payment to encourage more efficient investment policies. New rules would pay hospitals a fixed amount for capital for each Medicare admission, adjusted for geographic and caseload differences.
Medicare payment for medical education	Reconsider Medicare payment for medical education	Reagan and Bush Administrations have proposed reducing the amounts hospitals are paid for indirect effects of being teaching hospitals. Congress has not accepted. No followup on 1985 report's questioning of the logic of subsidizing people to become well paid professionals.
Medicare physician payment	Devise a new payment methodology and test changes through demonstrations	1989 reconciliation legislation ordered in motion a transition to Medicare payment of physicians on the basis of a fee schedule.

Medicare beneficiary payment	Increase beneficiary payments and examine ways to increase payments made by higher income beneficiaries	FY 1992 budget proposes reducing Part B subsidy for individuals with AGI over $125,000 to 25 percent of costs.
Uncompensated hospital care costs	Study uncompensated care to determine the dimensions of the problem, possible solutions and the appropriate level of government to address the problem	1985 reconciliation act reduced the allowance for indirect costs of training doctors and applied the savings to subsidies to hospitals with disproportionate shares of Medicaid and indigent patients. No action on recommendation for increased data gathering.
Medicare Hospital Insurance Trust Fund	Delay "not ... for a more than a year or two" decision to increase trust fund revenue or change retirement age until the impact of recent changes can be better assessed	No proposal has been made on increasing the age of initial eligibility from age 65. The 1990 reconciliation bill increased trust fund revenue through increasing the wages that will be subject to the tax. A March 1991 report from a technical panel advising the Steelman Council predicted the current benefit structure would lead to Medicare being 6.8 percent of GNP by 2060.
Medicaid	Give states incentives to control costs and tools to achieve savings	No additional tools or incentives for state level cost control have been advanced since the 1985 report.
Long term care	Continue studying long term care and avoid committing additional resources to it, especially through Medicare	Treasury forwarded a Congressionally-mandated report to Congress on tax issues relating to financing long-term care.
Veterans health care	Meet obligations to veterans within financially responsible limits	Appropriations for veterans health care continue to grow at a rate above that for domestic discretionary programs overall.
Department of Defense health programs	Control costs and evaluate interactions with the civilian health care system	DOD has used competitive awards as a tool to reduce costs of CHAMPUS (care for dependents); recent decisions have slowed expansion of demonstrations.

Tax policy and private health insurance	Alter the tax system's more favorable treatment of health benefits over wages	The Reagan Administration in 1983 proposed a "tax cap," limiting the cost of employer-provided benefits that employees could exclude from taxation. No Congressional action.
Health care technology	Foster the development of new health care technology by removing unnecessary barriers	Council on Competitiveness has formed principles for regulation of biotechnology. Congress passed (and the President signed) legislation in 1990 to overhaul federal government regulation of medical devices.
Prevention	Give priority to prevention efforts appropriate to the Federal government	FY 92 budget emphasizes prevention activities that have been proven effective.