Expanded Health Insurance Proposed

Kennedy Bill Would Require All Employers to Provide Coverage

By Spencer Rich
Washington Post Staff Writer

Sen. Edward M. Kennedy (D-Mass.) and other liberal Democrats yesterday launched a campaign to require all employers to provide health insurance to their workers.

Kennedy's bill, expanding previous proposals, also would create a new government program, akin to Medicaid, to provide insurance for nearly 15 million Americans who still would be uncovered after the employer-mandated insurance went into effect and who would not be eligible for existing public programs such as Medicare or Medicaid. This provision would be phased in from 1990 to 2000, starting with 6 million people below the poverty line, who would receive it free.

The bill will be the centerpiece of efforts by a coalition of labor, liberal, religious and social welfare organizations to guarantee health insurance to everyone in the country who does not already have it through the job or government programs. Kennedy has long been the legislative leader of this coalition. The bill drew more than 100 endorsements yesterday from these groups and from major health organizations such as the American Hospital Association, the Federation of American Health Systems and the American Society of Internal Medicine.

"Today we renew the effort to bring essential health care to all our citizens . . .. Thirty-seven million Americans have no health insurance at all, either public or private," said Kennedy, who was joined by Sen. Paul Simon (D-Ill.), Rep. Henry Waxman (D-Calif.) and Rep. William Ford (D-Mich.).

Waxman, chairman of the House Energy and Commerce health subcommittee, described the situation of so many people lacking coverage as "a national disgrace" that contributes to "desperate problems with infant mortality and AIDS . . . inadequate levels of prenatal care and immunizations" and other problems.

Kennedy, chairman of the Senate Labor Committee, said he hopes for committee approval "by early summer."

Under the Kennedy proposal, all employers would have to provide a basic minimum package of health insurance to employees normally working at least 17½ hours a week. The package would include medically necessary hospital care, doctor care and a $3,000 annual "catastrophic" limit on out-of-pocket outlays per family for covered benefits. The employer would have to pay 80 percent of the premiums.

Kennedy said this provision would provide new coverage for 23 million people in families where a full-time worker does not get health insurance through the job. He said the cost of this insurance would be $1,619 for each covered worker and family, but since the worker would pay 20 percent, it would cost the employer only $1,295.

He said total costs of premiums, including improving the benefits in existing employer-provided insurance up to the minimum level of the required package, would be $33 billion. But he said savings on existing hospital charity care, conversion of high-cost individual policies to employer-based group policies and other such provisions would reduce the net to $18 billion.

In the last Congress, a Kennedy bill mandating coverage by employers won committee approval by a 10-to-6 vote. But business groups fiercely opposed the measure, fearing vast increases in their costs, and it went no further.

The National Federation of Independent Business yesterday said it opposes the new version of the measure. Frederick J. Krebs of the the U.S. Chamber of Commerce said, "Health-care costs are out of control—so being forced to provide these benefits is like being told to jump on a runaway train."

Bush, during the presidential campaign, said he opposed mandating employer coverage.

Conceding this opposition, Kennedy said public opinion has decisively changed over the years, and "the American people have made up their minds" that everyone should be covered by health insurance in some form.

He said the bill includes special provisions and subsidies to ease the added cost burdens for small businesses.

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"The British Love Their National Health Service," Washington Post, March 15, 1988, Health Section, pp. 16-19

By Karen DeYoung
Washington Post Foreign Service

LONDON

For many Britons, the story of tiny David Barber confirmed what they already feared: The National Health Service, on which 90 percent of the nation depends for its medical care, was overstretched, out of money and on the verge of collapse.

David Barber was born last fall with a hole in his heart. Surgery to repair the infant's heart was scheduled and postponed five times during his first few weeks of life, because nursing shortages at Birmingham Children's Hospital meant that no post-operative bed was available for him.

Following extensive media coverage of his plight and public and political outrage that forced direct intervention by Prime Minister Margaret Thatcher, he finally got this operation in late November. Eleven days later, on Dec. 5, David Barber died.

The hospital and his physicians deplored the delay, even while insisting that the repeated postponement of surgery had nothing to do with his death.

Yet the Barber case marked the beginning of an unprecedented and still rising tide of public concern over the future of the service and criticism of Thatcher's stewardship.

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This year marks the 40th birthday of the NHS, the proudest achievement of Britain's postwar social reforms. Virtually all of Europe, and much of the rest of the world, now has some sort of socialized medicine. But the NHS, a cradle-to-grave program whose services are free to its users, remains one of the most comprehensive and extensively used systems of state owned and operated health care in the industrialized West. Its cost, which is paid out of general taxation, will be about $40 billion this year.

With a staff of more than 1 million, the NHS is believed to be Europe's largest single employer.

In England alone, the service owns more than 2,000 hospitals staffed with government-salaried physicians. It contracts for the full-time services of more than 25,000 general practitioners and 14,000 dentists.

Such a widely used service is the inevitable target of frequent complaints, and every postwar government has had to confront a health care "crisis."

But now for the first time in the health program's history, opinion polls show that Britons consider NHS the most urgent problem facing the nation. The charge, across a wide political spectrum, is that Thatcher is more interested in saving money than saving lives.

Thatcher has agreed to add $2 billion to the NHS appropriation in this year's budget, but even members of her own party have protested that it is not enough.

In recent weeks, Thatcher's critics have focused many of their demands on her government's 1988-89 budget, whose details are scheduled to be released today.

In mid-February, a group of senior Conservative members of Parliament, including two former Thatcher cabinet ministers, called for an increase in the proposed appropriation for the National Health Service.

Early this month, the bipartisan and Conservative-dominated Social Services Com-

Virtually all of Europe has some sort of socialized medicine. But the British NHS, a cradle-to-grave program whose services are free, is one of the most comprehensive.

mittee in the House of Commons put its own figure on the level of need, asking for an additional $1.8 billion for the NHS hospital service fund alone..

On March 5, about 50,000 trade unionists and health care workers, according to press accounts, marched in London and other cities in demonstrations pegged to the budget announcement. Yesterday many nurses at hospitals throughout Britain staged rallies and marches in a last minute attempt to pressure the government to increase NHS funding.

But government officials have said that despite a massive budget surplus and plans to cut income tax rates, no more NHS funds will be made available.

The storm over Britain's national health system goes beyond medical care to basic differences in political philosophy.

Many believe that Thatcher's aim is far more ambitious than merely making the NHS more efficient in its use of resources. It is widely felt among politicians and health care professionals that she has purposefully underfunded the system to create chaos and fear that will open the door to wider public acceptance of a private health care system that is more in keeping with her overall goal of "eradicating socialism" and getting the government out of all but the business of governing.

Meanwhile, the evidence that something is deeply wrong with the NHS comes with each day's news, a seemingly endless litany of endangered lives, despairing hospital administrators and angry staff.

David Barber was one of nearly 700,000 Britons on waiting lists for non-emergency surgery, many of them in line for a year or more. Hospital occupancy rates in some areas are more than 90 percent, yet thousands of beds have been taken out of service and entire wards shut down either because they lack funds or nurses—or both.

Tens of thousands of nurses have left the NHS, which pays nurses an average salary lower than that of a rookie police officer or a bus conductor.

Many of the nurses have emigrated to Australia, New Zealand and the United States. Picket lines of striking nurses have become a common sight outside NHS hospitals since early this year.

The three presidents of the Royal Colleges of Physicians, Surgeons and Obstetricians have warned the government that hospitals have "almost reached the breaking point."

There is general agreement between the government and its critics that the health service needs more money if it is to continue to exist in its present form. Where they part company is over whether it should. The political line is drawn between those who want the national health program to basically remain as it is and those who advocate a major overhaul of services to permit more private free-market medical practice in Britain.

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To Thatcher, the NHS is highly inefficient. It combines unlimited demand, ever-escalating costs and a lack of cost-control incentives to create a bottomless pit of public expenditure. In the face of relentless attacks from the opposition Labor Party, she points out that her government this year spent more than three times what Labor spent on the NHS in its last administration in 1979, and that nursing salaries have risen 30 percent over that same period. Thatcher repeatedly notes that waiting lists for hospital care are by no means a new phenomenon here.

Britain has far more hospital beds per patient than the United States, and the average length of hospital stay is more than twice as long. Thatcher has charged NHS doctors with restrictive practices and conspiring to limit their working hours to take private, paying patients on the side as a supplement to their health service salaries, averaging about $50,000 a year. She has accused NHS hospitals of inefficiency and expects them to pay for budget overruns and nursing salary shortfalls by finding new ways of making money outside their state allocation.

Many have done so, putting services traditionally provided by public employees, like catering and cleaning, up for competitive bids by private contracting firms. Some hospitals have opened flower shops and newsstands in their lobbies and begun taking photographs of newborn babies to sell to their parents.

These measures are merely "scraping at the surface" of their funding problems, one hospital administrator said. But they're easier than cutting back on services.

Administrators said they are not opposed to changes in NHS financing, and there is

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widespread agreement that the rigid, highly centralized structure of the health service, which leaves some hospitals nearly empty while others are full to bursting is a major part of the problem.

But Thatcher's solution of restricting funds does not address the bureaucratic problems of the NHS and instead hurts patients.

Government officials deny the charge that Thatcher is out to privatize the NHS, while acknowledging that the current crisis is "not unhelpful" in promoting needed change, as one Thatcher aide put it.

In early February, Thatcher announced an internal, "all options considered" review of the NHS, which is expected to be completed before the end of the year. "The prime minister thinks there has been a fundamental change in the politics of health," the aide said. "People are now ready for some kind of change, still undefined, which gives them a better service."

It seems clear that the change Thatcher has in mind is that people who can afford it should pay for their health care. She already has proposed highly controversial charges for vision tests and preventive dental examinations, which are now free.

Privatization has met with wide approval here when applied to things like the sale to the private sector of formerly state-owned automobile factories and oil companies. But with the NHS, Thatcher may be pushing the concept of privatization too far.

According to a Gallup poll last month, 67 percent of Britons would be willing to pay higher taxes if the money went to the NHS. In three separate opinion polls published the first week in March, an overwhelming majority expressed concern about the NHS, and most—nearly three quarters in one poll—said they thought the government should use some of its spare cash to help the national medical system.

The health service is the one thing that makes this class-divided society feel warmly egalitarian, and Britons of all political persuasions consider it the most sacred of national budgetary cows.

Britons often cite the U.S. health care system as the inevitable result of privatized medical care, and it is popularly believed that those without the right credit cards or insurance policies are virtually left to die in American streets.

Unlike most other public health systems in Europe, the NHS uses only state-owned facilities. Virtually all physicians in the country are government-employed, even those who accept private patients on their own time. Other systems allow private insurance to pay for state-provided care, or state insurance to pay for private treatment. Many are funded through payroll deductions and employer contributions. But although Britons have a small "national health" contribution deducted from their pay, 85 percent of the NHS budget comes directly from general tax revenues, appropriated by the government.

There is no means test that assesses a person's ability to pay for services, and no limit on care. The ruling principle of the NHS, as described by its founders, is that it provides a "comprehensive health service for everybody in this country" that "shall not depend on whether they can pay for [it], or on any other factor irrelevant to the real need."

Every Briton is automatically issued an NHS card and number at birth. Throughout his or her life, the person is registered with a local general practitioner under government contract. The doctor is paid an annual fee for each patient on his registration list—currently set at $13.50 for patients under 64—no matter how often he sees the patient. The doctor receives an additional flat, yearly fee per practice. Additional money can be earned for performing more than a minimum quota of special services, which are being encouraged by the government, such as cervical smears to screen for cancer.

The average general practitioner has about 2,000 patients on his or her list and frequently sees as many as 40 to 50 patients each day for an average of about $35,000 in annual income.

The general practitioner is the door through which patients must pass for any non-emergency specialist or hospital treatment. It is this doctor's referral that determines what further care a patient will receive, and where.

Once a referral is made, the hospital or specialist is obligated to provide treatment—when the time and bed are available.

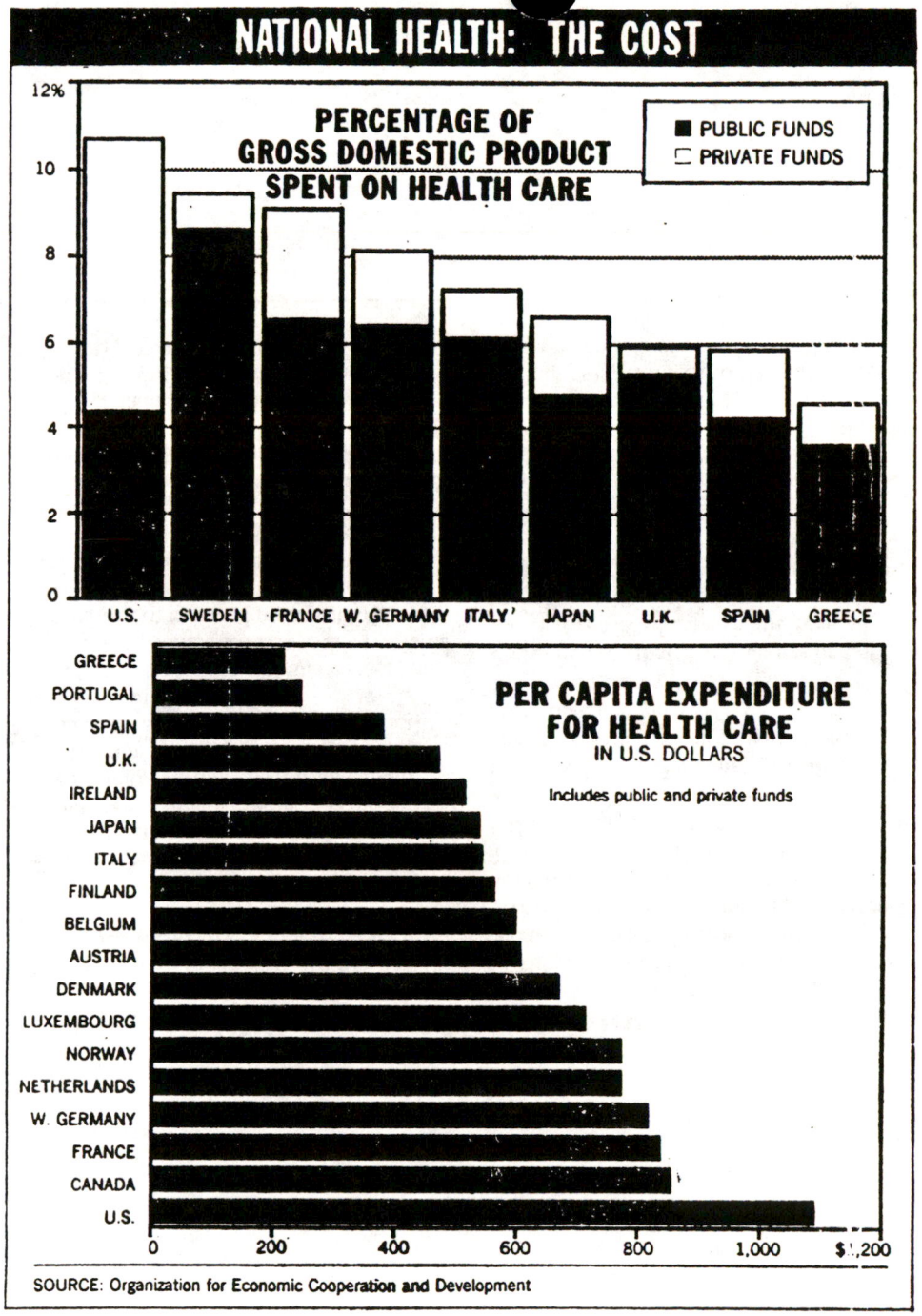
Advancing medical technology, resulting in new procedures, and Britain's steadily aging population have meant that more and more people are asking for more and more care, and the waiting list has grown accordingly. Much of the current list is made up of tens of thousands of elderly Britons waiting for hip replacement and hernia operations.

Despite NHS' problems, however, the legions of its defenders maintain that it provides the most cost-efficient public health service in the world. According to Social Democrat David Owen, a physician who has served as minister of both health and foreign affairs in previous governments, the NHS "is not in massive crisis. It is simply being skimped of resources."

Britain spends only 5.9 percent of its annual gross national product on health care, less than any Western European country except for Greece, Portugal and Spain, and little more than half of combined public and private expenditure in the United States.

To refuse to spend more, Thatcher's critics charge, is both niggardly and insulting to the citizens of a country that claims to have Europe's highest economic growth rate and most substantial cash reserves. "We already get pretty good value for money," Owen said. What Thatcher proposes amounts to "wantonly giving up something good for something that is no better." ■

NATIONAL HEALTH: THE COST



SOURCE: Organization for Economic Cooperation and Development

—THE WASHINGTON POST

One of Britain's Best Hospitals Still Struggles Financially

BRIGHTON, England

Since 1983, the Royal Sussex County Hospital here has maintained an exchange program with George Washington University Hospital in Washington. Every year, a handful of health professionals from each institution crosses the Atlantic to spend a few weeks looking at how the other side lives and works.

At George Washington University, Royal Sussex staffers say, they can learn about medical computer technology and advanced treatment of acutely ill patients. They study the American work ethic and what one veteran of the program described as "an atmosphere of relaxed informality" masking a "ruthless, cutthroat" system that brings performance results.

But the thing that really stands out for Britons is the amount of money in the U.S. system. "Their hospital is out of this world," said one about GW. "And they offer to take us out to Dominique's for lunch on expenses. You try to [get] a lunch out of the NHS . . . it's embarrassing."

The 460-bed Royal Sussex is typical of Britain's National Health Service general hospitals. Its hodge-podge of buildings, connected by uncovered walkways and alleys, ranges from a Victorian edifice built in honor of that queen's 1887 Jubilee, to a 20-year-old high rise. Both are in crumbling condition.

Inside, the fresh paint and carpets in renovated rooms contrast with cavernous wards where exposed pipes and beds divided by faded flowered curtains provide an atmosphere that hovers somewhere between threadbare hominess and Bedlam.

The Royal Sussex is the main hospital serving the Brighton District, one of 15 geographical divisions under the South East Thames Regional Health Authority that extends from inner-city London to this city on the English Channel.

By most indicators, the southeast is the best-off part of Britain, with more investment, more jobs and higher salaries in private industry. But South East Thames is one of the worst off of the 14 NHS regional authorities. Its surgical waiting list, about 44,000 people, is one of the highest in the country, with at least half of London district patients waiting more than one year.

District General Manager David Bowden notes that Brighton has one of the best records for productivity in recent years, treating 25 percent more patients in 1987 than in 1984 and reducing costs last year by $3.6 million in a $108 million budget.

"In any commercial setting, we would be regarded as a very successful business," Bowden said. "Yet we receive no more money . . . If we had the full funding of pay awards to the staff there would be no talk of crisis."

The Royal Sussex has done its part in cost-cutting plans. Competitive bidding for services saved about $126 million over the past three years. Part of the parking lot was sold to a flower shop franchise, and the hospital makes about $54,000 a year by renting out its radiation testing services to people like dentists.

But although the hospital budget has gone up from $27 million in 1982-83 to nearly $40 million last year, the number of patients treated over that same period grew from 14,000 to 21,000, with salaries and medical expenses also rising.

In November, despite a surgical waiting list of 800, the hospital decided to close a 12-bed ward and limit access to another.

"Systems in other countries have financing directly related to the number of patients treated," Forrer said. "If that were the case, we clearly wouldn't be in trouble. If we were profit-making, we would be in pretty good health."

— Karen DeYoung

SPECIAL ARTICLE

CONTROLLING HEALTH EXPENDITURES — THE CANADIAN REALITY

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Abstract Canada and the United States have conducted a large-scale social experiment on the effects of alternative ways of funding expenditures for health care. Two very similar societies, with (until recently) very similar systems of providing health care, have adopted radically different systems of reimbursement. The results of this experiment are of increasing interest to Americans, because the Canadian approach has avoided or solved several of the more intractable problems facing the United States. In particular, overall health expenditures have been constrained to a stable share of national income, and universality of coverage (without user charges) eliminates the problems of uncompensated care, individual burdens of catastrophic illness, and uninsured populations.

The combination of cost control with universal, comprehensive coverage has surprised some American observers, who have questioned its reality, its sustainability, or both. We present a comparison of the Canadian and American data on expenditures, identifying the sectors in which the experience of the two nations diverges most, and describing the processes of control. In any system, cost control involves conflict between providers and payers. Political processes focus this conflict, whereas market processes diffuse it. But the stylized political combat in Canada may result in less intrusion on the professional autonomy of the individual physician than is occurring in the United States. (N Engl J Med 1989; 320:571-7.)

AMERICAN interest in the Canadian health care system appears to be on the rise, as evidenced in a recent three-part article by Iglehart[1-3] in the *Journal*. Such interest has been intermittent in the past, depending in part on the position of national health insurance on the U.S. political agenda. In the early 1970s, the most recent period during which national health insurance seemed imminent, Americans paid considerable attention to the structure, logic, and history of the Canadian system.[4] At the time, that system had just been established in its entirety. Although its origins and organization were documented, there had been little experience with universal, public coverage, and data were not yet available on its performance. Universal hospital coverage was a decade or more old (in Saskatchewan, a quarter century), but the extension of insurance to cover physicians' services was very new. Then the moment passed, national health insurance moved off the American agenda, and after a variety of attempts to regulate the health care system at arm's length, competition and the marketplace became the dominant ideas of the 1980s. In this context the Canadian experience was of little relevance.

So far, however, market forces, at least as applied in practice, have been even less successful in containing the growth of health care expenditures than were the regulatory efforts of the 1970s.[5,6] The one major success in this field, prospective payment and diagnosis-related groups, is virtually a pure type of regulatory intervention, despite its being occasionally clothed in market rhetoric. At the same time, the proportion of the American population with no insurance coverage or grossly inadequate coverage is believed to be both large and growing,[7,8] and there is increasing uneasiness about the effect of market forces in health care on the interests of both patients and providers.[9-11] In this context, the radically different Canadian approach to funding may deserve a second look — not as a panacea, but as evidence that perhaps things could be different. By now that system has generated nearly two decades of experience that can be compared with the American record.

To an American audience, the most striking feature of the Canadian experience may be the association of universal coverage with substantially lower expenditures for health services. Despite (or, as many Canadians would argue, because of) universal access on equal terms and conditions, overall costs in Canada have risen more or less in line with the growth of national income, rather than eating up a steadily increasing share of it, as in the United States.

Before 1971, when the Canadian funding system was more similar to the American one, health care costs consumed a share of national income that was virtually identical in both countries and was rising steadily. In 1971 it reached 7.4 percent in Canada, as compared with 7.6 percent in the United States. After 1971, however, the Canadian share remained stable, whereas in the United States it continued to rise.[5,12-14] By 1981 their spending shares were 7.7 and 9.2 percent, respectively. In the 1982 recession, the share of expenditures for health care rose sharply in both countries, to 8.6 and 10.2 percent.[12,14] In both systems,

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health care escaped the effects of the recession — an interesting and unstudied observation. But the Canadian share stabilized at its new level; preliminary estimates for 1987 show it still at 8.6 percent. In contrast, the United States share continued to rise. Estimates for 1987 are in excess of 11 percent.[5,15]

The large and growing gap between the United States and Canada drives home the point that, for good or ill, the form of funding adopted by Canada does permit a society to control its overall outlays on health care. Furthermore, it is unnecessary to impose financial barriers to access in the process. In this paper we sketch some of the basic institutional and statistical facts of that process, and their implications for physicians in particular.

Cost control, although successful in general, can be a bruising political process, producing much sound and fury. External observers who rely on newspaper reports may not always get a clear picture, either of the critical issues in dispute or of the distinction between facts and rhetoric. Further confusion arises from casual interpretations of the comparative data, such as that by Feder et al.[16] Looking at the period from 1970 to 1984, they noted that health spending in Canada rose faster than in the United States, but that the gross national product (GNP) rose faster still. They concluded that the apparent success of the Canadian system with cost control was illusory, and that the stability of the share of the GNP applied to health care was simply the result of rapid economic growth. A more detailed look at the data shows this conclusion to be incorrect.

National Income and Health Expenditures in Canada and the United States

Table 1 provides the relevant data for Canada and the United States over the period referred to by Feder et al. The Canadian GNP does in fact outpace the American by 2 percent per year. But after adjustment for the more rapid rate of inflation in Canada, our advantage shrinks to 0.7 percent. When adjusted further for the slightly faster growth of the Canadian population, the difference in real per capita growth rates is less than half a percent per year — respectable enough over the long term, but not enough to account for the divergence in the shares of the GNP spent on health. The oversight of confusing nominal with real rates of GNP growth leads Feder et al. to their erroneous conclusion.

The relevant base year for examining the effect of national health insurance on health spending is not 1970, however, but 1971. Quebec, the second-largest province, with about a quarter of the Canadian population, adopted its health plan in October 1970, and New Brunswick began its plan on January 1, 1971. Correspondingly there was a substantial jump, from 7.1 to 7.4 percent, in the share of the GNP applied to health care for all of Canada.

Table 2 shows the annual rates of increase in total health spending in Canada and the United States since the completion of universal Medicare coverage

Table 1. Average Annual Percentage Increases in Gross National Product (GNP), 1970 to 1984.*

Measures of GNP	Canada	United States	Difference†
		percent	
Current dollars	12.1	9.8	2.0
Constant dollars	3.4	2.7	0.7
Constant dollars per capita	2.2	1.7	0.4

*Data for the United States are from the Health Care Financing Administration[5] and the Bureau of Economic Analysis[17]; data for Canada are from the Department of Finance.[18,19]

†Differences in annual growth rates must be calculated geometrically, not by subtraction [$d = (1 + r_1)/(1 + r_2) - 1$]. Rates have been rounded after calculation.

in Canada. Spending in nominal dollars did rise somewhat faster in Canada, by 0.7 percent per year. But when account is taken of the more rapid rate of general inflation in Canada and the slightly faster rate of population growth, health spending in constant dollars per capita rose more slowly in Canada, by 1.6 percent per year.

To put this more concretely, in 1985 Americans spent an average of $1,710 each on health care.[5] If their rate of cost escalation since 1971, in real terms, had been the same as that in Canada, they would have spent only $1,362, or 20 percent less. Preliminary estimates for 1987 show Americans spending just under $2,000 each for health care. Detailed Canadian data are not yet available, but the spending gap is clearly continuing to widen. One may estimate conservatively that if the Canadian rates of escalation in real cost since 1971 had prevailed in the United States, health spending would by 1987 be about $450 less, on average, for every person in the country, or at least $100 billion less in all.

The Process of Cost Control in Canada

How such control has been achieved, and with what effects, continues to form a major part of the agenda for research in health services in Canada.[20] As Iglehart pointed out,[2] virtually the entire difference between Canada and the United States in the share of GNP that is spent on health is accounted for by three components: insurance overhead, or costs of prepayment and administration; payments to hospitals; and payments for physicians' services. In 1985, these three items took up 0.59, 4.18, and 2.07 percent, respectively, of the U.S. GNP, and 0.11, 3.48, and 1.35 percent of the Canadian GNP.

Relative to the expenditures that might have been generated by a system comparable to Canada's, in 1985 Americans spent about $20 billion more for insurance and prepayment costs, and just under $30 billion more for each of physicians' services and hospital costs.

Administration and Prepayment Expenses

In relative terms, the most extraordinary difference between Canadian and American spending is in the area of administration and prepayment expenses. In 1985 the overhead component of health insurance —

Table 2. Average Annual Percentage Increases in Total Expenditures for Health Care, 1971 to 1985.*

Measures of Health Expenditures	Canada	United States	Difference†
		percent	
Current dollars	13.1	12.3	0.7
Constant dollars‡	4.3	5.8	−1.4
Constant dollars per capita‡	3.1	4.8	−1.6

*Data for the United States are from the Health Care Financing Administration,[5] Gibson et al.,[14] and the Department of Commerce[17]; data for Canada are from Health and Welfare Canada[12,13] and the Department of Finance.[18,19]

†Differences in annual growth rates must be calculated geometrically, not by subtraction $[d = (1 + r_1)/(1 + r_2) - 1]$. Rates have been rounded after calculation.

‡These constant-dollar measures are not real output measures for the health sector; they have not been adjusted by price indexes specific to the health sector. Rather, they are adjusted for changes in the general level of prices, economy-wide, as reflected in price indexes based on gross national expenditures, and they therefore reflect the increase in generalized purchasing power that is absorbed by the health care sector, in the form of either increased resource inputs or health sector–specific inflation.

the share of premiums that goes not to the reimbursement of physicians, hospitals, and other providers, but to paying for the handling of the flow of paper and dollars — cost Americans $95 each, out of their overall $1,710. Canadians spent $21 — and those were Canadian dollars. Indeed, Canadians spent less per capita to administer universal comprehensive coverage than Americans spent to administer Medicare and Medicaid alone (about $26 U.S. per capita[5]).

A universal, tax-financed system can simply be much less costly to administer, at all levels, and the Canadian system is. On the revenue side, once a tax system is in place, as it is in all modern societies — with income tax, sales tax, and everything else — the additional cost of raising more funds is minimal. (Some Canadian provinces continue to collect premiums, which are taxes in all but name. They are related to family size, but not to risk status; they cover only a portion of the total plan outlays; they are compulsory for most of the population; and most important, coverage is not conditional on payment.)

On the expense side, all the costs of determining coverage and eligibility are avoided — everyone is eligible, and for the same benefits. Patients drop out of the payment system entirely, and reimbursement takes place between the public insurer and the provider. There are no marketing expenses, no costs of estimating risk status in order to set differential premiums or decide whom to cover, and no allocations for shareholder profits; the process of claims payment, although not free of costs, is greatly simplified and much cheaper. In this area it is obvious that the public sector is more efficient and less costly than the private sector,[21] a fact that was recognized early on in Canada.[4] The 1964 Royal Commission on Health Services, which drew up the blueprint for Canada's universal system, described the private administration of insurance as "an uneconomic use of . . . limited resources."[22] This "uneconomic use" accounts for nearly one quarter of the difference in cost for health insurance between Canada and the United States.

Nor is that the end of the story. Himmelstein and Woolhandler[23] calculate that in the United States, the provider-borne overheads for hospitals, nursing homes, and doctors' offices (the accounting costs of complying with the requirements for documentation by a multiplicity of insurers, as well as coping with the determination of eligibility, direct billing of patients, and collections) amounted to $62.1 billion in 1983. They estimate that shifting to a national health insurance system could save $21.4 billion in the administrative costs of hospitals and physicians' offices. This would be 6 percent of total health care costs, or 0.63 percent of the GNP in 1983 — leading to the startling conclusion that the costs of running the American payment system itself, independent of the costs of patient care, may account for more than half the difference in cost between the Canadian and the U.S. systems.

For the Canadian physician, differences in the costs of insurance administration show up as a lower overhead for practice. The problems of determining insurance status and managing the collections process disappear, along with the problem of uncollectable accounts. The costs of compliance with the requirements of the health care reimbursement system also show up outside the area of health expenditures as it is normally defined, particularly in the budgets of the social welfare services, and to no inconsiderable degree in the monetary and nonmonetary costs borne by individual patients and their families. Furthermore, the considerable research, legal, and regulatory efforts required to put the complex and varied reporting and compliance requirements in place are not without cost, but will be counted as outside the health care system.

There is private insurance for some forms of health care in Canada. But for hospital and medical care, such coverage is prohibited for services that are included in the public plans. The original intent was quite explicit — to prevent private firms from skimming off the good risks, supporting the development of multiclass service, or both. But the restriction also has the very important effect of making provincial governments to all intents and purposes the sole funders of hospital and medical care, and of creating a bilateral bargaining situation as the foundation for cost control in these sectors.

The Effect on Hospitals

In Canada, controlling hospital costs is a two-part process. Operating budgets are approved, and funded almost entirely, by the Ministry of Health in each province, but they include no allowance for capital expenditures. New facilities, equipment, major renovations, and the like are funded from a variety of sources, but they require the approval of the same provincial agency, which generally also contributes the major share of financing. This process of centralized approval prohibits hospitals from accessing private capital markets, and has historically limited their efforts to support expansions of capacity from community sources. So far, it has been relatively successful in

limiting such expansion,[24] but somewhat less successful in managing the diffusion of major equipment.[25,26]

Centralized control over operating costs is more complete. Annual global budgets are negotiated between ministries and individual hospitals. Although political pressures have often forced governments to pick up the deficits of hospitals that are unable or unwilling to stay within these budgets, this process has resulted in a significantly less rapid rise in hospital expenditures in Canada than in the United States.[27,28]

The more rapid rate of escalation of hospital costs in the United States since 1971 has been shown to result from major differences in the growth in hospital costs per patient day at constant hospital input prices, or intensity of servicing.[27-30] This measure increases in response to increases in the number of nursing hours or drugs, or in the use of operating rooms, magnetic resonance imaging, and other such complex technology, per day of inpatient care. In the case of particular technologies that are embodied in specifically countable items like machines, capacities available per capita have tended to increase less rapidly in Canada. On the other hand, changes in the intensity of servicing in hospitals also include relative increases in internal administrative costs. Therefore, some portion of the apparent relative increase in servicing intensity simply reflects the increasing administrative intensity of the American hospital system.

But the different trends in servicing intensity also reflect quite different patterns in the use of beds in acute care hospitals. In Canada, a growing share of such beds has been occupied by patients over 65 years of age, whose stays exceed 60 days and whose daily care requirements are well below average. These patients prevent physicians from using the beds in question to treat short-term patients.[31]

Thus, Canada can have higher rates of hospitalization and greater average lengths of stay than the United States, yet also have lower per capita hospital expenditures.[32] Even if such expenditures, in terms of the cost of hospital care, are less different than is usually believed (because so much of the U.S. expenditure is for administrative activity), it does appear that the resulting mix of hospital activities favors intensive, high-technology services in the United States and long-term, chronic care in Canada. Nor should this come as a surprise, given the history of cost and procedural reimbursement in the United States, and of global budget-constrained funding in Canada. Which is preferable, in terms of value for money or benefits to patients, is harder to say. Possibly, each system generates its own forms of overuse and underuse.

One product that is clearly generated by the Canadian system, structured as it is to place the sole responsibility for control of hospital resources on the provincial governments, is intense, continuing public debate. The rhetoric of underfunding, shortages, excessive waiting lists, and so on is an important part of the process by which providers negotiate their share of public resources — including their own incomes.[33] Furthermore, there are reasons for the noticeable recent increase in such rhetoric. Increases in the supply of physicians per capita, in the face of a relatively constant supply of beds, have resulted in steady reductions in the number of short-term hospital beds available to each physician since 1971.[27] As bed availability and operating budgets have undergone increasing scrutiny, hospital administrators responded first (in the mid-1970s) by rationalizing administrative operations, and more recently by joining physicians in stepped-up rhetoric and pressure about underfunding.[34]

The difficulty for health policy and funding is that, since the boy always cries wolf (and must do so, given the political system of funding), one does not know if the wolf is really there. The political dramatics should not mislead external observers into believing that the wolf is always at hand. What varies most between the two nations in the method of establishing total hospital expenditures is the centralized, overtly political process in Canada, in contrast to the largely decentralized, institution-centered, and only implicitly political process in the United States. The Canadian controls on hospital expenditures impinge on individual physicians by limiting the complementary resources that are available to them. In this way, the environment of medical practice is changed, and practice patterns change in response. But individual physicians are not subject to any substantial direct intervention by hospital management or third parties. In this sense, Canadian physicians are actually much more autonomous than their American counterparts.

The Effect on Physicians

From 1971 to 1985, the share of the American GNP going to physicians has risen by over 40 percent. By contrast, Canadian physicians had an increase of only 10 percent. The stories that U.S. physicians hear about disaffected Canadian physicians, outmigration, underfunding, and occasional strikes correspond to an underlying reality of less generous funding. Despite the rhetoric, however, there has been no mass bailout of physicians from Canada. The supply of physicians per capita has risen throughout the period, is currently growing at between 1.5 and 2 percent per year, and is projected to continue its growth for the foreseeable future.[35] At the end of 1985 there were about 490 people per physician in Canada — very similar to the U.S. ratio. As in the United States, the policy concern is with surpluses, not shortages.[36] There may be some loss of superstars to the United States, but that is hard to document — individual anecdotes do not make a trend. In any case, there is always some leakage of stars in any field from countries with small populations to populous neighbors (the Gretzky effect).

The main explanation for the difference in outlays to physicians is that real fees have increased much faster in the United States than in Canada.[27,37] This difference, in turn, has resulted from the effect of uni-

versal public coverage on the process of fee determination. Increases in the general levels of fees and rules of payment are negotiated periodically between provincial medical associations and Ministries of Health. Over the long term, this complex negotiation process has had a major impact on the overall rate of escalation of fees.[37] Ironically, for a society that believes in the influence of competitive markets, the increasing supply of physicians in the United States seems to be associated with an acceleration in fee increases. In 1986, the rise in fees relative to the overall Consumer Price Index was one of the largest on record.[5]

Two other related issues have been particularly contentious for Canadian physicians — billing at rates above those reimbursed by the provincial plans ("extra billing") and the growth in the use of services per physician. Since 1971 these factors have become increasingly prominent in the political negotiating process, although the first one may at last have been pushed off center stage.

With the passage of the Canada Health Act in 1984,[38] the right to "extra bill" was removed in all provinces in which such billing had previously occurred. This act, passed unanimously by the House of Commons, was a response to public perceptions that extra billing was undermining the fundamental principle of universal access on uniform terms and conditions. The termination of extra billing was met with intense opposition from physicians in some provinces, however, culminating in a lengthy strike in Ontario.[2,39] Physicians argued that the threat of widespread extra billing was a safety valve, protecting them against overly aggressive bargaining by the Ministries of Health and helping to push up public reimbursement rates. Although relatively few physicians engaged in extra billing, the majority strongly supported the option. They were unable to mobilize any sizable public support, however.

The extreme distress among physicians in Ontario appears to have been based largely on symbolic considerations. The right of ultimate access to the patient's economic resources seems to have had a meaning difficult for nonphysicians to understand. In fact, no change has occurred in the prevailing pattern of private, fee-for-service practice with reimbursement at uniform, negotiated rates. But Canadian physicians do have real concerns about the future, which have been linked to the extra-billing issue.

Once governments have achieved control over fee levels by ensuring that the public reimbursement rates represent payment in full, it is feared that the next step in cost control will be to restrict the amount or type of care provided, or at least the number and mix of services for which reimbursement will be made. This is particularly likely if physicians increase their delivery of services to compensate for the loss of extra billing, for a stagnant fee structure, or both.

The latter possibility has been an important consideration in recent American discussions of physicians' reimbursement under Medicare.[40,41] Analyses of the U.S. experience with fee freezes in the early 1970s clearly demonstrated that increased billing occurred as a response.[42,43] Billing activity per physician has risen faster in Canada than in the United States since 1971, in a manner consistent with this concern, although in Canada fee controls have clearly moderated the rate of escalation of expenditures for physicians' services, not just that of fees. Until recently, the provincial governments have been willing to accept an additional rise in expenditures (increases in physicians' productivity or more creative billing, depending on one's point of view) over and above increases in fees and numbers of physicians. Nationally, this has averaged 1 to 2 percent per year since 1971.[37]

The exception was Quebec, where over a four-year period of unchanged fees (1971 to 1975) the increase became so large as to create a fiscal problem.[37,44] Starting in 1976, Quebec introduced modifications to the reimbursement process that limited its liability for increases in services, billings, or both (per practitioner and in the aggregate) that exceeded preset target levels. From a billing standpoint, 26 office-based diagnostic and therapeutic procedures were bundled into the office visit. These procedures had been billable separately, in addition to the basic visit fee, and during the early 1970s their number and cost per office visit had risen rapidly. Their consolidation into the office-visit fee removed one of the principal mechanisms by which Quebec physicians had been able to stem some of the erosion in their real incomes during the period of unchanged fees.[37]

In addition, there are ceilings on the quarterly gross billings of individual practitioners, above which physicians are reimbursed at only 25 percent of the allowable fee. For the profession as a whole, negotiated fee increases are implemented in steps, conditional on the rate of increase in use. If the rate of use per physician (i.e., average gross receipts) rises faster than a predetermined percentage, subsequent fee increases are scaled down or eliminated.

None of these measures impinge directly on the autonomy of individual physicians in their practices, however. Specific clinical decisions are not reviewed by the reimbursement agency, nor are therapeutic protocols established. If the aggregated bill for all clinical decisions exceeds the limits, then fees to either the individual or the group as a whole will be scaled down, but physicians remain free to determine their own practice patterns.

Committees to review patterns of practice have existed for years in each province, under various names. But they were established to monitor a very small number of practitioners whose patterns deviated radically from those of their peers, and to look for fraud or incompetence. Such committees have neither the mandate nor the resources to go beyond statistical outliers in their investigations; even in this role, a recent commentary suggests that they are not very aggressive or effective.[45]

Since 1985, British Columbia, Alberta, Saskatch-

ewan, Manitoba, and Ontario have all negotiated contracts setting limits on aggregate billings. British Columbia attempted to go further, by restricting the numbers of new physicians entitled to reimbursement by the provincial plan and controlling their locations of practice.[46] This policy, however, was successfully challenged on constitutional grounds. It was sustained at the provincial court, but overturned on appeal, and leave to appeal further was denied by the Supreme Court of Canada.

The absence of intrusion by any of these measures into the autonomy of individual practice contrasts markedly with the situation in the United States, where managed care systems and prospective payment, designed to alter individual physicians' care of individual patients, have become the principal tools for the control of expenditures for physicians' services. In the absence of a centralized bargaining mechanism between physicians and payers — a single-source payer — there is no way to limit the overall levels of billings. Hence the leap from constraints on capacity (as by a certificate of need) straight to the level of minute scrutiny of the behavior of individual physicians or the treatment of specific diseases.

Thus, many Americans already feel the threats to clinical freedom that Canadian physicians fear for the future. Whether such fears actually materialize will probably depend in large part on whether the provincial governments can continue to contain overall expenditures. What is disturbing, however, is that the current aggregate approaches to control of the use of services leave unexplored the cost-effectiveness, and even the efficacy, of the actual services provided. Such concerns, if left unaddressed by the profession itself, may become the catalysts for more detailed scrutiny of the use of services within the fee-negotiation process in Canada. To date, we see little evidence of this, but a decade ago there was little sign of the now widespread practice of bargaining over aggregate use along with fees. The context of policy decisions changes more slowly in Canada than in the United States, but it does move forward.

Orchestrated Outrage versus Diffuse Distress

Thus, the major difference between the two countries with respect to health expenditures lies in the degree of centralization of the cost-control process. In the United States the battles are fought in a myriad of private struggles between physicians and their employers, or their hospitals (or their competitors). When the struggle becomes public, as in the call by Minnesota physicians for unionization,[47] it takes the form of a series of isolated and localized incidents. The general pattern is obscured. In Canada, by contrast, the struggle over shares of income between physicians and the rest of the society is played out as large-scale public theater, with all the rhetorical threats and flourishes that political clashes require.[48] Physicians in Canada, and perhaps also in the United States, may perceive the Canadian conflicts as more severe and as arising from the presence of a universal public-payment system. That system serves to focus and channel such conflicts and to bring them into the headlines, but it has also afforded Canadian physicians a greater degree of professional autonomy.

Whatever the liabilities of such an overt and at times rancorous process, the Canadian approach has controlled health care costs more effectively. In the end, this may be the root of the sense of unease among Canadian physicians, who face a problem common to physicians in every country with a rapidly rising supply, including the United States. In such circumstances, every community of physicians must struggle for an ever-increasing share of national income or accept falling personal incomes. In the process, they must urge on the rest of society the benefits of buying the additional services that the additional numbers of physicians make possible (some would say inevitable) — and of doing so at fees that will sustain their own incomes. Whether such benefits are real or illusory is important from the standpoint of health policy, but irrelevant to the needs of the medical community.

The rest of society, or at least a sector of it, attempts to resist this expansion under the banner of cost control. When such resistance is organized collectively through public insurance, it is relatively successful. When it is disorganized and fragmented, an inconsistent and contradictory mix of strategies, as in the United States, it has so far been unsuccessful. Again, that observation is logically independent of whether the lack of success in the United States reflects waste, or whether the Canadian success leads to "underfunding."

In such an environment the pressure on physicians can only grow. To the extent that they resist such pressures successfully and continue to expand their share of the national income, as in the United States, the public and private responses to cost escalation will become increasingly radical. Major institutional changes are already transforming the American health care system to an extent much greater than has been the case in the more conservative Canadian environment. Fears and anecdotes about the erosion of professional autonomy, and even of incomes, are becoming increasingly widespread. In the United States, corporate competitors or employers may turn out to be more ruthless than public regulators.

Such are the costs of economic success. The Canadian environment is more stable and predictable precisely because its cost-control processes work relatively well. But in Canada, whatever has happened or may happen can be blamed on government and on the evils of "socialized medicine." Anxiety and dissatisfaction are easily, if not always accurately, focused and channeled collectively through the process of public negotiation. In the United States, it is harder for individual practitioners to find the villains, and still harder to identify an effective response.

At the same time, it is easier to misinterpret the experience of other countries with more visible bargaining processes.

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CHAPTER 3.—NATIONAL HEALTH INSURANCE

I. INTRODUCTION

In the 1970s, substantial legislative activity at the Federal level was directed at the creation of a national health insurance program. While the legislation took a variety of forms, the general thrust of the proposals was to make basic health insurance available to all Americans, so that access to health care would not be contingent upon a person's ability to pay. Although the specifics of the proposals varied, they shared a common goal of establishing universal entitlement to insurance for Americans of all ages.

In today's political and budgetary environment, such comprehensive proposals are receiving less attention. The emphasis is on encouraging or mandating more extensive access to private employer coverage, expanding the Medicaid program, and creating Federal or State pools to provide health insurance to specific populations such as the medically uninsurable. Consequently, expanded access to insurance coverage may result from a series of political decisions in which responsibility for financing coverage is spread among health care consumers, employers and the public sector. Under such a piecemeal or incremental strategy, it is possible to envision a point at which most Americans will be able to obtain access to health insurance at a price they can afford, although the scope, quality and cost of that coverage and the program(s) through which it is obtained may vary significantly. The U.S. could, in effect, achieve national health insurance by an aggregation of public and private sources of coverage at both the State and Federal levels. This uniquely American approach has been described as "slouching toward national health insurance." [54]

In the absence of significant change in the economic and political climate, this incremental approach to coverage seems likely to continue. It is also apparent that many lawmakers believe that access to coverage can be expanded in this country only in a step-by-step fashion. Thus, increasingly the incremental strategy is being explicitly articulated in government as well as academic circles. It is also reflected in a variety of congressional proposals that provide for Federal program changes and new initiatives that stop short of comprehensive system reform.

For example, a new study by Anderson, Lave, Russe and Neuman [55] proposes a five-part plan that could be implemented gradually, and that would draw on State and Federal authority, to increase access to health insurance:

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[54] Morone, James, and Andrew Dunham. Slouching Toward National Health Insurance: The New Health Care Politics. Yale Journal of Regulation, 2:2. 1985.

[55] Anderson, Gerard, Judith Lave, Catherine Russe and Patricia Neuman. No Free Lunch. Baltimore, MD, Johns Hopkins University Press, forthcoming.

- treat all employer contributions for health insurance as taxable income;
- offer all families a uniform refundable tax credit adjusted for family size;
- offer government subsidies to poor and near-poor persons for the purchase of health insurance;
- require all States to make health insurance available to all persons, including the uninsurable (States would retain their flexibility to design and finance individual programs, but the Federal Government would define the minimum level of benefits and maximum copayments); and
- eliminate the existing adjustments under Medicare and Medicaid for hospitals serving a disproportionate share of low-income patients. (Eventually all subsidies to public hospitals could be eliminated.) [56]

Numerous examples of this strategy exist in pending legislation, although it is a question of definition as to whether these proposals are most appropriately characterized as "national health insurance through aggregation" or a "mixed public/private scheme which results in national health insurance." If the criterion for the former is one of providing gap-fillers rather than universal coverage, then most of the current bills would fall under this category. They would include recent initiatives such as: (a) those to increase coverage under the Medicaid program by severing the connection between Medicaid and welfare eligibility (S. 1139 in the 100th Congress); (b) the Access to Health Care proposals of the 99th Congress (S. 2402, S. 2403, and H.R. 4742), which would have provided for increased coverage through requirements on employers to provide continued benefits to laid-off workers and their dependents, and on the States to create programs to finance indigent care; and (c) the various employer mandate bills introduced in the 100th Congress (S. 1265/H.R. 2508, H.R. 4951), which would fill the major gaps in coverage of the working uninsured but leave the remaining uninsured population uncovered.

While approaches of this nature are more politically feasible than the national health insurance proposals of the 1970s, they may not help to reduce the administrative waste, cost shifting and inflationary features that many people believe characterize the current patchwork system.[57] For example, under a piecemeal approach, there is likely to be duplication of administrative agencies and the accompanying red tape associated with operating programs. Also probable is duplication of effort in the areas of quality assurance, such as licensure, certification and peer review. At the same time, there are likely to be vast variations in such administrative functions as eligibility determinations, billing, and reporting of information. These factors not only add to the cost of cover-

[56] At full implementation of the tax credit and subsidy, Anderson et al. estimate that the maximum expenditures for these proposals would be $28 billion in FY 1989. Much would depend on the generosity of the subsidy, a component of this plan that would be subject to political negotiation. Some of this expenditure would eventually be offset by savings from reducing subsidies for uncompensated care.

[57] For an analysis of the administrative costs of the existing system, see Himmelstein, David, and Steffie Woolhandler. Cost Without Benefit. Administrative Waste in U.S. Health Care. New England Journal of Medicine, vol. 314, no. 7, Feb. 13, 1986.

age but also to difficulties and confusion for providers and consumers who must navigate through the maze of different eligibility criteria, benefit packages, and reimbursement rules. Also made more complicated is the task of coordination of benefits among the various sources of coverage. The more complex the design for providing coverage, be it multiple layers of government, mixed sources of financing, and/or the lack of uniform eligibility standards, the higher the likely costs for administration.

Coupled with administrative waste is the more general problem of rising health care costs. In the absence of a centralized budget and coordinated cost controls that typify comprehensive approaches to reform, inflation in health care prices may continue to be a significant problem. The U.S. cost containment experience so far suggests that efforts to constrain expenditures by applying restraints on one part of the health care system tend to lead to ballooning costs in other parts.

On the other hand, the piecemeal or incrementalist approach may be the most appropriate for the U.S. Given the size and complexity of our current system of financing and delivering health services, small steps with room for adjustment may make more sense than sweeping system-wide reforms. After all, the national health insurance systems in Europe and Great Britain did not spring forth overnight but instead evolved over many years. In Great Britain, for example, the National Health Service was created in 1948, but it followed on the heels of a medical insurance program begun in 1911 for much of the nation's workforce.

There are other possible arguments for an incremental and pluralistic approach. A system that builds upon private insurance preserves freedom of choice for consumers and autonomy for providers. Pluralism can also encourage innovation, encouraging program improvements and new solutions that might not be found in a centralized, more static system.

Nevertheless, it is possible that lawmakers may decide that universal coverage is most effectively and efficiently achieved through a comprehensive approach. Such an approach could take at least one of three basic forms: social insurance, the creation of a national health service, or a public-private mix. The following pages provide illustrations of each of these approaches.

II. Models of National Health Insurance

A. SOCIAL INSURANCE MODEL

This model is characterized by compulsory universal coverage, generally within the framework of Social Security, and financed by employer and individual contributions to nonprofit insurance funds. Typically, these proposals provide for a mixture of public and private ownership of the factors of production such as hospitals, physicians and ancillary services.[58] They therefore differ from national health service models, in which the direct delivery of care becomes a function of government.

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[58] Schieber, George J. Financing and Delivering Health Care. Social Policy Studies No. 4, OECD, 1987. p. 24.

Many of the prominent national health insurance proposals of the 1970s were of this nature. For example, the Health Security Act, introduced by Senator Edward Kennedy and Representative James Corman in the 94th Congress (S. 3, H.R. 21) would have established a universal national health insurance program financed by a Federal payroll tax on employers and employees, a tax on unearned income, and Federal general revenues. Providers would have had to meet specified standards of participation (e.g., to accept Federal payment as payment-in-full and not charge patients for covered services). Hospitals would have been paid on a reasonable cost basis from a predetermined budget. Physicians, dentists and other professionals would have been paid on a fee-for-service, capitation, or salary basis. The bill included provisions designed to reorganize the delivery of health services, improve health planning, and increase the supply of health care personnel and facilities.[59]

A more recent example of a social insurance proposal is the U.S. Health Program Act, introduced by Representative Edward Roybal (H.R. 200 in the 100th Congress). The bill would replace Medicare and Medicaid with a comprehensive national health insurance program covering all U.S. citizens and legal aliens. Everyone would have access to a basic health benefits package (similar to the Medicaid "categorically needy" package), and would be protected from the cost of catastrophic illness, once beneficiaries paid up to $500 per year (indexed for future years) for health care, skilled nursing home and home health costs, and $1,000 (indexed) for nonskilled, long-term care costs. The bill would provide for subsidization of the cost of coverage for low-income beneficiaries. The program would be financed by a tax on employers, beneficiary cost sharing, an increase in the excise tax on cigarettes, State revenues, and a surcharge on corporate and personal income taxes. The program would be administered by an independent agency in the executive branch.

B. NATIONAL HEALTH SERVICE MODEL

Far less common are proposals that are modelled after Britain's National Health Service. These are characterized by universal coverage, Federal financing derived from progressive taxes, and national ownership and/or control of the factors of production.[60]

An example of this approach is legislation sponsored by Representative Ronald Dellums that was first introduced in 1977 and has been introduced in each successive Congress. In the 100th Congress, the U.S. Health Service Act (H.R. 2402) would establish a Health Service that would provide free medical, dental, and mental health care and additional supplemental services to all individuals while within the U.S. and its territories. The program would be administered by a four-tiered system of national, regional, district and community health boards, all comprised of two-thirds health care users and one-third health care workers. It would be financed by a special health service tax on individuals and employers and by general

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[59] Waldman, Saul. National Health Insurance Proposals. Provisions of Bills Introduced in the 94th Congress as of February 1976. Department of Health, Education and Welfare, Social Security Administration, HEW Publication No. (SSA) 76-11920.

[60] Ibid.

Federal revenues. H.R. 2402 also provides that, in health facilities established by the Service, health services would be provided by salaried health workers.[61]

C. MIXED PUBLIC/PRIVATE MODEL

Similar to the incrementalist approach described above, mixed public/ private proposals rely largely on employer-based or individual purchase of private health insurance coverage financed by employer and individual contributions. Ownership of the factors of production remains unchanged from the current system.

Many proposals illustrate this approach. For example, the Nixon-Ford Catastrophic Health Insurance Plan (93rd Congress, H.R. 12684) provided for a three-pronged strategy to achieve full coverage of the population: (1) mandated employer-provided insurance, (2) a federally-assisted plan for the low-income and high medical risk populations, and (3) an improved Medicare program for the aged. In the same Congress, Senator Paul Fannin introduced the National Health Standards Act (S. 3353). Endorsed by the U.S. Chamber of Commerce, this bill would have established a two-part program to require all employers to make available a comprehensive health care package to their employees, and to provide comparable protection for low-income persons as a replacement for the Medicaid program. Under the provision mandating employer provided coverage, the bill specified a minimum benefit package and provided for "benefit value equivalency." The legislation also provided for the establishment of insurance pools to provide coverage for the self-employed and small employers. A second pool, in each State, was to pay all or part of the cost of the premiums for the poor and near poor from general revenues.

The Carter Administration's National Health Plan (introduced by Senator Abraham Ribicoff in 1979 as S. 1812) had two major components to achieve coverage: a public plan (known as "Healthcare") providing coverage to the aged, disabled, the poor, and the near poor, and offering catastrophic coverage to those individuals and firms unable to obtain such insurance in the private sector; and a program requiring employers to provide to their full-time employees, their spouses, and dependents health benefits meeting uniform Federal standards.[62] Employers would have been able to satisfy the mandate to provide coverage by buying Healthcare coverage for employees and their families. The States would have continued to help finance care for the low- income population by contributing to the Healthcare Trust Fund.[63] This Fund would also have subsidized employers whose premium payments attributable to the mandated minimum benefit coverage exceeded 5 percent of the employer's payroll. The subsidy would have been set at the difference between those payments and 5 percent of payroll.

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[61] For a discussion of the genesis of this proposal, see Rodberg, Leonard S. Anatomy of A National Health Program, Reconsidering the Dellums Bill After 10 Years. Health/PAC Bulletin, Winter 1987. pp. 12-16.

[62] Feder, Judith, John Holahan and Theodore Marmor, eds. National Health Insurance: Conflicting Goals and Policy Choices. Washington, The Urban Institute, 1980. Appendix.

[63] For a short critical analysis of the Carter proposal, see Enthoven, Alain C. Health Plan, The Only Practical Solution to the Cost of Medical Care. Reading, Mass., Addison-Wesley, 1980. p. 168-170.

S. 1812 would also have imposed requirements on insurers. Qualified non-employer plans would have been required to set premiums for groups of 10 to 50 individuals on a community-rated basis. In addition, a Health Reinsurance Fund would have been established in the Department of the Treasury. The Secretary would have been required to make reinsurance available to certified administrators of qualified plans and to HMOs, to cover 80 percent of expenses attributable to any individual that exceeded $25,000 annually (for a prescribed basic benefit package) and to cover other specified needs.

A more recent proposal is the Comprehensive Health Care Improvement Act of 1987 introduced by Representative Martin Sabo (H.R. 3766 in the 100th Congress). The bill would require all employers to offer coverage to their employees who work at least 17.5 hours per week, and to eligible employees' dependents. States are required to establish statewide pools of all health insurance companies that would in turn provide coverage to persons without employer-based coverage. These pools would be required to provide reinsurance for all insurers, self-insurers, HMOs, and other such entities. Businesses could also buy or offer insurance from the State pools. Through a new title to the Social Security Act, H.R. 3766 would also establish an optional Federal-State program to help low-income people buy health insurance. The bill would leave the design of the program to the State, but the Federal Government would contribute half of the funds needed to fund the program up to a specified maximum. The legislation would also create an optional State-Federal catastrophic health insurance program.

More incremental solutions to the problem of the uninsured are analyzed in the following chapters. In the next chapter, options to increase coverage through public programs such as Medicare and Medicaid are discussed.

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Washington Post, March 3, 1990, pp. A1, A4

Hill Group Backs Broad Health Plan

$66 Billion Tax Cost Is Left Unresolved

By Kenneth J. Cooper
Washington Post Staff Writer

A bipartisan congressional commission yesterday endorsed a comprehensive plan for providing health coverage for 31 million uninsured Americans and long-term care for the elderly and disabled. The expansive plan, which would require $66 billion in new federal funding, came under immediate attack for failing to specify how the government would raise the money.

The commission was established to devise solutions to two major problems of the nation's health care system: providing coverage to uninsured people, who often delay treatment until they must seek free care in hospital emergency rooms, and providing long-term care to the elderly with chronic diseases and the disabled of all ages, groups of people often bankrupted by the cost of nursing home care.

The panel's work, which began a year ago, was intended to produce a report that would frame the issues for Congress, which avoided action on them when it voted to expand Medicare in 1988.

Several members said the 15-member commission, by failing to agree on financing methods, had not fulfilled its mandate and would have little practical impact on congressional deliberations. The part of the plan covering the uninsured was approved on an 8-to-7 vote, while the long-term care section was accepted 11 to 4.

"It won't work. There's no financing, no way to pay for it. It's dead," declared Rep. Fortney H.

See HEALTH CARE, A4, Col. 1

HEALTH CARE, From A1

"Pete" Stark (D-Calif.), chairman of the House Ways and Means subcommittee on health. He voted against both parts of the plan.

"It does not get down to the bottom line," said Rep. Willis D. Gradison Jr. (R-Ohio). "On that point, we have made no useful recommendation whatsoever."

But Sen. Jay D. "Jay" Rockefeller IV (D-W.Va.), the commission chairman, called the proposal a "blueprint" and suggested it was the role of the tax-writing committees of Congress to decide on financing. He said the panel had made a breakthrough by estimating the cost of the health care expansions. "This commission has laid out a plan, and it can work," Rockefeller said.

Sen. Edward M. Kennedy (D-Mass.), another member, denied it was the commission's role to recommend a financing mechanism. "We're not the [Senate] Finance Committee or the [House] Ways and Means Committee," Kennedy said.

Rep. Dan Rostenkowski (D-Ill.), the Ways and Means chairman, criticized the panel for producing what he called incomplete recommendations, saying "when the question of financing arose, it ducked. That sort of evasion is unacceptable in today's budget climate."

Congress established the U.S. Bipartisan Commission on Comprehensive Health Care in the 1988 legislation that created "catastrophic" health coverage under Medicare, benefits that were repealed last year. The panel is commonly called "the Pepper Commission" after the late Rep. Claude Pepper of Florida, its first chairman and a tireless advocate for the elderly. At Pepper's insistence, the panel was established as a way to ensure Congress would return to the issues of long-term care and the uninsured.

A fact sheet distributed on commission letterhead yesterday said the law creating the panel directed it to make "specific recommendations" on financing and "consider" the amount of federal funds neccessary and "the sources of those funds."

In general terms, the panel agreed that "the final tax package ought to be progressive," taxpayers of all ages should contribute and revenues would need to grow 8 percent to 9 percent a year. In addition to federal costs of $42.8 billion for long-term care and $23.4 billion for covering the uninsured, businesses would absorb an estimated $20 billion in costs.

Under the long-term care proposal, state and federal governments would finance a nursing home program that would provide social insurance for a three-month stay and would not require residents to be impoverished before becoming eligible, as has traditionally happened under Medicaid. An individual could keep $30,000 in assets and a couple, $60,000. Private insurance would fill gaps in the nursing home program. In-home care would be provided to severely disabled persons through the social insurance.

To cover uninsured persons, most of whom are employed, large businesses would be required to offer specific health benefits to their workers or pay into a public health plan. The same mandate would apply to businesses with fewer than 100 employees if 80 percent of the uninsured in their ranks were not voluntarily covered. Small businesses would receive tax credits and subsidies.

The public health plan would replace Medicaid, the state-federal program for the poor. The unem-

ployed could buy coverage in the plan or would be subsidized.

A range of reactions to the commission's proposals came from business, health and elderly groups as well as public officials.

Health and Human Services Secretary Louis W. Sullivan, whom President Bush has asked to study the same issues, said disagreement among panel members "reflects the simple fact that there is no consensus in our country today on how to achieve the kind of health care system we want."

The U.S. Chamber of Commerce reiterated its traditional opposition to government mandates on health benefits. The Health Insurance Association of America complained that costly health coverage would go to "middle and upper income Americans who are able to pay for that coverage themselves."

Reviews from groups representing the elderly were mixed. Families United for Senior Action embraced the proposal. The National Council of Senior Citizens criticized the lack of a financing plan. And the American Association of Retired Persons, battered by some members for backing the catastrophic coverage law, said it would withhold judgment until its board meets later this month.

COMMISSION RECOMMENDATIONS

UNIVERSAL HEALTH CARE COVERAGE

- Businesses with more than 100 employees would provide private health insurance (for a specific benefit package) or contribute to a public plan for all employees and non-working dependents.
- Businesses with 100 or fewer employees would be encouraged to provide health insurance for employees and non-working dependents. Tax credits for some small employers would be available.
- The public plan would cover employees and dependents that contribute and non-working individuals who buy in or are subsidized. The plan would replace Medicaid for the specified services and would pay providers according to Medicare rules.
- The minimum benefit package would include primary and preventive care, physician and hospital care and other services. Services are subject to cost-sharing, with subsidies for low-income people and limits on out-of-pocket spending.

LONG-TERM CARE

- The commission plan would establish a Nursing Home Program for nursing home care that would provide financial protection and ensure that no one faces impoverishment.
- Nursing home patients would be entitled to social insurance for the first three months of nursing home care. Such "front-end" insurance would allow people who have short stays to return home with resources intact.
- Severely disabled persons would be eligible for social insurance for home and community-based care.
- The federal government would finance the home and community-based care program and the "front end" nursing home care. The federal and state governments would share in financing the Nursing Home Program.
- Private long-term care insurance would fill gaps not covered by the plan, subject to government oversight.

SOURCE: U.S. Bipartisan Commission on Comprehensive Health Care

THE WASHINGTON POST

IP421H
AS "The Disgrace of American Health Care," Washington Post. January 24, 1989, Health Section, pp. 12-16

By Victor Cohn
Washington Post Staff Writer

Most Americans are healthy, but too many are not.

Most Americans get good medical care, but too many do not.

Most Americans can pay for their medical care, but too many cannot.

George Bush has been president for only four days, and his words, "kinder and gentler," already have become overused. But this country badly needs kinder, gentler, better, better distributed, more affordable health care.

Now Bush and his team have their opportunity to shape the American medical future. No one can expect them to

PATIENT'S ADVOCATE

solve all the problems in the next four years, but they could begin. And they and many others could conduct a dialogue on the great fixes that are needed.

What needs fixing?

Some medical leaders are fond of saying that America has "the world's best medical care." A former Nixon administration health official recently put it more accurately. He said American medicine is the world's best "at its best."

And at its worst? The facts are almost tiresomely familiar.

Thirty-seven million Americans have no health insurance; one third are children or teen-agers, and most of the rest are the working poor. Medicaid is serving a decreasing portion of the poor—no more than two-fifths altogether. The nation's infant mortality rate is among the developed world's highest. The health of many blacks and Hispanics is abysmal.

Even among Americans who get medical care at its "best," there is much bad care. Those needed to give much of the care—nurses, medical technicians and therapists of many kinds—are in alarmingly short supply.

Public hospitals are jammed, underfinanced and undersupplied, and faced with treating thousands of patients a year transferred to them by other hospitals that want patients who can pay. In 1986, nearly 39 million Americans had trouble getting health care. Nearly half blamed the cost. Even citizens with health insurance are finding their premiums going up and up, while their coverage diminishes.

Medical costs are not just going up, they are "out of control," in the words of many medical leaders, economists, officials and business people trying to control them.

Hospital Squeeze

Society, not the health system, is to blame for many of these ills. But the medical system could help alleviate them—if it were in better shape.

Instead, it is in a state of "free-floating anxiety," said Dr. Robert Brook and Jacqueline Kosecoff of the University of California at Los Angeles. Uwe Reinhardt, a moderate Princeton University economist, said a system under which hospitals turn away sick people because they can't pay, and doctors post signs saying "pay now," is one that "disgraces America."

In all of this, the hardest nut to crack is runaway medical inflation. The Nixon, Carter and Reagan administrations have tried both clamping down regulations on hospitals and doctors and encouraging price competition between them. Both strategies have failed so far. In 1965, health care consumed 5.9 percent of the gross national product; in 1988, the figure rose to 11.3 percent.

To be sure, the combination of regulation—in the form of strict preset payment limits for Medicare patients in hospitals—and competition has moderated the rise in hospital costs. But the amount and cost of other kinds of care have gone through the ceiling, and expenditures for non-hospital procedures have skyrocketed. One example is outpatient surgery for persons who used to be admitted to the hospital for care.

In 1984, the government put a so-called "freeze" on doctors' Medicare fees. But the amount of care given Medicare patients—especially by surgeons, radiologists, cardiologists and gastroenterologists using new, often-beneficial but costly methods increased so fast that physicians' total Medicare charges have risen 12 to 15 percent yearly, defying the freeze.

If nothing is done, Medicare and Medicaid will continue to be the main villains in the federal budget deficit, with Medicare expenditures growing at about 14 percent yearly, and Medicaid by around 9 percent, hobbling all other efforts to improve medical services for those who are now left out.

The upshot of probable Bush and congressional efforts this year?

There is virtually no likelihood that medical inflation will be tamed in the near future. The Bush administration, like Reagan's, will push medical price competition—between hospitals, between doctors, between health plans—as a way to control costs. And it will rely just as heavily on regulation.

Hospitals will continue to bear the immediate brunt. Last month, a Department of Health and Human Services commission said that a majority of the nation's 6,000 hospitals lost money in 1988. Eighty-one hospitals closed last year, and a 1988 survey indicated that hundreds could close in the next five years. Many are indeed under-used, but many of the closings could leave big-city neighborhoods and rural areas without nearby care.

Meanwhile, virtually every hospital is trying to trim its budget by treating the average patient with less staff than it once did. Yet the fact is that the fewer patients who do get admitted to hospitals under strict new reviews are sicker and require more care. The new and sometimes lifesaving technologies are more complicated and expensive. And in the Catch-22 of medical cost control, many hospitals have been forced to hire more people per patient to give them more technologically advanced care. In 1972, hospitals needed 50 nurses for every 100 patients. By 1986, the desirable ratio had become 91 nurses for 100 patients.

What's more, while many under-used hospitals are closing wards, some hospitals are being overwhelmed. New York City hospitals are suffering what they call "gridlock," with beds in the corridors. The main causes: cutbacks in hospital beds in the 1970s and early 1980s because of apparent oversupply, followed by three new, unexpected and related epidemics—AIDS, drug abuse and increasing violence.

In many city hospitals, including D.C. General, up to a third of all babies are born to mothers who use drugs. Often, they need weeks of complicated and costly care. AIDS fills some wards. Violence crowds emergency rooms, and gunshots cost the nation more than a billion dollars in medical care last year. Taxpayers paid 85 percent of the bill. The cost of treating AIDS may top $6 billion this year. By 1991 it could reach $16 billion.

Can-Do Doctors

In the struggle to tame the cost spiral, the sums paid doctors will be a prime target. Doctors' fees may not get hit really heavily in this Congress, but the issue will remain high on its agenda. Other strategies being discussed: competitive bidding by hospitals to become regional centers for some costly medical procedures, which might reduce both the number of high-priced operations and the number of physicians performing them; nationwide or regional uniform fee schedules for physicians; and—because volume of care is far more inflationary than individual fees—a system of nationwide or regional budgets for *all* payments to doctors, a sort of medical Gramm-Rudman, saying, "Here's the pot this year. You divide it."

A possible starting point for physician fee reform: the "RVS" or "relative value scale," a 1988 proposal by a Harvard study group that doctors be paid according to the time (and other resources) they put in, whether questioning or advising patients or installing a pacemaker. Doctors are now paid far more for operations and other procedures than for talk, slighting patients and encouraging overuse of the most lucrative tests and treatments.

The Harvard group's goal was a way to equalize payments to doctors, cutting some, increasing others. But such guidelines could as easily be used to cut the fattest payments, while leaving others more or less where they are.

Given the ever higher cost of ever higher-tech care and the increasing volume of patients in need of services, the cost of the nation's medical care is certain to remain stubbornly high. Doctors may justifiably be blamed for overusing some new and old technologies. Many of these are almost certainly overpriced. But there may never be any way to put a really cheap price tag on heart operations, drugs that cost millions to develop or new imaging techniques like CAT scans and MRIs. A case in point: there were 350,000 laser cataract operations in 1978; in 1987, there were 1.4 million at a total cost of $4 billion.

Americans like this kind of care. It didn't always exist. When I was 12, I watched my grandmother die of the "dropsy"—edema—a body filled with fluids as a result of congestive heart failure. Her doctor came from a nearby corner and probably charged $5 a visit. The family called him "Dr. Alarmist" because he could only shake his head and do nothing.

Today a cardiologist would prescribe expensive drugs to clear the fluids and keep her heart pumping. My grandmother might have enjoyed several more years of life.

Patients avoided Dr. Alarmist. Now they seek out doctors who can do something.

For most Americans, medical insurance makes this possible. Between 1983 and 1985, there was an 18.7 percent increase in Medicare outlays for doctors' services in five studied states—Washington, Indiana, South Carolina and the Dakotas. A rising number of services rendered caused 31 percent of the increase (doctors did more); fee increases caused 21 percent (doctors charged more), and an increase in Medicare eligibles and claimants, 40 percent (more people showed up in doctors' offices).

The last reason underscores the fact that use of medical services will continue to increase, if only because the number of Americans over age 65 is increasing by a rapid 2.5 percent to 3 percent a year, and the most rapidly growing segment of the aged are the "frail elderly," generally those 75 and older.

Rationing Medical Services

For all patients, there will be more "managed care." This may be given by prepaid plans (HMOs, IPAs, PPOs) that provide care for so much a month, but in one way or another keep a lid on surgery, hospital stays and specialist visits. Or it may be care covered by conventional health insurance but using "pre-admission review" of hospital stays, in-hospital "utilization review," "certification" of expensive tests or treatments and "mandatory second opinions" to control costs.

This means there will be fewer opportunities for patients—and their doctors—to do as they please. More than half of all Americans in group insurance plans are now under at least some such restrictions. This can be good and bad: good when it eliminates unnecessary expense and harmful care but bad when it dictates skimpy or inexpert care.

Which is which? The Health Care Financing Administration (HCFA, the Medicare-Medicaid agency), the American Medical Association and groups of cardiologists and anesthesiologists have all started to try to establish what really works and what doesn't in medical treatment. The result will be "standards" or "parameters" or "protocols" as guides to better treatment.

This is long overdue. To do it right may require a nationwide computerized network linking thousands of hospitals and doctors' offices to update the outcomes of treatments on millions of patients, with the results guiding future treatments. HCFA's Dr. William Roper last year promised a beginning of such an effort. Who will now lead HCFA, and whether or how well this will be done, is not yet known. But nothing could be more important to patients' fates at the hands of the medical system.

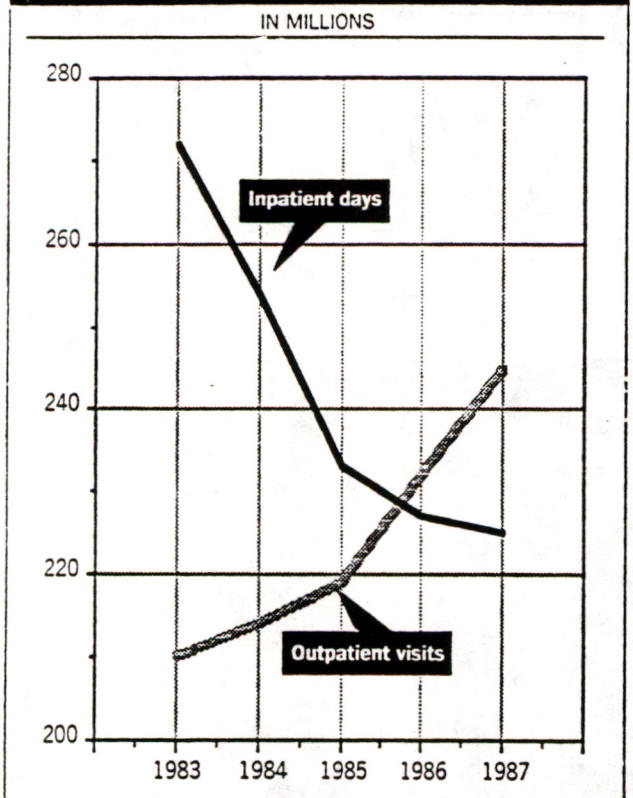
There will also, inevitably, be rationing of medical care. It already exists. Count the staff and look at the equipment in almost any large public hospital. Visit D.C. General. Just walk up and down the corridors. Then compare what you see with what you would see at Georgetown University Hospital or Johns Hopkins.

"The poor can no longer expect the same standards of care as the middle class," said Bruce Vladek, president of New York City's United Hospital Fund. "For example, indigent patients at a New York City public hospital will be moved to an eight-to-20-bed ward two days after surgery. They'd better hope that a family member shows up to assist in nursing."

There is also covert rationing—rationing called something else. Take the "transfers" of indigent patients from the emergency rooms of community hospitals to beds in hard-pressed public hospitals. "People want to cry 'dumping,' but this is one of the realities of tightening reimbursement" by insurers and government, said Thomas Chapman, president of Greater Southeast Hospital here.

"Sooner or later," said Victor Fuchs, a Stanford economist, "the only way to cut health care spending significantly

PATIENT STAYS AT COMMUNITY HOSPITALS



SOURCE: American Hospital Association. *Hospital Statistics*. 1982-1988

AGENDA. *From Page 13*

is to reduce the quantity of service rendered to patients." The most likely such patients, according to many predictions: the aged, the poor, the terminally ill.

Doctors are worried about this and all other measures that control what they do, or tell them what they can't do. Many are outright unhappy and are telling their sons and daughters not to go into medicine. Medical school applications are declining.

Rationing "drives a wedge between patient and doctor" and breaks the doctor's implied contract to do everything possible, said Dr. Arthur Feinberg, chairman of the board of governors of the American College of Physicians.

"Many physicians already feel pressured to provide some less-than-optimal care to patients—pressures brought by hospital administrators . . . by PROs [peer review organizations] or private peer review," said Dr. Joseph Boyle, executive vice president of the American Society of Internal Medicine.

Nurses complain too. In a recent poll, 74 percent told RN magazine that nurses have no time for a caring attitude; 65 percent said hospital staffs are short-handed; 63 percent said patients are discharged too soon.

When so many doctors and nurses worry, it seems logical for patients to start worrying too.

Reform Measures

If harsh medical rationing is not to become the everyday norm, and if doctors are to be free to practice good medicine, answers must be found that go well beyond the days of the Bush administration.

The most likely immediate strategy: "filling the gaps" (the phrase of Gail Wilensky, director of Project HOPE's Center for Health Affairs) by expanding Medicaid; establishing statewide or industrywide risk pools, often subsidized, by which small employers or employees with low incomes can afford health insurance; mandating employer-provided insurance, as does Massachusetts; voting tax incentives to individuals and employers to help them buy coverage. Several such state experiments are already under way.

The use of the tax system either to raise money or subsidize health coverage, or both, is being looked at ever more closely by members of Congress. "We're looking for money, we're looking for ways to help the uninsured," one congressional source explained.

Among possibilities here, savory and unsavory:

- Making higher-income Medicare beneficiaries pay out of pocket for a greater share of their medical bills, or pay taxes on all or part of their medical benefits, either as they receive them or as a tax on their estates.
- Using the tax proceeds to help give tax credits to small businesses for covering their employees, and providing health insurance or Medicaid to more people with marginal incomes.

What of long-term care, the long stays in nursing homes, at an average current bill of nearly $2,000 a month?

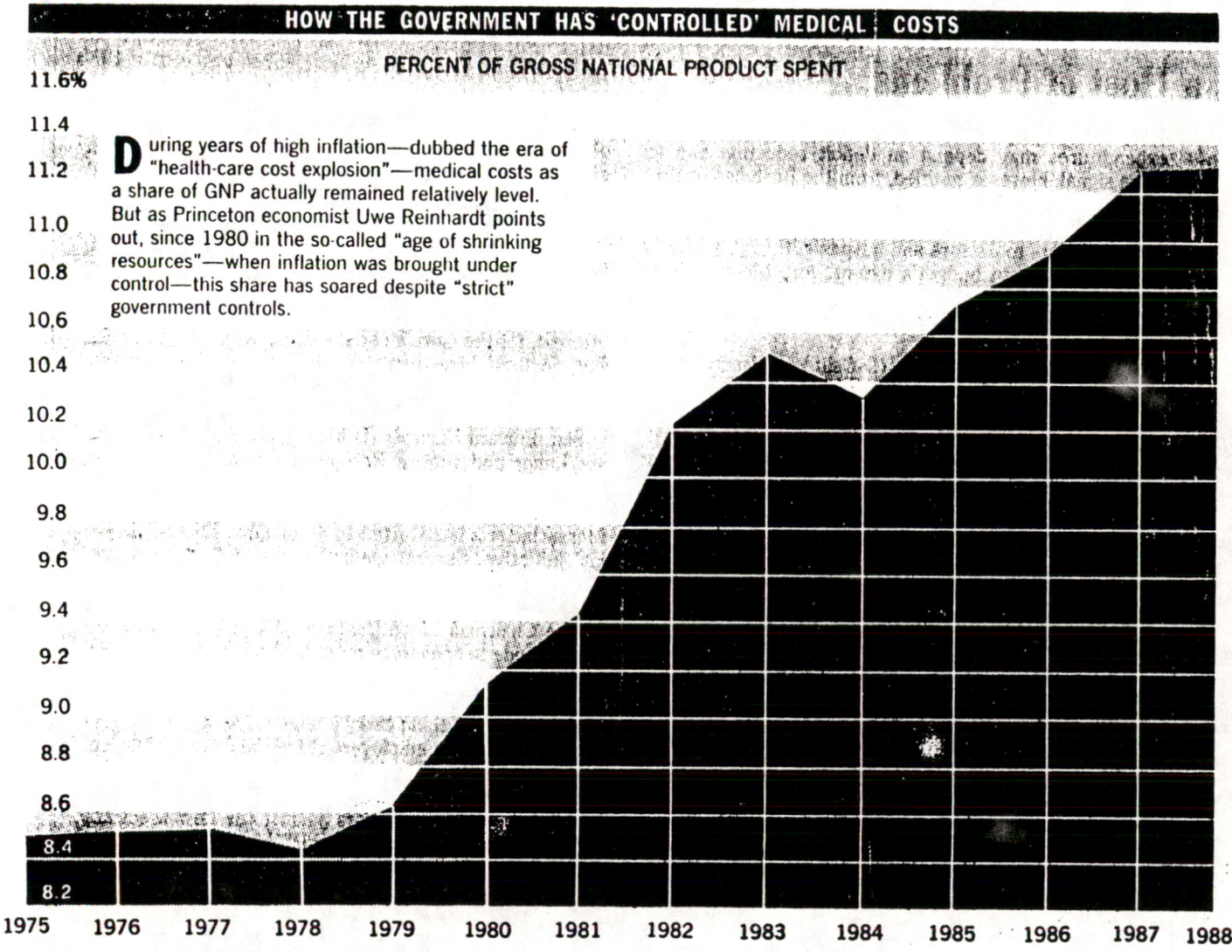
The Heritage Foundation advocates removing long-term care for those whose funds have been depleted from the Medicaid program, its present funding source, to a new federal-state program. As a first step, there would be tax incentives to encourage younger people who can afford them to buy long-term insurance policies. Later, such coverage would be mandatory, with financial assistance to low-income earners—the last as part of a program to offer tax incentives to individuals, generally, to buy health insurance, rather than depending on their employers. In this foundation's view, such a move would relieve business of an onerous burden.

The American Medical Association last month urged two remedies: a combination of federal, state and private-sector initiatives to expand Medicaid for the medically indigent, as well as a complete replacement of Medicare. The association proposed using the Medicare tax to finance a national voucher system, through which insurers would provide policies that cover both lifetime medical care and skilled nursing home care.

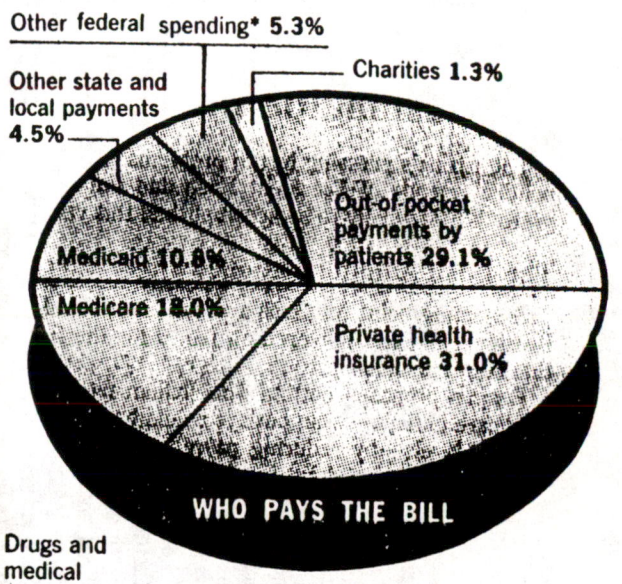
There are also far more aggressive ideas.

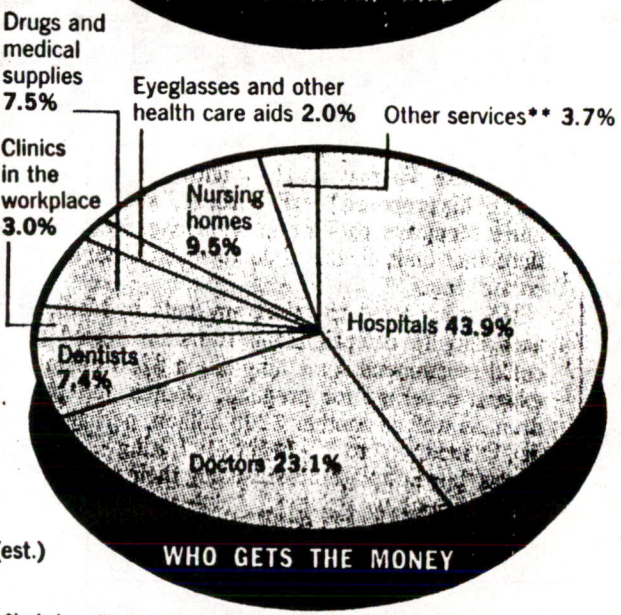
A recent issue of Health Affairs, the Project HOPE journal, said of Stanford economist Alain Enthoven: "More than any other individual, [he] has devoted his intellectual energies to transforming the rhetoric of health care competition into the reality of a policy agenda for action." Enthoven contended that managed competition, which he first advocated

HOW THE GOVERNMENT HAS 'CONTROLLED' MEDICAL COSTS



During years of high inflation—dubbed the era of "health-care cost explosion"—medical costs as a share of GNP actually remained relatively level. But as Princeton economist Uwe Reinhardt points out, since 1980 in the so-called "age of shrinking resources"—when inflation was brought under control—this share has soared despite "strict" government controls.





*Includes military and veterans' health care

**Chiropractic medicine, home health care and private-duty nursing

in the 1970s, has failed to control costs because key elements have been missing.

He calls now for "universal coverage under managed competition": medical care given by a variety of health plans that would compete for contracts either with employers—who would be required to cover employees—or with state-level "public sponsors" who would cover part-time workers and others without coverage. Employers would pay 80 percent of the cost of their employees' plans, employees 20 percent for a basic package, more if they wanted more coverage.

Employers would have to pay an average 8 percent payroll tax on the wages of all uncovered employees. Everyone not covered through employment would contribute through income tax. Those with incomes below the poverty level would continue to be covered by Medicaid. The elderly would continue on Medicare.

Complicated? Yes, but no more so than the current American pluralistic system.

"What is clear," Enthoven wrote, "is that continuing on the present path will produce results that are increasingly unsatisfactory: more and more people lacking coverage, expenditures rising to intolerable levels (15 percent of the gross national product and beyond), and little confidence that the money is being well spent . . .

"The only proved method for bringing the growth in total expenditures into line with the gross national product is for government to take over most of health care financing [as in Britain and Canada] and place it under firm global budgets . . . Even in that case, there is no assurance that stability . . . would not be achieved at the cost of many delays or denials of care . . . It seems reasonable to give comprehensive reform of incentives a serious try before something more alien and drastic is considered."

Something more "alien and drastic?" In the same issue of the New England Journal of Medicine in which Enthoven wrote, a group called Physicians for a National Health Program, founded mainly by doctors at medical schools and large medical centers, advocated a different national health program: a single national health insurance plan replacing private insurance, Medicare and Medicaid and covering everyone, financed entirely by taxes, with a set—not a penny more—appropriation each year to pay the bills, and state and regional boards negotiating with doctors, hospitals and others to decide compensation.

Something alien? This plan is not hugely different from a Canadian plan that is not perfect—it denies or delays some medical advances—but assures everyone access to care and has kept health costs below ours.

Almost overnight, national health insurance has become a subject of wide discussion in the publications of American business and health.

From Jeffrey Merrill and Alan Cohen of the Robert Wood Johnson Foundation: "Not only do the traditional liberal interests of the early 1970s still advocate some form of national health insurance, but they have been joined by some strange bedfellows: business coalitions, groups of physicians and other providers and even the insurance industry . . . seeking new financing mechanisms."

From Willis Goldbeck, president of the Washington Business Group on Health: "There has been a growing willingness among big business people to consider a government role on a level never seen before in this country. There might very well be support for the government being responsible for everybody other than full-time workers and for companies having the option of paying taxes into a government pool or providing a minimum health benefit."

From Lester Thurow, dean of the Massachusetts Institute of Technology's Sloan School of Management: "[There is] the sense that business is going to become the force for some sort of nationalizing of the responsibility [to provide medical coverage]."

In recent polls, 75 percent of respondents have said they favor the concept of national health insurance; 75 percent also have said they would be willing to pay higher taxes for long-term health care for the elderly.

If the country should fall into a deep recession or depression, with doctors and hospitals stuck with unpaid bills and hard-hit businesses unable to pay health insurance premiums, the call from all might become: "Take over, government."

What is clear is that there has been no true national health policy in this country, no overall strategy to attack the problems of the uncovered and the uncared-for, as well as to address the issues of medical quality and medical uncertainty that hobble the most conscientious doctors and result in grave waste of dollars and lives.

The Department of Health and Human Services, where some officials have tried to develop at least some elements of a coordinated policy, has itself been constrained by a budget-bound Office of Management and Budget, understandably looking askance at any new spending.

The problems of health care will not be solved without new sources of financing. Sooner or later, the "T" word—taxes—will have to pass somebody's lips, or even present programs like Medicare and Medicaid, incomplete as they are, will deteriorate.

There is wide agreement that the time has come to plan now, not just for the 1980s but for years ahead, to heal the wounds of American health care. ■

For Washington Policymakers, a Host of Problems

The nation's pressing health problems are now on the political agenda of President Bush and the 101st Congress. What is likely to be accomplished this year?

The Bush Administration

A starting point for Bush's people is the budget that President Reagan delivered on Jan. 9 for the fiscal year that starts in October.

Reagan proposed cutting $5.6 billion from projected Medicare outlays—what outlays would be if continued at current levels—by reducing payments to hospitals and doctors. He proposed cutting $1.4 billion from projected Medicaid grants to the states for care of some 22 million poor people. The cuts, said Reagan Administration budget officials, would not affect care. But Dr. Otis Bowen, Reagan secretary of Health and Human Services, called it "unrealistic" to expect the states to absorb the Medicaid reductions.

Bush's responses are not known and are in fact still incomplete. He may go along with the Medicare cuts as part of his proposed "flexible freeze," and also try to steer more Medicare patients into "managed care" organizations that limit choice of doctors and otherwise seek to control costs.

He is expected to reject any cuts in Medicaid. And, according to campaign and transition-period plans, he could recommend something like a $200 million fund to expand coverage for pregnant women and young children, as well as another $200 million, perhaps, this year or next, to begin letting low-income adults "buy in" to Medicaid, adding their own modest contributions.

As part of his campaign promise of "access to health care for all Americans," he might recommend tax benefits to encourage people to buy long-term care insurance, though most such insurance plans now go only part of the way toward financing the years of care that some of the aged ultimately need.

The Congress

There will be (read all this as reasonable prediction, not certainty) much talk this year of two subjects: expanding health coverage for the uninsured, probably by mandating more employer coverage, and finding ways to pay for long-term care of the aged.

Legislative action is at least possible on health coverage, but highly unlikely on the huge expense of long-term care.

However, Congress' first priority will not be health care, say many Congressional sources, but "deficit reduction, deficit reduction, deficit reduction." Any increased expenditures may depend on deficit reduction and on some signal, however muffled, from the Bush lips on new taxes.

Congress will inevitably do some squeezing of Medicare payments to doctors and hospitals, though probably not to the Reagan budget's extent. Any Medicaid cuts are probably "dead on arrival," in the unsubtle words of Chairman Leon Panetta (D-Calif.) of the House Budget Committee.

Rep. Fortney (Pete) Stark (D-Calif.), chairman of the House Ways and Means health subcommittee, wants to tie payments for hospital building or equipment to hospital occupancy, now only 60 to 75 percent in many hospitals. "Why should we waste money keeping inefficient or underutilized hospitals open?" he repeatedly asks.

A cut is likely, as in the Reagan budget, in payment to hospitals for "education"—meaning salaries—of the interns and residents who give most of the care in major medical centers. These hospitals have been making too much money, it's said. If applied with a meat axe, such cuts could mean fewer doctors at patients' bedsides. But such are runaway Medicare bills, predicted Ron Kovener, vice president of the Healthcare Financial Management Association, that Congress will continue cutting hospital payments "until they see blood on the floor."

Runaway Medicare costs are likely to result in a Congress that will continue cutting hospital payments "until they see blood on the floor."

Ron Kovener
Healthcare Financial Management Association

Doctors' fees will get much discussion. A Physician Payment Review Commission is required to suggest reforms to Congress early this year. Key members like Stark and Rep. Henry Waxman, still another California Democrat who heads another House health subcommittee, as well as Rep. Dan Rostenkowski (D-Ill.), House Ways and Means chairman, have called physician payment reform a priority.

But serious reform may not come easily, since there is no agreed method on the horizon except for cuts—or further cuts—in some heavily used services that many observers consider overpriced, including heart surgery, cataract surgery, radiology, anesthesiology, EKGs and colonoscopy, the exploration of the colon to look for cancer.

Stark also will be pushing for a law to limit doctors' investments in profit-making medical equipment or other endeavors where they give the care. This is a complex issue. Every doctor who collects a fee has a conflict of interest, for the more he or she does, the more the profit. But doctors' investments have been on the increase, there are stories of cases of resulting overuse, and Stark wants to get a vote on a bill.

Sen. Edward Kennedy (D-Mass.), chairman of the Senate Labor and Human Resources Committee, Waxman and Stark are backing "mandated benefits" proposals to require employers to cover uninsured workers, just as Massachusetts has started to do on Gov. Michael Dukakis' initiative. Several members have talked about tax benefits to encourage employers to cover workers. Another heavy hitter on health issues, Senate Finance Committee Chairman Lloyd Bentsen (D-Tex.), wants to use the tax code to encourage more health insurance for care of children.

Any extensive congressional action to expand coverage of the uninsured could carry a huge price tag, if the government as well as employers share the financial burden. Watch Bush's lips.

Congress meanwhile may have to deal with a growing backlash by unhappy seniors against the new Medicare expansion to cover "catastrophic" hospital, doctor and drug bills, all to be phased in over the next four years. The cause of what Republican Senator Robert Dole (Kan.) has called a "near revolt" of the elderly—an exaggeration, so far—is the fact that those over 65 must bear nearly all of the cost. They will do so partly in annual premiums and partly in an income-based income tax surcharge that together will reach a $1,561 maximum for the most affluent by 1993.

About 60 percent of the aged will pay only an extra $122 a year by 1993. But all those covered will also be required to pay considerable "deductibles" before the new insurance pays the rest of the bills, and some members are calling for delay or reconsideration of the 1988 legislation.

The 30-million-member American Association of Retired Persons supported the bill, though reluctantly swallowing the charges on the elderly. A new poll this month indicated that two-thirds of those over 65 favor the law as is. Bentsen vows that there will be no change.

— Vi[illegible]ohn

National Physicians' Group Urges Broad Federal Health Plan

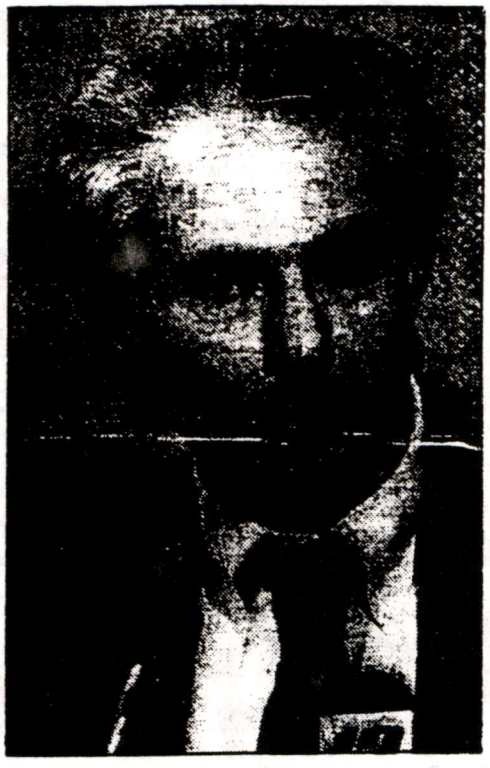
By LANIE JONES, *Times Staff Writer*

Declaring "our health-care system is failing," a national physicians' group Wednesday proposed a comprehensive federal health plan that would abolish private insurance but still guarantee medical care for every American.

In news conferences around the country and in an article published today in the New England Journal of Medicine, doctors from Physicians for a National Health Program, a 1,200-member physicians' group, made their case for a fundamental change in the way medical bills are paid.

At UC Irvine Medical Center in Orange, Dr. Howard Waitzkin, an internist and a founding member of the group, cited recent national surveys showing that there are now 35 million Americans with no insurance and another 20 million who are "under insured," with coverage that does not pay for all their medical needs.

"As practicing doctors, teachers and researchers, we're deeply troubled that many people can't get the most basic health services," Waitzkin said. "That has got to change."



GARY AMBROSE / Los Angeles Times

Dr. Howard Waitzkin

'As practicing doctors, teachers and researchers, we're deeply troubled that many people can't get the most basic health services. That has got to change.'

Change Needed

Dr. Jerome Tobis, a UC Irvine professor who chairs the medical center's ethics committee, agreed, saying, "The health-care system today in America is a jungle and correction is urgently needed."

Physicians for a National Health Program's solution is a plan, patterned after Canada's 20-year-old national health insurance program, that proponents say would cut bureaucracy, do away with the "often unjust dictates of insurance companies" and save up to $50 billion annually, but still allow patients to choose doctors, clinics and hospitals.

Instead of paying premiums to insurance companies, individuals under the plan would be taxed, paying an amount roughly equivalent to their premium into a new national health program. Most employers could expect to pay slightly less than they are now paying for health insurance benefits, proponents said.

As Waitzkin and the medical journal article described it, patients would not be billed for any medical service. Rather, all medical costs would be paid directly to providers through the federal program.

Under this program, regional or statewide payment boards would negotiate fees with doctors. Also, the boards would set budgets for hospitals, group practices and health maintenance organizations, a practice that would "eliminate billing," according to the Physicians for a National Health Program article

In addition, regional planning boards

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composed of "expert and community representatives" would decided whether a hospital or clinic could make capital outlays for new diagnostic equipment. That decision would be based on need and quality," and "for-profit investment would be barred," the journal article says.

Waitzkin and other Physicians for a National Health Program doctors said they would like to see demonstration projects in several states, including California, before the plan is enacted across the country. But they also hoped that their proposal, which currently has no congressional sponsor, would add new life to the controversy over national health insurance that has raged on and off again since the early 1900s.

According to figures from the California Medical Assn., 22% of all Californians have no medical insurance. In the Los Angeles-Long Beach area, 27% of residents are uninsured; 26% of San Diego County's residents have no insurance, and 23% of Orange County residents have no insurance.

"What we hope is to spark debate," said Dr. Isaac Taylor, retired dean of the University of North Carolina Medical School, who kicked off the group's press conference in Boston on Wednesday morning.

That was the hope too of Dr. Arnold S. Relman, editor in chief of the New England Journal of Medicine, who published the Physicians for a National Health Program article, as well as another plan for national health insurance in today's issue.

The second paper in the journal, written by Alain Enthoven and Richard Kronick of Stanford University Business School, proposed a less drastic plan for universal health insurance. Their program would retain private insurance but require employers to provide coverage for their workers. Those not covered at work would contribute through taxes, and poor people's coverage would be totally subsidized by the government.

The authors argued that a complete government takeover of health-care financing, such as the other group suggested, "would represent far too radical a change to be politically feasible in this country."

Relman did not endorse either plan. But in what amounted to a call to arms to doctors, his editorial in the same edition referred to "our disastrously inadequate health-care financing system. . . ."

"Now is the time for our profession to make common cause with the government and with the major private payers in seeking solutions to a pressing social problem that is not going to solve itself," he said.

Washington Lobby

Early reaction to the Physicians for a National Health Program plan ranged from quiet interest to flat rejection. Officials representing the multibillion-dollar insurance industry suggested that such a plan was absurd.

"We do not believe the American public wants a monolithic health-care system," said Pat Schoeni, director of public affairs for Health Insurance Assn. of America, a Washington lobby that represents 350 national health insurance companies.

"I think there's certainly problems with the [health] system. . . . Certainly people are not covered," Schoeni continued. "But the vast majority of people have health care, and everybody has access to emergency care. You may be able to fix the pieces that are wrong without having to redo the whole system," he said.

Dr. William G. Plested III, a Santa Monica thoracic surgeon who is president-elect of the California Medical Assn., agreed that there is a "crisis" in health care because of the large number of Americans who are uninsured.

However, Plested also questioned whether U.S. consumers would accept a Canadian-style health plan in which high-tech medical supplies are rationed, with some clinics getting scanning machines but others only allowed to have X-rays.

"I don't think the American consumer will stand for that," he said.

Like Schoeni, Plested argued against "dismantling" the whole medical system.

Consumer Advocate

But one consumer advocate, Dr. Sidney Wolfe, director of the Public Citizen Health Research Group in Washington, disagreed.

"Those who say, 'It ain't broke, don't fix it,' are wrong," Wolfe said. "Our country is in a worldwide scandal with its failure to act. It's the only industrialized country outside South Africa that does not

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have national health insurance."

Wolfe said he agrees with "many elements" of the Physicians for a National Health Program plan, but "the point is we have to get a national health plan. . . ."

"Anyone who says we don't need national health insurance is just off the wall," he said.

Though Physicians for a National Health Program has no congressional sponsor for its national health plan, Waitzkin said, some elements of the plan are contained in pending national and California legislation.

In Congress, Sen. Edward M. Kennedy (D-Mass.) will continue to push legislation that would require all employers to provide health insurance for their workers, Kennedy spokesman Paul Donovan said. But unlike the Physicians for a National Health Program proposal, the federal government would play no role in the Kennedy plan.

"There's no political support" for national health insurance, Donovan said.

Revised Form

However, in the House, Rep. Ronald V. Dellums (D-Berkeley) plans to reintroduce legislation to establish a national health service, Dellums' aide Max Miller said. Under the bill, which has been pending in revised form since 1977, health care would be funded out of general revenues, progressive taxation of individuals and employer contributions. Under the plan community boards would select area health-care providers, Miller said.

Also in the House, Rep. Henry Waxman (D-Los Angeles) plans to reintroduce a measure, like the Kennedy bill in the Senate, that would require all employers, regardless of size, to enroll their workers in a health-care plan. It would also prescribe minimum health benefits for all employees.

In California, Assemblyman Dan Hauser (D-Arcata) plans to reintroduce a bill he first proposed in 1987 that would set up a California health insurance plan. The proposal, which died in committee last year, would not eliminate private insurance, Hauser said, but would require all employers to pay at least 50% of a worker's health insurance costs.

Two-Part Tax Scheme Recommended

Panel Unveils Plan to Pay For Coverage for Uninsured

By LEAH R. YOUNG
Journal of Commerce Staff

WASHINGTON — A citizens' commission of health-care experts recommended enactment of new taxes on employers and employees to pay the costs of insuring 37 million uninsured Americans.

The National Leadership Commission on Health Care, which includes three former presidents, Jimmy Carter, Gerald Ford and Richard M. Nixon as honorary co-chairmen, revealed its findings Monday prior to briefing members of Congress later in the day.

The commission wants Congress to enact two sets of taxes. A so-called Y premium to be paid by every employer and every worker not below the poverty line and an X tax to be paid 75% by employers who do not provide health insurance benefits and 25% by employees without benefits.

Those workers will be covered along with other uninsured through a new Universal Access Program.

The program was described to reporters by the commission's co-chairmen, Robert D. Ray, a former Republican governor of Iowa and president of Life Investors Insurance Co. of America, and Paul G. Rogers, a former Democratic congressman from Florida, now an attorney with Hogan & Hartson here.

Gov. Ray explained that states would be required to form units to handle the pool of money in the Universal Access Program.

While there are $50 billion in new costs, Mr. Rogers explained that research into use of medical technology and medical practices is expected to create "potential savings" that could "far offset" the new costs.

But commission member Harry D. Garber, vice chairman of Equitable Life Assurance Society of the United States, quickly dissented.

He argued that "the proposed plans will produce a significant movement of persons from employer-sponsored plans and other private insurance arrangements to the government pools."

That is so, he said, because the plan calls for federal minimum standards for covered health-care services for all plans, complicated mandates for dependent coverage, limits on employee cost-sharing "and a rigid tax structure that ignores the immense variations in the cost of health care around the country."

Uwe E. Reinhardt of Princeton University, a member of the commission well known for his studies of medical economics, said the report envisions a 9.68% tax on compensation paid up to the Social Security tax limit, currently $45,000, for employers who do not provide health benefits.

Another 2% would be paid by uncovered employees to insure that those who can pay for benefits do not receive them without cost.

The commission estimated that employers with average wages that exceed 250% of the poverty level will choose to purchase private health insurance for their workers rather than pay the tax and have them covered by the insurance pool.

Part-time employees working less than 35 hours weekly could be covered by private insurance or employers could pay the tax for these workers, proportional to hours worked.

Additionally, all those with incomes above 150% of poverty and all employers would pay an additional tax to cover the costs of providing benefits to the poor. This tax, Mr. Reinhardt said, is projected to total 0.68% of adjusted gross income up to $45,000.

States are supposed to use the purchasing power of the state fund created from the federal tax to win health-care cost controls and extend benefits won to private insurers.

Mr. Garber of Equitable protested that, to keep expenses less than revenues, states will follow the Medicaid pattern and provide low reimbursements to those who provide medical care to the poor.

As with Medicaid, he said, there will be cost-shifting to the private sector.

Accordingly, he argued that state agencies cannot represent all payers of medical bills because of "an unresolvable conflict of interest to the state agencies."

One of the commission's advisers, Dr. Arnold Relman, M.D., editor of the New England Journal of Medicine, said the commission's proposal differs from recent suggestions in his publication for federal financing of care for the uninsured because it includes evaluations of technical advances, how physicians practice and the role of medical malpractice.

The commission is saying, Dr. Relman explained: "You can't just tinker with the financing. You have to look at the system as a whole."

Attorney Morris B. Abram with Paul, Weiss, Rifkind, Wharton & Garrison, a former chairman of the president's Bioethics Medical Advisory Commission, stressed that the report is urging widespread changes in state medical malpractice rules.

The commission wants states to adhere to minimum criteria establishing who qualifies as an expert witness.

Judges should be required to hold juries to a finding of negligence that demands "a clear departure from a recognized standard of treatment" and not just a difference in professional opinion about treatment, the commission said.

Punitive damages should be permitted only where there is "convincing evidence of grave dereliction of professional responsibility or reckless departure from generally accepted standards of care" and they should be awarded to the state, not the victim.

The commission also supports some regulation of contingency fees for attorneys and use of dispute resolution forums that keep medical malpractice cases out of the courts.

Strong dissents were also registered by J. Bruce Johnston, executive vice president of USX Corp., and W.E. Burdick, vice president of International Business Machines Corp., both members of the commission.

Mr. Johnston stated that "USX could never support these proposals or anything like them."

He insisted that the "report's fundamental failure to deal hard-headedly with cost containment fatally flaws its remaining wish-list."

Mr. Burdick also argued that "the report contains no real solutions to the cost escalation problem facing us today."

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CRS Issue Brief

Mandated Employer Provided Health Insurance

Updated June 1, 1990

by
Beth C. Fuchs
Education and Public Welfare Division

Congressional Research Service • The Library of Congress

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Mandated Employer Provided Health Insurance

SUMMARY

Between 31 and 37 million Americans under the age of 65 lack health insurance. Recent estimates have drawn special attention to the working uninsured: over 80% of the uninsured are employed or live in families of workers.

The increased number of uninsured has occurred when changes in reimbursement policy by private insurers and the Federal Government have made it harder for hospitals to shift the costs of treating the uninsured to privately insured patients. Consequently, access to health care for persons lacking insurance is a growing concern. These developments have led to new congressional interest in the problems of the medically uninsured. Faced with substantial Federal budget deficits and diminished interest in Government-financed solutions, Congress has begun to look to employers as a potential source of expanding access to health insurance coverage.

Under one approach gaining some support in Congress, the Federal Government would mandate that employers provide health insurance coverage and/or specific health benefits to their employees and to their employees' families. There is, however, substantial controversy over this approach. Proponents argue that providing health insurance is an employer's responsibility. They say that the costs of providing care to uninsured workers are being shifted by health care providers to those employers who provide and pay for health insurance. Opponents of mandated employer-provided insurance argue that it is not an employer's responsibility to provide health insurance. They say that many employers, especially smaller ones, cannot afford to offer insurance. Opponents also argue that the added costs of health insurance would reduce employers' ability to compete, harming the overall national economy.

As a result of past actions by Congress, employers who offer health insurance have to conform to specific requirements affecting the nature of their health insurance plans and the entitlement to those plans. Most larger employers have to offer their employees the option of becoming members of federally qualified Health Maintenance Organizations. Also, employers are prohibited from discriminating in employee benefit plans on the basis of disabilities arising on account of pregnancy. Certain employers have to offer Medicare-eligible workers and their spouses the option to elect the employer's health plan as their primary source of insurance. Finally, certain employers required to make available continued health insurance coverage to qualified employees and their families who would otherwise lose coverage as a result of specific events.

In the 101st Congress, bills have been introduced to expand access to health insurance by mandating that employers provide basic health insurance. One such bill, the "Basic Benefits for All Americans Act of 1989" (S. 768) has been voted out of Committee and is awaiting action by the Senate. Other proposals, placing new requirements on employers, may also be considered.

ISSUE DEFINITION

Most Americans have health insurance coverage through private group plans offered by their employer or through the two major Federal Government financed programs, Medicare and Medicaid. A much smaller number of Americans purchase individual policies through the private health insurance market. However, between 31 and 37 million Americans have no health insurance coverage. Moreover, the percentage of uninsured Americans has been climbing, increasing by some estimates by as much as 20% for the under age 65 population between 1979 and 1986. Recent U.S. Census Bureau estimates have drawn special attention to the working uninsured: over 80% of the uninsured are employed or live in families of workers. For these Americans, employment or connection to employment through a working family member has failed to result in coverage under a health insurance plan.

The increased uninsured population has occurred when changes in the reimbursement policies of private insurers and the Federal Government have made it more difficult for hospitals to shift the costs of treating the uninsured to privately insured patients. Consequently, there is growing congressional concern about decreased access to health care for persons lacking insurance. In search of a solution that will not result in major Federal spending, Congress has turned to employers as a potential source of expanding access to health insurance coverage. In past years, Congress has mandated that employers who offer health insurance to their workers must meet specific requirements affecting the nature of their health insurance plans and the entitlement to those plans. In the 101st Congress, legislation is being considered to mandate that employers provide basic health insurance to their employees and to require that employers provide specific health benefits in their insurance plans. The Pepper Commission has also recommended a "job-based" approach to increasing access to health insurance that includes a mandate on larger employers to provide health insurance or contribute a portion of payroll toward the cost of covering employees and dependents in a public insurance plan. (The Pepper Commission proposal is described in more detail in CRS Issue Brief 90005, Health Insurance, Janet Kline, Coordinator.) These proposals are stimulating substantial congressional debate.

BACKGROUND AND ANALYSIS

Uninsured Population

In 1987, between 31 and 37 million Americans did not have any health insurance. [Variations in estimates of the uninsured are explained by the different questions and methods of sampling used in the surveys.] Estimates from the March 1988 Current Population Survey (CPS) of the U.S. Census Bureau place the number at 31.3 million; estimates from the National Medical Expenditure Survey of the National Center for Health Research place the number at 37 million. In the late 1970s, between 13% and 14.5% of the under-65 population were uninsured. This number increased to 17.7% in 1984 and fell back to 17.5% in 1986. Estimates vary, and some studies report that the number of medically uninsured peaked during the economic recession of the early 1980s, and is now on a downward trend.

The effects on an individual of not having health insurance are not well documented. What is known is that the uninsured are less likely to use health services and are more likely to be in poorer health than the insured population. The 1986 National Access Survey (done for the Robert Wood Johnson Foundation) reports, for example, that the uninsured had approximately 40% fewer ambulatory visits and 19% fewer hospitalizations than the insured. Of those individuals surveyed who had chronic illnesses, 20% of the uninsured failed to see a physician or other provider over the course of a year, compared to 17% of the insured.

While data on the health consequences of lacking insurance are scarce, several studies do provide information on who make up the uninsured population. They indicate that low-income households are more likely to lack health insurance than those with middle or high incomes. They also indicate that the vast majority of uninsured are employed or live in families where the head of the household is employed. Most recent studies using Census Bureau data report that at least 80% of the uninsured live in families where someone is employed.

Working Uninsured

Largely as a result of labor union pressures for better employee benefits, and Federal tax incentives that allow employers to deduct the costs of providing health benefits to their employees, employer-related health insurance became increasingly commonplace after World War II. Today, after paid vacations, it is the most common fringe benefit offered by employers. For the nine out of ten Americans with private group insurance, that insurance is provided in the employment setting. As a result (and in contrast to other western nations where health and pension benefits are provided through public programs), workers in the United States have grown to rely on employer-provided benefits for these basic protections. However, as the following statistics reveal, not all employers offer health benefits and, when offered, not all employees accept them.

Some analysts argue that the decline in coverage is due to the shifting of our economy from jobs that carry health insurance to ones that do not. It is true that while civilian, nonagricultural jobs increased by about 7% between 1982 and 1985, the number of jobs with health insurance provided by an employer increased by less than 5%. However, more important may be changing demographics. For example, there appears to be an increase in the number of young adults without health insurance living in households in which the parents have insurance. In addition, dependent coverage has declined.

EBRI's May 1988 analysis of CPS data on the working uninsured reveal that in 1986, 18.1 million workers reported no coverage from an employer plan. Of that number, 10.9 million were the head of a family (meaning the family member with the greatest earnings or an individual without a family). Another 7.2 million were other family workers and not the head of the household. The majority of uncovered workers were low wage earners. In 1986, 74% of all uninsured workers earned less than $10,000; 93% earned less than $20,000. About 35% of all uninsured workers earned, on average, less than the Federal minimum wage in 1986; 50% of all uninsured workers earned less than 125% of the minimum wage. Most of these individuals worked full-time.

It is also useful to look at the working uninsured according to their primary source of employment. According to EBRI, workers in certain employment sectors are much more likely to lack health insurance coverage than the average American worker under age 65. These include workers in agriculture; retail trade; services (business, repair, entertainment and personal); and construction. Also included in this category are the self-employed. Workers in other employment sectors (including manufacturing, finance, transportation, and wholesale trade) lack insurance coverage only one-third to one-half as often as workers in the above employment sectors.

Move Toward Mandated Health Benefits

Since the early years of this century, national health insurance has been a hotly debated issue in the United States. While in the late 1960s and 1970s, the debate revolved around whether to enact a program of universal national health coverage, in the 1980s the emphasis has been on incremental expansions of health insurance coverage. Proposals have focused on expanding coverage for specific segments of the population (such as laid-off workers, low-income elderly, and children) and for people who, because of a major pre-existing health condition, are unable to obtain health insurance through the private market. Faced with substantial Federal budget deficits and an apparent diminished interest in Government-financed solutions, Congress has begun to look to employers as a potential source of expanding access to health insurance coverage.

One approach gaining some support in Congress falls under the general heading of employer mandates. Under this approach, the Federal Government would mandate that employers (private employers as well as State and local governments) provide insurance coverage and/or specific health benefits to their employees and, in some cases, also to their employees' families. This approach is consistent with the current reality that in the United States, health insurance for all but the old, disabled, and very poor, is primarily obtained through an employer's group plan.

In the 99th Congress, legislation was enacted that required certain employers to offer continued health insurance coverage to their employees who would otherwise lose coverage for certain reasons. Also, certain employers were required to offer their Medicare-eligible disabled workers primary coverage under the employers' health insurance plans. In the 100th Congress, legislation was considered to mandate that employers provide basic and/or catastrophic health insurance coverage. These proposals are being considered again in the 101st Congress.

Issues Related to Mandating Employer-Provided Health Insurance

The debate over mandating that employers provide health insurance raises philosophical issues such as the nature of an employer's obligation to his or her employees, and whether it is appropriate for the Federal government to require that employers offer insurance. In addition, it raises questions about the potential economic effects of mandates on employers as well as on the health of the national economy.

Question of Employer Responsibility

Proponents of mandatory employer-provided health insurance argue that employers have a basic obligation to ensure that their employees have access to health insurance just as they have an obligation to provide a liveable wage. They assert that a minimum health benefits law should be established in the same manner as the Federal Government has established a minimum wage law. They say that it will ultimately lower the Nation's health bill because more people will have access to health care. In addition, they argue that requiring employers to provide coverage is in keeping with the Nation's heavy reliance on employment-related insurance. They further assert that relying on private rather than government-provided insurance builds upon our Nation's tradition of leaving health insurance to the competitive market place.

Proponents also argue that this approach will increase equity across employers and taxpayers. Currently, health insurance premiums are priced to include not only the direct cost of providing health care services to the employer's workers, but also other costs borne by the providers of health care for uninsured or underinsured individuals, a substantial portion of which are uninsured workers. Employers who are paying for health care coverage for their employees are thus subsidizing those employers who are not paying for coverage.

Finally, proponents argue that employers who provide health benefits are also subsidizing other employers by insuring many of the latter's workers through family coverage. According to a CRS analysis (based on March 1987 CPS data), 23.6 million working Americans receive coverage through employers for whom they are not directly working. Moreover, individuals who are not offered insurance by their employers are paying some of the $37 billion in taxes that are used to subsidize (through tax expenditures) health insurance for other, generally higher-paid workers.

The opponents of mandatory employer-provided health insurance counter by arguing that employers have no inherent obligation to provide health benefits. They assert that the individual has a responsibility to purchase insurance in the private market. For those individuals who cannot afford to pay for health insurance, then the public sector should provide a minimum level of health care. Moreover, opponents argue that an employer's decision to provide insurance or to provide a specific set of health benefits should not be dictated by the Government. Rather, it is labor-management negotiations or free-market competition among insurers vying for employers' business that should determine whether employers provide insurance and if so what health services should be covered under the policy. Such reliance on the marketplace will also ensure greater efficiencies in the supply and demand of health coverage and services, thus helping to hold down costs.

There are also those who reject mandates because they would, in their view, undermine the voluntary nature of employer-provided health insurance. They argue that the majority of employers already provide coverage; it is a benefit that these employers have privately chosen to provide in a form that is most appropriate to their own employees. Some employers who already insure their employees argue that a Federal law mandating that employers provide insurance (particularly if that law were to require a basic minimum level of benefits) would result in higher employee benefit costs and new administrative burdens.

Critics of mandated employer-provided coverage also argue that such a policy might increase the costs of labor to the point where companies, especially smaller ones, would reduce their labor force or reduce wages. Health insurance is a relatively expensive benefit. The Small Business Administration (SBA) reports average employer health care costs totalled $1,500 (roughly 75 cents per hour) per worker in 1986. For the 35% of uninsured workers who are paid less than the minimum wage ($3.35 in 1987), the added hourly cost of a health insurance benefit could be prohibitive, even if the employee were required to pay a share of the premium. Although a mandated insurance package might be less comprehensive and therefore less expensive than the average policy cited by the SBA, it could still produce reductions in the employment of low wage workers as employers attempt to adjust to higher labor costs.

Mandated Employer-Provided Insurance and Competitiveness

In addition to the debate about employer responsibility, there is a different set of issues relating to the potential effects of mandating benefits on employers' ability to compete in domestic and world markets. Much of the analyses of these effects is speculative; however, the basic arguments tend to be articulated as follows.

Opponents of mandated employer-provided health coverage say that mandated insurance would drive up the cost of doing business and reduce the ability of firms to compete, both in the domestic and world markets. Industries that compete against foreign manufacturers (especially those from certain Third World nations) are competing against employers who do not as a rule provide health and other fringe benefits. This helps foreign manufacturers to hold their prices down. Small employers, especially, believe that mandating health insurance coverage might cause them to lose whatever competitive edge they may have since they would have to offset the cost of the new benefits by raising their prices. While many smaller firms do not directly engage in international trade, some proportion of them are suppliers to large companies that do compete internationally. Higher costs for a supplier affect the costs of the purchasing firms: if health insurance coverage were required, small employers might pass the cost of the coverage onto their clients. This reasoning is also extended to domestic competition.

Proponents of mandated benefits dismiss the competitiveness argument as invalid or not compelling. In their eyes, it is not a real issue because the companies that are struggling to maintain their competitive edge (such as the auto manufacturers) are the very companies that already provide health insurance. The majority of the working uninsured are not found in the transportation and manufacturing industries but in the service and retail trade industries, which are comparatively unaffected by foreign competition. It is these latter industries that have experienced the most growth since 1979: the services industry is projected by the Bureau of Labor Statistics to increase from about 21% of total U.S. jobs in 1979 to over 26% in 1995; the retail trade industry is projected to increase from 22% to 23% over the same period. Manufacturing and transportation, which have traditionally covered most of their workers, are predicted to decline. These statistics noted, mandated benefits proponents conclude that there are more critical variables, such as exchange rates, undermining American competitiveness than the cost to American firms of their employee benefit packages.

Small Employers and Mandated Employer-Provided Health Insurance

It is often assumed that smaller employers are less likely to offer health benefits because of the high costs of premiums, administrative burdens and the perception that workers prefer cash wages to benefits. Estimates place the costs of insurance for small employers at anywhere from 10% to 40% higher than for large employers. The SBA reports that very small firms that do not offer health benefits spend about 7% of payroll on fringe benefits. Those which do offer coverage spend 10%.

According to the SBA, in 1986, 46% of firms with fewer than 10 workers offered health benefits, compared to 78% with 10 to 24 workers, 92% of firms with 25 to 99, 98% of firms with 100 to 499, and 100% of firms with 500 or more workers. 84% of all workers who worked for employers without health plans worked in firms with less than 25 employees.

Based on surveys and other studies, the SBA has concluded that smaller employers tend not to offer health insurance because they (1) face higher per worker premiums since the risk for insurers is spread over fewer persons; (2) do not benefit to the same extent as larger firms from the tax advantages associated with offering health insurance; (3) experience higher fixed costs in choosing and administering a health plan; (4) have relatively higher worker turnover rates and a greater use of part-time and seasonal employees which increase their administrative fees relative to the fees charged for larger firms; and (5) tend to have narrower profit margins from which to pay relatively higher premiums.

Associations representing small employers use such findings to argue that forcing small employers to offer health insurance will result in higher prices, lower wages, more business failures and fewer jobs. They contend that small firms simply cannot spend more of their receipts on employee benefits.

Another argument used against mandated coverage for small employers is that low-wage workers prefer to receive cash benefits or are already covered indirectly through a family member's insurance policy, and should not be forced to accept reduced earnings. However, an SBA survey of employers found that 14% of eligible workers in small firms (less that 10 employees) which offer coverage turn it down, compared to the 13% average across all firms.

Many proponents of mandated coverage agree that small employers might be adversely affected if they were required to offer (as well as pay some portion of) health insurance. They suggest, however, that potential problems for small employers could be reduced through mechanisms designed to lower both the costs and the administrative burdens of offering health insurance. These mechanisms are generally designed to pool large numbers of small employers in one large group, enabling them to obtain health insurance at lower costs. For example, the Council of Smaller Enterprises (COSE) in Cleveland, Ohio, arranges with a number of insurance companies group health insurance for about 8300 firms, which in turn provide insurance to more than 120,000 employees. COSE is able to negotiate less expensive policies than would otherwise be available to these employers if they sought the insurance on their own.

Such pooling mechanisms have been employed with mixed success. Observers say that they are not as effective for the smallest employers, which are still subject to medical underwriting. They also tend not to attract those employers who have never offered coverage. In addition, their effectiveness in holding down premium rates is limited by the volatility of the small group insurance market. However these problems largely could be eliminated if employers were required to participate in the pool.

Underinsurance and Catastrophic Coverage

Some analysts advocate that an appropriate compromise between the two extremes of doing nothing and mandating that all employers offer health insurance is to require that all employers offer coverage under a catastrophic illness policy. These policies provide coverage for only very large medical expenses after the beneficiary has paid a large deductible; the premium cost of such coverage is, however, generally lower than for more comprehensive policies. A catastrophic illness policy would ensure protection of individuals against the devastating financial burdens of a major illness but would be less costly for employers to offer. On the other hand, such an approach would not address the need of the medically uninsured for basic health services.

History of Federal Employer Mandates

The Federal Government has traditionally left the regulation of insurance to the states. According to Blue Cross and Blue Shield Association, there are over 680 State-mandated benefit laws governing health insurance. They include specific services (e.g., maternity coverage and newborn care), the services of specific providers (e.g., dentists and chiropractors), as well as requirements that plans provide for continuation and conversion options. The States vary in the numbers and types of mandates. Some observers in the business and insurance communities contend that these mandated benefit laws are largely responsible for the high costs of health insurance. Advocates of State mandates say that they increase access to needed health services and encourage greater freedom of choice of providers, which in turn promotes competition and lowers health care costs.

While the business of insurance has been left largely to the States to regulate, employee welfare benefit plans are governed by the Employee Retirement Income Security Act (ERISA), a Federal law enacted in 1974. (Hawaii is an exception. ERISA was amended to allow Hawaii to continue its law requiring employers to provide health insurance coverage.) Included under employee welfare benefit plans are self-insured health plans, where the employer assumes the risk for paying claims, instead of paying premiums to an insurance company which in turn assumes the risk. Thus, while traditionally insured companies are affected by State mandates, self-insured companies are regulated by ERISA. ERISA regulates such aspects of welfare benefit plans as plan disclosure, but until recently, employers under ERISA were relatively free to structure plans as they desired or, if their employees were represented by a union, through the collective bargaining process. As discussed below, this changed with the enactment of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA, P.L. 99-272).

In the 1970s, changes were made in Federal law to mandate that employers offering health insurance meet specific requirements. For example, the Health Maintenance Organization Act of 1973 (P.L. 93-222) requires that certain employers with 25 or more employees offer a health maintenance organization (HMO) option in their health plan if a qualified HMO exists in their area. In 1978, Congress amended the Civil Rights Act to extend the prohibition against sex discrimination in employment to include discrimination on the basis of pregnancy, child birth, or related medical conditions (P.L. 95-555). As a result, larger employer health plans must treat women affected by these conditions similarly to other employees, based on their ability or inability to work.

Federal proposals mandating employers to provide coverage date back to the Nixon Administration. More recently, the Carter Administration developed legislation to require employers to provide basic health insurance as an employee benefit. The Carter proposal would have also expanded Federal programs to include those who remain uncovered under employer plans. It was criticized by representatives of small business who argued that requiring them to provide insurance would add significantly to their labor costs and threaten their viability. It also fell victim to the absence of consensus among other health policy actors.

Federal mandates on employers who provide health coverage have continued into the 1980s. In addition, new efforts have been made to broaden the scope of the mandates to those employers who do not already offer health insurance.

Title X of COBRA

The passage of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) in April 1986, marked a major departure in Federal law and regulation of employers' welfare benefit plans. It was the first time that the Federal Government mandated a specific benefit in employee welfare benefit plans. While COBRA does not mandate that employers provide health insurance, it does require that employers with 20 or more employees who do provide health benefits offer qualified employees and their families the option of continued health insurance at group rates when faced with loss of their coverage because of certain qualifying events. The qualifying events include termination or reduction in hours of employment, death, divorce, eligibility for Medicare, or the end of a child's dependency under a parent's health insurance policy. When a covered employee experiences termination or reduction of hours of employment, then the coverage of the employee and any qualified beneficiaries must continue for 18 months. For all the other qualifying events, the coverage for the qualified beneficiaries must be continued for 36 months. The employer's health plan may require the employee or beneficiary to pay the premium for the continuation coverage, but the premium may not exceed 102% of the otherwise applicable premium for that period. (See also CRS Issue Brief 87182, Private Health Insurance Continuation Coverage, by Beth C. Fuchs.)

In the Tax Reform Act of 1986 (P.L. 99-514), Congress included a number of technical corrections to Title X of COBRA. In the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Title X was expanded to require continuation coverage for retirees in cases where the employer files for bankruptcy. The Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647) made major changes in the penalties, and the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) extended

continuation of coverage from 18 to 29 months for certain disabled workers and their families. (See CRS Issue Brief 87182.)

Medicare Working Aged and Working Disabled Secondary Payer Requirements

A different type of employer mandate was legislated through changes in the Medicare program and amendments to the Age Discrimination in Employment Act of 1967. Prior to 1982, employers generally used Medicare coverage as the basic health insurance for their Medicare-eligible employees supplemented by an employer-provided policy which filled in gaps in the Medicare coverage. This tended to ensure that health care costs for their older workers were confined to supplemental as opposed to basic health care coverage. In 1982, as part of the Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248), Congress adopted a proposal by the Reagan Administration to require that private employers with 20 or more employees offer their employees and their employees' spouses, age 65-69, their health insurance plan, which would be the primary payer for all claims. This provision was adopted to reduce Medicare expenditures by shifting the health care costs of older workers onto employers. The "working aged" or "secondary payer" requirement was expanded through subsequent laws. The Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369) expanded the spousal coverage to include all beneficiaries 65-69 with working spouses under age 65. COBRA, (P.L. 99-272) made Medicare benefits secondary to those payable under employer group plans for employed individuals age 65 or over, and the spouses age 65 or older, of any employed individual regardless of age. OBRA of 1986 (P.L. 99-509) included a Reagan Administration proposal requiring employers with 100 employees or more to offer their disabled workers and their spouses the option of coverage under their employers' health plan as the primary insurance policy.

Bowen Catastrophic Proposal

In November 1986, Otis Bowen, Secretary of Health and Human Services, released a report to President Reagan on catastrophic illness expenses. This report was in response to the President's directive in his Feb. 6, 1986, State of the Union address that the Secretary report to him with recommendations on "how the private sector and Government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes."

While the Bowen report discussed options to encourage employers to provide catastrophic coverage, it recommended that States require that such coverage be offered in all employment-related plans. It specified that employers should not be required to finance such coverage, and also recommended the extension of full tax deductions for health insurance to the self-employed and unincorporated businesses (currently at 25%) as long as coverage is included for catastrophic expenses.

Although the Reagan Administration promoted Secretary Bowen's proposals for restructuring Medicare to cover catastrophic illness expenses, it did not endorse the recommendations in the Secretary's report for mandating catastrophic illness insurance under employer-provided health benefit plans. Some of these options were incorporated in legislation introduced in the 100th Congress, such as H.R. 2300

(Gradison), which would have denied the tax deduction for employer-provided health insurance to employers who failed to provide catastrophic coverage.

Types of Mandated Coverage Proposals

A variety of approaches to mandating coverage are incorporated in legislation that has been introduced in recent years. While most are aimed at expanding access to basic health insurance by mandating that employers provide health coverage, others seek also to define the nature of the benefits to be offered. There are also proposals that require employers to provide their existing benefit packages to employees, laid-off employees, retirees and/or dependents who experience a change in job or family status. Finally, other proposals require employers who already offer insurance to offer specific benefits, such as well-baby care.

Defining the Application, Nature and Scope of Mandated Health Benefits

One of the controversies in providing for any Federal mandate is whether or not it should apply to all employers, and if not, where the limits should be drawn. The Medicare working aged and COBRA Title X provisions exempt employers with fewer than 20 employees, although the Medicare working disabled provisions enacted in OBRA of 1986 (P.L. 99-509) apply to only those employers with 100 or more employees. Congress has been wary of applying mandates to smaller employers largely because of concerns that they are not as easily absorbed by such firms and could create economic hardships. Congress has also excluded the Federal Government and religious organizations from certain provisions.

The debate over mandated benefits is influenced by concerns about the lack of coverage as well as about concerns that working Americans are not adequately protected against the costs of a catastrophic illness. Consequently, there are proposals to require that employers provide basic hospital and medical insurance as well as those that would mandate only catastrophic illness protection. A more complex issue is whether the mandate should specify the nature of health benefits to be offered by employers. Again, the proposals vary in their approach. Some, such as the Kennedy-Waxman proposal in the 101st Congress (S. 786, H.R. 1845), require a minimum level of benefits in the health insurance package. However, an actuarial equivalency provision allows employers to offer different mixes of benefits and employee cost-sharing requirements. Other bills have left the nature of the benefit package unspecified. There have also been narrowly defined proposals that mandate that employers who already provide health insurance include within their benefit package specific services, such as coverage for pediatric preventive health care. (See S. 968 and H.R. 1449, in the 100th Congress.)

Defining the Population to be Covered and the Duration of Coverage

Whichever approach is pursued, it is necessary to define the beneficiaries who would receive the mandated health coverage. The employer's responsibility could be limited to active full time employees, or expanded to include any or all of the following: part-time employees, seasonal employees, retired employees, spouses, widowed and/or divorced spouses, dependent family members, and employees who

have terminated their employment, either voluntarily or involuntarily. Title X of COBRA and its subsequent amendments provide an example of a broad definition of beneficiaries.

In the same vein, some proposals are directed at ensuring that employers offer health benefits beyond the point at which the employee (and his/her dependents) has an immediate connection with the employer. In the past, Congress has considered proposals to require that employers pay for the continued group coverage of laid-off employees for a defined period of time. In this case, the benefit package may or may not be defined. Such continuation of coverage mandates may extend to laid-off or otherwise terminated employees, retirees of the firm and dependent spouses and dependents of such employees.

Defining the Liability of Employers and Employees

The proposals to mandate employer-provided insurance also generally define the limits of the employer's financial obligation to pay for those benefits. In Title X of COBRA, Congress authorized employers to require the employee to pay for the continued health coverage, plus a small fee to cover the employer's administrative costs. In other proposals, the focus is to keep the employee's costs for coverage low by requiring employers to pay a large portion of the premium. The Kennedy-Waxman plan in the 101st Congress (S. 768, H.R. 1845), for example, requires that the employer pay 80% of the employee's insurance premium (and 100% for low-income employees) which in turn is deductible from the employer's taxes as a cost of doing business. H.R. 2563, in the 101st Congress, prohibits employers from reducing their premium shares for certain part-time workers.

LEGISLATION

H.R. 43 (Clay)

Requires that certain contracts between the U.S. and private contractors contain provisions requiring the contractor to provide certain pension and health benefits to its employees. Introduced Jan. 3, 1989; referred to Committee on Education and Labor.

H.R. 1845 (Waxman)

Basic Health Benefits for All Americans Act. Amends the Public Health Service Act, Fair Labor Standards Act, Title XIX of the Social Security Act, and Employee Retirement Income Security Act to require that employers enroll employees in a health plan that covers specified health services and provides protection against catastrophic illness expenses. Also requires that State Medicaid programs provide health benefits on a phased-in basis to people in poverty and near poverty, and to all other individuals not covered by employer plans. Requirements for employer-based plans similar to S. 768 (see below). Introduced Apr. 12, 1989; referred to Committees on Education and Labor and on Energy and Commerce.

H.R. 2563 (Schroeder)

Part-time Temporary Workers Protection Act of 1989. Amends the Employee Retirement Income Security Act to prohibit a reduction in employer-provided premiums for employees solely because the employee works less than full-time with

less than 30 hours per week, allows employer to reduce the premium contribution to not less than a ratable portion of the premium ordinarily provided in the case of an employee who completes 30 hours of service per week. Introduced June 6, 1989; referred to Committee on Education and Labor.

H.R. 4070 (Grandy)

Universal Health Benefits Empowerment and partnership Act of 1990. Amends ERISA, the Internal Revenue Code, and the Public Health Service Act to provide for universal and more affordable coverage under group, State, or alternative health benefit systems. Requires employers to offer coverage for eligible individuals under basic group health plans or group health payroll deduction plans. Introduced Feb. 22, 1990; referred to Committees on Education and Labor, Ways and Means, and Energy and Commerce.

S. 768 (Kennedy)

Basic Health Benefits for All Americans Act. Amends the Public Health Service Act, the Fair Labor Standards Act, and ERISA to require that employers enroll employees in a plan that covers specified health services and provides protection against catastrophic illness expenses. Also requires that States establish programs to provide health benefits on a phased-in basis to people in poverty and near poverty, and to all other individuals not covered by employer plans. Failure of an employer to provide insurance would result in eligibility loss for grants, contracts, loans or loan guarantees under the Public Health Service Act or civil penalties under the Fair Labor Standards Act. Provides that an individual may sue in Federal court for injunctive relief. Under employer plans, limits the deductible to $250 per person ($500 per family) and copayments to 20% of the cost of any service (excluding certain services for which copayments are prohibited and other services for which different copayments are specified). Except part-time employees, limits the employee's share of the premium to 20% of the cost of coverage, and requires the employer to cover the full cost of at least one health plan for low wage workers. Provides that employers may provide benefits that are equivalent on an actuarial basis to those specified, and that new employers with 10 or fewer employees may provide a "tailored" plan, i.e., a plan that has one-half the actuarial value of benefits of a health benefit plan. Certain part-time employees may waive enrollment in the employer's plan, but the employer must pay what he/she otherwise would have paid for the employee's health plan to the State or Federal entity providing coverage to non-working persons. Employers without a plan meeting the minimum benefit standards are required to join regional insurance pools to be established by the Secretary of Health and Human Services that provide health benefits at community rates. Provides for a Federal subsidy for small businesses where compliance costs exceed 5% of gross revenues. Provides for Federal and State financing of the State programs, and specifies benefit package and cost-sharing. Introduced Apr. 12, 1989; referred to Committee on Labor and Human Resources. Hearings held May 1 and June 23, 1989. On July 12, 1989, the Committee voted to report an amended version of S. 768 to the Senate.

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CRS Report for Congress

Controlling Health Care Costs

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CONTROLLING HEALTH CARE COSTS

SUMMARY

Inflation in the medical sector has outpaced inflation in the rest of the economy for many years. There are concerns that continued growth in health care costs could impede efforts to improve access to health care and could eventually erode the access that already exists. While efforts to control medical spending have been a central issue in health policy at least since the early 1970s, these concerns have given the issue a new urgency.

Most proposals to limit health care spending have relied on one of four basic approaches. The first is to change the behavior of consumers by holding them directly responsible for a larger portion of the costs of their own care. Increases in required deductible and coinsurance payments by enrollees in health plans can reduce overall costs. However, they may have a disproportionate impact on low-income persons, deterring even necessary care, and may not affect the treatment decisions of providers, who control much of total health spending.

The second major approach is to change provider behavior through direct modification of medical practice, or by controlling the overall supply of medical resources. Insurers have had some success in controlling inpatient hospital services through external review systems, but savings have been largely offset by a growth in outpatient services. These have proved harder to manage, in part because there is little agreement about what constitutes appropriate care. There are hopes that further research on the effectiveness of medical treatments can provide a basis for limiting unnecessary care. If reductions in utilization are to achieve their full savings potential, however, they may need to be accompanied by controls on the overall supply of medical resources. Supply controls through local health planning systems were attempted in the 1970s, but encountered political barriers and had limited success.

The third cost control approach is to change provider behavior through reimbursement systems that provide incentives for greater efficiency. Several States, as well as Canada and other nations, have adopted payment systems that fix in advance the resources a provider can consume in treating an individual patient or an entire patient population. These systems may encourage more cost-effective treatment, but may also delay the introduction of new medical technologies or otherwise compromise quality. Their long-term potential for cost savings may rest on the willingness of the public to accept trade-offs between cost and other priorities.

The last major approach is to encourage consumers to choose from among multiple health plans that compete on the basis of their ability to develop structured and efficient delivery systems. Health maintenance organizations (HMOs) and other managed care systems have shown some ability to control costs, using utilization controls, financial incentives for providers, and other methods. The ability of these programs to achieve their full savings potential may be limited by the reluctance of higher-cost patients to accept the restrictions on choice of providers imposed by HMOs.

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CONTROLLING HEALTH CARE COSTS

INTRODUCTION

The United States spends more per capita, and a greater proportion of its gross domestic product (GDP), on medical care than any other industrialized nation. U.S. health expenditures in 1987 reached $500 billion, 11.1 percent of GDP, as compared to 8.6 percent in Canada, 6.8 percent in Japan, and 6.1 percent in the United Kingdom.[1] Despite its higher expenditures, the United States performs no better than other industrialized nations, and worse than many, on such measures of health care outcomes as life expectancy or infant mortality rates. These international comparisons have led many observers to conclude that our medical care system is much less efficient than those elsewhere, spending more for less.

Not everyone would agree. Gross measures of health status may reflect, not the relative efficiency of our medical care system, but other differences between the United States and other countries. Life expectancy, for example, may be tied to diet or environment, while infant mortality rates may in part reflect such factors as the rate of teenage pregnancy. Other aspects of quality may not be captured by these measures at all. For example, Americans (or at least insured Americans) may have greater access to advances in medical technology than persons in other countries or may be less likely to have to wait for non-emergency treatment. Assessing the efficiency of the American system depends in part on how one defines quality, a problem that will be considered further at the end of this report.

Whatever the relative quality of American medical care, there are concerns about the rate at which health expenditures are increasing. Inflation in the medical sector has outpaced inflation in the rest of the economy for many years. National health expenditures rose an average of 13 percent a year from 1970 through 1981. The rate of growth declined over the next several years, chiefly because of a decline in inpatient hospital admissions. Between 1984 and 1985 total costs rose just 7.9 percent, the lowest annual rate of increase since the enactment of Medicare and Medicaid in 1965 (though still greater than the growth in GDP). This moderation in expenditure growth proved short-lived. Costs rose 9.8 percent in 1987, and employers and insurers have reported dramatic cost increases over the next

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[1]Schieber, George J., and Jean-Pierre Poullier. International Health Care Expenditure Trends: 1987. *Health Affairs*, v. 8, no. 3, fall 1989. p. 169-177. (Hereafter cited as International Health Care Expenditure Trends: 1987.)

2 years. For example, one recent survey has found that employers' average cost per employee for health benefits rose 19 percent in 1988.[2]

The return of double-digit medical care inflation after a temporary respite has led to concerns that continued growth in medical care costs could impede efforts to improve access to health care and could eventually erode the access that already exists. Many employers have already reduced their contribution to employees' insurance expenses, while the costs of public insurance programs are consuming an increasing share of State and Federal budgets. Proposals to extend coverage to the uninsured have raised concerns that any expansion of the insured population might lend a further impetus to medical care inflation, as did the enactment of Medicare and Medicaid in 1965. While the issue of health care costs and ways of controlling them has been a central one in health policy at least since the early 1970s, these recent developments have given the issue a new urgency.

This report examines policy options for controlling the increase in health care costs by modifying the way medical care is delivered or financed. Most proposals have relied on one of four basic approaches:

- Changing the behavior of consumers by holding them directly responsible for a larger portion of the costs of their own care;
- Changing provider behavior through direct modification of medical practice, or by controlling the overall supply of medical resources;
- Changing provider behavior through reimbursement systems that provide incentives for greater efficiency;
- Changing the behavior of both providers and consumers by encouraging consumers to choose from among multiple health plans that compete on the basis of their ability to develop structured and efficient delivery systems.

The remainder of this report provides an overview of the concepts underlying these basic approaches and the evidence available about their ability to achieve savings and their potential impact on access and quality of care. The greatest attention is devoted to the last of the four strategies, competition, because this approach has dominated policy discussion in recent years.

The report does not consider changes outside the health care delivery system that could directly or indirectly affect medical care expenditures. For example, the incidence of illness or injury might be reduced through public health or health education measures, stronger environmental controls, or

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[2]Geisel, Jerry. Health Benefit Tab Rises 19% to New High. *Business Insurance*, Dec. 11, 1989. p. 1.

improved safety regulation. Changes in the civil litigation system (i.e., malpractice reform) could reduce the practice of "defensive medicine" that is alleged to result in the performance of unnecessary tests or procedures. Such measures might well play an important role in any comprehensive initiative to control medical care spending. They are omitted in order to allow this report to focus more directly on the medical care system itself and on proposals to change the way consumers and providers behave within that system.

COST SHARING

Proposals to hold consumers responsible for more of the costs of their own medical care begin with the premise that comprehensive insurance coverage, largely funded by employers or government, has distorted the health care market by freeing consumers of any need to consider the utility or price of the services they are consuming. While not all observers share the view that growth in health care costs is driven by consumer choices, there are increasing calls for measures to encourage consumers to become more conscious of the price and utility of the medical services they use.

There are two broad ways of doing so. The first is to require consumers to pay a higher share of the premiums for their health care coverage, thus giving them an incentive to choose the most efficiently operated plan. This approach is the subject of the final section of this memorandum. The second method, considered in this section, is to make consumers pay more of the direct costs of the services they use by increasing the deductibles or coinsurance payments required under their insurance plans.

Increases in enrollee cost-sharing responsibility can reduce overall medical expenditures only if they deter some enrollees from obtaining care. Otherwise, they merely shift expenses from the insurer to the consumer.[3] The major study of the impact of cost-sharing on health care utilization and costs was the Health Insurance Experiment (HIE) conducted between 1974 and 1982 by the RAND Corporation, under contract to the Health Care Financing Administration. The HIE randomly assigned 7,700 enrollees to a variety of health insurance plans, including a plan that included no cost-sharing (the "free" plan) and plans requiring coinsurance payments ranging from 25 to 95 percent (subject to overall limits on out-of-pocket expenditures).

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[3]Deductibles have other behavioral effects that may also produce cost savings. Enrollees whose costs during a year exceed the deductible by only a small margin may not go to the trouble of filing a claim. Other enrollees who are careless in record-keeping may be unable to document all of their out-of-pocket expenditures and may therefore spend more than the nominal deductible before the insurance takes over.

The key findings of the HIE were these:[4]

- Cost-sharing reduced the probability that individuals would seek care for any particular medical condition. The strongest deterrent effects occurred among the poor, especially poor children. They were at least 40 percent less likely to obtain care for a given condition than children in the free plan.

- Cost-sharing deterred enrollees from obtaining both "appropriate" and "inappropriate" medical care. Low-income enrollees in the cost-sharing plans were less likely to seek care for conditions for which medical care is highly effective, as well as for conditions for which medical care is rarely effective. Those in the cost-sharing plans had worse outcomes for specific conditions (such as hypertension) that can be improved by medical treatment.

- While cost-sharing prevented enrollees from initiating an episode of medical care, it did not change the course of treatment once an individual had entered the medical care system. Within any given episode of care, the cost-sharing enrollees received the same services and medications as other patients.

These findings raise several important concerns about the utility of cost-sharing as an approach for reducing medical expenditures. First, as would be expected, its impact is greatest on enrollees with the least income. This effect might be modified by developing cost-sharing requirements that varied by income. Such a system might be administratively cumbersome for employers or insurers. It might also defeat its own purpose, since cost-sharing may not reduce utilization unless it is financially burdensome. (The HIE enrollees in the least burdensome cost-sharing plan actually incurred slightly higher costs than those in the free plan.)

Second, cost-sharing may deter necessary as well as unnecessary care. The goal of making consumers more prudent in their use of health services may demand a degree of sophistication about the value of different services that not all enrollees possess. There have been attempts to develop more carefully targeted cost-sharing systems, to control only inappropriate utilization or to channel utilization in particular ways. For example, a higher coinsurance amount may be imposed for emergency room visits, in order to prevent enrollees from using the emergency room for non-urgent care; this approach is common in health maintenance organizations (HMOs) and has

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[4]This summary is drawn from Lohr, Kathleen, et al. Use of Medical Care in the RAND Health Insurance Experiment: Diagnosis and Service-Specific Analyses in a Randomized Controlled Trial. *Medical Care*, v. 24, no. 9, (Supplement) Sept. 1986. p. S74-S77; and Brook, Robert H., et al. Does Free Care Improve Adults' Health?: Results From a Randomized Controlled Trial. *New England Journal of Medicine*, v. 309, no. 23, Dec. 8, 1983. p. 1426-34.

been adopted by some State Medicaid plans. It is not certain, however, that even such narrower measures will deter only unnecessary care.

Finally, and perhaps most important from the perspective of cost reduction, cost-sharing may not modify the course of care once treatment has begun, presumably because the decision-making has generally shifted from the patient to the physician. This finding of the HIE is partly a result of the design of the experiment. Regardless of the level of cost-sharing required, each plan had an out-of-pocket limit, a point beyond which the insurer assumed full responsibility for all further expenses. In the absence of such a limit, enrollees might have been more likely to decline the services ordered by their physicians. At the same time, however, the most severely ill would have been subject to catastrophic financial losses.

Most medical care costs are incurred by a small minority of patients.[5] A cost-sharing system without catastrophic limits will leave that minority unprotected, while a system with limits on out-of-pocket expenses may have a minimal effect on the total costs of care once treatment has been initiated. The problem of controlling the costs of ongoing treatment is the subject of the next section.

CHANGING MEDICAL PRACTICE

Because most medical care purchasing decisions are made by physicians and other providers, rather than by the patients themselves, savings might be achieved if unnecessary services could be eliminated through external review of those decisions or through efforts to modify the providers' own decision-making.

External Utilization Controls

The term "utilization controls" embraces a variety of external constraints imposed by a payer on the volume or nature of services furnished or ordered by providers.[6] These include:

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[5]In 1978, 10 percent of U.S. families accounted for 67 percent of total health expenditures. U.S. Congress. Congressional Budget Office. *Catastrophic Medical Expenses: Patterns in the Non-Elderly, Non-Poor Population*. Washington, U.S. Govt. Print. Off., Dec. 1982. p. xviii.

[6]These techniques are sometimes referred to by health insurers as "managed care." Others restrict the term "managed care" to the more aggressive interventions in the health care system represented by HMOs or similar entities. This is the sense in which the term will be used later in this report.

- Pre-admission certification for elective inpatient stays;
- Concurrent review, under which patients already admitted to the hospital are monitored to ensure the appropriateness of their continued stay;
- Voluntary or mandatory second opinions before elective surgery;
- Case management, under which the payer or the payer's agent attempts to assume control of the overall delivery of services to an individual high-cost patient;
- Various approaches for shifting the locus of care from high-cost to low-cost settings. These include requirements that certain surgical procedures be performed on an outpatient basis, or that diagnostic tests ordinarily required for inpatients be conducted before the patient is admitted to the hospital.

Utilization controls, especially pre-admission certification and concurrent review, have become a standard feature of health insurance plans during the 1980s. They are now used in the Medicare program, in 29 State Medicaid programs (as of 1987), and in 72 percent of employer-sponsored health plans (as of 1988), up from 59 percent just a year earlier.[7] Despite the rapid adoption of utilization control systems by both public and private payers, they have received little systematic study, and evidence that they actually reduce spending is limited. Pre-admission review has the strongest track record; one controlled study found that it produced net savings for an average employee group of 7.3 percent, with even higher savings for groups that had very high utilization before the programs were initiated.[8] The evidence on some of the other approaches is less clear. For example, some studies have suggested that voluntary second surgical opinion programs may not deter enough unnecessary surgery to offset the costs of the second opinions themselves; mandatory programs appear to be more successful.[9]

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[7]Lindsey, Phoebe A. Medicaid Utilization Control Programs: Results of a 1987 Study. *Health Care Financing Review*, v. 10, no. 4, summer 1989. p. 79-92; and Gabel, Jon, et al. Employer-Sponsored Health Insurance in America. *Health Affairs*, v. 8, no. 2, summer 1989. p. 116-128.

[8]Feldstein, Paul, Thomas Wickizer, and John Wheeler. Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures. *New England Journal of Medicine*, v. 318, no. 20, May 19, 1988. p. 1310-14.

[9]For a review of the literature, see Ermann, Danny. Hospital Utilization Review: Past Experience, Future Directions. *Journal of Health Politics, Policy and Law*, v. 13, no. 4, winter 1988. p. 683-704.

There are also concerns that even the most successful utilization control approaches focus only on inpatient care and may merely shift the site in which care is delivered without fundamentally changing medical practice.[10] If a reduction in inpatient admissions is followed by an increase in outpatient services, savings may be only temporary; soon costs may begin to rise again as rapidly as before. One observer has argued that, because technologies that were once available only in hospitals are now widely diffused in the community, the hospital is no longer the appropriate focus of cost-containment efforts. At the same time, however, utilization controls for ambulatory services have been slow to develop. In part, this is because most ambulatory services have relatively small prices. The administrative costs of reviewing each service may outweigh any potential savings.[11] Some insurers have begun to require prior authorization for the most costly outpatient services, such as CAT scans or other major diagnostic procedures. Whether such measures are actually producing savings is not yet known.

Utilization controls face another barrier that may be even more important than administrative costs: the subjective nature of medical practice. Each patient is somehow unique, and external reviewers may have difficulty overriding the clinical judgments of individual practitioners in specific cases. This may be especially true when there is little consensus about the most appropriate treatment for a given condition, a problem to be discussed in the next section. In any event, some observers have contended that a persistent physician who is prepared to appeal a denial of authorization will often prevail. (The relative leverage of the individual practitioner may have been enhanced by recent legal decisions subjecting external utilization control agents to malpractice liability for denials of necessary care.) In consequence, utilization review may function as a delaying tactic rather than an absolute control, achieving savings only because some physicians will not take the trouble to protest the reviewers' decisions. The result has been termed "rationing by inconvenience."[12] Such savings as are achieved may diminish over time as physicians become more skillful in dealing with the system.

For this reason, some analysts have suggested that savings over a longer term may depend on the extent to which providers "sign on" to the concept

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[10]For a discussion of this issue, see *Institute of Medicine*. Controlling Costs and Changing Patient Care? The Role of Utilization Management. Washington, 1989.

[11]Goldsmith, Jeff C. Competition's Impact: A Report from the Front. *Health Affairs*, v. 7, no. 3, summer 1988. p. 162-173.

[12]Grumet, Gerald W. Health Care Rationing Through Inconvenience: The Third Party's Secret Weapon. *New England Journal of Medicine*, v. 321, no. 9, Aug. 31, 1989. p. 607-11.

of eliminating unnecessary services. In this view, real utilization control will require voluntary changes in the way physicians practice medicine.

Modifying Practice Styles

Beginning in the 1970s, studies by Wennberg and others showed that there was substantial geographic variation in the rate of use of specific medical or surgical procedures. For example, the rate of tonsillectomies in one area of New England was six times higher than the lowest rate in the region.[13] While some of the variations uncovered in "small area analysis" might be attributable to differences in the incidence of illness in different populations, this explanation appeared to be insufficient to account for all the variation; some other factors had to be at work. One hypothesis was that physicians in different areas had different "practice styles." Each community had its own medical culture, its own characteristic way of diagnosing or treating particular diseases or conditions. Physicians adopted the practice style of their community in the absence of firm and objective information about which treatment approach was actually superior.

Other explanations have been offered for small area variations in medical practice; these will be discussed further below. However, the practice style hypothesis has won many supporters and has led to proposals for controlling medical care costs by (a) improving knowledge of the relative efficacy of different medical treatments and (b) disseminating this knowledge to practitioners in the expectation that they will modify their practice styles accordingly. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) establishes a new program within the Department of Health and Human Services for research on the effectiveness of medical treatments and the development of practice guidelines. Not all of the proponents of this initiative view it as a cost-containment measure. Some view it chiefly as a possible way of improving quality of care, and therefore worth pursuing whether or not any cost savings result. The following discussion, however, considers only the potential of medical practice research to reduce costs.

To have a significant impact, guidelines will need to address areas of practice on which there is real disagreement among physicians. There have been some efforts in the past to codify elements of medical practice on which there already existed a consensus. However, if most physicians already agree on the best treatments, promulgating that agreement in the form of guidelines may not have a measurable impact on medical practice. (This appears to have been the case, for example, with a 1984 consensus report on

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[13]Wennberg, John, and Alan Gittelsohn. Variations in Medical Care Among Small Areas. *Scientific American*, v. 246, Apr. 1982. p. 120-134.

the treatment of high blood pressure.[14]) For this reason, the treatment research initiative will focus on conditions for which there is found to be a wide variation in current practice. Because the Nation is just beginning to devote significant resources to research on the outcomes of alternative medical treatments, it may take time for researchers to reach agreement in cases where practice variation is the result of real scientific uncertainty. The full potential savings from this strategy might therefore be realized only over the long term.

Assuming that future research can resolve disagreements over appropriate treatments, there would remain the task of inducing physicians to modify their practices voluntarily on the basis of the new findings. Some success in changing practices has been reported when physicians have been introduced to guidelines through structured face-to-face educational programs conducted by respected peers.[15] Some other efforts that relied only on printed materials to communicate practice recommendations have had disappointing results. Providers could be aware of and even approve the recommendations without making significant changes in practice. It is possible that some physicians may encounter barriers in implementing even guidelines with which they nominally agree. These may include concerns about malpractice liability, lack of the substitute skills or the special equipment needed to follow the guidelines, economic incentives, or pressure from patients.[16] These barriers might be overcome with more vigorous educational efforts. Still, countervailing economic and professional pressures may limit the willingness or ability of physicians to comply voluntarily with treatment guidelines.

One alternative is to use the results of outcomes research as the basis for mandatory, rather than voluntary, guidelines--that is, as a way of strengthening or broadening current utilization control programs. Proposals to do so have met strong opposition from the medical community, on the grounds that medicine cannot be reduced to a "cookbook" and that to compel physicians to comply with fixed practice rules would stifle innovation. In

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[14]Hill, Martha N., David M. Levine, and Paul K. Whelton. Awareness, Use, and Impact of the 1984 Joint National Committee Consensus Report on High Blood Pressure. *American Journal of Public Health*, v. 78, no. 9, Sept. 1988. p. 1190-94.

[15]See Chassin, Mark R. Standards of Care in Medicine. *Inquiry*, v. 25, no. 4, winter 1988. p. 437-453.

[16]Lomas, Jonathan, et al. Do Practice Guidelines Guide Practice? The Effect of a Consensus Statement on the Practice of Physicians. *New England Journal of Medicine*, v. 321, no. 19, Nov. 9, 1989. p. 1306-11; and Kosecoff, Jacqueline, et al. Effects of the National Institutes of Health Consensus Development Program on Physician Practice. *Journal of the American Medical Association*, v. 258, no. 19, Nov. 20, 1987. p. 2708-13.

addition, there would remain the problem of achieving sufficient savings to offset the administrative costs of review systems.

Another option is to replace service-by-service utilization review with general comparisons of each physician's practice patterns to those of his or her peers. Physicians who, over time, consistently furnished or ordered more of certain services than others in the peer group would be targeted for closer scrutiny, to determine whether patterns of inappropriate utilization existed. Physicians found to be outliers might be the focus of special educational efforts in the hopes of inducing voluntary change. Continued noncompliance might trigger requirements that individual services receive prior authorization or could even lead to exclusion from participation in a given public or private insurance program.

How much could be saved if all inappropriate services were eliminated? Some studies have found very high rates of unnecessary care. For example, Chassin et al., in a thirteen-site study, found that 17 percent of all coronary angiographies were unnecessary; for other procedures, the rate of inappropriate use was as high as 32 percent. They also found, however, that the unnecessary care explained only a small fraction of variations in utilization across geographic areas. If none of the inappropriate angiographies had been performed, the area with the highest use of this procedure would still have had more than twice the number of angiographies as the lowest-use area. The authors suggest that other factors must play a part in this difference: disease incidence, differences in the point at which primary care physicians decide to refer patients to specialists, or cultural or social differences in the stage at which patients sought care.[17] Another multi-site study has found that, while practice style may explain differences in utilization of certain specific procedures, it does not explain overall differences in per capita use of medical care in different areas. At the aggregate level, standard socioeconomic factors could explain much of the difference in use and intensity of services.[18]

These preliminary studies suggest that there could be underutilization of services in some areas, while there is overutilization of the same services in other areas. Treatment research could pinpoint, not only cases in which unnecessary services could be eliminated, but also cases in which patients have had insufficient access (whether physical or financial) to necessary care. It is for this reason that some proponents of outcomes research have emphasized its potential impact on quality, rather than its potential for cost

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[17]Chassin, Mark R., et al. Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? *Journal of the American Medical Association*, v. 258, no. 18, Nov. 13, 1987. p. 2533-2537.

[18]Folland, Sherman, and Milan Stano. Sources of Small Area Variations in the Use of Medical Care. *Journal of Health Economics*, v. 8, no. 1, Mar. 1989. p. 85-107.

savings. Precisely because there is uncertainty about the relative efficacy of many treatments, it may be too early to say whether optimal medical treatment would involve more or fewer services than are currently furnished.

SUPPLY CONTROLS

If utilization controls or practice guidelines succeed in limiting unnecessary care, the full potential savings from any reduction in the number of services delivered may be realized only if there is a proportionate reduction in the resources used to provide those services. For example, changes in medical practice in the late 1970s and early 1980s led to a decline in inpatient hospital admissions without a corresponding reduction in hospital capacity. The result in many areas has been underutilized facilities spreading their fixed costs across a declining number of patients; while there are fewer patients, the cost for each patient rises because the unused capacity must still be paid for.

In addition, the existence of excess capacity may generate continuing pressures to find some new way of using that capacity and restoring utilization to its previous levels.[19] The view that the use of medical services could rise to fill any underused resources led to what was perhaps the dominant approach to cost containment in the 1970s: health planning, the regulation of facility construction and other capital expenditures.

In 1964, New York became the first State to establish a certificate-of-need (CON) program, under which proposals to build a new facility or expand an existing one had to be approved by a government agency. Other States followed, and a 1972 amendment to the Social Security Act provided that facilities in those States proceeding with construction without obtaining a CON could be denied Medicare and Medicaid reimbursement for their capital expenditures. Finally, the Health Planning and Resources Development Act in 1974 required all States to establish similar programs. This requirement was repealed in 1986, along with all Federal support for State health planning programs. States may continue to operate programs on their own; 39 States and the District of Columbia still do so. However, Medicare reimbursement is no longer contingent on State approval of capital

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[19]The view that hospital admissions rise in proportion to hospital bed capacity was originally advanced by Milton Roemer, in Bed Supply and Hospital Utilization: A Natural Experiment. *Hospitals*, v. 35, no. 21, Nov. 1, 1961. p. 36-42; Some more recent studies have concluded that the relation between supply and utilization may not be as straightforward as "Roemer's law" would suggest. Brewer, W. Ross, and Mary Anne Freedman. Causes and Implications of Variation in Hospital Utilization. *Journal of Public Health Policy*, v. 3, no. 4, Dec. 1982. p. 445-454.

expenditures, and a number of States have now limited their reviews to nursing home construction.[20]

Several factors contributed to the reversal of policy on health planning. In part, it fell victim to the general preference for market as opposed to regulatory solutions during the early 1980s. From a Federal perspective, the adoption in 1983 of Medicare's prospective payment system (PPS) for inpatient hospital services was expected to offer a different way of limiting health care resources; this approach is discussed further in the next section.[21] Underlying this shift, however, were claims that health planning had been tried and had failed, largely because of conflicting political pressures. In many areas, the oversupply of facilities was such that savings would have required, not just limits on new construction, but closure or consolidation of existing facilities. Few States were able to overcome the political resistance to such closures. Attempts to limit duplication of services or the spread of new technologies often faced similar barriers; attempts to plan for the rational distribution of resources on a regional basis had to confront providers' fears of losing to competitors and individual communities' desires for the most up-to-date facilities.[22]

CON programs did have some successes, particularly in constraining the growth in nursing home beds. Because State Medicaid programs are the major source of payment for nursing home care, States had a strong motive to overcome the political barriers to supply constraint. In at least some States, the CON process was explicitly seen as a Medicaid cost-containment measure; the determination of the number of nursing home beds needed was related to the maximum number of patients the State was prepared to cover.[23] Even in this case, however, any savings were achieved by holding growth in bed supply below the rate of growth in the aged population. States generally did not close down existing capacity.

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[20]American Hospital Association. State Issues Forum. *State Health Planning Report*. Chicago, July 1989.

[21]The inclusion of capital expenditures in PPS payments has been repeatedly postponed. Hospitals are instead paid for Medicare capital expenses on a reasonable cost basis, subject to a fixed percentage discount (15 percent beginning Jan. 1, 1990).

[22]For an overview of the barriers to health planning, see Brown, Lawrence D. Common Sense Meets Implementation: Certificate-of-Need Regulation in the States. *Journal of Health Politics, Policy and Law*, v. 8, no. 3, fall 1983. p. 480-494. (Hereafter cited as Common Sense Meets Implementation.)

[23]Feder, Judith, and William Scanlon. Regulating the Bed Supply in Nursing Homes. *Milbank Quarterly*, v. 58, no. 1, 1980. p. 54-88.

Recent concern about the rate of medical care cost increases has led to some calls for a revival of health planning, and it is conceivable that these concerns might eventually be sufficient to overcome the political barriers faced by health planners in the past. However, not all of the problems with health planning are political ones. Effective planning may require a fuller understanding of the workings of the health care system than is currently available. That system is a dynamic one, and decisions that seemed sensible in the late 1970s have sometimes had unpredictable effects. For example, most planning programs focussed on institutional services in hospitals and nursing homes, because these were the major sources of expenditure, and did little to control the capital expenditures of community-based physicians or clinics. The resulting growth in the availability of high-technology facilities outside hospitals is one of the reasons that recent reductions in inpatient utilization have been offset by increased outpatient costs. (Some States are now applying uniform rules across settings.)

Moreover, a community's needs may change unpredictably. New York was more successful than most States in controlling inpatient bed supply; it was one of the few States in which hospital closures occurred on a planned basis. While the number of community hospital beds nationally dropped 1.1 percent between 1977 and 1987, the number in New York dropped 9.9 percent.[24] New demands on these facilities in the 1980s, such as the appearance of AIDS (acquired immune deficiency syndrome) and the rise in drug-related problems, have led to serious overcrowding in some New York hospitals. The reported crisis in New York illustrates one of the potential constraints on the planning process. On the one hand, it may be necessary to maintain enough excess capacity to meet unforeseen needs or random fluctuations in demand. On the other hand, this excess capacity is costly to maintain and may itself generate demand. If the supply of a given kind of service is sufficient that no one ever has to stand in line for it, then the savings from health planning may be limited.

The fullest potential savings from health planning would require a more controversial step: limiting the supply of health resources to the point at which patients may have to wait for some period to obtain needed but non-emergency services. The result is "queueing," the delays in surgery or high-cost diagnostic procedures that are alleged to occur to some extent in Canada and to a greater extent in the United Kingdom. The degree to which queueing actually occurs in either country's health system has often been debated by those who favor or oppose adoption of a similar system here. Some people say that essential care may be unavailable, while others argue that resource limits merely oblige providers to set priorities and avoid unnecessary services.

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[24]American Hospital Association. *Hospital Statistics*, 1978 and 1988 editions.

Whatever the extent to which resources have been limited elsewhere, rationing of supply in the United States might raise concerns that are not as significant in countries where the entire population participates in a single insurance program. In those countries, everyone is in the same queue, and one's place in line is chiefly determined by the urgency or duration of one's need. (There are exceptions: one can step out of line in the United Kingdom by finding a private provider, and there are anecdotal accounts that some Canadians with sufficient resources may seek care in the United States.) When queueing has occurred in the United States, however, places in line may have been determined by financial resources.

The facilities in New York reporting the greatest overcrowding have been those serving the poor and the uninsured. Similar effects may have resulted from health planning's major success, the control of nursing home bed supply. Because Medicaid payment is generally less than that available from private patients, nursing homes in areas with limited bed supply and high occupancy rates have an incentive to accept a private-pay patient when a vacancy occurs, while Medicaid beneficiaries may be unable to find a place. In 28 States, Medicaid administrators report that beneficiaries awaiting hospital discharge had difficulty finding a nursing home bed.[25] While supply constraints are not the only factors limiting access to care for low-income Americans, they may exacerbate existing problems. The acceptability of health planning as a cost control strategy may, then, depend in part on the extent to which supply limitations are accompanied by efforts to make distribution of limited resources more equitable.

One other issue should be raised in the context of a discussion of health resources: the debate over the possible oversupply of physicians and the potential consequences of physician supply on health care costs. In 1980, the Graduate Medical Education National Advisory Committee (GMENAC) reported that the United States would have a surplus of 150,000 physicians by the year 2000.[26] The extent of the potential surplus has since been the subject of continuing debate. There are questions about the extent to which technology and the aging of the population could increase demand, or the adoption of utilization controls or managed care could decrease it. The

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[25]For a fuller discussion of this problem, see U.S. Library of Congress. Congressional Research Service. *Medicaid Source Book: Background Data and Analysis*. Report prepared for the House Committee on Energy and Commerce. Washington, Nov. 1988. (Committee print 100-AA) p. 467-83. (Hereafter cited as Congressional Research Service, *Medicaid Source Book*.)

[26]Graduate Medical Education National Advisory Committee. *Report to the Secretary, U.S. Department of Health and Human Services*. Washington, 1980.

number of medical school admissions could decline, or physicians might spend more of their time on administrative activities and less on patient care.[27]

Even less clear than the extent of the future surplus is its possible effect on medical costs. Observations that per capita use of physician services increases in geographic areas with a high ratio of physicians to population have led to the hypothesis of "physician-induced demand." Just as excess hospital bed capacity may generate more hospital stays, this theory holds that a surplus of physicians all attempting to maintain their incomes would lead --in the absence of any controls--to excess delivery of services. Repeated efforts to demonstrate this have been inconclusive.[28] It is not clear that physicians actually modify their medical practice in order to maintain a "target income." Still, if the projected surplus does in fact appear, there might be greater pressures on physicians to increase the number of services they furnish to each patient. Some people believe that it may eventually be necessary to consider reducing the supply of physicians (or curtailing their working hours).

This has actually been attempted in one Canadian province, British Columbia. A physician who wants to participate in the health program that covers all citizens of the province must have a billing account, and since 1985 the number of accounts has been limited (limits vary by specialty and geographic area). A physician who fails to obtain a billing number cannot earn a living as a physician. Critics of the system contend, however, that British Columbia is merely exporting its physician surplus to other provinces or to the United States.[29] Given the political problems health planners in the United States have experienced in trying to close hospitals, it seems unlikely that British Columbia's efforts could be reproduced here, with government regulators telling new medical school graduates to find some other profession. However, there are proposals to achieve the same goal through private means. Some of the more ambitious "managed care" agendas discussed in the final

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[27]For contrasting views on these issues, see Schwartz, William B., Frank A. Sloan, and Daniel N. Mendelson. Why There Will Be Little or No Physician Surplus between Now and the Year 2000. *New England Journal of Medicine*, v. 318, no. 14, Apr. 7, 1988. p. 892-897; Schloss, Ernest P. Beyond GMENAC--Another Physician Shortage from 2010 to 2030? *New England Journal of Medicine*, v. 318, no. 14, Apr. 7, 1988. p. 920-922.

[28]See Rossiter, Louis F., and Gail R. Wilensky. A Reexamination of the Use of Physician Services: The Role of Physician-Initiated Demand. *Inquiry*, v. 20, no. 2, summer 1983. p. 162-72; Langwell, Kathryn M., and Lyle M. Nelson. Physician Payment Systems: A Review of History, Alternatives and Evidence. *Medical Care Review*, v. 43, no. 1, spring 1986. p. 5-58.

[29]Barer, Morris L. Regulating Physician Supply: The Evolution of British Columbia's Bill 41. *Journal of Health Politics, Policy, and Law*. v. 13, no. 1, spring 1988. p. 1-25.

section of this report contemplate enrollment of the entire population in health maintenance organizations (HMOs) or other structured delivery systems that would match their resources to the needs of the enrolled population; this approach would potentially reduce employment opportunities for physicians.[30]

REIMBURSEMENT REFORM

Proposals for reimbursement reform begin with the premise that traditional payment systems, under which providers receive their full costs or charges for whatever services they choose to furnish, encourage inefficiency and the delivery of unnecessary care.

The simplest type of reform is for payers to set fixed prices for defined units of service, such as a day of inpatient care or a physician office visit. However, this approach may not reduce costs if providers are able to modify the volume or nature of the services they provide to make up for the lost revenue on individual services. For this reason, the focus of reimbursement reform proposals is on developing pricing mechanisms that give providers incentives to control both volume and unit cost.

This is generally accomplished by redefining the commodity the insurer is purchasing. Instead of paying for individual units of service, the insurer makes one payment for an episode of care (as in Medicare's prospective payment system, PPS), for overall treatment of a patient during a given time period (capitation), or for treatment of an entire population (as in Canada's global budgeting system for hospitals). These approaches may be seen as aligned on an ascending scale depending on the degree of aggregation of the unit being purchased, with per-case payment at the low end and payment for an entire patient population at the other. In all cases, however, the aim is to define in advance the total amount of resources the provider may consume in furnishing treatment to a patient or group of patients.

Per-case payment and capitation give the provider an incentive to perform more efficiently in treating individual patients, either reducing the cost of producing each unit of service or reducing the number of units furnished to each patient. These approaches may therefore be seen as alternatives to external utilization controls. Global budgeting defines the total resources available for treating all patients, and may be seen as an

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[30]For example, Alain Enthoven has characterized the "buy right" scheme advanced by Walter McClure as requiring that "good-quality, efficient doctors prosper while others are induced to retire." Enthoven, Alain C. Managed Competition in Health Care and the Unfinished Agenda. *Health Care Financing Review*, 1986 Annual Supplement. p. 105-119.

alternative to health planning.[31] Reimbursement controls have the same goals as direct regulation of medical practice and supply, but shift the responsibility for decision-making from the third-party payer or the government to the actual providers of care. In order to live within the established rates or budgets, the providers must be self-regulating; they must make the same sorts of treatment and resource allocation decisions that would otherwise have been imposed externally.

As the Medicare program has demonstrated, it is possible for a single payer with sufficient market power to adopt such reimbursement changes on its own.[32] The effects of this unilateral approach in a pluralistic system are uncertain. While some providers may be driven to improve their efficiency, others may instead respond to shortfalls in reimbursement from one payer by raising charges to other groups, those without the market power to dictate prices. The possibility of "cost-shifting" may mean that savings for one purchaser are not translated into real reductions in total system expenditures.

In a sufficiently competitive market, the providers' ability to engage in this "cost-shifting" may be limited. A hospital may face, not only payment limits under Medicare and Medicaid, but pressure from private insurers or employer groups to grant price discounts in order to be assured of an adequate market share. Characteristics other than efficiency may determine a provider's success in the face of these competing demands. For example, a suburban non-teaching hospital with few uninsured patients may be at a relative advantage as compared to a center city teaching facility with a heavy uncompensated care load. Individual purchasers who reduce their costs by favoring the suburban hospital may leave the society to find some other means of subsidizing essential facilities that are handicapped in price competition.

A system in which multiple payers negotiate individually with providers may, then, lead either to cost-shifting or to a situation in which price concerns override other societal goals, such as medical education and charity

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[31]In practice, the Canadian system uses both global budgeting and health planning. However, some of the rate regulation systems in the United States have explicitly superseded the health planning system. A facility that has obtained a certificate of need for expansion may proceed only if the rate commission approves the necessary increase in capital costs. For a discussion of the interplay of planning and rate regulation, see Brown, Common Sense Meets Implementation.

[32]As the Medicaid experience has shown, adoption of payment restraints by a payer with too small a market share may reduce acess for the payer's enrollees. For example, low reimbursement rates are the major reason physicians decline to participate in the Medicaid program. See Congressional Research Service, *Medicaid Source Book*, p. 448-454.

care. For this reason, some people argue that real efficiency can be achieved only if all payers are paying under the same rules.

Uniform ratesetting is common in other industrialized nations, both those with single-payer health insurance systems (as in Canada) and those where many different entities provide insurance (as in West Germany). The experience in the United States is limited to experiments in a few States beginning in the 1970s. Federal waivers of Medicare and Medicaid rules made it possible for those two payers to participate in the programs on a demonstration basis, while State laws compelled participation by private insurers and individual payers, resulting in an "all-payer" system. Medicaid law now permits any State to include Medicaid in such a system, and Medicare may be included if the State can show that its system controls costs as effectively as PPS. However, full "all-payer" systems continue only in Maryland and in part of New York State. Several other States operate "partial-payer" systems that include all payers except Medicare.[33] These systems have generally used the price aggregation approaches described above. That is, they either establish a rate for total treatment of a case (as under PPS) or they establish a total budget for a hospital during a year, setting prices for the hospital in such a way as to achieve a target revenue amount.

It has been shown that, in 6 States with ratesetting systems, annual increases in cost per admission were consistently 3 to 4 percentage points below the national average from 1976 to 1984. During the same period, however, other States saw a drop in admissions per capita, while admissions in the ratesetting States were stable. As a result, the difference in growth in per capita rates of spending was not so striking: per capita costs rose at an annual rate of 11.5 percent a year in the ratesetting States and 13 percent a year in other States.[34] In addition, the ratesetting States had much higher costs at the outset than most other States. Some observers have questioned whether ratesetting could have achieved comparable savings in areas where costs were lower to begin with.[35]

Evidence from other countries with universal ratesetting systems suggests that greater savings may be possible. In Canada, where the provinces establish global budgets for each hospital, hospital expenditures per capita

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[33]Maine's system takes hospitals' Medicare revenues into account when determining what the hospitals may charge other payers, thus achieving overall budgetary control without direct Medicare participation. This approach has recently survived a legal challenge by hospitals.

[34]Schramm, Carl J., Steven C. Renn, and Brian Biles. New Perspectives on State Rate-Setting. *Health Affairs*, v. 5, no. 3, fall 1986. p. 22-33.

[35]Eby, Charles L., and Donald R. Cohodes. What Do We Know About Rate-Setting? *Journal of Health Politics, Policy, and Law*, v. 10, no. 2, summer 1985. p. 299-327.

were one-third lower than in the United States in 1985. (Similar systems in other industrial nations have been less successful.)[36] As admission rates are not markedly lower, there is considerable uncertainty about the sources of the difference. Some of the saving may be in administrative costs, simply because the hospitals do not need to meet the paperwork requirements of multiple payers. The rest of the difference is often attributed to differences in the intensity of the services furnished to each patient. Whether these differences reflect "underservice" in Canada or "overservice" in the United States is the subject of continuing debate.[37]

In a sense, the statistical evidence may be beside the point. An all-payer system could in theory fix its prices at any level, with the potential consequence of reduced access or quality if the prices are set too low. The available data may thus be taken as indicating, not the savings that could hypothetically be achieved, but the savings that were politically feasible in specific States during a specific period. Continuing pressure by consumers and providers for the adoption of new medical technologies may limit the ability of ratesetting systems to restrain expenditure growth over the long term. Even in Canada, overall medical expenditures outpaced inflation by 2.9 percent a year in the period 1980-87, almost the same as the 3.0 percent annual rate observed in the United States in the same years.[38] The ultimate efficacy of reimbursement controls may depend, in the same way that the success of health planning depends, on the political will to constrain health care consumption.

That political will might in turn depend on perceptions of the impact of reimbursement controls on the quality of care. The effect of Medicare's prospective payment system, for example, has been argued continuously since its implementation in 1983. One of the immediate responses of hospitals to the incentives of the new system was to shorten the average length of stay in the hospital for each Medicare patient (although average length of stay had already been dropping for several years). Opponents of the new system have contended that patients were being discharged "quicker and sicker," transferred to their own homes or to nursing homes at a stage in their recovery when they still required hospital-level care. Because of a lack of satisfactory measures of medical care outcomes for large populations, evidence on this issue remains largely anecdotal. Still, the possibility that there has been a deterioration in quality of care for at least some Medicare patients

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[36]Organisation for Economic Co-Operation and Development. *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries.* Paris, 1987. (OECD Social Policy Studies No. 4.) p. 63.

[37]For a variety of views on this subject, see the series of articles on Canada's hospital system in *Health Affairs*, v. 7, no. 5, winter 1988.

[38]Schieber and Poullier, International Health Care Expenditure Trends: 1987.

since the implementation of PPS cannot be ruled out. The hospitals themselves argue that current payment levels are insufficient to maintain adequate quality. At the same time, the Administration and the Prospective Payment Assessment Commission (the independent commission that reviews PPS) have argued that hospitals are still not operating at peak efficiency and that further payment restraint is needed to provide continued incentives for cost reduction.[39]

This debate illustrates one potential dilemma in the strategy of achieving savings by relying on the political process to limit the financial resources available to providers. On the one hand, legislators driven by budgetary concerns may continue to ratchet down spending limits until they have clear evidence that quality has been seriously affected. On the other hand, provider or constituent pressure may lead them to relax those limits before the providers have done everything possible to improve their efficiency. Because no one knows the ideal amount to spend on medical care, some people say that this process can never achieve equilibrium and that cost control efforts should instead depend on the process through which other sectors of the economy achieve "correct" spending levels: the free market. Proposals for encouraging competition in health care represent the last of the strategies to be reviewed in this report.

COMPETITION

The idea of reducing health care costs by promoting competition in the health care marketplace was first advanced in the 1970s. Some analysts, arguing that such initiatives as rate regulation, health planning, and utilization review had been compromised by political interference, contended that the free market was better equipped to control costs than Government was. By the early 1980s, this view had wide currency and had become the official policy of the Reagan Administration. Since then, there has been a continuing debate between advocates of competition and those who favored further regulatory interventions by Government. The debate has been complicated by a lack of agreement over what "competition" consists of. What is the health care market? Who are the purchasers, and what are they buying?

In a simple market, hospitals and physicians would compete directly for the individual consumer's dollar. The consumer would pick the best values just as he or she does when buying any other commodity. As was suggested

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[39]U.S. Prospective Payment Assessment Commission. *Report and Recommendations to the Secretary, U.S. Department of Health and Human Services*. Washington, U.S. Govt. Print. Off., Mar. 1989; For a recent review of hospital cost responses to PPS, see Sheingold, Steven H. The First Three Years of PPS: Impact on Medicare Costs. *Health Affairs*, v. 8, no. 3, fall 1989. p. 191-204.

in the discussion of cost-sharing, it is not clear that consumers are capable of making such evaluations; moreover, many purchasing decisions are made by physicians on their patients' behalf, rather than directly by consumers. Finally, because few people can afford the costs of care for a major illness, most of the consumer's dollar is spent on health insurance, not on medical care itself. As was suggested earlier, this is true even when the insurance plan imposes cost-sharing requirements on enrollees, because most health care costs are incurred by a relatively small number of high-cost cases. For this reason, most proponents of competition are really talking about price competition among insurers, and only indirectly among providers.

If the insurer is--as traditional health insurance plans were--a passive payer for services obtained by policyholders, there is little room for serious price competition. The only element of cost that the insurer can control is its own administrative cost. Competition, if any, may turn on such non-price factors as reputation or the insurer's ability to screen out high-risk applicants.[40]

Competition among insurers can result in real cost savings only if the insurers have some influence on the costs of health care itself. In this model, insurers compete to offer lower prices by acting as prudent purchasers, proxies for the rational consumer. The insurers are selling a new product, no longer simply insurance, but "insured health care." To some extent, this new insurance market has already arrived. As was suggested earlier, most insurance plans, both public and private, have adopted some utilization control measures. Very few insurers are still passive bill-payers.

Once all insurers have adopted these basic cost control measures, further competition would presumably require more aggressive interventions by insurers in the health care system. Proponents of competition contemplate a marketplace in which insurers develop structured delivery systems, with the highest profits going to those whose networks are most efficient. The prototype for these systems is the HMO. More recently, some insurers have been experimenting with hybrid programs, such as "point-of-service plans," that are less structured and provide somewhat greater flexibility to enrollees.

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[40]Alain Enthoven has summarized the alternatives to price competition: "[S]election of preferred risks, market segmentation, product differentiation that raises the costs of comparing products, discontinuity in coverage, refusal to insure certain individuals or exclusion of coverage for treatment of preexisting medical conditions, biased information regarding coverage and quality, and erection of entry barriers [that is, to new competitors]." Enthoven, Alain C. Managed Competition of Alternative Delivery Systems. *Journal of Health Politics, Policy and Law*, v. 13, no. 2, p. 305-321.

Health Maintenance Organizations

A health maintenance organization (HMO) is a form of health insurer; like any other insurer, it accepts financial responsibility for a defined set of health care benefits in return for a fixed monthly per capita premium. Unlike other insurers, HMOs directly provide or arrange for health care services, through affiliated physicians, hospitals, and other providers. The enrollees covered by the HMO agree to obtain all services, except emergency and out-of-area care, from or with the authorization of the HMO or its affiliated providers. The HMO has no liability to pay for unauthorized non-urgent care obtained outside the organization. Ordinarily, the enrollee's point of entry into the system is through a single primary care provider, who functions as a "gatekeeper," determining when a patient may see a specialist or be admitted to the hospital. The HMO exerts further administrative controls on use of services through authorization mechanisms and/or treatment protocols. HMOs also use a variety of other cost-saving techniques, such as negotiated discounts with providers and payment mechanisms that place individual providers at risk for the costs of the services they furnish or order.

The particular cost-saving techniques adopted by HMOs and other "managed care" plans are not fundamentally different from the regulatory approaches described in the preceding sections. An HMO imposes external utilization review on its participating providers and may develop practice guidelines or protocols. Staff or group practice model HMOs (those that employ physicians on a full-time basis) impose supply constraints, limiting available resources to those needed by their membership. Individual practice associations (IPAs, whose physicians practice in their own offices and see a mix of HMO and non-HMO patients) use payment methods that create financial incentives to control utilization, such as capitation or expenditure targets.

One additional cost-saving approach that was once unique to HMOs is "gatekeeping." Under a gatekeeping approach, a patient receives all non-emergency care from, or with the authorization of, a single primary care provider. The provider thus functions as a "gatekeeper," preventing the enrollee from independently accessing specialists or other services and presumably managing the overall care of the patient. The extent to which gatekeeping produces savings over and above those provided by the other cost-saving techniques adopted by HMOs is uncertain. The results of one experiment, the SAFECO health plan operated by United HealthCare in the early 1980s, suggest that gatekeeping alone has little effect on overall cost. While primary care providers reduced the number of referrals to specialists, they were unable to control the behavior of the specialists once a referral had occurred. There was no meaningful reduction in hospital admissions, 70

percent of which were controlled by the specialists.[41] Greater success has been reported by some State Medicaid programs, which have established "primary care case management" programs for segments of their covered populations. Gatekeeping reduced such inappropriate behaviors as the use of emergency rooms for primary care. However, the utilization patterns addressed by these programs may be characteristic of Medicaid beneficiaries in the inner city and not of other groups; it is not clear that equivalent savings could be achieved with a general population. There is some evidence that most patients' care is already "managed" by their primary care physicians, at least to the extent that it is managed under formal gatekeeping arrangements.[42]

Aside from the uncertain effects of gatekeeping, managed care depends on the same kinds of interventions in medical care practice, supply, and financing that might otherwise be attempted on a regulatory basis. The difference is that, instead of relying on the political process to make decisions about the allocation of health care resources, managed care privatizes these decisions. The choice among alternative cost control methods--and the stringency with which these methods will be applied--will be made by the free market. The fundamental contention of proponents of the competitive approach is that the market can impose discipline on the health care system that cannot be imposed through external regulation.

This contention rests on two key assumptions: first, that buyers will, all other things being equal, select the most cost-effective plan; second, that managed care offers greater cost-saving potential than the various regulatory controls described earlier.

One critical factor has made it difficult to generalize about the efficacy of HMOs as a cost-saving approach: the problem of "biased selection" in systems that allow a choice between a conventional health insurance plan and an HMO. Numerous studies of such "dual choice" employer group plans have shown that the members of the group choosing the HMO option used fewer health services before their enrollment than persons who chose an conventional plan. Similar patterns have been observed in Medicare HMO

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[41]Moore, Stephen, Diane Martin, and William Richardson. Does the Primary-Care Gatekeeper Control the Costs of Health Care? Lessons from the SAFECO Experience. *New England Journal of Medicine*, v. 309, no. 22, Dec. 1, 1983. p. 1400-1404; For the extent to which specialty referrals may determine overall costs, see Glenn, John K., Frank H. Lawler, and Mark S. Hoerl. Physician Referrals in a Competitive Environment: An Estimate of the Economic Impact of a Referral. *Journal of the American Medical Association*, v. 258, no. 14, Oct. 9, 1987. p. 1920-23.

[42]Dietrich, A.J., et al. Do Primary Physicians Actually Manage Their Patients' Fee-for-Service Care? *Journal of the American Medical Association*, v. 259, no. 21, June 3, 1988. p. 3145-49.

enrollment.[43] This does not necessarily mean that HMO enrollees were healthier. Studies using self-reported condition and similar limited measures of health status have found no difference between HMO and indemnity enrollees. It may be, then, that HMO enrollees are simply less prone to seek health services, regardless of their condition.[44]

In groups that have no HMO option but do offer a choice between high- and low-option plans the common selection pattern is for the higher users of services to choose the more comprehensive plan.[45] In most group health programs offering a choice between HMOs and conventional plans, the HMO options offer more comprehensive coverage, with less enrollee cost-sharing, than even a high-option conventional plan. That higher users of services still prefer the conventional plan suggests that non-financial aspects of HMOs affect the decision, such as limited choice of providers, bureaucratic constraints on treatment, or waiting time for non-urgent care. There is stronger evidence of biased selection for staff and group model HMOs, the most restrictive, than for IPAs, which are less likely to disrupt enrollees' traditional ways of obtaining medical care.

Possible solutions to the problem of selection bias will be discussed further below. One immediate consequence, however, is that the differences between the populations in HMOs and conventional plans have made it difficult to determine whether HMOs are actually more efficient than other insurers. Only one major study has corrected adequately for this problem. In a second component of the RAND Health Insurance Experiment (HIE) cited earlier, enrollees were randomly assigned to the Group Health Cooperative of Puget Sound and an equally comprehensive conventional plan; neither plan required cost-sharing. This arrangement allowed comparisons of efficiency with identical benefits and populations with comparable health needs. The results strongly confirmed the cost-saving potential of the HMO. The HMO enrollees had 40 percent fewer hospital admissions; their use of ambulatory services was about the same as that of the conventional enrollees. Overall, costs for the HMO group were estimated to be 28 percent lower than

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[43]For a review of the evidence, see U.S. General Accounting Office. *Medicare: Increase in HMO Reimbursement Would Eliminate Potential Savings*. Report to the Chairman, Subcommittee on Health, House Committee on Ways and Means. Washington, Nov. 1989. [GAO/HRD-90-38]

[44]Hellinger, Fred J. Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence. *Health Care Financing Review*, v. 9, no. 2, winter 1987. p. 55-63.

[45]Broyles, Robert W., and Michael D. Rosko. The Demand for Health Insurance and Health Care: A Review of the Empirical Literature. *Medical Care Review*, v. 45, no. 2, fall 1988. p. 291-338.

for the control group.[46] There were no perceived effects on quality; measures of health outcomes were generally the same for both groups.[47]

While the HIE findings are persuasive, two factors may limit the general applicability of the results. First, the study was conducted in the late 1970s; the comparison plan was the passive bill-payer prevalent in the insurance industry in that period, with no utilization control mechanisms. The more recent adoption by conventional plans of some of the cost-control measures once associated only with HMOs may mean that the difference in efficiency between the two types of plan has narrowed.

Second, the HMO used in the Health Insurance Experiment was a highly structured group-practice plan with many years of operating experience. Much of the growth in the industry in recent years has involved a different type of HMO, the individual practice association (IPA), which contracts with independent physicians who see a mix of HMO enrollees and other kinds of patients. There is evidence that these more loosely structured HMOs have not achieved savings comparable to those observed in the HIE.[48] Physicians may not modify their styles of practice in treating HMO enrollees if those enrollees constitute only a small share of their practice. In addition, some people believe that HMOs cannot impose cost-consciousness on practitioners who have not "signed on" to the concept of more efficient and less resource-intensive practice. Because so little is still known about the relative efficacy of different medical practices, external utilization controls may not be able to override individual physicians' judgment in many cases. The greater success of the "closed panel" plan, whose physicians treat HMO enrollees exclusively, has been attributed by some observers to the possibility that these plans attract physicians who are temperamentally more prone to conservative medical practice.

Because closed panel plans maintain their own medical facilities, they require greater start-up funding than IPAs. Federal funds were available to develop such plans in the 1970s, but new plans must now rely on private

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[46]Manning, Willard G., et al. A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services. *New England Journal of Medicine*, v. 310, no. 23, June 7, 1984. p. 1505-10.

[47]Ware, John E., Jr., et al. Comparison of Health Outcomes at a Health Maintenance Organisation With Those of Fee-for-Service Care. *Lancet*, May 3, 1986. p. 1017-22. One group, low-income HMO enrollees with existing health problems, had poorer outcomes, possibly because of difficulty dealing with the HMO's internal bureaucracy.

[48]For the most recent findings, see Hillman, Alan, Mark Pauly, and Joseph Kerstein. How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations? *New England Journal of Medicine*, v. 321, no. 2, July 13, 1989. p. 86-92.

investment. Investors have favored IPAs, not only because they require less capital, but also because the wider selection of physicians makes them more attractive to consumers. This attraction may, however, be purchased at the price of reduced efficiency.

Finally, while some types of HMOs or similar organizations may be able to reduce costs relative to conventional plans, it is not clear that they have so far reduced growth in health care costs. Data from 1961 through 1981 suggest that HMOs may instead achieve a one-time saving, after which costs rise at the same rate as those for other insurance programs. One explanation that has been offered is that providers in HMOs are as likely as other providers to use new medical technologies.[49] More recent data suggest that HMO premium increases have continued to resemble those of conventional insurance plans. The average HMO premium increase during 1988 was 17.2 percent, very close to the 19 percent increase for all employer coverage cited at the beginning of this report.[50]

That HMO cost increases have paralleled those of other insurers does not necessarily mean that HMOs have reached the limit of their cost-saving potential. Because competition among health insurers was relatively limited until recent years, many HMOs may not have faced the market pressures that could induce them to achieve greater savings. The next section reviews proposals to strengthen competition.

Competition and Consumer Choice

The competitive strategy depends on the willingness of consumers to choose the most cost-effective plans. As was suggested earlier, the consumers most likely to incur high costs may be least likely to choose the most efficient option. The problem of biased selection might persist even if conventional insurance plans were to disappear and consumers were able to choose only among managed care options. (Some industry analysts believe this will occur in the near future, chiefly because employers will refuse to offer conventional plans.) It is possible that the most costly patients, given a choice among competing managed care plans, would choose the plan that was least restrictive and potentially least able to achieve cost savings. The most efficient plans might continue to enroll the healthiest patients, for whom only limited savings are possible.

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[49]Newhouse, Joseph P., et al. Are Fee-for-Service Costs Increasing Faster Than HMO Costs? *Medical Care*, v. 23, no. 8, Aug. 1985. p. 960-66.

[50]InterStudy. *The Bottom Line: HMO Premiums and Profitability, 1988-1989*. Excelsior, Minn., 1989. Staff and group model HMOs generally had lower increases, possibly confirming their greater efficiency. However, these HMOs also tend to be older than IPAs; age of the HMO was also a determinant of the rate of increase.

Some people believe that biased selection is largely attributable to the fact that consumers are economically sheltered from the cost of their choice of plan, because most of the premium is paid by the employer. Various schemes have been advanced to make the employee more cost-conscious. For example, the employer's contribution might be tied to the cost of the least expensive offering, with the employee bearing the full cost of the difference between that plan and other more expensive options.

However, selection bias can occur even when the choice of the more expensive plan has real financial consequences for the enrollee. Under the Federal Employees Health Benefits Program (FEHBP), the monthly employee share of premium costs in 1990 ranges from $20.54 in the least expensive high-option HMO to $234.07 in the most costly high-option conventional plan, a difference of $213.53 per month.[51] Under one possible fixed contribution scheme, the Federal share of both plans would be set equal to the full cost of the HMO ($82.16); the employee share would then be zero for the HMO and $265.29 for the conventional plan. If some Federal employees or annuitants are already willing to pay 11 times as much as others in order to obtain the conventional plan, it is not clear that even this change would cause all of them to shift to the HMO. For at least some subset of enrollees, the preference for unrestricted coverage is apparently sufficient to override even strong financial incentives.

One possible solution to the problem of enrollee self-selection is to abandon multiple choices and oblige all members of a covered group to enter a single plan, one selected by the employer or other buyer from among competing plans. Assuming that employers disregarded their own personal plan preferences and chose the least costly option, this approach would theoretically lead to competition among plans on the basis of efficiency. However, both employers and HMOs have been hesitant to enter into arrangements under which enrollees are unwillingly locked into a highly restrictive plan. For this reason, there have evolved arrangements even less restrictive than IPAs, known as open-ended or point-of-service plans.

The predecessor of these plans is the preferred provider organization (PPO). PPOs negotiate discounted rates with certain providers. Enrollees are given a financial incentive, in the form of reduced deductible or coinsurance requirements, to obtain care from providers participating in the PPO network. However, payment will be made under the plan for services furnished by any provider. PPOs thus differ from HMOs, which deny payment altogether for unauthorized non-emergent care provided by providers outside the HMO network. While some PPOs have adopted managed care techniques, such as the use of gatekeepers, most of the savings from a PPO

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[51]The conventional plan is national, while HMOs are offered only in specific locations. The comparison presented here applies only in one area (Tampa, Florida) and represents the extreme of variation in the FEHBP system.

are expected to result from encouraging enrollees to use the participating providers.

The newer, open-ended plans are hybrids, combining some features of HMOs and PPOs. Typically, the plan operates a structured health care system comparable to that of an IPA-model HMO. Enrollees are expected to access the system through a primary care gatekeeper and obtain services from other network providers upon referral by the gatekeeper. Like an HMO, the plan also imposes external utilization controls and negotiates price discounts with providers. As in a PPO, enrollees are free to use non-network providers for covered services, but must pay higher cost-sharing amounts if they choose to do so. Enrollees are also subject to higher cost-sharing if they use specialists within the network without the authorization of the gatekeeper.

Open-ended plans have been adopted by some employers as the single plan available to their workers, replacing systems in which the workers had a choice between conventional and HMO options. Their attraction has been that they overcome the possible selection bias in dual choice systems by enrolling all employees in an HMO-like program. At the same time, they can reduce the employee resistance that would probably greet a proposal for universal HMO enrollment, because they offer employees the safety valve of being able to choose non-plan providers.

Officials of some major insurers that have experimented with open-ended plans in multiple markets report that the plans appear to be reducing the rate of health care cost increases, relative to the increases for their conventional offerings in the same markets.[52] Because these plans began operations only very recently, the data required for an objective evaluation are not yet available. Even PPOs, which have existed for a decade, have never been the subject of a controlled study. Some preliminary findings, however, suggest that the safety valve that makes PPOs attractive is potentially a serious weakness, one which may carry over to the newer hybrid plans.

One recent study of a PPO found that enrollees used the PPO's providers for preventive care and minor illnesses, but went outside the network about half the time for specialty care, major surgery, and hospitalization without surgery.[53] One study found a similar pattern among PPO enrollees who were actually employees of one of the providers in the

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[52]Personal communication with officials of Prudential and CIGNA.

[53]Wouters, Annemarie, and James Hester. Patient Choice of Providers in a Preferred Provider Organization. *Medical Care*, v. 26, no. 3, Mar. 1988. p. 240-255. The results may not be fully representative, because the PPO studied was somewhat skewed towards primary care providers.

PPO network.[54] While these findings are not definitive, they suggest a dilemma that may be common to both PPOs and the newer types of managed care plans. If the price for going out of plan is not punitive, enrollees may obtain much of their care outside the network; if the price is set high enough to deter outside utilization, the plan may lose its relative attractiveness.

Both solutions to the biased selection problem, higher premiums for the non-HMO plan or higher cost-sharing for using non-HMO providers, may then face the same potential barrier: the highest-risk enrollees, those for whom the greatest potential savings presumably exist, may be willing to pay much more out-of-pocket to retain free choice of providers and avoid bureaucratic restrictions. While the problem might be overcome by making the cost of unrestricted health care prohibitive, this solution may be foreclosed by the potential strain on labor relations (or, in the case of public programs, political resistance).

One other solution that has been proposed is to go to the roots of consumer resistance to managed care, the concern about quality. Some analysts argue that, because consumers have little information about the relative quality of different medical care providers, they must rely on "signals" of quality sent out by various providers, such as the use of elaborate technology or aggressive medical treatment styles.[55] If the persons with the highest expectation of requiring medical services will accept financial sacrifices to avoid managed care programs, this may be because they cannot evaluate the care offered by such programs and wish to remain free to seek out the providers who more actively signal quality. This preference might be overcome if consumers had reliable data on the actual quality of the care furnished by different providers or provider systems such as HMOs.

This view has led to such proposals as the "buy right" plan advanced by Walter McClure of the Center for Policy Studies in Minnesota. Under this plan, a community would collect and make available to consumers uniform data on patient outcomes from all providers. Consumers would then be in a position to determine whether the higher cost providers were actually furnishing superior care and could thus make rational purchasing decisions. The proposal assumes that the community can agree on objective measures of quality. Past efforts to develop uniform bases of comparison have been controversial. For example, the annual release by the Health Care Financing Administration of mortality data for Medicare beneficiaries in hospitals has been criticized on the grounds that numerous factors other than relative

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[54]Diehr, Paula, et al. Use of a Preferred Provider by Employees of the Preferred Provider. *Health Services Research*, v. 23, no. 4, Oct. 1988. p. 537-554.

[55]For an elaboration of this theory, see Robinson, James C. Hospital Quality Competition and the Economics of Imperfect Information. *Milbank Quarterly*, v. 66, no. 3, 1988. p. 465-81.

proficiency can affect the death rates of hospital patients. Highly specialized facilities may be treating the most seriously ill patients; facilities serving a low-income population may find that more of their patients have delayed medical treatment beyond the point at which they could be helped. Full implementation of the "buy right" strategy might have to wait until research can provide acceptable standardized outcome measures.

Assuming that those measures can be developed, how would competition then work? Consumers would be fully informed about the relative price and quality of competing health plans, and would thus be equipped to make medical care purchasing decisions in the same way that they decide about other purchases. Proponents of competition argue that the power of the market would then compel all providers to make steady improvements in both quality and efficiency. However, if the health care market could be induced to evolve in the same way as other markets, it is not necessarily the case that the end product would be a single class of providers uniformly striving to achieve the same goals. The health care market could instead be segmented in the way that the markets for other goods and services are; there might be economy and luxury health plans just as there are economy and luxury automobiles. Improving the information available to health care consumers might mean only that buyers would be better able to distinguish between the two, not that the distinction would cease to exist. Whether Americans are prepared to accept the same price/quality tradeoffs in buying medical care that they do in buying other products is an open question.

May 4, 1990, p. A7 THE WASHINGTON POST

Spending for Health Care Takes Record Bite of GNP

Costs Outpace Economy, Despite Control Measures

By Spencer Rich
Washington Post Staff Writer

National spending on health care moved sharply upward in 1988, reaching $539.9 billion, a record 11.1 percent of the U.S. gross national product, Secretary of Health and Human Services Louis W. Sullivan announced yesterday.

"The trends shown in this report are not cause for celebration," Sullivan said. "Health expenditures have been growing faster than the national economy for many years. This [illegible]wth will strain the ability of the American [illegible]le to pay for quality health care."

For more than a generation, health spending has been increasing far faster than the general cost of living. Yesterday's report shows that total health spending by all public and private sources, already the highest of any developed country as a proportion of national income, continues to grow rapidly, Sullivan said.

Health spending constituted 5.3 percent of gross national product in 1960 and rose to its new record despite widespread efforts by the government and private insurers to restrain burgeoning costs, the report showed. By contrast, defense outlays in 1988 were 6.1 percent of GNP.

Control of health costs is considered by many experts to be the number one health problem in the United States. Such costs are expected to bankrupt Medicare by the year 2003, and businesses and individuals are facing steeply rising premiums for health insurance. Many businesses are cutting back health insurance for their workers or forcing them to pay a larger share of the costs.

The 1988 health outlays amounted to $2,124 per person, 10.4 percent more than in 1987. General inflation in the economy—plus extra medical price inflation—accounted for two-thirds of the increase.

Experts say medical costs rose beyond the general 1988 inflation rate of 4.2 percent because medical care is a service with a large personal labor component, and many service industries cannot offset increased labor costs through technical innovations.

Another tenth of the rise resulted from population increase, and the remainder came from such factors as greater use of technology and a larger number of services per patient, the report said. Total spending on doctors rose 13.1 percent in 1988, while spending for hospital services rose 9.3 percent.

Federal, state and local governments pay about two-fifths of health costs, private health insurance about a third, and patients pay the rest.

In 1983 Congress moved to curb hospital costs and last year approved legislation to impose a national target each year for payments Medicare will make to doctors, a policy aimed at curbing unjustified increases in the volume of services. If outlays in any year exceed the target, fees to doctors in subsequent years can be frozen or reduced to recapture the excess.

The new policy does not directly affect private businesses and insurers, but if successful it is expected to be a model for similar curbs in the non-government sector.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Contact: Bob Hardy
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FOR IMMEDIATE RELEASE
Thursday, May 3, 1990

The nation's spending on health increased 10.4 percent in 1988, resuming a double-digit growth rate after a period of more moderate increases, according to a report released today by HHS Secretary Louis W. Sullivan, M.D.

The growth rate of national health expenditures was 15 percent in 1980 and increased at an average annual rate of 11 percent from 1980 through 1985. The annual rate of growth slowed to 7.2 percent in 1986 and was 8.5 percent in 1987.

National health spending of $539.9 billion in 1988 was 117 percent greater than the sum spent in 1980. Health spending in 1988 translates into $2,124 for each person, a 100-percent increase in per-capita spending since 1980.

National health expenditures in 1988 accounted for 11.1 percent of the gross national product, up from 9.1 percent in 1980, 7.3 percent in 1970 and 5.3 percent in 1960.

"The trends shown in this report are not cause for celebration," Secretary Sullivan said. "Health expenditures have been growing faster than the national economy for many years. This growth will strain the ability of the American people to pay for quality health care.

"Government and business leaders, public and private institutions, health care professionals and consumers must work

- More -

together on the problem of making quality health care affordable and available to every American," Secretary Sullivan said.

Personal health expenditures, the major component of national health spending, increased 10 percent in 1988. The general rate of inflation in the economy was responsible for only 43 percent of the 1988 increase in personal health expenditures, medical price inflation added 24 percent, population changes contributed 10 percent and other factors accounted for 23 percent of the increase. "Other factors" include elements such as utilization of technology and volume and intensity of health care services.

National expenditures for physician services increased 13.1 percent in 1988, while spending for hospital services grew at a rate of 9.3 percent.

Programs of the federal, state and local governments accounted for 41 percent of personal health care expenditures in 1988. Federal outlays, mainly for the Medicare and Medicaid programs, were 30 percent of personal health spending, while the states and local governments financed 11 percent.

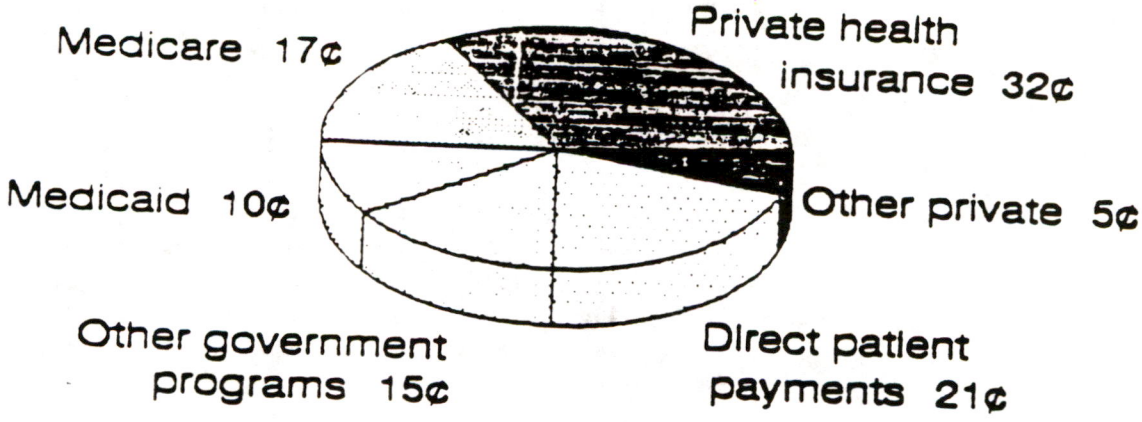
Private health insurance financed 32 percent of personal health care expenditures in 1988, and direct patient payments accounted for 24 percent.

The national health expenditures report for 1988, prepared by the Health Care Financing Administration, includes revisions of estimates previously published for prior years. The revisions were produced by using new methodology, new data sources and new categories for more accurate estimating of trends.

# # #

THE NATION'S HEALTH DOLLAR IN 1988

Where it came from...



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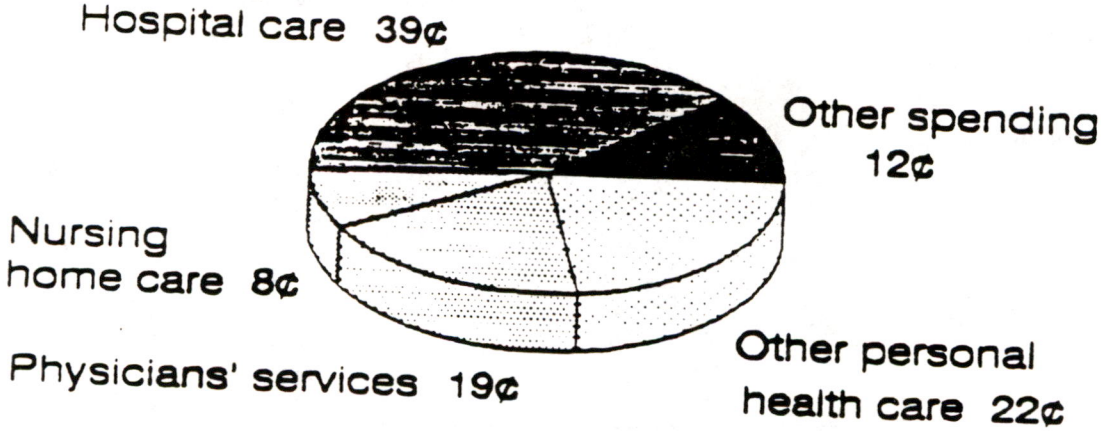


NOTES: Other private includes industrial inplant health services, philanthropy, and privately financed construction. Other personal health care includes dental, other professional services, home health, drugs, and durable medical equipment. Other spending is for program administration and the net cost of private health insurance, government public health, research, and construction.
SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

Table 1

National health expenditures aggregate, per capita, percent distribution, and percent change, by source of funds: Calendar years 1960-88

Item	1960	1965	1970	1975	1980	1985	1986	1987	1988
					Amounts				
National health expenditures (billions)	$27.1	$41.6	$74.4	$132.9	$249.1	$420.1	$450.5	$488.8	$539.9
Private	20.5	31.3	46.7	77.8	143.9	245.2	259.8	280.5	312.4
Public	6.7	10.3	27.7	55.1	105.2	174.9	190.7	208.3	227.5
Federal	2.9	4.8	17.7	36.4	72.0	123.4	132.8	144.0	157.8
State and local	3.7	5.5	9.9	18.7	33.2	51.5	57.9	64.3	69.6
U.S. population (millions)	190.1	204.0	214.8	224.7	235.2	247.1	249.5	251.8	254.2
Gross national product (billions)	$515	$705	$1,015	$1,598	$2,732	$4,015	$4,232	$4,524	$4,881
					Per capita amounts				
National health expenditures	$143	$204	$346	$592	$1,059	$1,700	$1,806	$1,941	$2,124
Private	108	154	217	346	612	992	1,041	1,114	1,229
Public	35	50	129	245	447	708	765	827	895
Federal	15	24	83	162	306	500	532	572	621
State and local	20	27	46	83	141	208	232	256	274
					Percent distribution				
National health expenditures	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Private	75.5	75.3	62.8	58.5	57.8	58.4	57.7	57.4	.9
Public	24.5	24.7	37.2	41.5	42.2	41.6	42.3	42.6	.1
Federal	10.7	11.6	23.9	27.4	28.9	29.4	29.5	29.5	29.2
State and local	13.8	13.2	13.3	14.1	13.3	12.2	12.9	13.2	12.9
					Percent of gross national product				
National health expenditures	5.3	5.9	7.3	8.3	9.1	10.5	10.6	10.8	11.1
					Average annual percent change from previous year shown				
National health expenditures		8.9	12.3	12.3	13.4	11.0	7.2	8.5	10.4
Private		8.9	8.3	10.7	13.1	11.2	6.0	8.0	11.4
Public		9.1	21.9	14.8	13.8	10.7	9.1	9.2	9.2
Federal		10.6	29.8	15.5	14.6	11.4	7.6	8.4	9.6
State and local		7.9	12.6	13.5	12.1	9.2	12.5	11.1	8.2
U.S. population		1.4	1.0	0.9	0.9	1.0	1.0	1.0	0.9
GNP		6.5	7.6	9.5	11.3	8.0	5.4	6.9	7.9

1 July 1 social security area population estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

Table 2. National health expenditures in 1988, by type of expenditure and source of funds

Year and type of expenditure	Total All sources	Private					Government		
		All private funds	Consumer						
			Total	Out of Pocket	Private insurance	Other	Total	Federal	State and local
	Amount in billions								
National health expenditures	$539.9	$312.4	$288.1	$113.2	$174.9	$24.3	$227.5	$157.8	$69.6
Health services and supplies	520.5	304.6	288.1	113.2	174.9	16.5	215.9	149.0	66.9
Personal health care	478.3	284.3	268.4	113.2	155.2	15.9	194.0	143.2	50.8
Hospital care	211.8	96.6	86.3	11.3	75.0	10.3	115.2	86.7	28.5
Physicians' services	105.1	70.0	69.9	19.9	50.0	0.0	35.2	28.7	6.4
Dentists' services	29.4	28.7	28.7	16.3	12.4	--	0.7	0.4	0.3
Other professional services	22.5	18.0	15.4	7.1	8.3	2.6	4.5	3.4	1.0
Home health care	4.4	1.1	0.8	0.5	0.3	0.3	3.3	2.6	0.7
Drugs and other medical nondurables	41.9	37.3	37.3	29.6	7.7	--	4.6	2.2	2.4
Vision products and other medical durables	10.8	8.6	8.6	7.6	1.0	--	2.3	2.0	0.2
Nursing home care	43.1	22.1	21.3	20.8	0.5	0.8	20.9	12.5	8.4
Other personal health care	9.3	1.9	--	--	--	1.9	7.4	4.7	2.7
Program administration and net cost of private health insurance	26.3	20.3	19.7	--	19.7	0.5	6.1	3.9	2.2
Government public health activities	15.9	--	--	--	--	--	15.9	1.9	14.0
Research and construction	19.4	7.8	-	-	-	7.8	11.5	8.8	2.7
Noncommercial research	9.9	0.7	-	-	-	0.7	9.1	7.9	1.2
Construction	9.5	7.1	-	-	-	7.1	2.4	0.9	1.5

NOTES: Research and development expenditures of drug companies and other manufacturers and providers of medical equipment are excluded from noncommercial research, being implicitly included in the value of the good or service being produced. "Other private funds" include funding through philanthropy and nonpatient revenues, business spending for industrial inplant health services, and privately financed construction.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

Table 3. Sources of funds for personal health care in 1988

Source of payment	Total Personal health care	Hospital care	Physicians' services	Dentists' services	Other professional services	Home health care	Drugs and non-durables	Vision products & durables	Nursing home care	Other personal health care
					Amount in billions					
Total personal health care	$478.3	$211.8	$105.1	$29.4	$22.5	$4.4	$41.9	$10.8	$43.1	$9.3
Direct patient payments	113.2	11.3	19.9	16.3	7.1	0.5	29.6	7.6	20.8	--
Third-party payments	365.1	200.5	85.2	13.1	15.4	3.9	12.3	3.2	22.2	9.3
Private health insurance	155.2	75.0	50.0	12.4	8.3	0.3	7.7	1.0	0.5	--
Other private	15.9	10.3	0.0	--	2.6	0.3	--	--	0.8	1.9
Government	194.0	115.2	35.2	0.7	4.5	3.3	4.6	2.3	20.9	7.4
Federal	143.2	86.7	28.7	0.4	3.4	2.6	2.2	2.0	12.5	4.7
Medicare	89.7	58.3	24.9	--	2.1	1.8	--	1.9	0.8	--
Medicaid	29.4	11.2	2.2	0.3	0.8	0.8	2.1	--	10.8	1.2
Other programs	24.1	17.1	1.7	0.1	0.6	--	0.1	0.1	1.0	3.5
State and local	50.8	28.5	6.4	0.3	1.0	0.7	2.4	0.2	8.4	2.7
Medicaid	22.9	8.9	1.6	0.3	0.6	0.7	1.5	--	8.4	0.9
Other programs	27.9	19.5	4.9	0.1	0.5	0.0	0.8	0.2	0.1	1.8
EXHIBIT: Total Medicaid	52.3	20.2	3.8	0.6	1.4	1.5	3.6	--	19.1	2.1
					Percentage distribution					
Total personal health care	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Direct patient payments	23.7	5.3	18.9	55.4	31.6	11.6	70.7	70.3	48.4	--
Third-party payments	76.3	94.7	81.1	44.6	68.4	88.4	29.3	29.7	51.6	100.0
Private health insurance	32.4	35.4	47.6	42.1	36.9	7.0	18.4	8.8	1.1	--
Other private	3.3	4.9	0.0	--	11.6	6.8	--	--	1.9	20.0
Government	40.6	54.4	33.4	2.5	19.8	74.6	10.9	20.9	48.6	80.0
Federal	29.9	40.9	27.3	1.4	15.2	58.7	5.3	18.7	29.0	50.7
Medicare	18.8	27.5	23.6	--	9.2	40.8	--	17.3	1.9	--
Medicaid	6.2	5.3	2.1	1.2	3.4	17.8	5.0	--	25.0	13.0
Other programs	5.0	8.1	1.6	0.2	2.5	--	0.2	1.4	2.2	37.7
State and local	10.6	13.4	6.1	1.1	4.6	15.9	5.7	2.2	19.6	29.3
Medicaid	4.8	4.2	1.5	0.9	2.6	15.5	3.7	--	19.4	10.0
Other programs	5.8	9.2	4.6	0.2	2.0	0.4	2.0	2.2	0.1	19.4
EXHIBIT: Total Medicaid	10.9	9.5	3.6	2.1	6.0	33.3	8.7	--	44.4	22.9

NOTES: -0.0 denotes less than $50 million. Medicaid expenditures exclude Part B premium payments to Medicare by States under "buy in" agreements to cover premiums for eligible Medicaid recipients.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

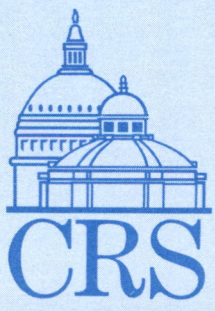
Order Code IB77066

CRS Issue Brief

Health Care Expenditures and Prices

Updated June 19, 1990

by
Kathleen M. King
Education and Public Welfare Division



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Health Care Expenditures and Prices

SUMMARY

National spending for health care services topped $500 billion for the first time in 1987, which represented a 9.8% increase over 1986 expenditures. Real spending on health care continues to increase. Adjusted for inflation, 1987 expenditures were 6.1% higher than 1986 expenditures. At least since the inception of Medicare and Medicaid in 1965, health care spending has grown faster than growth in the Gross National Product (GNP), and shows no signs of abating. In 1987, the latest year for which data are available, health care spending consumed 11.1% of the GNP, compared to 10.7% in 1986 and only 5.9% in 1965. Health care prices, as measured by the medical care component of the Consumer Price Index (CPI), are also increasing faster than the overall rate of inflation.

ISSUE DEFINITION

National health expenditures have increased every year for decades. At least since the passage of Medicare and Medicaid in the mid 1960s, the rate of growth in health care spending has outstripped growth in the Gross National Product. Medical care prices have also been rising rapidly. These growth factors concern congressional policymakers because the Federal Government funds approximately 30% of all health care spending. Rapidly escalating health care prices also erode the Government's purchasing power and jeopardize its ability to extend coverage to underserved populations or finance additional health care services.

BACKGROUND AND ANALYSIS

National Health Expenditures

National health expenditures have increased for decades, both in aggregate terms and on a per capita basis as a percent of the Gross National Product (GNP). The growth in national health care expenditures is shown in **TABLE 1**. During the 1970s, national health expenditures grew at an average annual rate of 12.7%. In both 1980 and 1981, national health expenditures grew over 15% annually. Beginning in 1982 and continuing through 1985, growth rates declined significantly. The 1985 7.9% growth rate was the lowest recorded since the 1965 enactment of Medicare and Medicaid. This relatively low rate of growth was probably due to many factors, including a low rate of inflation in the economy in general, increasing pressure to contain health care cost in both the public and private sectors and changing patterns of demand for services, in particular a decline in the use of inpatient hospital services.

Rate of increase inched back up again in 1986 and 1987, but are still in single digits. In 1987, the most recent year for which data are available, the rate of growth was 9.8%.

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TABLE 1
Aggregate and Per Capita National Health Expenditures, and Percent of Gross National Product, Selected Years, 1965-1987

Calendar year	Total Amt. ($ billions)	Average annual % increase	Per capita amount	Percent of GNP
1965	41.9	9.3	205	5.9
1970	75.0	12.3	349	7.4
1975	132.7	12.1	590	8.3
1976	150.8	13.6	665	8.9
1978	189.7	12.2	822	8.4
1979	214.7	13.2	921	8.6
1980	248.1	15.6	1,054	9.1
1981	287.0	15.7	1,207	9.4
1982	323.6	12.8	1,348	10.2
1983	357.2	10.4	1,473	10.5
1984	388.5	8.8	1,587	10.3
1985	419.0	7.9	1,696	10.4
1986	455.7	8.7	1,827	10.7
1987	500.3	9.8	1,987	11.1

Source: Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration.

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National expenditures for hospital care and for physicians' services exceed expenditures for all other health services. Hospital care expenditures are the largest component of the Nation's health spending (representing 39% of total health spending in 1987), and increased annually at "double-digit" rates between 1971 through 1982. The rate of increase fell sharply in 1984, partly in response to Medicare's implementation of a prospective payment system for inpatient hospital services. Rates have risen moderately since 1984, but are still below the growth rates of the 1970s and early 1980s. By 1987, annual expenditures reached $194.7 billion. Physicians' services, which represented 20% of national health expenditures in 1987, increased twelvefold from 1965 to 1987. Since 1965, rates of increase in physicians' services have been in double digits for all but 3 years: 1972, 1984, and 1985.

TABLE 2
National Health Expenditures and Average Annual Percent Change From Previous Year Shown for Hospital Care and Physicians' Services, selected years 1965-1987
(dollars in billions)

	Hospital care		Physicians' services	
	Amount	% increase	Amount	% increase
1965	14.0	NA	8.5	NA
1970	28.0	14.9	14.3	11.1
1971	31.0	10.7	15.9	11.1
1972	35.2	13.5	17.2	8.2
1973	38.9	10.5	19.1	11.0
1974	45.0	15.7	21.2	11.0
1975	52.4	16.4	24.9	17.5
1976	60.9	16.2	27.6	10.8
1977	68.1	11.8	31.9	15.6
1978	76.2	11.9	35.8	12.2
1979	87.0	14.2	40.2	12.4
1980	101.6	16.8	46.8	16.4
1981	117.9	16.0	54.8	16.9
1982	134.7	14.4	61.8	12.8
1983	148.8	10.5	68.4	10.7
1984	156.3	5.0	75.4	9.1
1985	167.2	7.0	82.8	9.8
1986	179.6	7.4	92.0	11.1
1987	194.7	8.4	102.7	11.6

Source: Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration.

Unlike other goods and services for which the consumer pays the provider directly, health care payments are often made by other entities including private health insurance and public programs which act as insurers. The following table shows the major sources of national health expenditures including private sources, such as private health insurance and direct consumer payments, and public sources, such as the Medicare and Medicaid programs and other Federal, State and local governmental sources of funds. In 1940, the percentage allocation of national health expenditures from private and public funding sources was 80% private and 20% public. After the implementation of Medicare and Medicaid in the mid-60s, the rate of increase in public spending for health care increased sharply and then levelled off in the early 1970s to approximately 40% of total spending. The percentage of Federal funds spent on health care has increased very gradually. By 1987, Federal spending accounted for nearly 30% of all health care expenditures.

TABLE 3
National Health Expenditures by Major Source of Funds, Selected Years, 1965-1987
(dollars in billions)

	Private Expenditures	Public Expenditures		
		Total	Federal	State/local
1965	30.9	11.0	5.5	5.5
1970	47.2	27.8	17.7	10.1
1971	51.8	31.7	20.3	11.4
1972	58.5	35.4	22.9	12.5
1973	64.0	39.4	25.2	14.2
1974	68.8	47.6	31.0	16.6
1975	76.3	56.4	37.1	19.3
1976	87.9	62.8	42.6	20.3
1977	100.1	70.1	47.4	22.7
1978	110.1	79.9	53.8	26.1
1979	124.2	90.9	61.0	29.8
1980	142.2	105.3	71.0	34.3
1981	164.2	121.7	83.5	38.1
1982	186.1	135.1	93.2	41.9
1983	207.0	148.1	102.7	45.4
1984	231.3	159.7	111.6	48.1
1985	246.6	176.0	124.5	51.5
1986	268.5	189.7	134.7	55.0
1987	293.0	207.3	144.7	62.7

Source: Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration.

The Price of Health Care, as Measured by the CPI

Over the past 20 years, increases in the prices of health care services, as measured by various components of the Consumer Price Index (CPI), have generally exceeded price increases in the rest of the economy. There are two exceptions to this pattern: during the Economic Stabilization Program (August 1971 through April 1974 for health), and during 1979 and 1980 when the overall level of inflation was at its highest point in 20 years.

Since 1982, figures suggest that inflation in the medical care sector has abated somewhat, and followed the downward trend of the overall CPI between 1982 and 1985. However, in spite of these drops, inflation in the overall medical care sector is still approximately twice the rate of inflation in the rest of the economy. Also, since the beginning of 1985, the inflation rate for hospital services has been steadily increasing.

TABLE 4 shows the trends in the CPI and in selected components of CPI since 1965.

TABLE 4
Percent Change in Selected Components of CPI, 1965-1988

	CPI all items	CPI, all items less medical care	Medical care Total	Hospital room	Physicians' services
1965	1.7	1.5	2.5	5.6	3.6
1966	2.9	3.0	4.4	10.0	5.8
1967	2.9	2.4	7.1	19.8	7.1
1968	4.2	4.1	6.1	13.6	5.6
1969	5.4	5.4	6.9	13.4	6.9
1970	5.9	5.8	6.3	12.9	7.5
1971	4.3	4.1	6.5	12.2	6.9
1972	3.3	3.3	3.2	6.6	3.1
1973	6.2	6.4	3.9	4.7	3.3
1974	11.0	11.1	9.3	10.7	9.2
1975	9.1	8.9	12.0	17.2	12.3
1976	5.8	5.5	9.5	13.8	11.3
1977	6.5	6.2	9.6	11.5	9.3
1978	7.7	7.6	8.4	11.0	8.3
1979	11.3	11.4	9.3	11.4	9.2
1980	13.5	13.6	10.9	13.1	10.6
1981	10.4	10.3	10.8	14.8	11.0
1982	6.1	5.9	11.6	15.7	9.4
1983	3.2	2.9	8.7	11.3	7.7
1984	4.3	4.1	6.2	8.3	7.0
1985	3.8	3.6	6.7	4.8	6.9
1986	1.9	1.5	7.5	6.0	7.2
1987	3.7	3.5	6.6	7.2	7.3
1988	4.1	3.9	6.5	9.3	7.2
1989	4.8	4.6	7.7	10.3	7.4

Sources: U.S. Dept. of Labor, Bureau of Labor Statistics, Consumer Price Index, various publications.

Hospital Expenses

The American Hospital Association (AHA) compiles detailed measures of expenses of the Nation's community hospitals, which are defined as all non-Federal short-term general and other special hospitals (excluding after 1971 hospital units of institutions) whose facilities and services are available to the public. **TABLE 5** shows historical expense data for community hospitals from the AHA's National Hospital Panel Survey. The Survey is a monthly survey of a randomly selected sample of about 1,800 of the approximately 5,800 community hospitals.

The total expenses of community hospitals, including expenses for both inpatient and outpatient care, were $177.7 billion in 1988, an increase of 196% over the preceding 10 years. The average cost of a day of hospital care was $632 in 1988, representing a 10-year increase of 211%. The increase in hospital inpatient costs per admission, or "cost per case" over the past 10 years was 186%, rising to $4,194 in 1983.

TABLE 5 displays, for measures of hospital expense, data for the years 1965 to 1988. The rate of growth in hospital expenses exceeded the rate of inflation as measured by the CPI in most years. In general, changes in the rate of growth in hospital expenses have followed changes in inflation. For example, the medical care component of the CPI and the rates of growth in the adjusted expenses per inpatient day and per admission were all relatively low during the Economic Stabilization Program (August 1971 through April 1974). Also, the rates of increase of all four measures of community hospital expenses followed the CPI downward since from 1981 to 1986. A short-term downward trend in the growth rate of hospital expenses which is not reflected in the CPI indexes is evident in the 1976 to 1979 interval. Some analysts have argued that this was due perhaps in part to the initiation in 1978 of a "voluntary effort" to reduce health care costs initiated by the American Hospital Association and other health organizations.

There are a variety of factors other than overall inflation which contribute to aggregate changes in hospital expenses. These factors include: population growth, factors such as aging of the population which affect admission rates, inflation over and above general inflation in the prices of goods and services purchased by the hospitals (input factor prices), and changes in the type and mix (intensity) of services rendered due to such factors as changes in the use of technology or treatment patterns. Arnett et al. (Health Care Financing Review, spring 1986) estimated that over 51% of the overall growth in inpatient hospital expenses between 1974 and 1984 was due to overall inflation, approximately 7.3% to population growth, 16.6% to excess inflation in hospital prices, and 33.4% to intensity of services per day. The recent decline in the number of inpatient days per capita has exerted downward pressure on inpatient hospital expenses. This decline held the growth in these expenses between 1974 and 1984 to 8.5% below what otherwise would have occurred.

TABLE 5
Selected Community Hospital Expenses Data, Totals and Percentage Increases, 1965-1988
(dollars in billions)

Year	Total expenses		Adjusted* expenses per inpatient day		Adjusted expenses per admission		Inpatient expenses	
	Amt.	% Chg.	Amt.	% Chg.	Amt.	% Chg.	Amt.	% Chg.
1965	$9.220	8.6	$41	7.5	$315	8.1	$8.414	8.7
1966	10.497	13.8	46	12.2	356	13.0	9.611	14.2
1967	12.624	20.3	53	15.2	425	19.4	11.551	20.2
1968	14.720	16.6	59	11.3	482	13.4	13.371	15.8
1969	17.247	17.2	68	15.2	551	14.3	15.635	16.9
1970	20.261	17.5	78	14.7	608	10.3	18.328	17.2
1971	22.496	11.0	87	11.5	670	10.2	20.269	10.6
1972	25.223	12.1	96	10.3	729	8.8	22.622	11.6
1973	28.248	12.0	105	9.4	784	7.5	25.173	11.3
1974	32.759	16.0	118	12.4	873	11.4	29.077	15.5
1975	38.492	17.5	138	16.9	1,017	16.5	33.971	16.8
1976	45.842	19.1	158	14.5	1,168	14.8	40.321	18.7
1977	53.006	15.6	181	14.5	1,312	12.3	46.437	15.2
1978	59.802	12.8	203	12.2	1,466	11.7	52.131	12.3
1979	67.833	13.4	226	11.3	1,618	10.4	59.060	13.3
1980	79.340	17.0	256	13.3	1,836	13.5	68.962	16.8
1981	94.187	18.7	299	16.8	2,155	17.4	81.651	18.4
1982	109.091	15.8	348	16.4	2,489	15.5	94.346	15.5
1983	120.220	10.2	391	12.5	2,742	10.2	103.403	9.5
1984	126.028	4.6	443	13.3	2,947	7.5	107.000	3.2
1985	134.043	6.6	493	11.2	3,226	9.4	111.402	4.4
1986	146.032	8.9	535	8.6	3,527	9.3	119.281	7.1
1987	161.322	10.5	581	8.6	3,859	9.4	129.815	8.8
1988	177.770	10.2	632	8.8	4,194	8.6	140,481	8.2

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* Adjusted to account for the volume of outpatient visits.

Note: Percentage changes may not correspond to published data because of rounding.

Source: National Hospital Panel Survey, American Hospital Association.

TABLE 6 shows the trends in community hospital inpatient expenses and utilization between 1981 and 1988. Since 1981, numbers of both admissions and inpatient days have been declining. In both cases, the largest percent declines were in 1984 and 1985. Despite these declines in utilization, overall inpatient expenses increased each year since 1981. While inpatient expenses recently have been growing at a slower rate than during the period of high inflation in the early 1980s, the trend since 1984 suggests that the rate of growth in inpatient expenses is accelerating.

Due to declining utilization and increasing total inpatient expenses, expenses per admission and expenses per inpatient day have both been growing rapidly over the 6-year period shown.

The trends outlined in **TABLE 6** stem from a variety of factors within and without the hospital industry. While these trends cannot be tied to any specified factors, there are two sets of potentially contributing factors which should be noted. First, the downward trends in the rate of growth in inpatient hospital expense during 1984 and 1985 are consistent with the decrease in inflation in the economy as a whole during these 2 years. Second, increasing attention has been given to health care cost containment programs in both the private and public sectors. Private sector initiatives have included utilization review and employee incentive programs within employer health benefit plans. Examples of changes in the public sector which might effect the rates of change in hospital expenses and utilization are the amendments to the Social Security Act enacted during 1982 and 1983 which set limits on Medicare payments for inpatient care.

TABLE 6
Annual Percent Change in Selected Community Hospital Expense and Utilization Data for 1982-1988

	Inpatient Expenses *	Inpatient Exp. per Admis.	No. of Admis.	Inpatient Exp. per Day	No. of Days
1982 over 1981	15.6	15.5	0.6	16.2	-0.6
1983 over 1982	9.5	10.2	-0.5	12.4	-2.5
1984 over 1983	3.2	7.5	-4.0	13.3	-8.9
1985 over 1984	4.4	9.4	-4.6	11.1	-6.2
1986 over 1985	7.1	9.3	-2.1	8.5	-1.4
1987 over 1986	8.8	9.4	-0.6	8.6	0.2
1988 over 1987	8.2	8.6	-0.4	8.8	-0.5

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* Adjusted to account for the volume of outpatient visits.

Source: National Hospital Panel Survey, American Hospital Association.

Hospital Utilization

A number of indices are reported as measures of hospital utilization: admissions, patient days, outpatient visits and hospitals beds per 1,000 population; average length of stay in days; and occupancy rates. The data for **TABLEs 8-10** are from the American Hospital Association's most recent Annual Survey of Hospitals, a yearly survey of the approximately 6,900 hospitals, with responses received from approximately 6,300 hospitals in 1987.

Admissions, patient days, outpatient visits and hospital beds per 1,000 population provide measures of hospital utilization adjusted for changes in the size of the population. From 1965 to 1983, admissions per 1,000 population increased by 13.1%, inpatient days per 1,000 population increased by 10.5%, outpatient visits per 1,000 population increased by 87.7%, and hospital beds per 1,000 population by 15.8%. A substantial proportion of the growth in all four measures occurred following the enactment of the Medicare and Medicaid programs, between 1965 and 1975. The number of admissions, inpatient days and beds per 1,000 were relatively constant between 1975 and 1982. Admissions, inpatient days, and beds per 1,000 have since declined by more than 10%. Except in 1982, the number of outpatient visits per 1,000 population also showed little change between 1975 and 1984. However, since 1984, the number of outpatient visits per 1,000 has begun to grow, due in part to the shift of some care out of inpatient hospital settings.

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TABLE 7
Admissions, Inpatient Days, Outpatient Visits, and Hospital Beds Per 1,000 Population Community Hospitals Selected Years 1965-1987

Year	Admissions	Inpatient days	Outpatient visits	Hospital beds
1965	137	1,062	479	3.8
1970	143	1,184	657	4.2
1975	155	1,196	885	4.4
1976	156	1,199	925	4.4
1977	156	1,187	904	4.4
1978	155	1,180	909	4.4
1979	156	1,182	885	4.4
1980	159	1,203	890	4.4
1981	159	1,214	884	4.4
1982	157	1,202	1,072	4.4
1983	155	1,173	899	4.4
1984	149	1,088	897	4.3
1985	140	994	918	4.2
1986	134	953	962	4.1
1987	130	933	1,009	3.9

Sources: Hospital utilization data (numerator) is from Hospital Statistics, 1988 Edition, American Hospital Association; population data (denominator) is the resident population as of July 1 of each year from U.S. Dept. of Commerce, Bureau of the Census, Current Population Reports, Series P-25.

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The average length of stay increased in the years immediately following enactment of the Medicare and Medicaid programs, but then declined during the 1968-1977 time period. It remained constant between 1977 and 1983 before dropping to its lowest point in 1985.

TABLE 8
Average Length of Stay in Days -- Community Hospitals
Selected Years 1965-1987

Year	Average length of stay
1965	7.8 days
1970	8.2
1975	7.7
1976	7.7
1977	7.6
1978	7.6
1979	7.6
1980	7.6
1981	7.6
1982	7.6
1983	7.6
1984	7.3
1985	7.1
1986	7.1
1987	7.2

The occupancy rate is defined as the average percentage of beds filled throughout the year. The occupancy rate provides a measure of the overall capacity of the community hospital system relative to the demand for services. The occupancy rate increased in the 1965-1970 time period, declined through 1978, and then increased again through 1981. The occupancy rate dropped by 15% between 1981 and 1986. For the past 3 years, the overall occupancy rate has been less than 65%.

TABLE 9
Occupancy Rate -- Community Hospitals
Selected Years 1965-1987

Year	Occupancy rate
1965	76.0
1970	78.0
1975	75.0
1976	74.6
1977	73.8
1978	73.6
1979	73.9
1980	75.6
1981	76.0
1982	75.3
1983	73.5
1984	69.0
1985	64.8
1986	64.3
1987	64.9

Source for TABLES 8 and 9: Hospital Statistics, 1988 Edition, American Hospital Association.

FOR ADDITIONAL READING

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CRS Issue Brief

Major Planning Issue

Health Insurance

Updated June 27, 1990

by
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Health Insurance

SUMMARY

Rising health care costs have created increasing pressures on public and private health care financing programs in a time of limited resources. Over the past 10 years, health care spending has grown faster than spending in the general economy. National health expenditures were $540 billion in 1988, over 11% of the gross national product. While payments by public and private health insurance programs account for a majority of payments (approximately three-fourths) for health care services, gaps in coverage and in the availability of insurance leave many persons at risk. Between 31 and 37 million people were uninsured in 1988. Generally, the uninsured are young (under age 24); they are poor; and they have ties to the work force (primarily in small firms, in industries with seasonal or temporary employment, and in firms with a lower skilled or less unionized work force). In the last decade, there was growth in the number and proportion of the uninsured population. Insurance status has implications for access to health services: the uninsured use fewer health care services and have poorer health status than the insured.

Even persons who are insured can face substantial health care costs if their insurance does not adequately cover their medical expenses. In 1986, the Department of Health and Human Services estimated that about 10 million persons (in addition to the number of uninsured) had insurance that was inadequate to protect them from risk of catastrophic illness expense. Private sector health plans and public programs such as Medicare and Medicaid all, to some degree, leave their enrollees underinsured because of cost-sharing requirements (i.e., enrollee deductible and coinsurance payments), limits on payment to providers, or uncovered services. A key coverage issue, particularly for the elderly, is that most health care plans (except Medicaid) either do not cover, or have only limited benefits for, long-term care services, including both nursing home care and home and community-based care.

Several issues for the future will continue to affect the numbers of uninsured and underinsured individuals. The rising cost of health care will put increasing pressures on public budgets, employer costs, and individuals' out-of-pocket expenses for medical care. A continuing focus of our public and private health care systems will be attempts to control those costs. The need for expansion of limited coverage for long-term care services will continue to be an issue. The future of employer-provided retiree health benefits is an issue resulting from rising employer costs for a growing retired population and questions about future commitments and funding for these costs.

ISSUE DEFINITION

Gaps in public and private health benefits coverage that result in large numbers of uninsured and underinsured individuals and families have been of concern to Congress for many years. There are a number of reasons for this. The rising cost of health care, which is reflected in rising health care premiums, underlies the problem. Cost discourages some employers and individuals from obtaining health care coverage and results in restrictive coverage definitions that exclude certain individuals under both public and private coverage. Other reasons for coverage gaps include the voluntary nature of insurance in this country.

Lack of health benefits coverage may result in individuals not seeking or not being able to obtain health care services; exposure to medical care expenses that may consume an individual or family's income and savings; shifting of costs from those who cannot pay to others who can; or services being provided in inappropriate settings, such as emergency rooms.

Congress is considering alternatives for more complete health insurance coverage. However, budgetary considerations may preclude alternatives that would involve substantial new Federal spending. Numerous bills have been introduced in the 101st Congress to expand health insurance coverage. The generic approaches embodied in these bills include expanding health insurance coverage through Medicaid; providing tax incentives to provide coverage privately; mandating employers to extend health insurance benefits to uncovered or underinsured groups; and instituting a national health insurance system.

There is also strong congressional interest in controlling health care costs. Rising costs affect the Federal budget (chiefly through Medicare and Medicaid) and State budgets (through Medicaid); access to care for the uninsured; and the competitiveness of employers who offer health benefits or the willingness of those employers to continue to offer benefits. Proposals have been considered by Congress that would contain health care costs or reduce Federal expenditures (for example, by changing the tax treatment of health benefits).

Several groups have been developing recommendations to address the issues of health care coverage, the uninsured, and health care costs. On Mar. 2, 1990, the U.S. Bipartisan Commission on Comprehensive Health Care (the "Pepper Commission") announced its recommendations on comprehensive health care services for all Americans and long-term care for the elderly. Two other groups are also examining these issues: a task force established by the Secretary of Health and Human Services is due to report in October 1990, and the Advisory Council on Social Security plans to issue its findings in January 1991.

BACKGROUND AND ANALYSIS

The Uninsured

According to a Congressional Research Service analysis of the March 1989 Current Population Survey (CPS) conducted by the Census Bureau, in 1988 most individuals (57%) obtained insurance coverage through their own or a family member's employment. Others received coverage through public programs such as Medicare (13%) or Medicaid (6%) and 9% received coverage from privately purchased policies, CHAMPUS or other health plans.

An estimated 36.8 million Americans (15%) were without any form of health insurance coverage in 1988. Other estimates, using different surveys or different assumptions, range from 31 to 37 million uninsured. While there is disagreement on the exact number of uninsured Americans, there is a consensus that the proportion of the population without coverage grew during the 1980s. The following discussion examines the characteristics of the uninsured, some possible explanations for recent declines in coverage, and the impact of lack of coverage on access to care. This is followed by a review of proposals for providing coverage to the uninsured.

Characteristics of the Uninsured

Age. Because most senior citizens have Medicare or other retirement health benefits, nearly all the uninsured are under 65, with the greatest concentration among children and young adults. Of those under age 18, nearly 1 in 5 are without coverage; children make up one-third of the total uninsured population. However, the rate of uninsurance peaks in the 18-24 age group; 25% of young adults are without coverage. The uninsured in this age group are often too old to be covered as dependents on their parents' policies. Those in poor families are no longer part of their parents' (often mother's) household and therefore ineligible for Medicaid. Those working may be in entry-level jobs that do not provide coverage. Some of the younger uninsured may also fail to obtain insurance that is available to them, because they do not foresee the need for medical care. The rate of uninsurance declines steadily from age 25 on, chiefly because older workers are more likely to obtain coverage through their own employment.

Employment Status. Of Americans with health insurance, two-thirds receive coverage through their own employment or that of another family member. (Most of the rest are covered by Medicare or Medicaid.) Among the uninsured in 1988, 84% had at least some ties to the work force; 35% were full-time, full-year workers or the dependents of such workers, but failed to obtain employment-based coverage. The uninsured are concentrated in small firms, especially those with fewer than 25 employees, in industries characterized by seasonal or temporary employment, and in those with a lower skilled or less unionized work force. The industries with the lowest rates of insurance coverage are agriculture, personal services, entertainment and recreation, and retail trade.

Income. The uninsured are disproportionately poor. In 1988, 41% of the uninsured had family incomes below 100% of the Federal poverty thresholds, and another 17% had incomes between 100% and 150% of the poverty line. Medicaid is

the major source of coverage for the low-income population. However, the maximum allowable income under Medicaid for most types of persons is below the poverty line. Also, Medicaid has categorical limits: some persons, such as single adults and childless couples who are neither aged nor disabled, cannot qualify regardless of income. As a result, Medicaid covered only 43% of persons in poverty in 1986.

Trends in Insurance Coverage

The proportion of the population that is uninsured rose sharply during the early and mid-1980s. In 1979, the uninsured represented 14.6% of the nonelderly population. By 1988, the proportion of uninsured had grown to 17.0%.

This growth in the uninsured has occurred for several reasons. First, although the proportion of the population in the work force has been growing, the percent receiving benefits has been dropping. Some analysts attribute this trend to shifts in employment. Many of the new jobs created in this decade have been in the service and other nonmanufacturing industries, the least likely to provide coverage. However, this factor accounts for only a small part of the growth in the uninsured.

Second, the proportion of the population receiving coverage through another family member's employment has been dropping. Several factors have contributed to this decline. As coverage of primary workers has dropped, so too has coverage of their dependents. Also, a growing number of workers appear to be electing coverage for themselves but not for their dependents. In 1986, workers who were themselves covered through employment failed to cover their spouses in about 3% of the cases. About 8% of the children of insured workers were uninsured. This reflects in part a decline in employer contributions to the cost of dependent coverage. In 1980, wholly-paid health care for individual and family coverage was available to 72% and 51% of employees in medium- and large-size firms. By 1988, wholly-paid individual coverage had dropped to 51% and family coverage to 32%. Changes have also occurred in family structure; there are more households with older children or unrelated individuals. Such family units are less likely to meet the definitions in insurance coverage rules.

Third, coverage from nonemployment sources declined, particularly Medicaid coverage. Welfare and Medicaid eligibility standards failed to keep pace with inflation; while the absolute number of people in poverty was rising, the number of people receiving Medicaid stayed relatively flat for a decade. Recent changes in the Medicaid program, such as initiatives to cover more pregnant women and children, may reverse this trend. However, data on the impact of these changes are not yet available.

Implications for Access

Insurance status has implications for access to health services. The uninsured use fewer health care services and have poorer health status than the insured population. The uninsured are more likely to delay seeking care; when they finally seek care, the ailment may be more serious and costly to treat. The uninsured also rely more on emergency rooms for basic services.

While the uninsured use comparatively fewer services, they nevertheless generally do receive health care. Some of the uninsured pay for these services out-of-pocket; some receive care from clinics and facilities that receive public subsidies; and some get it from providers who are subsidizing the care through increased charges to their paying customers. For example, hospitals recorded about $7 billion in free care and bad debt for 1986. Much of that uncompensated care was financed by increased charges to patients with insurance.

A problem facing the uninsured is that the sources of subsidized care may be dwindling. Increasing pressures on hospitals to negotiate rates and new methods of reimbursement are making it difficult for hospitals to make up their uncompensated care costs by raising their charges to insurers or other third-party payers. Hospitals' reduced profit margins and constraints on public monies are also limiting the dollars to finance uncompensated care. If these trends continue, the access problems of the uninsured could grow more severe. One reason these trends are likely to continue is our nation's inability to harness health care costs. It is relatively easy to provide free care when that care is inexpensive, but more difficult to do so when that care becomes a major cost.

Policy Options for the Uninsured

Policy responses to the uninsured are being considered at the State and local, as well as Federal, levels of government. The following discussion focuses on the major options being considered or likely to be considered by Congress, including proposals to reach specific target groups and broader proposals to cover virtually all of the population.

Public Programs. Existing Government insurance programs, such as Medicare and Medicaid, could be expanded to reach a larger population. There are proposals to expand Medicare, for example by eliminating the current 24-month waiting period for benefits for the disabled or permitting early retirees to purchase Medicare coverage. However, most legislative interest has focused on Medicaid, the Federal-State program for certain groups of low-income persons. In recent years, Congress has steadily expanded Medicaid eligibility for pregnant women and young children. Most recently, the Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) requires all States to offer coverage to pregnant women and children under age 6 with family incomes below 133% of the Federal poverty line by Apr. 1, 1990. As passed by the House, OBRA 89 would have extended coverage of pregnant women and infants to 185% of poverty and would have covered all children in poverty through age 17; these provisions were omitted from the conference agreement. Similar proposals targeted to women and children include H.R. 1573, S. 339, S. 440, S. 949, and S. 1230. S. 768 and H.R. 1845 would extend coverage to the entire low-income population, without regard to the current categorical limits that restrict Medicaid to certain families with children, the aged, and the disabled. H.R. 950 takes a similar approach.

Tax System Options. Federal or State tax law might be modified in a variety of ways to help more individuals purchase health insurance or to encourage more employers to provide group health plans. Some options being considered to encourage individuals to purchase coverage include: (1) allowing people who do not itemize their tax returns to deduct health care costs in excess of some specified percent of adjusted

gross income; (2) providing a refundable tax credit (much like the earned income tax credit) to low-income families to subsidize the cost of health insurance (see, for example, S. 1185 and S. 5 as passed by the Senate and S. 2032. See also H.R. 3 as passed by the Senate Apr. 24, 1990.); and (3) creating a voucher program using the Federal tax system to subsidize the purchase of health insurance by low-income families. Possible options to encourage employers to purchase group coverage include: (1) making the cost of purchasing health insurance for sole proprietors and the self-employed 80% or 100% deductible as opposed to the current law deduction of 25% (see, for example H.R. 694, H.R. 4122, H.R. 1846, S. 494, S. 1168, S. 1381, and S. 1507); and (2) changing/clarifying the tax treatment of prefunding mechanisms to encourage employers to self insure.

Another approach would be to change the tax treatment of employer contributions to their employee's health insurance. Under current law, the employer's premium contribution is not counted as taxable income to the employee. A cap could be placed on any employer contribution in excess of a specified amount, such as $100 per month for an individual and $250 per month for a family. Such a measure would produce new revenues that could be used to finance other access options. Such a measure might also curb medical inflation by removing the existing tax incentive for employers to provide rich benefit packages requiring little or no employee cost-sharing. However, it could be difficult to determine where to set the cap on the employer contribution so that it does not discourage the purchase of necessary health benefits. In addition, regional variations in health care costs mean that an employer contribution that purchases an excessive benefit package in one area might buy a much less generous package in another area. Opponents of the tax cap add that a cap could result in the elimination of important health benefits, such as the coverage of mental health services.

Employment-Based Options. Federal initiatives could be used to provide employment-based coverage to more persons or to improve coverage already provided by employers. Three distinct approaches are possible: (1) Federal requirements on existing health insurance plans to reach greater numbers of people or requirements on existing plans to provide specific benefits (for example, H.R. 2563 requires employers with existing plans to provide coverage to part-time workers); (2) requirements on employers receiving Federal funds, such as State and local governments and government grantees or contractors, to provide coverage to their employees (see, for example, H.R. 43); and (3) a Federal mandate on employers to provide coverage.

Legislation was enacted as part of OBRA 1989 (P.L. 101-239) to expand Federal health insurance continuation of coverage requirements (mandated by Title X of COBRA) to enable individuals who are determined to be Social Security disabled at the time of termination of employment to receive a total of 29 months of continued coverage under their employers' group plans. (See CRS Issue Brief 87182) Bills to mandate that employers provide health insurance and expand Medicaid to pick up those not covered under the employer mandate (H.R. 1845, S. 768) are under active consideration. (See CRS Issue Brief 87168.)

Universal Access. Universal access proposals were more widely considered in the 1970s than today, but renewed momentum has been gathering in and outside of Congress for some type of universal program. The legislative proposals have

generally taken one of three approaches: a social insurance program modelled after that of Canada or Western European nations in which services are primarily financed through general revenues but are furnished by independent providers; a national health service like the English National Health Service in which the government both finances and furnishes health care services; and a mixed public-private program in which the government shares the financing burden with employers (for example, through a combination of an expanded Medicaid program and mandated employer-provided health insurance), but health services would continue to be furnished by independent providers.

While a number of proposals are pending, S. 768 and H.R. 1845, combining an employer mandate and a Medicaid/Federal-State program expansion, have moved furthest along. Hearings have been held on both proposals and on July 12, 1989, the Senate Labor and Human Resources Committee voted to report an amended version of S. 768 to the full Senate (reported on Nov. 20).

Expanding Availability. Some individuals or employers may wish to purchase insurance coverage but find it unaffordable or unavailable because of characteristics of the private insurance market or other factors. The final set of options focuses on possible interventions that might help make coverage more accessible or affordable for potential purchasers. These include the following:

1. Regulation of insurance underwriting practices, under which certain individuals or groups expected to incur high medical costs may be refused coverage, receive coverage subject to exclusion of payment for "preexisting conditions," or be required to pay higher rates than other applicants. H.R. 2649 would require States to regulate the treatment of preexisting conditions.

2. Federal preemption of State mandated benefit laws. These laws, which require insurance policies to include specific types of coverage regardless of whether the purchaser desires the coverage, are alleged to increase the price of insurance. S. 1274 includes this approach.

3. Encouraging private insurers to develop pooling mechanisms to spread the risks of high-cost cases. H.R. 872 combines this approach with an employer mandate.

Finally, some proposals assume that the private insurance market may not be able to reach very low-income or high-risk individuals and would have government assume the role of selling insurance directly. One option is the development of a Medicaid "buy-in" program, under which individuals or families whose income exceeds Medicaid standards could obtain coverage by paying a premium which would be reduced through public subsidies. OBRA 89 provides for demonstrations to test this concept for low-income women and children. H.R. 2996 would provide grants to States to develop buy-in programs, while H.R. 2218 would establish a similar program on a national basis. States may also establish special programs to cover high-risk, "uninsurable" individuals. S. 1274 would provide grants to States for this purpose.

Recommendations of the Pepper Commission. The U.S. Bipartisan Commission on Comprehensive Health Care (known as the Pepper Commission) was established by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-230) to (1) examine shortcomings in the current health care delivery system and its financing

mechanisms which limit or prevent access to comprehensive health care; (2) make specific recommendations to Congress respecting Federal programs, policies, and financing needed to assure the availability of comprehensive health care services for all individuals in the U.S. and comprehensive long-term care services for the elderly and disabled; and (3) consider in making its recommendations the amount of Federal funds necessary to finance needed services, the sources of those funds, and the most efficient and effective manner for administering programs for those services.

The Pepper Commission recommendations, released Mar. 2, 1990, had two components: access to health care and long-term care. The net Federal cost of a fully phased in program based on the Commission's recommendations for both components would be $66.2 billion (in 1990 dollars). A description of the Pepper Commission's recommendations for access to health care follows. A description of the long-term care recommendations can be found in the "Long-Term Care" section of this issue brief.

Employers with more than 100 employees would be required either to provide health insurance to their employees (with a specified benefit package and paying 80% of the premium), or to contribute to the public plan on their behalf. Smaller employers would be encouraged to provide insurance through insurance market reforms (such as guaranteed acceptance of all employer groups wishing to purchase insurance); tax credits/subsidies for certain small employers; and 100% deduction for the self-employed and unincorporated. If small employers failed to meet specified coverage targets, they would be required to provide health insurance or contribute to the public plan.

The public plan would cover employees and dependents that contribute, and non-working individuals who buy in or are subsidized. The plan would be financed and administered primarily by the Federal government; replace Medicaid for specified services; and pay providers according to Medicare's rules. The Commission's plan would be phased in, beginning with coverage of children and pregnant women through the public plan.

The Underinsured

Even persons with insurance can face substantial health care costs if their insurance does not adequately cover their medical expenses. Private sector health plans and public programs such as Medicare and Medicaid may all, to some degree, leave their enrollees underinsured because of uncovered services, cost-sharing requirements (i.e., enrollee deductible and coinsurance amounts), limits on payments to providers, or maximums on plan benefit payments.

The extent of out-of-pocket expenses for health care can be measured in absolute dollars (such as $2,000) or as a percent of income (such as 5% or 10%). A study by the Department of Health and Human Services (*Catastrophic Illness Expenses*, November 1986) used a combination of these methods to determine the population at risk for out-of-pocket catastrophic medical expenses. For a catastrophic threshold that ranged from $4,400 plus 10% of income, to $2,200 plus 5% of income, the study reported that in 1986, the incidence of catastrophic out-of-pocket expenditures ranged

from 2.4 million to 6.2 million persons, or from 1.2% to 3.2% of those under age 65 or in families headed by a person under age 65. About 35% of poor families (those below poverty) and about 3% of high-income families (those above 400% of poverty) had out-of-pocket expenses exceeding 5% of income. Overall, the Department estimated that about 10 million persons (in addition to the approximately 35 million uninsured) had insurance that was inadequate to protect them from risk of catastrophic illness expense.

Several features of health insurance plans determine the extent of out-of-pocket expense for which an enrollee is at risk. First, if a health service is excluded from coverage, an enrollee must pay the full cost of such services. Although plans provided by large firms cover a variety of services, plans provided by some smaller firms may not cover services such as physician office visits, outpatient prescription drugs and mental health care. In addition, some plans may exclude coverage for specified conditions or diseases for a new enrollee, either permanently or for a specified period of time (these exclusions are known as preexisting condition clauses or exclusion waivers).

For medical care expense covered by a plan, cost sharing (deductibles, coinsurance, or copayments) are usually required. Many plans include a limit on enrollee out-of-pocket expenses due to cost-sharing requirements. Once the enrollee has reached the limit, the plan pays 100% for covered services. Such limits range from $500 to $4,000 for medium-to-large firms. Nongroup enrollees are more than twice as likely as group enrollees to be at risk for unlimited health care expenses due to the absence of an out-of-pocket cap.

Gaps in coverage under the Medicare program have been criticized; on average, Medicare covers less than half of the health care costs of the elderly because of its durational limits for certain covered services, cost-sharing requirements, rules for payments to providers, and exclusion of certain items and services from coverage. Congress expanded Medicare's protection by passing the Medicare Catastrophic Coverage Act of 1988. However, opposition to the financing mechanism and opposition from beneficiaries who felt they already had comparable protection under private plans led to repeal of the law in late 1989. In recent years, Congress has focussed on abuses in the sale of Medigap insurance, which is private insurance designed to fill in certain gaps in Medicare's coverage. Numerous hearings have been held and regulatory reform bills introduced in the 101st Congress.

Most options for improving the coverage of the underinsured do so only incidentally as a part of broader proposals to reach the uninsured. For example, proposals to require that employers furnish a minimum package of health benefits to all employees could widen the coverage of some employees who are already insured. Only a few proposals are more specifically targeted at underinsurance. First, existing insurance policies or employer health benefit plans could be required to include catastrophic coverage provisions. Such rules would not require any individual or employer to obtain insurance, but would specify the minimum benefits for those choosing to do so. Second, low-income persons enrolled in plans with deductible and/or coinsurance requirements could be assisted in meeting those requirements through a public program. Such assistance is already available through Medicaid for Medicare beneficiaries with incomes below the poverty line. There are proposals to

extend this assistance to higher-income beneficiaries or have Medicaid pay enrollee cost-sharing for the working poor enrolled in employer plans.

Other Health Insurance Issues

Several issues will affect the cost and availability of public and private health insurance coverage in the future. These include health care costs and efforts to control them, coverage for long-term care, and retiree health benefits.

Health Care Costs and Cost Containment

The United States spends more per capita, and a greater proportion of its gross domestic product (GDP), on medical care than any other nation. U.S. health expenditures in 1987 reached $489 billion, 10.8% of GDP, as compared to 8.6% in Canada, 6.8% in Japan, and 6.1% in the United Kingdom. All of these countries have universal health insurance coverage and perform at least as well as the United States on standard measures of health care outcomes, such as life expectancy or infant mortality rates. These international comparisons have led some observers to conclude that our medical care system is much less efficient than those elsewhere. There is also concern about the rate of growth in health care expenditures. Inflation in the U.S. medical sector has outpaced inflation in the rest of the economy for many years, averaging 15% a year from 1970-80. After a brief period of moderate increases in the mid-1980s, annual increases in health care expenditures again reached the double digit level in 1988. Costs grew 10.5% over their 1987 level, reaching $540 billion, or 11.1 percent of GNP. Continued health care inflation could affect the Federal budget (chiefly through Medicare and Medicaid) and State budgets, could impede efforts to expand access to care for the uninsured, and could either damage the competitiveness of employers who offer health benefits or lead some of those employers to reduce or eliminate benefits. For all these reasons, there is strong congressional interest in controlling health care costs.

Most Federal efforts in health care cost containment have focused on the Medicare program. Past initiatives have included reviews by peer review organizations (PROs) of the appropriateness of services furnished to beneficiaries and the 1983 enactment of the prospective payment system (PPS) for inpatient hospital services, which provides an incentive for greater efficiency by establishing a fixed pre-determined payment for each Medicare patient treated. OBRA 89 includes a revamping of the way physicians are paid. The previous system set maximum payments by comparing physicians' charges to those of their peers. The new system sets fixed rates for each type of service and sets overall targets for physician spending; rates in future years could be reduced if the targets were not met. The system is designed to encourage physicians to limit the number of services provided to patients, especially costly surgical and diagnostic procedures. OBRA 89 also provides for an expanded research program on the effectiveness and appropriateness of medical treatments. The program would seek to develop medical practice guidelines in order to improve quality and reduce the incidence of unnecessary treatments, both for Medicare beneficiaries and for other patients.

Private sector cost containment efforts have followed three main strategies. First, enrollees in employer plans have been held directly responsible for a larger portion of the costs of their care, through higher deductibles or coinsurance, in order

to discourage unnecessary utilization. Second, private insurers have followed Medicare in increasing their scrutiny of the appropriateness of services obtained by subscribers. Third, enrollees have been encouraged to join "managed care" programs, such as health maintenance organizations (HMOs), which attempt to control the care furnished to members through an organized system of health care providers.

Long-Term Care

"Long-term care" refers to a wide array of medical, social, personal, supportive, and specialized housing services needed by individuals who have lost some capacity for self care because of a chronic illness or condition. Long-term care services include skilled and therapeutic care for the treatment and management of chronic conditions. These services also include assistance with basic human functions, such as bathing, dressing, and eating, often referred to as activities of daily living (ADLs), as well as assistance with household tasks such as cleaning, cooking, and shopping. Major subgroups of individuals needing long-term care include the elderly and nonelderly disabled, the developmentally disabled (primarily the mentally retarded), and the mentally ill.

Both public program and private insurance coverage for long-term care services is very limited. Recent congressional action on catastrophic health insurance for the elderly brought new attention to the uncovered liability many persons face for long-term care services not covered by Medicare or private insurance. These services include both nursing home care and home and community-based care.

Expenditures for long-term care services, particularly nursing home care, strain private resources as well as the budgets of public programs. In 1988, total national nursing home expenditures of $43.1 billion were financed about equally by private resources and by public programs. Nearly all private spending for nursing home care was paid directly by the consumer out of pocket. With the average annual cost of nursing home care about $25,000, paying for such care can represent a catastrophic expense beyond the financial reach of most persons. Moreover, private insurance to cover the costs of both nursing home care and community-based services is very limited. For example, in 1988, private insurance covered only 1% of total spending on nursing home care.

The Medicare program covers principally acute health care services and was never expected to provide protection for long-term care. Coverage of nursing home care, for instance, is limited to short-term stays in certain kinds of nursing homes, referred to as skilled nursing facilities, and only for those persons who can demonstrate a need for daily skilled nursing care following a hospitalization. Many persons who require long-term nursing home care do not need daily skilled nursing care, and, therefore, do not qualify for Medicare's benefit. As a result of these restrictions, Medicare paid for less than 2% of the nation's expenditures for nursing home care in 1988.

Only one public program, Medicaid, the Federal-State health program for the poor, covers long-term stays in nursing homes. It does so, however, only for those persons who meet strict income and assets rules. For many persons facing the catastrophic expenses of nursing home care, these rules require that they first apply most of their assets and income toward the cost of their nursing home care before

they can become eligible for Medicaid coverage. In 1988, Medicaid payments for nursing home care amounted to 44% of total national expenditures for this care. The great majority of Medicaid's payments for nursing home care are for persons who are not initially poor by cash welfare standards, but who deplete their assets and income on the cost of needed care.

Public programs provide only limited support for nonmedical home and community-based long-term care services. The great majority of this care is provided by relatives and friends who are not compensated for the care they provide.

Developing a strategy for providing coverage for nursing home and home and community-based care is difficult for a number of reasons. These include uncertainty about the costs and utilization of services, budgetary constraints, and the complex interrelationships of Federal and State programs currently supporting long-term care.

In addition, observers differ in their views about what public and private sector responsibilities in financing long-term care should be. Some believe that the Federal government should assume the major role in financing long-term care for those in need regardless of their financial circumstances. Others believe that the costs of any public sector expansion may be prohibitive and that the private sector, through private insurance and other risk-pooling mechanisms encouraged with tax incentives, should take the lead. Still others believe that a combination of public and private sector strategies is needed, including Federal benefits together with beneficiary cost-sharing responsibilities that could be financed through the purchase of private insurance.

Long-Term Care Legislation. A wide range of long-term care proposals, introduced in the 100th and 101st Congresses, reflects these divergent views as to what public and private sector responsibilities should be for financing long-term care. Approaches range from those that would establish totally public benefits, without a role for the private sector or specifically private insurance, to those that would rely almost exclusively on the private sector--whether this be individuals or insurance--to provide the additional financing needed for long-term care.

S. 2163 (Kennedy), for example, would establish, in a new title of the Public Health Service Act, a long-term care program covering nursing home and home care for certain chronically disabled persons of all ages regardless of financial circumstances. Benefits would be primarily publicly financed, without deductibles or significant copayments. This bill aims to assure that additional sources of private financing would be unnecessary. H.R. 2263 (Pepper) takes a similar approach to public sector financing of long-term care, but focuses coverage strictly on home and community-based care.

At the other end of the spectrum are bills that leave to the private sector the responsibility for providing the additional financing needed for long-term care. Some of these bills would provide tax incentives to individuals for the care they provide others. Other bills would provide tax incentives to individuals and employers for the purchase of private insurance in order to encourage the growth of this fairly new market. The cost of these approaches is limited to the revenues that would be lost for providing tax deductions for various purposes.

In between are bills that would establish comprehensive long-term care benefits at the Federal level but, to a greater or lesser extent, would include with these new benefits certain beneficiary cost-sharing responsibilities that could be paid for with private insurance. H.R. 3140 (Waxman) and H.R. 5393 (Stark, 100th Congress) would each establish in Medicare comprehensive nursing home and home care benefits that would be accompanied by limited copayments and deductibles. For those below 200% of the Federal poverty level, Medicaid would share in the cost of these copayments and deductibles. Others could purchase private long-term care insurance to cover these costs. In this case, private insurance would function as a supplement to Medicare benefits in the way that Medigap policies have paid for costs of acute care benefits not covered by Medicare.

Another bill, S. 2305 (Mitchell, 100th Congress), would create a larger role for private insurance than the Medigap model, specifically with regard to coverage of a chronic nursing home benefit. Under this proposal, persons would be required to incur the first 2 years of nursing home costs before a new Medicare nursing home benefit would begin to pay. Since studies of nursing home utilization have shown that 75% of persons entering a nursing home stay less than 1 year and 83% stay less than 2 years, most persons would either have to rely on out-of-pocket payments for their care or purchase private insurance to cover the costs. This benefit has been designed to limit Federal expenditures and to encourage private insurers to develop policies and to encourage persons to be able to afford long-term care insurance.

Pepper Commission Long-Term Care Recommendations. The Pepper Commission's proposal for long-term care includes three components: (1) a federally financed social insurance program covering home and community-based care for severely disabled individuals of all ages; (2) a federally financed social insurance program covering the first 3 months of a nursing home stay; and (3) a means-tested Federal and State financed nursing home program covering stays beyond 3 months that would protect certain levels of income and assets of persons needing care. For both the home and community-based care program and first 3 months of a nursing home stay, individuals would be responsible for 20% of the costs of care, with the Federal government subsidizing this required cost sharing for persons with incomes below 200% of the Federal poverty level. For the nursing home program that would cover stays longer than 3 months, individuals would be required to apply to the cost of their care nonhousing assets above $30,000 for single persons and $60,000 for married persons, before the program would begin to pay for care. Individuals would also be required to contribute to the cost of their care income that remains after certain set-asides for housing and personal needs were made. Private long-term care insurance could fill in the gaps not covered by this plan. The Pepper Commission has estimated the costs of these benefits to be $42.8 billion (in 1990 dollars).

Retiree Health Benefits

Many medium and large employers offer their employees post-retirement health benefits. Employees usually qualify for these benefits after working 10 or more years and achieving a certain age. When a worker retires, the employer's health plan may be his or her only source of health insurance until becoming eligible for Medicare, and an important source of additional coverage thereafter. In 1987, an estimated 10.8 million retirees and their dependents were covered by employer-sponsored retiree health plans.

Congress is becoming increasingly concerned about the future of employer-financed retiree health benefits. As more and more companies seek to reduce or terminate their plans, the danger grows that retirees will lose an important source of privately sponsored health insurance.

Several factors are converging to make retiree health benefits more expensive for employers, including health care inflation, unfavorable demographic trends, and changes in Medicare payment policy. Perhaps most important is that certain companies have accumulated a vast unfunded liability for the coverage of current and future retirees. All but a small percentage of firms that offer retiree health benefits pay for the benefits as they are incurred. The total unfunded liability of employers for current and future retiree health benefits has been estimated by the GAO to be over $400 billion. The liability question may become explosive now that the Financial Accounting Standards Board has issued draft rules requiring companies to recognize the aggregate costs of their retiree health plans on financial statements. Companies with substantial commitments to pay for their retirees' health care and insufficient funds to pay for them may be seen as poor investment risks.

Some companies have already sought to reduce their retiree health commitment by modifying or eliminating their plans. Others have tried to eliminate their liability through Chapter 11 reorganization under the U.S. Bankruptcy Code. The latter approach was taken by the LTV Corporation. After filing for reorganization in 1986, LTV terminated health and life insurance benefits for more than 78,000 retirees. The company restored the benefits after substantial public pressure, and Congress stepped in with a stopgap measure to further protect the LTV retirees.

The LTV case sent a warning that retiree health benefits are uncertain for current, let alone, future retirees. The 99th Congress enacted a law to ensure that retirees of certain companies that had filed for bankruptcy continued to receive health benefits. In the 100th Congress, legislation was enacted to help safeguard retiree health benefits in cases where companies file for Chapter 11 reorganization. In the 101st Congress, House and Senate proposals were included in the Omnibus Budget Reconciliation Act of 1989 (H.R. 3299, S. 1750) to allow employers on a tax-favored basis to use excess pension funds to finance the health benefits of current retirees. These were dropped in conference although a technical provision relating to contribution limitations on 401(h) accounts was adopted.

Legislation (S. 2199, H.R. 4134) similar to the proposals dropped in conference has been introduced in the second session of the 101st Congress. The Administration's fiscal year 1991 budget also includes a proposal to permit the transfer of excess pension funds to pay current retiree health benefits. The transfer would have to occur before Jan. 1, 1993, and in a plan year beginning after Dec. 31, 1990.

Consideration may also be given to bills imposing new Federal requirements on employers to provide for vesting and portability of retiree health benefits, as well as new standards for plan administration.

LEGISLATION

P.L. 101-239, H.R. 3299

Omnibus Budget Reconciliation Act of 1989. Mandates Medicaid expansion for pregnant women and children up to age 6 with family incomes up to 133% of poverty level by Apr. 1, 1990. Codifies current regulatory requirements regarding sufficient payments to providers. Requires Medicare-participating hospitals to adopt and enforce a policy to ensure compliance with requirements relating to the examination and treatment of emergency medical conditions and women in active labor. Increases authorization of appropriations for the Maternal and Child Health Block Grant to $686 million per year; adds a new 12 3/4% set-aside to support infant mortality initiatives and community-based services for children; provides for demonstration projects to cover uninsurable children. Extends COBRA continuation coverage from 18 to 29 months for those with a disability at the time of termination of employment. Clean bill reported by the House Budget Committee Sept. 20, 1989. Passed House with amendments Oct. 5, 1989. Passed Senate with amendments Oct. 13, 1989. Conference report filed Nov. 21, 1989 (H.Rept. no. 101-386); agreed to by both houses Nov. 22, 1989. Signed into law Dec. 19, 1989.

P.L. 101-234, H.R. 3607

Medicare Catastrophic Coverage Repeal Act of 1989. Repeals the Medicare and financing provisions of MCCA (P.L. 100-360) while retaining the Medicaid provisions. Introduced Nov. 7, 1989; passed House Nov. 8, 1989, with provisions identical to those included in the House-passed H.R. 3299, the Omnibus Budget Reconciliation Act of 1989. Passed Senate amended Nov. 8, 1989, with provisions of Senate-passed S. 1726. Conference report filed Nov. 19, 1989 (H. Rept. no. 101-378). Signed into law Dec. 13, 1989.

S. 768 (Kennedy)

Basic Health Benefits for All Americans Act. Requires employers to enroll employees in a plan that covers specified health services and provides protection against catastrophic illness expenses. Requires that States establish programs with Federal and State financing to provide health benefits on a phased-in basis to people in poverty and near poverty, and to all other individuals not covered by employer plans. Employers without a plan meeting the minimum benefit standards are required to join regional insurance pools established by the Secretary of Health and Human Services that provide health benefits at community rates. Provides for a Federal subsidy for small businesses where compliance costs exceed 5% of gross revenues. Introduced Apr. 12, 1989; referred to Committee on Labor and Human Resources. Hearings held May 1, June 23, 1989. Amended version of the bill reported Nov. 20, 1989 (S. Rept. no. 101-217).

COVER STORY

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Curbing The High Cost Of Health Care

By Roger Thompson

PHOTO: J. MICHAEL KEZA

Philip and Bertha Leber, *center, along with their son-in-law—holding their grandson—and most of the employees of their tool-rental firm.*

It took Philip A. Leber Sr. 19 years to build his family-owned tool-rental business into a prosperous enterprise employing nine people. Yet his long record of entrepreneurial success suddenly is threatened by circumstances beyond his control.

Leber's business is on the verge of being crushed under the weight of health-insurance costs that average $17,372 a year per employee, perhaps the highest cost per worker of any business in America.

These costs for seven covered employees and their dependents, represent a five-fold increase from just one year earlier. Large medical expenses for a critically ill infant in the family of one of Leber's employees triggered the explosive rise in his firm's rates.

Says Leber, president of George's Tool Rental Inc. in Hatfield, Pa.: "It seems hard to visualize how a small business can survive with expenses such as this."

While the magnitude of Leber's rate hike is extreme, his bewilderment over sharply rising health-care costs is shared by thousands of small-business owners who are seeing their profit margins erode—or disappear—as health-insurance premiums jump 20 percent to 150 percent.

The surge in health-insurance premiums reflects the nation's unexpected failure to bring rising medical costs under control. Runaway price increases in the early 1980s forced many employers and insurers to devise new methods for medical-care cost control, such as insurance company approval for hospital admission and mandatory second opinions to confirm the need for surgery.

Those cost increases also spurred intense new competition in health-care delivery through the growth of health-maintenance organizations (HMOs), which provide all health services to members for a flat fee, and preferred-provider organizations (PPOs), in which affiliated medical practitioners provide services at a discount.

Those and other cost-containment steps were credited with holding cost increases for employer-sponsored medical plans to single-digit percentages from 1985 to 1987, prompting what proved to be a false sense of optimism among employers and insurers that the explosive inflation in health-care costs had been contained.

But double-digit health-cost inflation returned with a vengeance in 1988, driv-

Many small-business owners are seeing their profit margins erode as health-insurance premiums jump 20 percent to 150 percent. Yet there are many cost-management strategies that small firms can adopt to rein in these runaway expenses.

ing annual health-care costs per employee to a record high of $2,354, an 18.6-percent increase over the previous year, according to an annual survey conducted by the benefit consulting firm of A. Foster Higgins & Co. "Not only is double-digit inflation back in health plans," says John Erb, managing consultant in charge of the survey, "but there also doesn't appear to be much relief in sight."

In fact, double-digit increases are the norm again this year, according to a recent survey of 14 major insurers by Noble Lowndes, an international consulting firm. "By the end of the decade, the average employer's medical benefits costs will have increased to more than 13 percent of payroll, up from less than 5 percent of payroll in 1980," says David L. Brenneman, a Noble Lowndes vice president.

Experts attribute the continuing increases in health-care costs to several circumstances:

- Expanded coverage in the areas of mental health and substance abuse, which now account for nearly 10 percent of medical plan costs. In many instances, this expansion has been dictated by state governments.
- Failure of HMOs and PPOs to sustain their original promises of achieving major breakthroughs on cost reduction. A campaign to encourage use of outpatient services in place of hospital stays also fell below expectations for cutting costs.
- The high cost of advances in medical technology and drug therapy.
- A substantial increase in the population most likely to incur heavy medical costs—the elderly.

Although health insurers take the brunt of complaints about escalating costs, they simply are passing along their losses. The industry suffered a record underwriting—or pretax—loss of $5.6 billion in 1987, and its red ink amounted to $4.7 billion in 1988, according to *The National Underwriter*, an industry publication.

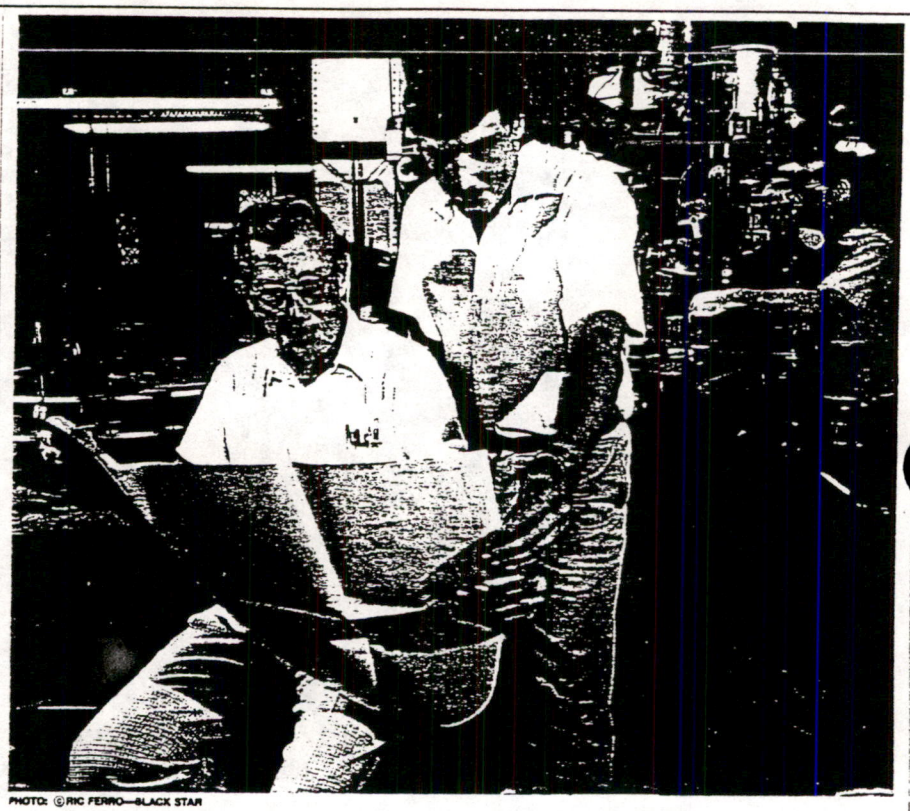


PHOTO: ©RIC FERRO—BLACK STAR

Employer Charles Mortensen, *with son Chip, says premium boosts started him thinking about government solutions to health-care needs.*

As a result, some major companies, such as Provident Mutual, Mutual of Omaha, Kemper, and Allstate, have withdrawn from the group-health-insurance business.

The physicians have been criticized for escalating their fees and generating incomes that rank them at the top for all professionals. In 1987, the typical income for a physician was $116,440, according to *Medical Economics* magazine. The median incomes of some specialists reached nearly three times that amount. (See chart on Page 24.)

On the other hand, physicians' earnings have not kept pace with consumer price inflation in seven of the past 10 years, says *Medical Economics*.

If physicians' income growth isn't fueling overall health-care inflation, the rising cost of the care they provide is a major factor. Numerous studies have concluded that doctors provide significant amounts of unnecessary and ineffective medical care, driving up overall expenditures, says Theodore J. Nussbaum, a principal with the accounting and consulting firm of Coopers & Lybrand. "Since the system is driven by physicians, they can be a major part of the problem," Nussbaum says.

Doctors maintain that the torrent of malpractice lawsuits during the 1980s has forced them to practice defensive medicine by ordering more tests and performing more services than they might otherwise believe necessary.

Some studies indicate that up to 25 percent of doctors' procedures are done for defensive reasons, says Karen

Brigham, manager of health-care policy for the U.S. Chamber of Commerce.

As inflationary pressures from a variety of sources rekindle double-digit premium increases, it's no wonder that health-care costs have become the No. 1 concern for many American companies—the nation's chief providers of group medical insurance.

Employer-paid health insurance covers an estimated 160 million Americans—workers, workers' dependents, and retirees. Employers will spend more than $140 billion this year to provide that coverage.

The nation's total health-care bill for 1989 is expected to hit a record $542 billion. That represents nearly 12 percent of the gross national product, which is twice the percentage of 25 years ago and is the largest share of GNP for health care among all industrialized nations. At the current rates of growth, health-care spending in the U.S. may reach 15 percent of GNP by the year 2000.

As the medical-care bill grows, so does the debate over who should pay it and how medical resources should be allocated. One facet of the controversy is how best to extend insurance coverage to the estimated 37 million people now lacking it. (See the box on Page 26.) And as costs soar, one state—Oregon—already has begun to ration health-care dollars. (See the box on Page 25.)

The debate also involves those who believe that the return of double-digit premium increases is proof that cost-containment efforts during this decade have failed and that the only alternative now is some form of nationalized health care, perhaps similar to that in Canada. (See the box on Page 22.)

But small business sees the problem as immediate, not as a matter of debate over long-term solutions. Charles Mortensen, president of Scandia Technologies Inc., in Clearwater, Fla., says his insurance plan covering 13 of 20 employees was hit with a premium increase of over 80 percent two years ago. He changed insurers and saved about $1,000 a month in premiums, but he expects another big rise in premiums this year. To make matters worse, he now fears that his current insurer may go out of business. Says Mortensen: "I've been anti-socialist all my life, but if there is one area where we might need this kind of help, it's medicine."

Don't throw in the towel yet, advises William L. Roper, a White House adviser on domestic policy. The assumption that health-care cost containment has failed simply isn't true, he maintains, because business hasn't made a serious effort yet to implement aggressive cost-management strategies. "I reject the premise that we've tried everything we know how to do and it's failed," Roper says. On the contrary, he maintains that most employer health plans encourage excessive use of medical services.

The basic problem is that employees typically pay only a relatively small portion of the cost of their health-care insurance or, in many cases, are under plans fully paid by employers. This insulates them from the full impact of rising costs and leaves them largely unconcerned about the economical use of services. "If food prices were going up by 15 percent a year, you'd have pickets in front of grocery stores," says Jon Gabel, associate research director for the Health Insurance Association of America, an industry research and lobbying group. "But you don't see pickets

Health Insurers Post Big Losses

Profit/Loss As Percent Of Gross Income

	Commercial Companies	Blue Cross/ Blue Shield
1977	0.4%	2.6%
1978	1.3%	2.3%
1979	0.2%	0.4%
1980	-2.9%	-4.6%
1981	-3.9%	-3.6%
1982	-4.0%	-0.9%
1983	-1.8%	1.3%
1984	1.5%	3.3%
1985	0.8%	0.7%
1986	-3.2%	-2.0%
1987	-6.4%	-4.1%

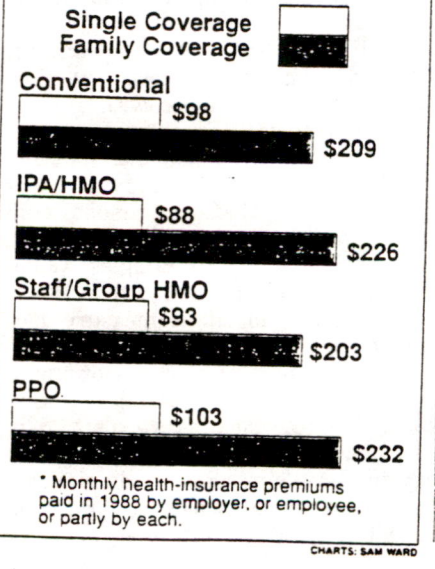
Source: Strategic Planning Associates, Best Insurance Reports

National Health Expenditures

Year	Total (in billions)	Percent Of GNP	Per-Capita Spending
1965	$41.9	5.9%	$205
1976	$105.8	8.9%	$665
1981	$287.0	9.4%	$1,207
1982	$323.6	10.2%	$1,348
1983	$357.2	10.5%	$1,473
1984	$388.5	10.3%	$1,587
1985	$419.0	10.4%	$1,696
1986	$455.7	10.7%	$1,827
1987	$500.3	11.1%	$1,987
1988*	$541.7	11.5%	$2,135
1990**	$647.3	12.0%	$2,511

* Estimated
** Projected

Typical Premiums*



* Monthly health-insurance premiums paid in 1988 by employer, or employee, or partly by each.

CHARTS: SAM WARD

in front of doctors' offices" because insurance covers virtually all the costs, he adds.

Despite the sharp rise in premium costs, an HIAA survey found "virtually no change in the average [employee-paid] deductible or the coinsurance rate [the percentage of costs paid by employees]" from 1987 to 1988. The survey found the typical individual deductible remained at $100, with a family deductible of $300, while the typical coinsurance rate remained at 20 percent. "Our analysis suggests that employers and insurers did not respond to the premium increases of 1987 and 1988 as if a crisis were at hand," the survey stated.

Although small firms typically pay 10 percent to 40 percent more for their health-insurance premiums than large companies pay, they are even less likely than large companies to pass any of the costs along to employees. A 1987 Small Business Administration study found that 70 percent of all firms with fewer than 100 employees paid all of their employees' health premium, and on average such firms paid 87 percent of family premiums.

Small firms also are far less likely to have implemented other cost-management strategies widely adopted in mid-decade by larger employers. Among the approaches that have been tried, not all of them effective:

- Preadmission certification, to approve medical necessity and determine length of stay before a patient enters the hospital;
- Second opinions, to confirm the need for elective surgery;
- Outpatient surgery, which does not require hospital admission;
- Concurrent review, to monitor a hospital patient's treatment and length of stay;
- Discharge planning, to coordinate the need for follow-up care outside the hospital;
- High-cost-case management, which determines the most cost-effective treatment for those with chronic illnesses such as AIDS or cancer.

Four out of 10 small and midsized Northeastern companies surveyed this year by the Wyatt Co., a benefits consulting firm, said they have not tried any cost-containment strategies. While 63 percent had implemented at least one strategy, no single measure had spread to even half of the companies.

There are several good reasons why small companies lag in taking effective steps to contain health-care costs. It is less of an administrative headache to pay full premium costs for employees, and doing so may make up for fewer benefits overall. Failure to share costs

Health Care, Canadian-Style

Canadians' total outlay for health care equals about 9 percent of their nation's gross national product—lower than the nearly 12 percent of GNP paid out in the U.S. And by some measures, Canada's population is healthier than that of the U.S. Canadians live longer, on average, and their infant-mortality rate is 25 percent lower.

Unlike the U.S., where some 37 million people have no health insurance, health insurance in Canada is universal. The tax-financed national system eliminates the need for deductibles and coinsurance. And Canadian law forbids doctors from charging patients more than the fees set by provincial governments.

Moreover, Canadians have the right to choose their physicians and hospitals, and physicians have the right to choose where they want to establish their practices and to charge on a fee-for-service basis.

Not surprisingly, at a time when U.S. health-care costs seem to be soaring out of control, American interest in the Canadian system is on the rise. Says Chrysler Corp. Chairman Lee Iacocca: "American industry cannot compete effectively with the rest of the world unless something is done about the great imbalance between health-care costs in the United States and national health-care systems in virtually every other country."

Yet health care Canadian-style may not cure what ails the U.S. system. The American Medical Association describes the Canadian system as "socialized medicine managed by an ever-enlarging and more expensive bureaucracy, financed by ever-increasing taxation, and featuring rationing, shortages, health-care waiting lists, and an absence of private-sector alternatives."

Canada bases its health care on the egalitarian ideal of providing universal access to basic hospital and physician services. When the program was begun in 1971, the Canadian government covered 50 percent of health-care costs through various taxes. To contain costs, the government in 1977 changed its form of funding to block grants for each of Canada's 10 provinces. The grants have not kept up with the rising costs of health care, however, with the result that federal support dropped to 38 percent in 1988.

The provinces have been forced to pick up the slack. While they are free to finance health costs with any taxes they choose, they derive most of their funds through general tax revenues.

Not all health needs are covered by the system. Excluded are payments for eyeglasses, dental care, outpatient prescription drugs, and treatment upgrades such as private or semiprivate hospital rooms. Most employers cover these costs through supplemental insurance plans.

Since federal and provincial governments are the sole payers of medical bills, they set ceilings on physicians' fees and hospitals' spending. Recent efforts to restrain rising costs have forced provincial governments to impose "tighter controls on the number of doctors and physician fees, hospital budgets, and home-care budgets," according to the Employee Benefit Research Institute, a nonpartisan research organization in Washington, D.C. In a report on the Canadian health-care system, the organization states: "These controls have directly resulted in supply shortages and queues for some types of health-care services, restricting access to some types of care."

To handle the increasing demand for hospital beds, Canadian hospitals have had to resort to a type of rationing. In his book *Condition Critical*, medical journalist Nicholas Regush likens the rationing to the medical decision-making in mobile medical units like those on the television show "M*A*S*H." Patients are classified as emergency (situation is life-threatening), or urgent (patient needs treatment within 24 hours), or elective (patient needs treatment or surgery for a condition that is not life-threatening).

Maclean's magazine, Canada's leading newsweekly, took a rather alarmist view of the state of Canadian health care in a cover story earlier this year: "Hospitals across the country are taking beds out of service, limiting the number of operations they perform, and cutting back on other services as governments battle to keep down health-care costs." In an introductory column, the magazine's editor concluded, "People are dying because doctors and the medical establishment cannot find the time or the available facilities to save their lives."

Despite these obvious flaws, recent opinion polls show that Canadians are generally satisfied with their government health-care system. It is doubtful, however, that many Americans would embrace a Canadian-style system with such equanimity.

—Kara Finnegan

also may reflect the fact that many small firms employ family members.

It is also clear that smallness itself is a major handicap in holding down costs. Small firms pay higher premiums per employee largely for two reasons: Insurers use questionnaires to assess the health status of each covered individual, a practice called medical underwriting. And insurers incur higher administrative costs per individual when handling small accounts.

Medical underwriting is the practice that drove Philip Leber's insurance rates through the roof. His problems began last year when the wife of one of his employees gave birth to a child with serious medical problems, causing the company's insurance carrier to pay claims 2½ times larger than premiums received.

At renewal time, Leber's insurance company evaluated the health status of each employee and covered dependent, and it assigned premiums accordingly. Insurance brokers characterize this as "medical red-lining," describing it as an attempt to discourage business from companies or groups likely to incur high medical costs.

Medical underwriting also leads to denial of coverage for people who have chronic health problems, such as heart disease or cancer. This makes it nearly impossible for many small companies with covered individuals in need of expensive care to shop around for lower rates, because no insurance company will bid on a plan that includes someone with a chronic illness. "Unless you have a healthy group, you can't move," says Howard Soltoff, a partner in the insurance brokerage firm of Foster, Soltoff & Love Ltd., located in Bethesda, Md.

In addition, administrative costs are higher for small companies because of low volume. It is more expensive for an insurer to handle 10 employees in 100 companies than 1,000 employees in one company.

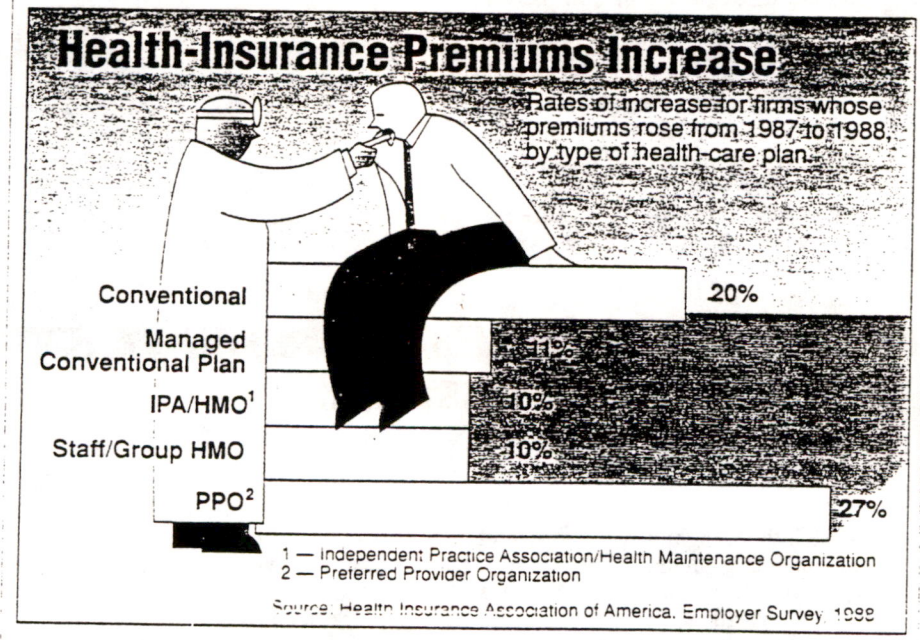
Most large companies now trim administrative costs, which run as high as 30 percent of premiums, by self-insuring, essentially putting money in a bank account and paying claims as they come in. Large firms can do this because they spread the risks over many employees. This option is unrealistic for small companies, because a single major claim could bankrupt the health-care reserve.

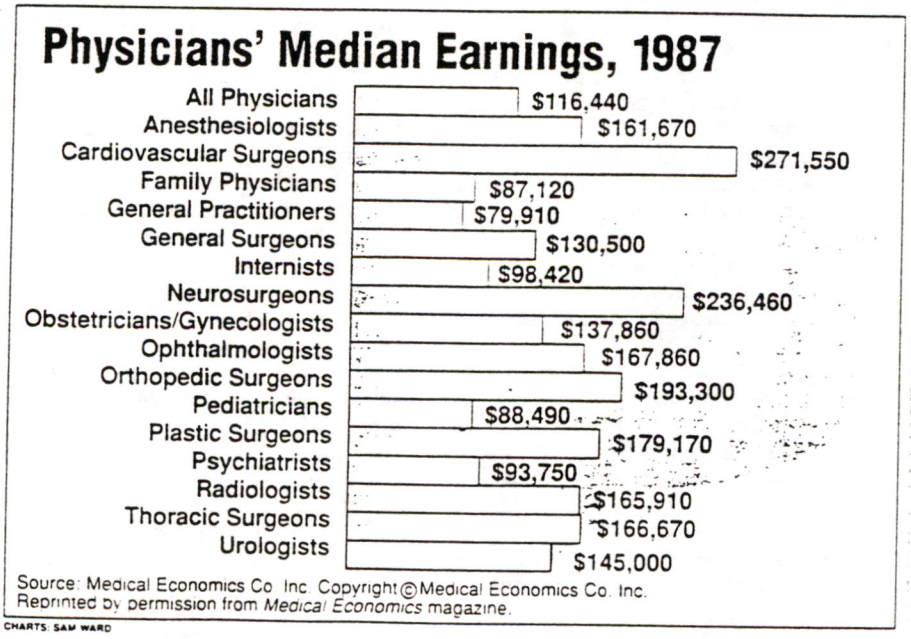
There are other, even more important benefits to self-insurance. Under federal law, an employer who self-insures need not comply with state mandates for specific types of health coverage. There are 686 such mandates nationwide, covering ailments from AIDS to alcoholism and drug abuse, and services ranging from acupuncture to in-vitro fertilization. Federal employees, Medicare patients, and most state employees are exempt from these requirements, putting the burden of compliance on those firms that aren't large enough to escape through self-insurance.

Smallness also is a barrier when it comes to participation in HMOs or PPOs. While both can produce significant cost savings and represent a rapidly growing segment of the health-care market, small employers have only limited access to either. HMOs and PPOs have concentrated their marketing efforts among midsized and large firms.

With only limited access to HMOs and PPOs, small employers are left with two basic fee-for-service choices for health plans. One is a comprehensive plan in which employees pay a deductible and coinsurance on all services. The other is a basic hospital/major-medical plan in which deductibles and coinsurance typically apply only to non-hospital charges and to a portion of inpatient physician and surgeon fees remaining after an initial plan payment. Under both plans, employees choose their own doctors, who set their own fees.

Neither type of plan is structured to reward employers for cutting costs. A small company that manages to hold claims to 60 percent of premiums paid to the insurer still could get a hefty increase based on the traditional "community rating" system. Under it, premium increases are based on the overall experience of an insurer-designated pool of similar-sized firms in the area. Thus, even a company with relatively





CHARTS: SAM WARD

low use of health-care services can face premium increases if others in the pool cause significant expenditures.

Charles Gorenstein's experience is typical. His Falls Church, Va., law firm—Birch, Stewart, Kolasch, and Birch—has received two rate hikes this year totaling 47.5 percent, although health-insurance claims last year totaled only 57 percent of premiums.

"They [the insurance company] are basically trying to push us out the door," Gorenstein says. He added that he did not understand why the insurer was discouraging business from his firm when "they are making money on us hand over fist." The health plan at Gorenstein's firm covers about 75 employees.

A newer "tier rating" system does reward companies that hold costs down, but it clobbers those with big claims. Under the tier system, increases are based on the cost of medical inflation plus a charge for actual experience. Insurers divide employers into three or more claims-experience tiers and assign premium increases based on the tier. The problem is that almost every small company has a big claim sooner or later, making a leap in premium costs inevitable.

The question remains. What works?

A number of cost-management strategies are available to small companies willing to take a tougher approach to the challenge of restraining health-care costs:

- Shifting costs to employees to make them more sensitive to the wise purchase of health services;
- Requiring various forms of health-care management that reviews the appropriateness and effectiveness of services;
- Joining a well-run multiple-employer trust that gives small companies clout in the insurance marketplace;
- Adopting a wellness program that encourages employees to stay healthy and provides the resources to help them do so;
- Changing insurance carriers.

Although cost sharing with employees is potentially a highly effective management strategy, it is also the most controversial. Most employers don't want to be put in the position of charging more or cutting back on a benefit that employees have come to regard as an entitlement.

For competitive reasons alone, boosting employee health-care costs looks like a bad idea to many employers. "Frankly, if we pass these increases on to our employees, we are afraid we would start losing our employees to employers with lower health-care costs,"

The Terms You Need To Know

In managing your company's health-care costs, you should be familiar with these terms:

Deductible: The initial amount of expense for medical or health services that must be paid out-of-pocket by the patient or the patient's family before the health plan begins payment.

Coinsurance: The percentage of costs that a patient pays after the deductible has been met. Total out-of-pocket expenses for an individual patient usually are capped at less than $1,000.

Health Maintenance Organization (HMO): An organization that provides health services for a set premium, regardless of treatment. HMOs typically operate through one of two basic models of organization. One is a staff practice organized around a group of doctors; the other is an individual practice association (IPA), which does not require doctors to form a group. There are currently about 607 HMOs nationally, enrolling 32 million people.

Managed Care: Refers to three basic approaches to controlling the costs and the use of medical services: HMOs, PPOs (definition below), and conventional insurance plans that impose any of various utilization-review strategies, such as preauthorization for hospital care or second surgical opinions.

Multiple Employer Trust (MET): A group of employers, usually from small companies, who band together to purchase health insurance at lower prices than available to individual companies.

Preferred Provider Organization (PPO): A hospital or a group of doctors that contracts with an employer to provide health services at a discount—usually 10 percent to 20 percent—in exchange for volume business. There are approximately 620 PPOs nationwide, offering services to more than 36 million people.

Self-Insurance: The employer acts as an insurance company, assuming the full or partial risks for health-plan costs and paying all claims directly rather than providing premiums to an insurer. The paperwork for requesting claims typically is handled by a so-called third-party administrator.

Is Rationing The Answer?

In 1987, the Oregon legislature voted to stop spending Medicaid money on costly organ transplants, diverting scarce funds instead to help thousands of poor, pregnant women obtain prenatal care.

Last spring, the legislature went a giant step further, voting to guarantee all poor people minimal treatment under Medicaid.

To stretch available funds, the state will rank treatment in order of importance and pay only for services at the top of the list.

Rankings will be based on a combination of cost, lifesaving potential, and degree of improvement expected in a patient's life.

Although no one likes rationing health care, Oregon's approach to setting priorities may be a model of what is to come nationwide unless health-care costs are brought under control.

Since approximately one-third of U.S. health-care expenditures are incurred by people over 65, some experts foresee a different form of rationing in the future—one that is dependent on age.

Studies have shown that 25 to 35 percent of Medicare expenditures in any year go to 5 to 6 percent of enrollees who will die within a year.

The British National Health Service largely uses age to determine who receives certain types of treatment. For example, in Britain, lifesaving kidney dialysis is not given to people over the age of 55.

As the baby-boom generation begins to retire early in the next century, some experts believe, health-care rationing is inevitable.

The demand for services will simply outstrip available resources.

Daniel Callahan, one of the nation's leading medical ethicists, maintains that an age-based standard for rationing would be legitimate since, in any event, medicine can provide only limited benefits to people over 70.

Critics of rationing argue that the U.S. can afford to take care of the poor and elderly by raising taxes and allocating medical resources more efficiently.

says David A. Raine, president of Raine & Son Inc., a plumbing contractor in Hyattsville, Md. He maintains a plan without cost to his 75 employees.

Nevertheless, studies have shown that insulating employees from the cost of care encourages higher use of health services. A landmark Rand Corp. study of health-cost management found that participants required to pay a $100 deductible used the health plan 19 percent less than those who paid no deductible. Those who paid a $500 deductible cut usage 27 percent compared with those with no deductible; and those who paid a $1,000 deductible cut usage by 39 percent. After five years of tracking the health status of 8,000 people in the study, no significant health differences were found between groups that used the most health services and those that used the least.

To squeeze out unnecessary use of doctors' services, many health-care consultants believe the individual deductibles should move into the $300 to $500 range over the next several years, with

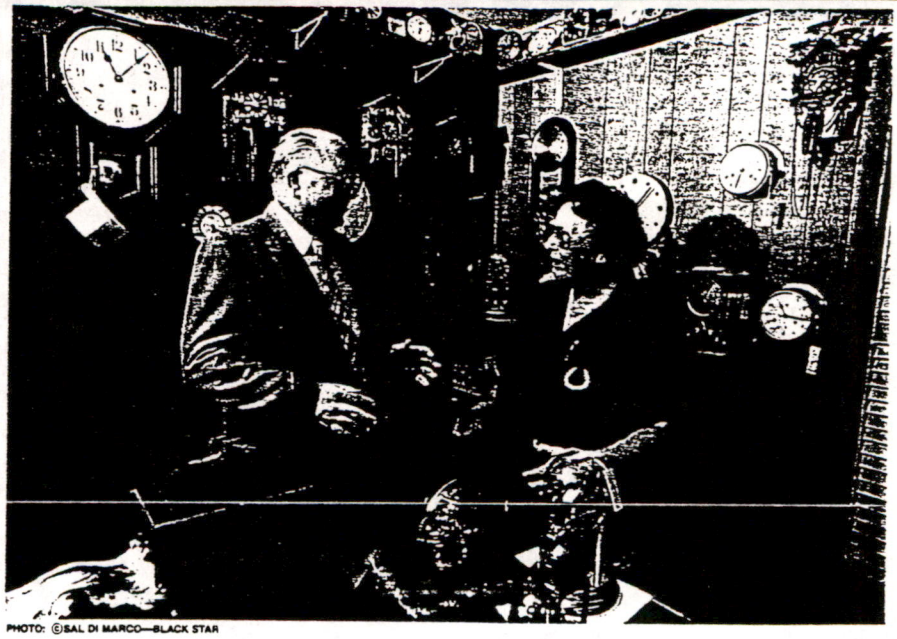


PHOTO: ©SAL DI MARCO—BLACK STAR

Fred Rohm, *president of the New Castle County Chamber of Commerce in Newark, Del., administers a multiple-employer trust that sells health insurance to more than 1,000 small-business owners like Ruth Campbell, who operates a clock-repair business from her home.*

An Alternative To Mandates

As health-care costs continue to soar, Congress is being pressured to do something about providing health coverage for those who do not have it now. The question is, what approach should Congress take?

Mandating employers to provide health insurance is one option under consideration. Sen. Edward M. Kennedy, D-Mass., has introduced legislation to do just that. Business overwhelmingly opposes it. "The Kennedy approach fails to recognize that the real problem with providing health care to more people is that it costs too much," says Rick Berman, chairman of the Partnership on Health and Employment, a rapidly growing, Washington, D.C.-based coalition representing nearly 1,000 companies nationwide.

The Partnership, spearheaded by the U.S. Chamber of Commerce, has taken a leadership role in opposing mandates while promoting reforms "to make the whole system more efficient and thereby more affordable," says Berman.

"The mission of the Partnership is to educate the media, the Congress, and the general public that the Kennedy 'political-quick-fix' approach will cause more long-lasting harm than good," says Berman. "Partnership resources largely will be committed to that goal."

"The Kennedy approach is that Washington can dictate what every employer should be doing," says Frederick J. Krebs, manager of business-government policy for the U.S. Chamber. "There is a real 'inside-the-Beltway' arrogance about that approach."

Small companies would be hardest hit by the Kennedy bill because they could least afford the stiff costs. Mandates would force many small-business employers to shift the costs of health care back to employees in the form of lower wages or reduced employment. Thus, "employer-mandated health insurance will end up hurting the very people it is intended to help," says Princeton University Prof. Uwe Reinhardt, an expert in medical economics.

But the Kennedy bill also would hurt larger firms, as they find that their health plans fall short of the specific benefit requirements, Berman warns. "In fact, if the Kennedy bill were enacted, every year Congress would be asked to mandate broader and broader coverage."

In testimony recently on behalf of the U.S. Chamber of Commerce, David A. Raine, a Hyattsville, Md., plumbing contractor, told the Senate Labor Committee that rather than mandates, "filling the gaps in coverage will require building upon the employer-sponsored system by making coverage more affordable and available for small business and ensuring that public-sector programs meet the needs of the poor."

A bill that closely follows this approach has been introduced by Sen. Orrin Hatch, R-Utah, and has been endorsed by the Partnership on Health and Employment. Hatch's health package would take these steps:

- Pre-empt all state-mandated health benefits, allowing small firms to work with insurance companies to develop low-cost, no-frills health plans.
- Promote the development of state insurance risk pools for individuals who are uninsurable.
- Authorize development of federal treatment-practice guidelines for physicians, which, if followed, would be a defense against medical malpractice.

Hatch says he soon will introduce additional legislation to:

- Expand Medicaid, the federal-state health-care program for the poor, to cover all the poor (not just the 40 percent now covered) and allow those just above the poverty level to purchase Medicaid coverage.
- Give self-employed people and unincorporated firms the same 100-percent tax deduction for health-care premiums now given to incorporated businesses.

For more information about the Partnership, including details on joining, contact Rick Berman, Chairman, Partnership on Health and Employment, P.O. Box 27414, Washington, D.C. 20038. The telephone number is (202) 463-5327.

family deductibles twice to three times the individual rate.

Once deductibles are adjusted upward, employers can avoid the problem of periodically ratcheting deductibles even higher. They can index the figure to adjust automatically with, for example, annual medical-cost inflation, says Nussbaum of Coopers & Lybrand. This prevents the reverse effect—shifting costs to the employer.

While cost sharing will slow demand for health services, it is unwise to focus solutions on only that area, says Larry S. Chapman, president of Corporate Health Designs, a consulting business based in Seattle. He stresses the need to manage the use of health services.

In fact, "managed care" has become the fastest-growing trend in the health-care industry. Seventy-two percent of Americans who obtain health insurance through an employer now are enrolled in a managed-care plan, compared with less than 20 percent in 1984, says Gabel of the HIAA. For the purposes of its survey, the organization defines managed care as an HMO, a PPO, or a conventional fee-for-service plan with preadmission certification for hospitalization. The term "managed care," however, usually encompasses any mandatory review of health-care services.

While the industry is rapidly converting to managed care, Gabel advises insurers and employers not to overestimate the possible savings. "If it's done right, [managed care] certainly will be better than the way business was done in the past," says Gabel. "But it isn't done right in many cases."

Gabel recalls that the insurance industry was overly optimistic about previous managed-care initiatives. To curb unnecessary hospital admissions, many insurers in the mid-1980s began to require second opinions for many types of surgery and to offer incentives for use of less expensive outpatient clinics. Typically, outpatient treatment required no preauthorization and no coinsurance payments.

Second opinions, however, may cost more than they save. Recent surveys indicate that 92 percent of all second opinions uphold the first. In many cases, outpatient care now rivals the cost of hospitalization as doctors and hospitals shift costs to make up for the loss of inpatient revenue. Most consultants now recommend preauthorization for outpatient treatment and the same coinsurance required for hospital care.

HMOs, once heralded as a revolution in health-care delivery, also have failed to deliver promised cost savings. Only one-third of the employers surveyed by Foster Higgins in 1988 said their HMOs were effective in controlling costs. While some firms have saved 30 percent or more with PPOs, the discounts offered by the medical group providing care typically are offset by more frequent office visits, says Jack Mahoney, vice president of Alexander Consulting Group Inc., in Lyndhurst, N.J.

Despite these drawbacks, many consultants still view well-run HMOs and PPOs as attractive alternatives to conventional insurance plans for small firms.

Without joining an HMO or PPO, one effective way for small employers to obtain lower rates is to join a purchasing group known as a multiple employer trust (MET). Most METs are run by associations on behalf of their members. By pooling the needs of many small companies, the MET can secure lower rates not available to individual companies. To date, however, very few have been aggressive about health-care cost containment, says Chapman.

There are some notable exceptions, however. Fred Rohm, president of the New Castle County Chamber of Commerce, in Newark, Del., directs a MET that supplies health insurance for about 1,000 small businesses, covering 3,000 people. The MET offers one conventional plan and two HMOs. Rates usually are comparable to those offered to much larger employers, thus saving costs for those enrolled.

John Polk, executive director of the Council of Smaller Enterprises of the Greater Cleveland Growth Association, runs the country's largest association health plan for small employers. Though technically not a MET—a term that implies certain legal requirements—the council negotiates the terms of group health-insurance plans on behalf of 6,200 of its members, covering 44,000 employees and 76,000 dependents. Two-thirds of those companies employ five or fewer workers.

"The cost of our health insurance has increased a total of 21.5 percent in five years," says Polk. The average individual premium is about $180 a month, or $2,160 a year. "That's pretty good for a town where health-care costs are about twice the national average."

Generally, insured METs—those backed by an insurance company—have a better track record than self-insured METs—those not backed by an insurer. Under state insurance regulations, insured METS "can't collapse and leave employers holding the bag," says George Pantos, a Washington labor lawyer with the firm of Vedder, Price, Kaufman, Kammholz and Day.

Many small employers who face the group health-insurance market on their own end up changing insurers every two or three years in search of lower rates. In an industry with roughly 1,500 commercial insurers, shopping for a better buy is standard practice. With many buyers and sellers churning the market, however, insurers typically will offer an attractive rate initially, then seek higher premiums at renewal time, Chapman says. "The way to smoke out the lowball deals is to negotiate a two- or three-year contract."

The most effective way to contain health costs is to prevent illness and disease. The U.S. Centers for Disease Control estimates that 53 percent of the premature deaths in the country are attributable to lifestyle circumstances such as smoking, drug and alcohol abuse, diets high in fat and low in fiber, sedentary living, and failure to use automobile seat belts.

A growing number of employers, though few small ones, have implemented wellness programs to encourage employees to alter behavior that could harm their health. Typically, these programs monitor cholesterol and blood pressure, encourage smokers to quit, and promote fitness, stress management, and weight control. Some programs offer cash incentives for staying healthy and not using the medical plan.

"More and more insurance companies seem to be interested in giving a discount to employers who participate in wellness programs,'" says Jan Peter Ozga, president of Ozga Operations, a Falls Church, Va., health-consulting firm.

While it is clear that the system of health-care delivery in the U.S. must change, it's too early to tell what form that change will take. Private-sector solutions to spiraling costs are available, but as yet they have not been implemented aggressively.

Small companies must make hard choices. It's time to rethink the goals of company-sponsored health insurance; it's time to design plans according to new realities of the marketplace.

Experts maintain that cost-sharing, tighter management of care and delivery, and effective wellness programs are the ways to go. But insurers and businesses appear to be running out of time to make these strategies work. Warns Ozga: "This may be the private sector's last shot before we get a national system of health insurance." NB

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Medicare Payment to Hospitals and Physicians IP 317M

In 1983 Congress approved a prospective payment system (PPS) of reimbursing hospitals for inpatient services covered by the Medicare program. Under PPS, Medicare pays hospitals a predetermined rate according to the classification of a patient's diagnosis into one of approximately 470 Diagnosis Related Groups (DRGs).

Since 1984 Congress has also focused on legislation aimed at reducing the cost to Medicare of reimbursing physicians for services provided under the program. The enclosed material explains the origin and operation of PPS and physician reimbursement under Medicare as well as proposed legislative changes in both systems.

Members of Congress who want further information on this topic may contact CRS at 707-5700. Additional CRS Reports may be identified by looking in the current *Guide to CRS Products* (for congressional use only) under "Medicare" and in the latest *Update* under "Health."

Additional information can be located at a local library through use of indexes such as the *Readers' Guide to Periodical Literature*, Public Affairs Information Service *Bulletin* (PAIS), and various newspaper indexes. Individuals with questions relating to specific situations under PPS and physician reimbursement may address them to:

Health Care Financing Administration
Office of Legislation and Policy
U.S. Department of Health and Human Services
Humphrey Building, Room 341-H
200 Independence Avenue, SW.
Washington, DC 20201

We hope this information will be helpful.

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Health Care Costs
IP 223H

National health expenditures have increased for decades. By 1988, the last year for which Government figures are available, total health spending in the United States had reached $539.9 billion, or 11.1% of the Gross National Product. The price of medical care as measured by the Consumer Price Index has also increased rapidly. These factors have focused increasing congressional attention on costs in the health sector, particularly on hospital costs.

This Info Pack includes background information on health care expenditures and information on methods of controlling the costs of hospital care, physicians' fees, and technological advances.

Members of Congress who want further information on this topic may contact CRS at 7-5700. Additional CRS Reports may be identified by looking in the current *Guide to CRS Products* (for congressional use only) under "Medical Economics" and in the latest *Update* under "Health."

Additional information, primarily in periodicals and newspapers, may be found at a local library through the use of such indexes as the *Readers' Guide to Periodical Literature*, Public Affairs Information Service *Bulletin* (PAIS), and various newspaper indexes.

We hope this information will be helpful.

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New York Times, December 7, 1989, pp. D1, D5

Volleyball on Health Care Costs

U.S. and Employers Battle Over Billions

By MILT FREUDENHEIM

The Government and private industry are scrambling to make each other pay billions of dollars in medical bills for the elderly and the working poor.

The Government is intensifying efforts to force private health plans to pay bills for elderly workers covered by such plans. Until the early 1980's, the Federal Medicare program had the primary responsibility for the people it covers, those age 65 and older.

Also, both Medicare and the Medicaid plan for low-income people no longer fully cover medical costs incurred by patients under the two programs; thus, doctors and hospitals are raising rates for private payers.

Cutbacks by Employers

At the same time, some employers are cutting back health benefits for retirees and older workers eligible for Medicare, leaving the cost to the Government. And smaller employers are deciding not to offer health insurance, leaving their workers to fend for themselves. Uninsured people often end up owing money to tax-supported hospitals or are too sick to work and thus eligible for public aid programs.

"The tension is growing," said Walter B. Maher, director of Federal health policy relations with the Chrysler Corporation. "It is a symptom of the absence of any type of national health policy. We have all these thousands of bill payers trying to dodge a bullet, trying to shift costs and pay less."

The efforts to shift the bill to other parties have spurred complaints and accusations, as well as a debate about what should be done. Proposed solutions include suggestions to increase competition in the health-care marketplace; mandates that would tax businesses that do not provide benefits, and a Government-controlled national health system like Canada's.

There are no current statistics to show how much of the nation's health-care costs have been shifted by the Government to private insurers. But most private experts believe that the Government has had most of its success in the last two years. The latest Government figures, which are for 1987, show that private insurers and patients themselves paid about 59 percent of the nation's health-care bill in that year, about the same as they had for the previous decade. Public programs, including Medicare and Medicaid, paid the remaining 41 percent.

The cost shifting by the Government takes a number of forms. Medicare officials say the Government saved $1.3 billion this year by shifting to private employers doctor and hospital bills for elderly workers and their spouses. This move was accomplished by requiring employer health plans to fulfill their benefit obligations before Medicare kicks in.

Moving to increase the savings, Congress voted Nov. 22 to authorize computerized checking of Internal Revenue and Social Security records to identify workers over 65 who are covered by employer health benefits. The new search is expected to shift $780 million to $900 million more in expenses to private payers, according to estimates by the Congressional Budget Office and the Administration. The nation's total health-care bill is expected to exceed $600 billion this year, up about 11 percent from 1988.

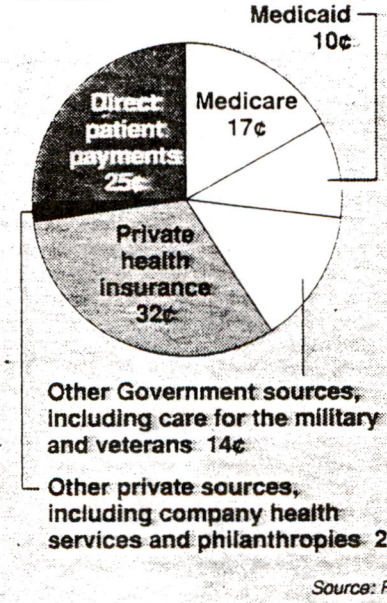
On another front, ceilings on what Medicare and Medicaid will pay for a procedure have prompted hospitals and doctors to raise charges for pa-

Continued on Page D5

Who Pays Medical Bills?

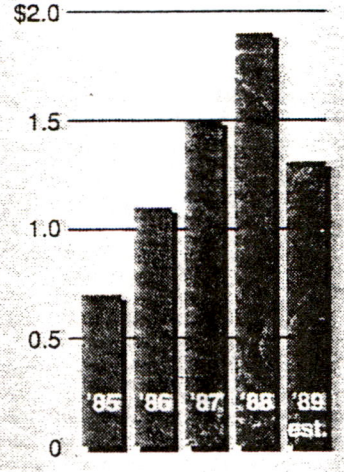
While the Government pays for 41 percent of American health care . . .

What sources contributed to each dollar spent for U.S. health care in 1987.



. . . Some costs have been shifted to employers and private insurers.

What Medicare saved by shifting to employers the bulk of the cost of medical care for workers age 65 and over and their spouses, in billions.



Source: Federal Health Care Financing Administration

The New York Times / Dec. 7, 1989

Continued From First Business Page

tients covered by private insurance, says the American Hospital Association, which represents hospitals.

But not everyone agrees that hospitals are doing this. Guy King, chief actuary of the Federal Health Care Financing Administration, said hospitals were generally absorbing such costs by reducing payroll expenses and limiting charity care.

Increasingly tight eligibility requirements for Medicaid have left more low-income people without coverage and unable to pay.

The American Hospital Association said unpaid hospital bills amounted to $8.3 billion last year. "Business can find itself paying as much as a 20 percent surcharge to cover the needed cost shift," said Carol McCarthy, the hospital group's president.

Meeting Higher Costs

One-third of the increase in health insurance costs charged to employers this year resulted from cost-shifting, mainly from Government programs, said Dr. Dan Dragalin, vice president for medical services with the Prudential Life Insurance Company.

Many employers expect cost shifting to them to increase under newly approved changes in the way Medicare reimburses physicians. Congress has just approved a system that will pay more for doctors' consultations with Medicare patients and less for surgery and expensive technology. The employers worry that specialists like surgeons and radiologists will compensate for their loss of Medicare income by raising charges for private patients. "Those costs will be shifted to the private sector, too," said Thomas R. Burke, a former Reagan Administration health policy official who is a principal with A. Foster Higgins & Company, a benefits consulting firm.

And on the state level, legislatures in several states are considering programs like those in Hawaii and Massachusetts, which require employers to provide health benefits for employees.

Subsidy Programs

Also, Medicaid programs for low-income patients have begun to adopt policies that experts say transfer some costs to other payers. At least a dozen states are experimenting with subsidy programs that encourage small employers and low-income employees to pay at least part of the cost of private health insurance.

The programs are supposed to save money for the state in the long run. If the employees or their families become ill, the state-subsidized insurance would help them to get care without exhausting their savings and becoming nonpaying patients in tax-supported hospitals or giving up their jobs in order to become eligible for Medicaid.

In a similar experiment, Michigan recently started paying insurance premiums to maintain the private health coverage of Detroit-area AIDS patients, who were running out of money and would have become eligible for the state's Medicaid program. Michigan hopes the program will allow a net saving of $4 million a year in potential Medicaid expenditures by 1991.

State Programs

State Representative David C. Hollister, Democrat of Lansing, who sponsored the Michigan law, said that similar legislation was under consideration in Wisconsin and Colorado and that 21 other states had inquired about the program.

John Luehrs, director of health programs with the National Governors Association, noted that most states spend 15 percent of general revenues on Medicaid, up from 8 percent five years ago.

For their part, employers have been working to hold down expenditures by deflecting costs. A few large companies, including Ralston Purina, Boise Cascade and the Whitman Corporation, have eliminated company-paid health benefits for future retirees, replacing them with employee stock and savings programs. As a result, when these people reach age 65, they will be more likely to rely on Government programs to pay their medical bills — Medicare and, in cases when they have drained their savings, Medicaid.

Plight of Small Employers

Many small employers have dropped or cut back their coverage in recent years as insurers raised their rates or rejected applicants they thought had a high risk of becoming ill.

Because many large employers and insurers are leaning on hospitals to provide discounts for their groups, businesses that are too small to negotiate such favored treatment have been hit with increases of 30 percent or more in their health insurance premiums.

At least 15 million working people, many employed by small businesses, have no medical insurance. The Government has picked up the health-care costs of some by expanding Medicaid to cover more low-income mothers and their children.

"As the insurance industry has gotten more competitive, insurers have been less willing to take anybody who is going to be unprofitable," said Dr. Karen Davis, a health policy economist at the Johns Hopkins University School of Public Health. "I am worried about who falls through the cracks between public and private programs."

Blaming Each Other

Such concerns have given rise to accusations and counteraccusations about which side is not living up to its responsibilities.

"It's interesting that those who profess to provide insurance are avoiding it," said Bob Hungate, who watches health policy in Washington for the Hewlett-Packard Company. Medicaid and some insurers are avoiding risks by shifting costs to other payers, he continued, adding, "We don't think it's going to work in the long run for us to pay four times as much as Medicaid and for small employers to pay probably 50 percent more than we do."

For their part, insurers say the Government programs are ducking responsibilities that they used to bear. "A whole new theory of public finance has grown out of fiscal limitations in the public budget," said Carl Schramm, president of the Health Insurance Association of America, an insurers' trade group.

He said AIDS was the first epidemic in which primary care was not provided by the states. "Even in the 1950's, municipalities were opening publicly owned or sponsored hospitals for tuberculosis," Mr. Schramm said.

The more than 30 million Americans without health insurance represent a similar evasion of responsibility, he said. "Congress is inclined to lay blame on the private sector and attempt to shift costs into the private sector," he said. "But the large number of people without insurance represent a broken promise on the part of the Government. In the late 1970's, Medicaid was available to 76 percent of the people whose incomes were under the Federal poverty level, but now only 38 percent of those under the poverty level are eligible."

Dr. Davis at Johns Hopkins said both the Government and private insurers should be required to pull their weight.

"We're going to have to do patchwork for some time," she said. "The Federal Government should take the lead, but it is not realistic to abolish private coverage and rely exclusively on universal public coverage. For a long time, we will have some people covered by public programs and some by private insurance."

John J. Sweeney, president of the Service Workers Employees International Union, added, "The major forces in business, government and unions and consumers are all coming to the point where they agree that health care is a national problem that has to be addressed — not just cost containment but access to care and the quality of care."

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CRS Issue Brief

Medicare: Prospective Payments for Inpatient Hospital Services

Updated June 21, 1990

by
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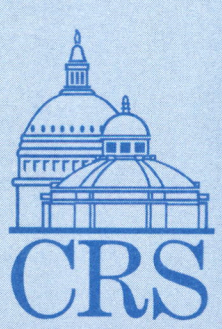
Education and Public Welfare Division



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Medicare: Prospective Payments for Inpatient Hospital Services

SUMMARY

The Social Security Amendments of 1983 (P.L. 98-21) established a prospective payment system (PPS) for making payments to hospitals for inpatient services provided to Medicare beneficiaries. Hospitals included in this system are paid a predetermined fixed payment rate, which varies depending on which of the approximately 470 Diagnosis Related Groups (DRGs) the patient has been classified into, based on diagnosis.

The DRG payment is intended to cover the cost of treating the typical case in that DRG in a reasonably efficient hospital. The payment rates are adjusted to allow for differences among hospitals in the types of patients treated and services provided, through such mechanisms as an adjustment for teaching hospitals. The payment rates are also adjusted to account for differences in local hospital market conditions, through an area wage adjustment and different payment rates for urban and rural hospitals.

PPS hospitals are also eligible for additional payments intended to cover certain additional costs of maintaining a hospital (e.g., capital-related costs such as interest expense, depreciation, etc.), operating special programs (e.g., medical education programs) or operating in special circumstances (e.g., serving low-income patients).

Since hospitals are allowed to keep any difference between the PPS payment and their actual costs, PPS provides incentives for hospitals to contain costs, thus potentially reducing costs to the Medicare program. However, the PPS payment approach has raised such issues as whether the payment levels are set too low or too high, thus underpaying hospitals or increasing costs to the Medicare program. Of particular concern has been the impact of PPS on rural hospitals, many of which report financial losses from treating Medicare patients. Some analysts have also questioned whether a system based on a fixed payment regardless of the services provided encourages a reduction in services, possibly reducing the quality of care provided to Medicare beneficiaries.

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89), includes several provisions affecting PPS. The Act increases reimbursement to rural hospitals and those serving a disproportionate share of low-income patients. Costs for these increases are offset by an across-the-board reduction in PPS payment rates and a 15% reduction in payments for capital costs.

The President's FY1991 budget proposal includes reductions of $3.4 billion in reimbursement for inpatient hospital services paid under PPS. The largest Part A savings would result from two proposals: reducing payment for capital-related costs (15% reduction for rural hospitals, 25% reduction for urban hospitals), and reducing the indirect medical education adjustment from the current level of 7.7% to 4.05%.

ISSUE DEFINITION

A new method of Medicare reimbursement for hospital inpatient services, known as the prospective payment system (PPS), was established by Congress under Title VI of the Social Security Amendments of 1983 (P.L. 98-21). This payment system became effective for hospital cost reporting periods that began on or after Oct. 1, 1983. Under PPS, fixed hospital payment amounts are established in advance of the provision of services. As a result, it is believed that this method provides incentives for hospitals to contain their costs, thus potentially reducing costs to the Medicare program. However, many have expressed concern about the system's impact on hospitals, on the elderly, and on the practice of medicine.

BACKGROUND AND ANALYSIS

Major Features of the Prospective Payment System

PPS Payments

Medicare payment for hospital inpatient services is currently made according to PPS, rather than the former retrospective cost-based system. Medicare-eligible hospital inpatients are classified into one of approximately 470 diagnosis related groups (DRGs) based on the patient's diagnosis. Hospitals are paid a predetermined rate based on the patient's DRG classification; the rate is designed to represent the national average cost per case for treating a patient with that diagnosis. Separate PPS rates apply depending on whether a hospital is located in a large urban area (over 1 million people, or 970,000 in New England), other urban area, or rural area, as determined by the Metropolitan Statistical Area (MSA) system maintained by the Office of Management and Budget. The rates are adjusted for area differences in hospital wage levels. An area wage index is calculated for each MSA; a single wage index is established for all the rural areas in each State.

The national (urban and rural) PPS payment rates were phased in over a 4-year transition period. During the transition period, a hospital's payment rate was composed of a blend of a hospital-specific amount and the Federal DRG payment amount. In addition, the Federal DRG amount was based on a combination of national and regional payment amounts (the standardized payment amounts) for each of the nine census regions of the country. The transition was completed during FY1988. Payments are now based on the Federal DRG amount, with no hospital-specific component. In most areas, the Federal amount is a fully national rate. In a few regions with historically higher costs, the Federal amounts will be based in part on regional rates until Sept. 30, 1990. This final transition provision is known as the regional floor.

To determine the total payment to a hospital for a particular DRG, the applicable Federal payment amount is multiplied by the relative weight for that particular DRG. Each of the approximately 470 DRGs has been assigned its own

weight, which reflects the relative costliness of treating a patient in that DRG compared to the average Medicare patient.

The Act creating PPS required the appointment of a commission of independent experts, known as the Prospective Payment Assessment Commission (ProPAC), to provide analysis of and advise HHS and Congress on PPS. The Commission is required, by March 1 of each year, to report to the HHS Secretary its recommendations for the appropriate change in Medicare hospital payments for the following fiscal year. In addition, the Commission must recommend to the Secretary any needed adjustments in the DRG classifications and weighting factors and report to Congress its evaluation of any adjustments that the Secretary makes.

Updating PPS Rates

The PPS payment rates are updated each year by the use of an "update factor." Before FY1988, the same factor was used for all hospitals. For FY1988, FY1989, and FY1990, separate factors have applied to hospitals according to location. Hospitals in rural areas and in large urban areas (MSAs with more than 1 million people, or 970,000 in New England) received larger increases than hospitals in smaller urban areas. Current law would end this distinction after FY1990.

Originally, the update factors were supposed to be established by the Secretary of HHS, taking into account the recommendations of ProPAC. The Secretary was to consider the likely increase in the "market basket index," which measures the cost of goods and services purchased by hospitals, but could also make upward or downward adjustments to reflect other factors, such as improved efficiency or adoption of new medical technologies. However, the 99th, 100th and 101st Congresses repeatedly postponed the Secretary's authority to set the update factor and instead set the factors for FY1986 through FY1990 directly in legislation. For FY1991 and all subsequent years, current law provides that the update factor is to be set equal to the market basket index, with no adjustments.

Issues in the development of the update factor for FY1991 are discussed further below.

Additional Payment Amounts

Additional Medicare payments are made to PPS hospitals for the following:

Outliers. Additional amounts are paid for atypical cases (known as "outliers") which have either extremely long lengths of stay or extraordinarily high costs compared to most patients classified in the same DRG. The law requires that total outlier payments to all hospitals represent no less than 5% and no more than 6% of the total estimated PPS payments for the fiscal year. Outlier payments are financed by an offsetting reduction in the Federal portion of the DRG rates, with separate set-aside factors for urban and rural hospitals. For FY1990, the Secretary of HHS has set the outlier pools equal to 5.1% of total payments.

Before FY1989, about 85% of outlier payments were made for "day outliers," cases with very long hospital stays. The remaining 15% were for "cost outliers," cases with very high costs. In the Sept. 30, 1988, final rule, the Secretary changed the

outlier formula to give greater emphasis to cost outlier cases. Beginning with discharges on or after Oct. 1, 1988, cost outliers are expected to account for 60% of all outlier payments. This shift in policy affects the distribution of outlier payments among hospitals, rather than the aggregate total of those payments. Hospitals in New York, Massachusetts, and some other areas are expected to receive reduced payments; others will receive higher payments. Some of the affected hospitals argue that their patients have very long stays because they are more severely ill or are poor and may remain in the hospital because of problems arranging for nursing home or home health care. Those in favor of the change argue that cases with very long stays may or may not be especially costly, depending on the services they receive, and that it is fairer to target the outlier payments to the highest cost cases. H.R. 1026 would limit any further shifts in emphasis from day to cost outliers.

Indirect Medical Education Costs. Additional payments are made to compensate for the indirect costs associated with the presence of approved graduate medical education programs (residency training). Indirect costs may be due to factors such as extra demands placed on the hospital staff by the teaching activity, or additional tests and procedures that may be ordered by residents. Congressional reports indicate that these payments are also intended to account for factors not directly related to medical education which may increase operating costs in teaching hospitals, such as more severely ill patients or higher staff-to-patient ratios.

P.L. 99-272 (COBRA) provided for additional payments to teaching hospitals based on a formula that increases the Federal portion of the DRG payment approximately 8.1% from May 1, 1986, to Oct. 1, 1989. (Congress lowered the indirect payment during the time that disproportionate share payments, see below, are made, to preclude teaching hospitals from receiving both payments.) The payment increases with a hospital's ratio of interns and residents to bed size on a curvilinear or variable basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to bed size). OBRA 87 reduced the adjustment to approximately 7.7%, effective for hospital discharges occurring on or after Oct. 1, 1988, and before Oct. 1, 1995. After Oct. 1, 1995, when the disproportionate share payment is scheduled to expire, the increase would be approximately 8.3%.

The President's FY1991 budget proposes to reduce the adjustment factor from 7.7% to 4.05% calculated on the same curvilinear basis. The Administration estimates savings from the adoption of this proposal would be $1.03 billion. HHS argues that this amount more accurately reflects the estimated effect of teaching programs on a hospital's costs. The General Accounting Office, noting that teaching hospitals have experienced higher than average profits under the PPS, has made a similar proposal. ProPAC has suggested that the cut might be made over a 3-year period. The Senate passed in its FY1990 reconciliation proposal a reduction in the indirect medical education adjustment to an average of 7.1% for each 0.1% increase in the hospital's ratio of interns and residents. The House FY1990 reconciliation package did not include a provision on the indirect medical education adjustment. The Senate proposal was not included in OBRA 89.

Disproportionate Share Hospitals. P.L. 99-272 (COBRA) required additional payments from May 1, 1986, to Oct. 1, 1989, to hospitals that serve a disproportionate share of low-income patients. P.L. 100-647, the Technical and

Miscellaneous Revenue Act of 1988 continues such payments through Sept. 30, 1995. A hospital's percentage of low-income patients is defined as the hospital's total number of inpatient days attributable to Federal Supplemental Security Income Medicare beneficiaries divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by the total patient days.

For urban PPS hospitals with 100 or more beds and rural hospitals with 500 or more beds having a percentage of low-income patients of at least 15%, the Federal portion of the hospital's PPS payment is increased by 2.5% plus one-half (a multiplier of .5) the difference between 15% and the hospital's percentage of low-income patients. For urban hospitals with less than 100 beds having a percentage of low-income patients of at least 40%, the payment increase is 5%. For rural hospitals having a low-income patient percentage of at least 45%, the payment increase is 4%. For urban hospitals with 100 or more beds which demonstrate that more than 30% of their revenues are derived from State and local government payments for indigent care (excluding payments from Medicare and Medicaid), the payment increase is 25%.

OBRA 89 increases the Federal portion of the disproportionate share hospital's PPS payment adjustment for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, by 2.5% plus 60% (a multiplier of 0.6) of the difference between 15% and the hospital's disproportionate patient percentage. Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds that have a disproportionate patient percentage of over 20.2% receive a further increase in the adjustment. For these hospitals with a disproportionate share percentage of low-income patients over 20.2%, the payment adjustment is increased by 5.62 plus 65% (a multiplier of 0.65) of the difference between 20.2% and the hospital's percentage of low-income patients. Rural hospitals classified as rural referral centers receive an adjustment of 4% plus 60% of the difference between 30% and the hospital's percentage of low-income patients. Rural hospitals classified as a SCH receive a 10% adjustment. Rural hospitals classified as rural referral centers and as sole community hospitals (SCHs), receive the greater of a 10% disproportionate share adjustment or an adjustment of 4% plus 60% of the difference between 30% and the hospital's disproportionate patient percentage. The disproportionate patient percentage required to qualify for a payment adjustment for a rural hospital with more than 100 beds or a rural hospital classified as an SCH is 30%. Hospitals receiving an adjustment based on revenue for indigent care received from State and local government would receive a 30% disproportionate share adjustment in FY1990, increased from 25% in FY1989.

Direct Medical Education Costs. The direct costs of approved medical education programs (salaries of residents and teachers and other costs for training residents, nurses, and allied health professionals) are excluded from PPS. The direct costs of training nurses and allied health professionals are paid on a reasonable cost basis. P.L. 99-272 (COBRA) replaced reasonable cost reimbursement for graduate medical education (residency training programs for physicians) with formula payments based on each hospital's per resident costs.

The Medicare payment to each hospital is equal to the hospital's cost per full-time equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. Each hospital's per FTE resident amount will be calculated using data

from a base year, increased by 1% for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. The number of FTE residents will be calculated at 100% after July 1, 1986, only for residents in their initial residency period (i.e., within the minimum number of years of formal training necessary to satisfy specialty requirements for board eligibility plus 1 year, but not to exceed 5 years). For residents not in their initial residency period, the weighting factor will be 75% before July 1, 1987, and 50% after that date. On or after July 1, 1986, residents who are foreign medical graduates will not be counted as FTE residents unless they have passed certain designated examinations.

HHS issued final regulations implementing the COBRA payment changes for graduate medical education costs on Sept. 29, 1989. The changes are effective retroactively to 1985. Retroactive adjustments for interim direct medical education payments made between July 1, 1985, and the date of the final rule are estimated to save Medicare $440 million.

The Administration's FY1991 budget proposes revising payments for the direct costs of graduate medical education by basing the payment on a per resident payment derived from the national average of FY1987 salaries paid to residents, updated by the CPI. The proposal would also include a system of different weights applied to primary care residents, nonprimary care residents, and nonprimary care residents not in their initial residency period. Payments for primary care residents would be weighted at 180% of the per resident amount, those for nonprimary care residents would be weighted at 140% of the per resident amount, and those for nonprimary care residents not in their initial residency period would be weighted at 100%. The Administration estimates the savings from the enactment of this proposal to be $170 million.

Bad Debts of Medicare Beneficiaries. An additional payment is made to hospitals for bad debts attributable to deductible and coinsurance amounts not paid by Medicare beneficiaries. OBRA 87 prohibited the HHS Secretary from making any change in the policy in effect on Aug. 1, 1987, concerning payments for bad debts. P.L. 100-647 clarified that the prohibition applies to any changes in requirements that hospitals document a reasonable effort to collect amounts due before claiming bad debt.

ESRD Beneficiary Discharges. Additional payments are made to certain hospitals for inpatient dialysis services provided to end stage renal disease (ESRD) beneficiaries admitted for unrelated illnesses.

Payments on a Reasonable Cost Basis. Costs for certain items are excluded from PPS and thus are not included in the PPS rates. Medicare pays for its share of the following costs on the basis of the actual reasonable costs:

-- **Capital-related costs.** Capital-related costs (including depreciation, leases and rentals, interest, and a separate return on equity payment for proprietary hospitals) are excluded from PPS and are paid for on a reasonable cost basis (i.e., the hospital's actual capital costs multiplied by Medicare's share of total hospital inpatient services). The Secretary was originally authorized to develop a method for including capital costs in PPS, but Congress repeatedly postponed this authority. Most recently, P.L. 100-203 (OBRA 87) required the Secretary to provide payment for

capital-related costs in accordance with a prospective payment system, effective for hospital cost reporting periods beginning on or after Oct. 1, 1991, and repealed the Secretary's authority to establish prospective payments for capital before that date.

In the interim, Medicare has been paying a reduced share of capital costs. OBRA 87 reduced reasonable cost payments for capital-related costs by 12% for FY1988, effective for discharges or portions of cost reporting periods occurring on or after Jan. 1, 1988, and 15% for FY1989.

OBRA 89 extends the 15% capital-related reduction for portions of cost reporting periods or discharges occurring beginning on Jan. 1, 1990 and continuing through the remainder of FY1990. For the period between Oct. 1, 1989 and Dec. 31, 1989, hospitals will receive 100% of capital costs, subject to the Gramm-Rudman-Hollings budget sequester reduction of 2.1% of total Medicare payments. SCHs remain exempt from capital-related payment reductions.

H.R. 712 would tie Medicare capital payments to a State health planning system. Except in States with high hospital occupancy rates, Medicare reimbursement for major new capital expenditures would be available only if the expenditures were approved by a State review agency. Total capital payments in a State, relative to Medicare payments for operating costs, could not exceed a national capital/operating cost ratio. H.R. 1812 would determine capital payments based on a hospital's annual occupancy rate during a cost reporting period and vary occupancy rate requirements based on the location and size of the hospital.

The President's FY1991 proposal would extend the current 15% reduction in capital payments to rural hospitals and increase the capital payment reduction to 25% for urban hospitals. The Administration contends that continued reductions are necessary to provide hospitals with an incentive to control their expenditures for new equipment or the expansion of facilities. The capital payment reduction of 15% for rural hospitals is estimated to save $170 million, and the 25% reduction for urban hospitals is estimated to save the program $1.36 billion in FY1991.

-- **Kidney acquisition costs.** The estimated net expenses associated with kidney acquisition in certified renal transplantation centers are excluded from PPS and paid for on a reasonable cost basis.

Special Treatment of Certain Facilities

Certain facilities receive special treatment under PPS as follows:

Sole Community Hospitals. Sole community hospitals (SCHs) are hospitals that (because of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals) are the sole source of inpatient services reasonably available in a geographic area. For cost reporting periods beginning before Apr. 1, 1990, SCHs are paid on the same basis as all other hospitals are paid in the first year of the transition period: 25% of the payment is based on Federal regional DRG rates and 75% on each hospital's cost base.

Under the provisions of OBRA 89, the criteria for SCH designation are liberalized by allowing hospitals to be designated as such if they are located more than 35 road miles from another hospital. In addition, OBRA 89 provides that the Secretary can designate a hospital as an SCH if, by reason of factors such as travel time to the nearest alternative source of appropriate inpatient care, location, weather conditions, travel conditions, or absence of other like hospitals, the Secretary determines that it is the sole source of inpatient hospital services reasonably available to individuals in a geographic area.

In addition, OBRA 89 establishes new payment provisions that are applied to all SCHs for cost reporting periods beginning after Apr. 1, 1990. An SCH may receive the higher of the following rates as the basis of reimbursement: a target amount based on 100% hospital-specific prospective rates based on FY1982 costs updated to the present; a target amount based on hospital-specific prospective rates based on FY1987 costs updated to the present; or the Federal PPS rate. An SCH may request additional payments if it experiences a decrease of more than 5% in its total inpatient discharges due to circumstances beyond its control. A hospital may receive such payments if it meets sole community hospital criteria but is not being paid as a sole community hospital. Current SCHs not meeting the new proposed criterion are allowed to continue to qualify for payments as provided under current law.

Referral Centers. Special payment provisions apply to referral centers defined as follows:

-- rural hospitals having 275 or more beds;

-- hospitals having at least 50% of their Medicare patients referred from other hospitals or from physicians not on the hospital's staff, at least 60% of their Medicare patients residing more than 25 miles from the hospital, and at least 60% of the services furnished to Medicare beneficiaries are furnished to those who live more than 25 miles from the hospital; or

-- rural hospitals meeting the following criteria:

(a) a case mix index at least equal to the national median case mix index for all urban hospitals, or the median case mix for urban hospitals located in the same region, excluding hospitals with approved teaching programs (case mix index is a measure of the relative costliness of the patients, or cases, treated by a hospital compared to the national average cost for all Medicare cases);

(b) inpatient discharges equal to the lesser of either 5,000 (3,000 in the case of osteopathic hospitals), or the median number of discharges for urban hospitals located in the same region; and

(c) at least one of the following three criteria: more than 50% of the hospital's medical staff are specialists, at least 60% of inpatient discharges reside more than 25 miles from the hospital, or at least 40% of inpatients have been referred either from physicians not on the hospital's staff or from other hospitals.

Hospitals meeting these criteria are paid according to the payment rates for "other" urban areas, rather than the rural rates, adjusted by the hospital's area wage index, for a 3-year period. P.L. 99-509 (OBRA 86) provided that hospitals classified

as referral centers on the date of enactment (Oct. 21, 1986) would retain that status through cost reporting periods beginning before Oct. 1, 1989.

OBRA 89 extends the status of current referral centers for 3 additional years, including all hospitals classified as referral centers as of Sept. 30, 1989.

Hospitals Excluded from the Prospective Payment System

Medicare payments to certain hospitals or parts of hospitals are made through systems other than PPS.

Hospitals in States With Cost Control Systems. Some States have established their own prospective systems for setting hospital rates. A State may apply for a waiver to permit Medicare to participate in such a system, paying the State-defined rates instead of those that would be paid under PPS. Of the 4 States originally excluded from PPS under this provision, only Maryland still has a waiver.

Hospitals Paid on a Reasonable Cost Basis. The following hospitals or parts of hospitals are excluded from PPS and are paid on the basis of reasonable costs, subject to certain rate of increase limits:

- -- psychiatric, rehabilitation, children's, and long-term hospitals;
- -- psychiatric and rehabilitation units which are distinct parts of hospitals;
- -- hospitals outside the 50 States and the District of Columbia. Hospitals in Puerto Rico are included in a specially modified version of the PPS.

Cancer hospitals extensively involved in treatment for and research on cancer (according to criteria established in regulations) may elect to be paid on a reasonable cost basis. OBRA 89 exempts cancer hospitals classified as such before Dec. 31, 1990, from PPS. In addition, the Act provides an exemption for any hospital classified as a cancer hospital before Dec. 31, 1991, that is located in a State that has a PPS waiver under Section 1814(b) (i.e., Maryland).

PPS Issues for the 101st Congress

Payment Increases

The 99th, 100th, and 101st Congresses repeatedly postponed the Secretary's authority to set the update factor, the annual rate of increase for basic PPS payments, and instead set the factors for FY1986 through FY1990 directly in legislation.

As **TABLE 1** indicates, these update factors were below the market basket index. At the same time, the average Medicare payment per case rose faster than the update factors. This is because the update factor is not the only element affecting payment increases. For example, there have been changes in policies relating to add-on payments (such as those for medical education, disproportionate share hospitals, and capital costs). More important, there has been a steady change in the

kinds of Medicare cases hospitals have reported treating; each year, more cases fall into the higher-paying DRGs and fewer into the lower-paying ones. The "case mix index" shown on **TABLE 1** is a measure of this trend. Part of the change is real, reflecting hospitals' decisions to admit only more seriously ill patients while treating others on an outpatient basis, while part of the change results from improved accuracy in hospitals' reporting on their patients.

In setting the annual update factors below the rate of inflation, Congress acted in part on reports that most hospitals realized a profit on their Medicare cases in the early years of PPS. Both ProPAC and the HHS Inspector General have estimated that hospitals overall had a PPS operating margin of about 14% in the first 2 years of the new system (the hospital industry regards these figures as overstated). Estimated margins in the third year were somewhat lower, 8% to 9%, and continued decline is believed to have occurred in the fourth and fifth years. Conclusive data are not yet available, because of long delays in hospital cost reporting. However, ProPAC has projected that the overall margin for FY1988 was zero; that is, hospitals' PPS revenues equaled their PPS costs.

Even when hospitals in the aggregate were earning surpluses under PPS, not all hospitals did equally well. Urban and teaching hospitals had the highest margins, small rural hospitals the lowest. In the first year of PPS, 20% of hospitals were estimated to have negative margins; the proportion was higher in rural areas. By the third year, ProPAC estimates that 36% of hospitals were losing money under PPS.

Numerous factors contributed to these trends. Basically, however, hospitals were initially able to respond to the financial incentives of the new system by increasing their efficiency, by shifting some patients to outpatient settings, and by reducing the length of time patients stayed in the hospital. Hospitals' costs for Medicare patients actually dropped in the first year of PPS. For reasons not yet clear, costs began to rise again in subsequent years at rates well in excess of inflation. Some people argue that recent cost increases are due to circumstances beyond the hospitals' control, such as the adoption of costly new medical technologies. Others say that hospitals, buoyed by their early financial success under PPS, stopped working to improve efficiency.

On Oct. 16, 1989, the President issued a final sequester order under the Balanced Budget and Emergency Deficit Control Act of 1985, imposing a 2.1% reduction on total Medicare payments. OBRA 89 extends the sequester reductions for Medicare Part A payments until Dec. 31, 1989. For payments after Dec. 31, 1989, OBRA 89 exempts Medicare Part A services from the continuing Government wide sequester imposed for the remainder of FY1990.

OBRA 89 sets the following hospital update factors for FY1990 for discharges occurring on or after Jan. 1, 1990: for hospitals located in large urban areas, the market basket minus 0.12 percentage points; for hospitals in other urban areas, the market basket minus 0.53 percentage points; and for hospitals in rural areas, the market basket plus 4.22 percentage points. In addition, OBRA includes a DRG weighting factor reduction of 1.22% for discharges in FY1990. This reduction is the same as one proposed by the Secretary in regulations for FY1990. The DRG weighting factor reduction will have the effect of reducing PPS payments as if the

base had been decreased by 1.22%. The net effect of this reduction is to produce the following actual FY1990 update factors: for hospitals in large urban areas, the market basket minus 1.1 percentage points; for hospitals in other urban areas, the market basket minus 1.75 percentage points; and for hospitals in rural areas, the market basket plus 3 percentage points. OBRA 89 prohibits the Secretary from adjusting DRG weighting factors on anything other than a budget neutral basis beginning in FY1991.

For FY1990, HCFA estimates that the market basket will increase by 5.5%. The following are therefore the final update factors for FY1990: 4.4% for large urban hospitals, 3.75% for other urban hospitals, and 8.5% for rural hospitals.

OBRA 89 provides that for FY1991 and later years the update factor for all hospitals, regardless of location, will be equal to the market basket increase. That is, future rate increases are to take account of inflation but not of any other factors potentially affecting costs. If hospitals' costs continue to rise faster than inflation, Congress may face pressure to grant higher increases. On the other hand, deficit reduction concerns may give rise to proposals for further rate reductions. The President's FY1991 budget proposes setting the average update factor at 4.1%, an amount 1.5 percentage points less than the projected MBI increase. The savings from this proposal is estimated to be $640 million.

Rural Hospitals

As noted earlier, rural hospitals have been more likely than urban ones to lose money under PPS. The rate of hospital closures in rural areas has been rising, and many more rural hospitals report that they are financially distressed.

Not all of the rural hospitals' problems stem from the Medicare reimbursement system. Hospitals in rural areas with declining populations may have low occupancy rates; the smaller patient load may be insufficient to cover their fixed costs. These problems may be compounded if there is a shortage of physicians in the area, so that patients are drawn to urban physicians and hence to urban hospitals. Still, the failure of some rural hospitals' PPS revenues to meet their costs for Medicare patients may be especially critical. Because many rural areas have an aging population, rural hospitals may have a high proportion of Medicare patients. They may have been less able than other hospitals to make up any Medicare losses through higher charges to other patients.

Several factors may have contributed to small rural hospitals' losses under PPS. Smaller hospitals may have been less able than larger ones to improve their efficiency in response to the financial incentives created by the new system. Some may also have suffered large losses on a few cases. In paying for a "typical" case in each DRG, PPS assumes that more costly cases in that DRG will be balanced by less costly ones. If a hospital treats a very small number of cases, the law of averages may not work.

More fundamentally, however, rural hospitals argue that some of the basic premises of PPS are wrong, including the urban/rural payment differential and the area wage indexing system used to adjust hospitals' payments for local differences in labor costs. Although the payment differences are based on historical data about

actual urban and rural hospital costs, rural hospitals argue that conditions have changed and that the gap between urban and rural costs may have narrowed.

Congress has repeatedly modified PPS to improve payments to rural hospitals. Many of these changes have been discussed earlier, including revisions in the outlier system and special payment provisions for sole community hospitals and rural referral centers. OBRA 87 and OBRA 89 have granted rural hospitals higher FY1988, FY1989, and FY1990 rate increases than urban hospitals. OBRA 87 also increased payments to certain rural hospitals on the fringes of urban areas and potentially obliged to compete in the urban labor market. H.R. 1110 would base the wage indexes on statistically established labor market areas, instead of using the current MSA/non-MSA boundaries. OBRA 89 requires the Secretary to establish a Geographical Review Board for hospitals to direct appeals for a change in classification from rural to urban, or from one urban area to another urban area.

Legislation in the 101st Congress includes a variety of more sweeping proposals to change the way rural hospitals are paid. One option would be to eliminate the urban-rural differential. This would raise payments to rural hospitals and lower payments to urban ones. H.R. 880 and S. 205 would phase out the differential over a 3-year period. OBRA 89 requires the Secretary of DHHS to develop a proposed phase-out plan; further congressional action would be needed to implement the plan. Other proposals, including H.R. 186, H.R. 762, H.R. 1270, H.R. 1583, S. 10, and S. 306, would permit certain rural hospitals to return to retrospective cost-based reimbursement. OBRA 89 permits small rural hospitals that are classified as Medicare-dependent (with caseloads consisting of 60% or more Medicare beneficiaries) to be paid on the same basis as sole community hospitals (see above).

Some people say that there may be areas in which it is more feasible to maintain access to essential services through some means other than operating a full-service hospital. The prototype for these proposals is Montana's program to develop a class of acute care providers called "medical assistance facilities" (MAFs). An MAF is licensed to provide inpatient care while a patient is awaiting transfer to another hospital, or for stays lasting 4 days or less. OBRA 89 establishes the Essential Access Community Hospital (EACH) demonstration project providing grants in up to 7 States for developing a rural health network. Under the demonstrations a new type of facility, Rural Primary Care Hospitals (RPCHs), would serve as providers of only limited emergency inpatient care and temporary inpatient care for patients requiring stabilization before discharge or transfer to another hospital. RPCHs would be linked in networks with full service hospitals (EACHs). The Administration's FY1991 budget proposal does not include funding for the EACH demonstration.

TABLE 1. Historical Trends in Factors Affecting the PPS Rates and Average Payments per Case
(Percentage change from the previous year)

	FY83	FY84	FY85	FY86	FY87	FY88	FY89
Market basket index	5.9	4.9	4.1	3.1	4.5	4.7	5.4
Update factor	---	5.9 a/	4.4 a/	0.5 b/	1.15	1.6 c/	3.3 c/
Case mix index	---	8.4	2.5	2.7	2.4	1.5	0.5
Average payment per case	10.4	10.4	14.9	7.1	4.1	2.0	1.9

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a/ The update factor for this year was offset by adjustments including the budget neutrality adjustment.

b/ Effective beginning with the eighth month of the fiscal year.

c/ Weighted average of the separate update factors for large urban, other urban, and rural areas, effective Apr. 1, 1988.

Source: U.S. Congress. House. Committee on Ways and Means. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. [WMCP: 100-29] Mar. 24, 1988: 212. Figures for FY1989 are revised to reflect estimates included in the FY1989 final rule as published in the *Federal Register*, Sept. 30, 1988.

Many of the legislative proposals of the 101st Congress affecting rural hospitals are included in OBRA 89. OBRA 89 sets a higher PPS update factor for rural hospitals than for urban hospitals, increases the disproportionate share adjustment, extends for 3 years the classification of referral centers, and liberalizes the criteria for classifying hospitals as SCHs. The Act also increases rural health care transition grants to $25 million for FY1990, and provides that the grants may be awarded for telecommunications projects. The President's FY1991 budget proposal does not include funding for rural health care transition grants.

LEGISLATION

P.L. 101-239 (H.R. 3299, Panetta)

Omnibus Budget Reconciliation Act of 1989. Extends 2.1% payment reduction under Sept. 16, 1989 sequester order through Dec. 31, 1989. Sets hospital PPS update factors for discharges occurring during FY1990 equal to the market basket increase minus .12 percentage points for large urban hospitals, the market basket increase minus .53 percentage points for other urban hospitals, and the market

basket increase plus 4.22 percentage points for rural hospitals. Reduces DRG weighting factors by 1.22%. Reduces capital-related payments for FY1990 by 15%, and increases the PPS payment adjustment for disproportionate share hospitals. Extends the status of currently designated rural referral centers for 3 additional years. Expands the designation of sole community provider hospitals to include all hospitals more than 35 miles from another hospital and provides designated hospitals with the option of receiving prospectively determined rates, based on 100% of hospital-specific costs based on costs reported in FY1982 or FY1987, or PPS rates. Establishes an Essential Access Community Hospital (EACH) Demonstration program in up to 7 States providing funds for the conversion of full-service rural hospitals to facilities providing short-stay inpatient care and emergency services. Introduced Sept. 20, 1989; passed House, amended, Oct. 5, 1989; passed Senate, amended, Oct. 13, 1989; conference agreement reported Nov. 21, 1989; passed House Nov. 21, 1989; passed Senate Nov. 22, 1989; signed into law Dec. 19, 1989.

H.R. 1026 (Downey)

Prohibits any change in percentage of total outlier payments made for day outlier cases before FY1993; limits any change in FY1993 or a later year to 5% a year. Introduced Feb. 21, 1989; referred to Committee on Ways and Means.

H.R. 1110 (Skelton)

Provides that payment for cases in DRGs with a high degree of cost variation will be made on the basis of a blend of a hospital-specific rate and a national rate. Eliminates separate urban and rural rates. Changes wage indexing system to require that labor market areas consist of groups of political subdivisions with comparable wage levels. Introduced Feb. 23, 1989; referred to Committee on Ways and Means.

H.R. 1812 (Donnelly)

Extends for 2 years the automatic reductions in payments to hospitals for capital-related costs of inpatient hospital services. Provides further reductions in capital-related costs for low occupancy hospitals, with large urban, other urban and rural hospitals subject to different occupancy requirements. Disproportionate share hospitals would be exempt from capital reductions. Introduced Apr. 12, 1989; referred to Committee on Ways and Means.

S. 2019 (Symms)

Requires the Secretary and ProPAC to each submit a report to Congress on or before Apr. 1, 1990, recommending a method for eliminating separate average standardized amounts for hospitals located in urban, other urban, or rural areas. Requires the different standardized amounts to be phased out beginning on Oct. 1, 1990, and eliminated by Oct. 1, 1992.

89-681 L

CRS Report for Congress

Physician Payments by Medicare: Bibliography-in-Brief, 1988-1989

Edith Sutterlin
Senior Bibliographer, Education and Public Welfare
Library Services Division

December 1989

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PHYSICIAN PAYMENTS BY MEDICARE: BIBLIOGRAPHY-IN-BRIEF, 1988-1989

SUMMARY

Medicare reimbursements to physicians have undergone some changes since 1984, but more significant revisions have been proposed in the 101st Congress. Medicare reimbursement: selected references, 1986-1988, CRS report 88-679 L, identifies materials on early proposals and changes in payment for hospitals and physicians and on quality of care. This bibliography focuses on proposals made in 1988-1989, particularly the recommendation of the Physician Payment Review Commission favoring a relative value scale system for payment.

Citations have been selected from the CRS Public Policy Literature data base, as well as the CRS products file.

PHYSICIAN PAYMENTS BY MEDICARE: BIBLIOGRAPHY-IN-BRIEF, 1988-1989

Alston, Chuck.
Belt-tightening in Medicare pits doctor vs. doctor. Congressional Quarterly weekly report, Oct. 7, 1989: 2605-2609. LRS89-9163

Describes Congress' recent actions to overhaul the Medicare payment system and what it pays for physician fees. Also describes a split in the medical lobby.

Cahill, Kenneth R. Reuter, James. Langwell, Kathryn. Shin, Richard.
Prospective budgeting for Medicare's physician service. Oct. 31, 1989. Washington, Congressional Research Service, 1989. 128 p.
89-600 EPW

Examines many of the basic issues that would be addressed in an assessment of prospective budgeting for Medicare. Among the issues are: the basic purpose and scope of the budget, the geographic areas and/or physician or service groups for which budgets would be developed, methods for setting the budgets, strategies for monitoring performance, and the type of feedback used to encourage compliance.

Edwards, Winston O. Fisher, Charles R.
Physician charges and utilization trends. Health care financing review, v. 11, fall 1989: 117-123.

Gives a synopsis of charge and payment trends of Medicare physicians and other noninstitutional suppliers of goods and services for 1975-1987.

Fisher, Charles R.
Physician charges for surgical services under Medicare, by medical specialty: 1980 and 1985. Health care financing review, v. 9, summer 1988: 127-132. LRS88-8157

"Since 1980, a number of Medicare practice and utilization patterns have changed as a result of payment reform, certification of new types of providers, and changes in technology. The shift in physician surgical charges by specialty and by setting is examined in this article."

Medicare payments to hospitals and physicians: info pack. Updated as needed. Washington, Congressional Research Service. IP317M

Includes information both on the origin and operation of the prospective payment system and proposed changes in Medicare reimbursement.

O'Sullivan, Jennifer.

Medicare: physician fee schedule; issue brief. Updated regularly. Washington, Congressional Research Service. IB89116

From 1984 to 1987, Congress, as part of the budget reconciliation process, approved a number of amendments to Medicare's physician payment rules which were designed to stem high expenditure increases. As of December 19, 1989, the President signed into law P.L. 101-239, the Omnibus Reconciliation Act of 1989, which provides for establishment of a new payment system for physician services paid for by Medicare. This issue brief discusses the new law and related issues.

Physician-payment reform. New England journal of medicine, v. 319, Sept. 29, 1988: 865-888. LRS88-8570

A three part discussion of "a resource-based relative-value scale as an alternative to the system of payment based on charges for physicians' services. Resources inputs by physicians include (1) total work input performed by the physician for each service; (2) practice costs, including malpractice premiums; and (3) the cost of specialty training. These factors were combined to produce a relative-value scale denominated in nonmonetary units." Includes the response of the Administrator of the Health Care Financing Administration.

Contents.--Perspectives on physician-payment reform, by William L. Roper.--Estimating physicians' work for a resource-based relative-value scale, by William C. Hsiao and others.--Results and policy implications of the resource-based relative-value study, by William C. Hsiao and others.

Physician Payment Review Commission (U.S.)

Physician Payment Review Commission: annual report to Congress. Washington, The Commission, 1988. 321 p. LRS88-8837

Proposes a fee schedule and provides analysis of "options to moderate the growth in expenditures without reducing quality of care and issues related to capitation and Medicare data needs." Includes lengthy bibliography.

Physician Payment Review Commission: annual report to Congress, 1989. Washington, The Commission, 1989. 400 p. LRS89-4364

Recommends that "the current CPR [customary, prevailing, and reasonable] payment system should be replaced with a Medicare Fee Schedule (MFS) based primarily on the resource costs incurred in efficient medical practice," consisting of a relative value scale, geographic multiplier, and possibly specialty multiplier."

The Physician Payment Review Commission report to Congress. JAMA [Journal of the American Medical Association], v. 261, Apr. 28, 1989: 2382-2385. LRS89-4655

Outlines the Commission's recommendations regarding payments to physicians by Medicare designed to slow the rate of increase in program costs so that they are affordable to beneficiaries and taxpayers."

Reuter, James A.

Medicare: geographic variations in payments for physician services. Dec. 28, 1988. Washington, Congressional Research Service, 1988. 70 p. 88-775 EPW

Prices physicians charge for their services vary among geographic areas. These variations lead to differences in the amounts paid by Medicare for these services. In recent years, there has been growing concern that the extent of geographic variations in payments for services may be excessive. This report provides background data on the extent of geographic variations that exist in current Medicare payments, and discusses issues and options involved in the design and implementation of an index for adjusting payments among areas. The paper concludes with a brief summary of recent legislation that has had an impact on geographic variations in Medicare payments for physician services.

Medicare: physician payments. Oct. 1988. Washington, Congressional Research Service, 1988. 26 p. 88-658 EPW

This report provides background information on the physician reimbursement system currently used to make payments under the Part B program of Medicare. Chapter I provides background on Medicare and Medicare's Part B or Supplementary Medical Insurance (SMI) program. This section includes historical data on Medicare expenditure and Medicare payments for physician services. Chapter II describes Medicare's reasonable charge methodology for determining payments to physicians. This section includes a description of three aspects of current policy, assignment, participation, and the so-called Maximum Actual Allowable Charge (MAAC) limits that determine beneficiary liability for covered services. This section also describes the special limits that have been placed on the reasonable charges of procedures that are perceived as being overpriced. Chapter III describes the major provisions of recent legislation that have effected physician reimbursement under Medicare.

Second report on the Physician Payment Review Commission (PPRC). Washington, Office of Technology Assessment, 1988. 6 p. LRS88-11790

Summarizes changes in the Commission's organization, operation, and funding.

Stevens, Carol.
Here's what RBRVS will really do to your income. Medical economics, v. 66, May 15, 1989: 19-20, 22, 24, 26-28, 32, 34. LRS89-3380
"The Physician Payment Review Commission endorsed a resource-based relative value scale for Medicare payments. It recommended that Congress adopt a fee schedule, based on resource costs, which would have the general effect of lowering payments to surgeons and increasing reimbursement to primary-care doctors."

Symposium on medical cost containment. Notre Dame journal of law, ethics & public policy, v. 3, no. 2, 1988: whole issue (161-291 p.) LRS88-7450
Partial contents.--Balancing efficiency and quality--toward market-based health care, by William R. Roper.--The ethics of cost-containment: bureaucratic medicine and the doctor as patient-advocate, by Barry R. Furrow.--The Medicare prospective payment system: impact on the frail elderly and an alternative reimbursement formula, by Phoebe D. Sharkey and June Buckle.

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and the Environment.
Medicare peer review organizations. Hearings, 100th Congress, 1st session. Washington, G.P.O., 1988. 459 p. LRS88-4639
Hearings held Apr. 30 and Oct. 26, 1987.
"Serial no. 100-85"
Hearings on H.R. 1445--a bill to amend title XI of the Social Security Act to ensure physicians hearing and judicial review rights before exclusion from the Medicare program [and] H.R. 2116--a bill to amend part B of title XI of the Social Security Act with respect to providing due process and equity for all providers under the peer review program.

Medicare physician payment reform. Hearing, 101st Congress, 1st session. May 25, 1989. Washington, G.P.O., 1989. 259 p. LRS89-7099
"Serial no. 101-36"

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Coverage of psychologists' services under the Medicare Program, including H.R. 774. Hearing, 101st Congress, 1st session. Mar. 6, 1989. Washington, G.P.O., 1989. 130 p. LRS89-8571
"Serial 101-23"

Fiscal year 1990 budget issues relating to Medicare payments to physicians. Hearing, 101st Congress, 1st session. Apr. 17, 1989. Washington, G.P.O., 1989. 146 p. LRS89-8573
"Serial 101-19"

Fiscal year 1990 budget issues relating to physician incentive payments by prepaid health plans. Hearing, 101st Congress, 1st session. Apr. 25, 1989. Washington, G.P.O., 1989. 61 p. LRS89-9836

"Serial 101-30"

1989 report of the Physician Payment Review Commission. Hearing, 101st Congress, 1st session. Mar. 21, 1989. Washington, G.P.O., 1989. 140 p. LRS89-9541

"Serial 101-40"

Includes testimony from invited witnesses from the American Association of Retired Persons, the American College of Surgeons, and the American Medical Association as well as the report of the Commission and written statements from other medical groups.

Payments of physicians by the Medicare program. Hearing, 100th Congress, 2nd session. May 25, 1988. Washington, G.P.O., 1989. 112 p. LRS89-927

"Serial 100-71"

Includes discussion of recommendations made by the Physician Payment Review Commission.

U.S. Congress. Senate. Committee on Finance. Subcommittee on Medicare and Long-Term Care.
Physician payment reforms. Hearings, 101st Congress, 1st session. Washington, G.P.O., 1989. 216 p. (Hearings, Senate, 101st Congress, 1st session, S. Hrg. 101-173, pt. 1) LRS89-7614

Hearings held Mar. 17 and Apr. 20, 1989.

"Part 1 of 2"

U.S. Congress. Senate. Special Committee on Aging.
Medicare physician reimbursement: issues and options; information paper. Washington, G.P.O., 1988. 105 p. (Print, Senate, 100th Congress, 2nd session, S. Prt. 100-134) LRS88-10838

"Serial no. 100-L"

Partial contents.--Beneficiary cost-sharing and the medicare program.--Growth in physician expenditures.--Health expenditures in the United States.--Physician services and the SMI program.--Problems with the current physician reimbursement system.--Recent legislation.--Physician payment reform options.

U.S. General Accounting Office.
Medicare: impact of State mandatory assignment programs on beneficiaries; report to the chairman, Subcommittee on Housing and Consumer Interests, Select Committee on Aging, House of Representatives. Sept. 19, 1989. Washington, G.A.O., 1989. 43 p.
"GAO/HRD-89-128, B-236487" LRS89-10484

Analyzes Medicare payment data in Connecticut, Massachusetts, Rhode Island, and Vermont, States which have enacted laws that require physicians, under certain circumstances, to accept Medicare's approved amount as payment in full.

Medicare: physician-sponsored organizations receive priority for peer review contracts; report to congressional requesters. Jan. 21, 1988. Washington, G.A.O., 1988. 4 p. LRS88-5653
"GAO/HRD-88-43, B-229169"

Concludes that HCFA does give the required preference to physician-sponsored organizations when awarding PRO contracts.