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Chapter 6

Problems with Alternative Approaches

Many of the proposals for health system reform are patterned after one of two basic models: a centralized Canadian-style national health insurance system or an employer "play-or-pay" mandate. While widely discussed,

these proposals are often designed in relatively cursory fashion, with little or no assessment or analysis of impacts for implementation in this Nation. This chapter presents a rigorous analysis of these models.

A. The Canadian Model

Overview

While apparently successful in many respects and highly popular with the Canadian people, the Canadian system—like all other universal public insurance systems—suffers from two basic structural flaws—flaws that are bound to lead to serious long term problems with cost, access, and quality.

- There are no demand side incentives for efficiency. Because medical care is free to consumers, consumers do not play the same role they play in normal markets.

Market forces that normally drive economic systems to greater efficiency simply do not exist. Moreover, consumers are unable to express their preferences through market choices.

- Second, all major resource allocations are made centrally through the political process; health care is too complex, too sensitive to micro-level conditions, for centralized management to be effective.

The Canadian system relies on blunt, macro-level, supply-side constraints such as global budgets, limits on high-tech equipment, and limits on physician supply.

But, efficiency—high quality care at the lowest possible cost—requires that optimal decisions be made at the hospital bed-side and in the physician's office.

This cannot result from central planning, so resources are bound to be wasted and quality is at risk.

These flaws are already beginning to be manifest in the actual experience of the Canadian system:

- Costs have not been controlled effectively despite the enormous power that a single payer has under a universal public insurance program. Indeed, Canadian costs have been rising slightly faster than U.S. costs.

Costs growth can be moderated through non-market means, but with significant inefficiency. Resources are wasted on low-priority care while blunt cost containment measures limit spending where added resources could make a real difference in outcomes.

- Supply-side constraints has led to artificial shortages of critical personnel and equipment.

Canadians have significantly less access to state-of-the-art technologies and often have to wait weeks or months for effective treatments that are readily available for Americans from all walks of life.

While waiting, many Canadians are at an increased risk of death or must endure painful or disabling symptoms that could have been corrected. And, certain procedures, such as coronary bypass surgery,

appear to be rationed, especially for senior citizens.

Lost productivity and other costs associated with delays in surgery are estimated at 0.6 percent of Canadian GDP. These losses could be even higher if delays for other medical services are taken into account.

- Incentives for Canadian physicians and hospitals reward additional care regardless of appropriateness or quality. As a result, utilization rates have increased rapidly and resources have been wasted.
- Reliance on crude global budgets as a means of controlling costs has forced Canadian hospitals to cut back on staffing in critical areas. As a result, post-operative death rates in Canada are a full 40 percent higher than in U.S. hospitals, for certain high-tech, life saving surgical operations.

Even if the Canadian system were an unqualified success, its success, if imported into the United States would be less than assured. Each nation has its own unique political, cultural, and economic environment. Experience with the Medicare and Medicaid programs in the United States suggests that a Canadian-style universal public insurance program could not be imported successfully.

- Over the past decade and a half, effective management of Medicare and Medicaid has been stymied by increasing politicization. Virtually all payment rates are fixed by law. Thus, an Act of Congress is needed to change the amount that Medicare pays for a routine lab test or X-ray.
- As a result of this inflexibility, Medicare and Medicaid per capita costs continue to grow more rapidly than per capita costs for the remainder of the population.

If the U. S. political process has been unable to control 30 percent of health spending, there is little reason for optimism that it could be more successful in controlling costs for the entire health system.

Indeed, the thought that as much as 16 percent of the GDP by the year 2000 (32.7 percent if non health-related federal spending included) could be subject to direct political

control should be enough to give most Americans pause for serious concern.

Basic Features of the Canadian Model

For the past two decades, the ten Canadian provinces have operated government-based health insurance plans that cover hospital and physician care. The Canadian system was not implemented all at once, but gradually evolved over many years following World War II. The Canadian system itself, and American proposals to implement a Canadian-style approach, share a number of basic structural features:

- Health insurance is provided to all citizens through a centralized, publicly administered program. Health care services are provided by private-sector hospitals, physicians, and other providers. Private insurance is prohibited, except for services not covered by the public program.
- Covered benefits include hospital, physician, mental health, and preventative care. (Some Canadian provinces also cover prescription drugs and long-term care.) Care is free with no cost-sharing at the point of service.
- Hospitals and other institutional providers are paid on the basis of global budgets that cover all patient care costs during a year. Global budgets are set annually by government authorities, through a process that involves some element of negotiation.
- Physicians, and other non-institutional practitioners and providers are paid on a fee-for-service basis according to a government-established fee schedule. Overall payment for physician services are limited by a global budget or "expenditure target."
- To control costs, the supply of facilities, equipment, and providers is strictly regulated. Hospitals are limited to government-set budgets for capital expenses. Construction projects and high-cost equipment purchases require special approval. Physician supply is limited and the specialty distribution is regulated to encourage general practice.
- Financing is primarily through broad based taxes (including a payroll tax). Some

Canadian provinces also require small premium payments. Others place a special tax on employers.

- The Canadian system is administered through the provinces with supplemental Federal financing. A Canadian-style system in the U. S. could be jointly administered by federal and State governments (as proposed by Senator Kerrey) or primarily by the national government (as proposed by Congressman Russo).

Basic Structural Flaws in the Canadian Model

Lack of Demand-Side Incentives.—At a fundamental level, the Canadian system lacks effective incentives for efficiency. Because medical care is free to consumers, market forces that normally drive economic systems to greater efficiency simply do not exist. This flaw could be partly remedied by requiring some cost-sharing at the point of service. The RAND health insurance experiment has conclusively shown that modest levels of cost-sharing reduce demand with little or no measurable impact on health status (Brook et al., 1983). But, the flaw in the Canadian system is much deeper than a simple lack of cost-sharing.

Because consumers do not have a choice of alternative health plans and do not pay any portion of the premium cost, there is no dynamic that could lead to the development of more efficient systems for delivering high quality care at low cost. It is no accident that innovative health care delivery systems, such as Kaiser Permanente or Group Health of Puget Sound, have emerged in the United States, but not in Canada.

In the U.S., employers and individuals, concerned about getting good value for their health care dollars, have incentives to demand better forms of health care delivery. This, in turn, creates a market for such systems, and organized health plans then compete with one another for market share, leading to progressive improvements in cost-effectiveness and quality. This consumer-driven process of progressive improvement simply cannot occur in a Canadian-style system. All significant change requires legislation.

As a result, the Canadian health care system is curiously frozen in time, resembling the U.S. health care system as it existed in the mid-1960s. Medical care continues to be an unorganized cottage industry. Physicians are subject to little oversight to assure efficiency and quality of care. And physicians continue to be paid exclusively on a fee-for-service basis despite clear evidence that this approach is inflation. None of the improvements in health systems delivery or innovative payment arrangements that have been developed in the United States over the past decades have taken root in Canada.

Overall, Canadian citizens as individuals are relegated to a diminished role in decision making in the health care system. Because they cannot make their own choices in the market, they are forced to rely on the vagaries of the political process.

Supply-Side Controls.—Because incentives for needed, appropriate care only are so poorly structured, the government is left with controlling costs through crude supply side controls. These measures must be implemented through a politicized central planning process. There are at least three main problems with this approach.

- Supply side controls are macro-level interventions that cannot achieve micro-level efficiency. So resources are invariably wasted. And because these control are indiscriminate, needed services are often caught in the squeeze compromising quality and good medical care.

Every day, medical personnel make hundreds of decision that affect resource allocation. Should a particular test be provided? What level of staffing should be provided in a busy emergency room? Consumers also must make important decisions regarding their care. Efficiency—high quality care at the lowest possible cost—requires that optimal decisions be made at the hospital bed-side and in the physician's office.

For efficient decisions to result, all of the participants must have appropriate incentives and must have critical information. Macro-level budget constraints do nothing to assure that proper incentives and accu-

rate information are brought to bear. As a result, they simply are crude means of controlling cost. They can do little to assure efficiency. In fact, they are well suited to encourage waste and poor medical care.

Global budgets for physicians are a good example. Under the Canadian system, physicians are paid on a fee-for-service basis, but overall payments are subject to a macro-level province-wide spending cap. If total spending on physician services in the province exceeds the cap, fees levels for the next year will be held down for all physicians. But, because there are thousands of physicians in the province, an individual physician's conduct makes little difference to this outcome. If anything, physicians have a clear incentive to increase their volume of services to ensure that their revenues are maximized in the event that the cap is exceeded.

- Supply side measures are often arbitrary and inflexible. Regulators must make thousands of decisions each year—decisions that involve billions of dollars to implement global budgets, limits on high-tech equipment, and similar measures. Regulators must decide questions such as whether to increase a hospital's budget or whether to approve the construction of a new cardiac surgery facility. Decisions for new facilities and the purchase of new technology can take months or even years to complete. The application process can be cumbersome, expensive and politicized, without resulting in an efficient allocation of resources. (Deber and Leatt, 1987; Feeny et al., 1986). Lowered quality of care can result from lags in the decision process.

In an effort to be impartial, the regulators tend to develop complex, highly technical methods to assess relative needs—methods that often are incomprehensible for the general public and even for most legislators. And despite this complexity, defining and measuring need is difficult, if not impossible. So subjective judgements invariably enter into what is supposed to be an objective process. While the details of these policies are highly arcane, they generally have enormous mone-

tary significance. Often there is no correct decision. Yet, once the policy is set, the policy tends to be stoutly defended by whichever interested parties that benefit.

- Weak Political Incentives to Contain Costs. The third general problem is that the centralized process may be too removed or too politicized to effectively contain costs. The link between health costs and the consumer preference for benefits relative to costs may be too attenuated. Broad-based political support for cost-containment may be unrealistic. Lobbying by providers and special interest groups, partisan disputes, and a host of other complications make success in containing costs erratic, at best.

Canada: The Evidence to Date

The preceding discussion suggests that the design inherent in any centralized, government-controlled health insurance scheme will have adverse impacts on costs, access, appropriate use of resources, and quality. In fact, a growing body of evidence is strongly suggestive of these impacts in the current Canadian system.

Failure to Control Cost Growth.—Even with strict global budgeting and some rationing of care, Canadian health costs continue to grow faster than U.S. costs. Between 1970 and 1980, Canada's annual compound rate of growth for per capita health expenditures was 12.4 percent, compared with 11.9 percent in the U.S. Between 1970 and 1990, Canada's expenditures grew annually 10.8 percent, compared with 10.5 percent in the U.S. (OECD, 1990; Schieber et al., 1991).

Cost-containment also has become more difficult in Canada in recent years. Rising demands on the system resulting from free universal access have placed increased financial burdens on the government—burdens which are increasingly difficult to bear.

Declining national contributions and cost-containment measures have initiated a recent round of hospital staff layoffs and bed closings. In Ontario, for example, the richest and most populous province, where more than a third of the Canadians live, has lost nearly 5,000 hospital jobs and 3,500 beds

(21)
[Bar Chart or Growth: Chart 18]

over the last two years. In Toronto, the provincial capital, 2,900 of 15,000 acute-care beds have been taken out of service (Media Digest, November 25, 1991).

To contain costs, Canada has cut payments to providers, making the yearly price negotiations more and more difficult. The rising Canadian costs, kept artificially under control by government price and spending caps, has been described as "a pressure cooker that is building steam on a hot stove" (Iglehart, 1986).

Treatment Delays.—Reliance on crude supply side constraints to control costs will inevitably lead to shortages and delays in treatment. This has occurred in practice. Canadians must often wait to receive treatment. For example, Canadians can wait (on average) 4.9 months for open heart surgery, and 5.5 months for bypass surgery (Globerman, 1990).

These waiting times for medical treatment can have potentially adverse effects on patients' health. Patients not receiving timely access to diagnostic procedures—such as MRIs,

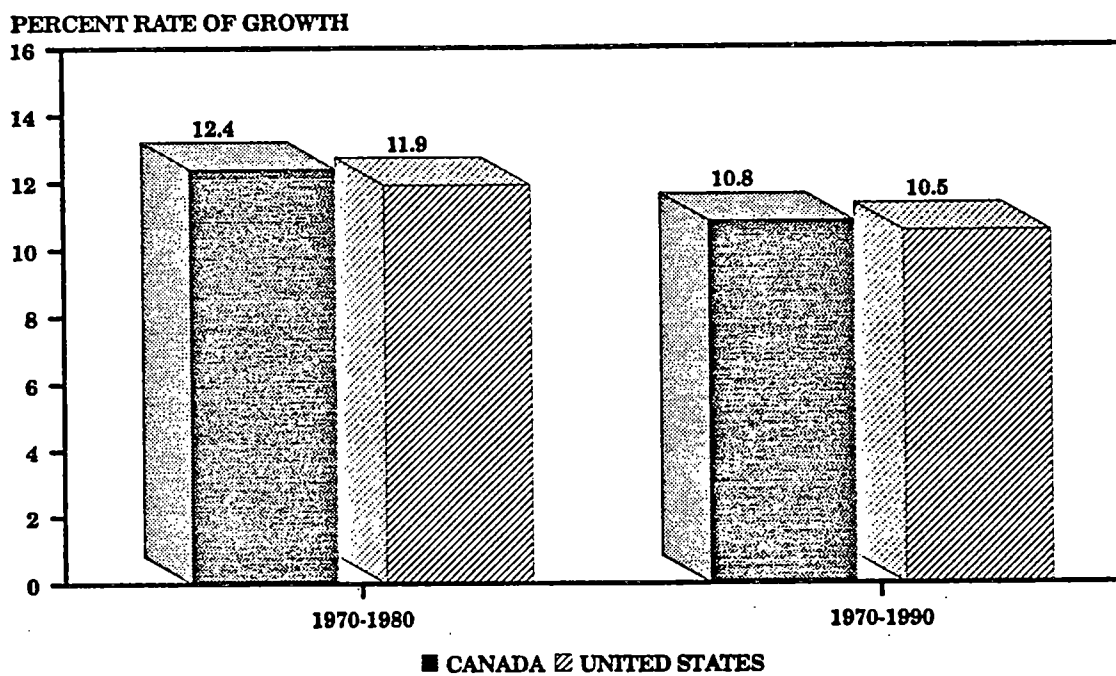
CT scans and mammograms—can suffer setbacks due to delayed treatment. Those waiting for acute procedures—such as open heart surgery—can risk death waiting for care.

Waiting for treatment also results in a direct economic loss. If unable to work while waiting for care, individuals may face financial setbacks. Some may even lose their jobs. There is the additional social loss of productivity. The overall cost of delays in surgery has been estimated at 0.6 percent of Canadian GDP (Danzon, 1991).

Limited Access to Advanced Technology.—Government control of hospital capital and operating budgets limits the penetration of medical technology in the Canadian market. For example, U.S. citizens have access to more open heart surgery, cardiac catheterization, organ transplants, radiation therapy, extracorporeal shock and lithotripsy, and magnetic resonance imaging.

Data from Anderson et al. (1989) also suggest rationing of selected expensive procedures for older age groups. Heart valve

**Chart 21. COMPOUND ANNUAL PERCENTAGE RATES OF
PER CAPITA NOMINAL GROWTH**



SOURCE: OECD, 'OECD Health Systems: Facts and Trends' (Paris: OECD forthcoming)



[Bar Chart 20: Waiting Times]

surgery and bypass surgery for patients ages 65-74 and 75+ were consistently performed less often in Canada. For patients age 75 and above, a full 4 times as many bypass procedures were performed in the U.S. as in Canada for the same age group of patients.

Limited availability of medical technology has prompted the Canadian government to even send some patients to the U.S. to seek advanced medical care. For example, the British Columbia Health Association has contracted with Seattle hospitals for coronary bypass surgeries (Washington State Hospital Association, 1990), and Ontario and Alberta have similarly contracted with U.S. hospitals for high technology care (Goodwin, 1990; Sherlock, 1990).

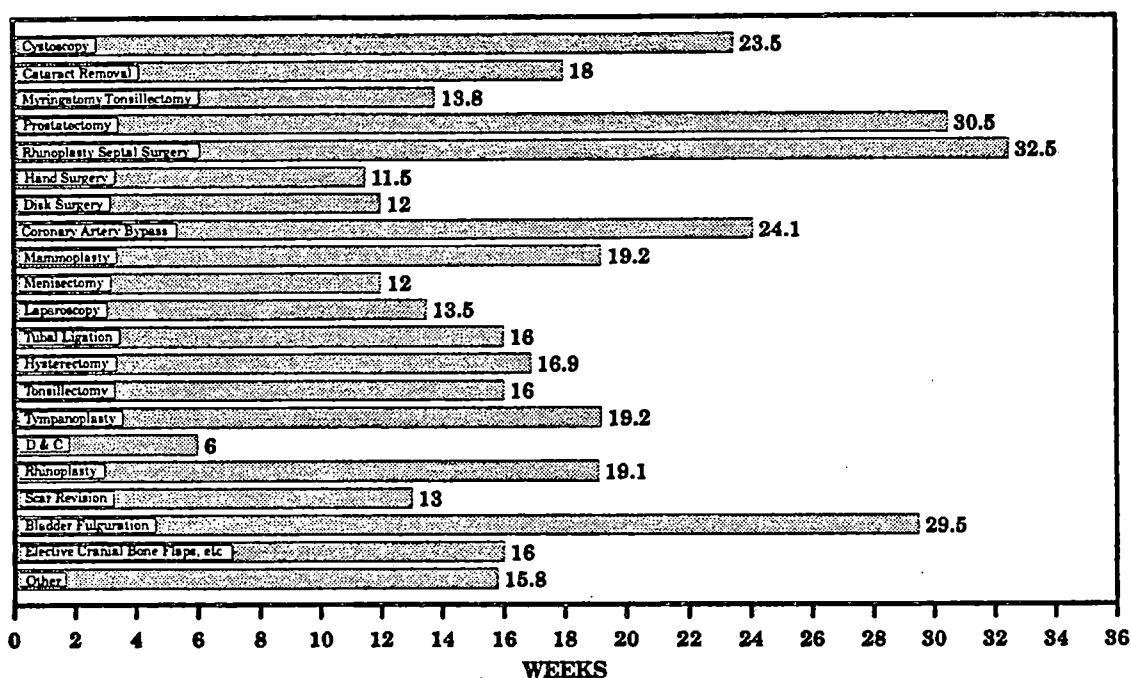
While these instances may be rationalized as temporary problems, the Canadian system generally is able to use U.S. access to technology as a "safety valve." Since the U.S. provides an available supply of medical technology just across the boarder, Canada may have an incentive not to invest in sufficient supply. If the U.S. were to adopt a Canadian

system, this safety valve would no longer exist for Canada, nor would one exist for Americans (HIAA, 1990).

Limited hospital budgets for capital improvements also has meant that the physical plants and equipment in many hospitals is nearing obsolescence (Iglehart, 1986). This lessens Canadian hospitals' ability to provide the best structural attributes for high quality care.

Ineffective Use of Resources Resulting from Inappropriate Incentives.—Because Canada continues to rely primarily on fee for service payment, physicians are rewarded for additional care regardless of need or quality. As a result, utilization per physician increased by 25.1 percent in Canada between 1971 and 1985, compare with only 7.0 percent in the United States (Barer et al., 1988). Overall, Canadian physicians provide a much higher volume of services than U.S. physicians. While no data are available on rates of appropriateness, these substantially higher levels of medical utilization raise concerns about the amount of inappropriate and unnecessary care being

Chart 22. AVERAGE WAITING TIMES IN BRITISH COLUMBIA



SOURCE: Steve Globberman, *Waiting Your Turn: Hospital Waiting Lists in Canada* (Vancouver: Fraser Institute, 1990).

(Bar Chart 21: Medical Technologies, U.S. vs Canada Dale Rublee, Health Affairs)

delivered and paid for by the Canadian taxpayer.

Hospitals also face perverse incentives. Because hospitals are paid on a fixed global budget, the financial incentive is to use available beds for patients with the lowest cost. As a result, Canadian hospitals are filled with chronically ill, but low cost, patients, termed "bed blockers." These incentives affect quality as well for hospitals spill-over to staffing decisions. There are lower

staff-to-patient ratios in Canada (1.87) versus the United States (3.47) (Newhouse et al., 1988). The mix of staff is less specialized reflecting lower case severity; quality and intensity of care for high-risk patients, however, can suffer as a result of these staffing patterns (see below).

Generally, service production in Canada is poorly integrated across the continuum of care. Because settings and sets of providers are paid on a fee-for-service basis, efficiencies

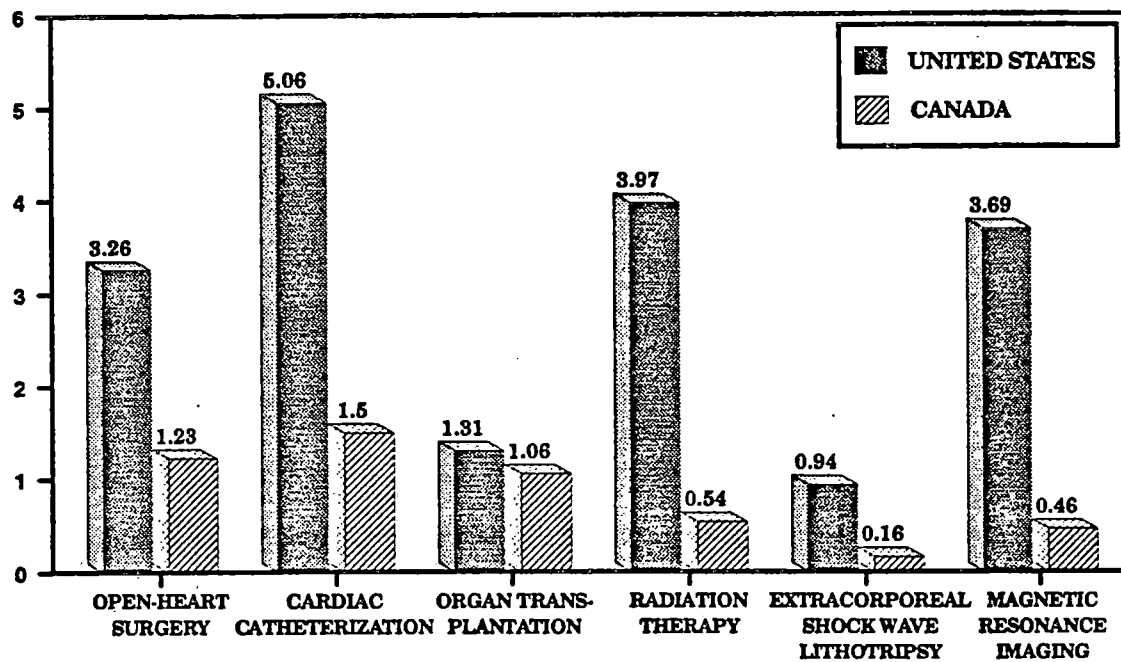
Table 6-1. Relative Use of Physician Services in Canada and the United States
(Services per capita)

Service Type	Canadian Rate as Percent of U.S. Rate
Diagnostic and Therapeutic Procedures	120
Office Visit and Consultations	156
All Physician Services	139

Source: Fuchs, 1990.

**Chart 23. ACCESS TO MODERN MEDICAL TECHNOLOGY
UNITED STATES (1987) VS. CANADA (1989)**

PER MILLION PEOPLE



SOURCE: Dale A. Rublee, "Medical Technology in Canada, Germany and the United States," Health Affairs, Fall 1989, Table 1, p. 180.

Table 6-2. Comparison of Hospital Care in Canada and the United States

(Use rates for people aged 65 and older)

	United States	Canada	Canadian Rate as Percent of U.S. Rate
Admissions Per Capita	0.33	0.35	106
Length of Hospital Stay (in days)	7.96	13.32	167
Hospital Days Per Capita	2.63	4.66	177
Hospital Staff Per Occupied Bed	3.47	1.87	54

Source: Newhouse, 1988.

across settings lag behind the U.S. experience. Fully integrated health plans such as Kaiser are able to achieve production efficiencies that are difficult to achieve in fee-for-service settings. Same-day, ambulatory surgery and substitution of outpatient for inpatient care has lagged behind its U.S. counterparts.

Pressures on Quality.—While comparative studies are scant, Roos et al. (1989) recently reported a comparison of Canadian and U.S. post-operative mortality rates. Interestingly, Canadian hospitals did as well as U.S. hospitals on low risk surgical procedures. However, relative risk of post-operative survival was much poorer in Canada than in the U.S. for high risk procedures. These outcomes may be due to (again) incentives of hospital budgeting practices which encourages lower staff-to-bed ratios, which in turn mean that needed intensive care support following surgeries is far less available and effective in the Canadian system.

Quality assurance activities such as peer review, second opinion, utilization management and outcomes information also are relatively undeveloped in Canada compared with the United States. Similarly, Canadian hospitals have few incentives to compete based on increased quality of care, and because of tight budgets, do not invest to any significant level in data collection and quality review.

Could a Canadian-Style System Be Successfully Implemented in the United States?

Critical Differences Between the United States and Canada.—The notion of simply copying the Canadian system is simplistic. Each nation has its own unique political, cultural, and economic environment and history. Even if the Canadian system were an unqualified success in Canada, its success, if imported into the United States would be less than assured.

One major difference between the United States and Canada is our form of government. We rely on a system of checks and balances, with independent executive, legislative, and judicial branches. Canadians, in contrast, have a parliamentary form of government, which effectively combines legislative and executive functions. The result is, that there is little potential in Canada for the political deadlock that has characterized health policy in the United States over the past decade.

Experience with the Medicare and Medicaid Programs.—Experience with the Medicare and Medicaid programs suggests that a Canadian-style universal public insurance program could not be translated successfully into the United States. While these programs have succeeded in expanding access to the elderly, the disabled and many low income Americans, these programs has become increasingly politi-


Chart 22

cized over the past 10 years with the result that effective program management has been stymied.

When enacted in 1965, Congress delegated broad responsibility for management of Medicare and Medicaid to the Executive branch and to the States. Congress legislated only the broad outlines of the programs and limited its role to oversight. Today, virtually every detail of operation of Medicare and Medicaid is dictated in hundred of pages of dense legislative language that are comprehensible only to a handful of Congressional staff and executive branch experts.

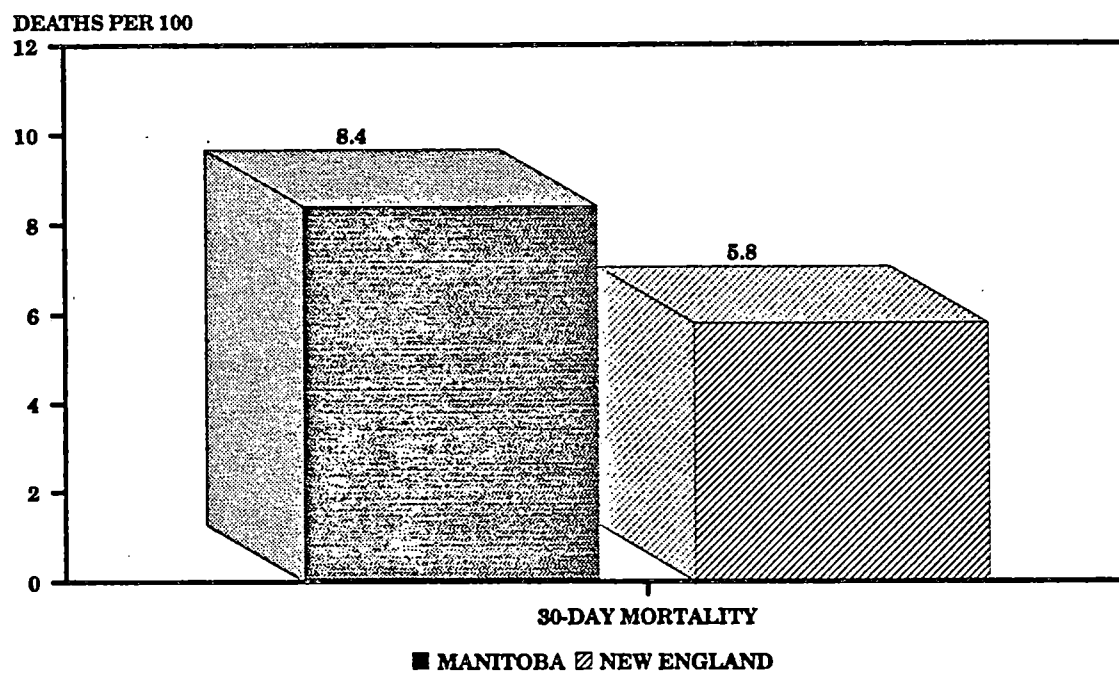
With the increasing complexity of the legislation, few Members of Congress even have an opportunity to vote on the issues involved. Over the past decade, the full House and Senate have only had a handful of opportunities to debate and vote on critical programmatic issues. Generally, these issues are decided in Committee or Subcommittee, with other members being limited to an up or down vote on the whole package.

Micromanagement of program details by legislators may be inevitable because it extends political power and influence of key Committee members. The technical details of payment policy often are highly arcane but of great monetary significance. Often there is no "correct" decision. Thus, many payment policies are somewhat arbitrary. Yet, once the policy is set, it tends to be rigid and is stoutly defended by the interested party that benefits.

This process of politicization has progressed to the point where it now virtually requires an Act of Congress to change how much Medicare pays for a wheel chair. As a result, per capita health care costs for Medicare and Medicaid recipients have grown consistently faster than per capita health care costs for the remaining population.

If the political process has been unable to control 30 percent of health spending, there is little reason for optimism that it could be more successful in controlling costs for the entire health system. Indeed, the thought that as much as 16 percent (32

Chart 24. POST-OPERATIVE MORTALITY (PER 100) FOR HIGH RISK SURGICAL PROCEDURES FOR PATIENTS 65 AND OLDER



SOURCE: Roos, et al., JAMA, Vol. 263, No. 18, May 9, 1990

Chart 25

percent if non health-related federal spending included) of the GDP by the year 2000 could be subject to direct political control should be enough to give pause for serious concern for most Americans.

Potential for Massive Transition Costs and Disruptions.—Establishing a universal public insurance program in the United States would involve massive transition costs and dis-

ruptions. Taxes and government spending (federal and/or State) would have to increase by approximately \$557 billion (using 1992 dollars). If coverage is financed through a payroll tax that would increase the cost of employment, job loss could exceed one and one half million workers. And, millions of people who currently are satisfied with their current insurance arrangements would be forced to switch their coverage.

B. Problems with "Play-or-Pay"

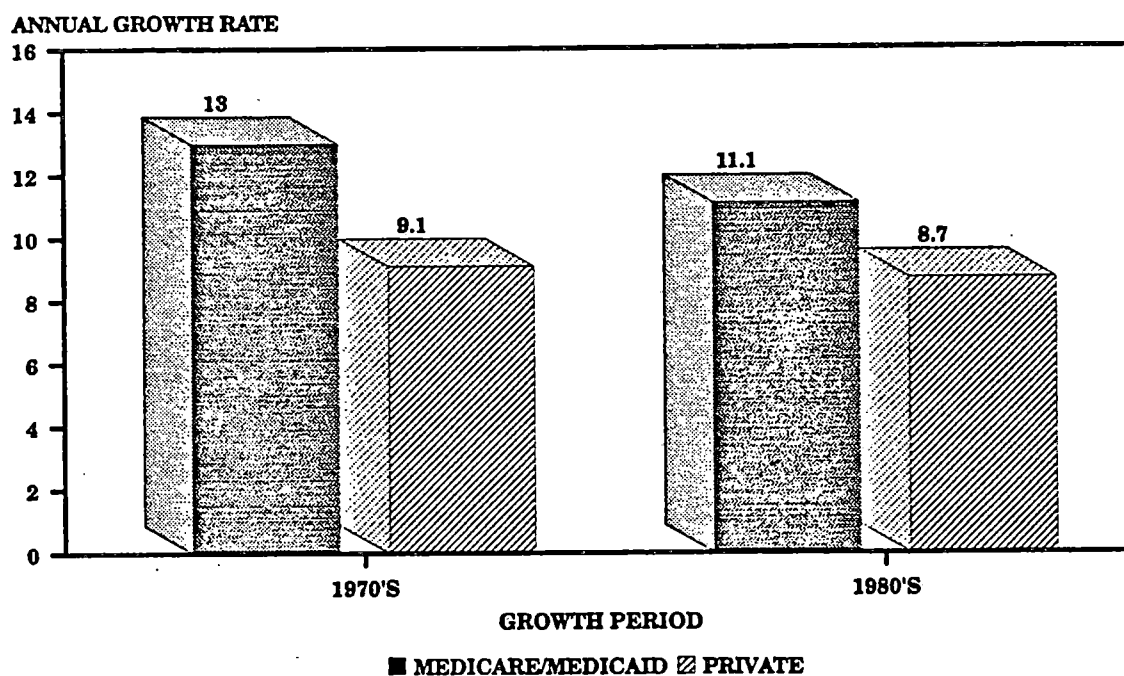
Overview

"Play-or-pay" is a widely discussed approach for expanding health insurance access. Employers would be required to play, e.g., provide private insurance for workers and dependents or pay a payroll tax to fund public insurance for their workers and dependents. Variants of this approach have been proposed by Senators Mitchell and Kennedy and by Representative Rostenkowski, among others.

While "play-or-pay" would expand insurance coverage, it suffers from four serious drawbacks. "Play-or-pay" would:

- Hurt workers by increasing unemployment and by forcing employers to cut wages to offset mandate costs. While "play-or-pay" seems to put the burden on employers, this is largely an illusion. Employers will inevitably shift the burden to employees. Between 350,000 and 750,000 jobs could be lost in the short-run, with a long-

Chart 25. ANNUAL GROWTH IN PER CAPITA HEALTH CARE EXPENDITURES



SOURCE: HCFA, Office of the Actuary, Office of National Health Statistics

term potential as high as two million. Moreover, cash wages for many of the "beneficiaries" of the mandate would decrease by 7 to 9 percent depending on the payroll tax rate.

- Be a back door to national health insurance. "Play or pay" is inherently unstable and would rapidly degenerate into national health insurance. According to the Urban Institute, 60 million workers and dependents who now have private coverage would be shifted into the public plan. Overall, 58 percent of Americans would be insured publicly. At this point, the public plan would undoubtedly use its near-monopsony position to gain deep discounts from providers resulting in a massive cost-shift that would rapidly price the remaining private coverage out of the market.
- Increase inflation and hurt small business. While the \$30 billion cost of the mandate will be shifted to workers, in the near-term, employers will bear the burden. Some employers may try to pass this added cost on to consumers in the form of higher prices. But, many businesses that do not currently provide coverage have low profitability and are engaged in intense competition. Of particular concern, small business will suffer disproportionately.
- Increase costs for government by \$37 billion over and above the new payroll tax receipts. "Play or pay" is not self-financing. A federal subsidy of \$37 billion would be needed to fund the gap between payroll tax receipts and actual costs, and this gap is likely to grow rapidly. Although premium costs average 7 percent of payroll, actual costs vary widely. Low-wage firms incur costs well in excess of 7 percent. These firms will disproportionately opt to "pay," but the tax will be grossly inadequate for health coverage for these firms. This problem will be compounded by the fact that premium costs also vary widely. Firms with higher premiums due to an older or sicker work force would have a strong incentive to opt into the public plan, further undermining the solvency of the plan.

How Play or Pay Plans Operate

"Play or pay" employer mandates are designed to provide coverage for workers and their dependents with little direct cost to government. Employers are required to provide coverage directly or pay a payroll tax. Mandates typically apply for all workers employed more than 17.5 hours a week.

- To "play," employers would be required to provide "basic" health coverage. Typically, employers could require workers to pay up to 20 percent of premium costs and could require workers modest cost sharing on benefits.
- Employers not providing health benefits directly would be required to pay a payroll tax to cover a portion of the cost of benefits provided through a public insurance program. Typical payroll tax rates are in the range of 7 to 9 percent. Generally, there is no cap on taxable wage base.

"Play or pay" mandates usually are accompanied by an expanded public insurance program to replace Medicaid and provide subsidized coverage on a sliding-scale basis for those without employer-paid coverage or Medicare. Some form of price regulation also generally accompanies "play or pay" proposals as a means of restraining costs. The regulation may involve some form of payer/provider negotiations or may be administered directly by a regulatory agency.

Characteristics of the Working Uninsured

The working uninsured are the intended beneficiaries of "play or pay" mandates. Thus, it is important to understand who they are.

In 1987, almost half (47.4 percent) of the uninsured workers were low wage workers earning \$5 or less an hour. Sixty percent were employed in small establishments with 25 or fewer workers. Most worked in low-skilled occupations and in industries that are characterized by intense competition and comparatively low profitability.

Consequences of "Play or Pay"

Effects on Insurance Coverage.—From this standpoint, "play or pay" appears to be a success. According to a simulation of this

Table 6-3. A Profile of the Uninsured Employed Persons
(First Quarter, 1987)

Employee characteristics	Population	Uninsured	Percent uninsured in category	Uninsured as percent total uninsured
Age in Years:				
Under 19	4,259	719.77	16.90	4.57
19-24	16,639	4,409.34	26.50	27.97
25-54	75,243	9,631.10	12.80	61.09
55-64	10,629	1,009.76	9.50	6.41
65 & over	2,705	51.40	1.90	0.33
Sex:				
Male	59,281	9,247.84	15.60	58.66
Female	50,195	6,675.94	13.30	42.35
Size of Establishment:				
Under 10	25,909	6,218.16	24.00	39.44
10-25	18,170	3,125.24	17.20	19.82
26-100	22,760	2,731.20	12.00	17.32
101-500	18,968	1,251.89	6.60	7.94
Over 500	16,610	930.16	5.60	5.90
Hourly Wage:				
Under \$3.50	8,592	2,328.43	27.10	14.77
\$3.50-5.00	19,843	5,139.34	25.90	32.60
\$5.01-10.00	42,485	5,692.99	13.40	36.11
\$10.01-15.00	22,773	1,503.02	6.60	9.53
Over \$15.00	14,730	824.88	5.60	5.23
Industry:				
Agriculture	2,135	631.96	29.60	4.01
Mining	723	71.58	9.90	0.45
Construction	5,914	1,667.75	28.20	10.58
Manufacturing	20,235	2,023.50	10.00	12.84
Transport/Utilities	8,016	769.54	9.60	4.88
Sales	22,158	4,631.02	20.90	29.38
Finance	7,068	480.62	6.80	3.05
Repair Services	5,941	1,194.14	20.10	7.57
Personal service	3,447	923.80	26.80	5.86
Entertainment	1,404	383.29	27.30	2.43
Professional services	23,713	2,015.61	8.50	12.79
Public Administration	5,687	346.91	6.10	2.20
Occupation:				
Professional	18,464	1,329.41	7.20	8.43
Management/Administration	15,541	1,165.58	7.50	7.39
Sales	11,391	1,754.21	15.40	11.13
Clerical	17,403	1,653.29	9.50	10.49
Craftsmen/Foremen	12,073	2,040.34	16.90	12.94
Operatives	7,439	1,041.46	14.00	6.61
Transport operator	4,568	776.56	17.00	4.93
Service Workers	14,099	3,679.84	26.10	23.34
Laborers/non farm	4,588	1,284.64	28.00	8.15
Farm owners/managers	585	94.77	16.20	0.60
Farm laborers/foremen	1,343	478.11	35.60	3.03
Total	109,476	157,64.54	14.40	100.00

Source: AHCPR, National Medical Expenditure Survey, Household Survey, Round One, 1987.

policy conducted by analysts at the Urban Institute, an estimated 33 million uninsured Americans and their dependents would receive insurance coverage as a result of the mandate—22 percent through their employer and 78 percent through the new public plan.

Assuming a 7 percent "play or pay" tax, insurance costs would increase by \$30 billion for employers, in 1989 dollars, and by \$37 billion for employers with a 9 percent tax. Premiums paid by individuals would increase by less than \$1 billion, while uncompensated hospital care would decrease by \$15 billion.

The Effects on Wages and Employment.—"Play or pay" mandates appear to put the burden on employers, but in the long-run, the burden falls primarily on workers. As a result, workers will be hurt more than they are helped. For primary breadwinners and others who will need to hold a job under all circumstances, the main effect of the expanded health insurance coverage is likely to be a drop in real take-home pay. For workers who are able to move in or out of the labor force, the effect is likely to be a combination of lower take-home pay and reduced jobs.

The reason is a straight forward matter of economics. At the margin, the total com-

Table 6-4. Shifts In Insurance Coverage for the Under 65 Population

	Employer Sponsored Insurance	Private Nongroup	Government (Excluding Medicare)	Uninsured
Number of People Covered in Millions:				
Current System	142	18	23	33
Under Pay-or-Play:				
With a 7 percent tax	105	0	112	0
With a 9 percent tax	132	0	85	0
Percentage of Population Covered:				
Current System	66	8	11	15
Under Pay-or-Play:				
With a 7 percent tax	48	0	52	0
With a 9 percent tax	61	0	39	0

Table 6-5. Insurance Costs
(Billions of 1989 dollars)

	Total	Employers	Individ- uals	Govern- ment
Total Insurance Costs:				
Current System	202	129	46	28
Under Pay-or-Play:				
With a 7 percent tax	269	159	46	64
With a 9 percent tax	272	173	46	53
Added Insurance Costs:				
With a 7 percent tax	67	30	0	36
With a 9 percent tax	70	44	0	26
Less Savings from Reductions in Uncompensated Care:				
With a 7 percent tax	15	—	—	—
With a 9 percent tax	15	—	—	—
Net Added Insurance Costs:				
With a 7 percent tax	52	—	—	—
With a 9 percent tax	55	—	—	—

pensation an employer is able to pay (including wages and fringe benefits) must equal the marginal value to the employer of the labor that is provided. As a result, if employers are forced by a government mandate to increase benefits, employer will reduce employment or reduce cash wages. A mandate simply cannot force an employer to pay more in compensation than the value of the labor to the employer. This conclusion has been supported by a number of empirical studies that have analyzed other mandates (see, e.g., Gruber and Krueger, 1990)

For workers who are not free to leave the labor market, the cost of keeping their jobs with a 7 percent "play-or-pay" payroll tax would be a 7 percent reduction in gross wages, and a larger proportionate drop in after-tax income. The burden would be particularly great because most of the working uninsured are low-wage workers who are already struggling just to make ends meet. For example, the mandate would result in—

- A pay cut of \$1,900 a year for the average 30 year old male high-school graduate, currently earning \$24,000 a year in wages; and
- A pay cut of \$1,400 a year for the average 30 year old male high-school dropout, currently earning \$18,000 a year in wages.

For other workers, 350,000 to 700,000 jobs would be lost. Moreover, if the "play-or-pay" mandate evolves into a universal public insurance program, as seems likely, available to all regardless of employment, job losses could reach two million.

A review of the characteristics of the uninsured workers makes these predictions seem even more realistic. (See Table 6-3.) Most of uninsured workers are low-wage, low-skilled workers. To be blunt, these workers simply do not have the "clout" in the market place to command costly fringe benefits. While unfortunate, this is a fact that cannot be overlooked.

A far better approach is to provide direct assistance for low-income workers through tax credits, as the President has proposed. This approach is much more "progressive" in terms of income distribution. Income is actually transferred directly to assist low-

income workers, without the risk of job loss or reduction in wages that a mandate inevitably involves.

"Play or pay" has other disadvantages for workers as well.

- With a 7 percent payroll tax, 37 million currently insured workers with employer-based plans would be forced to change coverage. Another 6 million would be forced to give up their private insurance and would be forced into a "one size fits all" public insurance plan that may not meet their needs. These shifts in coverage are illustrated in Table 6-6.
- Families that depend on supplemental income from part-time employment of a spouse could be hurt. If the mandate applies to part-time work. Employers will cut back on part-time jobs because of the added cost. On the other hand, if the mandate does not apply, it would fail to close an important gap in coverage and government would be forced to pick up the costs through the back-up public plan.
- Finally, "play or pay" may be lead to frequent changes in coverage that would be confusing for workers and increase administrative costs. Only 32 percent of currently uninsured workers end the year in the same job. In contrast, 72 percent of people who start a year employed and insured end the year in the same job (Klerman and Buchanan, 1990). Job change often forces a changes in coverage because employers contract with different insurers.

A Backdoor to National Health Insurance

Advocates present "play or pay" as means of providing universal coverage while avoiding national health insurance with all of its shortcomings. (See Chapter 6.A.) But, this argument is flawed. "Play or pay" is inherently unstable and will inevitably collapse into a full blown national health insurance system.

Many employers who now provide private health insurance to their workers will have strong incentives to shift coverage to the public plan "pay" option because a 7 or even 9 percent payroll tax will be significantly less costly than private coverage. Incentives

Table 6-6. Who Would Be Covered By the New Public Plan
(Numbers in millions)

	Workers	Dependents	Nonworkers
With a Pay-roll Tax of 7 Percent			
Former Source of Coverage:			
Employer	37	15	0
Private Insurance	6	2	6
Government	2	4	13
Uninsured	12	6	8
Total	57	27	28
With a Pay-roll Tax of 9 Percent			
Former Source of Coverage:			
Employer	24	8	0
Private Insurance	5	2	6
Government	2	3	13
Uninsured	9	4	8
Total	40	18	28

will be particularly great for small firms that have comparatively low average wages. A recent study conducted for the Labor Department by independent policy analysts at the Urban Institute reaches some startling conclusions on the potential size of such a shift.

With a 7 percent payroll tax, total enrollment in public insurance (including Medicare) would be 144 million or 58 percent of the population. Fifty-two million Americans would shift from employer provided private insurance to the new public plan. Twenty-six million of the 33 million who are currently uninsured would end up in the public plan. Only 7 million would actually receive health insurance through their employers.

For workers in small firms, private health insurance would quickly become a thing of the past under pay-or-play. At a 7 percent tax, 81 percent of the workers in firms with 25 workers or less would be enrolled in the public plan. Even with a 9 percent payroll tax 117 million, or 47 percent of total population would be covered by public insurance. Thirty-two million Americans who currently have private employer-paid coverage would shift into the new public plan as would 22 million of the currently uninsured.

It is important to note that the Urban Institute study focused only on the "static" effects of a pay-or-play mandate. Once a pay-or-play system is in effect, however, dynamic forces will be set in motion that drive the system further toward universal public coverage.

In the absence of other reforms, health care costs are likely to increase much more rapidly than wages. As a result, the public plan will become increasingly underfunded unless the payroll tax is increased to keep up with health care inflation. But, due to political pressures, the Congress is unlikely to let this happen. So, the Congress is likely to turn increasingly to general revenues to subsidize the public plan. Or the Congress may try to use some form of blunt price regulation to hold down public plan costs. Either way, the public plan would gain an increasing competitive advantage over private health plans, and private health plans would rapidly lose market share.

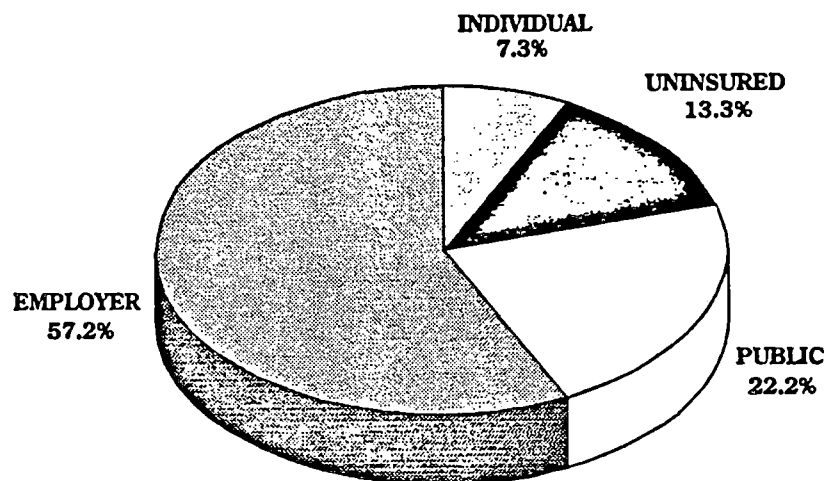
Effects on Employers

In the short-run, employers will not be able to react fully to the mandate by reducing wages or employment. As a result, the initial harmful effects of the mandate will fall mainly on employers. Small firms would

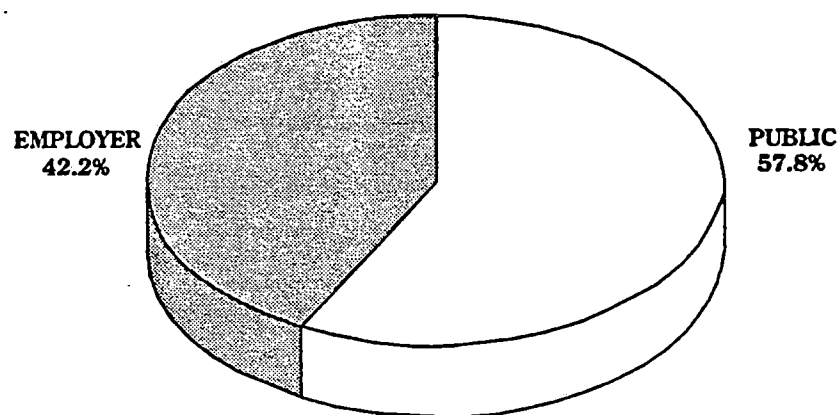
Chart 26: [Insert pie chart -- Health Insurance Coverage Under a "Play or Pay" Mandate: Public Versus Private. Chart is to have three wedges: private coverage, new public plan (including Medicaid) and Medicare, assuming a 7 percent tax rate.]

Chart 26.

CURRENT SYSTEM



PAY-OR-PLAY WITH A 7% TAX



SOURCE: The Urban Institute, "Pay or Play Employer Mandates: Effects on Insurance Coverage and Costs," January 8, 1992.

be especially hard hit—threatening the most dynamic sector of the U.S. economy.

- Health insurance costs for employers would increase by \$30 billion under a mandate with a 7 percent payroll tax—a 23 percent increase in current health insurance costs. With a 9 percent tax, the added cost for employers would be \$44 billion—a 34 percent increase in insurance costs.
- The largest proportional increases would be for small employers. For firms employing fewer than 25 workers, costs would rise by 71 percent with a 7 percent payroll tax rate, and by 101 percent with a 9 percent tax. As noted, 60 percent of currently uninsured workers are employed in establishments with 25 or fewer workers.

In the short run, a pay-or-play mandate will lead to somewhat higher prices and increase in the inflation rate. For firms, that cannot pass on increases in costs through higher prices, there would be a fall in profits. Assuming the monetary authorities maintain their existing targets for inflation, the effect of the mandate would be to raise unemployment and lower real GDP.

The Cost to the Government of Pay-or-Play

A pay-or-play mandate would give rise to a vast new federal health insurance program, four times as large as Medicaid and inadequately funded.

The Urban Institute estimates that a pay-or-play mandate with a 7 percent payroll tax would not be adequately funded. The new payroll tax would not cover the full cost of the new public plan. A subsidy of \$37 billion would be needed from general revenue. A 9 percent payroll tax would lower the subsidy to \$25 billion, but not eliminate it. The subsidy is likely to grow over time for reasons noted previously.

Pay-or-Play Fails to Address Cost-Control Effectively

Play-or-pay proposals are often coupled with “all-payer” price regulation schemes that attempt to limit aggregate payments by all public and private insurers to hospitals, physicians, and other providers to pre-set global budget targets. These schemes are closely related to Canadian-style national health insurance plans and share the same drawbacks.

All-payer rate setting preserves a role for private insurers, but is otherwise identical to a Canadian-style system in primary reliance on supply-side constraints to control costs. Neither approach addresses the dynamic factors that are driving up health care costs. In the absence of meaningful reforms, imposing price controls is like putting lid on a pressure cooker. If the heat remains, the lid eventually blows off and the pot boils over. The disadvantages of the Canadian system are discussed in detail elsewhere. Problems with all-payer rate setting are briefly summarized here (see Table 6-7).

Potential Problems with All-Payer Rate Setting

Although advocates often argue that of all-payer rate setting would encourage coordinated care plans, the opposite seems more likely to be the case. All payer rate setting robs coordinated care plans of their cost-savings advantage relative to traditional fee-for-service arrangements by artificially holding prices down.

The more rate setting succeeds in controlling costs, the less incentive that consumers (and therefore providers) will have to switch to coordinated care. So, all-payer rate setting, like Canadian-style national health insurance, seems likely to preserve inefficient forms of service delivery. The U.S. health care delivery system would be frozen in time, just as is true for the Canadian system.

Table 6-7. Potential Problems with All-Payer Rate Setting

1. Supply constraints will lead to shortages and waiting lines. Tight global budgets will force hospitals to cut back on personnel in critical areas—jeopardizing the quality of patient care.
2. Rate setting fails to reward efficient physicians while creating incentives for overutilization.
3. Rate setting fails to reform incentives/structure/organization at the micro-level and so will lose effectiveness with time.
4. Rate setting will reduce the competitive edge of coordinated care—thereby retarding critically needed change in the delivery system.
5. The link between health costs and the consumer pocket book may be too attenuated for there to be broad political support for cost containment. And, incentives for government to control costs are be weak, because government will be paying only a portion of the cost.
6. Primary reliance on all-payer regulation to control costs opens up a broad range of issues to political interference and manipulation.

Chapter 7

Examples of Impacts on Individuals and Families

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.¹

Case #1

A family of three with one working parent, and a total family income of \$10,000 (just below the poverty level):

[Full Credit of \$3,750]

- Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- Under the President's plan, this family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning \$8,500 per year. No employer health insurance is provided:

[Full Credit of \$3,750]

- Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for 6 months; after the 6 month period, the family is charged 3 percent of the family income as a Medicaid premium. After 1 year, the family is no longer eligible for Medicaid.
- Under the President's plan, the family would qualify for a \$3,750 transferable credit to buy basic health insurance through the State group health plan (or another private plan) when they no longer qualify for Medicaid.
- The President's plan removes the current disincentive for AFDC families to remain

on welfare because they fear losing Medicaid coverage—the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of 4 with a household income of \$35,000, and no employer sponsored health insurance:

[Full Health Care Deduction of \$3,750 and Access to Group Coverage]

- Under the current system, they often cannot find affordable coverage.
- Under the President's plan they would receive a \$3,750 tax deduction (a benefit of approximately \$1,050) to help with the purchase of insurance.
- In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family can buy more affordable coverage through a large employer group—with larger risk pools rather than costly individual coverage.

Case #4

A single individual below the poverty level not eligible for Medicaid (e.g. woman with no children and most males):

[Individual Credit of \$1,250]

- Under the current system, this individual has no access to health insurance, and usually receives "unreimbursed care" through hospital emergency rooms.
- Under the President's plan, this person would receive a \$1,250 transferable credit for the purchase of group health insurance

¹The examples presented assume the fully-phased in program.

through the basic State health plan, or some other private plan.

Case #5

A homeless person who currently relies on emergency room treatment for serious illnesses:

[Individual Credit of \$1,250]

- Under the current system, hospitals and other providers give uncompensated care, shifting the costs and higher charges to government and individuals with insurance.
- Under the President's plan, this person would use the \$1,250 credit to choose a basic health insurance package. If the individual did not choose a plan, the State and/or hospital could assign them to one of the "basic plan" insurers—with the premium paid by the transferable credit. Hospitals would receive reimbursement for most costs formerly provided for free.

Case #6

A family of 4 with household earnings of \$50,000, and a \$1,000 employer contribution to health insurance:

[Health Care Deduction]

- Under the President's plan, this family would receive a health care tax deduction of \$2,750 (\$3,750 minus employer contribution of \$1,000), making their health insurance much more affordable.

Case #7

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. Pre-existing conditions exclusions may also apply, interrupting coverage.
- Under the President's plan, regardless of health status, the new insurer would be required to offer unrestricted access to the new employer's group coverage.

- In addition, insurers would not be permitted to deny coverage due to health status, and persons with previous health benefits could be not denied coverage of pre-existing conditions. (So long as no insurer can avoid pre-existing conditions, and all must accept new risks, no insurer will be disadvantaged).

Case #8

An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

[Small Market Reforms]

- Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.
- Under the President's plan, small employers would have access to larger group coverage through Health Insurance Networks (HINs) spurred by major insurance and ERISA reform. Large group coverage is less expensive and more efficient, since insurance administrative costs are much lower and risk is more effectively distributed.
- In addition, the plan would set limits on the variation of premiums insurers can charge to different groups. Insurers would not be able to deny coverage to any individual, or drastically increase premiums when one member of a group becomes ill. Additionally, a "risk adjuster"—implemented within a few years—between insurance pools would remove the incentive for insurers to compete by "cherry picking" low risks and encourage competition on service, price and quality.

Case #9

An individual just diagnosed with a serious health problem applies for health insurance for the first time:

[Guaranteed Issue]

- Under the current system, uninsured persons with serious health problems are

often denied health insurance—for any price.

- Under the President's plan, insurers would be required to offer coverage to any individual, regardless of health status. Premium levels would be limited so that costs would not be prohibitive.

Case #10

A family earning \$17,000 has no employer coverage and currently cannot afford health insurance:

[Partial Health Credit]

- Under the President's plan, this family would receive a partial health tax credit towards the purchase of health insurance (or a \$3,750 deduction—whichever provides the greater benefit).
- Affordable group coverage would be made available through a State coordinated "basic plan" pool that would guarantee access to basic health insurance coverage.

Case #11

An individual is planning on choosing a health plan, and wants to get the best

quality plan for the most competitive price. But he is unsure of which plan to choose:

[Consumer Information]

- Under the current system, consumers have limited objective knowledge of the relative prices of insurers, providers. Nor are they aware of the hospitals and doctors included in the plan—or of the relative quality of local hospitals and doctors.
- Under the President's plan, comparative information on quality and price of health care will be available to consumers and large purchasers of care. Area provider groups will collect and disseminate information on plans and also individual providers such as physician, hospitals, labs and other facilities—both on price and quality. A type of local health care market "blue book" will allow consumers to identify the best health plans, and providers. As a result, consumers will be better equipped to choose the health plan or provider that is best suited to their needs and is the best value for their health care dollar.

Chapter 1 : Overview

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The President's Plan is a comprehensive, market-based reform that *assures access to affordable insurance for all Americans*. The President's Plan also *saves almost one trillion dollars* in total health costs through the end of this decade. Unlike competing proposals, the President's Plan *builds on American strengths* -- choice, diversity, innovation, technology, and the world's best quality. Nor does it ~~require~~ ^{involve} a massive tax increase or loss of jobs through crushing mandates on small businesses.

Assuring Access ~~for all Americans~~

- Providing universal coverage for low income families -- with incomes of up to 150 percent of poverty as a result of a new transferable health insurance tax credit (certificate). The credit (\$3,750 for a family) would be sufficient to purchase basic health coverage .
- Helping middle income families -- 57 million middle income Americans ~~would~~ benefit from a new tax deduction of up to \$3,750 per family to help pay for health premium costs not covered by employers.
- Assuring security and portability of coverage -- The fear of "job lock" -- where workers can't move to another job without losing access to insurance -- is ended. Insurers would be required to provide coverage regardless of health status and use of pre-existing coverage exclusions would be prohibited.
- Helping small business -- Small businesses would be able to pool their purchasing power to make coverage more affordable. Through health insurance networks -- they would have all of the advantages available to larger businesses.
- Expanding access for underserved areas -- Funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to expand to help improve access for millions of Americans living in inner city and rural areas.

Controlling Health Care Costs

- Relying on market forces -- Costs would be controlled by encouraging providers and health plans to compete more effectively to provide Americans better health care at lower cost. As a result, the system would be driven by consumer preferences and more responsive to their needs.

would be

- **Promoting consumer choice** -- For the first time, government assistance for the low-income will be provided through ~~tax~~ credits rather than through a publicly administered health insurance program. This approach gives families the freedom to choose the coverage that best suits their needs.
- **Providing comparative value information** -- Purchasers of health care services would be helped to make cost-effective choices by a new initiative to provide information ("blue books") that would compare costs and quality of providers and health plans.
- **Reforming health insurance markets** -- Competition based on "cream skimming" or favorable risk selection would be effectively blocked forcing health plans to compete based on cost-containment and quality.
- **Encouraging coordinated care** -- Expansion of coordinated care enrollment in Medicaid and Medicare will be encouraged. Laws limiting coordinated care and mandating costly non-essential services will be prohibited.
- **Preventing costly and disabling illness** -- Funding for vaccination, screening tests, and health promoting will be increased. Prevention is a "win-win" investment, health costs can be cut while improving well-being and increasing productivity. ✓
- **Reforming medical malpractice** -- A comprehensive liability reform plan will reduce the \$20 billion annual cost of defensive medicine and malpractice litigation that burdens the U.S. health system.
- **Reducing administrative costs** -- Electronic billing and "smart cards" will streamline the current paperwork maze, save \$4 billion a year, and make the system easier for doctors and patients. And, by allowing small employers to share and thereby reduce overhead costs, health insurance market reforms will reduce further overhead costs.

The President's Plan builds on a system that provides the world's best health care. The plan provides all Americans access to affordable health care coverage through a transferrable health insurance credit (voucher) -- available even to low-income Americans who do not file tax returns -- that can be applied to the purchase of a basic health benefit package. To reduce the rapid growth of health spending, the plan makes radical reforms in the health insurance system and includes strong incentives for the development and expansion of coordinated care systems and other efficient and effective arrangements for delivering high quality health care.

SUMMARY HIGHLIGHTS

Expanding Access to Health Care [see Chapters 3 and 4]

Transferrable Health Insurance Credits (vouchers) and Deductions - Benefitting Over 90 Million Americans

- A transferrable health insurance credit (voucher) or tax deduction would be available to ensure access to affordable health care coverage for moderate and low-income families. Over 90 million families would receive assistance. When fully implemented, families with incomes at or below the poverty line would receive a \$3,750 credit sufficient to purchase basic health benefits. Similarly, individuals would receive \$1,250 and two-person families \$2,500. A health insurance credit (voucher) or deduction (also up to \$3,750 per family) would be available to individuals, two-person, and larger families with annual incomes up to \$50,000, \$65,000 and \$80,000, respectively.

Market Reform

- *Basic Benefits* - States would be required to develop a basic health insurance package equal to the value of the health insurance credit. This would enable low-income families to purchase adequate health care coverage.
- *Insurance Security* - No longer would workers changing jobs be concerned about job lock -- the inability to change jobs for fear of losing access to insurance. Health insurers would be required to insure all comers. Coverage would be guaranteed, renewable, and preexisting condition limits would be eliminated.
- *Health Insurance Networks (HINs) -Pooled-Purchasing Power* - When it comes to health insurance, small businesses do not have many of the advantages of large businesses. Large companies can self insure and avoid expensive benefit mandates and premium taxes. If insured, because they have large employee groups, large firms are sold coverage similar to that purchased by small firms, but at much lower prices. A new way of purchasing insurance, HINs would enable small firms to purchase low cost, high quality health insurance. HINs would give small businesses the clout to buy lower

priced insurance by reducing administrative costs and by exempting insurance purchased from HINs from excessive State mandates, anti-managed care laws, and premium taxes. For the first time, groups like the National Federation of Independent Business, National Small Business United, and the U.S. Chamber of Commerce would be able to offer affordable health plans to their members nationwide or join with other groups to increase purchasing power in State or local markets.

- *Insurance Affordability* - In the near term, premium costs for similar policies sold to firms in a single block of business could vary by no more than 50 percent. A health risk adjustment across insurers would be phased in -- removing premium disparities and allowing for plan flexibility within a new insurance market driven by competition on quality and costs.

Containing Health Care Costs [see Chapter 5]

- *Malpractice Reform* - Threat of malpractice litigation prompts physicians to order tests and perform procedures simply to show that every effort has been made to provide the best health care. The President's plan would direct States to: (i) eliminate joint and several liability for non-economic damages, (ii) cap non-economic damages, (iii) eliminate rules that permit double recovery, (iv) require structured awards, (v) promote pretrial alternatives, and (vi) implement new procedures to improve quality of care. Also, standards of care, developed in conjunction with the medical community, would be explored to lessen physician uncertainty over malpractice litigation
- *Reducing Administrative Costs* - Insurance law changes and market reforms will eliminate the paperwork blizzard that afflicts all Americans with insurance -- and costs billions of dollars. Standardized claims procedures and other reforms will reduce administrative costs. For small employers, administrative costs may account for as much as 40 percent of the cost of insurance purchased. Marketing to and servicing small employer policies is costly. HINs, because they bring together many purchasers, would cut the cost of insurance administration and therefore substantially reduce premiums. These costs are usually under 10 percent for large businesses. Federally certified HINs would also be required to adhere to uniform claims processing standards, a source of additional administrative savings.
- *Expanded Use of Coordinated Care* -
 - In 1990, some 40 million Americans were enrolled in a coordinated care system -- up from 10 million in 1980. The President's plan encourages broader use coordinated care including preferred provider

organizations, point-of-service choice plans, case management, HMOs, and other forms of coordinated care.

- States would be encouraged to develop coordinated care systems and would be prohibited from having laws that hinder effective operation of these systems. Excessive state-mandated benefits -- that increase the cost of insurance -- would be prohibited.
- Reforms in Medicare would encourage increased coordinated care enrollment and coordinated care systems would have increased incentives to contract with Medicare. The President's plan also would make it easier for beneficiaries with retiree group health benefits to be served by coordinated care systems.
- *Increased Flexibility for State Programs* - States are encouraged to move to a coordinated care-based Medicaid program. They also would have the flexibility to redesign their entire health care systems.
 - States could choose to combine current Medicaid funding with the new benefits provided through the health insurance credit (voucher) to develop a single unified health plan for their low-income residents.
 - With the new Federal health insurance credit (voucher), all poor residents are guaranteed basic health coverage -- without any further fiscal burden on the States. This will allow States to more effectively allocate their health resources for Medicaid and for the nonpoor population.
- *Services are Expanded in Underserved Areas* - The inner city and rural America have acute shortages of doctors and clinics. The President's Budget expands funding for Community Health Centers, Migrant Health Centers, and the National Health Service Corps to expand preventive care in these areas.
- *Prevention* - The 1993 Budget includes \$26.4 billion, a nearly \$4 billion (18%), increase for preventive health activities. Prevention funding has increased over \$11 billion (74%) since 1989. Among other activities, the 1993 Budget proposes increases of 18% for childhood immunizations and infant mortality reduction, a 27% increase for Head Start and Early Childhood Development, a 24% increase for breast and cervical cancer mortality prevention, and a 90% increase for childhood lead poisoning prevention.
- *Improving Consumer Information* - To assist individuals and employers shopping for insurance and health care, localities would provide consumer

Chapter 1 : Overview [Note: below goes in box on page 1)

HIGHLIGHTS: The President's Plan For Comprehensive Health Care Reform

The President's Plan is a **comprehensive, market-based** reform that builds on the strengths of our current system to provide access to affordable insurance for all Americans.

- **The President's plan guarantees access to health insurance for all poor families** through a transferable health insurance tax credit (voucher) -- available even to those too poor to file taxes -- that is large enough to purchase a basic health package (\$3,750 for a family).
- **The President's plan provides insurance security for all Americans.** The fear of "job lock" -- where workers can't move to another job without losing access to insurance -- is eliminated. Limits on the availability of insurance for those with "preexisting conditions" are eliminated.
- **The President's plan will reduce the cost of health insurance through major market reforms.** Smaller businesses and individuals would be pooled into larger groups -- so they can enjoy the health coverage of large employers. Millions of people who now can't find affordable insurance will be helped.
- **The President's plan provides new help to the middle class to pay for health care.** Up to \$3,750 in health insurance costs can be deducted by families with incomes to \$80,000. Over 90 million Americans will receive new assistance for health costs.
- **The President's plan encourages the growth of coordinated care** -- in private plans, Medicare and Medicaid. Laws limiting coordinated care would be prohibited -- as are costly state mandated benefit laws. The comprehensive package guides individuals, employers and health providers toward coordinated care systems.
- **The President's plan would reduce administrative costs** through regulatory reforms that will streamline the current paperwork maze, and through market reforms that allow small employers to share -- and thereby substantially reduce -- administrative costs.
- **The President's plan includes major malpractice reform.** A comprehensive liability reform plan is proposed to reduce the costs of malpractice and the resulting defensive medicine that burdens the US health system.
- **The President's plan would expand services in underserved areas.** The inner city and rural America have acute shortages of doctors and clinics. The

President's budget expands funding for Community Health Centers, Migrant Health Centers and the National Health Service Corps to expand preventive care in these areas.

The President's Plan Does Not:

- include governmental price regulation or rationing of health care
- burden small business with new and costly mandates that will stifle the creation of new jobs and be passed on in higher product costs and higher taxes for all Americans
- require massive tax increases like "play or pay" and national health insurance
- threaten poor older Americans with benefit reductions or premium increases.

Hanns.

[NOTE: EDITING IN PROGRESS]

CHAPTER 6

PROBLEMS WITH ALTERNATIVE APPROACHES

Many of the proposals for health system reform are patterned after one of two basic models: a centralized Canadian-style national health insurance system or an employer "play-or-pay" mandate. While widely discussed, these proposals are often designed in relatively cursory fashion, with little or no assessment or analysis of impacts for implementation in this Nation. This chapter presents a rigorous analysis of these models.

A. CANADIAN MODEL

Overview

While apparently successful in many respects and highly popular with the Canadian people, the Canadian system -- like all other universal public insurance systems -- suffers from two basic structural flaws -- flaws that are bound to lead to serious long term problems with cost, access, and quality.

- There are no demand side incentives for efficiency. Because medical care is free to consumers, consumers do not play the same role they play in normal markets.

Market forces that normally drive economic systems to greater efficiency simply do not exist. Moreover, consumers are unable to express their preferences through market choices.

- Second, all major resource allocations are made centrally through the political process, but health care is too complex, too sensitive to micro-level conditions, for centralized management to be effective.

The Canadian system relies on blunt, macro-level, supply-side constraints such as global budgets, limits on high-tech equipment, and limits on physician supply.

But, efficiency -- high quality care at the lowest possible cost -- requires that optimal decisions be made at the hospital bed-side and in the physician's office.

This cannot result from central planning, so resources are bound to be wasted and quality is at risk.

These flaws are already beginning to be manifest in the actual experience of the Canadian system:

- **Costs have not been controlled effectively despite the enormous power that a single payer has under a universal public insurance program. Indeed, Canadian costs have been rising slightly faster than U.S. costs.**

Costs growth can be moderated through non-market means, but with significant inefficiency. Resources are wasted on low-priority care while blunt cost containment measures limit spending where added resources could make a real difference in outcomes.

- **Supply-side constraints has led to artificial shortages of critical personnel and equipment.**

Canadians have significantly less access to state-of-the-art technologies and often have to wait weeks or months for effective treatments that are readily available for Americans from all walks of life.

While waiting, many Canadians are at an increased risk of death or must endure painful or disabling symptoms that could have been corrected. And, certain procedures, such as coronary bypass surgery, appear to be rationed, especially for senior citizens.

Lost productivity and other costs associated with delays in surgery are estimated at 0.6% of Canadian GDP. These losses could be even higher if delays for other medical services are taken into account.

- **Incentives for Canadian physicians and hospitals reward additional care regardless of appropriateness or quality. As a result, utilization rates have increased rapidly and resources have been wasted.**
- **Reliance on crude global budgets as a means of controlling costs has forced Canadian hospitals to cut back on staffing in critical areas. As a result, post-operative death rates in Canada are 40 percent higher than in U.S. hospitals, for certain high-tech, life saving surgical operations.**

Even if the Canadian system were an unqualified success, its success, if imported into the United States would be less than assured. Each nation has its own unique political, cultural, and economic environment. Experience with the Medicare and Medicaid programs in the United States suggests that a Canadian-style universal public insurance program could not be imported successfully.

- Over the past decade and a half, effective management of Medicare and Medicaid has been stymied by increasing politicization. Today, an Act of Congress is needed to change the amount that Medicare pays for a wheel chair.
 - As a result, Medicare and Medicaid per capita costs continue to grow more rapidly than per capita costs for the remainder of the population.
- If the U. S. political process has been unable to control xx% of health spending, there is little reason for optimism that it could be more successful in controlling costs for the entire health system.

Indeed, the thought that as much as xx% of the GNP by the year 2000 could be subject to direct political control should be enough to give most Americans pause for serious concern.

Basic Features of the Canadian Model

For the past two decades, the ten Canadian provinces have operated government-based health insurance plans that cover hospital and physician care. The Canadian system was not implemented all at once, but gradually evolved over many years following World War II. The Canadian system itself, and American proposals to implement a Canadian-style approach, share a number of basic structural features:

- Health insurance is provided to all citizens through a centralized, publicly administered program. Health care services are provided by private-sector hospitals, physicians, and other providers. Private insurance is prohibited, except for services not covered by the public program.
- Covered benefits include hospital, physician, mental health, and preventative care. (Some Canadian provinces also cover prescription drugs and long-term care.) Care is free with no cost-sharing at the point of service
- Hospitals and other institutional providers are paid on the basis of global budgets that cover all patient care costs during a year. Global budgets are set annually by government authorities, through a process that involves some element of negotiation.
- Physicians, and other non-institutional practitioners and providers are paid on a fee-for-service basis according to a government-established fee schedule. Overall payment for physician services are limited by a a global budget or "expenditure target."

- To control costs, the supply of facilities, equipment, and providers is strictly regulated. Hospitals are limited to government-set budgets for capital expenses. Construction projects and high-cost equipment purchases require special approval. Physician supply is limited and the specialty distribution is regulated to encourage general practice.
- Financing is primarily through broad based taxes (including a payroll tax). Some Canadian provinces also require small premium payments. Others place a special tax on employers.
- The Canadian system is administered through the provinces with supplemental Federal financing. A Canadian-style system in the U. S. could be jointly administered by Federal and state governments (as proposed by Senator Kerrey) or primarily by the national government (as proposed by Congressman Russo).

Basic Structural Flaws in the Canadian Model

Lack of Demand-Side Incentives.-- At a fundamental level, the Canadian system lacks effective incentives for efficiency. Because medical care is free to consumers, market forces that normally drive economic systems to greater efficiency simply do not exist.

This flaw could be partly remedied by requiring some cost-sharing at the point of service. The RAND health insurance experiment has conclusively shown that modest levels of cost-sharing reduce demand with little or no measurable impact on health status. (references to follow) But, the flaw in the Canadian system is deeper than a simple lack of cost-sharing.

Because consumers do not have a choice of alternative health plans and do not pay any portion of the premium cost, there is no dynamic that could lead to the development of more efficient systems for delivering high quality care at low cost. It is no accident that innovative health care delivery systems, such as Kaiser Permanente or Group Health of Puget Sound, have emerged in the United States, but not in Canada.

In the U.S., employers and individuals, concerned about getting good value for their health care dollars, have incentives to demand better forms of health care delivery. This, in turn, creates a market for such systems, and organized health plans then compete with one another for market share, leading to progressive improvements in cost-effectiveness and quality. This consumer-driven process of progressive simply improvement cannot occur in a Canadian-style system.

As a result, the Canadian health care system is curiously frozen in time, resembling the U.S. health care system as it existed in the mid-1960s. Medical care

continues to be an unorganized cottage industry. Physicians are subject to little oversight to assure efficiency and quality of care. And physicians continue to be paid exclusively on a fee-for-service basis despite clear evidence that this approach is inherently inflationary. None of the improvements in health systems delivery or innovative payment arrangements that have developed in the United States over the past decades have been able to take root in Canada.

Overall, Canadian citizens as individuals are relegated to a diminished role in decision making in the health care system. Because they cannot make their own choices in the market, they are forced to rely on the vagaries of the political process.

Supply-Side Controls.— Because incentives for needed, appropriate care only are so poorly structured, the government is left with controlling costs through crude supply side controls implemented through a central planning measures. There are at least problems with this approach.

Arbitrariness of Measures. An initial problem is the relative crudeness of the measures used for budgeting; technical details tend to be highly arcane. Hospital budgets have historically not accounted for case-mix differences or efficiencies in care across settings. Only recently have some provinces begin to experiment with Diagnosis-Related Groups (developed and used in the United States for over a decade) for assessing severity of its caseload. Overall, centrally planned budgets and spending caps may or may not be developed with adequate information about patient population needs or appropriate funding for cost-effective care. Frequently, there is no correct decision and policies tend to be arbitrary.

Loss of Flexibility. A second problem is that use of central controls necessarily curtails local flexibility and needs. Decisions for new facilities and the purchase of new technology can take months or even years to complete; the application process can be cumbersome, expensive and politicized, without necessarily resulting in an efficient allocation of resources (NEJM cite). Lowered quality of care can result from lags in the decision process.

The Veterans Affairs (VA) system in the U.S. is an analogous example of using supply controls to determine resource distribution. The VA has been a recognized leader in such areas as cardiac care and radioisotopes, but not all facilities have been adequately utilized. At the same time, even as late as the mid 1980s, fewer than one-third of VA centers had CT scans. An earlier, extensive study by the National Academy of Sciences (1979) found widespread evidence of maldistribution in terms of equipment, basic and specialized services, staffing, and number of beds.

Weak Political Incentives to Contain Costs. The third general problem is that the centralized process may be too removed or too politicized to effectively contain costs. The link between health costs and the consumer preference for benefits relative to costs may be too attenuated. Broad-based political support for cost-

containment may be unrealistic. Lobbying by providers and special interest groups, partisan disputes, and a host of other complications make success in containing costs erratic, at best.

At the other extreme, centralized systems are often vulnerable to swings in economic cycles. Because revenues are raised through the tax system, budgets must adjust to revenue flows. This means that Federal contributions are cut back during recession or economic downturn. Federal contributions in Canada in fact have been frozen starting in 1991; the freeze will be extended through 1995 (Barer and Evans, 1991). During this recent downturn, the Canadian health system has made-up for declining federal revenues by both adding user fees and cost-shifting to provincial budgets.

Canada: The Evidence to Date

The preceding discussion suggests that the design inherent in any centralized, government-controlled health insurance scheme will have adverse impacts on costs, access, appropriate use of resources, and quality. In fact, a growing body of evidence strongly suggests five of these impacts in the current Canadian system.

Failure to Control Cost Growth.-- Even with strict global budgeting and some rationing of care, Canadian health costs continue to grow faster than U.S. costs. Between 1970 and 1980, Canada's annual compound rate of growth for per capita health expenditures was 12.4 percent, compared with 11.9 percent in the U.S. Between 1970 and 1990, Canada's expenditures grew annually 10.8 percent, compared with 10.5 percent in the U.S. (OECD, 1990; Schieber et al., 1991).

[Bar Chart or Growth]

Cost-containment also has become more difficult in Canada in recent years. Rising demands on the system resulting from free universal access have placed increased financial burdens on the government -- burdens which are increasingly difficult to bear.

Declining national contributions and cost-containment measures have initiated a recent round of hospital staff layoffs and bed closings. In Ontario, for example, the richest and most populous province, where more than a third of the Canadians live, has lost nearly 5,000 hospital jobs and 3,500 beds over the last two years. In Toronto, the provincial capital, 2,900 of 15,000 acute-care beds have been taken out of service (Media Digest, November 25, 1991).

To contain costs, Canada has cut payments to providers, making the yearly price negotiations more and more difficult. The rising Canadian costs, kept

artificially under control by government price and spending caps, has been described as "a pressure cooker that is building steam on a hot stove" (Iglehart, 1986).

Limited Access to High-Tech Services.-- Reliance on crude supply side constraints to control costs will inevitably lead to shortages and delays in treatment. This has occurred in practice.

Treatment Delays -- Canadians must often wait to receive treatment. For example, Canadians can wait (on average) 4.9 months for open heart surgery, and 5.5 months for bypass surgery (Globerman, 1990).

Chart 1: Bar Chart: Waiting Times

These waiting times for medical treatment can have potentially adverse effects on patients' health. Patients not receiving timely access to diagnostic procedures -- such as MRIs, CT scans and mammograms -- and can suffer setbacks due to delayed treatment. Those waiting for acute procedures -- such as open heart surgery -- can risk death waiting for care.

Waiting for treatment also results in a direct economic loss. (Danzon, 1991). If unable to work while waiting for care, individuals may face financial setbacks. Some may even lose their jobs. There is the additional social loss of productivity. The overall cost of delays in surgery has been estimated at 0.6 percent of Canadian GDP. (reference -- see Danzon for primary cite)

Technology. The most advanced medical technology is limited to Canadian citizens. Government control of hospital capital and operating budgets limits the penetration of medical technology in the Canadian market. For example, U.S. citizens have access to more open heart surgery, cardiac catheterization, organ transplants, radiation therapy, extracorporeal shock and lithotripsy, and magnetic resonance imaging.

[Bar Chart, Medical Technologies, U.S. vs Canada Dale Rublee, Health Affairs]

Data from Anderson et al. (NEJM, 1990?) also suggest rationing of selected expensive procedures for older age groups. Heart valve surgery and bypass surgery for patients ages 65-74 and 75+ were consistently performed less often in Canada. For patients age 75 and above, a full 4 times as many bypass procedures were performed in the U.S. as in Canada for the same age group of patients.

Limited availability of medical technology has prompted the Canadian government to even send some patients to the U.S. to seek advanced medical care. For example, the British Columbia Health Association has contracted with Seattle

hospitals for coronary bypass surgeries (Washington State Hospital Association, 1990), and Ontario and Alberta have similarly contracted with U.S. hospitals for high technology care (Goodwin, 1990; Sherlock, 1990).

While these instances may be rationalized as temporary problems, the Canadian system generally is able to use U.S. access to technology as a "safety valve." Since the U.S. provides an available supply of medical technology just across the boarder, Canada may have an incentive not to invest in sufficient supply. If the U.S. were to adopt a Canadian system, this safety valve would no longer exist for Canada, nor would one exist for Americans (HIAA, 1990).

Innovation. There are several areas of evidence of the Canadian system lagging in organizational and managerial innovations. For example, coordinated care arrangements have just recently taken hold in a few of the Canadian provinces. As mentioned in Chapter xx, these Health Service Organizations use similar approaches for more cost-effective care.

Limited hospital budgets for capital improvements has meant that the physical plants and equipment in many hospitals is nearing obsolescence (Iglehart, 1986). This lessens Canadian hospitals' ability to provide the best structural attributes for high quality care.

Ineffective Use of Resources Resulting from Inappropriate Incentives.-- Because Canada continues to rely primarily on fee for service payment, physicians are rewarded for additional care regardless of need or quality. As a result, utilization per physician increased by 25.1 percent in Canada between 1971 and 1985, compare with only 7.0 percent in the United States (Barer et al., 1988). Overall, Canadian physicians provide a much higher volume of services than U.S. physicians. While no data are available on rates of appropriateness, these substantially higher levels of medical utilization raise concerns about the amount of inappropriate and unnecessary care being delivered and paid for by the Canadian taxpayer.

Relative Use of Physician Services in the Canada and the United States (services per capita)	
Source: Fuchs, 1990.	
Service Type	Canadian Rate as percent of U.S. Rate
Diagnostic and Therapeutic Procedures	120%
Office Visit and Consultations	156%
All Physician Services	139%

Hospitals also face perverse incentives. Because hospitals are paid on a fixed global budget, the financial incentive is to use available beds for patients with the lowest cost. As a result, Canadian hospitals are filled with chronically ill, but low cost, patients, termed "bed blockers." These incentives affect quality as well for hospitals spill-over to staffing decisions. There are lower staff-to-patient ratios in Canada (1.87) versus the United States (3.47) (Newhouse et al., 1988). The mix of staff is less specialized reflecting lower case severity; quality and intensity of care for high-risk patients, however, can suffer as a result of these staffing patterns (see below).

Comparison of Hospital Care in Canada and the United States (use rates for people aged 65 and older) (Source: Newhouse, 1988)			
	Unites States	Canada	Canadian Rate as % of U.S. Rate
Admissions Per Capita	0.33	0.35	106%
Length of Hospital Stay (in days)	7.96	13.32	167%
Hospital Days Per Capita	2.63	4.66	177%
Hospital Staff Per Occupied Bed	3.47	1.87	54%

Generally, service production is poorly integrated in the current system across the continuum of care. Because settings and sets of providers are paid on a fee-for-service basis, efficiencies across settings lag behind the U.S. experience. Fully integrated health plans such as Kaiser are able to achieve production efficiencies that are difficult to achieve in fee-for-service settings. Same-day, ambulatory surgery and substitution of outpatient for inpatient care has lagged behind its U.S. counterparts.

Pressures on Quality.-- While compartive studies are scant, Roos et al. (1989) recently reported a comparison of Canadian and U.S. post-operative mortality rates. Interestingly, Canadian hospitals did as well as U.S. hospitals on low risk surgical procedures. However, relative risk of post-operative survival was much poorer in Canada than in the U.S. for high risk procedures. These outcomes may be due to (again) incentives of hospital budgeting practices which encourages lower staff-to-bed ratios, which in turn mean that needed intensive care support following surgeries is far less available and effective in the Canadian system.

Quality assurance activities such as peer review, second opinion, utilization management and outcomes information are also relatively undeveloped in Canada compared with the United States. Historically, Canada has not attempted to question physicians' judgements about the medical necessity of the treatments they

recommend. This professional sovereignty and freedom from outside interference is an aspect of their health care system that Canadian physicians value highly. One observer has characterized it as the price they extract for their participation in an otherwise highly regulated system (HIAA, 1990).

Similarly, Canadian hospitals have few incentives to compete based on increased quality of care, and because of tight budgets, do not invest to any significant level in data collection and quality review.

Could a Canadian-Style System Be Successfully Implemented in the United States?

Critical Differences Between the United States and Canada.— The notion of simply copying the Canadian system is simplistic. Each nation has its own unique political, cultural, and economic environment and history. Even if the Canadian system were an unqualified success in Canada, its success, if imported into the United States would be less than assured.

One major difference between the United States and Canada is our form of government. We rely on a system of checks and balances, with independent executive, legislative, and judicial branches. Canadians, in contrast, have a parliamentary form of government, which effectively combines legislative and executive functions. The result is, that there is little potential in Canada for the political deadlock that has characterized health policy in the United States over the past decade.

Experience with the Medicare and Medicaid Programs.— Experience with the Medicare and Medicaid programs suggests that a Canadian-style universal public insurance program could not be translated successfully into the United States. While these programs have succeeded in expanding access to the elderly, the disabled and many low income Americans, these programs has become increasingly politicized over the past 10 years with the result that effective program management has been stymied.

When enacted in 1965, Congress delegated broad responsibility for management of Medicare and Medicaid to the Executive branch and to the States. Congress legislated only the broad outlines of the programs and limited its role to oversight. Today, virtually every detail of operation of Medicare and Medicaid is dictated in hundred of pages of dense legislative language that are comprehensible only to a handful of Congressional staff and executive branch experts.

With the increasing complexity of the legislation, few Members of Congress even have an opportunity to vote on the issues involves. Over the past decade, the full House and Senate have only had a handful of opportunities to debate and vote on critical programmatic issues. Generally, these issues are decided in Committee or

Subcommittee, with other members being limited to an up or down vote on the whole package.

Micromanagement of program details by legislators may be inevitable because it extends political power and influence of key Committee members.. The technical details of payment policy often are highly arcane but of great monetary significance. Often there is no "correct" decision. Thus, many payment policies are somewhat arbitrary. Yet, once the policy is set, it tends to be rigid and is stoutly defended by the interested party that benefits.

This process of politicization has progressed to the point where it now virtually requires an Act of Congress to change how much Medicare pays for a wheel chair. As a result, per capita health care costs for Medicare and Medicaid recipients have grown consistently faster than per capita health care costs for the remaining population.

If the political process has been unable to control xx% of health spending, there is little reason for optimism that it could be more successful in controlling costs for the entire health system. Indeed, the thought that as much as xx% of the GNP by the year 2000 could be subject to direct political control should be enough to give pause for serious concern for most Americans.

Potential for Massive Transition Costs and Disruptions.--

[discussion of budget and transition costs association with shift to national health insurance system]

References

Steven Globberman, Waiting Your Turn: Hospital Waiting Lists in Canada (Vancouver: Fraser Institute, May 1990).

Carol Goodwin, "U.S. Miracle Workers Take Pay Cuts the Help Canadians," The Kirchner-Waterloo (Ontario) Record, February 15, 1990.

John K. Igelhart, "Canada's Health Care System," New England Journal of Medicine 315 (3): July 17, 1986, p. 203.

Howard Kim, "Canada Tabs Washington Hospital," Modern Health Care, March 26, 1990.

Ed Neuschler, Canadian Health Care: The Implications of Public Health Insurance, HIAA Research Bulletin, June 1990.

Karen Sherlock, "Detroit Offers Short Wait for Health Surgery," The Edmonton Journal, January 6, 1990.

Washington State Hospital Association Weekly Report 15:8 (February 23, 1989).

6. B. THE PROBLEMS WITH "PLAY-OR-PAY"

Overview

"Play-or-pay" is a widely discussed approach for expanding health insurance access. Employers would be required to play, e.g., provide private insurance for workers and dependents or pay a payroll tax to fund public insurance for their workers and dependents. Variants of this approach have been proposed by Senators Mitchell and Kennedy and by Representative Rostenkowski, among others.

While "play-or-pay" would expand insurance coverage, it suffers from four serious drawbacks. "Play-or-pay" would:

- Hurt workers by increasing unemployment and by forcing employers to cut wages to offset mandate costs. While "play-or-pay" seems to put the burden on employers, this is largely an illusion. Employers will inevitably shift the burden to employees. Between 400,000 and 700,000 jobs could be lost in the short-run, with a long-term potential as high as one and a half million. Moreover, cash wages for the "beneficiaries" of the mandate would decrease by 7 to 9 percent depending on the payroll tax rate.
- Be a back door to national health insurance. "Play or pay" is inherently unstable and would rapidly degenerate into national health insurance. According to the Urban Institute, xx million workers and dependents with private coverage would be shifted into the public plan. Overall, xx% of Americans would be insured publicly. At this point, the public plan would undoubtedly use its near-monopsony position to gain deep discounts from providers resulting in a massive cost-shift that would rapidly price the remaining private coverage out of the market.
- Increase inflation and hurt small business. While the \$30 billion cost of the mandate will be shifted to workers, in the near-term, employers will bear the burden. Some employers may try to pass this added cost on to consumers in the form of higher prices. But, many businesses that do not currently provide coverage have low profitability and are engaged in intense competition. Of particular concern, small business will be disproportionately impacted.
- Increase costs for government by \$xx billion \$37 billion over and above the new payroll tax receipts. "Play or pay" is not self-financing. A Federal subsidy of \$37 billion would be needed to fund the gap between payroll tax receipts and actual costs, and this gap is likely to grow rapidly. Although premium costs average 7 percent of payroll, actual costs vary widely. Low-wage firms incur costs well in excess of 7 percent. These firms will disproportionately opt to "pay," but the tax will be grossly inadequate for health coverage for these firms. This problem will be compounded by the fact that premium costs also vary widely. Firms with higher premiums due to an

older or sicker workforce would have strong incentive to opt into the public plan, further undermining the solvency of the plan.

How Play or Pay Plans Operate

"Play or pay" employer mandates are designed to provide coverage for workers and their dependents with little direct cost to government. Employers are required to provide coverage directly or pay a payroll tax. Mandates typically apply for all workers employed more than 17.5 hours a week.

- To "play," employers would be required to provide "basic" health coverage. Typically, employers could require workers to pay up to 20 percent of premium costs and could require workers to pay modest cost sharing on benefits.
- Employers not providing health benefits directly would be required to pay a payroll tax to cover a portion of the cost of benefits provided through a public insurance program. Typical payroll tax rates are in the range of 7 to 9 percent. Generally, there is no cap on taxable wage base.

"Play or pay" mandates usually are complemented with an expanded public insurance program to replace Medicaid and provide subsidized coverage on a sliding-scale basis for those without employer-paid coverage or Medicare. Some form of price regulation also generally accompanies "play or pay" proposals as a means of restraining costs. The regulation may involve some form of payer/provider negotiations or may be administered directly by a regulatory agency.

Characteristics of the Working Uninsured

The working uninsured are the intended beneficiaries of "play or pay" mandates. Thus, it is important to understand who they are.

[insert table from Monheit & Short article showing health insurance status and characteristics of employed persons: age, sex, race, size of establishment, hourly wage, and occupation]

[summary of pertinent features from table: uninsured workers tend be predominantly low wage, low skilled occupations, therefore highly vulnerable to a shift in burden of mandate from employers]

Consequences of "Play or Pay"

Effects on Insurance Coverage.— From this standpoint, "play or pay" appears to be a success. According to a simulation of this policy conducted by analysts at the Urban Institute, an estimated xx million Americans and their dependents would receive insurance coverage as a result of the mandate. An additional xx million Americans would be covered through a public plan for unemployed and self-employed individuals and dependents.

[insert summary table 2 and 3 on changes in coverage from Urban Institute study; tables need to be consolidated and clarified]

Assuming a 7 percent "play or pay" tax, insurance costs would increase by \$29.7 billion for employers, in 1989 dollars, and by \$36.8 billion for employers. Premiums paid by individuals would increase by \$0.8 billion, while uncompensated hospital care would decrease by \$15 billion.

[insert summary table 7 from Urban study]

The Effects on Wages and Employment.— "Play or pay" mandates appear to put the burden on employers, but in the long-run, the burden will fall primarily on workers. As a result, workers will inevitably be hurt more than they are helped. For primary breadwinners who will need to hold a job under all circumstances, the main effect of the expanded health insurance coverage is likely to be a drop in real take-home pay. For workers who are able to move in or out of the labor force, the effect is likely to be a combination of lower take-home pay and reduced jobs.

The reason is a straight forward matter of economics. At the margin, the total compensation an employer is willing to pay (including wages and fringe benefits) will equal the marginal value to the employer of the labor that is provided. As a result, if employers are forced by government mandate to increase benefits, employer will reduce employment or reduce cash wages. A mandate simply cannot force an employer to pay more in compensation than the value of the labor to the employer. This conclusion has been supported by a number of empirical studies that have analyzed other mandates. (See, e.g, Gruber and Krueger, 1990; insert other references)

For workers who are not free to leave the labor market, the cost of keeping their jobs with a 7 percent "play-or-pay" payroll tax would be a 7 percent reduction in cash wages. The burden would be particularly great because most of the working uninsured are low-wage workers who are already struggling just to make ends meet. For example, the mandate would result in --

- A pay cut of \$xxx a year for the average 34 year old male high-school graduate, currently earning \$xx,xxx a year; and
- A pay cut of \$xxx a year for the average 34 year old male high-school dropout, currently earning \$xx,xxx a year.

For other workers, 400,000 to 700,000 jobs would be lost. Moreover, if the "play-or-pay" mandate evolves into a universal public insurance program, as seems likely, available to all regardless of employment, job losses could exceed one and one half million.

A review of the characteristics of the uninsured workers makes these predictions seem even more realistic. (See table xx). Most of uninsured workers are low-wage, low-skilled workers. To be blunt, these workers simply do not have the "clout" in the market place to command costly fringe benefits. While unfortunate, this is a fact that cannot be overlooked.

A far better approach is to provide direct assistance for low-income workers through tax credits, as the President has proposed. This approach is much more "progressive" in terms of income distribution. Income is actually transferred directly to assist low-income workers, without the risk of job loss or reduction in wages that a mandate inevitably involves.

"Play or pay" health mandates have other disadvantages for workers as well.

- XX million currently insured workers would be forced to change coverage. XX million would be forced to give up their private insurance and would be forced into a "one size fits all" public insurance plan that may not meet their needs. These shifts in coverage are illustrated in table xx.

[Be sure that tables are provided to illustrate these shifts.]

- Families that depend on supplemental income from part-time employment of a spouse could be hurt. If the mandate applies to part-time work. Employers will cut back on part-time jobs because of the added cost. On the other hand, if the mandate does not apply, it would fail to close an important gap in coverage and government would be forced to pick up the costs through the back-up public plan.
- Finally, "play or pay" may lead to frequent changes in coverage that would be confusing for workers and increase administrative costs. Only 32 percent of currently uninsured workers end the year in the same job. In contrast, 72 percent of people who start a year employed and insured end the year in the same job. (Klerman and Buchanan, 1990) Job turnover will force often a changes in coverage because different employers tend to contract with different insurers.

A Backdoor to National Health Insurance

Pay-or-play is often presented as an alternative to universal public health insurance like that in Canada or Britain. Such plans remove choices from patients and limit doctors' flexibility as described in more detail elsewhere in this document. Recognizing these shortcomings, proponents of pay-or-play have generally presented their proposals as simple extensions of the existing system of employer provided health insurance in which the public component is downplayed.

This overlooks the strong temptation that employers, who now offer health insurance to their workers, will have to choose the shift to the public pay option, if the new payroll tax rate is as low as 7 or even 9 percent. A recent study conducted for the Labor Department by independent policy analysts at the Urban Institute reaches some startling conclusions on the potential size of such a shift.

**PIE CHART -- HEALTH INSURANCE COVERAGE PUBLIC VERSUS PRIVATE:
3 WEDGES: PRIVATE, NEW PUBLIC(INCLUDING MEDICAID), AND MEDICARE.
ASSUME A 7 PERCENT TAX RATE.**

- o A pay-or-play plan with a 7 percent payroll tax would cause a shift of 52 million Americans from employer provided health insurance to the newly created public plan. Even if the tax were as high as 9 percent, there would still be a shift of 32 million.
- o At the 7 percent tax rate, 26 million of the 33 million who are currently uninsured would end up in the public plan. Only 7 million would actually receive health insurance through their employers. At the higher 9 percent rate, 22 million of the uninsured would join the public plan.
- o When the Medicare population is included, the enrollment in public health insurance is 144 million or 58 percent of the total population, when the payroll tax is 7 percent; it is 117 million, or 47 percent, of total population at a payroll tax of 9 percent.
- o For workers in small firms, private health insurance would quickly become a thing of the past under pay-or-play. At a 7 percent tax, 81 percent of the workers in firms with 25 workers or less would be enrolled in the public plan.

The Urban Institute study only considers the static effects of a pay-or-play mandate. It analyzed the initial shifting that would take place as employers selected the least-cost option. Once a pay-or-play system is in effect, however, dynamic forces will be set in motion that drive the system further toward universal public coverage.

- o As long as some private employers continue to offer coverage, a pay-or-play mandate does not require Congress to raise taxes to "improve" that coverage. It will be difficult for lawmakers to resist pressures from provider groups to

include extra services in the mandated benefit package. Over time this will induce more employers to shift to the pay option.

- o Unless Congress is willing to let the payroll tax rise to whatever level is needed to fund the public plan entirely out of its revenues, there will be a marked cost advantage to employers from paying rather than playing. This competitive advantage is likely to widen over time as Congress adds benefits to the mandate.

Effects on Employers

The initial harmful economic effects of a pay-or-play mandate will fall mainly on employers. Small firms would be especially hard hit.

- o Employers would have to come up with \$30 billion in extra health insurance premiums or higher taxes under a pay-or-play mandate with a 7 percent payroll tax, a 23 percent increase in their current health insurance costs; if the tax is 9 percent, the added payments from employers are larger, \$44 billion, a 34 percent increase.
- o The largest proportional increases are for small employers. For firms employing less than 25 workers, employer payments for health insurance would rise by 71 percent with a 7 percent payroll tax rate, and by 100 percent if the tax rate were 9 percent.
- o Many employers would be forced to pay a higher share of premium costs under a pay-or-play mandate, since most proposals limit sharply the amount of employee cost-sharing.
Some employers would also be required to provide broader benefits, the estimated cost of the required upgrades for a typical pay-or-play mandate is \$15 billion.
- o Health insurance coverage varies widely by sector ranging from a low of 24 percent in agriculture to a high of 80 percent in local and state government. Sectors with low rates of coverage will be hard hit by the mandate.
- o Coverage also varies widely by firm size, ranging from 40 percent for small firms with less than 25 workers to 73 percent for firms with 500 or more employees. A sharp increase in costs for small firms relative to large firms would threaten the most dynamic sector of the U.S. economy.
- o In the short run, a pay-or-play mandate will lead to somewhat higher prices and increase in the inflation rate. For firms, that cannot pass on increases in costs through higher prices, there would be a fall in profits. Assuming the

monetary authorities maintain their existing targets for inflation, the effect of the mandate would be to raise unemployment and lower real GNP.

The Cost to the Government of Pay-or-Play

A pay-or-play mandate would give rise to a vast new Federal health insurance program, four times as large as Medicare and inadequately funded.

BAR CHARTS – COST TO GOVERNMENT UNDER PAY-OR-PLAY WITH 7 PERCENT AND 9 PERCENT PAYROLL TAXES COMPARED WITH CURRENT

- o The Urban Institute estimates that a pay-or-play mandate with a 7 percent payroll tax would not be adequately funded. The new payroll tax would not cover the full cost of the new public plan. A subsidy of \$37 billion would be needed from general revenue. A 9 percent payroll tax would lower the subsidy to \$25 billion, but not eliminate it. The subsidy is likely to grow over time.

Pay-or-Play Fails to Address Cost-Control Effectively

Pay-or-play proposals are often coupled with proposals to control rising medical costs through price regulation schemes. Price controls of this sort are doomed to fail, since pay-or-play does nothing to address the dynamic factors that are driving up health care costs. In the absence of meaningful reforms, imposing price controls is like putting lid on a pressure cooker. If the heat remains on the lid eventually blows off and the pot boils over.

- o The flawed incentives present in the existing system that lead consumers to use more and physicians to provide more are left in place.
- o Some features of pay-or-play could drive up costs. Coverage will be duplicated for families with multiple employers. That could lead to more inefficient "first dollar" coverage in which employees do not face any out-of-pocket health costs.

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Case Studies

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.'

Case #1

A family of three with one working parent, and a total family income of \$10,000 (just below the poverty level):

[Full Credit of \$3750]

- o Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- o Under the President's plan, this family would qualify for a \$3750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning \$8500 per year. No employer health insurance is provided:

[Full Credit of \$3750]

- o Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for 6 months; after the 6 month period, the family is charged 3 percent of the family income as a Medicaid premium. After 1 year, the family is no longer eligible for Medicaid.
- o Under the President's plan, the family would qualify for a \$3750 transferable credit to buy basic health insurance through the State group health plan (or another private plan) when they no longer qualify for Medicaid.
- o The President's plan removes the current disincentive for AFDC families to remain on welfare because they fear losing Medicaid coverage -- the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of 4 with a household income of \$35,000, and no employer sponsored health insurance:

[Full Health Care Deduction of \$3750 and Access to Group Coverage]

- o Under the current system, they often cannot find affordable coverage.**
- o Under the President's plan they would receive a \$3750 tax deduction (a benefit of approximately \$1050) to help with the purchase of insurance.**
- o In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family can buy more affordable coverage through a large employer group -- with larger risk pools rather than costly individual coverage.**

Case #4

A single individual below the poverty level not eligible for Medicaid (e.g. woman with no children and most males):

[Individual Credit of \$1250]

- o Under the current system, this individual has no access to health insurance, and usually receives "unreimbursed care" through hospital emergency rooms.**
- o Under the President's plan, this person would receive a \$1250 transferable credit for the purchase of group health insurance through the basic State health plan, or some other private plan.**

Case #5

A homeless person who currently relies on emergency room treatment for serious illnesses:

[Individual Credit of \$1250]

- o Under the current system, hospitals and other providers give uncompensated care, shifting the costs and higher charges to government and individuals with insurance.**

- o Under the President's plan, this person would use the \$1250 credit to choose a basic health insurance package. If the individual did not choose a plan, the State and/or hospital could assign them to a "basic plan" insurer -- with the premium paid by the transferable credit. Hospitals would receive reimbursement for most costs that they formerly had to provide for free.

Case #6

A family of 4 with household earnings of \$50,000, and a \$1000 employer contribution to health insurance:

[Health Care Deduction]

- o Under the President's plan, this family would receive a health care tax deduction of \$2750 (\$3750 minus employer contribution of \$1000), making their health insurance much more affordable.

Case #7

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- o Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. Pre-existing conditions exclusions may also apply, interrupting coverage.
- o Under the President's plan, regardless of health status, the new insurer would be required to offer unrestricted access to the new employer's group coverage.
- o In addition, insurers would not be permitted to deny coverage due to health status, and persons with previous health benefits could be not denied coverage of preexisting conditions. [So long as no insurer can avoid pre-existing conditions, and all must accept new risks, no insurer will be disadvantaged].

Case #8

An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

[Small Market Reforms]

- o Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.
- o Under the President's plan, small employers would have access to larger group coverage through Health Insurance Networks (HINs) spurred by major insurance and ERISA reform. Large group coverage is less expensive and more efficient, since insurance administrative costs are much lower and risk is more effectively distributed.
- o In addition, the plan would set limits on the variation of premiums insurers can charge to different groups. Insurers would not be able to deny coverage to any individual, or drastically increase premiums when one member of a group becomes ill. Additionally, a long term "risk adjustment" between insurance pools would remove the incentive for insurers to compete by "cherry picking" low risks and encourage competition on service and cost effectiveness.

Case #9

An individual just diagnosed with a serious health problem applies for health insurance for the first time:

[Guaranteed Issue]

- o Under the current system, uninsured persons with serious health problems are often denied health insurance -- for any price.
- o Under the President's plan, insurers would be required to offer coverage to any individual, regardless of health status. Premium levels would be limited so that costs would not be prohibitive.

Case #10

A family earning \$17,000 has no employer coverage and currently cannot afford health insurance:

[Partial Health Credit]

- o Under the President's plan, this family would receive a partial health tax credit of \$XX towards the purchase of health insurance (or a \$3750 deduction -- whichever provides the greater benefit).
- o Affordable group coverage would be made available through a State coordinated "basic plan" pool that would guarantee access to basic health insurance coverage.

Case #11

An individual with an income of \$200,000 and an employer contribution of \$1940 towards health insurance:

[Limit on Deductibility of Rich Plans for High Income People]

- o Under the President's plan, nothing would change for this individual.
- o However, if the employer contribution increased above \$1940 (the projected 70th percentile level of average national employer contributions for 1993) to, for example, \$2140, the individual would realize \$200 of imputed taxable benefits.
- o This is intended to address the prevalent problem of high income people overconsuming health care because of excessive employer-purchased insurance coverage that is a tax free benefit to the individual. This will encourage high income individuals and their employers to buy more reasonable insurance plans.

Case #12

An individual is planning on choosing a health plan, and wants to get the best quality plan for the most competitive price. But he is unsure of which plan to choose:

[Consumer Information]

- o Under the current system, consumers have limited objective knowledge of the relative prices of insurers, providers. Nor are they aware of the hospitals and doctors included in the plan -- or of the relative quality of local hospitals and doctors.
- o Under the President's plan, comparative information on quality and price of health care will be available to consumers. Area provider groups will collect and disseminate information on insurers, physician, hospitals, labs and other facilities -- both on price and quality. This local health care "blue book" will allow consumers to identify the best health plans, and providers. As a result, consumers will be better equipped to choose the health plan that is best suited to their needs.

1. The examples presented assume the fully-phased in program.

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Chapter 2

Principles for Reform

In part, that requires No Nation or people can grow and remain strong without good health and access to high quality medical care. *become more sophisticated and costly* Health care in the United States has evolved and changed through more than two centuries of our Nation's history. What once was rudimentary science has grown to the world's most sophisticated and advanced system. *truth is; everything has evolved + changed!*

Our health care system has its strengths and weaknesses. A clear understanding of both is essential as a guide to policy development. This understanding serves as the basis for the principles that guide the President's approach to health reform.

Costs are increasing rapidly and many Americans are without adequate access to health care. But, at the same time, it is important to remember that most Americans today have ready access to state-of-the-art medical care. Breakthrough treatments spread rapidly from our Nation's finest hospitals and laboratories to become routinely available throughout the country. We must be careful not to jeopardize this excellence in our efforts to solve our problems.

Building on American Strengths

Major changes will be necessary to provide this level of care for all Americans, and assure that state-of-the-art health care remains broadly affordable as we move into the next century. Nevertheless, in many ways, progress over the last several decades makes health care in the United States the envy of the world.

In an era when some U.S. products are subject to increasing scrutiny in terms of quality relative to other Nations, the level of quality of care for the average American is unparalleled. Our leadership has several dimensions: professional expertise, research and development, innovation in terms of technology -- new drugs, devices and procedures, and quality assurance activities. All of these have combined to result in a rapid improvement life expectancy, and a coincident reduction in mortality and morbidity rates.

The strengths of the U.S. health care system reflect its reliance on consumer preference to guide decisionmaking in the allocation of resources for good health. Despite problems with the current system, the medical marketplace provides incentives that encourages hospitals, physicians, and health plans to respond to consumer needs and preferences. Providers compete for patients, and compete on the basis of perceived quality and price for their services. These competitive forces must be nourished

and strengthened.

The complexity and uniqueness of health care has meant that the working of the market and the use of market forces has varied from classical, "textbook" models. Nevertheless, it is critical that a health care system that is uniquely responsive to American needs be designed and implemented. This means the building blocks of freedom, choice and competition maintain their critical role in the workings of a U.S. health care system.

Choice.-- Individual consumers and families are free to choose their own physician and hospital and the health plan that is best suited to their needs. Individuals and families are free to choose, in an open market, the best and most cost-effective care. Some groups routinely choose from over 100 plans and insurers for their care. As Table xx shows, most Americans enjoy multiple choice.

[Nguyen's table here on average and distribution of choices per person]

Diversity and Flexibility.-- Choice and the open competition by providers for patient care also assures diversity and innovation in the financing, organization and delivery of care. The last two decades have witnessed substantial innovation in organization and management of care, again unparalleled in the world.

General acute hospital-based care has been replaced by more specialized care across many different organizational settings, such as specialized heart centers, rehabilitation, and psychiatric facilities. Ambulatory care (e.g., same day surgery) has replaced more costly inpatient hospital care. Payment systems for care, tied to resource use (as with Medicare's Diagnosis-Related Groups), have encouraged greater efficiencies in care.

Perhaps most importantly, a diverse and evolving group of coordinated care practices (e.g., Health Maintenance Organizations, Preferred Provider Organizations, and Independent Practice Associations) have established and enjoyed a growing market share in the United States. Coordinated care plans now provide care to over 40 million people. These organizations combine financing and delivery of care, and integrate utilization management to assure and coordinate high quality service across the entire continuum of care -- from prevention to palliative care for chronic illnesses.

Skilled Medical Professionals.-- When the average American needs care, there is first and foremost the reassurance that U.S. physicians and allied medical professionals are the best educated and most skilled health care work force in our Nation's history and the most proficient in the world community. These educational and technical skills have generated the advances in

science that has conquered many age-old diseases. Hospitals and medical schools located throughout the Nation are world's leaders for particular specialties and treatments.

Biomedical Research.-- The U.S. leads the world in biomedical research -- levels of funding, the pace of new discoveries, and America's continued dominance of the world wide competition for Nobel prizes attests to that pre-eminence. Advances in biomedical research such as new breakthrough vaccines for polio and other dreaded diseases have improved the quality of health care while helping saving billions in health care costs. Human gene therapy experiments promise untold benefits in the years ahead.

Federal investment in biomedical and applied behavioral research has increased as a proportion of GNP from 0.12 percent in 1970 to 0.16 percent in 1992. U.S. public and private funding together forms the lion's share (Graph xx) of the funding in the entire world.

[Princeton pie chart here]

Technology.-- Similarly, the development and application of new ideas through the U.S. drug and medical device industry has grown exponentially over the last three decades. [Nguyen's table/graph here] The diversity and innovation of its products both increase quality of care for Americans and, as an economic sector, stand as one of the most competitive internationally. Net exports in 1992 were \$xx (Nguyen will provide).

For the American consumer, access to high technology is unparalleled. A comparison with other prosperous Western nations -- Canada and Germany -- in Chart xx [Ruble chart here] presents some astonishing implications of the relatively ready -- almost instant -- access that Americans enjoy to sophisticated diagnostic and therapeutic technology today. A difference in access to technology, of course, is very often the critical difference between health and disability, life and death.

Quality Assurance.-- Finally, leadership in the development and implementation of new methods for assuring quality of care has been a hallmark of health service delivery in the United States for over a decade. Peer review, practice guidelines, research on patient outcomes, and other activities mean that appropriate interventions are applied correctly to the individual's clinical condition. Again, other countries are just beginning to develop and implement approaches to assure "total quality management" for the medical care they provide for their citizens.

Improved Health.-- The level of quality and effectiveness of care is ultimately measured by changes in health. While the need for progress remains, the vast improvements in health over the last few decades are unmistakable. Tables xx and xx, for

example, show continued and consistent trends in improvements in overall life expectancy and declines in infant mortality over the last several decades. Measures more sensitive to the effect of medical interventions, such as risk of death for high risk procedures and surgery generally (Tables xx and xx), further show the relative benefits of U.S. medical care.

There is little indication, either, that these trends need to reverse or even plateau. Tables xx and xx show that improved health is possible into the next century. Prevention and greater personal responsibility could increase average life expectancy from about 77 years to 82 years. At the same time, new drug regimens and technologies offer the very real promise for lowering deaths due to major killers such as heart disease (Nguyen to develop prevention bar chart and Battelle study trend).

Consumers also seem satisfied with the current level of quality. The results of a recent Social Security Commission survey (1991) indicate that 78 percent of Americans were "very satisfied" or "somewhat satisfied" with the quality of their health care services.

Understanding the Cost and Access Problems

While our current system has many strengths, there are significant problems that must be addressed if the system is to continue to meet the needs of the American people over the coming decades. There is an emergent consensus concerning the importance of addressing the issues of the unsustainable growth in U.S. health care costs, while at the same time finding ways to provide greater access to millions of Americans now uninsured or without appropriate care.

The causes of the health care problems of cost and access are complex and do not allow for an easy solution. While simplistic proposals to fix the system, such as reducing unnecessary administrative costs to fund a universal access program, have populist appeal, such funding scenarios have never been realistic (Doherty, 1991). To solve the complex problems at the heart of our current system -- rising costs and declining access -- detailed analysis and systemic reform that changes the behavioral incentives for individuals, insurers, and health providers is what is needed to truly affect change. These are issues that go far beyond simply cutting paperwork.

The health care problems of cost and access are not problems which are easily solved simultaneously; the political system has tended to trade cost-control for access, and vice-versa. Addressing the access problem inescapably means equitably re-allocating health care financing from existing sources. Addressing the cost problem means fundamentally changing the inefficient incentives and market distortions found in the

present system -- to encourage more efficient behavior.

Unsustainable Increases in Costs

Currently, total health care expenditures are 13.1 percent of the Gross National Product (GNP) -- up from 5.3 percent of GNP only three decades ago. If the current system were to continue, health care could consume over 16 percent of GNP by the year 2000, and over 43 percent of GNP by 2030 (Sonnenfeld et al., 1991).

[Chart 9 from Director's Oct 10 Testimony]

These high costs are shouldered by everyone -- individuals, business and government. The federal government is spending increasing proportions of the federal budget on mandatory health outlays. Before the year 2000, health entitlement programs (Medicare and Medicaid) will surpass Social Security as the single largest component of federal spending. Federal Medicaid spending alone has grown from \$14 billion in 1980 to \$37 billion in 1989 to a projected \$89 billion in 1993. These figures reflect a 43 percent increase for last year alone, an increase of 227 percent since 1989, and an increase of 600 percent since 1980.

[Chart 5 from Director's Oct 10 Testimony]

Medicare spending has grown from \$34 billion in 1980 to over \$150 billion by 1993 -- an increase of over 400 percent. Unrestrained, under current law Medicare will grow at an average rate of 11.5 percent per year from 1993 through 1997. By 2025, Medicare is expected to exceed 27 percent of the federal budget. This means that to support current Medicare projections alone, either the federal budget would have to grow far beyond 20 percent of GNP, or the rest of the federal budget would have to decline by more than 20 percent in real terms, just in order to make room for Medicare.

Even if it were possible to sustain health spending at nearly 30 cents of every dollar, it is difficult to imagine who would pay these enormous costs. Most individuals already feel that they are overburdened with health care costs. Businesses are spending increasing percentages of wages and other compensation on health care premiums -- currently in excess of 100 percent of after-tax profits.

[Charts 10 and 11 from Director's Oct 10 Testimony]

Clearly, health care costs must be contained, both in public programs and in the private sector. Neither individuals, business, nor government can afford to pay for the currently

projected growth.

Increased Investment, Declining Access

Despite this rapid rise in health care spending, more and more Americans lack health care insurance. Roughly 13 percent of Americans have been estimated to be uninsured (CPS, 1988). While making increasing investments in health care, the Nation is getting a diminishing return for its money, as increasing numbers of Americans are without insurance and adequate access to care.

Most of the uninsured are lower-income Americans -- almost 62 percent are below 200 percent of poverty (Needleman et al., 1990).¹ Despite this, most of the massive federal spending on health care goes to the non-poor. In 1992, only 21 percent of total federal spending is estimated to be spent for the poor. Almost 90 percent of Medicare spending goes to individuals above the poverty line.

[Chart 15 from Director's Oct 10 Testimony]

Uninsured Americans do receive some health care, either by paying for it out-of-pocket, or in the form of "uncompensated" or "charity" care (Needleman et al., 1990). "Uncompensated" care is not really free in the sense that insured individuals must pay higher fees and thus higher premiums (approximately 13 percent), and hospitals receive public (such as Medicare and Medicaid "disproportionate share" payments and non-profitable tax treatment -- now over \$15 billion per year) and private (such as charitable contributions) subsidies to cover the costs.

The uninsured are more likely to receive health care in hospital emergency rooms, rather than in physician's offices and clinics (NMES, 1987). This form of care can be harmful to the individual, who may only receive care for serious illnesses in the place of coordinated, preventive care from a physician familiar with the patient. Emergency room care is also a much more expensive and inefficient use of resources, since emergency room visits are much more costly than physician office visits.

No Easy Solution

Rising health care expenditures are a function of many interrelated factors. These include: general inflation,

¹ Based on Needleman et al. (1990) estimates using March 1988 Current Population Survey data, 30 percent of the uninsured are below poverty, and an additional 31.6 percent of the uninsured are between poverty and 200 percent of poverty.

population growth, relative aging of the population, growth in volume and intensity of medical care (HCFA, 1989), and "cost shifts" that re-allocate the costs of caring for the uninsured. The result has been medical inflation that is consistently more than double the rate of growth of the Consumer Price Index.

General inflation, population growth and relative aging necessarily occur -- health care reform cannot address these. Other factors that contributed more heavily to this growth are more alarming and should be addressed, such as the growth of the intensity of medical services (HCFA, 1989; Schieber et al., 1991)² and the growth of preventable illnesses and conditions.

[Chart 19 from Director's Oct 10 Testimony]

In addressing the growth in service intensity, it is difficult to know how much of the increase is due to positive advances in medical technology, and how much is attributable to excessive defensive medicine, poor health care management, and manipulation of a public price-regulated system. For preventable illnesses and conditions, though, the issues are more apparent. For example, at 13.8 per 100,000, the male homicide rate is more than 12 times that of Germany and 5 times that of Canada. There are currently about 200,000 AIDS patients in the US plus an additional 200,000 cases of HIV infection. In 1989, the rate of incidence of AIDS was more than three times that of Canada and six times that of then-West Germany. And, there are about 375,000 drug-exposed babies in this country. This problem is far less prevalent in most other countries (Schwartz, 1991).

The rising cost problem is also influenced by market distortions within health care. Because medical treatment is largely in the hands of doctors and hospitals (who have some financial and defensive malpractice incentives to provide more medical care without full counterbalancing market pressures), and not the consumer, consumer-based market discipline has been weak. Under the current system, Americans with insurance are often overinsured and have few incentives to use medical care prudently. Instead, consumers tend to be risk-averse were health is concerned. Insulated from the real cost of medical treatment by employer and government subsidized insurance, Americans tend to over-consume health care. Rather than relying on more medical care, individuals and the Nation must begin to place greater

² Comparative data of the United States and other western developed nations suggests that the U.S. has lower rates of utilization (hospital admission, average lengths of stay, bed days per capita), but pays much more per unit of service. (U.S. expenditures per admission of \$5609 are almost double the \$2912 average of other developed nations.) This suggests far more intensive medical treatment (Schieber et al., 1991).

emphasis on prevention and personal responsibility for health.

The health care market is further distorted by limited consumer information about both the treatments patients receive and the efficiency of their care and insurance. Faced with few objective sources of information on which to base cost and quality comparisons of health plans or provider services, consumers and large purchasers often make poor decisionmakers in a market system.

Thus, solving the problems of access and cost constraint are inextricably linked with consumer choice and preference. They must be addressed together in a series of reforms that provides access to health insurance for all, and in a marketplace that works by restraining cost-shifting and providing information for better decisions. Only then can all Americans begin to enjoy efficient health care at affordable prices.

Principles for Reform

In this context of addressing these issues of access and costs, the President directed the Secretary of Health and Human Services, Dr. Louis Sullivan, to lead the development of a comprehensive approach to health reform.

The President determined that several principles should be applied in this effort. The approach to reform should:

- o build on the strengths of an American health system that enjoys the highest levels of quality in the world;
- o assure access to basic health insurance coverage for Americans, and increase the affordability of such coverage;
- o strengthen incentives for cost control and consumer choice;
- o emphasize prevention;
- o reduce abuse and wasteful excess;
- o meet the requirements of fiscal responsibility and budget discipline.

The approach should not:

- o lead to comprehensive governmental price controls and rationing by government;

- o create new spending mandates for states and employers;
- o require a net increase in taxes; or
- o threaten older Americans with the prospect of either benefit cuts or premium increases.

These tests cannot be met by either "Canadian-style" or "Play-or-Pay" approaches to reform. Such approaches necessarily involve major tax increases, comprehensive governmental price controls, or rationing. Both require a combination of these undesirable characteristics; over time, these approaches threaten to structurally degenerate.

By contrast, the President's Plan meets these tests. It gives far greater emphasis to individual choice and to incentives for more cost-effective delivery of high quality American health care. The details of the President's plan are presented in the following chapters.

References

Current Population Survey, Department of Labor, Washington, D.C., 1988.

Doherty, Robert B., "Wishful Thinking and the Clamor Over Administrative 'Waste'," The Internist, May 1991: 22-27.

Health Care Financing Administration, Office of Research and Demonstrations, Report to Congress: Paying Physician -- Choices for Medicare, sent by the Secretary of Health and Human Services to the U.S. Congress, October 1989.

Needleman, Arnold, Sheils, and Lewin, The Health Care Financing System and the Uninsured, April 4, 1990, HCFA research contract.

Sonnefeld, Sally T., Daniel R. Waldo, Jeffrey A. Lemieux, and David R. McKusik, "Projections of National Health Expenditures Through the Year 2000," Health Care Financing Review, 7(3): 1-27.

Schieber, George J., Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Care Systems in Twenty-Four Countries," Health Affairs, Fall 1991: 23-38.

Waldo, Daniel R., Sally T. Sonnefeld, Jeffrey A. Lemieux, and David R. McKusik, "Health Spending Through 2030: Three Scenarios," Health Affairs, 10 (4): 231-242.

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Chapter 3

EXPANDING ACCESS AND INCREASING AFFORDABILITY THROUGH MARKET REFORM

Overview

The President's proposal for reform of the health insurance market will make coverage more secure, more available, and more affordable for millions of American.

- Everyone -- young and old, healthy and sick -- will benefit from the assurance that affordable health insurance will be available regardless of future changes in health.
- Moreover, workers will be able to change jobs without fear that insurance coverage will be denied due to a preexisting illness.
- Premium costs will be reduced by as much as xx% for xx million workers in small firms.
- And, most importantly, over 8 million Americans will become newly covered as a result of the health insurance market reforms.

The market reform proposal has four major components. These components will --

- **Assure availability and security of coverage.** Insurers would offer coverage to all comers without regard to health status. Coverage would be renewable, and preexisting condition limits would be eliminated. Employers would provide access to group coverage to all employees and dependents. And, colleges and universities would provide continued access to group coverage to recent graduates and other students for six months after leaving school.
- **Assure affordability of coverage through broad risk pooling.** Insurers would participate in broad pooling arrangements to spread health risks evenly across insurers and thereby allow insurers to charge uniform premiums for the sick and the healthy. On an interim basis, pending phased implementation of this new system, insurers would be subject to limits on their ability to vary premiums to reflect differences in health risk.

- **Encourage group purchasing of health insurance by small businesses to give them the same cost advantage enjoyed by larger businesses.** Small businesses would pool their purchasing power through Health Insurance Networks (HINs). This will help small businesses negotiate discounts and save on overhead and marketing costs. Moreover, the ERISA preemption that allows larger self-insured firms to avoid cost-increasing state laws will be extended to small businesses purchasing coverage through HINs. For the first time national and regional small business associations and other groups will also be able to establish multistate HINs to better assist their membership.
- **Give health plans increased flexibility to control costs.** All Health plans would be protected from mandated benefit laws and "antimanaged care" that hinder design of cost-effective benefit packages to meet individual and family needs. Health plans would also be protected from laws and regulations that hinder innovative cost control measures, such as utilization review and selective contracting.

Another important benefit of these reforms is that competition among health plans will be significantly strengthened. In today's environment, health plans can gain a significant premium cost advantage by avoiding high risk individuals and groups. The resulting advantage is so great that it can overwhelm any cost savings resulting from greater efficiency. Under the Administration's reform proposal, such "risk avoidance" will be stopped. As a result, competition will focus on price and quality, leading to long-term gains in efficiency and improvements in quality.

Strengths and Weaknesses of the Current System

xx million working age Americans and their dependents -- xx% of the total -- are covered through private health insurance. Most of these are covered through employment. This system has worked well because employment can be a stable basis for risk-pooling, particularly for medium and large firms and because substantial administrative savings and economies of scale are possible through employment-based group coverage.

[insert graph showing source of coverage for under 65 population]

Special Problems for Small Business.-- While generally successful, there are significant problems with the current system, especially for small group and individual coverage. Workers at small firms are much more likely to be uninsured than workers at medium and large firms.

Number of Uninsured Workers and Dependents By Firm Size -- 1987 (Source: AHCPR, 1991)					
Establishment Size	Number of Workers & Dependents	Percent of Workers & Dependents	Number Uninsured	Percent Uninsured	Percent of All Working Uninsured
<25	74.2 m	44%	17.2 m	23.1%	68%
26 - 100	34.6 m	21%	4.3 m	12.3%	17%
>100	59.2 m	35%	3.9 m	6.6%	15%
Totals	168.0 m	100%	25.4 m	15.1%	100%

This disparity in coverage reflects three main problems. First, many small businesses cannot afford to provide costly fringe benefits. Second, health insurance is more costly for small businesses due to (i) higher overhead and marketing costs and (ii) costs resulting from state mandated benefit laws and premium taxes which generally do not apply to self-insured coverage ("ERISA exempt" from state laws) typically provided by larger businesses. Finally, the market for health insurance for small business is in turmoil due to risk selection.

Erosion of Risk Pooling.-- For people with serious illness, the cost of medical care can easily consume a substantial share of family income. With *broad risk pooling*, through insurance, the costs of illness are spread across a broad pool of premium payers, making costs more uniform, thus more affordable. The value of risk pooling is particularly great because health spending is highly skewed. At any given time, most of the population is healthy, and has little need for medical care. However, a small percent of the population is seriously ill, and requires extremely costly care. People who are at the top 5 percent of the population in terms of use of health care (e.g.,

the 95th percentile) have per capita health expenditures (\$7,100) 26 times greater than costs (\$270) for people at the midpoint of the population in terms of use of health care (e.g., the 50th percentile).

Distribution of Per Capita Health Spending By Age and Within Age Categories, 1987 (Source: AHCPR, 1991)					
Age	Mean	25th Percentile	50th Percentile	75th Percentile	95th Percentile
TOTAL	\$1591	\$50	\$270	\$1000	\$7100
0-6 yo	\$1133	\$50	\$180	\$600	\$3800
7-18 yo	\$643	\$15	\$120	\$400	\$2500
19-24 yo	\$839	\$0	\$150	\$550	\$4000
25-54 yo	\$1238	\$50	\$260	\$860	\$5500
55-64 yo	\$2469	\$160	\$570	\$1600	\$11424
>65 yo	\$4551	\$330	\$960	\$3500	\$22528

Insurance risk pooling is a good value for everyone because even those who are healthy today are at risk of developing a serious illness at some point in life. However, risk selection can undermine insurance as a pooling mechanism. Risk selection occurs whenever a particular pool has a non-random selection of risks. As a result, this pool will have higher or lower average per capita cost when compared with other pools (adverse or favorable selection).

Risk selection is extremely difficult to prevent. This is true because healthy and sick people have different needs for health insurance and will choose different health plans to best meet these needs. Generally, healthy people will be attracted to leaner benefit packages (higher cost sharing, fewer covered benefits) because they expect that they will not have a need for more extensive coverage. In contrast, sicker people will prefer richer benefit packages because of their expected needs. Moreover, certain features of coordinated care, such as a greater emphasis on preventive care, could be predictably more attractive to the healthy. As a result, sick and healthy people will sort themselves into different plans, even without any effort at selective marketing by insurers. The result will be that sick people will face high premiums due to a non random distribution of health risks.

Risk selection is especially likely in the market for small group because a single small business cannot serve as a stable risk pool. One or two sick workers can greatly increase average per employee health benefit costs. Insurers originally combined many small businesses into a single risk pool and charged all members of the insured group a uniform (or age-adjusted) premium that did not vary based on health risk. This approach helped to make coverage affordable for individuals with chronic illness.

However, in today's market, some insurers have developed strategies for attracting low risk groups, while leaving higher-risk groups without coverage or with unaffordable high premiums. Favorable risk selection provides an opportunity to make a profit by offering low premiums to attract healthy groups while discontinuing coverage (or increasing premiums to a prohibitive level) once a group becomes more costly. Some insurers are also using medical information to exclude higher-risk groups or individuals from coverage. And, insurers can exclude preexisting medical conditions from coverage. In some cases, even individuals with relatively mild health problems have been denied coverage.

As aggressive insurers succeed in attracting low-risk groups and avoiding high-risk groups, traditional insurers face a premium spiral. This makes it difficult for traditional insurers to spread risk among a broad pool of companies and forces them to shift to narrower pools to compete. It also forces even the most responsible insurer to risk select to keep up with competitive pressures. Similar -- possibly even more severe -- problems affect the market for individual non-group coverage.

These problems are increasingly common. Moreover, there appears to be no natural end point to current trends. Thus, if left unchecked, broad risk pooling seems likely to unravel in the small group and individual coverage markets. If this were to happen, health insurance would become unaffordable for many Americans -- especially those most in need of coverage.

Assuring Availability of Coverage

The President's reform proposal contains several initiatives to assure that health insurance coverage is readily available. These reforms apply broadly to all private health insurance coverage regardless of group size and to coverage provided by employers who self-insure.

Prohibition on Exclusion from Coverage Due to Health.-- All insurers wishing to sell group health insurance in a state would be required as a condition of doing business to (i) accept every individual and employer group in the state that applies for coverage and (ii) provide coverage to all members of the employer group. In addition, all employers (regardless of size) would be prohibited from excluding any individual from health insurance coverage for reasons of health status.

Guaranteed Renewability.-- Insurers wishing to sell group coverage in a state would be required to renew coverage for a group except in the case of nonpayment of premiums, fraud, or misrepresentation.

Portable Access.-- Under the proposal, workers would be able to change jobs without loss of coverage due to a preexisting coverage exclusion. Currently, some health insurance does not cover costs related to any illness or disease diagnosed prior to the initial date of coverage. As a result, many working Americans with chronic illnesses have been afraid to change jobs for fear that the insurance provided at their new job would no longer cover their medical expenses.

Use of preexisting condition exclusions would be phased-out for all insurers and employers. In 1993, the maximum duration for a preexisting condition exclusion would be 5 months. This would phase down to zero by 1997. Moreover, during the transition, workers with continuous coverage could credit each month of continuous coverage against this maximum duration. Thus, during the transition period, preexisting conditions exclusions generally would only affect the typical worker's first entrance into the work force.

[Note: suggested policy change -- why not eliminate preexisting condition exclusions outright without any transition. This would make for a stronger political message. Current policy with transition is overly complex, hard to understand.]

Access to Group Coverage for Workers and Dependents.--- All employers would be required to arrange access to a plan that provides for individual and family coverage to all employees -- but would not be required to administer or make any contribution towards the cost of the coverage. States would assist employers by making available information regarding the availability and cost of "basic" coverage from various health plans. Employers would be required only to arrange for deduction of premiums from

paychecks but would have no other administrative burden. Health insurance networks -- group purchasing arrangements for small employers -- would facilitate this process and it is anticipated that most small employers would join a HIN. (see below).

Access to Group Coverage for College Graduates.-- To help fill a significant uninsured gap for new work force entrants, all colleges and universities that provide group coverage to students would be required to offer extended group coverage for new graduates and others for six months after they leave undergraduate and post-graduate programs. The college or university need not make any contribution toward the cost of coverage under such a plan.

Assuring Access to Coverage for Individuals and Families Receiving Health Insurance Tax Credits (vouchers).-- Each state would define a "basic" benefit package or a series of packages with an estimated actuarial value equal to the value of the health tax credit. A number of benefits packages are provided as illustrative examples (See box xx for illustrative examples).

Basic Benefit Plan Examples for Approximate Amount of the Full Health Insurance Tax Credit in 1993
(Plans and illustrative only - States will design benefits)

"Managed" Fee-For-Service Plans

Plan A -- Unlimited inpatient hospital, inpatient physician care, prescription drug coverage, 3 ambulatory physician visits and associated diagnostic services with a \$10 co-pay per visit.

Plan B -- Unlimited inpatient hospital, inpatient physician care, and 5 ambulatory physician visits and associated diagnostic services with a \$10 co-pay per visit.

Plan C -- Unlimited inpatient hospital, inpatient physician care, 10 ambulatory physician visits and associated diagnostic services with a \$10 co-pay per visit.

Plan D -- Inpatient hospital up to 15 days, inpatient physician, lab, emergency room, and ambulatory physician visits and associated diagnostic services covered for \$5 fee per visit for the first three physician visits, then a 10 percent co-pay up to a \$500 out-of-pocket limit.

Plan E -- Includes all services under Plan D, but with a 20 percent co-pay on physician visits after 3 visits.

Plan F -- Includes all services and co-payment under Plan E, but would offer prescription drug coverage.

?? - What
is "managed"
about these
designs?

Model HMO Benefit Plan

Plan G – Unlimited inpatient hospital and inpatient physician services, emergency room, and unlimited ambulatory physician visits with associated diagnostic services (subject to a \$10 copayment), prenatal care, and prescription drugs (subject to a \$5 copayment).

Any health plan in a given state could offer the state-defined "basic" benefit package to credit recipients and to others. To ensure that credit recipients have a variety of plans available, if no insurers offer the "basic plan" the State insurance commissioner could require two or more health plans with a substantial market share to offer the "basic" benefit plan. Health plans could charge a market price for the "basic" benefit package.

The State and Federal government would implement outreach programs with the goal of securing 100% participation among credit eligibles. Broader participation would help prevent unnecessary and costly emergency care by encouraging primary and preventative care.

In cases where a hospital emergency room is an individual's first point of contact with the system, rotating assignment would be used to enroll an uninsured credit-eligible individual to a specific health plan if the individual were unable to make a choice. So for example, a homeless person entering the hospital and has no preference for any carrier would be assigned to an insurer by rotation and the credit would automatically flow to the insurer.

Assuring Affordability of Coverage Through Risk-Pooling

As noted above, broad risk pooling is essential if health insurance is to be affordable for the sick as well as for the healthy. The President's market reform proposal provides both interim and longer-term solutions. Transition measures, including "premium bands" would be implemented immediately to stabilize the small group market pending full implementation of longer-term measures.

In the near term, premium bands will spread risks within an insurer's pool by limiting the difference in premiums that an insurer may charge to groups with different health risks. This will make coverage less costly in the near term for higher risk groups. However, premium bands may be unstable in the longer term. Because an insurer would be unable to vary premiums to reflect fully actual differences in expected health care costs, healthy enrollees would have incentives to shift to other insurers that have fewer sick people in their pools.

Health risk pooling would assure affordable coverage over the long term both for small groups (under 100 employees) and for

individuals and families receiving health insurance tax credits. Under this approach, health plans insuring a sicker than average population would receive a net transfer from the risk pool while other insurers will be net payers into the pool. This will assure stable risk pooling over the long-term and will level the competitive playing field among insurers to focus competition on efficiency and quality.

This approach would be implemented immediately for credit recipients and would be phased-in over a five year period for small group coverage. Delayed implementation in the small group market is needed to permit an orderly transition and to avoid undue disruption of existing arrangements. Immediate implementation of health risk pooling would, however, be possible for credit recipients since this is a new market of defined plans.

Transition Measures for Small Group Coverage.-- These transition measures would apply to all insurance provided to small businesses employing fewer than 100 workers. The premium standards (or "bands") limit variation in premiums within each insurance company's overall set of offerings. They would not constrain premium variation between insurers. The premium standards would be temporary and could be phased-out with full implementation of a system to equalize risk among insurers.

- Premium Standards Across and Within Demographic Categories
Insurers could vary premiums by age. This means that younger workers would not be forced to subsidize older workers (who typically have higher incomes). But, insurers would be limited in their ability to vary premiums based on health status or prior use of care. Premiums could not differ by more than 50% within age/sex categories in the first year decreasing to 35% by the third year.

• Rate of Increase Standard for Renewal Premiums -- Insurers could not increase premiums unfairly for groups with deteriorating health status or claims experience. The maximum percent increase in renewal premiums would be set at 5 percent plus the percent change in the "base premium rate." The "base premium rate" is the lowest premium the insurer could have charged under the relevant block of business for a group with similar demographic characteristics, excluding factors related to health status, claims experience, industry, occupation, or duration of coverage.

- Premium Standards Across "Blocks of Business" Premiums could vary by up to 20% across different blocks of business. A carrier may establish different blocks of business: (i) for business acquired from another carrier, (ii) for business obtained through a distinct system of marketing (e.g., brokers vs. associations), and (iii) for business obtained through different associations (for example, HINS). Carriers could establish three different blocks of business for each of the three reasons, for a total of nine different blocks of business.

- Enforcement -- An independent actuary would certify compliance. Failure to have a valid certification would trigger a violation. The state enforcement agency could conduct a look-behind investigation to verify certifications.

States could also implement a prospective reinsurance or risk allocation system on an interim basis to pool risk between insurers.

- Under prospective reinsurance model, an insurer could obtain optional reinsurance for any group or newly eligible group member. The primary insurer would be liable for an individual's health costs up to a threshold amount. Above the threshold, the reinsurance program would be responsible for most of the cost. The program would be funded by a reinsurance premiums and an assessment on all small group insurers.

- Under risk allocation, each insurance carrier would have a quota of assigned risks based on the carrier's market share. Insurers could initially refuse to provide coverage based on health risk. However, the rejected group or individual would have a right to select any insurer from an assigned risk list maintained by the state provided that the insurer's allotment has not been filled.

Health Risk Pools. -- Each state would implement two broad health risk pools: one for small group coverage and another for coverage provided to individuals and families receiving transferrable health insurance tax credits. These pools would spread risk broadly across all health plans providing such coverage within a state.

Under this system, health plans that cover a sicker than

average population would receive a net payment from the pool, while other health plans would be net payers into the pool. Payments from and to the pool would be based on the difference between the expected health care costs for the entire covered population and the expected health care costs for the population covered by the insurer.

As a result, insurers would no longer have an incentive to deny coverage to individuals with chronic disease. Moreover, insurers would be able to provide coverage at a near uniform premium for the sick and the healthy. The health risk pool would have this effect because a health plan that enrolls an individual with a high-cost chronic illness will receive a transfer of funds from the pool equal to the difference between the expected health care costs for the individual involved and the average expected cost. This moves the system back toward a flexible community rate -- where choice in plans is maintained, but risk is truly pooled.

A number of methods have been developed for measuring expected health care costs based on the health characteristics of the population involved. These methods include the Diagnostic Cost Group system developed at Boston University and the Ambulatory Care Group system developed at Johns Hopkins. Other systems are available for use by the states. The Department of Health and Human Services would fund research to refine these systems and to develop improved systems for adjusting for health risk. The Department would also provide technical support to assist states in the process of establishing the risk pools.

As is true for any system of this type, some degree of "upcoding" is possible, but upcoding would not have an adverse effect on the pooling system unless some insurers were more significantly more successful at upcoding than others. If necessary, to prevent this outcome, a random sample audit of insurance claims and other records could be used to verify the accuracy of health risk assignments.

The health risk pools for small group coverage and for credit recipients would be similar in most respects. Participation would be required for all health plans providing coverage to small groups and to credit recipients. However, the health risk pool for small business coverage would pool health risks within age categories while the risk pool for credit recipients would pool health risks across age categories.

Pooling across age categories, in the context of small group

coverage, would involve a transfer of income from younger to older workers. Such a transfer may be unfair because younger workers generally have lower incomes. However, pooling across age categories is needed for credit recipients to ensure that the fixed credit amount is sufficient to provide access to coverage for older individuals.

States would implement pools for credit recipients simultaneously with Federal implementation of the transferable health tax credit system. Implementation of health risk pools for small group coverage would occur over a five-year period on a phased-in basis, starting in the third year after enactment of the reform proposal. Transition measures, including premium limits, would apply in the small group market in the interval.

Encouraging Group Purchasing For Small Employers: Health Insurance Networks

The President's reform proposal will help reduce insurance costs for small businesses by encouraging group purchasing. Group purchasing can reduce health insurance costs by as much as xx% through efficiencies of scale, lower administrative costs, and through pooling of purchasing power that helps small businesses negotiate better rates with insurers.

Cleveland's Council of Smaller Enterprises (COSE) operates a successful health insurance group purchasing program for small firms. While COSE has been successful, surprisingly little of this type of group purchasing is going on nationwide. The reforms described in the preceding sections will spur group purchasing by protecting against some of the abusive practices that have daunted some local purchasing groups. Additional assistance is provided as well to encourage rapid formation of group purchasing arrangements.

ERISA Reform/Incentives for Group Purchasing -- The Federal preemption of state regulation of self-insured health benefit plans under ERISA that benefits virtually all large employers would be extended to small businesses that purchase coverage on a group basis through a Health Insurance Network (HIN). This would protect against (i) state mandated benefit laws that require firms to provide certain costly services, (ii) state health insurance premium taxes, (iii) and state anti-managed care laws. These laws can increase premium costs by xx to xx percent. HINs