

Labor Mobility

PROFILE OF THE UNINSURED: MYTH VS. REALITY

As health reform reaches a critical stage in Congress, fashioning the right solution requires having a clear understanding of the characteristics of the uninsured. Contrary to popular myth, the uninsured are not all poor, elderly, or otherwise vulnerable. In fact, over half of the uninsured live in families where at least one spouse is a *full-year, full-time* worker. Approximately 84 percent come from families whose head works at least part of the year. In addition, while even short exposures without insurance put people at significant financial and health risk, being uninsured is predominately a long-term problem. Finally, those who do purchase insurance, and taxpayers as a group, bear much of the burden of the uninsured -- through both "cost shifting" to private insurance premiums and increased spending on public programs.

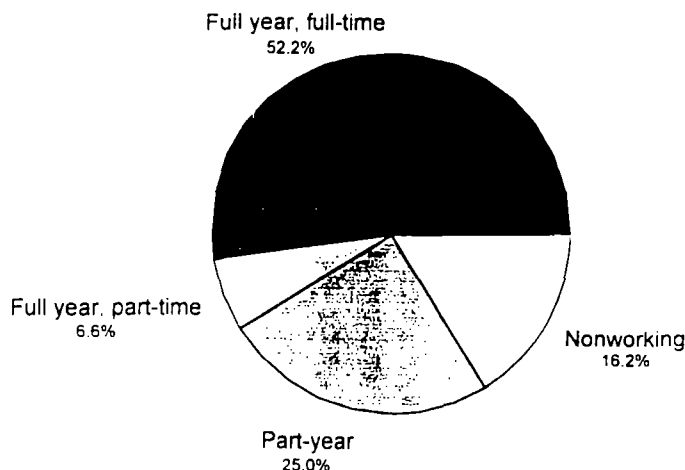
Myth #1: *The uninsured are unemployed.*

Reality: The uninsured are working Americans.

The vast majority of the uninsured -- 83.8 percent -- belong to working families. Federal programs already cover most of the non-working population. Medicare provides near-universal coverage for those over 65, and Medicaid covers 50 percent of those in poverty and 25 percent of those just above the poverty line.

As a result, large numbers of the uninsured are clustered in working families with moderate incomes, who do not qualify for Medicaid. Insurers in general charge higher rates to the self-employed and small businesses, which makes it difficult for them to obtain affordable coverage.

Job Status of the Uninsured



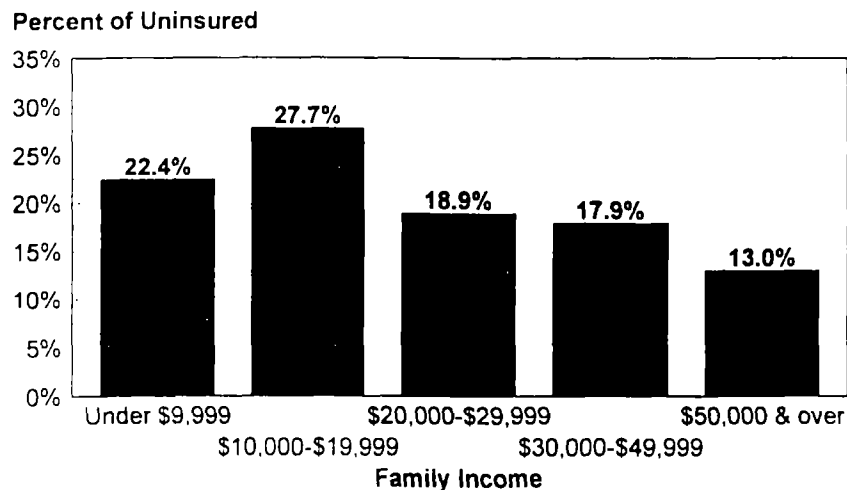
Myth #2: *The uninsured are poor.*

Reality: **The bulk of the uninsured have moderate incomes; many are middle-income.**

The vast majority of the uninsured -- 72 percent -- have incomes above the federal poverty threshold. While the average uninsured American family has a modest income, it is far from being in poverty.

The bulk of the uninsured are in hard-working families for whom health insurance is unaffordable. Because small businesses and the self-employed have difficulty obtaining affordable insurance, almost one in three of the uninsured is a member of a family making more than \$30,000 a year.

Family Income of the Uninsured

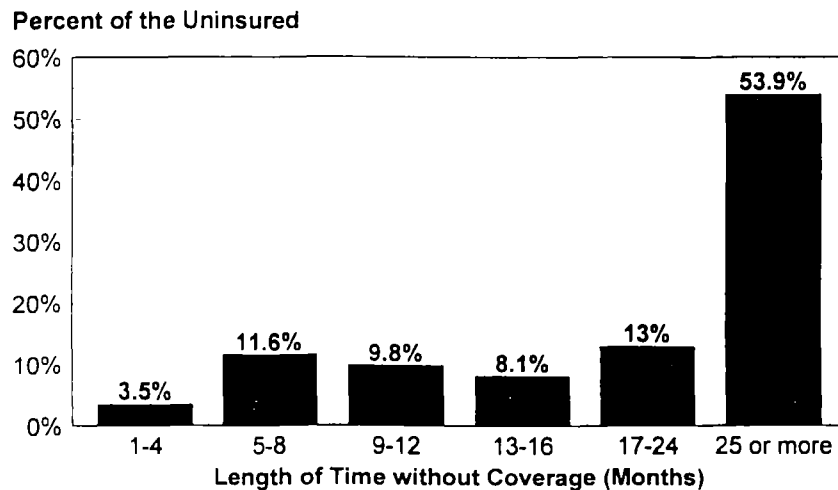


Myth #3: *For most of the uninsured, being without health insurance is a short-term, rather than a long-term, problem.*

Reality: **54 percent of those uninsured today will be uninsured for more than two years. 75 percent will be uninsured for more than a year.¹**

Some have suggested that being uninsured is a short-term problem, not a long-term condition. Even short periods of time without insurance do put people at significant financial and health risk. But being without health insurance is not a short-term problem. A recent study from the University of Missouri reports that nearly 75 percent of uninsured Americans are "chronically" uninsured, and will remain uninsured for longer than one year. Less than one in twenty out of those uninsured today will obtain health coverage before they have been uninsured for five months.

Distribution of Uninsured, by Time without Coverage

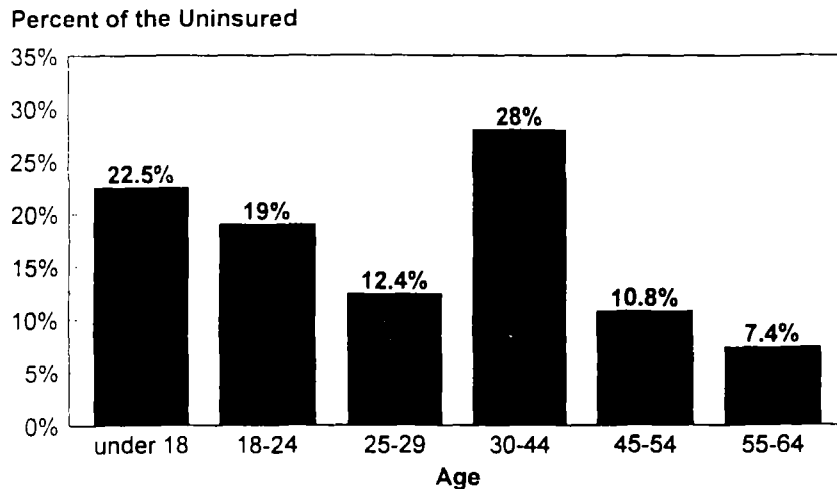


Myth #4: *The uninsured are mainly young and healthy; they choose not to buy insurance.*

Reality: Almost one quarter of the uninsured are children. Nearly half of the uninsured are over 30. Less than 30 percent of the uninsured are between 18 and 30 years of age.

Most of the uninsured are not young, healthy adults, but rather children and persons over 30. Nevertheless, the young are a disproportionate share of the uninsured, because, with modest incomes and poor access to affordable coverage, they cannot pay for insurance.

Age of the Uninsured



Myth #5: *I have health insurance--the uninsured do not affect me.*

Reality:

- Americans who lose their jobs may well become uninsured.
- Private insurance costs are high because of the uninsured.
- Taxes are higher because of high Federal health costs.

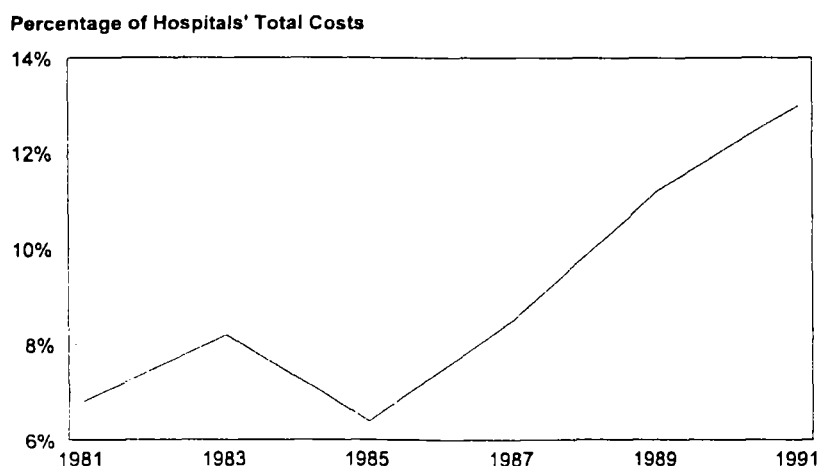
Nine out of ten Americans with private health insurance receive insurance through employers. Those who lose their jobs for an extended period of time may well lose their health insurance.

In addition, the uninsured place a large direct burden on those who do have insurance -- through higher taxes and through higher private insurance premiums. The effects of a large uninsured population go well beyond the individuals without coverage. The uninsured do receive health care -- often in emergency rooms, at very high costs. Hospitals, doctors and other providers raise the fees they charge those who have private insurance in order to cover the bill for the inefficient, high-cost services received by the uninsured.

The lack of private health insurance for some raises taxes for all. Some say the obvious solution is to cut, or "cap," Medicare and Medicaid. But cutting these programs puts pressure on doctors, hospitals and other providers to raise the fees they charge those with private insurance. As government programs pay less, everyone else pays more.

According to the Congressional Budget Office, unreimbursed costs for hospitals alone totaled over \$28 billion in 1991. As a result, private payers are charged substantially more by hospitals than the actual cost of their services.

Hospitals' Unreimbursed Costs, 1981-1991



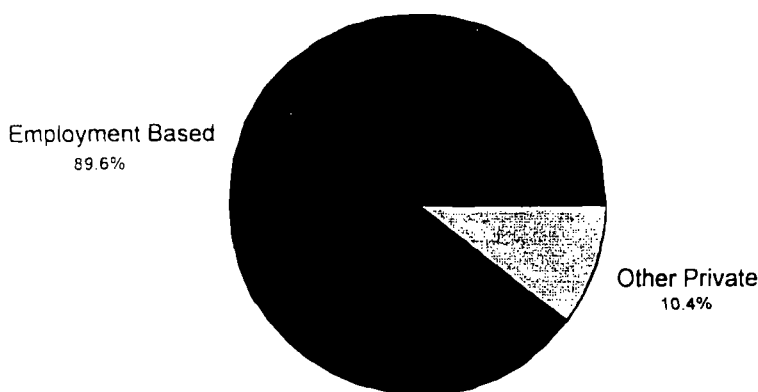
Myth #6: *An employer mandate is not necessary to fix the health care system, or to decrease the number of uninsured.*

Reality: **The United States has an employment-based health care system. The major cause of increasing numbers of uninsured is employers not providing coverage.**

According to the March 1993 Current Population Survey, nine out of ten of the nonelderly who purchase private insurance obtain it through the workplace.

Recent increases in the number of uninsured can be attributed to a decline in the number of employers who offer coverage. The share of the nonelderly population with employment-based coverage declined from 66.8 percent in 1988 to 62.5 percent in 1992. This fall was partly offset by a rise in the number of nonelderly Americans with publicly-financed health insurance -- from 12.4 percent to 15.1 percent. Even with this boost in publicly-financed coverage, the share of the non-elderly who are uninsured grew from 15.9 percent of the population in 1988 to 17.4 percent in 1992.

Source of Private Health Insurance, 1992



Conclusion

For millions of Americans with health insurance, the fear of losing their health coverage is a constant source of insecurity: over 38 million Americans were uninsured at some point in time in 1992.

Universal coverage is a universal issue. It is not simply about the unemployed, the poor, or the young and healthy. Hard-working Americans are disadvantaged by today's health care system, and have the most to gain by reform that includes universal coverage. Today, the statistics show that the poor and elderly are covered by government programs, while millions of working Americans and their families are uninsured. Universal coverage is essential to strengthen the link between work and security.

It makes sense to build on the employer-based system. Most people today with private insurance obtain it through their employer -- it is a system that works for the vast majority of Americans. With universal coverage, small business will not be disadvantaged compared to large businesses, and those who purchase insurance will no longer pay more than their fair share.

NOTES

Unless otherwise indicated, all numbers come from the March 1993 Census Population Survey. All CPS numbers refer to the non-elderly population (less than 65 years of age).

1. *Whither the Health Care Crises? Misinterpretations of Chronically Uninsured Estimates*, Timothy McBride, University of Missouri-St. Louis, April 1994.

FACT SHEET

ADDITIONAL STATISTICS ON THE UNINSURED

I. OVERALL

- 39 million without coverage in 1994, up from 36.3 million in 1991. [Employee Benefits Research Institute]
- 58 million uncovered for part of the year. [EBRI]
- The current figure of 37 million uninsured is growing 100,000 a month. [WSJ, June 9, 1993]
- 2.25 million Americans lose health insurance each month [Families USA, September 15, 1993]
- 726,000 more Americans in 1991 went without health insurance than in 1990, despite a large expansion of the Medicaid program. [Center for National Health Program Studies, Dec. 16, 1992]

II. WORKERS AND FAMILIES

A. Workers

- 84 percent of the uninsured are full-or part-time workers and their families. [U.S. Census]

B. Children

- There are 9.8 million uninsured children, which is 14.8 percent of all American children [EBRI, Jan. 1994]

C. Middle Class

- 18 million middle-class Americans have no health insurance. [CBO]
- Most uninsured Americans are middle-class working families. 59 percent of the uninsured have incomes between \$11,600 and \$45,000 per year. [EBRI]
- 44.7 percent of the uninsured make over \$20,000. [EBRI, using 1992 figures]
- Nearly one third of the uninsured -- 12.5 million of the 39 million people without coverage -- have incomes between the official poverty level and twice that amount. [NYT 7/8/94]

- In 1992, 48 percent of the uninsured earned between \$14,000 and \$50,000 a year. [HHS, June 29, 1994]
- Only 16 percent of the uninsured are in families "without an attachment to the workforce." [Kaiser Family Foundation Feb, 1994]
- Two out of five Americans who lose their insurance have incomes of \$30,000 or more. [Families USA, April 1994]
- Ron Anderson, president of Parkland Memorial Hospital (a public hospital)- *"The impression the average person has is that we're talking about welfare mothers. But the majority of our patients are working people. Some work several jobs or in small businesses. We have seen a marked increase in the number of persons who never thought they would use a public hospital."* [Wash. Post, 12/15/93]

D. Employees of Small Businesses

- Less than a third of firms with fewer than 25 workers offer health insurance, compared to 95 percent for firms with over 100 employees. [Kaiser Family Foundation, Feb. 10, 1994]
- 25 percent of uninsured are from firms with less than 25 employees. [Kaiser Family Foundation, Feb. 10, 1994]
- 42 percent of the additional 2.2 million uninsured during 1991-1992 were from families employed by firms with less than 25 employees. [EBRI, Jan. 1994]

E. Voluntarily Uninsured

- A small minority -- only 7 percent of the uninsured population -- are uninsured because they choose to be that way. [Kaiser Commonwealth Survey, August, 1993 and JAMA, May 15, 1993]

F. Security

- Without universal coverage, all Americans, even those with good policies today, are at risk of losing their insurance.

SUMMARIES OF SELECTED ARTICLES: COVERAGE

The following articles on universal coverage are attached:

- "Can The United States Reform Its Health Care System" by Henry J. Aaron [Health Affairs, 11/1/93]. One page summary and original attached.
- "Universal Coverage: It's Now or Never" [NYT 6/29/94] In this recent op-ed, Princeton economist Uwe Reinhardt articulates many of the macroeconomic reasons for universal coverage and criticizes the Senate Finance incremental approach. Reinhardt argues that without universal coverage, many reform provisions, such as community rating, are doomed to failure. He criticizes the lack of available subsidies in the Senate Finance proposal, the firm-based subsidy structure in most of the bills (including the HSA), and warns that the faulty financing in the Finance proposal will lead to rationing of health care services for low-income people.
- "An Unpleasant Choice if Employers Won't Pay" [NYT 7/6/94] This article by Robert Pear examines the employer mandate and why many health policy experts favor it as a means to universal coverage. Pear also highlights the large number of working class people who comprise the uninsured, but argues that the mandate will be passed along to workers in the form of lower wages. Good quote from William Custer, Director of EBRI: *"Uninsured people at the poor end of the middle class are least likely to pick up coverage as a result of these [incremental] reforms."*
- "Frayed Nerves of People Without Health Coverage" [NYT 7/11/94] This article contains anecdotes about uninsured individuals and families. It is useful as background for the human interest side of the debate over the uninsured. Good quote from Drew Altman of the Kaiser Foundation: *"All the studies show that the uninsured get less care and end up sicker than people with insurance."*

- "Players and Payers" [NYT 6/12/94] Yale law professor Michael Graetz and Yale economist James Tobin attack the HSA's chief financing mechanism for universal coverage -- the employer mandate -- as administratively awkward and inequitable. The authors contend that the mandate is passed back to employees in the form of lower wages and that it involves enormous administrative difficulties. They argue instead for a tax cap, an individual mandate with a Stark-like version of Medicare -- in this case called "FedMed" -- with a risk adjustment and reinsurance mechanism.
- "Health System Reform: Let's Not Miss Our Chance" [Stuart Altman, Excerpted from Health Affairs, Spring, 1994] "The Clinton plan incorporates three key components that should be strongly supported by all: universal and comprehensive coverage, a mandated employer-based financing system, and a national expenditure limit." Altman expresses three concerns about the Health Security Act's efforts to achieve universal coverage:
 - 1) relies too heavily on savings from Medicare and Medicaid.
 - 2) health spending growth reduction targets are unrealistic.
 - 3) regional alliances are too powerful.
- "A Dangerous Year" [NYT 10/28/93] Harvard doctor Rashi Fein argues against delays in the time table for universal coverage because it could take time to realize savings from reform necessary to finance reform in the absence of a broad-based tax. This article is useful background for two reasons: it makes the argument that universal coverage is necessary to eliminate cost shifting in the current system and it counters the Cooper-type argument that we should expand coverage only as savings from competition materialize.
- "Universal Care: Not From Clinton" [NYT 6/12/94] This article by Harvard doctors Steffie Woolhandler and David Himmelstein is useful to get a sense of criticism from proponents of a single payer system. The two doctors contend that managed competition will not produce savings necessary to finance reform. The authors maintain that the Health Security Act would enrich the largest HMOs and open the door to gaming by providers and patients. In addition to criticizing the administrative costs and bureaucracy of the Clinton plan, the authors maintain that the

HMOs that would thrive under reform would threaten quality of care.

- "The Logic of Comprehensive Coverage" [Excerpted from "A New Framework" in The Logic of Health Care Reform, by Paul Starr 1993] This excerpt from Princeton sociologist Paul Starr's book discusses the principles behind universal coverage. It is helpful background material to understand how universal coverage eliminates the problems inherent in a non-universal system, including: cost shifting, adverse selection (only high risk people buying insurance), high administrative costs, and avoiding purchasing insurance until a serious illness develops. Note: Starr is for the employer mandate but argues against employers *providing* health benefits to their employees because he believes it limits consumer choice, discriminates against the unemployed and imposes large administrative costs on employees.

Note on Secretary Bentsen's Statements on Universal Coverage

A nexis search spanning the last ten months revealed statements by Secretary Bentsen on the following three issues related to universal coverage:

- *Lower Threshold for Firms that Want to Self-Insure* The address to the National Association of Manufacturers immediately after the State of the Union address (1/27/94) promising to lower threshold for businesses who want to self-insure.
- *The Need for Cost Containment* The Secretary's prepared remarks before NAM focused on the need to contain costs, contain entitlements, and increase preventive care. Transcript of remarks attached.
- *Slower Phase-In* The Secretary was quoted in the Post in May saying that "*you'll probably see some of these things phased in more than the administration proposed -- both the mandates and the benefits package...there will certainly be a carve out for small businesses...The measure will aim for universal coverage...but...such coverage will 'never be 100 percent.'*" [5/10/94]

Can the United States Reform Its Health Care System?
by Henry Aaron

SUMMARY

In this paper, Henry Aaron examines the prospects for health care reform from more of a political and practical perspective than an economic one. His basic point is that the scope of the administration's proposals are unprecedented in U.S. history and beyond the capacity of our political system to deliver in their entirety. Nevertheless, Aaron looks favorably on many aspects of the President's plan, and he believes a less extensive compromise has the potential to be enacted to "serve as the seed from which real reform can grow."

The author begins with an overview of structural obstacles to fundamental reform, including the political difficulties of changing a multi-billion dollar industry and the shifting of resources that comes with such change. Aaron focuses on the President's proposals in recognition of these underlying forces, and he comments on some of the other major plans. While he labels the President's initiative as "unavoidably complex," he says the Chafee plan "contains no coherent road map to universal coverage and relies upon the rosy claims for cost containment of the more euphoric proponents of managed competition."

Finally, Aaron analyzes five fundamental "questions" that will drive the health care reform debate.

1) Universal Coverage

Support for this goal has grown. The debate will focus on timing and method, which together strongly influence cost.

2) Employer Mandate

A compromise "limited mandate" would allow opponents to claim victory in practice and proponents to win in principle.

3) Spending Limits

The magnitude of savings the President is calling for will take more than four years to achieve. While spending limits are preferable, they will not win majority support.

4) Role of Alliances

Some form of "health alliances" will be approved, although the role and powers of the alliances will not be as extensive as proposed by the President.

5) How much can be implemented over the remainder of this decade

The scope and timing of what can be done ultimately depends on political leadership and will.

Can the United States Reform Its Health Care System?

by
Henry J. Aaron¹

All too often participants in the debate on health care reform present "best" new systems, rather than "best" reforms of the system that exists. Rather than worrying about how to move from where we now are to where they would like us to be, such advocates pretend that it is possible costlessly to erase current arrangements and start afresh.

Such immaculately conceived visions fail because they do not recognize the enormous investment that the United States (and every other country) has in its current system. Creating wholly new arrangements entails wholesale changes in methods of paying for care, the relationships between patients and health care providers, and perhaps the organization of the delivery of care itself. In a country such as the United States, fundamental change in the health care financing system forces renegotiation of billions -- quite literally billions -- of significant contractual and personal relationships. The wrench of change is compounded if, as under the plan advanced by president Clinton, a large cut in the use or price of medical services is the keystone to financing the new system. Such savings require massive income shifts, changes in practice patterns, or both.

Short of economic or military catastrophe, democracies seldom break so much china in the name of reform. Even parliamentary systems seldom make revolutionary changes when the population is sharply divided, although narrow pluralities can and sometimes do effect sweeping reforms. Under the U.S. governmental system, in which

¹Director of Economic Studies, The Brookings Institution

minority interests can marshal numerous and powerful defenses to block major changes not supported by dominant and well-mobilized majorities, they are inconceivable.

The structure of U.S. health care problems compounds this political difficulty. Americans recognize the need to assure and extend insurance coverage. This step will cost money. But most reformers say they also want to sharply slow the growth of health care spending. If both goals are met, reform must inflict losses on some people, businesses, industries, and regions, as the gainers win resources that would otherwise have flowed elsewhere. Such shifts run afoul of the political law, peculiarly apt in this case, that Charles Schultze articulated, "Never be seen to do direct harm."

As noted, however, health reform must do some harm. To pay for extending benefits, one must either raise taxes, which is always politically difficult, or cut somebody's income, which is politically insupportable under Schultze' law, unless the somebody is shown to be a fool ("we are cutting waste") or a knave ("we are slashing fraud and abuse").

I believe that a recognition of these underlying forces is important for interpreting the various proposals for reforming the U.S. system of paying for health care and for making sense of the forthcoming debate. I shall focus on the proposal President Clinton outlined on October 22nd, but will comment briefly on other major proposals that will play a meaningful part in the debate.

The President's Plan

President Clinton's plan begins with a basically conservative political vision, but deviates substantially from it in execution. The conservative vision sees that most Americans are currently well, if unreliably, insured and that all can be covered securely by building on, rather than replacing, the current system. This vision recognizes that curbs on premium growth linked to limits on approved cost sharing and prohibition of balance-billing can create the budget discipline that is largely missing from the current system.

Unavoidable Complexity

Although advocates of the President's plan would deny it, the vision behind the plan rests on an acceptance of the complexity and cumbersomeness of the current system. It does so, because it forswears neat alternative program designs that would scrap the current system. In fact, the president's strategy must increase complexity because his plan cannot rely exclusively on any one of the three possible ways to achieve universal coverage, but must use all three – an employer mandate to pay for insurance, an individual mandate to purchase insurance, and government provision of insurance.

- ◆ Since most Americans, other than those who depend on public programs, are insured through work, the president would extend that system to workers not currently covered by requiring all employers to pay most of the cost of insurance coverage for their employees and families. However, for companies with fewer than 5,000 employees the plan scraps the current employer practice of sponsoring insurance plans for their employees and creates new "regional alliances" that would approve a limited number of insurance plans among which individuals must choose.

- ♦ The range of insured services that all approved plans must cover is at least as generous as the average current benefit package, particularly in coverage of mental health and preventive services.
- ♦ Exclusion from personal income tax is retained unchanged for required employer-financed benefits. Exclusion for extra employer-financed benefits, such as payment for the share of premium for which employee's would otherwise be responsible, is retained for ten years.
- ♦ To avoid disrupting coverage for the elderly and disabled, the Clinton plan would retain government insurance through medicare. But the option of medicare beneficiaries to elect coverage through regional alliances hints at the eventual replacement of government administered insurance with insurance administration by regional alliances for everyone. Meanwhile, the plan adds a new drug benefit and modest long term care coverage. These extensions simultaneously address real problems of the elderly and secure their political support for reform and boost plan costs.
- ♦ By definition, self-employed or not-employed nonelderly Americans cannot be covered through an employer. The only way to assure them coverage, in the absence of direct government payment for health coverage, is through what amounts to an individual mandate.

To make the individual mandate affordable, the plan provides subsidies for households containing full-time workers and retirees with incomes below 150 percent of official poverty thresholds, a limit covering most of this group.² To ease the shock of the employer mandate for companies that do not currently pay insurance for their employees, the plan contains explicit government subsidies for some companies with 75 or fewer employees in which average earnings of full-time workers are under \$24,000 annually. The cap on employer liability for health insurance costs of 7.9 percent of payroll indirectly subsidizes all companies for which the current cost of services

²The plan also provides subsidies to individuals or families with incomes up to 250 percent of official poverty thresholds if the family contains one or more part-time workers, but no full-time worker. The incentives of these varied thresholds are quite odd.

mandated under the president's plan exceeds 7.9 percent of payroll. These subsidies are paid for by the government or by payments made by companies that do not now pay for employee health plans.

The president's plan will also redistribute insurance costs among companies in other ways. Companies whose employees are now covered by the plans of relatives employed by other companies will have to shoulder those costs directly. The shift from experience to community rating for all companies with more than fifty but fewer than 5,000 employees will cause even larger inter-company shifts in costs of health care. Companies with above average current costs receive subsidies paid, at least at first, by increased charges on companies with below average costs.³ If growth of spending is slowed, most companies would have lower insurance costs after a few years. Reportedly at the last minute, a provision crept into the plan to relieve companies of costs of retiree health benefits for people under age 65. This provision, a massive gift mostly to the shareholders of a few, large, old corporations is likely to be subject to the political equivalent of LIFO accounting -- last in, first out.

Each of these steps is initially costly. Exactly how costly is determined by the comprehensiveness of coverage provided under the plan, the generosity of new benefits for the elderly, and the depth of subsidies. The estimated costs of these benefits is \$100

³The consensus among economists is that most health insurance costs, before and after reform, are borne by workers through reduced wages. For a thorough review of these issues, see Alan B. Krueger, "Observations on Employment-Based Government Mandates, With Particular Reference to Health Insurance," duplicated, October 15, 1993. Few people other than economists believe in this off set, and economists acknowledge that the adjustment process may be slow and painful.

billion in 1998, the first year in which the plan would be fully operational and four years after presumed enactment.

Paying the Bill

The next step is to decide how to pay for the added costs of new and extended services. The problem for government payers is quite different from that of private payers. Governments have four options. Two -- deficit financing and cutting nonhealth programs -- can be disregarded. The deficit is already too high, and elected officials have paid in political blood with program cuts to bring it down; further politically acceptable spending cuts in nonhealth programs are decidedly scarce. The fall-out from the deficit reduction debate seems also to preclude more than token use of the third instrument, tax increases. The added federal costs of the president's health plan are therefore financed largely from cuts in current health programs, notably medicare and medicaid.

The added private costs are met initially by public subsidies and by cost shifting among private payers. The magnitude of inter-company shifts⁴ has not been reported, but is likely to be quite large, as the cost differences among plans are now frequently on the order of two or three to one. Moreover, these variations arise primarily from variations in local prices, differences in local practice patterns, and work force characteristics. While the president's plan would perpetuate some of these differences, most would be levelled out by proposed community rating within each regional alliance.

⁴As noted in the preceding footnote, what appear as inter-company shifts in the short run can be expected over time to become shifts in the composition of worker compensation.

Over the longer run, both private and public payers are projected by the Administration to benefit from a sharp slowdown in the growth of health care spending. Real growth of medicare and medicaid, projected to grow under current policy at an annual rate of 8 percent from 1995 to 2000 would be slashed to 1.4 percent in 2000. The ferocity of the implied cost containment is indicated by comparison with the 1980s, when the number of hospital days per person was slashed 30 percent, when medicare and medicaid payments to providers were slashed, but medicare expenditures rose an average of 7.7 percent annually, medicaid expenditures rose 6.5 percent annually,⁵ and all other health care spending rose 5.3 percent annually, all after adjustment for inflation.

Administration

President Clinton's plan would also massively change the administration and politics of health insurance. Employers with fewer than 5,000 employees and all individuals would be prohibited from dealing directly with insurers or at-risk providers such as prepaid group practices. Each state would be required to establish one or more non-overlapping regional health alliances that jointly cover the whole state. These alliances would be required to accept applications from entities wishing to sell health insurance and to approve those plans that meet certain conditions, some of which are outlined in the draft plan. The alliances would be the conduit for subsidies paid to

⁵Part of this increase was attributable to extension of medicaid eligibility. In the latter years, part of the increase occurred as states exploited a loophole in federal legislation that permitted them the increase federal payments by an accounting gimmick.

small businesses and low-income households. The alliances would administer risk-rated payments to health plans.

Serious technical and political issues surround these new entities. How would the alliances prevent cream-skimming by health plans? Are available techniques of risk-rating adequate to squeeze the profit out of cream-skimming? If states tried to gerrymander health alliances, are there objective and legally defensible techniques for identifying when such practices are improper? How would the provision prohibiting alliances that span two or more states from favoring providers located locally over providers located in neighboring alliances be enforced? If political differences arise between the president and Congress, on the one hand, and governors and state legislatures, on the other, regarding administration of the plan, are enforcement techniques politically plausible? No reliable answers exist because these questions have never been put in practice.

For example, suppose that the National Health Board allocates to a given state a share of national health spending well below the level the governor or the state legislature deems appropriate or acceptable. Suppose further that they respond by refusing to enforce such limits on local health plans. Is it plausible that the federal government will take over operation of these alliances as called for in the President Clinton's plan? Would it not be preferable to place the states at financial risk, as is done in Canadian provinces, a measure that the administration is reported to have considered and rejected?

Major Alternative Approaches to Reform

Plans that claim to achieve universal insurance coverage without an employer mandate can choose either of two alternative options -- mandatory individual and family purchase of insurance or tax-financed, government insurance -- or a blend of the two.

The Chafee Plan

The proposal advanced by Senator John Chafee and cosponsored by other senate Republicans relies on a mandate that employers make group insurance available to all employees without regard for preexisting conditions or certain other limitations currently common in the group insurance market. But employers would not be required to pay any of the cost of such insurance. Current tax advantages would be extended to the unemployed, but limited in amount for all individual income-tax payers.

Individuals and families would be required to purchase insurance to achieve universal coverage. Unfortunately, however, low income households cannot afford insurance without subsidy. How the Chafee mandate would deal with this problem is unclear. It would provide some subsidies to low-income households, but limit the subsidies initially to households with incomes below 90 percent of official poverty thresholds. The subsidies would gradually be broadened, extending to families with incomes up to 240 percent of official poverty thresholds by the year 2000. The subsidies would be financed out of savings from shaving 2 percentage points annually from the growth of medicare and medicaid spending.

The Chafee proposal leaves fundamental questions about the subsidy and the mandate for universal coverage unanswered. The subsidy budget is implicit in this cost

control target, but the outline of the proposal does not specify the exact size of the subsidies. Would the individual mandate take effect gradually from the bottom of the income scale as subsidies become available? Would it apply immediately to those who will never be eligible for subsidies? Or would it be introduced in some other pattern? The plan does not say, and the absence of evidence that these issues and others (for example, how would the mandate to have insurance be policed?) have been thought through raises doubts on whether the sponsors are genuinely serious about universal coverage.

Like President Clinton's plan, the Chafee plan would create new regional health alliances, although their powers would pale beside those of the Clinton alliances. The Chafee alliances would be responsible for creating an insurance pool for employers with fewer than 100 employees and individual purchasers, but would not be empowered to approve health plans or to enforce fee schedules. The Chafee plan would institute some features of managed competition, but would contain no other administrative measures to slow the growth of private health care spending. As the materials accompanying release of the plan acknowledge, the Congressional Budget Office is not likely to credit the plan with any savings in health care spending other than for scorable cuts in medicare and medicaid.

Like the president's proposal, the Chafee plan would rely on reductions in growth of medicare and medicaid spending to pay for the federal costs of subsidies to low income households. Unlike the president's plan, however, the Chafee proposal calls for

no additional revenues and contains no controls to discourage providers from shifting additional costs to private payers, as they have done over the last decade.

In contrast to President Clinton's plan, which unambiguously promises universal coverage and a genuine budget constraint in the form of limits on the growth of premiums, the Chafee plan contains no coherent road map to universal coverage and relies upon the rosy claims for cost containment of the more euphoric proponents of managed competition.

Full National Health Insurance

Several plans call for the government to directly provide health insurance to everyone. All contain broad benefit packages, contain some form of budget control or fee regulation on physicians and hospitals, and depend on new taxes along with savings from reduced growth of current programs to pay for the new program.

Long advocated by a solid core of liberal Democrats, this approach credibly promises universal coverage and would create powerful regulatory instruments to control growth of spending. But its even more credible promise to move health care spending from private to public budgets has effectively discouraged support among centrist and conservative members of both parties. Nothing in the current debate has so far suggested that the fate of full national health insurance as the perennial bridesmaid will change soon.

Conservative Options

While all of the preceding options promise universal coverage, proposals for reform advanced by conservative House Democrats led by Representative Jim Cooper and by House Republicans and Senator Gramm make no such claim. These plans would mandate that employers make available group insurance to employees but not pay for it. These plans would prohibit underwriting practices that bar new employees from eligibility and would bar preexisting condition limitations. The Republican proposal would expand tax sheltered savings for medical expenses. The plan advanced by Representative Cooper would establish the framework of managed competition, but not force any employer to pay for insurance. The Cooper plan would pay for coverage for households with incomes below poverty thresholds and partial subsidies for households with incomes up to twice official poverty thresholds. No limits would be placed on the growth of medical expenses except those arising from the incentives created by tax sheltered savings for upper income households to buy high cost-sharing plans.

Defining Questions for the Health Reform Debate

The course of the health care reform debate will be determined by how the Congressional participants respond to five fundamental questions. While members of Congress are clearly responsive to their constituents' views and President Clinton and other members of the administration will try hard to shape these views, I believe that the positions of members of Congress are sufficiently set on the first four so that one can predict the opening and middle-game of the great chess match now beginning. The final

moments of this contest, likely to enliven late summer 1994, hinge on answers to the fifth question and still hold important mysteries.

Question 1 Do participants embrace the principle that government should assure essentially all Americans health insurance coverage?

Support for this guarantee has clearly grown. The ranks of supporters have long included most Democrats in both houses and now number many Senate Republicans who have endorsed the Chafee plan. Whether a clear majority in the House endorses this proposition remains unclear, but whatever the count may be on the *principle* of universal coverage, what counts is agreement on timing and method, which together strongly influence cost. The critical but still unresolved question is whether the president can mobilize the growing and well-founded middle class fear of curtailment or loss of health insurance coverage into an irresistible force in support of his approach and timetable.

Question 2 Should universal coverage be achieved by requiring employers to sponsor, *and pay most of the cost for*, insurance for their employees?

On the answer to this question hinges the fate of President Clinton's approach to health care reform. In the Senate, nearly all Republicans and a few Democrats, constituting (at least) a filibuster-sustaining minority oppose such a mandate. Nearly all House Republicans and a solid bloc of conservative House Democrats, who together form a majority, also now oppose a mandate as extensive as that proposed by the president.

The outcome of the health care reform debate may well hinge on whether the president and his administration can persuade enough opponents to a full blown mandate to accept a limited mandate that would initially force relatively few businesses to change their practices. Opponents of a sweeping mandate would claim that they had won in practice, while proponents would claim they had won in principle.

Question 3 Should the United States impose an effective budget constraint on growth of health care spending?

If this question refers to a nationally legislated limit on the annual growth of health insurance spending, whether translated into caps on health insurance premiums or imposed through fee controls and hospital budget caps, the line-up in both the House and Senate closely resembles that on forcing employers to pay for health insurance for their workers.

The important difference, as far as President Clinton's proposal is concerned, is that no obvious compromise exists. The administration could easily accept less stringent limits on premium growth than it proposes. But opponents cannot agree to any such limit without capitulating, *in flagrante delicto*, on the fundamental principle of disagreement with the president's approach to cost control. Furthermore, many opponents to a legislated cap on spending hold fast to the faith (I believe to an illusion) that their method of controlling costs is not only "lighter but tastes better." They believe that various measures to promote price sensitivity among insurance purchasers and to standardize the health insurance product will suffice to produce a sustained slow-down

in the growth of health care spending, while the president's approach will fail through bureaucratic elephantiasis.

President Clinton will no doubt continue to try to persuade the public that national spending goals can be met, at least through the year 2000, by eliminating medical waste, fraud, and abuse. In so doing, I believe he will be making a serious blunder. First, trying to wring so much out of health care spending as quickly as he proposes is not practicable. Cuts of the magnitude he projects -- one sixth of baseline acute care spending by 2000 -- would require radical changes in medical behavior of providers or large cuts in their incomes. But while many providers acknowledge instances of waste, I think most believe they are now doing the right thing most of the time. And large cuts in provider incomes are likely to provoke guerilla warfare by the groups whose complicity in, if not actual support for, reform is essential for its success.

Those who note that citizens are more satisfied with their health care financing systems in countries that spend far less than the United States does should acknowledge that large savings will *eventually* be possible. But they can still insist that such savings will take much more than the four years the president allows their achievement.

Second, large sustained reductions in the growth of health care spending must eventually force the denial of some beneficial care to some people. Despite the palpable truth of this assertion, it is more effective in emptying a room of elected officials than shouting "fire." The efforts of elected officials to avoid it is understandable, as the choices that rationing will impose are ethically and politically distressing. But health care reformers who insist on claim that enormous savings can be quickly achieved

complicate the task of politicians bent on fuzzing this truth. The president's claims of fast and large savings, which come too quickly for cuts in waste, fraud, and abuse credibly to generate, defeat the political desire to banish the ogre of rationing.

For all of these reasons, I believe that President Clinton's proposed national health budget and limits on premium increases will fail to win majority support. The limited chances for acceptance of the principle of a national health budget were doomed by the high cost of the plan developed by his advisors. The atmosphere created by the 1993 budget debate made politically unthinkable the advocacy of increased taxes on anything but the voluntary inhalation of poison. This situation is highly regrettable, in my view, as President Clinton's repeated insistence on national spending limits are essential for the sustained control of growth of spending is correct. Spending limits are also necessary to create the incentives for efficient resource allocation and even to enable managed competition to achieve its full potential.*

President Clinton's health proposal also embraces price regulation of physicians and hospitals that continue to deliver services for fee. But it is not clear how this mandatory extension to the private sector of current practice under medicare and medicaid could win approval outside the general framework of the president's plan.

*Henry J. Aaron, *Serious and Unstable Condition: Financing America's Health Care*, Brookings, 1991; Henry J. Aaron and William B. Schwartz, "Managed Competition: Little Cost Containment without Budget Limits, *Health Affairs*, vol. 12 (supplement 1993), pp. 204-215; Henry J. Aaron, "Budget Limits and Managed Competition, *Health Affairs*, vol. 12 (Fall 1993), pp. 132-136.

Question 4 What role, if any, should mandatory associations of insurance buyers play in mediating the purchase of insurance by private businesses and individuals?

Something called "health alliances" is likely to win congressional approval, given their inclusion in both the president's plan and that of Senate Republicans. But the role and powers of the alliances remains in doubt. At a minimum, they would assemble small purchasers into large groups for the purchase of insurance. The larger question is whether they will be vested with regulatory powers to approve health plans, to regulate fees, to pay subsidies to business (if an employer mandate survives), and to pay subsidies to households.

For reasons set forth above and elaborated below, I think Congress is not likely to approve powers for health alliances as extensive as proposed by President Clinton. The incentives are large for health alliances in states politically in the control of a party different from that in control in Washington (even assuming one party is in control) to pursue policies that are intolerable to Congress or the president. The regulatory demands on the National Health Board or other federal agencies to police the health alliances are enormous and probably unmanageable.

Despite these difficulties, however, the infinite variations in the design and possible powers of health alliances make this the most negotiable element of the reform debate. A broad consensus has developed on the failures of the small group market. Health alliances are a natural vehicle for effectuating any limitations on permitted practices. The case for insisting that health plans all quote prices for a standard plan to help purchasers compare prices is also powerful. This requirement is an element of the

president's and Senator Chafee's plan. It could easily be accepted by all participants in the debate other than those who never met a government function they didn't dislike. Alliances could become the agency for administering medicaid and for offering coverage to any medicare beneficiaries who wished to switch from HCFA.

Any compromise is likely to invest health alliances with powers well short of those proposed in the Clinton plan. A process of gradual evolution would then commence, as Congress added, subtracted, and modified alliance powers. The eventual character of the alliances would be influenced by their initial design, but it would be determined largely by future decisions. The creation of health alliances would be a watershed event, bringing into existence entities that in the future could become enforcers of managed competition, managers of an employer mandate, or the administrators of government sponsored health insurance.

Question 5 How much change in health insurance arrangements can be implemented over the remainder of this decade?

No hard analysis can answer this question. How much can be done and how fast it can be done depend on political leadership and will. In fact, U.S. history contains no example of legislation that remotely resembles the President's proposal for reforming health insurance in the depth and pervasiveness of institutional change. It has become commonplace to compare reform of health care financing to enactment of the Social Security Act in 1935. This analogy is faulty, but instructive. On a scale of complexity starting at zero, if the Social Security Act rates a 10, President Clinton's health reform plan rates 200.

The Social Security Act was passed during a time of great economic distress, an era of chaos in the American capitalist system that more closely resembles the current conditions of Russia or the near collapse of Britain after World War II than the slowly emerging and comparatively minor chronic difficulties the United States is now experiencing. Nevertheless, the largest element of that landmark legislation, old age insurance, was financed by taxes that did not start until 1937, nearly two years after enactment, to pay for benefits that did not start until 1940, more than four years after enactment. Survivors insurance was enacted only in 1939. These programs began with a delay and grew slowly. More fundamentally, they replaced essentially nothing and required virtually no one to rewrite existing contracts or change then existing pension arrangements.

In contrast, the president's health care reform would transform the financing and organization of the delivery of roughly 11 percent of gross domestic product. It would bring into existence a wholly new type of agency, the regional alliances, with sweeping regulatory powers and would do so in the space of less than two years. Quite apart from the huge administrative task this represents, the successful operation of these alliances hinges on the successful execution of difficult technical tasks, such as risk rating, that have never been carried out in practice before and whose feasibility remains in doubt, even among experts sympathetic to an employer mandate.

Under some circumstances, such enormous change is possible. The mobilization for World War II involved direct control of most of the U.S. domestic economy and the creation of countless agencies with new and untried powers. The exigencies of war

elicited enough cooperation and tolerance for mistakes to make that episode the most glorious triumph of government policy in U.S. history.

The practical question facing Congress involves how much change to ask the American people to embrace during a peacetime of relative prosperity and how fast to ask them to accept it. In making this decision, Congress and the administration that will have to administer the new legislation will not be able to draw on the good will, patriotic fervor, and sense of shared sacrifice that united the nation after Pearl Harbor. They will not even be able to count on the toleration of experimentation born of economic desperation that smoothed the way for the untried and often unsuccessful innovations of the New Deal. They will confront a public suspicious of government and elected officials, that is mostly satisfied with the access to health care it now enjoys but is worried about losing it, and that is bombarded by information and disinformation provided by groups with enormous economic stakes and not all of whom hold truth in high regard. Against this background, I believe that the plan advanced by President Clinton asks more of the political system than it can or will deliver.

The mystery that will not be settled until late next year is whether the administration can keep alive in the public the recognition that reform is imperative and that its plan contains many good ideas that should survive in any compromise plan. Can those committed to reform prove sufficiently flexible to start down a road to reform the end of which cannot be seen and that will not be reached within the political lives of most of those asked to begin the journey?

Universal Coverage. It's Now or Never.

By Uwe E. Reinhardt

A lone in the industrialized world, the typical American family must worry that medical bills could bankrupt it some day, or that a stricken parent, son or daughter could go without needed care. That nightmare haunts not only the millions of Americans who are uninsured, it should worry anyone whose insurance coverage comes with a job that may be lost.

When he was elected President, Bill Clinton vowed to end this insecurity through "universal coverage." His reform proposal would require all employers to provide employees and their dependents with comprehensive coverage and to pay 80 percent of the premium. Americans who were unemployed or self-employed and not covered by Medicare or Medicaid would be required to buy private insurance, with the help of Federal subsidies where needed.

There can be no question that Mr. Clinton remains passionately committed to reaching the goal of universal coverage before the year 2000. Alas, he must work with a Congress that remains deeply divided not only over how best to achieve it but over the goal itself.

At the moment, there are numerous proposals before Congress, none of them coming close to offering universal coverage. One of the plans that is at least keeping the process moving, however, is the compromise bill

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being worked out in the Senate Finance Committee. Made public yesterday by the chairman, Daniel Patrick Moynihan, the bill would rely on a combination of incentives, new regulations and so-called "triggers," which would require employers to insure their workers if more than a certain percentage of the population remained uninsured by some future date. Whether even this version will prevail is very much in doubt.

Fundamental to this compromise strategy is a reform of the private insurance market. All insurers would be required to sell policies to all comers in order to preclude the game of "cherry picking" by which private carriers have traditionally sought to avoid customers with health problems.

For this to work, the carriers' premiums would have to be averaged over a large pool of policyholders in a defined geographical area, so that an individual's premium would be insulated from his or her health status. These "community-rated" policies could not exclude people with existing illnesses. The new regulations, it is hoped, would make insurance coverage more accessible to the chronically ill and a more effective safety net for employees who lose their jobs.

The legislators who worked long hours to forge this compromise may have had the best of intentions. They may believe that this is all the health reform the American voter will accept, and they may be right. Their strategy, however, would leave many Americans behind. Unless insurance coverage is made compulsory, as President Clinton had

proposed, many young and healthy Americans might choose to go without insurance, then throw themselves on the mercy of community-rated insurance when they grow older or get sick. This would leave insurers with a relatively sicker group and thus drive up the community-rated premiums.

Unless Congress stands ready to spend \$60 billion to \$100 billion a year in premium subsidies for unemployed or low-income working families, community-rated insurance may be no easier to afford than a Mercedes-Benz — which, in principle,

Congress seesaws while 20 million Americans will remain uninsured.

is "accessible" to all Americans now.

At the moment, the financing for adequate subsidies is nowhere in sight. Many members of Congress seem to believe that the rapid growth of health maintenance organizations and other managed-care plans, with their strict cost-control systems, will make health insurance more affordable. But there is no assurance that managed care will significantly cut health spending. And if it does, lowered spending will deprive doctors and hospitals of the financial cushion with which they have long been able to underwrite the care they give to people without insurance.

Thus, unless it includes some as-

urance of adequate financing, the compromise strategy could impose very harsh rationing on the millions of low-income Americans it is likely to leave uninsured. Not only the uninsured will bear the expense of that rationing, it will spill over onto the rest of us. Prolonged neglect of proper health care for millions of Americans could unleash a major public health hazard, in the form of communicable diseases.

In short, one need not be a card-carrying socialist to support the principle of universal coverage for very pragmatic reasons, which is probably why so many Americans do support it and why so many of our overseas competitors instituted it decades ago. Americans might be surprised to learn that both Japan and Germany finance their universal insurance systems through the employer, with premiums that vary with the employee's income, usually in the form of a flat percentage of the gross payroll, shared equally between employer and employee.

These countries do not tie the size of that premium or of public subsidies to the size of the firm, to avoid tempting employers to, for example, hire part-time workers or pay more overtime rather than hire another employee who will put them over the limit. Unfortunately, most of the reform proposals now before Congress do make an issue of the firm's size.

In the end, the seesaw in Congress over health reform could leave us without any bill at all this year, or with one that allows so many key provisions to be delayed that it recalls Scarlett O'Hara's famous remark, "Tomorrow is another day." Even this would probably be better

HEALTH CARE SECOND OPINIONS

An occasional series.

than nothing. But these proposals are likely to leave 20 million Americans uninsured by the end of the decade, most of them in the lower-middle-income groups. By then the cost of ordinary spells of illness will quickly break the bank of such families, and even that of many solidly middle-class people.

If American voters are content to couple their otherwise excellent health care system with this unseemly game of Russian roulette in health insurance, then let them be mindful that the game may hit their own households one day, when they are sick and for some reason uninsured.

Let them then be "individually responsible" for their plight, as many affluent Americans would no doubt like them to be, and as they themselves had planned to be, when they were employed and well insured, or just young and healthy.

On the other hand, if American voters truly crave secure and affordable health insurance, as survey after survey suggests, then now is the time to communicate that to Congress, loudly and unmistakably. Opportunities for significant health reform arise only every couple of decades. If we miss the train this time, the next one may be far behind.

An Unpleasant Choice if Employers Won't Pay for Health Care

By ROBERT PEAR

Special to The New York Times

WASHINGTON, July 7 — President Clinton's goal of health insurance for all Americans is often described as a moral imperative or a political objective, but it is also a pocketbook issue.

In one sense, there is no mystery about how to reduce the number of uninsured: It just takes money. The question is who should pay.

In trying to achieve universal health insurance coverage, Mr. Clinton and Congress will confront an unpleasant choice in the next few weeks. If employers do not pay most of the cost, as Mr. Clinton has proposed, then the Government and consumers must pay more.

Many people describe Mr. Clinton's proposal for an "employer mandate" as an alternative to taxes. Still, the public would ultimately pay. Economists say that employers would pass on the costs to their workers by reducing the amount of money available for wages or future pay raises.

Guarantees, but Not for All

Members of Congress are skittish about requiring everyone to obtain insurance, and many flatly oppose Mr. Clinton's proposal to make employers pay most of the cost. Many lawmakers now suggest that the Government should initially try to guarantee coverage for some fraction of the population, perhaps 65 percent, as the Senate Finance Committee has proposed.

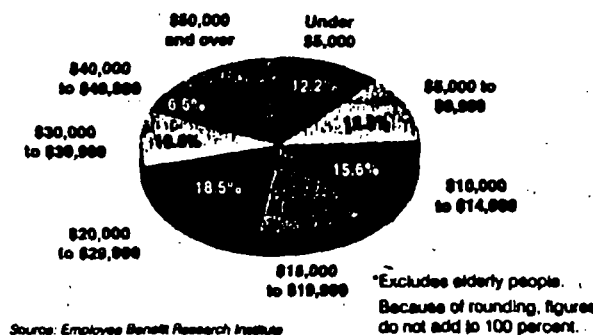
What difference does it make whether 65 percent or 100 percent of the people have insurance? And who is most likely to remain uninsured? Those questions are at the heart of the current debate over how to redesign the nation's health care system.

Currently, the Government estimates that 39 million Americans, accounting for 16 percent of the population, have no health insurance. But such numbers imply far more precision than is possible with any measuring now available. People's insurance status is continually changing as they change jobs, marry and divorce, move from one area to another and go on and off the rolls of

DEMOGRAPHICS

The Uninsured, by Income

The percentage of uninsured Americans in each family income category, 1992 figures.



The New York Times

programs like Medicaid and Medicare.

Virtually all the major health care proposals now in Congress would make health insurance more available, prohibit insurers from denying coverage to people with a history of illness or disability and prevent insurers from charging extremely high premiums to people with high medical risks.

But such changes, by themselves, would not solve the problem, and experts warn that half measures could have unintended adverse effects. Alice F. Rosenblatt, an actuary at Coopers & Lybrand, the accounting firm, said that "a small proportion of the uninsured, probably less than 5 percent, have been denied coverage because of pre-existing conditions like cancer and cardiovascular problems."

Moreover, there is no mechanism for enrolling all people in health plans, millions of Americans are likely to remain uninsured be-

cause they do not want to be bothered, see no need for coverage or cannot afford their share of the cost.

"Many people may rationally choose not to purchase health insurance coverage, either because they have low income or because they believe they have a low risk of needing health care services," said William S. Custer, research director of the Employee Benefit Research Institute, a nonpartisan organization whose members include businesses and labor unions.

The Young May Go Without

If there is no requirement for people to have insurance, many who are young and healthy will probably go without it because they see no immediate need, given the cost. If significant numbers of healthy people go without insurance, the average risk of older people rises, and their premiums rise as a result. Six million people 18 to 29 years old have no health insurance. They account for 30 percent of the

uninsured. It is desirable to have these people in the insurance pool because their medical costs are generally lower than those of older people, actuaries say.

Under most of the proposals in Congress, poor people would pay little or nothing for health insurance. The Government would pay the premiums for people with incomes below the official poverty level, now \$14,784 for a family of four. Lawmakers assume that affluent people can buy private health insurance, costing \$4,000 to \$6,000 a year for a family, if they do not receive coverage through employers.

So, health policy experts say, if employers are not required to provide insurance to their employees, the people most likely to be uninsured are people in the middle-income range, particularly those who work for small companies.

"All the major proposals would give full coverage to people below the poverty line," said Mr. Custer of the Employee Benefit Research Institute. "That's the first group that would pick up coverage. Uninsured people at the poor end of the middle class are least likely to pick up coverage as a result of these reforms."

Eleven million people without insurance, or 28 percent of the uninsured, have incomes below the poverty level. They could get coverage at little or no charge under most of the proposals pending in Congress.

If the Government provided coverage similar to what the average employer now offers, it would cost \$2,000 a year for each uninsured person. For every million people who received fully subsidized coverage, the Government would have to pay at least \$2 billion a year.

Nearly one-third of the uninsured — 12.5 million of the 39 million people without coverage — have incomes between the official poverty level and twice that amount. Under the major proposals, these people would get some financial assistance from the Government to help them buy insurance.

Whether such subsidies be adequate depends on many factors: the amount of the assistance,

the cost of the insurance and its portion, if any, paid by employers.

Mr. Custer sounds a cautionary note. "It is extremely unlikely that simply lowering the costs of insurance will achieve universal coverage," he said.

Clinton Administration officials say that universal coverage is not only good health policy but also good politics. Health care is a pocketbook issue, they say, because people can be impoverished by medical bills.

"People who work should not be left behind when we reform the health care system," said Gregory E. Lawler, a lawyer coordinating the health care campaign at the White House. "They should have guaranteed private insurance."

More than half of the uninsured are working adults. Eighty-four percent of the uninsured live in families headed by workers. But in recent years, there has been a decline in coverage provided by companies with fewer than 25 employees. Such companies say they are often unable to obtain affordable health insurance for their workers because insurers charge them higher premiums, reflecting the risks and the administrative costs associated with small groups.

Concern for Children

Congress has for years shown special concern for the medical needs of children, and that impulse is clear in many proposals to overhaul the health care system. The Finance Committee, for example, accepted a proposal by Senator Donald W. Riegle Jr., Democrat of Michigan, to provide extra subsidies to help pay insurance premiums for children in families with incomes up to 2.4 times the poverty level.

Nearly 10 million children under 18 years old have no health insurance coverage, and most of them could obtain it under the bills now pending in Congress.

About one-third of the uninsured children are in poor families. Another third live in families with incomes between the poverty level and twice that amount. The rest live in families with incomes exceeding the poverty level.

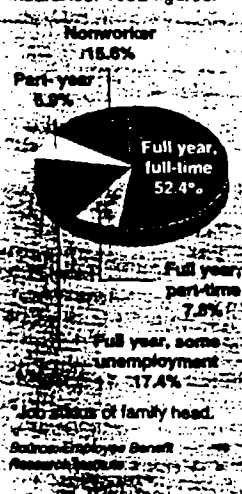
Frayed Nerves of People Without Health Coverage

By ERIK ECKHOLM

At the age of 52, unemployed after an international career as a manager, Bob Hughes is astonished to find himself without health insurance and wishes Washington would do something about it.

"I don't want a dole from the Government," said Mr. Hughes, who lives with his wife next to a golf course near Houston and cannot afford the \$568 monthly premiums they were quoted this year. "Just a little help, a little protection until I get re-employed."

Job status of people under 65 who lack health insurance, 1992 figures.



Continued From Page A1

points unequivocally to serious hardships for tens of millions of Americans. But this problem cannot be swept away, it is clear, without costly Government subsidies or painful mandates on employers and possibly both — a predicament that goes a long way toward explaining the pitched combat that will resume this week in Congress.

"All the studies are finding the same numbers," said Drew E. Altman, president of the Henry J. Kaiser Family Foundation in Menlo Park, Calif. "The argument over the size and shape and seriousness of the problem is really a smoke screen for the more legitimate debate over how to solve it."

Profile of the Uninsured

The burdens fall largely on working families with low-to-moderate incomes. In half of uninsured households, a person works full time and in another third of households a person works part time or part of the year, according to Federal data analyzed by the Employee Benefit Research Institute.

Many uninsured people work for small businesses offering no benefits, or in low-wage or contract jobs. A vast majority be-

The Uninsured: Who Are They?

A special report

Mark Elias, a 36-year-old self-employed woodworker in New Orleans, has plenty of business, but he and his wife think they would rather spend their money on private schools for their three children than on health insurance. Mr. Elias, who makes custom doors and windows to the sonorous voice of Rush Limbaugh, would rather live with risk than see the Government meddle with health care.

Lauren Bright, a 26-year-old actress, survives in New York City by waiting on tables. "I'm honestly thinking of giving up acting in search of a career with benefits," she said. "It's a sad thing."

In San Francisco, Trinidad Estrada, a 29-year-old mother of three who stands in a restaurant all day making burritos, wonders how she will come up with \$1,000 for foot surgery; she resents the free coverage the state gives to people she regards as loafers.

These are some of the 39 million uninsured people, more than one in seven Americans, at the center of an epic political battle as Congress decides how far the country will go toward universal coverage. Their plight has been called a crisis and a non-crisis, their numbers called understated and overblown.

Whatever the politics, evidence

Continued on Page A12, Column 3

millions uncovered who live in stifling need.

Minority members with lower-than-average incomes are disproportionately uninsured. While 14 percent of white Americans under 65 were uncovered in 1992, 23 percent of blacks under 65 and 35 percent of Hispanic Americans under 65 were.

Disparities among the states are also striking. In much of the South and the West, where jobs without benefits are more common and Medicaid is often less generous, more than one in five people under 65 are uninsured. In many Northern and Midwestern states it is closer to 1 in 10.

People who are excluded by insurers because of pre-existing medical conditions — a history of cancer or a chronic disease — have provided heart-rending stories in the health care debate. Banning such exclusions is a goal of many bills in Congress. Yet, these account for only a small fraction of the uninsured, perhaps one million of them, studies suggest.

The commonly quoted figure of 39 million or so uninsured is a snapshot of the population at any point and includes a changing mix of people. Over the course of a year, 55 million people are uncovered at least temporarily, research shows, but many regain coverage when a family member finds a new job

Going Without Care

But a closer reading of the statistics shows that despite the turnover, the long-term uninsured remain numerous. A new analysis by Timothy D. McBride, an economist at the University of Missouri, finds that three-fourths of those who are uninsured on a given day, or about 29 million people, remain uncovered for one year or more and more than half of them, or 21 million people, for at least two years.

Beyond anxiety, being uninsured takes a medical toll. Most people find ways to get care when it is vital, either paying out of pocket or finding charity care. But they tend to seek help less often and late.

"All the studies show that the uninsured get less care and end up sicker than people with insurance," Mr. Altman of the Kaiser Foundation said. "Insurance per se makes a huge difference."

Many younger, healthy people voluntarily forgo the expense of insurance. In a survey last year of 2,000 adults, conducted by Louis Harris and Associates for the Commonwealth Fund and the Kaiser Foundation, 7 percent of those who lacked insurance said they did not want it, though the reasons were not specified.

Owners of restaurants and other small businesses who have offered to help pay for premiums note that some employees choose to be uncovered rather than pay their share. But it is not clear whether this is more a reflection of lack of interest or the financial strains on many workers.

Between Jobs

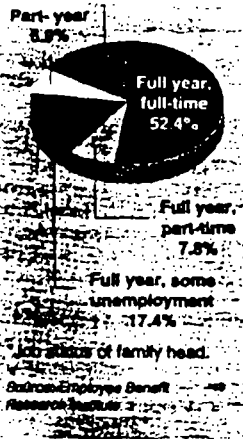
Medical Insurance Or Their House

The home of Bob and Susie Hughes, in Conroe, Tex., north of Houston, is filled with mementos of a career abroad: dolls from Shanghai, an incense burner from Indonesia, a painting from Vietnam. Mr. Hughes admits he never thought much about health costs during his years as an executive and sales manager with several companies. That changed after Mr. Hughes left his last job in early 1992 as Southeast Asian sales manager for a petroleum equipment supplier, just as the company was going under.

With no new job in sight, the couple bought a private insurance policy. "They kept raising the premiums and the deductibility to the point where we couldn't afford it," he said of the premiums that jumped this year to \$568 a month with a \$2,500 deductible. "Faced with the choice of a house or medical insurance, I chose my house," he said. Their coverage ended two months ago.

"I've never taken unemployment from the state or the Federal Government," he said. "I've gone through my savings and I've had to take money from my 401(k). All I want is a little parachute."

Mr. Hughes said his main focus was to



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Many uninsured people work for small businesses offering no benefits, or in low-wage or contract jobs. A vast majority believe they simply cannot afford to pay hundreds of dollars a month in insurance premiums.

The uninsured do not include the group that would otherwise be most vulnerable, the elderly. Since the creation of Medicare in the looser fiscal climate of the 1960's, everyone 65 and over has basic coverage that is largely paid for by the public.

The uninsured also do not include many of the poorest Americans, who are often covered by Medicaid, the Federal-state program. Yet, fewer than half of Americans who live below the official poverty line — an annual income of around \$15,000 for a family of four this year — are on Medicaid, leaving

millions uncovered who live in stifling need.

Minority members with lower-than-average incomes are disproportionately uninsured. While 14 percent of white Americans under 65 were uncovered in 1992, 23 percent of blacks under 65 and 35 percent of Hispanic Americans under 65 were.

Disparities among the states are also striking. In much of the South and the West, where jobs without benefits are more common and Medicaid is often less generous, more than one in five people under 65 are uninsured. In many Northern and Midwestern states it is closer to 1 in 10.

People who are excluded by insurers because of pre-existing medical conditions — a history of cancer or a chronic disease — have provided heart-rending stories in the health care debate. Banning such exclusions is a goal of many bills in Congress. Yet, these account for only a small fraction of the uninsured, perhaps one million of them, studies suggest.

The commonly quoted figure of 39 million or so uninsured is a snapshot of the population at any point and includes a changing mix of people. Over the course of a year, 55 million people are uncovered at least temporarily, research shows, but many regain coverage when a family member finds a new job with benefits, just as Mr. Hughes in Texas hopes to do.

This turnover has been seized on by both sides in the health care debate. Seeking broad support from the middle class, the White House stresses how widely shared the insecurity is, noting that one in every four currently insured Americans will spend vulnerable months at some point over the next two years. Opponents, asserting that relatively small numbers are chronically uncovered, say the whole problem has been exaggerated.

with insurance." Mr. Altman of the Kaiser Foundation said. "Insurance per se makes a huge difference."

Many younger, healthy people voluntarily forgo the expense of insurance. In a survey last year of 2,000 adults, conducted by Louis Harris and Associates for the Commonwealth Fund and the Kaiser Foundation, 10 percent of those who lacked insurance said they did not want it, though the reasons were not specified.

Owners of restaurants and other small businesses who have offered to help pay for premiums note that some employees choose to be uncovered rather than pay their share. But it is not clear whether this is more a reflection of lack of interest or the financial strains on many workers.

Between Jobs

Medical Insurance Or Their House

The home of Bob and Susie Hughes, in Conroe, Tex., north of Houston, is filled with mementos of a career abroad: dolls from Shanghai, an incense burner from Indonesia, a painting from Vietnam. Mr. Hughes admits he never thought much about health costs during his years as an executive and sales manager with several companies. That changed after Mr. Hughes left his last job in early 1992 as Southeast Asian sales manager for a petroleum equipment supplier, just as the company was going under.

With no new job in sight, the couple bought a private insurance policy. "They kept raising the premiums and the deductibility to the point where we couldn't afford it," he said of the premiums that jumped this year to \$568 a month with a \$2,500 deductible. "Faced with the choice of a house or medical insurance, I chose my house," he said. Their coverage ended two months ago.

"I've never taken unemployment from the state or the Federal Government," he said. "I've gone through my savings and I've had to take money from my 401(k). All I want is a little parachute."

Mr. Hughes said his main focus was on finding a job, not on politics, and he is active in Forty Plus, a group that helps experienced professional people find work. Asked about the Washington debate, he chuckled heartily. "I'd like to get the same kind of coverage Bob Dole gets for the same premium," he said, referring to the Republican Senator who has called universal coverage too expensive.

"I think if the Federal Government has their employees on a master plan, they ought to offer it to everybody in career transition," Mr. Hughes said.

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Out of Reach

No Funds for Care Or for Insurance

Enrique and Trinidad Estrada of San Francisco, parents of children aged 9, 7 and 4, are struggling toward the middle class. Mr. Estrada, who is 31 and has lived in this country nearly all his life, works all night delivering tortillas; his wife, who came from Mexico to marry him at age 19, works all day making burritos in a restaurant. Neither receives health benefits.

For years they lived with Mr. Estrada's parents, saving to buy their small blue house in the Mission District. To meet the \$1,600 monthly payments they rent out the bottom floor for \$700, cramming themselves into the top floor, where they have one bedroom and a fold-out sofa on which all three children sleep. Between house payments and baby sitters, Mrs. Estrada said, buying health insurance would be unthinkable.

Mrs. Estrada has not paid much attention to the battles in Washington over health care, but she wonders about the fairness of things. Because of their jobs and home ownership, she said, her family did not qualify for Medi-Cal, the California version of Medicaid. "The people who are working — why shouldn't we have it?" she asked. "I see people who are as young as I am begging on the streets, and they get everything from the Government."

Still, the Estradas do not seem to dwell on the issue of health care. Mr. Estrada has never been to a doctor. Mrs. Estrada received free care under a public program when she was pregnant, but has not seen a gynecologist in the four years since she gave birth, she said with no sense of alarm.

The children get low-cost checkups at a publicly financed clinic. "They look so healthy," Mrs. Estrada said, "and I don't worry about it."

But a painful condition in her right foot has caused her concern and highlighted the family's vulnerability. She had one operation at a cost of \$300, which she paid in monthly installments. But the operation did not cure her, and doctors say she needs another procedure, which will cost \$1,000. "It's going to be very difficult for us to find the money," she said.

Out of Luck

Aspiring Actor Gets Pneumonia

Milo Pacheco is a 26-year-old aspiring actor who has lived in New York City since 1991, working as a waiter or bartender to pay the bills. Like many of his friends in the arts and the restaurant world, he was last covered during college, when he stayed on his parents' policy, but now he has no money to spare for insurance.

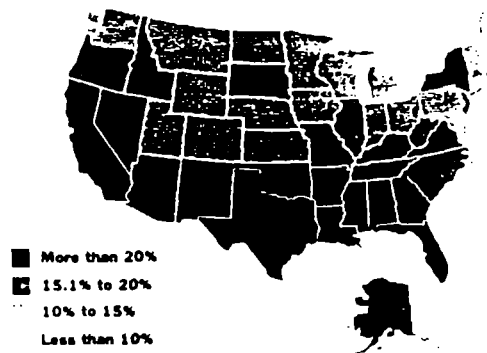
Until March he was lucky, paying for doctors as he needed them. Then disaster struck, a severe pneumonia and infected fluid around the lungs. He had a chest tube inserted and spent 18 days in the hospital, racking up bills of more than \$25,000.

BY THE NUMBERS

The Uninsured: A National Snapshot

The percentage of people under 65 in each state who were uninsured in 1992.

Nev	26.6%
Ore	25.8
La	25.7
Tex	25.7
D.C.	25.5
Fla	24.2
Ariz	23.5
Miss	22.7
N.M.	22.5
Ga	22.4
Calif	22.2
S.C.	20.8
Ala	20.1
Alaska	19.3
Idaho	19.0
W.Va	18.5
S.D.	18.5
Ariz	18.5
U.S.	17.4
Va	17.4
Ky	17.1
Mo	16.6
N.C.	16.4
N.Y.	16.1



■ More than 20%
■ 15.1% to 20%
■ 10% to 15%
■ Less than 10%

Tenn	16.0%	Ohio	13.0%	R.I.	11.1%
Ore	15.5	Utah	13.0	W.V.	11.1
Ill	15.3	Kan.	12.6	Penn	10.7
N.J.	15.3	Ind.	12.6	N.D.	10.5
N.H.	14.8	Wash	12.4	Wisc	10.5
Colo	14.6	Mass.	12.4	Minn	10.0
Md	14.0	Mont	12.3	Conn	9.5
Wy	13.8	Mich	11.9	Hawaii	8.1
Del	13.4	Iowa	11.7		
Me	13.1	Neb	11.3		

Source: Employee Benefit Research Institute

Mr. Pacheco said he now owed several thousand dollars for doctor bills and a CAT scan, which he will slowly pay off. A thoracic surgeon near his parents' home in southern New Jersey, where he sought treatment, was a guardian angel, accepting a surfboard in lieu of a hefty fee. The hospital is chalking off his \$20,000 bill to charity care and will recoup much of that from the state and the bills of the well-insured.

Mr. Pacheco's experience has only added to the fears of his girlfriend, Lauren Bright, who is also 26 and waits tables between acting jobs. "When you're paying rent and trying to save a little money, you just hope that you don't get sick," she said.

—She has avoided going to the doctor but is grateful that gynecological care, at least, is available on a sliding scale through Planned Parenthood. But now, largely because of the threat of health costs, she said, she is rethinking her choice of careers.

Mr. Pacheco and Ms. Bright both scoffed at the suggestion, made by some economists, that many young adults were not worried about living uninsured. Among people working in restaurants, who seldom receive benefits, for example, "health care is a regular topic of discussion these days," Mr. Pacheco said. "It's always a concern."

He added that he believed that employers ought to contribute at least a share of the cost of worker coverage, as President Clinton proposed.

Ms. Bright said she would welcome government health subsidies; if a plan with complete coverage were made available in the range of \$100 a month, she would take it. But existing cut-rate plans, she said, are not worth it because of their limited benefits.

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Against Principles

Business Owner Hates Regulation

A talk with Mark Elias, the woodworker, suggests why the President's proposals for universal coverage have not drawn an irresistible groundswell of support. Running his own business in Slidell, La., a gritty town east of New Orleans, and making an annual income of about \$40,000, he feels he cannot afford to buy insurance for his own family, including his wife—a 13-year-old and 11-year-old twins, let alone his three employees. But, his sense of independence extends to his attitude about government regulation of health care.

The family has been uninsured for two years, since Mrs. Elias left a job with an insurance agency. They looked into buying a policy but especially in light of their desire to send their children to private school, they believed they could not afford rates of \$300 a month, with a \$2,500 deductible.

"Fortunately, we haven't had any kind of doctor bills," said Mr. Elias, who admits to some worry. He guesses that someone in the family goes to a doctor about once a year, but he cannot remember the last time anybody went.

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Interestingly, while health care costs had risen dramatically since the passage of Medicare and Medicaid in 1965, Nixon's Comprehensive Health Insurance Plan (CHIP) included very limited cost containment. Growth in health care costs was not then the compelling issue it was to become in the 1990s.

Further action on this or any other national health insurance proposal was halted by a series of unanticipated events, including the resignations of both President Nixon and Rep. Wilbur Mills (D-AR), then chairman of the powerful House Ways and Means Committee. Not until late in President Jimmy Carter's term did the reform debate resurface, and even then congressional activity was limited, with no results. Almost a decade later, in the late 1980s, the huge growth in the cost of health care, the realization that millions of Americans lacked health insurance, and a growing fear by millions more that their health insurance coverage would not be available when they needed it made health care reform a major national issue again.

Who are the uninsured? The profile of the uninsured, as traditionally low-income working families, undoubtedly influenced the Clinton administration's decision to expand the employer-based system as the solution for universal coverage. Linkage to employment makes it easier to track and administer national health care coverage. It also keeps much of the funding for the health care system off the government's "books."

Not surprisingly, there is considerable evidence that the uninsured receive less health care than the insured receive.¹ When the uninsured do receive care, they often use the expensive emergency departments of tertiary care hospitals. In addition, delayed treatment adds significantly to the cost of health care today.² Thus, even though the uninsured make up 16 percent of our population, it is estimated that their coverage would add only about 5 percent to total health care spending.³

Serious as the problems of the uninsured are, this is not the issue driving the current political debate. What is different than in the past is the heightened insecurity of the middle class regarding continuation of their own health insurance plans. The underlying problems are a partial breakdown in the private health insurance market, particularly for small firms and individuals, and the uncontrolled growth in health care costs.

Growing health care costs. The U.S. health care crisis has been exacerbated by health care costs that continue to escalate at twice the rate of general inflation. The United States also spends much more than other industrialized nations for the health care of its citizens. Nevertheless, these other countries—among them Canada, Japan, Germany, and the United Kingdom—provide universal access to a broad range of health services.

The substantially higher expenditures in the United States are related to several factors—in particular, our lack of a national system that limits total

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Kv	17.1	Md	14.0	Mont	12.3	Conn	9.6
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"Even if it was a good deal, I'd rather not have the government give me something," he said. "I'd rather not have my taxes go for social programs."

But he also knows that if medical catastrophe strikes, he could get help. "I'd probably have to go to the clinic," he said, referring to a nearby public medical center. "We'd work something out. They couldn't leave us out on the street, at least that's the way I understand it."

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Players And Payers

By Michael Graetz
and James Tobin

THE PRESIDENT and First Lady have achieved remarkable consensus on a truly revolutionary principle: All Americans must be entitled to adequate medical services without regard to ability to pay or risk of ill health. Now it's up to Congress to embody that principle in law, a historic opportunity comparable to the enactments of Social Security in 1935 and Medicare in 1965.

Unfortunately, excessive solicitude for existing institutions and interests, and the difficulties of reconciling them with the Clintons' fundamental principles, have made their proposal a bureaucratic and legalistic morass.

The biggest flaw in the administration proposal is the requirement that employers pay the premiums — a mandate whose awkwardness and unfairness stand out starkly in a system dedicated to universal coverage.

Employer-based medical insurance is a historical accident — one that no one would choose now if given a clean slate. During World War II, trade unions and employers circumvented Federal wage ceilings by offering medical fringe benefits. Their popularity and generosity boomed after the war, as Congress sheltered them without limit from income and Social Security taxes.

The fact that employers write the checks for medical care does not mean that they bear the full costs. They can generally shift some costs to workers in reduced take-home pay and some to customers in higher prices. The sure losers are taxpayers who have to make up the revenue lost to the tax shelter.

Much of the Administration's 1,300-page proposal is devoted to expedients intended to mitigate the difficulties

Michael Graetz, professor of law at Yale, was Assistant to the Secretary of the Treasury from 1990 to 1992. James Tobin, emeritus professor of economics at Yale, won the Nobel Prize in Economic Science in 1981.



ties and anomalies of employer mandates. It's a hopeless task. Some families have no employed members. Some have two or more. Many employees work part time. Some have more than one job. Americans frequently change jobs, employers, work locations, places — even states — of residence.

Under an employer mandate, responsibilities for paying a family's premiums would frequently be divided among several sources — various employers, governments and the family itself — in proportions varying month to month. Keeping track of these liabilities would surely involve extensive paperwork and administrative hassle, contrary to Mrs. Clinton's claim that an employer mandate eliminates the need to track individuals.

Nor would the new system be equitable. Equity demands that public subsidies, direct or via employers, be a larger share of premiums and of income the poorer the family. Equity also requires that families' subsidies be the same if their incomes are the same.

But in the Clinton plan, subsidies depend more on the size of employers' payrolls than on families' ability to pay. The system is also full of bad

incentives — for example, not to hire workers with dependents.

It's individuals who get sick and need medical services. It's individuals and families whose ability to pay is the natural criterion of equity. It's individuals who must be guaranteed coverage. So it's individuals who must be required to have insurance. Let employers help pay the premi-

The misbegotten employer mandate.

ums if they wish, but count those payments as taxable income. Treat the self-employed exactly the same as employees.

Let people choose where they will buy insurance. One option should be a version of Medicare or a selection of the health plans made available to Federal employees. Let's call this option Fedmed.

Fedmed would offer the basic universal medical insurance package at

premiums that in total would cover the costs. Let private health plans offer the same package, provided they do not pick and choose members or charge higher premiums for risky cases. As in the Clinton plan, it would probably be necessary to collect money from plans that happen to have low-risk clientele and distribute them to plans with high-risk members.

With these provisions, Fedmed would be protected against becoming the last-resort insurer of bad risks. As in Medicare itself (which would continue as at present), people could choose their own physicians and other providers.

Fedmed would have low administrative costs and would wield enough clout to limit payments to providers. It would also let people change employment status, residence or family situation without losing coverage. But it need not be a monopoly.

Federal subsidies to individuals would take the form of refundable tax credits, "vouchers" or a credit card payable to Fedmed or other insurers. For low-income families the subsidies would cover the whole premium of the basic package; most other families would receive vouchers at least as valuable to them as the current tax exemption for employer-provided insurance.

A family of four in the 28 percent tax bracket with a \$4,300 insurance package would receive vouchers of \$1,204 — 28 percent of the premium. No family would face an out-of-pocket cost of more than 10 percent of income for the basic package.

This plan would not require new broad-based taxes or new levies on employers. One source of financing would be redirecting the Clintons' proposed subsidies to employers and low-income people, about \$100 billion in 1999. Eliminating the tax shelter for employer-paid premiums would contribute \$125 billion, and our plan would replace Medicaid acute care for those under 65 (about \$75 billion more).

Robert Reischauer of the C.B.O. destroyed a semantic attraction of employer mandates when he testified recently that federally required purchases of insurance should be included in the budget. Their popularity is waning among businesses and in Congress, where support appears to be growing for the plans of Representative Jim Cooper and Senator John Chafee; unfortunately, these plans do not assure universal coverage in this century.

Our proposal is not a radical reconstruction. It builds on the best of existing institutions. A victory for it would be a victory for the principles that the Clintons have so eloquently set forth.

Economic Analysis

Health System Reform: Let's Not Miss Our Chance

by Stuart Altman

Abstract: Support for reform is at its highest level, but criticism of President Bill Clinton's plan is widespread. Nevertheless, the core components of the Clinton plan should be supported. These include (1) building on existing employer-based health insurance with a mandate that employers offer coverage to all workers and pay a substantial portion of the premium; (2) requiring that coverage be universal and benefits comprehensive; and (3) controlling total health care spending via a national expenditure limit. This paper does, however, suggest three changes to strengthen the plan: developing a broader base than Medicare and Medicaid to pay for reform; setting the national health care spending limit at a higher level (gross domestic product plus 1 percent); and strengthening the powers of the regional health alliances.

As early as 1920, while many other European countries were establishing national health programs, the United States began to assess ways to finance health care and improve its delivery system. In 1930 President Franklin D. Roosevelt decided not to include a national health plan with his Social Security program. This lost opportunity resulted in periodic tinkering with the U.S. health care system, such as the Hill-Burton Hospital Construction Act in 1946, until the passage of Medicare and Medicaid in the mid-1960s. In some cyclical fashion, the United States has revisited health care reform every ten to fifteen years since 1935. This effort has been challenged by one or more of the dominant three issues: the lack of adequate financial coverage, rapidly rising health care costs, or questions about the appropriateness and the quality of care.

The debate in the mid-1960s centered on advancing access for the elderly and disabled. With the leadership of a strong president, the country passed the first significant federal health legislation, which created the Medicare and Medicaid programs. During the 1970s the growing problem of the uninsured among the nation's working population forced an examination of the private insurance market. President Richard M. Nixon proposed his version of a national health insurance system, which built on the existing private employer-based system and mandated that all employers must offer and help pay for a comprehensive range of health benefits.

Stuart Altman is Sol C. Chaikin Professor of National Health Policy at the Heller School, Brandeis University, in Waltham, Massachusetts.

health care spending, such as exists in these other countries. These countries also have enacted government policies and regulations that control the number of medical specialists and actively promote the use of primary care providers as the basis of their health care delivery systems. In addition, European health systems use global budgeting, which places controls on the development and diffusion of high-cost new technologies and restricts the growth of hospital budgets and physician fees. These European global budgeting systems, which rely on sector-specific budgets—that is, a separate hospital budget and a separate budget for outpatient and physician services—differ from the budgeting system proposed in the Clinton plan. The Clinton plan instead would use controls on the rate of growth in spending, leaving to each health care plan the decision on how to allocate its funds.

Business response. Variation among payers for health care services allows providers to obtain additional revenue from some payers to offset losses from other payers, or to shift costs. This cost shifting to well-insured private patients translates into health insurance companies paying 30 percent more than the actual costs of the care received.⁴ As a result, many health care providers have not had to directly confront the financial pressures imposed by governmental payment and coverage restrictions.

Increasingly, businesses that are faced with high and rising health insurance premiums and that lack the same bargaining power as government are being forced to reduce the health care benefit package provided through insurance, limit coverage for nonworker family members, or shift a larger portion of the insurance bill onto workers. Thus, while it might appear that employers are paying more of the bill, it is actually workers themselves who are paying more. Of course, most economists believe that it is workers who pay for the coverage even when it is "paid" by the employer. Psychologically, however, workers resent the high costs more when they pay directly for insurance.

Medicare spending. Legislated in 1983, the Medicare hospital prospective payment system (PPS), and more recently, the Medicare fee schedule for physicians (resource-based relative value scale, or RBRVS), have reduced the rate of growth in spending by the federal government.⁵ By the end of the 1980s the rate of Medicare spending growth was below that of growth in national health spending. Preliminary data from the Health Care Financing Administration (HCFA) on Medicare outlays for physician services show an increase of only 5.6 percent for the first ten months of 1993, compared with 9.5 percent for the same period in 1992.⁶ The private rate of growth was significantly higher.

Because PPS affects only the payment rate for Medicare, hospitals have managed to increase their costs beyond the Medicare limits and to maintain profit margins by charging more to other payers. Hospitals also have sought

to recoup lost revenues by providing services that pay higher Medicare rates, such as open-heart surgery, and by providing services not controlled by PPS payments, such as expanded outpatient services.⁷

The ability of the Medicare program to control its payments to hospitals while total hospital expenses continued to rise at pre-PPS levels strongly suggests that, to be truly effective, cost controls must be comprehensive and must apply to all payers of the service, public and private. Should the Clinton plan be enacted as proposed, it will be complicated but necessary that the same level of control be developed with the two separate spending control systems, one for Medicare and one for private health plans.

Analysis Of The Clinton Plan

Given the complexity of designing any comprehensive national health insurance plan, including offering a realistic financing system, one can easily find aspects of the plan to criticize. I, too, have several concerns. But in basic design the Clinton plan does address the major problems of our health care system. By building on rather than destroying our current financing system, it minimizes the disruptions that would be caused if we went to a completely governmental, tax-based system. Most importantly, the Clinton plan incorporates three key components that should be strongly supported by all: universal and comprehensive coverage, a mandated employer-based financing system, and a national expenditure limit.

Universal and comprehensive coverage. First and foremost, the Clinton plan provides universal coverage with health care benefits that are broad-based and comprehensive. Some have criticized the benefits as being too comprehensive (and therefore too expensive). Such criticisms come from a mind-set that is focused on designing a benefit package for low-income populations that is paid for by someone else and that leaves the general population either to receive different benefits or to supplement the core benefits. This is the wrong way to think about a true national health insurance plan. Using the political process to decide what level of benefits the average American wants and is willing to pay for (either through a community-rated premium or from taxes) may not be perfect, but it does bring into play all of the forces for expanding and contracting the benefits offered. The president or Congress cannot, as some contend, simply add benefits without balancing value with cost, since they must develop the means to pay for the added coverage or face the added political pressure from those who would be required to pay for it.

The debate surrounding the benefits included in the plan will go on throughout the reform process, and some changes no doubt will occur. Such changes, however, will be marginal and will not affect the ultimate likeli-

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hood of passage of the plan. What is critical to the Clinton plan and to whether this country does create a universal health insurance system is the requirement that all employers offer the agreed-upon benefits to all workers and pay a substantial proportion of the premiums.

The employer mandate. The Clinton plan requires that employers pay 80 percent of the average premium for mandated benefits offered by health plans in their region. Interestingly, this is the same percentage required under President Nixon's CHIP. There is nothing magical or crucial in the percentage selected, other than that it should be a substantial proportion of the total premium. Perhaps this proportion will be one of the compromise items during the legislative process.

Much of the criticism of the Clinton plan comes from representatives of small businesses and some economists who believe that the employer mandate would destroy hundreds of thousands or even millions of jobs.⁸ In response to these dire predictions, several alternative proposals have been introduced, which, while still relying on an employer-based insurance system, drop the requirement that employers pay a major proportion of the premium. I believe that these predictions seriously distort what would happen to the employment market under the Clinton plan. Recent testimony by the chair of the Council of Economic Advisors and economists of the RAND Corporation supports this conclusion.⁹ Further, it should be clearly understood that the alternative plans are neither universal nor comprehensive.

While these alternative plans would provide subsidies to help low-income uninsured populations purchase coverage, and most of the plans attempt to reform the health insurance market for small businesses and individuals, all of these proposals would still leave millions of Americans without coverage. To me, the employer mandate is critical to any proposal that seeks to provide universal coverage and still retain an employment-based insurance system.

Ironically, the uninsured are disproportionately represented in just those small businesses the alternative proposals would free from the mandate. The uninsurance rate is almost 34 percent in firms with fewer than twenty-five employees and 26 percent in firms with twenty-five to ninety-nine employees.¹⁰ This uninsurance rate would be much larger were it not for the fact that for many of these workers, other family members receive insurance from their employers. Thus, the health care expenses of workers whose firms do not provide coverage are added to the insurance costs of the employers that do provide coverage.

Given the market assumption that requiring firms that do not offer health insurance to do so leads to a loss in jobs, it also should hold that reducing employment costs to firms that now insure their workers will

increase employment in those firms. In addition, one must consider the employment effects on firms that now pay for the cost of care used by the uninsured. The Prospective Payment Assessment Commission (ProPAC) estimated that for 1991 the uninsured generated unreimbursed expenses of \$10.8 billion for hospital inpatient care alone.¹¹ To this amount must be added billions of dollars for unreimbursed expenses incurred for outpatient care, particularly emergency room services, as well as for physician services and other types of health care. These expenses are added to the bills of those who are privately insured. If everyone were insured, this hidden tax would be eliminated, thereby further reducing the cost for those firms that now provide insurance—perhaps adding jobs as well.

There is no model at this time that reflects all of the expected gains and losses that would result from the Clinton plan, or any other plan. But, given the likelihood that the increase in total health care spending from the reform plan will be small—or as under the Clinton plan, negative—once the cost containment features are factored in, I postulate a positive net employment effect for the nonhealth sector and a negative impact on health care employment. In total, the net employment results are likely to be small in either direction or could completely offset each other.

Mindful of the criticisms by those opposed to an employer mandate, the Clinton plan includes a series of subsidies for firms most likely to be affected. Not only would firms with fewer than seventy-five employees and an average annual payroll of less than \$24,000 per worker have a limit on the percentage of payroll required for health insurance (between 3.5 percent and 7.9 percent), but all firms whose employees receive health insurance coverage through a regional alliance would have the percentage of payroll for such coverage limited to 7.9 percent. This includes firms with more than 5,000 employees who choose to use the regional alliance. Employees who work for firms using the regional alliance also can receive a subsidy to assist them in paying their share of the coverage if their family income is below 150 percent of the federal poverty level. Such employees are entitled to this subsidy even if they work for a firm whose average payroll is in excess of the subsidy limit, regardless of the firm's profitability. Such a provision is certainly justified on equity grounds for such low-income employees relative to others with comparable income, but this subsidy is in effect a hidden wage increase paid for by the government. It may be that the designers of the Clinton plan overreacted to critics of the employer mandate and provided too many subsidies to private companies and their workers. This concern is heightened when the subsidy for early retirees is added.

National health expenditure limits. There has been much criticism about the size, scope, and power of the regional alliances, particularly about

their control proposals, with firms and increasing these including hospital

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The administration rather than time periods been bid up in supply and increase in flow of funds many types own allocation the best way of the health have been health care services act

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Concern

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their control over health plan premiums. Many of the alternative reform proposals, while requiring regional purchasing associations to help small firms and individuals to buy insurance economically, stop well short of giving these regional entities any influence over the health care system, including how much is spent. This, I believe, is a mistake.

To control future growth in health care spending, this country has three choices: (1) rely completely on market forces, (2) use tight price controls and supply constraints, or (3) limit the total flow of funds going for health services and leave allocation of these funds to market forces.

The administration is correct in relying on indirect spending controls rather than direct price controls. Price controls can be effective for limited time periods when excessive spending results from price increases that have been bid up by rapid and artificial increases in demand or drastic reductions in supply as, for example, in wartime or during panic buying. Today's increase in medical spending, however, has resulted from an uncontrolled flow of funds into the health care system, leading to excess capacity for many types of expensive services. Having health plans responsible for their own allocation decisions within externally generated budgets is likely to be the best way of both reducing total spending and increasing the efficiency of the health care system. Other countries that use sector-specific budgets have been successful in reducing total spending but have less-efficient health care systems. These sector-specific budgets impede the transfer of services across sectors as, for example, from inpatient to outpatient care.

Without an external spending limit, competition among managed health care plans alone cannot generate sufficient savings to bring total health care spending down to levels that are in line with the growth in the nation's income or inflation rates. Experience with managed care plans indicates that savings of at most 10 to 20 percent can occur. For the most part, these are one-time savings with yearly increases similar to those in traditional fee-for-service systems.¹² The president's plan, however, would require reductions in the annual growth in private spending of closer to 50 percent. Such savings cannot be generated without an external budget constraint. Without such savings, this country faces the real prospect that its spending for health care will still reach 20 percent of gross domestic product (GDP), despite expanded market competition to slow the growth rate. As we approach this rate of spending, serious dislocations in other sectors of the economy surely will occur.

Concerns About The Clinton Plan

Among my concerns about the Clinton plan are the following: (1) It relies too heavily on savings from Medicare and Medicaid to fund the new

Medicare benefits and broader health reform; (2) it may bring total health spending down to almost no real per capita growth; and (3) it limits the responsibilities of the regional alliances over the shape and size of the delivery system. Let me state at the outset that I believe it is appropriate to look to expected savings to help pay for reform. My problems are with focusing primarily on savings from Medicare and Medicaid, the expected magnitude of these savings, and the ceiling level for private spending.

Do not rely on savings from only Medicare and Medicaid. The major beneficiaries of health care reform, in addition to newly insured persons, would be currently well insured Americans, including those associated with our largest and most profitable corporations. Well-insured companies and their employees now pay extra premiums in three ways: They pay for employees' noninsured family members; they pay for the health care costs incurred by the uninsured; and they pay when government forces providers to accept payments that are lower than the cost of the medical care used by government beneficiaries. Covering all Americans and including Medicaid recipients in private health care plans would help to reduce these add-on costs. In addition, if the Clinton plan is successful in reducing the rate of growth of all health care spending, those who are currently well insured by private plans will see additional savings.

We should not, therefore, rely exclusively on the savings from government programs, particularly programs that already have in place much stronger financial control systems than is the case in the private sector. Instead, we should ask all who are now well insured to invest some of the savings they will realize under total health care reform. Some will call this a tax increase (and I know there is political reluctance to raise taxes), but this is not a normal tax increase. It is a form of shared savings or an investment. Such shared savings could come in various forms: an earmarked add-on in all provider rates, a set-aside or add-on fee to private health plan premiums, or some form of a broad-based health tax. Most surveys suggest that Americans would be willing to pay a small amount to see health care reform become a reality.

You may ask, Why not accept the political reality that it is much easier to get through Congress a payment system that relies only on savings from government programs? The answer is that we are not likely to see the savings that are required from only these two programs without opposition from providers of these services and their patients. Opposition to cuts in the growth rate in Medicare spending for hospital care and outpatient services will not be eliminated because these savings will be used in part to finance the new Medicare prescription drug and community long-term care benefit programs. Some of these savings will be used to fund broader health reform. Concerns also will be raised about the negative impact of these cuts on the

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quality and availability of services whose payments have been reduced. Some of these concerns may be real, for several reasons.

First, Medicare payments for inpatient care and for physician services already have been cut back significantly below provider costs and private payment rates. Even before the reductions legislated in the Omnibus Budget Reconciliation Act (OBRA) of 1993, Medicare hospital payments were estimated to equal only 88 percent of provider costs. For physician services, Medicare payments are now on average 30 percent below private rates, and for several services they are 50 percent or more below private rates. Volume growth in these large spending items also has slowed and has even declined in the case of hospital care. Further spending cuts in these two programs may therefore require reductions in Medicare services.

Second, Medicare thus far has been able to reduce growth in payment rates to providers without seeing a backlash from providers or a cutback in services to beneficiaries. This is due to the ability of most providers to find other patients whom they can charge higher rates. Under the Clinton plan such extra revenue generation or cost shifting would become very difficult, as tight limits would be placed on private spending rates. With no place to add extra revenues, hospitals and doctors would be forced to make major cuts in costs. Given that the cuts will be real and are likely to require significant and noticeable reductions in services to beneficiaries and in health care workers' incomes, providers and their patients are likely to mount extensive lobbying campaigns on state legislatures and Congress to provide new funds for Medicare.

Third, the major growth areas in spending under the two government programs in recent years have been in outpatient testing and procedures, home health care, and other noninstitutional care. There are no provisions in the Clinton plan to significantly change Medicare's utilization controls. Even if the plan wanted to, there are no good programs for controlling services in these areas without questions about restricting needed care. The one mechanism that does exist is to cut provider payment rates. To make the kind of cuts needed, however, would require sizable reductions in the payment rates for these services.¹³

Finally, the payment rates for most Medicaid programs are lower than for Medicare and much lower than private rates. Therefore, health plans covering Medicaid individuals under the reform plan would have to produce sizable utilization reductions. If they did not, substantial amounts of cross-subsidization would be needed in regions with extensive Medicaid populations. These subsidies would be more extensive because each state's payment rate would be capped at 95 percent of its current level.

Set lowest spending control levels at rate of GDP growth. The Clinton plan expects that within two years of enactment, the growth rate

in total private health care spending will fall 2.5 percentage points below the baseline (a reduction in the expected growth in spending of 30 percent). Within four years spending growth would be required to fall still further to only the overall per capita growth in the Consumer Price Index (CPI) (in essence, no real growth in spending). Hence, the expected rate of growth of private spending would be expected to fall by more than 30 percent between 1995 and 2000. Thereafter, the plan leaves control of the level of spending to Congress or, if by default, to the National Health Board. The board would be required to set the ceiling at the rate of per capita growth in GDP. For Medicare the long-term growth rate is expected to fall by somewhat less than private spending, or about 30 percent, from a baseline of 11.1 percent to 7.8 percent. This is before the additional spending for the two new high-demand and high-growth services of outpatient prescription drugs and community-based long-term care are added. Therefore, it is not that the cuts in growth in Medicare spending are too large relative to expected reductions in private spending, but that combined reductions in the rate of growth of total spending may be too large.

I support aggressive controls on health spending. However, the reductions suggested by the Clinton plan seem unrealistically tough. To succeed, they would shift the United States from being among the fastest-growing health-spending countries to one of the slowest. The average real growth in health expenditures per capita in Organization for Economic Cooperation and Development (OECD) countries during 1986-1991 was 3.4 percent.¹⁴ The U.S. rate was 5.3 percent. The Clinton plan would bring the per capita U.S. growth rate down to slightly above 2 percent by the year 2000. Thereafter, it will be up to Congress to decide the tightness of the limits.

If spending growth is not brought down to these tight limits, then several components of the plan would begin to add significantly to the cost of reform, or Congress will be forced to reduce subsidies for low-income persons or low-wage firms or to scale back the new Medicare benefits. By relying so heavily on Medicare savings to finance health reform and to keep Medicare payments in line with private payments, the private premium growth limits must be kept very tight. Thus, these limits should not be thought of as benign targets or a "backup" system; rather, they are critical to the success of the Clinton plan. This could spell trouble in the years after passage if these tight spending caps are not met. I suggest instead that the spending growth rate and subsidy rates be revised to reflect a higher ceiling for health care spending, such as real per capita GDP plus 1 percent. Such a growth rate is more in line with the controls used by other major industrial countries. These reductions still would generate substantial savings from the baseline growth rate.

To compensate for lower Medicare/Medicaid savings, President Clinton

and Congress should move from health care reform to a classic form of a tax. We do not move in to oppose comprehensive as a justification to plan does pass, finally the spending limits.

Strengthen, no making the nation that the regional shape of the health powers of a region administrative and the health care dealing between planning inefficiencies from some process. Further will ever achieve it.

The Clinton plan authorities should of high-cost services to the point that show other countries.

We also should controlling costs. requiring employers. To assist the region firms of 500 workers alliance. Their expenditures. But concerning no cost would have to be. This would keep the health care containment power care system to bring administrative in.

Summary

A true nation:

and Congress should build upon the fact that most Americans will benefit from health care reform and should help pay for it. This would not be in the classic form of a tax increase, but rather a reduction in the savings rate. If we do not move in this direction, we face the real possibility that those who oppose comprehensive reform will use the tightness of the premium limits as a justification to sabotage the entire package. Or, if the Clinton reform plan does pass, financing problems will occur very quickly as we find that the spending limitations are unattainable.

Strengthen, not weaken, the regional alliance. If we are serious about making the national health care budgeting system work, then it is likely that the regional alliances will need more authority to affect the size and shape of the health care system. As envisioned under the Clinton plan, the powers of a regional alliance are limited to only indirect controls over the administrative and financial aspects of the health plans in its region, not the health care delivery system itself. While over time tough price negotiating between plans and providers could "wring" some redundancies and inefficiencies from the system, this is likely to be a very long and cumbersome process. Furthermore, there is no evidence that market forces alone will ever achieve the level of constraints necessary.

The Clinton plan requires substantial savings very quickly. Regional authorities should have the power to assist in reducing the excess capacities of high-cost services in the region and even to force the system to cut back to the point that some waiting for nonemergency care might occur. This is how other countries have kept their spending rates below U.S. rates.

We also should not eliminate most of the business community as allies in controlling costs. There is little to be gained in administrative savings by requiring employers with more than 500 workers to join a regional alliance. To assist the regions in controlling spending, therefore, I recommend that firms of 500 workers or above be required to operate their own corporate alliance. Their premiums would be affected by how well they control their expenditures. But they would not be allowed to violate the reform rules concerning no coverage restrictions based on health status, and all workers would have to be covered with the firm paying 80 percent of the premium. This would keep these powerful community interests involved in controlling the health care costs of their region. If we do not strengthen the cost containment powers in the community, we cannot then expect the health care system to bring spending down close to GDP growth. Easy savings from administrative inefficiencies or "fat" in the system will not do it.

Summary

A true national health insurance system has been long in coming to the

United States. If we let this opportunity for reform pass without making some significant changes, the problems will be much more serious a decade from now. I therefore applaud the Clinton administration for pushing this issue to the top of our domestic agenda and strongly support the basic approach it has taken to solve our health system's interrelated problems. The changes I have recommended, while important, are small in comparison to the many areas with which there is agreement. I also believe that these changes can be added without doing serious harm to the plan's overall structure. What is most important is that we enact a reform plan that will solve the pressing problems of our current health care system.

The author thanks Carmella Bocchino for her valuable assistance in writing the paper by providing technical material as well as critical analytical insights. The final judgments of this paper are, however, the author's.

NOTES

1. J. Needleman et al., *The Health Care Financing System and the Uninsured* (Report to the Office of Research, Health Care Financing Administration, Department of Health and Human Services, 1990), 32-48.
2. Ibid.
3. Estimates prepared by the White House, published in Congressional Health Care Workshop material (September 1993).
4. Estimates by the Prospective Payment Assessment Commission, *Report to Congress*, 1993 (Washington: ProPAC, June 1993).
5. Congressional Budget Office, *Projections of National Health Expenditures* (Washington: CBO, October 1992), 15; and Physician Payment Review Commission, *Annual Report*, 1993 (Washington: PPRC, 1993), 1-25.
6. Estimates by the PPRC, October 1993.
7. ProPAC, *Report to Congress*, 1993.
8. Study done by Consad, Inc., Pittsburgh, Pennsylvania, 1993, under contract from the National Federation of Independent Business.
9. L.D. Tyson, "The Economic Effects of Health Care Reform," and J.A. Klerman, "Job Loss Due to Health Care Reform" (Testimony before the Senate Labor and Human Resources Committee, 19 October 1993).
10. Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured*, Special Report (Washington: EBRI, February 1992), 224.
11. ProPAC, *Report to Congress*, 1993, 31.
12. H.J. Aaron and W.B. Schwartz, "Managed Competition: Little Cost Containment without Budget Limits," *Health Affairs* (Supplement 1993): 208; and U.S. General Accounting Office, *Managed Health Care: Effect on Employers' Costs Difficult to Measure* (Washington: U.S. Government Printing Office, 19 October 1993), 12.
13. ProPAC, *Global Budgeting: Design and Implementation Issues* (Washington: ProPAC, July 1993), 65.
14. Organization for Economic Cooperation and Development, *Premium Growth Targets under the Clinton Proposal: Comparisons with the OECD Experience*, OECD Health Data 1993 Report (Washington: Price Waterhouse Consulting, October 1993).

A Dangerous Year ✓

10/28/93

By Rashi Fein

AMERICANS have waited a very long time for a national health insurance program. So what difference does it make that between President Clinton's address to Congress on health care reform in September and his presentation of the plan yesterday, the timetable for completing the phase in has slipped

Delayed universal coverage could sink the plan.

from 1997 to 1998? After all, it is nearly half a century since President Harry S. Truman called for universal health insurance.

Does one year matter? You bet it does. It makes a real difference not only to Americans without insurance but also in containing the costs of

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health care. President Clinton knows that, and surely did not want to delay full coverage. But he evidently chose to do so because he has decided to finance the program out of savings in the cost of health care delivery rather than out of taxes. Realizing such savings will take extra time.

The President's Health Security Plan is complex. Unwilling to break the link between insurance and employment and to substitute broad-based taxes for today's premiums, he was forced to achieve universal coverage by requiring that employers provide insurance.

Still, he needs dollars to pay for extending benefits to employees whose employers can't bear the full costs and to individuals who need financial help.

These dollars would come largely from reductions in unnecessary paperwork in medical offices, from reductions in the cost of care and from savings in Medicare and Medicaid, rather than from broad-based taxes.

To achieve such gains and savings, the program combines reform in financing with reform in health care delivery — even though both concerns operate in very different time frames. The attempt to cram evolutionary changes into a revolutionary timetable promotes further complexity.

Obviously, everyone should support the search for efficiency. It's more desirable to cut waste than to raise

taxes. But the savings that come from reforming the system will come only over a long period of time.

The tree must be planted today, but will not provide shade tomorrow, per-

HEALTH CARE SECOND OPINIONS

An occasional series

haps not even by 1998.

As a result, there will surely be new pressure to lengthen the phase-in timetable beyond 1998.

Opponents will argue that although universality is meritorious, America cannot afford it: "Some year, perhaps, but not so soon. Let's save the dollars first, then phase in universal enrollment."

But it would be disastrous to hold universal enrollment hostage to cost containment. That would break faith with the millions of uninsured and underinsured who need help immediately, and the millions more who would benefit from knowing they would never lose their insurance.

Another reason to reject delay is that the program can easily collapse. Opponents could make the apparently reasonable (but fallacious) argument that it would be rational and judicious not to enact universal coverage until the gains in efficiency materialized. They would be wrong.

The fundamental reason to reject delay is that we cannot have real savings and real cost containment without universal enrollment. Such enrollment is not a welcome bonus delivered with cost containment dollars; it is what makes cost containment possible. Only with universality can we eliminate the practice of making patients with insurance pay the medical costs of those without it.

There are numerous ways to finance health care subsidies without increasing the deficit. If we need more money to erect the structure of benefits, let's raise it with broad-based taxes wholly earmarked for the Health Security Plan.

A surcharge of 5 percent on individual and corporate income taxes would raise more than \$40 billion in 1998. Proposals for a value-added tax, rejected at an earlier stage, can be re-examined.

Universal health insurance is worth paying for. If, over time, we reduce the increases in medical costs and expenditures, so much the better. We can use the dollars for deficit reduction.

Over the last month, the timetable has slipped one year. If the misguided critics of the Health Security Plan seek to postpone rather than to improve it, they will argue for still another year's delay, and another. In the end, Harry Truman — and Bill Clinton — will have gone unheeded. X

Universal Care? Not From Clinton

By Steffie Woolhandler
and David U. Himmelstein

CAMBRIDGE, Mass. President Clinton's evanescent promise of health security merely distracts from outcomes his plan would guarantee: more bureaucracy, less consumer choice and a health system owned by a few insurance giants. As Congress sorts out the options, it needs to scrap the Clinton plan in favor of the single-payer approach that works so well in Canada, where virtually all medical providers are paid by the Government.

Advocates for managed competition, which forms the basis of the Clinton plan, attribute soaring costs to overinsurance that leads to too much care, too much choice and too little medical competition. But Americans already pay the world's highest out-of-pocket costs yet have fewer doctor visits, hospital days and even transplants than Canadians, who spend less and have greater choice.

No evidence links competition with

Steffie Woolhandler and David U. Himmelstein, professors at Harvard Medical School, helped found Physicians for a National Health Program.

lower costs. Big employers and state Medicaid programs already use the hard bargaining and restrictions on choice that Mr. Clinton envisions, but their health spending has soared. Premiums for health maintenance organizations have risen as fast as traditional Blue Cross premiums.

Massachusetts has the nation's highest percentage of people in H.M.O.'s — and the highest per capita health costs. Nor does experience here bode well for the Clintons' employer mandates: as costs soared, the state's requirement that employers cover their workers was postponed, then abandoned. Six years after passage of Gov. Michael Dukakis's "universal health insurance" law, there are more uninsured, not fewer.

Insurers and H.M.O.'s have found more profit in gaming the system than in cutting costs. Ten percent of the population consumes 72 percent of health care, so the surest way to undercut competitors is to avoid the sick or drive them away with unsatisfactory care. Mr. Clinton's plan would augment these scams with new games. His health alliances would pay higher premiums for sick patients; clever insurance executives could recommend batteries of unproven screening tests for all enrollees, dubiously labeling millions with premium-inflating diagnoses like "borderline diabetes" or "early Alz-

heimer's." Regulators can't stop such abuses; they failed to prevent even the gross fraud of Empire Blue Cross or flagrant neglect of patients by I.M.C., the largest Medicare H.M.O. The complexity of the Clinton plan would open more loopholes than its arcane regulatory structure could ever plug.

What the Clinton plan would do is enrich the biggest insurers and wipe out small insurers and individual medical practices. The Clintons loudly denounce the small insurers' trade association. But the biggest insurers, like Aetna and Prudential, helped finance the Jackson Hole Group, which honed the managed competition plan.

Only such giants have the capital to assemble the sprawling provider networks demanded by big employers and regional health alliances, and the clout to extract discounts from hospitals and doctors by threatening to withdraw a large chunk of business. Costs would be shifted to smaller plans, driving their premiums up and subscribers away; the big plans could also wipe out smaller competitors through price wars.

Once they'd muscled out competitors, the big insurers would enjoy a quasi-monopoly. (Already, 10 insurers control 70 percent of the H.M.O.'s.) Oligopolies don't compete.

The mirage of competition among hospitals is already evaporating. Boston's two biggest hospitals have merged; mergers have made many smaller cities one-hospital towns. Half of Americans live in areas too sparsely populated to support competition.

While a single-payer system could save \$100 billion a year on administrative overhead, the Clinton plan would boost administrative costs. It would pump an extra \$300 billion

More bureaucracy, less choice, bigger insurance giants.

through private insurers, whose current overhead is 14 percent. It would privatize Medicaid (current overhead, 4 percent) and, in some states, Medicare (current overhead, 2 percent). Private insurers would administer coverage for those who are now uninsured (current overhead, 0 percent). The \$30 billion hike in insurers' overhead would dwarf any savings from the Clintons' streamlined billing form.

Moreover, Mr. Clinton would add a new layer of bureaucracy — the

of spending goes for administration; in the U.S., it's 24.8 percent. The growth of managed care would increase the bureaucracy; the Mayo Clinic employs 70 people just to phone cost reviewers for managed-care plans.

The President's rosy image of universal coverage under clones of today's best H.M.O.'s is hardly germane; they haven't slowed cost growth. Managed competition means harsher limits imposed by profit-driven insurers. Mediocre doctors who prescribe low-cost care will be H.M.O. favorites; superb but less frugal clinicians will be unemployable. Already some H.M.O.'s forbid their doctors to speak publicly about quality problems.

Low-income patients stuck in bottom-tier H.M.O.'s would fare worst, but others are also at risk. To cut costs, Boston's Bay State H.M.O., a middle-class plan, abruptly fired hundreds of psychiatrists. Patients were to call an 800 number, describe their problems and be assigned a new therapist. Press 1 if you're schizophrenic!

The President would force working Americans to pay dearly for care. Employer-paid premiums are, in effect, deductions from employees' wages. By mandating a fixed contribution per employee, the plan would impose identical deductions on a C.E.O. making \$1 million a year and on his \$20,000-a-year secretary. (By contrast, with a 5 percent payroll tax, the boss would pay \$50,000, and the secretary \$1,000; paying for health care through the income tax would be even more progressive.) So a disproportionate burden would be borne by the working poor (and the sick, through co-payments and deductibles) — a hidden tax that Congress would surely reject if it were made explicit. Mr. Clinton is trying not so much to avoid taxes as to avoid fair taxes.

If the President's plan does pass, its inevitable collapse will make single-payer reform harder. Because managed competition would foster ownership of health care by big insurers, dislodging them would require buying back the hospitals and practices they'd bought with our mandated premiums and tax dollars. The small-scale care most Americans prefer — the familiar receptionist answering the phone, the doctor able to schedule an extra-long visit without a manager's permission — would be gone, with any chance of decline as a calling card. Their resurrection would be as difficult as repurchasing

liance with a premium up to the average. Others previously covered by Medicaid, such as the "medically needy" who have exhausted their assets paying for medical care, will have been covered under an alliance plan to begin with.

Medicare would remain a separate program, although at age sixty-five retirees could opt to remain in the alliances and pay the difference between the amount Medicare would pay to the plan and its premium for the elderly. The Clinton plan would expand Medicare to include the same coverage of prescription drugs available to the under-sixty-five population.

The Health Security Act also includes support for home- and community-based long-term care for the disabled of all ages, and it calls for new tax incentives and tighter standards for private long-term care insurance. While veterans would retain existing rights to health services run by the Department of Veterans Affairs, the VA would begin transforming its facilities into integrated health plans that could enroll veterans for comprehensive coverage through the alliances. The Department of Defense health care system would also move in the same direction. Coverage of all federal employees would shift to the health alliances; thus members of Congress would get their coverage through the same alliances and health plans as average citizens.

The transition to a reformed system would take place in stages. The Clinton plan phases in universal coverage, state by state, between 1996 and 1998, and defers some elements of the benefits package, notably broader mental health and adult dental coverage, until 2001. Regional caps on premium increases would not go into effect until 1996. The proposed support for home-based long-term care would be introduced gradually between 1996 and 2000.

While establishing a federal framework for financing, coverage, benefits, and consumer protections, the Health Security plan gives the states authority to set up the regional alliances and to adopt a variety of different approaches to controlling costs and improving the delivery of care. At the federal level, a presidentially appointed National Health Board would interpret rules about coverage and benefits, allocate limits on premium growth among the alliances, and establish a system for monitoring how well plans, providers, and the system as a whole are performing. The states would not only establish the alliances but also retain authority to regulate insurance, certify plans, and license health professionals.

The Health Security plan would affect nearly every aspect of the health care system. Without trying to cover every feature, I want to explore the core elements in more detail in order to help explain how they fit together—and why they work.

The Logic of Comprehensive Coverage

Although hardly anyone opposes universal coverage or comprehensive benefits in principle, many have doubts whether they are workable or affordable in practice. But much as other industrialized countries provide comprehensive coverage for all their citizens, so can the United States—if we use reform to insist on mutual responsibility for payment and clear accountability for the costs.

The Health Security plan requires universal participation in the interest not only of fairness but also of lower cost to the community at large. Lack of coverage doesn't prevent money from being spent on medical care; most of the sick and injured still receive treatment, albeit less adequate care often at a later and more costly stage of illness. If insurance is voluntary, some who are healthy

gamble on their good fortune and then throw themselves on the compassion of others in the hour of their need. A decent society will not leave them to suffer, but a prudent nation will have asked them beforehand to share in the cost. Most of us willingly pay for fire protection even though our house may never burn. Similarly, we must pay for health coverage to support the health care in our communities that may someday save our lives.

Universal participation makes coverage more affordable for three distinct reasons. First, it reduces the number of free riders who force others to pay more in taxes and medical bills for the uncompensated care that they (or their employees) receive. So while universal coverage provides protection to the uninsured, it also protects the rest of the community from hidden cost shifts.

Second, universal coverage reduces the problem of adverse selection that afflicts a voluntary system. If coverage is voluntary, the individuals and small groups that purchase it will include disproportionate numbers of people with high expected costs, and the resulting higher premiums will then deter many other lower-risk people who otherwise might have bought insurance.

Third, a universal system has lower administrative costs. It obviates the need of hospitals for elaborate admitting and eligibility verification procedures to protect against unpaid bills, and it cuts the administrative cost of insurance itself by eliminating functions performed in a voluntary system, such as screening out the sick.

Universal participation also makes it feasible to remove some of the most egregious limitations on coverage in the current system. Under a voluntary system, some people will wait until they get sick to buy insurance; that is one reason why insurers restrict coverage of preexisting conditions. A universal system can fairly

Covered Benefits

- Hospital services, including bed and board, routine care, therapeutics, laboratory and diagnostic and radiology services and professional services
- Emergency services
- Services of health professionals delivered in professional offices, clinics, and other sites
- Clinical preventive services
- Mental health and substance-abuse services: inpatient mental health treatment, up to thirty days per episode and sixty days per year; psychotherapy up to thirty visits per year
- Family planning services
- Pregnancy-related services
- Hospice care during the last six months of life
- Home health care, including skilled nursing care, physical, occupational, and speech therapy, prescribed social services and home-infusion therapy after an acute illness to prevent institutional care
- Extended care services, including inpatient care in a skilled nursing home or rehabilitation center following an acute illness for up to 100 days each year
- Ambulance services
- Outpatient laboratory and diagnostic services
- Outpatient prescription drugs and biologicals, including insulin
- Outpatient rehabilitation services including physical therapy and speech pathology to restore function or minimize limitations as a result of illness or injury

- Durable medical equipment, prosthetic and orthotic devices
- Routine ear and eye examinations every two years
- Eyeglasses for children under age eighteen
- Dental care for children under age eighteen

Additional Benefits in the year 2001

- Preventive dental care for adults
- Orthodontia if necessary to prevent reconstructive surgery for children
- Expanded coverage for mental health and substance abuse treatment

prohibit such limitations because no one can put off paying for insurance until the moment they need it.

Comprehensiveness of health coverage, like universality, reflects an interest in efficiency as well as equity. Benefits packages vary in their scope of coverage and extent of cost-sharing. The scope of benefits covered in the guaranteed package in the Clinton Health Security plan corresponds to the list in good corporate health plans today (see chart, above). The benefits package, however, is especially comprehensive on the "front end" (primary and preventive care) and on the "back end" (there are no lifetime or annual limits on hospital or physician coverage).

Broad benefits in these areas reflect two central objectives of reform: preventive care and security. The plan encourages a shift toward preventive care by guaranteeing coverage of a basic list of clinical preventive services of proven efficacy, such as immunizations and specific

screening tests, without any copayment. And it eliminates the annual and lifetime limitations on hospital and physician coverage as well as other exclusions buried in the "fine print" of insurance contracts that expose many families to catastrophic costs and financial ruin.

Restricting both the "front" and "back" ends of health coverage often produces counterproductive results and savings that prove to be illusory. Limits on primary and preventive care lead to avoidable illness, costly delays in treatment, and greater use of emergency rooms. And when coverage runs out, many people facing catastrophic health costs end up at public hospitals or with unpaid bills, and the taxpayers or privately insured pay for their care anyway.

While its coverage is broad in scope, the Health Security plan does not eliminate all patient cost-sharing. Rather, it provides for three types of cost-sharing that correspond to the principal modes of coverage in the market today. For *fee-for-service coverage*, the cost-sharing would be in the middle range of private plans. There would be deductibles of \$200 per individual and \$400 per family, with 20 percent coinsurance for physician and hospital care, up to a maximum out-of-pocket cost of \$1,500 per individual and \$3,000 per family. Prescription drugs would carry a separate \$250 deductible and 20 percent cost-sharing, up to a maximum out-of-pocket expense of \$1,000.

For *HMO coverage* (the low cost-sharing option), there would be no deductibles, nor would there be any coinsurance on hospital care. The Health Security plan does, however, call for a \$10 copayment per physician visit, which is higher than many HMOs charge today. The HMO copayment for drugs would be \$5 per prescription.

The third type of plan, a *combined* structure, offers

the low HMO cost-sharing when patients use providers within the network but requires the higher fee-for-service cost-sharing level when patients use providers outside the network. This is the arrangement used by preferred provider networks.

The level of benefits in the Health Security plan is squarely in the mainstream; the plan does not ask Americans to accept a lower standard of coverage or offer them only minimal protection if they lose a job or get divorced.

Several other proposals for reform, however, call for only minimal coverage, restricted to catastrophic costs or a mere "barebones" package. Some conservatives believe that Americans are "overinsured" and want to use tax policy and health reform to encourage high deductibles and copayments as a method of cost containment. That approach, however, will not only fail to guarantee security; it is also unlikely to control costs effectively for the most basic of reasons: Most people won't accept it.

If national reform provides only minimal coverage, the great majority of Americans will obtain supplementary insurance. Nine out of ten Medicare beneficiaries today have supplementary coverage either through a private Medigap policy or Medicaid. These supplementary benefits typically reduce patient cost-sharing and generate higher rates of physician and hospital use *under Medicare*. Thus widespread supplementation raises costs in the basic insurance program, defeating the economic rationale of the coverage limits. A new federal program with high cost-sharing and limited benefits for the under-sixty-five population would just repeat the same mistake. Most Americans would get extra coverage from their employers, and the very poor would retain the broader coverage of Medicaid. With only

low-wage workers facing the benefit limits, there would be little effective discipline on costs. A reformed system is far more likely to control costs by making a single health plan accountable for comprehensive coverage than by dividing coverage between a minimal basic package and widespread supplementation.

This is the broader lesson of integrated health plans. Many coverage restrictions that developed under traditional insurance do not make sense as rules for the emerging health care system. Since traditional insurers have not had contracts with providers, much less control over them, they have been unable to allocate resources among different types of services or achieve savings by managing services more efficiently. To control costs, they have often simply excluded services—such as primary and preventive care, outpatient drugs, and home health services—that can reduce overall costs if managed properly. Integrated health plans do precisely that, substituting ambulatory for inpatient care and managing the full range of services to provide broader coverage more economically.

The new paradigm of integrated health care requires a change in thinking about coverage. Under a more integrated system, arbitrary limits on coverage by type of service or provider often get in the way of cost-effective treatment; coverage without those restrictions yields better treatment at lower cost. Genuine savings in health care come not from trying to shift risks to individuals, but from placing those risks on organizations that can manage them and be held clearly accountable for both costs and quality.

A uniform benefits package among competing plans facilitates that clear accountability. If each plan offers a different package, the myriad complex variations make it difficult for consumers to make clear-cut price com-

parisons. A uniform package enables consumers to compare apples with apples and thereby encourages plans to compete on price. Consumers will also feel more confident about choosing a lower-cost plan if they know there are no hidden exclusions.

Requiring plans to offer a uniform package does not prevent them from offering other benefits in supplementary packages (although those must be fully priced to include utilization effects on the basic plan). The required package sets a common reference point that is essential not only for price competition but also for determining rights and obligations. If a national guarantee of universal coverage is to have any meaning, there needs to be a national standard. All parties involved must know what is included in the coverage that citizens have a right to expect, plans have an obligation to provide, and government has a pledge to guarantee.

Some reform proposals accept the need for a standard benefits package but, rather than spell it out in legislation, assign the responsibility to an administrative board. The political appeal of this approach is obvious. Defining a benefits package is inevitably contentious. However, if the American people are to evaluate any proposal, they must know what the benefits are. Moreover, no one will be able to determine how much coverage will cost without knowing what coverage includes. Some critics have charged that the Clinton program vests too much power in government bureaucracies. The National Health Board set up under the Clinton plan, however, would only interpret the benefits package. Other proposals give an administrative board authority to *determine* the standard package, which would make the board far more powerful. In another area as well—the role and power of the purchasing alliances—conservative alternatives ostensibly

aimed at reducing costs and bureaucracy actually increase them.

The Role of the Health Alliances

No aspect of reform is so poorly understood and so critical to its success as the broad-based purchasing alliances of the Health Security plan. Without the alliances, it will not be possible to shift the choice of health plans from employers to consumers, to restore genuine community rating, and to achieve effective reform of the insurance system.

The Clinton plan calls for two types of purchasing alliances. Regional health alliances would cover all employees of firms with fewer than 5,000 workers, public employees, part-time workers, the unemployed, and other individuals outside the labor force—in all, more than 80 percent of the population under age sixty-five. The regional alliances would thus constitute a pool covering the vast majority of Americans at community rates. Corporations with more than 5,000 employees, as well as some multiemployer plans of similar size established through collective bargaining, would be eligible to establish their own corporate health alliances. Corporate alliances would still have to provide their employees at least the guaranteed benefits package and a choice among the three types of plans, but they would not be eligible for any federal subsidies and would pay an assessment equal to 1 percent of payroll. (The assessment goes for medical education and public health and makes up for the cost advantages that companies enjoy in running a self-contained pool without the unemployed, the retired, and the poor.) Large corporations could opt into the regional alliances on an initially risk-adjusted basis, a provision designed to offset the costs of large companies with many older workers. If they came

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BODY:

From remarks by Treasury Secretary Lloyd Bentsen in Washington yesterday before a meeting of the National Association of Manufacturers and the Association of Private Pension and Welfare Plans:

It doesn't make any sense to me that our nation accounts for 40 percent of all health care spending around the world, and we have only 5 percent of the people. It doesn't make any sense to me that what we get for that additional spending is a lower proportion of citizens with health care than the other industrial countries. And listen to this one: A typical insurance policy here provides less coverage ... than in any of the other major industrial countries.

... think we agree on universal coverage within an employment-based system. I think we agree on portability regardless of where you work or your health status. We need to reduce job lock and to start agreeing to insure unhealthy people instead of only healthy people.

We agree we need to do more in the way of preventive medicine -- immunizations and the like -- so that doctors don't have to see children coming into an emergency room because the parents couldn't afford an immunization shot. We agree consumers need more information, need to know more about quality and the costs of their care. And we agree that to be effective the plan must achieve real cost containments head-on ...

We've had experience with runaway entitlements. And the president has made it clear that he will not support a plan that could become another runaway entitlement. And that's why you have the circuit breakers; that's why you have the limitations on the subsidies. If someone can convincingly demonstrate the numbers are wrong, we'll modify the plan to make it right. In this town, you don't do anything big anymore if it's not going to reduce that deficit.

LANGUAGE: ENGLISH

LOAD-DATE-MDC: January 27, 1994

Alternative Plans

SENATE FINANCE COMMITTEE'S BILL

BENEFITS

- Standard benefit package equal to the actuarial value of the Blue Cross/Blue Shield Standard Option under the Federal Employee's Health Benefits (FEHB) program (this is 8 percent less than the HSA premium).
- Expanded public coverage of home and community services for the severely disabled.
- No Medicare drug coverage.

INSURANCE MARKET

- Community rating, adjusted for age and type of plan (individual, family) is available to firms with fewer than 100 employees, the self-employed, and individuals.
- Voluntary cooperatives through which individuals and firms under 100 can purchase coverage. States are required to establish a cooperative, if necessary.
- Individuals and small groups allowed to join FEHB plans, but would pay a community rate. (Federal employees remain in a separate premium-rating pool.)
- Firms with more than 100 employees are allowed to self-insure, along with large Taft-Hartley plans.
- Guaranteed issue, annual open enrollment, restrictions on pre-existing condition clauses (one-time open-enrollment with no limitations, then maximum 6-month exclusion only for the previously uninsured)
- Mandatory risk-adjustment of premiums (developed by HHS and implemented by the States) for all plans in the community-rated market.

MANDATE

- **SOFT TRIGGER:** If 95% of Americans are not insured by 2002, a national commission makes recommendations to Congress in the form of draft legislation about ways to increase coverage to 95 percent.
- **Non-discrimination:** Employers that voluntarily contribute towards the coverage of employees must make the same contribution for all full-time and part-time workers (pro-rated), or pay an excise tax equivalent to denying the employer's tax deduction for health benefit expenses.

SUBSIDIES

- Premium subsidies available to individuals and families up to 200 percent of poverty. Full subsidy up to 100 percent of poverty, pegged to the average premium for community-rated plans in the area. The subsidized share of the premium decreases by each percentage point over the poverty line. Subsidies reduced dollar-for-dollar by the amount of any employer contributions.
- Premium subsidies also available to uninsured pregnant women and children under age 18 below 250% of poverty. Full subsidy up to 185% of poverty, phased out according to a sliding scale. Mandatory maintenance of effort for employers currently offering coverage of children.
- Cost-sharing for the poor is reduced to "nominal" levels. Plans are required to absorb reduction. Two billion dollars per year is available to the States, who must match Federal payments, to structure and provide cost-sharing subsidies to persons between 100% and 200% of poverty.
- Individuals (including the self-employed) without employer contributions are allowed to deduct 100% of premiums for the standard benefit package from their taxable income.

MEDICAID

- AFDC and non-cash Medicaid recipients are integrated into the subsidized community-rated pool.
- Medicaid recipients receiving SSI are not included in the community rate. States negotiate with health plans for rates to enroll the disabled.
- Current Medicaid rules governing covered services and recipient eligibility would be retained.

COST CONTAINMENT

- Savings from competition
- Plans whose premiums exceed the 60th percentile in the area, and are not among the lowest 25 percent of geographically-adjusted premiums nationally, are assessed 25% of the difference between the plan premium (including both standard package and supplements) and the average standard premium in the area. The assessment and evaluation of plans that are not community-rated is done on "an actuarial basis."
- FAIL-SAFE FEDERAL DEFICIT CONTROL: OMB determines annually, through 2003, whether enactment of health care reform had caused an

unprojected increase in the deficit. Any deficit increase would trigger proportional reductions in premium subsidies (through a delay of eligibility), revenue losses from the tax deduction for individually purchased insurance, and increases in out-of-pocket limits in the benefit package. The National Commission may propose and Congress may enact an alternative proposal for offsetting the deficit effect. Congress may vote to suspend these procedures in the event of two consecutive quarters of real economic growth of less than one percent.

FINANCING

- Increases tobacco tax to \$1.24 per pack
- Tax of 1.75% on insurance premiums to fund academic health centers and research.
- Extends Medicare HI tax to all State and local employees
- Recaptures Medicare part B subsidies for individuals with incomes over \$90,000 and couples with incomes over \$115,000

STATE FLEXIBILITY

- If a State demonstrates that a single-payer program would substantially increase coverage or lower health care spending, it can be exempted from the ERISA preemption.

SENATOR DOLE'S HEALTH REFORM PROPOSAL

BENEFITS

- Every health plan selling in the individual and small group market (firms 50 and under) must offer the "FedMed" benefit package, which would be defined by the Secretary of HHS and would have an actuarial value of the package of the highest enrollment plan under the FEHB program in 1994 (Blue Cross Standard Option).
- Health plans could offer supplemental packages to the FedMed package, but could not require an individual or a group to purchase supplemental coverage or link the pricing of a supplemental benefit package to that of the standard package.
- Large self-insured employers would not have to offer the FedMed package.
- Medical savings accounts (MSAs) would be linked with the purchase of catastrophic coverage.
- No changes in Medicare benefits (i.e., no prescription drug coverage).

INSURANCE MARKET

- Community rating, adjusted for age and type of plan (individual, family) for firms with fewer than 50 employees, the self-employed, and individuals. The ratio between the highest and the lowest age factor may not exceed 4:1 for the first 3 years after implementation and 3:1 thereafter.
- Administrative costs could vary based on size of group.
- Possible voluntary cooperatives could be put in place for individuals and firms under 50.
- Self-employed individuals and small employers with 50 or fewer employees would have the option to purchase health benefit plans through the FEHB program. Insurers would have to offer these enrollees the same benefit plan(s) that are available to Federal employees at the same premium price plus an administrative fee.
- All health plans (large firms included) would have to have guaranteed issue and annual open enrollment. They could keep some restrictions on pre-existing condition clauses, such as a 6 month exclusion for those who did not previously have insurance. Each state will set an initial 90 day open enrollment period during which individuals who have not previously had health

benefit coverage can enroll without being subject to pre-existing condition limitations.

- States are to risk adjust (for the individual and small group market only) across insured health plans and self-insured plans of employers with 50 or fewer employees. All employers with 50 or fewer employees are required to carry "stop loss" insurance.

MANDATE

- No mandate.

SUBSIDIES

- Partial premium subsidies would be available to individuals and families up to 90 percent of poverty. This subsidy would be pegged to the amount the Federal government uses to calculate its maximum contribution (75 percent) for Federal employees under the FEHB program. Individuals would not be eligible for any subsidies if their employers contribute anything to their health costs.
- If additional funding becomes available, subsidies would be extended up to 100 percent of poverty, phasing out up to 150 percent of poverty.
- Self-employed individuals and individuals who do not get insurance through their employers would get a tax deduction equal to 100 percent of the cost of insurance (phased-in by the year 2000).

MEDICAID

- AFDC and non-cash Medicaid recipients can be gradually integrated into the small group pools at State option.
- Federal Medicaid spending for acute care services, including expenditures for payments to qualified health plans, will be subject to an annual per capita payment cap for each state.
- Current Medicaid rules governing covered services and recipient eligibility would be retained.

COST CONTAINMENT

- Savings from competition
- FAIL-SAFE FEDERAL DEFICIT CONTROL: OMB determines annually whether enactment of health care reform had caused an unprojected increase in

the deficit. Any deficit increase would trigger a freeze in the phase-in of tax deductions, a freeze in contributions to MSAs, and the low income subsidy phase-in would be slowed or rolled back.

FINANCING

- Savings from public programs, primarily Medicare reductions and cap on Federal Medicaid payments.

HOUSE WAYS AND MEANS BILL

BENEFITS

- Guaranteed national benefit package equivalent to Medicare Part A and B (newly named Medicare Part C) with several improvements including additional coverage for women and children, the mentally ill, the chemically dependent, as well as prescription drug and preventative service coverage.
- Deductible of \$500, no out-of-pocket limit until 2003; separate \$500 deductible and \$1000 out-of-pocket limit for drugs.
- New public long-term care program for home and community services.

INSURANCE MARKET

- Community rating, adjusted for geographic region and type of plan (individual, single parent, or family) required for all markets except large group (employers with more than 100 employees).
- Firms with more than 100 employees would be able to self insure.
- Regional health alliances could be established by a State or local government with a population of at least 1 million. Alliances could be mandatory with State approval.
- Community-rated, supplemental benefit policies available in 10 standardized packages.
- Guaranteed renewable coverage, no denial or limiting of coverage based on pre-existing conditions, and no discrimination against an individual.

MANDATE

- Individuals would be covered under a private health plan or Medicare Part C (for low-income employees in firms of 100 or fewer employees; temporary, part-time or seasonal workers; the unemployed; and AFDC and SSI recipients) by January 1, 1998. Individuals would be required to pay for their premium minus the employer contribution.
- Employers would be required to contribute 80 percent of the premium of the standard benefit package. Employers with more than 100 workers would need to meet this obligation by January 1, 1996; employers with less than 100 employees and those self-insuring through Medicare Part C would be required to do so by January 1, 1998.

- Employers would be required to offer both a managed care plan and a plan that offers unlimited choice of providers.
- Employers would be required to provide coverage for family members, but would receive credits for these premiums from the employers who do not have to supply coverage because their employees are covered by another employer.
- These employer responsibilities apply to employees working over 25 hours per week and for longer than 4 months, and for retirees.

SUBSIDIES

- Individuals below the poverty line would pay no premium. Individuals between the poverty line and 240% of poverty would pay less, based on a sliding scale. These subsidies would be phased in from 1998 to 2003.
- Employers with 50 or fewer employees with average salaries below \$26,000 would be eligible for tax credits to reduce premium costs. The maximum credit would be 50 percent for firms with 25 or fewer employees and average salaries below \$12,000.
- Self-employed individuals would be allowed to deduct up to 25 percent of premium costs through December 31, 1997, and 80 percent thereafter.
- A wrap-around benefit package provided under Part C to all persons below 100 percent of poverty. All early and periodic screening, diagnostic, and treatment services included in the wrap-around for children up to age 18, as well as vision and hearing.

MEDICAID

- Individuals currently covered by Medicaid would be covered by Medicare Part C, equivalent to the standard benefit package, beginning January 1, 1998. Premiums to be subsidized as detailed above.

COST CONTAINMENT

- Savings from competition.
- Stand-by controls on private expenditures and immediate controls on Medicare (A/B and C) expenditures. National and State expenditure targets established by statute in 1996, by type of service. Target gradually reduced from current path to 5-year average of per-capita GDP. Beginning in 2001, if a State exceeds a target for private expenditures, maximum payment rates based on Medicare methodologies will go into effect provided that the National Health Cost Commission does not propose, and Congress does not approve, an

alternative cost containment system.

FINANCING

- Increases tobacco tax to 69 cents by 1999.
- Eliminates exclusion from income of employer-provided accident or health coverage provided through a cafeteria plan or flexible spending arrangement.
- Imposes a 2 percent excise tax on health insurance premiums and self-insured plans.
- Extends Medicare HI tax to all State and local employees.
- Employers not enrolling their employees and dependents because they are covered by another employer would pay 80 percent of an individual Part C premium which would fund a premium credit for employers paying for more than their employees.

STATE FLEXIBILITY

- States would be given broad flexibility to establish their own health care reform plans as long as the cost of the program is less than without the program and the plan covers all residents. Self-insuring employers with more than 5,000 employees in at least two states would be able to exempt out of state benefit management programs.

SENATE LABOR COMMITTEE

(Kennedy)

BENEFITS

- HSA standard benefit package.
- Enhanced benefits, including additional coverage for women, children, the disabled, and the mentally ill (financed by raising the out-of-pocket limit).

INSURANCE MARKET

- Every American will have the option to participate in the Federal Employees Health Benefits Plan.
- In addition to the FEHBP option, the each state must create at least one "voluntary consumer purchasing cooperative".
- Large businesses of over 1,000 employees will have to purchase insurance outside of the community-rated purchasing cooperative system (but they will be able to join together with other large businesses to form their own purchasing cooperatives).
- Firms with 500 to 1,000 employees that choose to self-insure must pay an assessment of one percent of payroll and forego any government subsidies.

MANDATE

- All employers with more than 10 employees will be required to contribute 80 percent of the premium for their workers.
- CARVEOUT: Small businesses with 10 or fewer employees and average wages of less than \$24,000 per worker will not be required to provide health insurance for their employees. Firms with 2-5 employees would pay a 1 percent payroll assessment and firms with 6-10 employees would be required to contribute 2 percent of payroll toward the cost of the program if they chose not to offer coverage.

SUBSIDIES

- Employers with more than 75 workers will have their contribution capped at 12 percent of each worker's wages.
- For employers with fewer than 75 workers, the employer's share of the cost will be capped on a sliding scale from 4.2 percent to 12 percent of each employee's wage, based on the size of the firm and the average payroll.

- Individual contributions for the 20 percent share are capped at 3.9 percent of income for all families. Workers' contributions in exempt firms will be capped on a sliding scale of 4 to 6 percent of income.

MEDICAID

- Not in jurisdiction; assumed Administration proposal.

COST CONTAINMENT

- National Health Board sets fallback premium caps to limit growth in premiums.
- The Board may recommend reductions in benefits to reduce costs in order to avoid increasing the federal deficit. Such recommendations would be considered by Congress under fast-track procedures.

FINANCING

- Increases the cigarette tax to \$1.74 per pack.
- Assessment of 1 percent of payroll on large employers that self-insure (employers with more than 1,000 employees must self-insure; those with over 500 can if they so choose).

HOUSE EDUCATION AND LABOR BILL

BENEFITS

- HSA standard benefit package.
- Enhanced benefits, including expanded mental illness, dental, and women's and children's coverage.

INSURANCE MARKET

- Consumer purchasing cooperatives established by the States or private clearinghouses for each community rated area required.
- Firms with more than 1,000 or more employees would be able to self-insure.

MANDATE

- All firms with less than 1,000 employees are required to purchase 80% of community-rated insurance for employees.
- Firms with more than 1,000 employees are required to provide 80% of experience-rated insurance or self-insure.

SUBSIDIES

- Firms with average annual wages below \$24,000 and with 25 to 75 workers receive subsidies to keep insurance costs below 3.5 to 7.9 percent of payroll depending on firm size. Small businesses with less than 25 employees will not have to pay more than 2 percent of payroll (more generous than HSA which had limit of 3.5 percent of payroll).
- Extends premium subsidies in the HSA for the "20-percent share" to 200% of poverty, and increases the income disregard from \$1000 to \$2000.
- Wrap-around benefit package provided for children up to 200 percent of poverty; for pregnant women up to 185 percent of poverty.

MEDICAID

- AFDC and non-cash Medicaid recipients are integrated into the subsidized community-rated pool.

COST CONTAINMENT

- Savings from competition.
- Premium caps if insurance and market reforms do not reach cost containment targets.

FINANCING

- Increases tobacco tax to 99 cents per pack.
- Imposes a 1 percent payroll assessment on firms of 1,000 or more employees.

ORIGINAL COOPER/BREAUX PLAN -- 91 PERCENT OPTION

BENEFITS

- Not defined.

INSURANCE MARKET

- Modified community rating, adjusted for age and type of plan (individual, family) for those in accountable health plans (AHPs).
- Standard benefit package.
- One voluntary health plan purchasing cooperative (HPPC) in each geographic area.
- Tax cap at lowest cost plan, or "reference premium" (lowest cost plan that has a specified minimum enrollment).

MANDATE

- Employers must **offer**, but are not required to provide insurance.
- Individuals and firms of up to 100 employees would purchase coverage through a HPPC, all others would have to buy coverage outside of the HPPC.
- Small firms would have to buy through the HPPC in order to get the tax deduction.

SUBSIDIES

- Individuals with incomes of up to 100 percent of poverty would be fully subsidized to the reference premium (with some wrap-around benefits).
- Subsidies phased out between 100 and 200 percent of poverty.
- Health plans would have to absorb subsidy shortfalls if Federal revenues were not sufficient.
- No subsidies for employer contributions.
- Cost-sharing subsidies for out-of-pocket expenditures for individuals with incomes below 200 percent of poverty would be constant up to 200 percent of poverty.

MEDICAID

- Abolished and fully integrated into private plans (with subsidies above).

COST CONTAINMENT

- Savings from competition.
- Tax cap on plans above the reference premium.

FINANCING

- Deductibility cap on employer health insurance expenditures.
- Reduced Medicare provider payments.
- Phase-out of Medicare's disproportionate share payments to hospitals.
- Increase Medicare premiums for upper-income beneficiaries.

*America's Health Care
Safety Net*

*Emergency Medicine:
1968-1993 and Beyond*



1968 - 1993

American College of Emergency Physicians

a major portal of entry into the health care system for abused children;¹⁸ as many as one-third of all female emergency patients have been battered.¹⁹ AIDS, drugs, and alcohol also are taking their toll.

In a 1991 Michigan Hospital Association survey, researchers found that nearly five percent of the emergency department patients studied were victims of violence-related trauma from gunshot wounds, stab wounds, personal assaults and/or sexual assaults. Nearly six percent of the visits had alcohol and/or drugs listed as a possible cause.²⁰

In other areas, the percentage is far higher; in Los Angeles, roughly half of those with serious traumatic injuries have been stabbed or shot. At Philadelphia's Albert Einstein Medical Center, three-quarters of those screened at the trauma center tested positive for illegal or prescription drugs.²¹

In New York, which heralded many of the dilemmas now facing emergency departments nationwide, the number of inpatient beds required by AIDS patients doubled between 1985 and 1987 and has continued to increase since then. In 1990, researchers estimated that New York would need four additional 600-bed hospitals by 1994 just to accommodate AIDS patients.²² While the average hospital stay is around eight days, the typical AIDS patient remains between 20 and 30 days.²³

In 1990, there were 92 million ED visits to the 93.4 percent of hospitals with emergency departments, compared to 30 million in 1965. At the same time, the overall number of hospitals fell from 1,123 to 6,649.²⁴

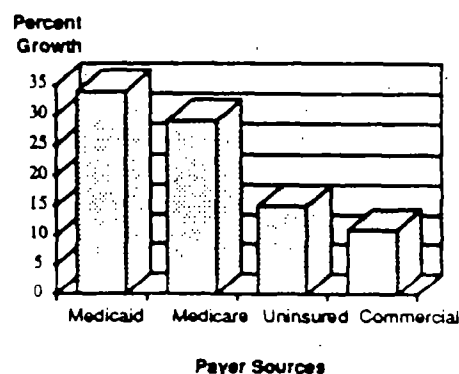
OVERCROWDING THREATENS EMERGENCY CARE SYSTEM

"The patient visiting an emergency department may have to sit in a drafty corridor along with 25 or 30 other outpatients. He is cared for in facilities that long since have passed their point of efficient use -- facilities frequently designed for one-half to one-third the present volume of patients encountered," said a report in the November 1, 1966, *Journal of the American Hospital Association* (JAHA). "This naturally results in harassment to the professional and technical staff, who, under the best of circumstances, find it difficult to keep pace with the ever-increasing numbers of patients they serve."²⁵

Public demand and the influence of a growing number of emergency specialists led to dramatic improvements in conditions in emergency departments throughout the 1970s and early 1980s. But by 1988, emergency physicians began reporting conditions much like those described in 1966, though the causes were quite different.

Many of North America's major urban centers report frequent overcrowding, but the problem is not just urban; emergency physicians in rural states report that overcrowding affects them as well. The General Accounting Office reported that between 1985 and 1990, emergency department caseloads increased more than 19 percent, while total hospital admissions decreased by seven

Growth in ED Use (1985-1990)



Reference: GAO/HRD-93-4

Growth and Change in Emergency Department Use

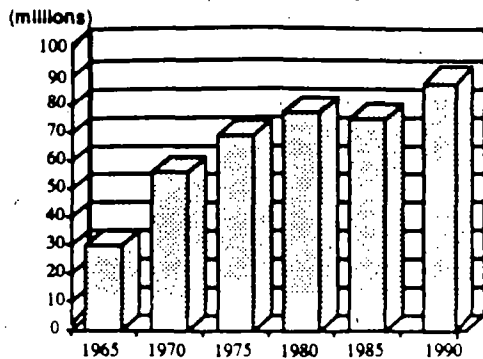
Factors Increasing ED Visits (1985-90)

	(% of hospitals reporting)
Uninsured people seeking nonurgent health care	81
People who are 65 years or older	80
People without health insurance	79
Severity of illness	79
People who do not have a regular physician	71
People who are unemployed	67
Alcohol-related illness or injuries	64
Violence-related injuries	63
Illegal drug-related medical problems	61
Insured people seeking nonurgent care	54
AIDS-related illnesses	51

Reference: GAO/HRD-93-4

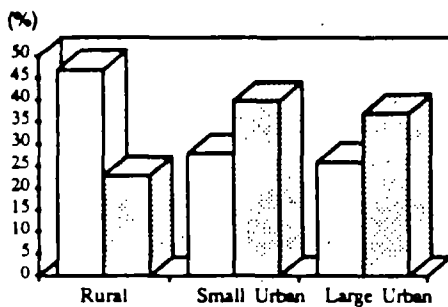
Growth and Change in Emergency Department Use

Emergency Department Visits



Reference: American Hospital Association
Hospital Statistics, Annual Survey of Hospitals

Most ED Patient Visits Were In Urban Hospitals (1990)



Emergency Departments
Emergency Department Visits

Reference: GAO/HRD-93-4
Growth and Change in Emergency Department Use

percent. The rates of increase were most pronounced in rural areas and smaller hospitals.²⁶

According to a 1988 report from ACEP's New York chapter, produced in association with ACEP, overcrowding results from a shortage of health care professionals, both nurses and emergency physicians; increased use of the ED for hospital admissions; high numbers of inpatients; increased number of poor and/or uninsured patients; inpatients waiting for nursing home beds or home care; hospital and/or emergency department closures; AIDS patients; and drug abuse.²⁷

In some overcrowded emergency departments, admitted patients are forced to queue up while waiting for bed space as inpatients. In a 1988 survey of public hospitals and teaching hospitals, researchers reported three-and-a-half hour average waits for a floor bed, and nearly three-hour average waits for an intensive care unit bed. The maximum wait for a floor bed was 25.3 hours, and for an ICU bed, it was 15.7 hours.²⁸ In 1990, one in three hospital EDs nationwide reported a delay of four hours or more in transferring some ED patients to inpatient beds.²⁹

The waiting time for walk-in patients in emergency departments has grown tremendously in the past 20 years, and some patients leave without receiving care. In a study published in 1971, patients waited an average of one-half hour to see an emergency physician.³⁰ By 1978, a majority of patients in one study waited more than two hours to see a physician, and about one percent walked out before being seen.³¹

Two reports published in JAMA in 1991 addressed the impact of waiting times on emergency care, and found that patients who left the emergency department without being seen by a physician were generally as sick as those who stayed.³² In one study, about eight percent of patients walked out without receiving care after waiting more than six hours. Forty-six percent of those patients were judged to need immediate medical attention, and 11 percent were hospitalized within the next week.³³

In major metropolitan areas, overcrowding frequently forces hospital EDs to divert incoming ambulances to neighboring facilities. Two-thirds of non-rural hospitals that responded to a 1992 survey by the United States General Accounting Office diverted incoming ambulances at least once in the preceding year. Twenty percent diverted ambulances 25 to 100 times.³⁴

While ambulance diversion is an indication of crisis-level overcrowding in urban areas, the infrequency of the practice in rural hospitals should not be viewed as reassuring, according to Arthur Kellermann, M.D., recently appointed director of the Center for Injury Control at Emory University and the former medical director of the emergency department at the Regional Medical Center in Memphis, Tenn.

"Many of these rural hospitals are the only game in town," Dr. Kellermann says. "Ambulance diversion is not a realistic option when your community has only one ambulance and the next ED is 30 miles away."

INADEQUATE INSURANCE IMPACTS EMERGENCY CARE

According to the GAO, the growth in ED use between 1985 and 1990 was most often attributed to the number of people without health insurance and those whose medical care is not fully reimbursed, such as Medicaid patients. At the same time, there was little growth, if any, in ED visits by patients with private insurance. The report cautioned that this disproportionate growth may make it difficult for hospitals to absorb or offset losses due to unreimbursed ED patient care costs.³⁵

A 1992 review of billing data from 33 Florida hospitals found that the average collection rate for emergency physicians was 59 percent. One-quarter of all emergency patients never made a single payment to the emergency physician for their care.³⁶

"Both hospitals and emergency physicians are facing a crisis because they are being asked to provide more care in the ED with dwindling resources," says Dr. Robert Williams, 1992-93 ACEP president. "It threatens the ability of every American, with or without insurance, to get emergency care when they need it."

The costs and headaches involved in operating trauma centers are already driving some hospitals out of the business. The American Hospital Association reported that in 1990 there were 446 fewer state-certified hospital trauma centers than in 1985, although there are some signs that this trend may be reversing.³⁷

STRESSFUL CONDITIONS LEAD TO BURNOUT

Problems such as AIDS and violence are changing the practice of emergency medicine in other ways as well. In a survey of ACEP leadership, 37 percent of respondents reported that violent incidents occurring in the emergency department had increased in the past two years, and nine percent reported that the threat of violence hampered their ability to recruit medical staff.³⁸

According to Diana Williams, M.D., who practices at MacNeal Memorial Hospital in Berwyn, Ill., a Chicago suburb, "AIDS has affected the way we practice and is keeping people from choosing emergency medicine as a career."

"It used to be, if a young person would come in nearly dead, you wouldn't stop for anything as you tried to save him. Now, if there's a tear in your glove, you have to stop to change your gloves before you can go on."

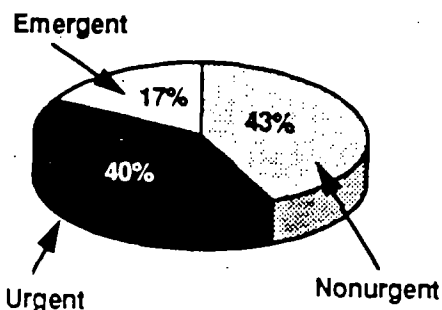
Adds Dr. Anderson Jr.: "AIDS and tuberculosis are giving people pause. On the other hand, you have to understand that the breed of emergency physician is a different one. The excitement, variety and challenges are very appealing."

This intimate view of society's problems, coupled with high-stress, intense work and rotating shifts, leads to another problem in emergency medicine: burnout. One expert has estimated that two-thirds or more of emergency physicians suffer from some level of burnout.

"It used to be, if a young person came in nearly dead, you wouldn't stop for anything as you tried to save him. Now, if there's a tear in your glove, you have to stop to change your gloves before you can go on."

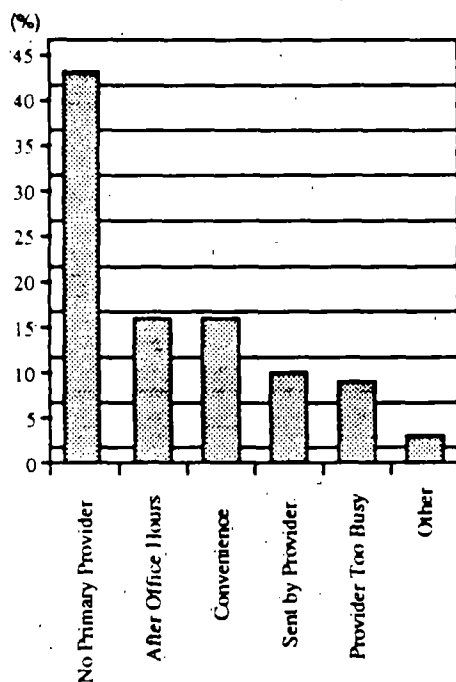
Diana Williams, MD

Types of ED Visits (1990)



Reference: GAO/HRD-93-4
Growth and Change in Emergency Department Use

Reasons For Nonurgent ED Use (1990)



Reference: GAO/HRD-93-4
Growth and Change in Emergency Department Use

ever, neither the patient who seeks care in the ED, nor the emergency physician providing care, should be penalized as the patient learns how to use a managed care system, or as the patient defines his or her particular medical problem as an emergency."⁵²

PRIMARY CARE IN THE EMERGENCY DEPARTMENT

One of the biggest questions emergency medicine must answer is how it should handle the large number of patients who continue to visit the emergency department for non-emergency care. "The fact is," says Dr. Anderson Sr., "that for a large segment of the population, the only care they get is care in the emergency department."

The issue of whether emergency departments should see patients with minor conditions is an old one; researchers in the 1950s recognized that increasing numbers of patients without acute problems were using the emergency department, rather than a personal physician. By 1966, according to a study in the *Journal of the American Medical Association (JAMA)*, between 42 and 46 percent of patient visits at a variety of hospitals could be classed as "non-emergent."⁵³ A study of 1990 ED visits found that 43 percent were for "nonurgent" conditions.⁵⁴

All emergency departments see some patient problems that could be categorized as "non-emergencies," and some report that up to two-thirds of their patients could have been seen by primary care physicians. An emergency department in Sacramento, California, saw 22,390 walk-in patients during the last six months of 1988; of these, 41 percent were triaged to the main ED, 20 percent to the pediatric acute care clinic, and 20 percent to the adult minor emergency clinic. The rest -- 19 percent -- were classed as non-emergencies and were referred elsewhere. Of the non-emergency patients, back pain and joint pain were the most common complaints.⁵⁵

"We conclude that selective triage criteria can be used to send large numbers of patients away from EDs," the authors wrote. "More than 99 percent of these patients cooperated with the system, and they appeared not to be harmed by this system. Using such a system, ED resources can be focused on patients who actually require immediate care."⁵⁶

But other emergency physicians are vehemently opposed to the concept of "triaging out" of the emergency department. Many cite studies showing that patients who leave the emergency department without treatment are just as sick as those who remain, and argue that it is often difficult or impossible to exclude a serious problem at the triage desk. Others point to a report by the GAO which found that 42 percent of the patients whose conditions were classified as nonurgent had no primary care provider.⁵⁷

"The emergency department is the only site of care mandated by law to evaluate anyone who presents for care," said Dr. Kellermann. "Patients know they can count on us when the chips are down. Refusing care in the ED sets a dangerous precedent, especially when we know that many of these patients cannot easily

get care elsewhere. Do we really want them to stay at home until they are critically ill? I don't think that's the answer."

Dr. Kellermann maintains that society must reform the health care system so that patients have someplace else to go for care. "In my view, we have two options – provide patients with affordable, accessible care in more traditional settings such as doctors' offices and primary care clinics, or develop cost-effective systems to provide critically needed care and preventive services in the ED. To date, our health care system has failed to provide the poor and the underinsured with adequate access to primary care. That's why these patients have turned to emergency departments for care."

Dr. Diana Williams agrees. "We need to educate parents better about how to take care of, for example, vomiting and diarrhea in a one-year-old. We need to educate parents about alternatives, more appropriate sources of primary care."

Dr. Wiegenstein, who has practiced emergency medicine for more than 25 years, thinks that some primary care patients will always be seen in the emergency department. "Health care reform needs to provide incentives to attract more physicians to primary care, but it's unlikely that primary care physicians will ever be available 24 hours a day."

SUBSPECIALIZATION IN EMERGENCY MEDICINE

Emergency medicine is not just "emergency department medicine." The delivery of acute, episodic care encompasses areas of medicine including disaster response and toxicology. ACEP membership sections cover such areas as pediatric emergency medicine, disaster medicine, rural emergency medicine, health policy, and emergency medical services.³⁸

Subspecialization, in which emergency physicians complete additional training in one narrowly defined area within the specialty, is also increasing. The American Board of Emergency Medicine and the American Board of Pediatrics jointly offered the first certifying exam in pediatric emergency medicine, November 1992. A subspecialty in toxicology is also being developed.

The trend towards subspecialization is attracting mixed reviews from some emergency physicians. Some, like Dr. Diana Williams, believe it's good for the specialty: "I love to be able to talk to one of the toxicology people."

Others, however, don't want too much subspecialization, because it could fragment emergency medicine. "It's cause for some concern," said Dr. Anderson Jr. "We want to be cautious about losing emergency medicine in the headlong rush towards subspecialization."

Still, the trend could slow fairly quickly. Dr. Graves says that emergency medicine is limited in the number of subspecialties it can spin off. "I don't see a lot of new subspecialties other than the ones that exist."

"Refusing care in the ED sets a dangerous precedent, especially when we know that many of these patients cannot easily get care elsewhere. Do we really want them to stay at home until they are critically ill? I don't think that's the answer."

Arthur Kellermann, MD

Number 245 • March 2, 1994

Advance Data



From Vital and Health Statistics of the CENTERS FOR DISEASE CONTROL AND PREVENTION/National Center for Health Statistics

National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary

by Linda F. McCaig, M.P.H., Division of Health Care Statistics

In December 1991, the National Center for Health Statistics inaugurated the National Hospital Ambulatory Medical Care Survey (NHAMCS) to gather and disseminate information about the health care provided by hospital emergency and outpatient departments to the population of the United States. Ambulatory medical care is the predominant method of providing health care services in the United States. Since 1973, data have been collected on patient visits to physicians' offices through the National Ambulatory Medical Care Survey (NAMCS). However, visits to hospital emergency and outpatient departments, which represent a significant segment of total ambulatory medical care, are not included in the NAMCS (1). Furthermore, hospital ambulatory patients are known to differ from office patients in their demographic characteristics and are also thought to differ in medical aspects (2). Therefore, the omission of hospital ambulatory care from the ambulatory medical care database leaves a significant gap in coverage and limits the utility of the current NAMCS data. The NHAMCS fills this data gap. This survey was endorsed by the American Hospital Association, the Emergency Nurses

Association, and the American College of Emergency Physicians.

This report presents data on emergency department (ED) visits from the 1992 NHAMCS, a national probability survey conducted by the Division of Health Care Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention. A forthcoming report will provide data on visits to outpatient departments.

The estimates presented in this report are based on a sample rather than on the entire universe of hospital ED visits. Therefore, they are subject to sampling variability. The technical notes include a brief overview of the sample design used in the 1992 NHAMCS and an explanation of sampling errors. A detailed description of the 1992 NHAMCS sample design and survey methodology will be published.

The ED Patient Record form is used by hospitals participating in the NHAMCS to record information about patient visits. This form (figure 1) serves as a reference for readers as they review the survey findings presented in this document.

Patient characteristics

During the 12-month period from January–December 1992, an estimated

89.8 million visits were made to ED's of non-Federal, short-stay, or general hospitals in the United States—about 35.7 visits per 100 persons. ED visits by patient's age, sex, and race are shown in table 1. Persons 75 years of age and over had a higher ED visit rate (55.8 visits per 100 persons) than persons in the five other age categories. Females made 51.9 percent of all ED visits. There was no significant difference in total visit rates by sex.

White persons made 78.5 percent of all ED visits, with black persons and Asian/Pacific Islanders accounting for 19.1 percent and 1.6 percent, respectively. The visit rate for black persons was significantly higher than for white persons overall and in the following age categories: 15–24 years, 25–44 years, and 45–64 years.

Emergency department visit characteristics

The largest proportion of ED visits were made in the South (32.9 percent); the Midwest had a higher ED visit rate (42.0 visits per 100 persons) than the West (31.5 visits per 100 persons) (table 1).

Urgency of visit

The majority (55.4 percent) of ED visits were not urgent and 44.6 percent



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Center for Health Statistics



Department of Health and Human Services
Public Health Service, Centers for Disease Control
National Center for Health Statistics

OMB No. 0920-0278

CDC 64.53

NOTICE — Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or the establishment in accordance with section 308(f) of the Public Health Service Act (42 USC 242ml). Public reporting burden for this phase of the survey is estimated to average 3 minutes per response. If you have any comments regarding the burden estimate or any other aspect of this survey, including suggestions for reducing this burden, send them to the PHS Reports Clearance Officer, Attn: PRA: HMM Building, Rm. 721-B, 200 Independence Ave., S.W., Washington, DC 20201, and to the Office of Management and Budget, Paperwork Reduction Project (0920-0278), Washington, DC 20503.

**NATIONAL HOSPITAL AMBULATORY
MEDICAL CARE SURVEY
EMERGENCY DEPARTMENT
PATIENT RECORD**

3. DATE OF VISIT _____ Month Day Year		5. SEX 1 ☐ Female 2 ☐ Male		6. RACE 1 ☐ White 2 ☐ Black 3 ☐ Asian/Pacific Islander 4 ☐ American Indian/Alaska Native		7. ETHNICITY 1 ☐ Hispanic 2 ☐ Not Hispanic		8. EXPECTED SOURCE(S) OF PAYMENT <i>(Check all that apply)</i> 1 ☐ Medicare 2 ☐ Medicaid 3 ☐ Other government 4 ☐ Private/Commercial 5 ☐ HMO/Other prepaid 6 ☐ Patient paid 7 ☐ No charge 8 ☐ Other		9. MAJOR REASON FOR THIS VISIT <i>(Check one)</i> 1 ☐ Injury, first visit 2 ☐ Injury, follow-up 3 ☐ Illness, first visit 4 ☐ Illness, follow-up 5 ☐ Other reason																					
4. DATE OF BIRTH _____ Month Day Year		10. CAUSE OF INJURY <i>(Complete if injury is marked in 9. Describe cause and place of injury.)</i> _____ _____ _____										11. PATIENT'S COMPLAINT(S), SYMPTOM(S), OR OTHER REASON(S) FOR THIS VISIT <i>(In patient's own words)</i> a. Most important: _____ b. Other: _____ c. Other: _____										12. PHYSICIAN'S DIAGNOSES a. Principal diagnosis/problem associated with item 11a. _____ b. Other: _____ c. Other: _____									
13. URGENCY OF THIS VISIT <i>(Check only one)</i> 1 ☐ Urgent/Emergent 2 ☐ Non-urgent				15. DIAGNOSTIC/SCREENING SERVICES <i>(Check all ordered or provided.)</i> 1 ☐ None 2 ☐ Blood pressure check 3 ☐ Urinalysis 4 ☐ HIV serology 5 ☐ Other blood test 6 ☐ EKG 7 ☐ Mental status exam 8 ☐ Chest x-ray 9 ☐ Extremity x-ray 10 ☐ CT scan/MRI 11 ☐ Other diagnostic imaging 12 ☐ Other (Specify) _____								16. PROCEDURES <i>(Check all provided on this visit)</i> 1 ☐ None 2 ☐ Endotracheal intubation 3 ☐ CPR 4 ☐ IV fluids 5 ☐ NG tube/gastric lavage 6 ☐ Wound care 7 ☐ Eye/ENT care 8 ☐ Orthopedic care 9 ☐ Bladder catheter 10 ☐ Lumbar puncture 11 ☐ Other(s) (Specify) _____																			
14. IS PROBLEM ALCOHOL-OR DRUG-RELATED? 1 ☐ Neither 2 ☐ Alcohol-related 3 ☐ Drug-related 4 ☐ Both				17. MEDICATION <i>(Record all new or continued medication ordered, administered, or provided at this visit. Use the same brand name or generic name entered on any Rx or medical record. Include immunizations and desensitizing agents.)</i> ☐ None 1. _____ 2. _____ 3. _____ 4. _____ 5. _____										18. DISPOSITION THIS VISIT <i>(Check all that apply)</i> 1 ☐ Return to ED PRN 2 ☐ Return to ED - appointment 3 ☐ Return to referring physician 4 ☐ Refer to other physician/clinic 5 ☐ Admit to hospital 6 ☐ Transfer to other facility 7 ☐ DCA/sled in ED 8 ☐ Left AMA 9 ☐ No follow-up planned 10 ☐ Other (Specify) _____								19. PROVIDERS SEEN THIS VISIT <i>(Check all that apply)</i> 1 ☐ Resident/Intern 2 ☐ Staff physician 3 ☐ Other physician 4 ☐ Physician assistant 5 ☐ Nurse practitioner 6 ☐ Registered nurse 7 ☐ Licensed practical nurse 8 ☐ Nurse's aide									

Figure 1. Patient Record form.

Table 1. Number, percent distribution, and annual rate of emergency department visits with corresponding standard errors by selected patient and emergency department characteristics: United States, 1992

Characteristic	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Number of visits per 100 persons per year ¹
All visits	89,796	3,202	100.0	...	35.7
Patient characteristic					
Age:					
Under 15 years	22,523	1,485	25.1	1.3	39.9
15-24 years	14,848	702	16.5	0.4	43.2
25-44 years	27,240	1,097	30.3	0.7	33.5
45-64 years	12,509	528	13.9	0.4	25.8
65-74 years	5,806	267	6.5	0.2	31.4
75 years and over	6,871	313	7.7	0.3	55.8
Sex and age:					
Female					
Under 15 years	46,512	1,688	51.9	0.4	36.1
15-24 years	10,196	540	11.4	0.5	37.0
25-44 years	8,051	421	9.0	0.3	46.6
45-64 years	14,045	615	15.6	0.4	34.0
65-74 years	6,629	302	7.4	0.3	26.3
75 years and over	3,350	175	3.7	0.2	32.9
Male					
Under 15 years	4,342	216	4.8	0.2	56.4
15-24 years	43,184	1,605	48.1	0.4	35.3
25-44 years	12,327	878	13.7	0.8	42.7
45-64 years	6,787	336	7.6	0.2	39.8
65-74 years	13,195	560	14.7	0.4	33.0
75 years and over	5,880	279	6.5	0.2	25.2
Race and age:					
White					
Under 15 years	2,456	121	2.7	0.1	29.7
15-24 years	5,017	252	5.6	0.2	30.7
25-44 years	10,134	477	11.3	0.4	24.3
45-64 years	11,598	628	12.9	0.4	42.2
65-74 years	16,878	1,028	18.8	0.8	37.5
75 years and over	70,478	3,008	78.5	1.3	33.6
Black					
Under 15 years	5,132	781	5.7	0.9	57.3
15-24 years	2,877	214	3.2	0.2	56.4
25-44 years	5,840	437	6.5	0.5	59.6
45-64 years	2,111	190	2.4	0.2	42.3
65-74 years	685	86	0.8	0.1	41.6
75 years and over	505	64	0.6	0.1	51.7
All other races:					
Asian/Pacific Islander	1,400	247	1.6	0.3	---
American Indian/Eskimo/Aleut	769	315	0.9	0.4	---
Emergency department characteristic					
Geographic region:					
Northeast	16,950	1,108	18.9	1.2	33.9
Midwest	25,790	2,051	28.7	1.9	42.0
South	28,542	1,778	32.9	1.8	35.0
West	17,515	1,546	19.5	1.6	31.5

¹Based on U.S. Bureau of the Census estimates of the civilian, noninstitutionalized population of the United States as of July 1, 1992.

were urgent/emergent (table 2). When compared with all other age categories, persons 75 years of age and over had the highest urgent visit rate (36.6 visits per 100 persons). Persons 15-24 years of age had a higher rate of nonurgent visits (26.3 visits per 100 persons) than any other age group except children less

than 15 years of age. There was no significant difference between urgent or nonurgent visit rates by sex.

Type of visit

The majority of ED visits (58.5 percent) were made for illness and 35.2 percent were made for injury

(table 3). Eighty-seven percent of all ED visits were first visits for the presenting problem.

Injury-related visits

A visit was considered to be injury related if "injury, first visit" or "injury, follow-up" was recorded in

Table 2. Number and annual rate of urgent/emergent and nonurgent emergency department visits with corresponding standard errors by patient's age, sex, and race: United States, 1992

Patient characteristic	Number of urgent visits in thousands	Standard error in thousands	Number of urgent visits per 100 persons per year ¹	Number of nonurgent visits in thousands	Standard error in thousands	Number of nonurgent visits per 100 persons per year ¹
All urgent/emergent visits	40,078	1,803	15.9	49,718	2,175	19.8
Age						
Under 15 years	8,874	1,030	15.7	13,849	756	24.2
15-24 years	5,900	353	16.9	9,048	499	26.3
25-44 years	11,080	514	13.6	16,160	818	19.9
45-64 years	6,379	321	13.2	6,131	334	12.8
65-74 years	3,434	193	18.6	2,371	164	12.8
75 years and over	4,513	236	36.8	2,358	148	19.1
Sex and age						
Female	20,338	904	15.7	26,275	1,216	20.3
Under 15 years	3,842	418	13.9	6,353	348	23.1
15-24 years	2,992	213	17.3	5,059	289	29.3
25-44 years	5,573	295	13.5	8,472	484	20.5
45-64 years	3,159	174	12.5	3,471	226	13.8
65-74 years	1,943	114	19.1	1,407	119	13.8
75 years and over	2,829	161	36.7	1,513	106	19.6
Male	19,741	945	16.2	23,443	1,067	19.2
Under 15 years	5,031	628	17.4	7,296	448	25.3
15-24 years	2,807	181	16.4	3,990	241	23.3
25-44 years	5,508	258	13.8	7,889	422	19.2
45-64 years	3,220	187	13.8	2,660	164	11.4
65-74 years	1,492	109	18.0	964	74	11.7
75 years and over	1,684	107	36.5	845	73	18.3
Race and age						
White	32,097	1,580	15.3	38,381	2,005	18.3
Under 15 years	6,629	589	14.7	10,250	684	22.8
15-24 years	4,662	325	17.0	6,936	437	25.2
25-44 years	8,473	452	12.5	12,108	682	17.9
45-64 years	5,208	300	12.5	4,928	286	11.8
65-74 years	2,997	180	18.3	2,020	160	12.3
75 years and over	4,131	222	37.0	2,141	143	19.2
Black	7,158	633	22.8	9,992	703	31.8
Under 15 years	2,087	531	23.3	3,045	330	34.0
15-24 years	1,030	99	20.2	1,847	178	36.2
25-44 years	2,271	191	23.2	3,569	307	36.4
45-64 years	1,035	109	20.7	1,076	111	21.6
65-74 years	396	56	24.1	289	40	17.6
75 years and over	338	51	34.7	166	25	17.0

¹Based on U.S. Bureau of the Census estimates of the civilian, noninstitutionalized population of the United States as of July 1, 1992.

item 9. Almost 31.6 million ED visits were made for injury (table 4). Persons 15-24 years of age had a higher injury-related visit rate (18.9 visits per 100 persons) than persons in each of the other five age categories. Males had higher injury-related visit rates (14.8 per 100 persons) than females (10.5 per 100 persons) overall and in each age category except for 65-74 years and 75 years and over, where females had higher rates. There was no significant difference between injury-related visit

rates by race. However, black people had a higher rate than white people among persons 25-44 years of age, while white people had a higher rate than black people in the 75 years and over age category.

Cause of injury

Up to three external causes of injury are coded and classified according to the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (3)*.

Displayed in table 5 are ED visits by the first-listed cause of injury using the major cause of injury categories specified by the ICD-9-CM. "Other accidents" was the most frequently recorded cause of injury and represented 35.8 percent of visits in which a cause was reported. Accidental falls (26.6 percent) and motor vehicle accidents (14.3 percent) were also prominent on the list.

Table 3. Number and percent distribution of emergency department visits with corresponding standard errors by major reason for this visit: United States, 1992

Visit characteristic	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits	89,786	3,202	100.0	...
Major reason for this visit				
All illness visits	52,528	2,128	58.5	0.9
Illness, first visit	49,691	2,033	55.3	0.9
Illness, follow-up	2,837	229	3.2	0.2
All injury visits	31,567	1,210	35.2	0.7
Injury, first visit	28,389	1,046	31.6	0.7
Injury, follow-up	3,178	241	3.5	0.2
All visits for other reasons	4,430	511	4.9	0.6
Unknown	1,271	166	1.4	0.2

Table 4. Number, percent distribution, and annual rate of injury-related emergency department visits with corresponding standard errors by patient's age, sex, and race: United States, 1992

Patient characteristic	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Number of visits per 100 persons per year ¹
All injury-related visits	31,567	1,210	100.0	...	12.6
Age					
Under 15 years	8,162	426	25.9	0.9	14.5
15-24 years	6,489	307	20.6	0.5	16.9
25-44 years	10,500	446	33.3	0.8	12.9
45-64 years	3,681	207	11.7	0.5	7.6
65-74 years	1,305	98	4.1	0.3	7.1
75 years and over	1,430	100	4.5	0.3	11.6
Sex and age					
Female	13,540	539	42.9	0.6	10.5
Under 15 years	3,290	181	10.4	0.4	11.9
15-24 years	2,442	148	7.7	0.3	14.1
25-44 years	4,305	237	13.6	0.6	10.4
45-64 years	1,647	101	5.2	0.3	6.5
65-74 years	852	69	2.7	0.2	8.4
75 years and over	1,004	77	3.2	0.2	13.0
Male	18,027	734	57.1	0.6	14.8
Under 15 years	4,872	278	15.4	0.6	16.9
15-24 years	4,048	206	12.8	0.4	23.7
25-44 years	6,195	280	19.6	0.6	15.5
45-64 years	2,034	151	6.4	0.4	8.7
65-74 years	453	49	1.4	0.1	5.5
75 years and over	426	50	1.3	0.2	9.2
Race and age					
White	26,271	1,180	83.2	1.1	12.5
Under 15 years	6,794	372	21.5	0.7	15.1
15-24 years	5,456	293	17.3	0.5	19.9
25-44 years	8,405	418	26.6	0.7	12.4
45-64 years	3,096	197	9.8	0.5	7.4
65-74 years	1,160	93	3.7	0.3	7.1
75 years and over	1,359	101	4.3	0.3	12.2
Black	4,556	304	14.4	1.0	14.5
Under 15 years	1,214	138	3.8	0.5	13.6
15-24 years	903	82	2.9	0.3	17.7
25-44 years	1,783	151	5.6	0.5	18.2
45-64 years	490	61	1.6	0.2	9.8
65-74 years	111	23	0.4	0.1	6.8
75 years and over	54	12	0.2	0.0	5.5

¹Based on U.S. Bureau of the Census estimates of the civilian, noninstitutionalized population of the United States as of July 1, 1992.**Alcohol- or drug-related problem**

Over 2.7 percent of ED visits were recorded as being alcohol related and 1.1 percent were drug related (table 6). For injury-related ED visits, the proportion of visits that were alcohol related (3.6 percent) was higher than that for noninjury-related visits (2.3 percent). The most commonly recorded principal diagnosis for an alcohol-related ED visit was alcohol abuse, and for a drug-related visit it was "poisoning by other and unspecified drugs and medicinal substances."

Reason for visit

In item 11 of the Patient Record form, the patient's (or patient surrogate's) "complaint(s), symptom(s), or other reason(s) for this visit (In patient's own words)" is recorded. Up to three reasons for visit are coded and classified according to *A Reason for Visit Classification for Ambulatory Care (RVC)* (4). The principal reason is the problem, complaint, or reason listed first in item 11a of the ED Patient Record form.

The RVC is divided into eight modules or groups of reasons as shown in table 7. More than 71.3 percent of all visits were made for reasons classified as symptoms with general symptoms accounting for 15.2 percent of all visits and symptoms referable to the musculoskeletal system accounting for 14.8 percent.

The 20 most frequently mentioned principal reasons for visit, representing 46.3 percent of all visits, are shown in table 8. It is important to note that the rank ordering presented in this and other tables may not always be reliable because near estimates may not differ from each other due to sampling variability. "Stomach and abdominal pain, cramps and spasms" was the most frequently mentioned reason for visit overall (5.5 percent), while "laceration and cuts—upper extremity" was the most frequently mentioned reason for visit in the injury module (2.6 percent).

Principal diagnosis

The principal diagnosis or problem associated with the patient's most

Table 5. Number and percent distribution of emergency department visits with corresponding standard errors by cause of injury: United States, 1992

Cause of injury and E code ¹	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits with an E code entered	28,812	1,127	100.0	...
Other accidents E918-E928	10,309	477	35.8	0.7
Accidental falls E880-E888	7,669	348	26.6	0.6
Motor vehicle accidents, traffic and non-traffic E810-E825	4,130	196	14.3	0.5
Homicide and injury purposely inflicted by other persons E980-E989	1,553	119	5.4	0.4
Accidents due to natural and environmental factors E900-E909	1,374	110	4.8	0.3
Accidents caused by submersion, suffocation, and foreign bodies E910-E915	1,040	84	3.6	0.3
Other road vehicle accidents E826-E829	635	71	2.2	0.2
Surgical and medical procedures as the cause of abnormal reaction of patient or later complication without mention of misadventure at the time of procedure E878-E879	404	49	1.4	0.2
Drugs, medicinal and biological substances causing adverse effects in therapeutic use E930-E949	370	52	1.3	0.2
Accidental poisoning by drugs, medicinal substances, and biologicals E850-E858	332	50	1.2	0.2
Accidental poisoning by other solid and liquid substances, gases, and vapors E860-E869	192	35	0.7	0.1
Suicide and self-inflicted injury E950-E959	160	38	0.6	0.1
Accidents caused by fire and flames E880-E889	127	25	0.4	0.1
Late effects of accidental injury E929	52	13	0.2	0.0
Injury undetermined whether accidentally or purposely inflicted E980-E989	39	10	0.1	0.0
Other ²	109	21	0.4	0.1
Unknown ³	315	45	1.1	0.2

¹Based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (3).

²Includes railway accidents (E800-E807); water transport accidents (E830-E838); air and space transport accidents (E840-E849); vehicle accidents not elsewhere classifiable (E848-E849); misadventures to patients during surgical and medical care (E870-E879); legal intervention (E870-E879); and injury resulting from operations of war (E980-E989).

³Includes uncodable E codes and illegible E codes.

important reason for visit and any other significant current diagnoses are recorded in item 12. Up to three diagnoses are coded and classified according to the ICD-9-CM (3). Displayed in table 9 are ED visits by principal diagnosis using the major disease categories specified by the ICD-9-CM. Injury and poisoning accounted for 32.7 percent of all visits, and diseases of the respiratory system accounted for 12.1 percent.

The 20 most frequently reported principal diagnoses are shown in table 10. These are categorized at the three-digit coding level of the ICD-9-CM and account for 38.4 percent of all ED visits. The most commonly recorded diagnosis was suppurative and

unspecified otitis media, occurring at 3.5 percent of all visits.

Diagnostic and screening services

Statistics on various diagnostic and screening services ordered or provided by hospital staff during an ED visit are displayed in table 11. Approximately 87.9 percent of all ED visits included one or more diagnostic or screening service. The most frequently mentioned diagnostic service was blood pressure check, recorded at 73.7 percent of visits. Other frequently mentioned services included other blood test (28.7 percent), chest x ray (16.8 percent), urinalysis (15.2 percent), and extremity x ray (15.1 percent).

Readers should note that for items 8, 15, 16, 18, and 19, hospital staff were asked to check all of the applicable categories for that item, with the result that multiple responses could be coded for each visit.

Procedures

Procedures were performed at 42.3 percent of ED visits (table 12). The most frequently mentioned procedure was the administration of intravenous fluids, recorded at 14.4 percent of visits. Other frequently mentioned procedures were wound care (12.9 percent) and orthopedic care (7.9 percent).

Expected source of payment

Expected sources of payment were most often private/commercial insurance (36.0 percent), Medicaid (22.7 percent), and Medicare (15.1 percent) (table 13). "Patient paid" and "HMO/other prepaid" were mentioned at 13.8 and 7.3 percent of ED visits, respectively. The patient-paid category includes the patient's contribution toward "co-payments" and "deductibles."

Table 6. Number and percent distribution of alcohol- or drug-related emergency department visits with corresponding standard errors: United States, 1992

Visit characteristic	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits	88,796	3,302	100.0	...
Alcohol- or drug-related visit				
Neither	86,015	3,026	95.8	0.2
Alcohol-related	2,459	198	2.7	0.2
Drug-related	996	91	1.1	0.1
Both	327	44	0.4	0.0

Americans from around the country of the rich Chinese culture that flourishes in this land.

My strongest hope for the future of the U.S.-ROC relationship is that the American base of support for Taiwan will grow beyond its conservative seed and touch the entire United States. There is no serious obstacle to this and many positive developments to encourage it. Security is a prerequisite of Taiwan's continued economic growth, and this growth is a powerful stimulus to the positive transformation of the PRC. The ROC is America's sixth largest trading partner, and its democratization builds a bridge to Washington that is a traditional and unique element of America's foreign policy. Taipei's offer to enter into a free trade agreement with Washington could serve as the keystone of a trans-Pacific free trade area that may someday engage the productive energies of over half the world's population. And, finally, the genuine bonds of friendship that connect the ROC with the U.S. are, by diplomatic standards, old. They have survived and prospered through World War,

regional conflict, and the alarming tensions of the Cold War.

And, a closing word. Do not be discouraged by the fascination Americans have long held at the size of the Chinese mainland. Nineteenth century missionaries' excitement at the potential number of converts, the wonder of Marco Polo's discoveries passed down the ages through the Europeans who settled the U.S., the colorful mystery of an unfamiliar, ancient, and sophisticated civilization: all of these do indeed exert a powerful grip on the American imagination.

But pragmatism and idealism are far more a part of the American character than a preoccupation with the exotic. Taiwan's economic vitality, and its growing movement towards democracy appeal to these fundamental and shared traits. They are the sturdy blocks on which the future of relations between the United States and the Republic of China must be built. There is no stronger or more enduring material.

Thank you.

Preventive and Medical Services

HEALTHY PEOPLE 2000

By JAMES O. MASON, Assistant Secretary of Health, Head of the U.S. Public Health Service,
U.S. Department of Health and Human Services

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THANK YOU Captain Young. It's an honor to present the Richard Kern Lecture. I was pleased to accept. I just hope I can do this distinguished past President of AMSUS justice.

We can be proud of the improvements in general health status. All Americans have benefitted from advances in medicine, technology and public health. Since the turn of the century, the average life span in our country has increased from 47 to 75 years. That's more than 28 years, or like adding two and one half days to every weekend.

However, for all our technology and all our spending, we do not have the health outcomes we might expect. U.S. life expectancy at birth ranks 18th among 39 industrialized countries for females, 22nd for males. For comparison, life expectancy for an American male born in 1988 was 71.5 years; a Japanese male born at the same time had a life expectancy of 75.8 years, a difference of over 4 years. In 1988, the United States ranked 22nd among 39 industrialized countries on infant mortality with a rate almost twice as great as in Japan; Canada ranked 7th. The per capita health care expenditure for the U.S. in 1989 was 40 percent higher than Canada and 127 percent higher than Japan.

The importance of continued scientific and biomedical advances to increase our healthy, productive life span can scarcely be overstated. But, to maximize the contributions of science and technology, we need to understand its precise role in our health.

Americans have developed a faith in the magic of medicine. We expect miracles — but the world of science isn't always able to deliver. The impossible takes a little longer. AIDS provides us an example. We're in the 12th year of this

disastrous epidemic. There is still no vaccine and although medicines extend life, there is no cure — even on the horizon. There is a gap between what we want and what science can deliver.

We have an overconfidence in new technologies, new pharmaceuticals, new medical devices and new medical procedures as quick fixes for health problems. So much so that we often don't take personal responsibility for our own good health.

The truth be known, two-thirds of all premature deaths and disabilities in this country are the result of people making poor choices for themselves. The limits of what medicine and surgery can do are painfully clear.

When Secretary Sullivan and I launched Healthy People 2000 in September 1991, we spelled out three broad goals that could be accomplished in the United States by the Year 2000.

First, we want to increase the span of healthy life for all Americans.

Second, we want to reduce health disparities among Americans. All Americans have not equally shared in the benefits of medical and preventive care. A disproportionate share of premature death and disability in the United States occurs in minority communities. In 1985, the Department of Health and Human Services estimated that Black Americans experienced 60,000 excess, unnecessary, preventable deaths per year, compared to the White population. The impact of human immunodeficiency virus (HIV) and the increase in the incidence of violence have added to the annual toll of excess deaths in the Black population. Even with recent improvement, the gap in life expectancy

between black and white men is still greater in 1990 than it was in 1984. Other racial and ethnic groups also lag behind in health status. Differences exist for American Indians, Alaskan Natives, Hispanics and some Asian Americans and Pacific Islanders.

The third goal of Healthy People 2000 is access to preventive services for all Americans.

Fundamental to accomplishing the first two goals is achievement of the third. Health promotion and disease prevention have not reached their potential in reducing premature morbidity and mortality in the U.S.

Dr. Dennis Burkett used the example of archers on boats offshore killing and wounding villagers. He asked what would we do? Bandage the wounded and bury the dead? Put armor on the citizens? Or, sink the ships?

Let's contrast Dr. Burkett's example with our policy on tobacco.

Thirty percent of all cancers in the U.S. are caused by tobacco. Over 1000 people die each day from diseases attributed to smoking. An estimated 27 billion dollars in health care costs were attributed to tobacco-related illness in 1990. Yet, we have failed to save millions of lives and we are allowing millions more to be at risk. Society seems quite willing to underwrite the extraordinary costs of surgery. Unfortunately we are not doing all we could to see that young people don't become addicted or that those who are hooked get unhooked.

We know higher taxes on tobacco products curb usage, especially in adolescents.

We know cigarette advertising influences our nation's youth.

The industry tells us that they only advertise to influence adults to switch brands. Do you believe that? Why are they concerned about minors being denied access to tobacco? A health officer in Utah called me because he needed help with strengthening laws that prevent the sale of tobacco products to minors. His action was met by powerful, coordinated opposition from groups organized and financially backed by the out-of-State tobacco industry.

No battle is too small for the tobacco industry. Every adolescent is important to the industry's future profits. They prove it by seducing our youth. Three thousand start smoking every day.

So, where should our Nation's efforts and resources be focused?

We should sink ships, when we've been bandaging and burying. I use tobacco as an example, but I could just as easily have been talking about, heart disease, infant mortality or substance abuse.

Our aspirations exceed our resources. The spiraling costs of medical care, ever increasing demands for services and new technologies have created a huge chasm between what we want and what we can afford.

The United States spends more on health care per citizen than any other country. In 1992, we will spend an estimated \$800 billion on medical care. That's nearly 13 percent of the U.S. Gross Domestic Product (GDP). That's up from 6 percent only three decades ago. If the current system could continue unchanged, medical care would consume over 1.6 trillion dollars, 16 percent of GDP by the year 2000, and between 27 and 43 percent of GDP by the year 2030.

The Federal government is spending increasing proportions on mandatory health outlays. Before the year 2000, Medicare and Medicaid will surpass Social Security as the single largest component of federal spending. Federal Medicaid spending alone has grown from 14 billion dollars in 1980 to a projected 84 billion dollars in 1993. This represents an increase of 600 percent. Medicare spending will grow from 34 billion dollars in 1980 to about 131 billion dollars by 1993 — an increase of nearly 300 percent. At current rates of increase, by 2025, Medicare is expected to exceed 27 percent of the Federal budget.

Looking at these rising medical expenditures and the example on tobacco, it is evident that America has created a medical system designed for the treatment of illness and injury. Our system is sickness oriented. It has become a business rather than a service. It is generally set up to generate revenue, rather than keep people well. Health seems to be only indirectly a goal of doctors, hospitals, insurance companies, pharmaceutical firms, and device manufacturers.

In most areas of our economy, a competitive market exists where price is influenced by the consumer's willingness and ability to pay. In such a competitive market place, over production, poor quality and high cost lead to inefficient enterprises that ultimately close and lock their doors. However, in the medical marketplace, even when there is an over supply — too many beds, too many doctors, too many MRIs, no one fails and prices rise rather than fall. Surgeons generate their own demand. The number of hysterectomies performed in a population is not related to the number of women in the population, but instead to the number of OB/GYNs practicing in the community.

In the medical market place, there is no competition in regard to price, quality or service. The medical industry lacks moderating controls. Self regulated and self control is virtually absent. Consumer based market discipline is weak. Americans with insurance have few incentives to use medical care prudently. They are insulated from the real cost of medical treatment by employer and government subsidized insurance. Doctors and hospitals who have financial incentives to provide more medical care are largely in control. American's want and feel entitled to, the best medical care, regardless of cost, and providers are eager to supply that demand.

An example of the cost generating forces at work in the medical industry is provided by the rapid spread of Magnetic Resonance Imagers. Introduced in the mid 80's, MRIs came on the heels of another major advance in diagnostic imaging, the CAT scan. Today there are about 2500 MRIs in the U.S.

Entrepreneurs, sensing profits, set up specialized imaging centers, often attracting doctors, who as co-owners could refer patients to the centers. The *New York Times* reported that a survey for Florida's Health Care Cost Containment Board found that 75 percent of the imaging centers in the State had doctors as part or full owners. A report in this week's *New England Journal of Medicine* showed that self referral increases the cost of medical care covered by workers compensation for each of 3 types of service studied: MRI, psychiatric evaluation and physical therapy! The same is undoubtedly true for other areas of self referral.

The purchase of one MRI by one hospital inspires others to keep up. Hospital's are pressured to buy MRIs to retain their competitive status as full-service, modern health care centers. Having bought such expensive machines, hospitals and imaging centers have an incentive to push as many patients through as possible to capitalize the investment. Fear of malpractice also contributes to the machines' use. The malpractice system alone adds an unnecessary 21 billion dollars to overall health care costs.

Despite high volume, MRI prices have not fallen. A study, reported in the *New York Times*, was conducted by the New York State Department of Health estimated that a high volume imaging center could reduce the cost per scan below 250 dollars. Yet, an estimated five million MRI scans were performed in the nation last year, at a price of 600 to 1,000 dollars each. That means magnetic resonance imaging alone is adding about 5 billion dollars to the nation's medical bill. And, on the heels of Magnetic Resonance Imaging is Positron Emission Tomography. PET scan fees reach upward to 2,500 dollars. So you can perceive how technology more often adds to medical costs. This shouldn't be, but our overly entrepreneurial non system has made it so.

Also adding to skyrocketing unaffordability are wasteful administrative costs. They contribute an estimated 80 billion dollars to the cost of medical care. There are over 1500 third-party payers in the United States. All with their own forms to fill out and layers of bureaucracy.

Our perverse system also generates the wrong kind of providers. There are enough physicians in the United States. We have overspecialization. We have the wrong kinds and egregious geographic maldistribution.

Using the USDA "Food Pyramid" as a template, we should build the health care pyramid with prevention and primary care services at the base — and high cost tertiary procedures, that benefit a few, at the peak.

When we examine the U.S. mix of providers, we are overwhelmingly top heavy. We have an abundance of pastry bakers and ice cream makers and few who can cook and serve whole grains, vegetables and fruit. No wonder it's the most expensive system in the world.

The Institute of Medicine estimated that 90 percent of medical complaints could be resolved at the primary care level. A health care system firmly based on nurse practitioners, physicians assistants, family doctors, general internists and general pediatricians could be much more cost-effective than our specialist dominated system.

Primary care providers tend to include more prevention services, hospitalize patients less often and order fewer medical tests, procedures, and prescription drugs for their patients. A recent study indicated that, even after adjusting for patient case mix, hospitalization rates were from 50 to 200 percent higher, and drugs prescribed were double, when patients were cared for by a specialist rather than family physicians. Those who believe that primary care, with appropriate referral to specialists would adversely effect medical outcomes and quality should show me the data.

At a time when we need more primary care physicians we have fewer. In the last 25 years the percentage of primary care doctors has dipped from 50 percent to 33 percent in

1991. In 1981, about 40 percent of the graduating medical class planned to become board certified in primary care specialties. By 1989, the percent had dropped to 25. This disastrous trend continues. If we set a goal of 50 percent primary care physicians in each graduating class it would take until some time between 2020 and 2030 to correct our problem. Can we wait?

Too many expensive medical procedures are being over-used. We are squandering our assets. We are doing things that don't work or aren't needed. As a nation, we have under-invested in outcomes research.

A recent study estimated 50 percent of coronary angiography undertaken in the U.S. are unnecessary, or at least could be postponed. In 1989 this would have represented over 400,000 unnecessary tests at a cost of over 3 billion dollars.

This diagnostic tool often leads to subsequent coronary angioplasty or bypass surgery. The study also chronicled the ever lowering threshold for carrying out bypass surgery as well as angioplasty. From 1983 to 1990, Coronary angioplasty increased from 30,000 to almost 285,000 procedures. Over the same time period, coronary bypass increased from 180,000 to 380,000. Coronary bypass surgery now accounts for 1 of every 50 dollars spent on health care in the U.S. One study suggested that more than 40 percent of such operations did very little, if anything, for the patients.

Another example where outcomes research can save us dollars is in the use of medications. For example, treatment of myocardial infarction with Streptokinase costs approximately 200 dollars whereas therapy with tPA costs 1,800 dollars. Preliminary outcomes research indicates long term survival is equivalent with either drug in most patient populations. We need this kind of data on other pharmaceuticals, and we need informed physicians who tailor their prescribing practices to sound medical economics.

While we must be concerned about the overutilization of services we also know that there are cost effective services that are underutilized. Prime examples are clinical preventive services. Cost effectiveness and health benefits have been documented after rigorous evaluation by the U.S. Preventive Services Task Force.

Immunizations work and they're highly cost effective. Every dollar spent on vaccinations for childhood diseases saves 10 to 14 dollars in long-term costs. Yet, we recently did a survey in the U.S. and found only 40 to 50 percent of kids under 2 years of age are fully immunized. In Nigeria, they'd tell you that about 60 percent of their kids under 2 years of age are immunized.

Research tells us that mammography and clinical breast examination could reduce cancer deaths by 30 percent in women aged 50 and older. Yet, despite increased federal spending on cancer screening in the United States, the National Institutes of Health predicts that more than 45,000 women in this country will die from breast or cervical cancer next year. With better application of what we already know, about 19,000 deaths would be prevented.

In our country, 13 percent — 35 million people lack insurance or are significantly underinsured. Surprisingly many of these people are employed or the dependents of employed persons. Workers at small businesses are likely to be uninsured

Uninsured Americans receive medical services by paying out-of-pocket, when they can, or through provision of so called uncompensated care. These latter Americans rarely receive preventive or primary care services. They enter the medical system through the "back door" — the emergency room. This keeps them from dying on the street, but it is unquestionably associated with more hospitalizations and poorer outcomes. Once in the hospital, the uninsured suffer negligent medical injuries more than twice as often as insured or self paying patients.

We now see why deaths due to nearly all cancers, asthma and other conditions are much higher in disadvantaged populations. They die of cancer of the cervix and the breast at a higher rate because they're not being screened, and their tumors are not seen while they're treatable. Higher rates of admission for avoidable hospital conditions should serve as a national marker for poor access to, or poor quality of, primary care. Uncompensated care, in spite of its hazards is not free. It results in cost shifting which increases the cost for the insured by nearly 15 percent.

Twenty five percent of Americans receive medical care through public or publicly financed systems. Providers include the Veterans Administration, the Department of Defense, the Department of Health and Human Services, and Department of Justice. Within these agencies, I count no less than 7 separate and independent federal systems. When we talk about the private sector, we must admit Congress and the Administration can't get their act together either.

The final 62 percent of Americans, a total of 153 million working people and their dependents, have a full range of medical services through private health insurance. It's either feast or famine in our country. Our system rations vertically rather than horizontally. This is the system that we tout as the best in the world, and it is. This group enjoys, the best of everything money can buy, the best that science and technology have to offer.

But there are some problems. Insurers offer lower premiums to attract healthy groups, while discontinuing coverage or increasing premiums, once an individual or group becomes more costly. Insurers often exclude pre-existing medical conditions from coverage. A recent court ruling that allows self insured companies to change insurance plans in the midst of an employee's illness, have effectively excluded sick persons — those most in need — from coverage.

Even those who do have insurance coverage often experience job lock, when a pre-existing condition threatens coverage if the person changes employers. Even in the best plans, immunization and other prevention services are often ignored. Since 1989, due to escalating costs, the number of people with private medical insurance has been declining. The parade of people moving from compensated to uncompensated care continues.

I have spent my allotted time somewhat pessimistically discussing some of the problems with federal health. I have suggested, and I'm not the first, that the system is broken. We are nearing a catastrophe. We are caught in a medical arms race.

Only in this race, deterrence is suffering from the cost of proliferation. There is a trade off between growth in spending for treatment services and declines in other types of spending. As the percentage of gross domestic product dedicated to medical care grows, less money is available for health promotion and disease prevention, for basic research, for education, job training, housing, transportation, and welfare assistance.

American companies are being priced out of medical insurance. They can't continue to hide the inflated costs of health insurance in the price tags of goods and services. Our country's balance of payments is disadvantaged as our products fail to compete price-wise in international markets. We do seem to have a problem. The future of Federal Health depends on *how* and *how soon* we fix our system. We cannot continue as we are. We cannot afford to.

The economic costs are profound. The human cost are immeasurable. A low birth weight baby that is the result of no early prenatal care, may never reach his or her genetic potential — may never even be capable of independent living.

What is my bottom line for future expectations? No American should be locked out of necessary health care. Every American child — every adult in the U.S. should expect to receive preventive and medical services.

Reform will not be easy. Even taking simple easy steps can be fraught with danger. Ask former Secretary Ed Derwinski. He proposed banning smoking in Veterans Administration health care facilities. He and Secretary Sullivan also proposed limited access in *one* underserved community to an under-utilized VA hospital. And, in a second community, veterans living far from a VA hospital could use a convenient community health center. In each case the facility would be reimbursed for services rendered from appropriate accounts. No robbing Peter to pay Paul. Both these proposals made good health sense. They prevented disease. They were cost effective and increased availability and access to services. But, a good man stepped down, a victim of the tobacco industry and advocacy self interests. The future of Federal health will be glorious if we can rise above ourselves.

Looking at the glass being half full, Charles Dougherty wrote,

"there are countervailing values in American experience, the biblical and republican traditions that stress the obligation of citizens to rise above self interest and to focus on the common good of society. Serious health care reform must draw on these traditions to balance the dominant note of individualism. Every stakeholder in the health care arena will have to be a little less concerned about what is in his or her own personal, professional, and institutional interest and fix more directly on what is in the best interest of the nation."

When we fix on what is best for our Nation, then the over 50 separate health reform proposals already on the table will coalesce to produce broad and workable areas of natural consensus.

I'm optimistic!

BC-HEALTH-WELLNESS-NNS

How Much Is an Ounce of Prevention Worth?

Two optional trims to 1,100 words

By MILES BENSON

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WASHINGTON There is something important missing in the national debate over health care reform.

The absent element: a focus on what can be done to make Americans more healthy, not just guaranteeing that their illnesses will be treated when they get sick.

President Clinton does advocate preventive care but thus far the political dialogue over health reform has been more about ways to finance the treatment of illness than about ways to prevent it.

Prevention, early detection and incentives to promote wellness are an important part of the administration's reform plan, but they are rarely discussed.

Not that everyone agrees on the president's approach. On the contrary, some of the alternative plans that have been proposed on Capitol Hill contain far less prevention than Clinton advocates.

But if the fast-rising cost of health care is creating a crisis, one way to dramatically reduce the rate of growth would be to improve public health. Potential savings are enormous.

Doctors say more than half of all illness is preventable. Much of it is self-inflicted, the result of smoking, drinking, drug abuse, suicidal eating habits and sedentary lifestyles that helped push the national cost of health care to \$900 billion in 1993, and will likely boost it over the \$1 trillion mark in 1994.

Clinton's plan would cover periodic physical checkups, which many health insurance plans currently do not pay for. It also covers immunization, prenatal care, cancer and diabetes screenings, mammograms and pap smears, with no co-payments required from patients. Raising taxes on cigarettes 75 cents a pack will improve health if, as expected, it reduces smoking. And Clinton would increase funding for research in children's health and disease prevention and wellness promotion.

Perhaps the most important preventive element of the Clinton plan is little understood and rarely discussed. It is Clinton's attempt to reverse the financial incentives for most doctors who now operate under a system that provides them no economic benefit for keeping patients healthy.

In most cases under the present system, the more medical services doctors provide, the more money they make. Clinton seeks to change that.

Under his reform plan, doctors would be part of a health plan that is paid a fixed amount of money for taking care of a group of patients over time. The healthier the patients, the less money consumed treating sickness and the greater the financial reward for the health plan and its doctors.

Clinton advisers believe this pocketbook motive will cause doctors to more intensely monitor patient behavior and devote more time and attention to counseling about good health habits.

"When it comes right down to it, physicians and people working in medical treatment centers have not been closely involved," said Dr. J. Michael McGinnis, deputy assistant secretary for health promotion and disease prevention in the Department of Health and Human Services. "Their incentive is primarily to treat illnesses that walk in the door. Now there will be a different set of incentives at play. Not only is there the obligation to treat illness, but also because of the structure of the entire system there would be a real incentive for plans to keep their patients healthy," McGinnis said.

"At least under this system you will be in a health plan which has every reason to encourage you and educate you about how to take better care of yourself," said Walter Zelman, a White House health adviser. "The conscientious physician today may try to tell you about nutrition and

exercise. Now there will be an additional issue involved. Now the plan has more incentive to make sure you learn about nutrition, about alcohol and drug use, to make sure you understand the dangers of smoking and how to reduce intake of things not healthy for you. They have every reason to get you at better."

The impact could be most dramatic among lower-income families where death rates now are almost twice as high as they are among those among upper-income Americans, said Jeff Jacobs of the American Public Health Association.

"The wealthy get the information they need to make lifestyle changes," Jacobs said. "Lower income people don't get that advice, they don't get the tests."

The universal health care coverage proposed by Clinton would fill that gap.

(FIRST OPTIONAL TRIM BEGINS)

Not everyone believes that promoting wellness would reduce health costs.

Uwe Reinhardt, a health care economist at Princeton University, scoffs at the idea, saying people would live longer and ultimately heap new cost burdens on society.

"Over their life-cycle, people consume a certain amount of health care," Reinhardt said. "If they don't consume it sooner they consume it later. Smokers are probably lowering health care costs because on average they die so much earlier that they consume less health care per life-cycle."

But many doctors and other experts disagree.

(FIRST OPTIONAL TRIM ENDS)

A recent report by the Robert Wood Johnson Foundation in Princeton, N.J., said smoking adds \$28 billion a year to the nation's health care costs, while alcohol abuse adds \$10.7 billion and drug abuse another \$4.7 billion.

The Center on Addiction and Substance Abuse at Columbia University in New York said that patients with substance abuse problems tend to recover more slowly from a variety of ailments, running up bigger hospital bills. On average, Medicaid patients with substance abuse as a secondary diagnosis are hospitalized twice as long as patients with the same primary diagnosis and no substance abuse problem.

Joseph A. Califano Jr., former secretary of Health Education and Welfare who heads the center, puts the medical costs of substance abuse at \$140 billion a year.

A study by the Medical College of Wisconsin said more elderly Medicare patients are hospitalized for alcohol abuse than for heart attacks. More broadly, between 25 and 40 per cent of people in general hospital beds across the country are being treated for the complications of alcoholism.

More than 70 conditions commonly requiring hospitalizations are the result, in whole or in part, to substance abuse, including tumors, spontaneous abortion, respiratory diseases including asthma, bronchitis, emphysema, pneumonia and influenza, coronary heart disease, hypertension, ulcers, dementia, epilepsy, diabetes, leukemia, arthritis and seizures.

People who smoke and drink are 135 times more likely to get throat cancer than those who abstain from both. Those who smoke and drink are 24 times more likely to get oral cavity cancer than those who do not drink or smoke.

"Much of the impetus behind the growth in health care expenditures can be traced to lifestyle factors and social problems," said a report by the American Medical Association.

-END-OF-AUTOTAKE(1)-

AUTOTAKE(2)-FOLLOWS

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SPECIAL ARTICLES

REDUCING HEALTH-CARE COSTS BY REDUCING THE NEED AND DEMAND FOR MEDICAL SERVICES

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HEALTH care costs in the United States exceed 14 percent of the gross domestic product, far more than in any other nation. Overall costs were \$838 billion in 1992, or over \$3,000 per person.¹ Well over 30 million Americans are uninsured, partly because of rising premium costs.^{2,3} We propose an approach to part of this problem that has been neglected, one that focuses on systematically reducing the need and thus the demand for medical services. This approach requires expanding the definitions of "health promotion" and "preventive care," paying selective attention to strategies that have been found to result in net cost savings.

During the past 30 years, while health care expenditures have risen in the United States from 4 percent to 14 percent, many cost-control strategies have been tried to varying degrees, without success.⁴⁻⁶ The inflation of costs, influenced by technology, specialization, and a variety of other factors, has continued unabated.⁶ Thoughtful criticisms of administrative cost-control solutions have been advanced, and it has been noted that these measures ration productive and non-productive activities alike.⁷ Despite their merits, proposed programs of reform introduce new problems, such as reduced access, increased costs, rationing, or adverse economic effects on small businesses.^{2,4,8-10} On the face of it, broadening access and reducing costs at the same time is difficult.

A THEORETICAL SOLUTION — REDUCING THE NEED AND DEMAND FOR MEDICAL SERVICES

If there were no illness and no accidents, health care costs for a society would theoretically be zero. For much of this century, the decrease in acute illness and the proportional increase in chronic disease have fueled inflation in medical costs.¹¹ Preventing chronic illness would offer hope of a reduction in de-

mand: if a coronary-artery bypass graft procedure costs \$50,000, then avoiding that procedure could save up to \$50,000, depending on the cost of the intervention, on whether the procedure is postponed or prevented, and other offsetting factors.¹² Approaches involving self-management could potentially yield similar benefits: if a visit to the emergency department for a cold, including cultures, x-ray films, and antibiotics, costs \$130, then that amount is saved if the visit is not made. If they are based on well-documented and proved interventions, health policies directed at reducing the burden of illness constitute a positive approach: individuals become healthy and society may save money.^{13,14}

How can we reduce the burden of illness and thus the need and demand for medical services? Ideally, a society of healthy people does not smoke, does not consume alcohol to excess, exercises regularly, eats wisely, uses seat belts, treats hypertension, provides other preventive health services, and sees that care at the end of life is humane.¹⁵ People assume more responsibility for their own health by requesting health services when such services can be of help and avoiding them when they cannot. There is emphasis on both disease prevention and collective individual restraint. To be sure, there are offsetting factors involving cost as well, including the direct and indirect costs of the interventions themselves. With programs of early detection (screening) in particular, it has been notoriously difficult to document cost savings.¹⁶ The same can be said of drug treatment for control of hypertension or reduction in cholesterol levels.¹⁷⁻¹⁹ Not all "preventive" interventions save money.

We believe one requirement is broad access to wisely designed programs of health promotion, in which the concept of health promotion is expanded to include a goal of cost reduction. This expanded concept directly addresses the challenge of preventing illness as well as that of reducing health care costs.

THE POTENTIAL FOR REDUCING DEMAND

A health policy directed at reducing demand would be unlikely to make a major contribution to lowering costs if a number of conditions were not present: if preventable illness made up only a small fraction of the demand, if risky behavior were not expensive in terms of lifetime medical costs, if approaches involving self-management did not reduce costs, if the present system already linked the use of resources closely to the requirements of illness,

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or if health-promotion programs in the workplace increased overall health care costs.

Much Disease Is Preventable

Preventable illness makes up approximately 70 percent of the burden of illness and the associated costs. Well-developed national statistics such as those outlined in *Healthy People 2000*, *Health U.S. 1991*, and elsewhere document this central fact clearly.^{1,15,20,21} McGinnis and Foege have carefully reclassified the causes of death in the United States, using underlying actual causes rather than the traditional disease-oriented classifications; they found that preventable causes account for eight of the nine leading categories and for 980,000 deaths per year. (McGinnis JM, Foege WH: personal communication).

Risky Behavior Costs Money

Lifetime medical costs, which average approximately \$225,000 per person, are clearly linked to health habits.²²⁻²⁴ For example, the lifetime costs for smokers, despite their shorter lives, are higher than those for nonsmokers^{22,25} by approximately one third.^{20,22} Breslow and Breslow²³ have demonstrated that poor health habits are strongly associated with greater burdens of illness and that these effects are similar in magnitude to the effects on mortality. Yen et al.²⁶ showed that self-reported health habits strongly predicted annual claims costs over the next three years; people at low risk had average claims of \$190, whereas those at high risk had claims averaging \$1,550. Using cross-sectional data from the National Health Interview Survey, Wetzler and Cruess found that increased physical activity was associated with fewer visits to the doctor.²⁷ Tsai et al. confirmed statistically significant associations between smoking habits and overall morbidity; overall morbidity was higher by 60 percent among smokers.²⁸ Sokolov demonstrated that in a large corporate setting, people with three or more risk factors on a list that included smoking, obesity, hypertension, hypercholesterolemia, and diabetes had claims costs that were double those of people who had no risk factors.^{29,30}

Variability in Regional Costs Implies Slack in the System

Wennberg and others have documented striking regional differences in the use of services.^{31,32} Cesarean-section rates in the United States have risen from 5 percent in 1965 to over 25 percent in 1988; moreover, current rates range from 9.6 to 31.8 percent in different settings.³³ Hospital expenditures per capita are twice as high in Boston as in New Haven. In some communities in Maine, over 50 percent of men undergo prostatectomy, as compared with only 15 percent in nearby communities, yet the health outcomes in these men appear similar.^{31,32,34} In the case of elective hospitalizations, admission rates correlate with the number of hospital beds per capita rather than the incidence of illness.^{35,36} Educating the consumer so that more informed decisions are made decreases the frequency

with which certain procedures are performed.^{31,32} When patients are given information and alternatives, they have been shown, on average, to select less invasive (and less expensive) strategies than their physicians.³⁷ Health maintenance organizations cost as much as 20 percent less than traditional programs of health care delivery, with no discernible negative effects on health outcomes.³⁷

Self-Management Can Result in Savings

Multiple studies have demonstrated that providing medical consumers with information and guidelines about self-management can lower rates of use of services, often by 7 to 17 percent, in association with modest interventions.³⁷⁻⁴¹ These interventions offer objective guidelines to help a person decide whether medical assistance is required for a particular problem and provide information about home treatment when appropriate. They appear to work through two mechanisms: better information and increased confidence that much illness can be self-limited. Education that increases confidence about health decisions has been shown to reduce the costs of long-term health care, even in people with chronic disease.^{42,43}

Care for Terminal Illness Has Become Extraordinarily Expensive and Inhumane

The costs of medical care in the last year of life are high, and a portion of them represent overly intensive services in terminal illness.⁴⁴ Some 18 percent of lifetime costs for medical care, or over \$40,000, is estimated to be incurred in the last year,⁴⁵ and 29.4 percent of Medicare and Medicaid payments for those over the age of 65 are for people in the last year.⁴⁶ Imminent death is not always predictable, but sometimes the reality is clear. Seventy percent of people request no life-sustaining treatments for themselves when they are dying, and 89 percent desire living wills and other advance directives. Yet only 9 percent have made such directives.⁴⁷⁻⁴⁹ Schneiderman and colleagues⁵⁰ point out that not only signed documents but also physician-patient communication is important if dying patients are to receive less unwanted care. Roos and colleagues have discussed the factors associated with expensive and inexpensive terminal care.³¹

Health Promotion at Work Has Successfully Reduced Costs

A growing literature documents the potential of well-formulated health-promotion programs to decrease health care costs in the workplace.^{38-41,52-69} Multiple studies of such programs have shown substantial decreases in the number of sick days,^{52-54,56,59,60,65,68,69} outpatient costs,^{52,57,58,61,64-66,68,69} and hospitalization costs.^{55-57,60,61,64-66,69} Many of these studies have used randomized or parallel control groups in similar plants or facilities for soundness of the experimental^{61,62,67} or quasi-experimental^{53,55,59,63,69} design. Savings have frequently been confirmed by analyses of claims data.^{60-62,65,67,69}

A recent review of 28 separate studies of health promotion in the workplace emphasized the effects on documented cost reduction, with the savings generally being three or more times greater than the program costs.⁶⁶ A low-cost intervention delivered by mail^{61,62} had a higher percentage return. A well-executed study sponsored by the National Institutes of Health in Birmingham, Alabama, showed a 10-to-1 return and held costs to the city constant over a five-year period.⁶⁷ Increasing collaboration by universities and corporations has substantially improved the quality of recent studies.⁷⁰ There already are model programs that improve health and decrease costs. It is not knowledge that is lacking, but penetration of these programs into a greater number of settings.

REDEFINING HEALTH PROMOTION

We propose that health-promotion programs attempt to improve both physical and financial health. The central goal remains improvement in health habits, and ultimately the postponement and prevention of major chronic illnesses require reduction in risk factors. Available data, however, suggest a lag of two or three years between improvement in health habits and signs of better health and reduced costs.^{12,71} Some studies have suggested that costs may even be increased during the first year of a program intended to improve health habits.⁷²

There are, however, elements of a broadened health-promotion model that have the potential for more immediate savings. Materials on self-management that offer guidance in the appropriate use of services have been shown to produce savings in the first year,^{38,41} particularly those that raise people's confidence in making health-related decisions.⁴² Programs intended to improve a person's level of confidence in dealing with chronic illness have been shown to lower costs both immediately and over a four-year period.⁴³ Interventions directed at reducing the number of low-birth-weight babies can theoretically have immediate effects: a stay in the intensive care unit for a single low-birth-weight baby can easily cost more than \$100,000. Using advance directives, such as a living will or durable power of attorney, that emphasize humane and dignified care at the end of life and are coupled with appropriate communication could reduce costs as well as provide more humane care in a short period.⁴⁷⁻⁴⁹ Dollar incentives for the appropriate use of health care, a measure sure to be controversial, may yet play a part in reducing costs and may do so over a brief period.^{29,30,67,72}

Who Will Pay?

Widespread dissemination of programs such as those described here costs money — not a great deal of money in comparison with overall health costs, but some money. The costs should be borne by those who will ultimately have the savings — that is, those now paying the costs. Insurers, industry, and government can pay out of their potential savings. What is re-

quired is a widespread conviction that appropriately designed programs directed at reducing need and demand can actually save money.^{13,14,69}

THE HEALTH PROJECT

The Health Project is a voluntary consortium of business leaders, health insurers, policy scholars, and members of government, with representation from the Centers for Disease Control and Prevention, the Office of Health Promotion and Disease Prevention, and present and past administrations. Its members believe that reducing demand and need can have a substantial positive effect on health care costs. We propose a private-public partnership, with nominal federal expenditure, to promote improved health and reduce costs. The consortium believes that there already are programs capable of making a change in demand, but that except for demonstration projects, their availability now extends only to perhaps 1 or 2 percent of the population. Disseminating such programs is the issue.

The consortium plans to review the evidence, identify the best programs, and promote their replication in additional workplaces and communities. In an initial review of more than 200 health-promotion programs in the workplace, there was a convincing documentation of savings in 8: Johnson and Johnson,⁵⁵ Du Pont,⁵³ Tenneco,⁵² Blue Shield of California,^{61,62} Travelers,^{39,40} Southern California Edison,^{29,30} the County of Ventura (California), and Coors.⁵⁸ Collectively, these programs had developed many of the features that influence costs directly over the short term. Two had a heavy emphasis on self-management, two used cost incentives, one emphasized advance directives for terminal care, several contained elements directed at enhancing self-confidence with regard to health-related decisions, and several had defined approaches to people at high risk.

PROBLEMS AND CAVEATS

Why have solutions aimed at reducing costs by reducing demand not been implemented more widely? Two common answers are the popular belief that high costs are necessary if we are to have the finest medical system in the world and the idea that technology is essential to improved health and longevity. Economists have focused on administrative and financing issues. Across-the-board solutions have been sought, rather than selective ones, partly because they are easier to conceptualize. Advocates of health promotion have themselves caused delays, first by not making cost reduction a primary goal and second by neglecting rigorous economic evaluation. The government has not funded evaluative research to any substantial degree. It can be argued that academic conservatism has held preventive policy to a more stringent standard of proof than that generally applied in other areas of health policy.

In addition, there has been the suggestion that health-promotion programs might actually increase

costs or that at best the reductions would be small.⁷³⁻⁷⁶ Smoking cessation, for example, might increase costs by promoting greater longevity with its attendant costs. Furthermore, proposals to teach people to use hospitals and doctors less can be seen as raising another kind of barrier to access, even though the intention is quite different. Health-promotion programs have also been viewed as intrusive and as jeopardizing privacy. There has been doubt that large segments of the population can learn to practice self-management. Concern that powerful interest groups (doctors, hospitals, industry, or the medical-industrial complex) will effectively oppose such approaches has engendered a sense of hopelessness.

In the end, however, the payers are consumers, who can learn to act in their own interests to control costs and who ultimately constitute the strongest interest group.⁷⁷ Moreover, the proposals outlined here are not antimedicine; rather, they are in the tradition of a profession devoted to improving health. Ultimately, a service profession must applaud this initiative, and many if not most physicians already support these strategies. It is time to confront concern directly about whether efforts to reduce need and demand can be of real value. The evidence is that they can.

CONCLUSIONS

Reducing the need and demand for medical services is theoretically plausible and practically documented, and there is a funding mechanism in place, through the savings accruing to the present payers. The approach complements multiple proposals for the reform of health care financing that are now under consideration, and indeed it is essential to any such plan, for all face the question of costs. The Health Project Consortium believes that widespread implementation requires ever broader collaboration among business, labor, the insurance industry, government, and the university. This approach does not directly address many other important issues in medical reform, including access, overspecialization, and the development of a two-tiered system, although it may provide indirect help in some of these areas. Nor does it, as now conceived, adequately address the issues of health promotion and reduction of demand for services as they affect the unemployed, the uninsured, and the poor; to the extent that it can free funds, however, it may provide benefits for them. Reducing the need and demand for medical services is a positive solution, one that will bring better health for the individual, and that will ultimately lower medical costs.

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REFERENCES

1. National Center for Health Statistics. Health United States, 1991. Hyattsville, Md.: Public Health Service, 1992. (DHHS publication no. (PHS) 92-1232.)
2. Sullivan LW. The Bush administration's health care plan. *N Engl J Med* 1992;327:801-4.
3. Clinton B. The Clinton health care plan. *N Engl J Med* 1992;327:804-7.
4. Schroeder SA, Cantor JC. On squeezing balloons — cost control fails again. *N Engl J Med* 1991;325:1009-100.
5. Ginzberg E. Health care reform — where are we and where should we be going? *N Engl J Med* 1992;327:1310-2.
6. Weisner BA. The health care quadrilemma: an essay on technological change, insurance, quality of care, and cost containment. *J Econ Lit* 1991;29:523-52.
7. Welch HG. Should the health care forest be selectively thinned by physicians or clear cut by payers? *Ann Intern Med* 1991;115:223-6.
8. Reinhardt UE. Politics and the health care system. *N Engl J Med* 1992;327:809-11.
9. Brown ER. Health USA: a national health program for the United States. *JAMA* 1992;267:552-8.
10. Simmons HE, Rhoades MM, Goldberg MA. Comprehensive health care reform and managed competition. *N Engl J Med* 1992;327:1525-8.
11. Fries JF, Crapo LM. Vitality and aging. San Francisco: W.H. Freeman, 1981.
12. Patrick DL, Erickson P. Health status and health policy: quality of life in health care evaluation and resource allocation. New York: Oxford University Press, 1993.
13. Somers AR. Why not try preventing illness as a way of controlling Medicare costs? *N Engl J Med* 1984;311:853-6.
14. Leaf A. Preventive medicine for our ailing health care system. *JAMA* 1993;269:616-8.
15. Healthy People 2000, national health promotion and disease prevention objectives. Washington, D.C.: Government Printing Office, 1991. (DHHS publication no. (PHS) 91-50213.)
16. Eddy DM. Screening for cervical cancer. *Ann Intern Med* 1990;113:214-26.
17. Hulley SB, Walsh JMB, Newman TB. Health policy on blood cholesterol: time to change directions. *Circulation* 1992;86:1026-9.
18. Edelson JT, Weinstein MC, Tosteson ANA, Williams L, Lee TH, Goldman L. Long-term cost-effectiveness of various initial monotherapies for mild to moderate hypertension. *JAMA* 1990;263:407-13.
19. Goldman L, Weinstein MC, Goldman PA, Williams LW. Cost-effectiveness of HMG-CoA reductase inhibition for primary and secondary prevention of coronary heart disease. *JAMA* 1991;265:1145-51.
20. Department of Health and Human Services. Prevention 89/90: federal programs and progress. Washington, D.C.: Government Printing Office, 1990.
21. McGinnis JM. Investing in health: the role of disease prevention. In: Blank RH, Bonnickson AL, eds. Emerging issues in biomedical policy: an annual review. Vol. 1. New York: Columbia University Press, 1992:13-26.
22. Leigh JP, Fries JF. Health habits, health care use and costs in a sample of retirees. *Inquiry* 1992;29:44-54.
23. Breslow L, Breslow N. Health practices and disability: some evidence from Alameda County. *Prev Med* 1993;22:86-95.
24. Manning WG, Keeler EB, Newhouse JP, Sloss EM, Wassermann J. The costs of poor health habits. Cambridge, Mass.: Harvard University Press, 1991:223.
25. Hodgson TA. Cigarette smoking and lifetime medical expenditures. *Milbank Q* 1992;70:81-125.
26. Yen LT, Edington DW, Witting P. Associations between health risk appraisal scores and employee medical claims costs in a manufacturing company. *Am J Health Promot* 1991;6:46-54.
27. Weitzler HP, Cruess DF. Self-reported physical health practices and health care utilization: findings from the National Health Interview Survey. *Am J Public Health* 1985;75:1329-30.
28. Tsai SP, Cowles SR, Ross CE. Smoking and morbidity frequency in a working population. *J Occup Med* 1990;32:245-9.
29. Sokolov JJ. National health care reform: a corporate perspective. *Compens Benefits Manage* 1992;Spring:1-6.
30. Sokolov JJ. Building a prototype for the nineties. *Healthcare Forum J* 1992;Spring:36-42.
31. Wennberg JE, Mulley AG Jr, Hanley D, et al. An assessment of prostatectomy for benign urinary tract obstruction: geographic variations and the evaluation of medical care outcomes. *JAMA* 1988;259:3027-30.
32. Wennberg JE. Outcomes research, cost containment, and the fear of health care rationing. *N Engl J Med* 1990;323:1202-4.
33. Goyert GL, Bonomo SF, Treadwell MC, Nehra PC. The physician factor in cesarean birth rates. *N Engl J Med* 1989;320:706-9.
34. Wennberg JE, Freeman JL, Culp WJ. Are hospital services rationed in New Haven or over-utilized in Boston? *Lancet* 1987;1:1183-9.
35. Wennberg JE, Freeman JL, Shelton RM, Bubolz TA. Hospital use and mortality among Medicare beneficiaries in Boston and New Haven. *N Engl J Med* 1989;321:1168-73.
36. Wennberg JE. Population illness rates do not explain population hospitalization rates: a comment on Mark Blumberg's thesis that morbidity adjusters are needed to interpret small area variations. *Med Care* 1987;25:354-9.
37. Morrison EM, Luft HS. Health maintenance organization environments in the 1980s and beyond. *Health Care Financ Rev* 1990;12(1):81-90.

35. Long K, Kraines RG, Brown BW Jr, Richardson N. A workplace health education program that reduces outpatient visits. *Med Care* 1985;23:1044-54.
36. Vickery DM, Golaszewski TJ, Wright EC, Kalmer H. The effect of self-care interventions on the use of medical service within a Medicare population. *Med Care* 1988;26:580-8.
40. Golaszewski T, Snow D, Lynch W, Yen L, Solomita D. A benefit-to-cost analysis of a work-site health promotion program. *J Occup Med* 1992;34:1164-72.
41. Vickery DM, Kalmer H, Lowry D, Constantine M, Wright E, Loren W. Effect of a self-care education program on medical visits. *JAMA* 1983;250:2952-6.
42. Pelletier KR, Joss JE, Locke SE. Personal efficacy: a research data base for the clinical application of self-efficacy in mental health. In: *In pursuit of wellness*. Vol. 7. Sacramento: California Department of Mental Health; 1992.
43. Long KR, Mazonson PD, Holman HR. Evidence suggesting that health education for self-management in patients with chronic arthritis has sustained health benefits while reducing health care costs. *Arthritis Rheum* 1992;35:439-46.
44. Scitovsky AA. Medical care in the last twelve months of life: the relation between age, functional status, and medical care expenditures. *Milbank Q* 1988;66:640-60.
45. Fuchs VR. "Though much is taken": reflections on aging, health, and medical care. *Milbank Mem Fund Q Health Soc* 1984;62:143-66.
46. Temkin-Greener H, Meiners MR, Perry EA, Szydlowski JS. The use and cost of health services prior to death: a comparison of the Medicare-only and the Medicare-Medicaid elderly populations. *Milbank Q* 1992;70:679-701.
47. Greco PJ, Schulman KA, Lavizzo-Mourey R, Hansen-Flaschen J. The Patient Self-Determination Act and the future of advance directives. *Ann Intern Med* 1991;115:639-43.
48. Emanuel LL, Barry MJ, Stoeckle JD, Etelson LM, Emanuel EJ. Advance directives for medical care — a case for greater use. *N Engl J Med* 1991;324:889-95.
49. Podrid PJ. Resuscitation in the elderly: a blessing or a curse? *Ann Intern Med* 1989;111:193-5.
50. Schneiderman LJ, Kronick R, Kaplan RM, Anderson JP, Langer RD. Effects of offering advance directives on medical treatments and costs. *Ann Intern Med* 1992;117:599-606.
51. Roos NP, Shapiro E, Tate R. Does a small majority of elderly account for a majority of health care expenditures? A sixteen-year perspective. *Milbank Q* 1989;67:347-69.
52. Baun WB, Bernacki EJ, Tsai SP. A preliminary investigation: effect of a corporate fitness program on absenteeism and health care cost. *J Occup Med* 1986;28:18-22.
53. Benner RL. The effects of workplace health promotion on absenteeism and employee costs in a large industrial population. *Am J Public Health* 1990;80:1101-5.
54. Blair SN, Smith M, Collingwood TR, Reynolds R, Prentice MC, Sterling CL. Health promotion for educators: impact on absenteeism. *Prev Med* 1986;15:166-75.
55. Bly J, Jones RC, Richardson JE. Impact of worksite health promotion on health care costs and utilization: evaluation of Johnson & Johnson's Live for Life program. *JAMA* 1986;256:3235-40.
56. Bowne D, Russell ML, Morgan JL, Oprenberg SA, Clarke AE. Reduced disability and health care costs in an industrial fitness program. *J Occup Med* 1984;26:809-16.
57. Gibbs JO, Mulvaney D, Henes C, Reed RW. Worksite health promotion: five-year trend in employee health care costs. *J Occup Med* 1985;27:826-30.
58. Henricz J, Brummell H. Phase II cardiac wellness at the Adolph Coors Company. *Am J Health Promot* 1989;4:25-31.
59. Jones RC, Bly JL, Richardson JE. A study of a work site health promotion program and absenteeism. *J Occup Med* 1990;32:95-9.
60. Jose W, Anderson D, Haigh S. The StayWell strategy for health care cost containment. In: Opatz J, ed. *Health promotion evaluation: measuring the organizational impact*. Stevens Point, Wis.: National Wellness Institute; 1987:15-34.
61. Leigh JP, Richardson N, Beck R, et al. Randomized controlled study of a retiree health promotion program: the Bank of America study. *Arch Intern Med* 1992;152:1201-6.
62. Fries JF, Bloch DA, Harrington H, Richardson N, Beck R. Two-year results of a randomized controlled trial of a health promotion program in a retiree population: the Bank of America study. *Am J Med* 1993;94:455-62.
63. Lynch WD, Golaszewski TJ, Clearie AF, Snow D, Vickery DM. Impact of a facility-based corporate fitness program on the number of absences from work due to illness. *J Occup Med* 1990;32:9-12.
64. Shephard RJ, Corey P, Renzland P, Cox M. The influence of an employee fitness program and lifestyle modification program upon medical care costs. *Can J Public Health* 1982;73:259-63.
65. Steffy BD, Jones JW, Murphy LR, Kunz L. A demonstration of the impact of stress abatement programs on reducing employees' accidents and their costs. *Am J Health Promot* 1986;2:25-32.
66. Tsai SP, Bernacki EJ, Baun WB. Injury prevalence and associated costs among participants of an employee fitness program. *Prev Med* 1988;17:475-82.
67. Harvey MR, Whitmer RW, Hilyer JC, Brown KC. The impact of a comprehensive medical benefit cost management program for the city of Birmingham: results at five years. *Am J Health Promot* 1993;7:296-303.
68. Burton WN, Conti DJ. Value-managed mental health benefits. *J Occup Med* 1991;33:311-3.
69. Pelletier K. A review and analysis of the health and cost-effective outcome studies of comprehensive health promotion and disease prevention programs. *Am J Health Promot* 1991;5:311-5.
70. Pelletier KR, Klehr NL, McPhee SJ. Developing workplace health promotion programs through university and corporate collaboration. *Am J Health Promot* 1988;2:75-81.
71. Lipid Research Clinics Program. The Lipid Research Clinics coronary primary prevention trial results. II. The relationship of reduction in incidence of coronary heart disease to cholesterol lowering. *JAMA* 1984;251:365-74.
72. Gibbs J, Mulvaney D, Henes C, Reed WR. Worksite health promotion: five year trend in employee health care costs. *J Occup Med* 1985;27:826-30.
73. Verbrugge LM. Longer life but worsening health? Trends in health and mortality of middle-aged and older persons. *Milbank Mem Fund Q Health Soc* 1984;62:475-519.
74. Schneider EL, Brody JA. Aging, natural death, and the compression of morbidity: another view. *N Engl J Med* 1983;309:854-6.
75. Warner KE, Wickizer TM, Wolfe RA, Schildroth JE, Samuelson MH. Economic implications of workplace health promotion programs: review of the literature. *J Occup Med* 1988;30:106-12.
76. Russell LB. *Is prevention better than cure?* Washington, D.C.: Brookings Institution; 1986.
77. Vickery DM, Fries JF. *Take care of yourself*. 5th ed. Reading, Mass.: Addison-Wesley; 1993.

PREVENTIVE HEALTH

A Costly Ounce of Prevention

Early Medical Screening May Save Lives, but Not Money

By Spencer Rich

PREVENTIVE HEALTH care has been touted by President Clinton and many others as a way to cut the nation's rising medical costs. It will be an important factor in the president's health care plan and has a powerful appeal in a society where, by some estimates, preventable illness accounts for as much as 70 percent of medical expenditures. Yet many of the best-known prevention strategies—including the major screening tests for cancer and high cholesterol—cost far more money than they save.

In fact, the expense involved in screening millions of people who have no obvious symptoms of a health problem, and giving them appropriate early treatment, often averages as much as \$50,000 or more to extend the life of one person for a single year. Such outlays are inevitable for diseases in which testing costs are comparatively high and incidence rates relatively low.

As a result, many experts worry that the role of prevention in reducing health care expenditures has been misunderstood and could lead to misguided policy and seriously mistaken expectations.

"For health care in general, there are very few things that save money," says Jeffrey Koplan, director of the National Center for Chronic Disease Prevention in the government's Centers for Disease Control. "To hold prevention up to a standard that it *must* save money is unfair and doesn't yield us the best choices in how we do spend money."

To be sure, some prevention efforts do result in substantial net savings. Standard childhood immunization programs and fluoridation of water both save money, says Milton Weinstein of the Harvard School of Public Health. Studies now underway indicate immunizations save \$2 to \$3 for every dollar spent.

Moreover, a one-specimen hospital blood test to screen newborns for the metabolic disorder PKU and hyperthyroidism saves thousands of infants from a lifetime of severe disability and also saves millions of dollars by averting the need for future care, says the congressional Office of Technology Assessment (OTA).

And "a campaign to get people to stop smoking offers a high potential for an actual net saving of health care dollars," says Kenneth E. Warner, chairman of the Department of Public Health Policy at the University of Michigan.

But surprisingly few preventive programs can meet Clinton's stated goal of improving health while also reducing medical spending through such mass measures as "regular checkups, screenings, mammograms, immunizations and prenatal care."

"Cost-effectiveness studies, which estimate the net costs and net health benefits of interventions, show that preven-

tive care usually increases medical expenditures," said Louise B. Russell of Rutgers University, who has studied prevention economics for many years, in the July 29 issue of the *New England Journal of Medicine*. Elsewhere she has said, "Prevention adds billions of dollars to health care spending."

The reason that early detection and many other prevention strategies cost money is that millions of people must be screened or given preventive care at substantial cost to prevent serious future illness. Only a relatively small number of these people would later get the disease if not given preventive care.

Indeed, numerous studies have shown that some of the most familiar testing techniques are not cost-saving. They may be medically effective, and one may judge that their net cost is worth the resulting health improvement; but they do not actually save money.

■ Annual manual breast cancer screening recommended for all women 55 to 65 was estimated in 1985 by David Eddy, a leading researcher, as having a net cost of \$15,500 for every one-year extension of life for one woman—even after considering how much would be saved by finding the disease early. If, in addition, every woman in this age group got yearly mammograms (as some authorities recommend), more cases would be found but the net incremental cost for each additional year of life saved for one woman would rise to \$84,000.

■ Pap smears for cervical cancer conducted every three years for all women age 20 to 75 would have cost a net of \$13,300 in 1985 for every year of life saved for one woman, according to estimates by Eddy, who said that the cost is "well worth it." His study also found that if the smears were done every two years instead of three, the extra cost for every additional life-year saved for one woman would be \$419,000; and if done annually, the incremental cost compared to the two-year strategy would be more than \$1 million for each additional life-year saved.

■ Cholesterol screening of healthy adults to ward off heart problems does not save money, according to a 1991 OTA study by Judith Wagner and Alan M. Garber of Stanford Medical School. They based the study on guidelines endorsed by the American Heart Association that call for cholesterol screening of all persons over 20 at various intervals, dietary guidelines for those found to have high cholesterol and costly drug therapy when appropriate.

Under those guidelines, huge numbers of people would be screened and treated, including young people unlikely to have heart attacks despite their cholesterol levels and women whose heart attack rates early in life are low.

James Cleeman, director of the National Cholesterol Education Program of the National Heart, Lung and Blood Institute, believes the study overestimated the need for drug use and therefore came up with costs that were too high. He says making lifestyle changes instead of drugs the mainstay of

preventive treatment would be "much cheaper," though not necessarily cost-saving.

■ Colorectal cancer screening in the elderly also has net costs, according to a 1991 study by OTA's new director, Roger C. Hérdman, and Wagner. They concluded that annual blood-stool testing plus periodic sigmoidoscopy examination "would prevent more cases of cancer but could cost between \$43,000 and \$47,000 per year of life gained."

■ Prostate cancer screening for older men—and particularly frequent use of a new test for a protein called PSA—probably would not save money, the National Cancer Institute's Barnett Kramer says, though "it might save lives." One reason is that the cost of screening, tests and treatment is high, but many prostate cancers are so slow-growing that the person is more likely to die of other diseases before needing surgery.

How do policy analysts come up with net-cost figures? Clyde Behney, assistant director of OTA, and OTA health policy analysts Wagner and Tami Mark, described the process:

For each disease, analysts calculate the costs of screening large blocks of people, of any necessary follow-up examinations and of any immediate treatments required. Then they estimate how many people, in the absence of any prevention program, would eventually contract that illness and how much it would cost to treat them and care for them—the "downstream" costs. Analysts then estimate how much of the downstream cost is actually averted by the prevention program.

Such calculations, says Wagner, are extremely sensitive to differences in assumptions, such as the price of a vaccine per dose, how likely it is that the group being screened would have a large incidence of a disease and the cost of treatment.

The OTA experts say some analysts (but not OTA) also put into the calculation higher lifetime earnings by people saved from disease or death (a saving); higher costs to society for Social Security and/or welfare payments for a person who is kept alive by a screening instead of dying (a downstream cost added) or added downstream costs for other diseases if the person is kept alive.

Wagner says these added savings and costs, not related to the specific medical costs of the disease involved in the preventive care, are speculative and full of problems; for example, if you include future earnings, you might end up with the "morally absurd" conclusion that the lives of women or black males are worth less than those of white males whose average lifetime earnings are higher.

Frequency of testing is a key factor in cost. Russell used Eddy's Pap test study to demonstrate why. "Testing every three years detects more than 90 percent of all cases of invasive cervical cancer," she says. Doing it every two years captures another 2 percent or so and every three years another 1 percent. So the extra screening finds only a relative handful of added invasive cervical cancers, "but the cost of screening all women age 20 to 75 annually—just the test itself and the doctor's visit, but not follow-up care for positive tests—is \$6 billion, triple the \$2 billion for doing it every three years."

There is no formal rule decreeing the value to society of extending the life of one person for one year. But Thomas H. Lee, an associate professor of medicine at Harvard Medical School, says analysts often use \$50,000 or so as an informal benchmark. That is what the federal government sometimes routinely spends to keep one kidney-disease patient alive for a year under the Medicare dialysis program, says Randall R. Bovbjerg, a health policy analyst at the Urban Institute. Lee says the notion is that if the government is willing to spend \$50,000 to extend the life of a kidney patient for a year, it should be acceptable to spend the same amount to extend the lives of other patients through screenings for other diseases.

Despite campaign rhetoric, Clinton health planners know that many worthwhile prevention actions can cost money rather than save. "We see this as a humanitarian thing, not just a financial question," says the White House spokesman on health, Robert O. Boorstin.

As part of its forthcoming health plan, other officials say, the administration is considering guaranteeing to every American a package of preventive-care benefits costing about \$60 to \$70 per person annually for those of average risk. About half of all Americans already have such benefits in existing health plans, so the net additional cost for the half who don't will be perhaps \$65 times 125 million, or about \$8 billion a year. This will cover only the immediate up-front costs of Pap smears, mammography, routine childhood and adult immunizations, occasional cholesterol and blood tests and the like.

Many doctors recommend that such tests be conducted annually. But Kenneth E. Thorpe, a top health official, says the administration is studying the frequency that would produce the most health benefits from each dollar spent.

"The main objective of preventive medicine is to avoid illness and its consequences—from diminished quality of life for the patient through illness, suffering, pain and impairment of functioning," says Leroy Schwartz, a pediatrician and president of Health Policy International, a nonprofit study group.

"If in the course of doing that we can also save money, so much the better. But saving money is not the main purpose."

Prevention May Be Costlier Than a Cure

By David Stipp

WHICH SAVES LIVES MORE CHEAPLY: HEART transplants or curbing industrial pollution to prevent cancer?

It may be a tough choice. Ponder this: Each year of life bought by a heart transplant costs, on average, \$104,000. But a life-year saved by preventing factories from releasing carcinogenic substances like formaldehyde and benzene generally costs more than \$2.5 million.

That's what a sweeping study of cost-benefit estimates by the Harvard School of Public Health's Center for Risk Analysis shows. The jangling, lifesaving study is the first to attempt to take a life-year estimated to be lost from cancer and other premature deaths.

Findings so far suggest that:

- Medical care generally saves lives at less cost than workplace safety or environmental measures.
- Extravagant large sums are spent to alleviate minor cancer risks.
- Oregon's ranking of Medicaid services — touted as a possible national model for setting medical priorities — falls far short of maximizing cost-effectiveness.

Some cancer deaths could be averted annually in the U.S. if the \$110 billion spent on 150 major life-preserving pro-

grams were reallocated so more went to the most beneficial measures and less to the others. Cost-effective spending could cut about \$31 billion in health-care and other costs without increasing the death rate.

Childhood immunizations, drug and disease-treatment programs and prenatal care are among the biggest life-saving bargains, the study shows. These lower the costs of caring for sick people; thus, total costs can be more than offset by health-care savings, bringing per-life-year costs to less than zero.

Medical treatments sometimes cost surprisingly little in the study's analysis because they are used on a small target group — sick people. For example, kidney dialysis typically saves a life-year for about \$46,000. But broad-brush prevention, such as installing seat belts in all school buses (\$2.5 million per life-year), generally pays off for only a small fraction of the population.

But the Harvard study doesn't factor in

the myriad considerations that might make spending effective or ineffective. For example, a school district where children died in a bus without seat belts might pay huge legal settlements, as well as incur adverse publicity that might cost the schools voter support for tax levies.

Still, the study shows many prevention programs are like gold-plated cannons aimed at flies. The estimated "excess mortality" they avert, especially in pollution control, often is minuscule. Consider the study's most expensive intervention: preventing releases of carcinogenic chloroform at pulp mills, which costs an estimated \$99.4 billion for each life-year saved. The chloroform controls at 48 mills studied cost only \$30.3 million annually, says Tammy Tengs, lead author of the study. But researchers estimate it would be necessary to spend that much on controls for more than 33,000 years to avert a single fatal case of cancer. Dividing the annual cost by the tiny mortality risk yields the huge cost-benefit ratio.

"There's a degree of public anxiety about cancer that's probably disproportionate to other causes of death," says Harvard's Dr. Graham. "Cancer is primarily a disease of old age, and we don't have a very effective battery of strategies to prevent it. But society places great demands on institutions to deal with it."

Indeed, the median cost for a life-year saved by programs to avert cancer deaths is about \$750,000, the study found. The comparable cost for heart disease is \$14,000. The heart programs include cholesterol screening for boys at age 10, which saves a life-year for an estimated \$6,500.

Dr. Tengs notes that selective anticancer prevention can be cost-effective. A life-year saved by screening women over 30 annually for cervical cancer costs \$221,000, compared with \$11,000 for annually screening women over 60.

The Harvard study highlights low- or no-cost ways to avert death that haven't been widely implemented or enforced, including screening people over 40 for colon cancer and mandating that motorcycle drivers keep their lights on.

But "people don't want to live by cost-effectiveness numbers alone," says Oregon's Mr. Slovic. "People get direct benefit from cars, so they're willing to tolerate more risk (from auto accidents) than from cancer caused by strange chemicals used by industry." Moreover, many favor high-cost pollution controls because "pollution is seen as a symbol that the earth is fragile and that we're destroying it."

The Harvard team's analysis of Oregon's Medicaid rankings underscores how politics can skew cost-effectiveness. To extend health-care coverage, the state ranked Medicaid services to reflect comparative benefits; only services above a certain ranking are covered.

Lifesaving Costs

Median cost of a year of life saved by various interventions

	COST
Childhood immunizations	Less than zero
Prenatal care	Less than zero
Flu shots	\$600
Water chlorination	\$4,000
Pneumonia vaccination	\$12,000
Breast cancer screening	\$17,000
Construction safety rules	\$38,000
Home radon control	\$141,000
Asbestos controls	\$1.8 million
Radiation controls	\$27.4 million

Source: Harvard Lifesaving Study

grams were reallocated so more went to the most beneficial measures and less to the others. Cost-effective spending could cut about \$31 billion in health-care and other costs without increasing the death rate.

Critics often blast risk-analysis studies as biased guesswork doled up by spin-control experts to look like hard data. But outside researchers say the Harvard study, begun in 1990, appears quite rigorous. Some 90% of its data were drawn from government studies or peer-reviewed ones in technical journals. "Nothing comes close to the study in breadth and the number of interventions analyzed," says Paul Slovic, a risk expert at Decision Research, a Eugene, Ore., think tank.

Other studies have analyzed cost-benefit ratios for a few dozen measures. The Harvard team used hundreds of studies to estimate such ratios for 587 interventions — from requiring airbags in cars to prescribing cholesterol-lowering drugs.

The team calculated the costs per life-year saved in three main categories: medicine, injury prevention and pollution control. Costs varied widely. But the study showed medical interventions generally thwart the Grim Reaper for less than injury-prevention measures, such as construction-safety rules or highway improvement, which save lives only when relatively rare accidents occur. And preventing injuries generally yields more bang than stringent toxic-release standards.

"It's fashionable to criticize the extravagance of American medicine," says author John Graham. But "our study shows a lot of what is done in medicine is quite effective and reasonable

between 1990 and 1993, the state put more weight on cost-effectiveness. Oregon's Medicaid rankings are based on a study by the Harvard School of Public Health's Center for Risk Analysis. The study found that the state's Medicaid rankings are based on a study by the Harvard School of Public Health's Center for Risk Analysis. The study found that the state's Medicaid rankings are based on a study by the Harvard School of Public Health's Center for Risk Analysis.

EXECUTIVE SUMMARY

The ongoing debate on national healthcare reform has recently focused on President Clinton's insistence that the final bill include universal coverage. Three congressional committees have reported-out bills with universal coverage while the Senate Finance Committee recently completed work on a bill which achieves partial coverage. This paper estimates the number of persons covered under selected partial approaches to health reform and then quantifies the differences among partial and universal approaches with regard to: health spending for persons who remain uninsured; insurance premiums for those who are currently insured; and household spending on health care. We compare:

- ◆ Insurance market reforms alone;
- ◆ Insurance market reforms combined with premium subsidies as in the Managed Competition Act (whose lead sponsors are Representative Jim Cooper (D, TN) in the House and Senator John Breaux (D, LA) in the Senate);
- ◆ Universal coverage as applied to the Managed Competition Act (individual mandate)^{ES-1} ; and
- ◆ Universal coverage under the President's Health Security Act (employer mandate).

The bills recently reported-out by the Senate Labor and Human Resources Committee and the House Education and Labor Committee include universal coverage and are similar to the Health Security Act. The bill reported-out by the Senate Finance Committee and legislation recently introduced by Senator Bob Dole include insurance market reform and subsidies, but not universal coverage.

Our analysis shows that premiums are lower under universal coverage than under insurance market reform or insurance market reform linked to subsidies. Further, we estimate that middle income families that currently have insurance will pay more in general for health care under partial reform than under reform that includes universal coverage. In addition, ^{for} currently insured households earning less than \$100,000 annually, health spending will decline under universal coverage with an employer mandate and cost constraints.

^{ES-1} The Managed Competition Act as written does not include universal coverage. For illustrative purposes only this analysis assumes an expansion of the act to include all persons.

INSURANCE COVERAGE

We estimate that insurance market reforms alone will cover about 1.1 million persons, or about three percent of all persons projected to be uninsured in 1998 (*Table ES-1*). When these reforms are linked with subsidies as specified in the Managed Competition Act, about 40 percent of the uninsured would be covered. This would leave about 22.3 million uninsured persons in 1998.

TABLE ES-1
NUMBER OF PERSONS REMAINING UNINSURED UNDER SELECTED APPROACHES IN 1998

Reform Scenario	Number of Persons That:		Percent Reduction
	Become Insured (millions)	Remain Uninsured (millions)	
Current System	--	37.2	--
Insurance Market Reform Only ^a	1.1	36.0	3.0%
Insurance Market Reform with Subsidies ^b	14.9	22.3	40.0%

- a Insurance market reform includes guaranteed renewability and portability, limits on pre-existing condition exclusions and community rating for individual and small group (under 100) markets.
- b As specified in the Managed Competition Act, 100 percent premium subsidy for persons with income below poverty and sliding scale subsidies for persons up to 200 percent of poverty. The Act also includes changes in the tax deductibility of premium payments.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM)

EXPENDITURES FOR THE REMAINING UNINSURED

Under current policy, the uninsured would consume about \$45.4 billion in health services in 1998.^{ES-2} Persons who remain uninsured under the Managed Competition Act would continue to consume about 55 percent of this amount, or \$24.8 billion. This amount includes out-of-pocket spending, free care provided by physicians, hospital uncompensated care, and care provided in public hospitals and clinics. Overall, about 97 percent of health spending would be covered through insurance under the Managed Competition Act.

Much of the remaining care for the uninsured would continue to be financed through cost shifting to the privately insured. As markets become increasingly competitive, physicians and hospitals will be put under increasing pressure to either avoid the uninsured or lose financially. In this way partial reform could perpetuate the destabilizing effects of the cost shift.

ES-2 Assuming a benefits package comparable to that of the President's Health Security Act.

CHANGES IN INSURANCE PREMIUMS FOR THE CURRENTLY INSURED

In general, we find that average premiums would increase if coverage were expanded through insurance market reforms and premium subsidies (*See Table ES-2*). This is because those who would obtain coverage under these policies would tend to be individuals in relatively poor health who are above average users of health services.

**TABLE ES-2
NUMBER OF PERSONS AND NATIONAL AVERAGE PREMIUMS FOR
PERSONS UNDER ALTERNATIVE REFORM SCENARIOS IN 1998**

Reform Scenario	National Average		Increase In Average Annual Premium for an Insured Family ^d
	Size of Pool (in millions)	Monthly Per-Capita Premium	
Currently Insured	185.6	\$172	---
Insurance Market Reform Only ^a	186.8	\$176	\$104
Insurance Market Reform with Subsidies ^b	200.5	\$182	\$260
Universal Coverage ^c	222.8	\$175	\$78

- a Insurance market reform includes guaranteed renewability and portability, limits on pre-existing condition exclusions and community rating for individual and small group (under 100) markets.
- b As specified in the Managed Competition Act, 100 percent premium subsidy for persons with income below poverty and sliding scale subsidies for persons up to 200 percent of poverty. The Act also includes changes in the tax deductibility of premium payments.
- c For consistent analysis, universal coverage is based on the Managed Competition Act expanded to include an individual mandate. An employer mandate could be used to attain universal coverage as in the Health Security Act. The premium changes shown in this analysis would be the same under either mandate because we focus only on premium amounts regardless of payer.
- d Change in average premium compared to premium without reform. All premiums have been standardized to the Health Security Act benefits package.

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM)

This increase in average premiums is largely averted under a program of universal coverage because such a plan would require all individuals to participate in the insurance pool including healthier individuals who receive little health care. Specifically:

- ◆ Without reform, the overall average monthly premium for currently insured persons would be \$172 per person in 1998.^{ES-3}

ES-3 This premium amount for 1998 is standardized to reflect the standard benefits package in the Health Security Act. The benefit package is used throughout this analysis because the Managed Competition Act does not specify a standard benefit package.

- ◆ Subsidies linked to insurance market reforms (as in the Managed Competition Act) would increase average monthly premiums from \$172 to \$182 for persons who already have coverage. This amount translates into an annual increase of \$260 for currently insured families.
- ◆ Going beyond the Managed Competition Act to provide for universal coverage would lower the average monthly premium to \$175 per person as healthier persons are brought into the insurance pool, less than 2 percent higher than the average premium paid by the currently insured. This translates into an annual increase of about \$78 for a currently insured family in 1998.

It is important to note that a universal coverage program would require a net increase in federal premium subsidies. For example, we estimate that an expansion of the Managed Competition Act to include universal coverage would increase federal subsidy costs by \$17 billion and reduce tax revenues by \$11 billion in 1998. However, federal subsidy costs would vary by specific proposal.

Universal coverage also reduces consumer exit and entry into health insurance markets because if people can move freely in and out of the system, the healthy will tend to avoid insurance coverage until they become ill. The Managed Competition Act addresses this by permitting six month pre-existing condition exclusions which encourages people to maintain insurance coverage. To the extent that this issue is not addressed in a reform proposal, premiums are driven up, encouraging more people to become uninsured.

CHANGES IN HOUSEHOLD HEALTH SPENDING

In addition to the effects on premiums, we examine the impact of insurance reform linked to premium subsidies and universal coverage on net household health care spending. This analysis accounts for household premium payments, subsidy policies, tax deduction revisions, and wage effects resulting from changes in employer costs under health reform. Specifically, we compare changes in household health spending for the under 65 population across: the Managed Competition Act as written; the Managed Competition Act coupled with universal coverage; the President's Health Security Act as written; and the Health Security Act without premium growth constraints.

On average, all reform scenarios reduce spending of households earning less than \$10,000. The Health Security Act also reduces spending for families earning less than \$100,000, assuming that employers absorb the 80 percent share of the premium they are required to pay under the Act. Generally accepted economic theory suggests that most of these employer costs are shifted to employees in the form of wage reductions. When this "wage effect" is considered, all of the reform scenarios result in some additional costs for families earning \$20,000 to \$75,000, although the amounts are generally higher for the Managed Competition Act with universal coverage than for the Health Security Act.

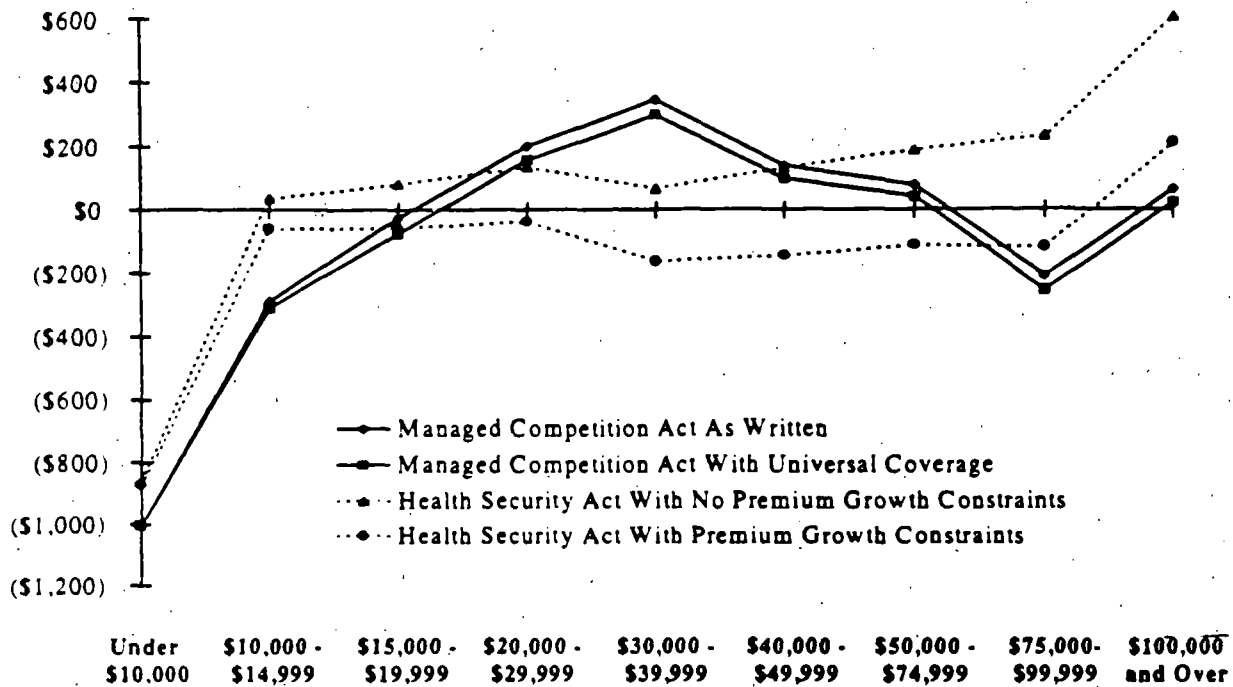
For the 76.5 million households that currently have insurance, we estimate that health spending is generally higher under partial reform than under universal coverage with or without wage effects.^{ES-4} *Figure ES-1* shows the net changes in household health spending for the currently insured population in 1998 by family income accounting for wage effects. *Figure ES-2* shows the same effects but does not include the wage effect.

Currently insured families earning less than \$10,000 a year see a net decrease in health spending under all four approaches, but middle income families that already have insurance generally see an increase in spending under the Managed Competition Act with or without universal coverage. These middle income families also spend slightly less under the Managed Competition Act if it includes universal coverage because average premiums are lower when all persons are brought into the pool.

Of the three universal coverage approaches, the Health Security Act as written is the only one that reduces household spending for currently insured middle income families, with or without wage effects.

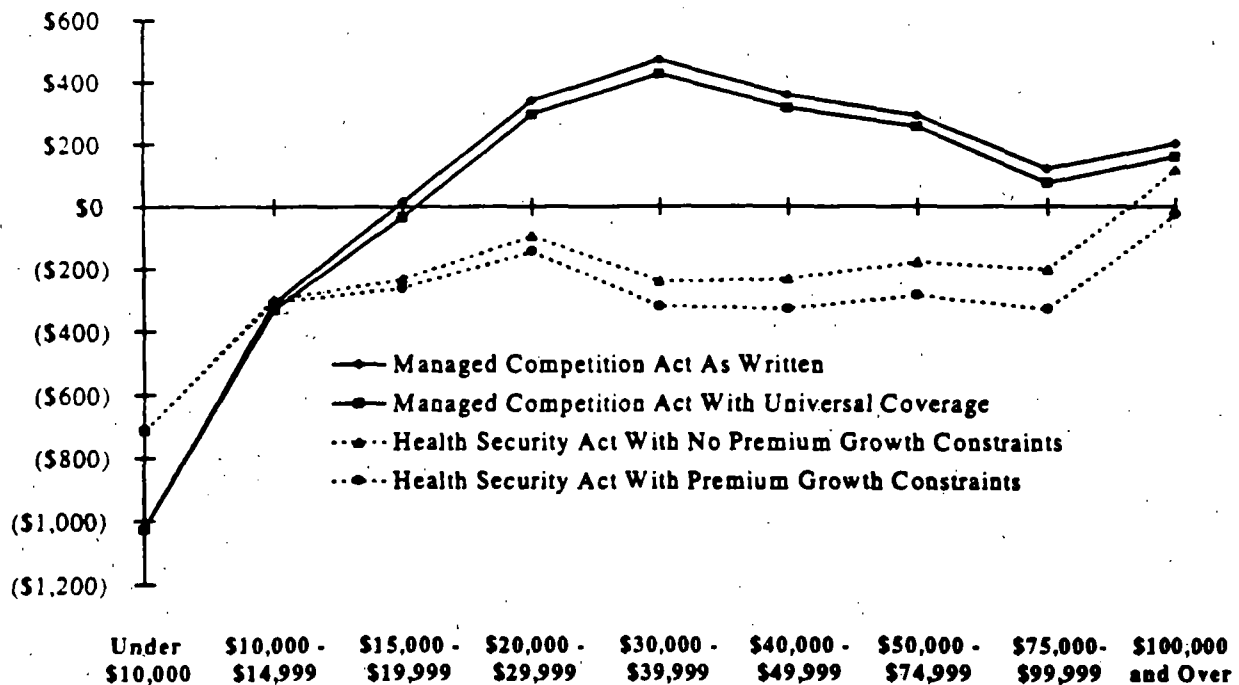
ES-4 To estimate the wage effect, we assume that 88 percent of new employer costs (based on econometric studies) are eventually passed on to employees in the form of wage reductions, and that 88 percent of new employer savings are generally passed on to employees in the form of wage increases.

FIGURE ES-1
NET CHANGES IN HOUSEHOLD HEALTH SPENDING IN 1998 FOR CURRENTLY INSURED
POPULATION UNDER AGE 65 BY INCOME
WITH WAGE EFFECT



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

FIGURE ES-2
NET CHANGES IN HOUSEHOLD HEALTH SPENDING IN 1998 FOR CURRENTLY INSURED
POPULATION UNDER AGE 65 BY INCOME
WITHOUT WAGE EFFECT



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).