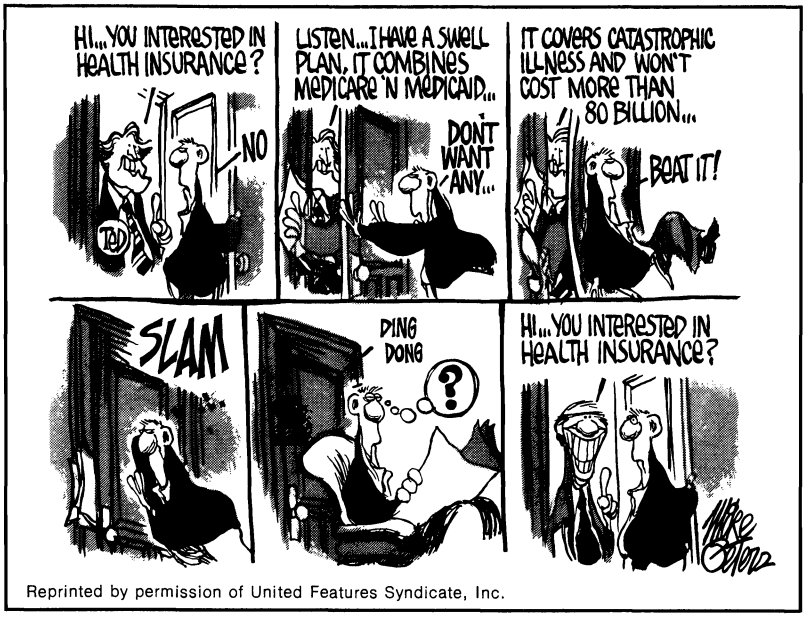
HIDING THE COSTS OF NATIONAL HEALTH INSURANCE

Jack A. Meyer

PROPOSALS FOR national health insurance (NHI) have been before Congress for years. Until recently, the main idea of most of them was government-provided insurance for everyone—an explicit federal takeover of the private health insurance industry. The huge increase in the federal budget that would have accompanied such a takeover and the generally unsavory image of "socialized medicine" consigned these proposals to the legislative back burner. But now, a new round of NHI proposals has emerged. Their trademark is the requirement that *private* employers offer their employees health insurance coverage tailored to federal standards. The government's role has shifted from financier to regulator.

These new plans, according to their proponents, can provide universal and more comprehensive coverage without a federal takeover and without any significant long-term net increase in federal outlays. Some argue, in fact, that their plans can actually moderate the sharp escalation of health-care costs in the United States. Indeed, they claim a legitimate rebirth—that their intention is to preserve, and work through, the private health insurance market. In thus abandoning any (explicit) federal takeover, proponents of national health insurance have accomplished two tricks of



magic in one stroke: a large part of NHI costs seems to have vanished before our very eyes, and the "private sector solution" rabbit, so much in vogue today, comes proudly out of the hat.

This act plays well to a national audience that is both dubious about Washington-based solutions and apt to see actions that swell federal spending as more clearly inflationary than those that bypass the budget and work through regulatory control of the private economy. But it *is* an act. A close reading of the major NHI proposals now before Congress brings back the specter of a federal takeover, albeit in a shape less easy to discern. Gone are the tangible threats of salaried doctors and $100 billion increases in the federal deficit. In their place, there is an elaborate federal regulatory scheme that would, just as surely, transform the private health-care industry into a shadow of its former self.

Thus, a new approach to a federal takeover —but the same outcome. Moreover, because the new threats are more subtle and less explicit, those who sound the alarm are more likely to be ignored.

Making the Wrong Distinctions

Because of the fixation with any new program's impact on the federal budget, the temptation is to jump to the conclusion that the new "backdoor" NHI plans represent genuine concessions to austerity. In fact, however, what we are observing is not so much diminished aspirations as old ideas refashioned in ways that obscure their total costs—public and private, as line items in the federal budget, as rising employer-paid premiums, and as outlays from consumers' pockets. These plans involve no wholesale reformation or recantation on the part of longtime advocates of NHI. The costs of national health insurance have not shrunk; they have simply been hidden.

In addition to making the wrong distinction between the old and the new, there is a tendency to make the wrong distinction among the new plans. Public attention is focused too narrowly on differences in the initial benefits promised by the plans—differences that could and probably would disappear in time as any one of the plans expands to fill in gaps in coverage. The important differences, however, involve the plans' approaches to containing the increase in total outlays for health care, from all sources, that the new benefits would call for.

Comprehensive NHI plans would mandate coverage of everything down to relatively routine health-care services, whereas so-called catastrophic plans would cover major illnesses only. But because the price tags are stated in terms of the estimated total premiums for the coverage mandated, some of the plans seem much less expensive than others. The catastrophic plans—which would cover only annual outlays for health care beyond some stipulated amount, say $5,000—are depicted as "bargains" compared to the proposals that would provide more comprehensive coverage at perhaps three times the "cost." But the difference in cost largely reflects the distribution of outlays between insurance premiums and patient out-of-pocket payments. Clearly, somebody has to pay for health expenses, and the more the patient pays in the form of deductibles or copayments (that part of the cost not covered by the insurance policy), the smaller will be the premiums paid by the employer and/or the patient. Thus, initially, the differences among the plans come down not to differences in total cost but to who pays what part of that cost. In the long run, however, the more comprehensive plans would mean higher total spending because greater insurance coverage has been shown to inflate demand for health services.

Similarly, the budgeted *federal* cost of some NHI proposals far exceeds that of others because some plans broaden Medicaid coverage —where the government pays the tab—and some do not. Yet, for the vast majority of Americans, for whom the government's role in the various proposals is to set rules rather than pay the bills, the two kinds of proposals are virtually identical.

More Important Distinctions

Far more important in distinguishing the various NHI plans is their strategy for containing the cost increases that would be fueled by the mandated expansion in insurance coverage. Two fundamentally different strategies are used. One targets health-care providers and imposes direct controls on physician fees, hospi-

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tal revenues, and hospital capital expenditures. The other seeks to change the tax incentives related to the purchase of insurance and to increase competition among different insurance arrangements and health-care delivery mechanisms—in effect, financing added benefits by reducing "waste." What is involved here is a basic division of opinion among health-care experts regarding the nature of the market for medical services. Those who favor more regulation of providers stress inherent "market failure" in medical markets and believe that supply creates its own demand; the answer, then, is to control supply. Those who favor tax reform and incentives to induce consumers to shop for health insurance stress "regulatory failure" and argue that the alleged excess spending on health care is best contained by altering the system of signals to which providers, patients, and insurers all respond.

There is a dangerous allure, let us note at once, in a strategy of increasing health benefits while clamping down on fees, hospital charges, and hospital capital investment through regulatory spending limits. This may postpone or mask cost pressures for a time, so that the new benefits actually do seem to be "costless." The benefits are immediate and apparent while the costs are delayed and less discernible, a fact that the political process is tempted to ignore. Moreover, the initial appearance of favorable results weakens the pressure for more lasting solutions.

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These competing conceptual viewpoints translate into an array of national health insurance plans that can be grouped along a spectrum running from the command-and-control model to the carrot-and-stick model. (It should be noted that these proposals are all opening bids, subject to substantial revision as the legislative process unfolds.) The Kennedy-Waxman plan (S. 1720 and H.R. 5191), command-and-control in the extreme, would plunge the health-care industry into a labyrinth of new regulations that would ensure an outcome similar to one with federal regulators actually running the health-care system. At the other end of the spectrum are the tax incentive bills—Ullman (H.R. 5740), Martin (H.R. 6405), Durenberger (S. 1968), and Schweiker (S. 1590). Shunning the regulatory approach, they would attempt, instead, to improve incentives to economize on health spending (1) by imposing a limit on the tax-free premium that an employer could contribute to a health plan, (2) by requiring employers to offer a range of options, and (3) by allowing employees who selected a low-cost plan to reap the savings (or requiring those who selected a high-cost plan to pay the excess premium over a fixed employer contribution). Under prevalent circumstances today, employers either offer no choice of health plans or pay more on behalf of workers who select high-cost plans than on behalf of those choosing efficient plans. With insurers often reimbursing fully in both situations, providers have little incentive to be efficient.

President Carter's bill (S. 1812) and Senator Long's as well (S. 760) fall in the middle of the spectrum. Carter would rely on provider controls to a greater extent than would the tax incentive bills, but these controls would be far less restrictive, less comprehensive, and less detailed than those in the Kennedy-Waxman bill. Both Carter and Long would mandate the provision of insurance meeting federal standards.

When only the range of benefits is considered, the Kennedy-Waxman and Carter bills are quite similar. Though the first-year cost of Kennedy's plan ($40 billion) is higher than Carter's ($18 billion), because the latter phases in new benefits and beneficiaries, both would ultimately mandate universal comprehensive coverage that included inpatient hospital services, physicians' services in and out of hospitals, x-rays, lab tests, and some home health services. Both would improve coverage for Medicare and Medicaid recipients. Unlike Kennedy-Waxman, however, Carter would try to control costs by relying primarily on existing regulatory mechanisms, supplemented or reinforced by his proposed hospital cost-containment plan (which would strive to restrain the growth of hospital revenues according to a formula tied to inflation trends). The government would negotiate fees with physicians serv-

ing Medicare and Medicaid patients, but only the fees for those patients. Private insurance companies would have to certify that they were offering a package of health benefits consistent with those stipulated in the legislation but would not be subjected to intensive ongoing scrutiny.

Kennedy-Waxman: The Regulatory Approach

Three features of the Kennedy-Waxman plan make it more of a "command-and-control" scheme—a lot more—than any of the others. First, it is the only one that uses the device of "prospective budgeting" to limit total health-care expenditures. State-by-state expenditure ceilings would be far more comprehensive and restrictive than the controls in Carter's hospital cost-containment legislation. Carter would limit the growth in *hospital* revenues only, not total spending on health. Moreover, the caps he proposes are so riddled with triggers, exemptions, and exceptions as to have little bite. For example, labor costs, which account for about half of the typical hospital's total expenses, would in effect be exempt from the cost-containment cap.

Second, Kennedy-Waxman requires hospital charges and physicians' fees be negotiated —with no extra billing to patients—for *all* patients, not just for Medicare and Medicaid patients. And Kennedy-Waxman, unlike the Carter plan, provides for negotiated health insurance premiums, and the reallocation of premium revenues among groups of insurers called "consortia." Third, in addition to requiring that private insurance companies offer a qualified health plan that includes all covered health-care services, Kennedy-Waxman would force insurance companies to enroll individuals on a first-come, first-served basis (with the records of enrollees accessible to new regulatory entities). No other plan calls for ongoing federal regulation of insurance companies.

Boards, Commissions, Consortia, and Institutes

The primary new regulatory entity under Kennedy-Waxman would be a National Health Board, appointed by the President and given a broad mandate. While this board may create as many new commissions as it desires, it is *directed* to set up Commissions on Benefits, on Quality, on Access, on Health Care Organization, and on the Health of Americans.

Judging from the duties outlined for all these commissions, they would be involved up to their eyeballs in private-sector decision making. The Commission on Quality, for example, is directed to "examine the standards used with respect to the qualification and certification of participating providers . . . and recommend to the Board actions which should be taken to maintain and improve the quality of such services." Private insurance companies are required to sign a Participation Agreement with the board stipulating that they will accept for enrollment "all eligible individuals . . . in the order in which they apply for enrollment, up to the limits of its capacity and without restriction (except as may be authorized by regulation of the National Health Board)." The agreement also obligates commercial insurance companies, Blue Cross/Blue Shield plans, and health maintenance organizations (HMOs) to join consortia for their respective types of organization. The authority of these consortia, which are wedged between the insurance companies and providers on the one hand and the National Health Board on the other, is vague. The companies are "to comply with such rules as the consortium may establish consistent with this Act" and the agreements are to "provide for the collection of premiums and reallocation, in concert with the other consortia, of such premiums. . . ." What sort of reallocation system would the consortia develop? If government dictates the terms on which private insurance companies accept patients, along with the amount of the premiums they may retain, in what sense would we still have a private health insurance market?

By now, some glimmer of the elaborate network of agencies, procedures, and rules that would materialize under this legislation must be apparent. But this is not all. In addition to the commissions and consortia reporting to the National Health Board, the regulatory pyramid would include some special offices and institutes. Thus, the national board is to have an ombudsman to investigate complaints; an advocate to "assist consumers in determining their rights to services and reimbursements . . .

and [to] take such actions as may be appropriate to protect such rights"; and an Inspector General to audit the board's activities and ferret out fraud and abuse. The board is to establish a National Institute of Health Care Research composed of an Institute of Health Statistics, an Institute of Health Service Research, and an Institute of Health Technology Evaluation.

And still we are not finished! The National Health Board would spawn and charter fifty state health boards to hear complaints and appeals from consumers and providers regarding enrollment, benefit determinations, and certification. The state boards also would supervise periodic negotiations between participating providers and those who pay, directly or indirectly, for health services.

Up to now, the discussion has focused only on the single section of the Kennedy-Waxman bill entitled "Administration"—which, incidentally, accounts for just 37 of the 298 pages of this legislative behemoth. Other sections of the bill contain a comparable amount of detail and presage a corresponding expansion of the regulatory morass in which the health-care industry already is stuck. For example, under "Methods of Reimbursement of Providers" the secretary of labor is called on to hold hearings to ascertain whether the wage and fringe-benefit adjustments for health-care personnel contained in one of those prospective state budgets exceed prevailing compensation adjustments for similar occupations in the same locality, and to disallow excess reimbursements. Such determinations would require great effort and be subject to considerable dispute. In another section, entitled "National Formula for Updating Maximum Fee Schedules," the National Health Board is instructed to take five factors into account in setting fees—including "the increase of an index of the earnings of non-physicians" and "the increase in an index of the cost of operation of offices of the different types of providers." Imagine the wrangling over which index of earnings would be appropriate: the Bureau of Labor Statistics publishes several, each a little different from the others in the components of total compensation included or the amount of the work force covered.

Kennedy-Waxman, touted as a manifestation of the senator's conversion to the need to preserve and utilize the private health-care industry, is really a detailed blueprint for government control of that industry. It would not bring about an outright takeover, to be sure. But, in my opinion, it would crush the industry's vitality under the weight of new agencies, boards, commissions, consortia, and institutes. With all of these bodies undertaking studies, making determinations, and issuing regulations, and with advocates pushing (and ombudsmen mediating) consumer complaints in one forum after another, the director of the Institute of Health Statistics—who is blandly charged with "minimizing duplication in the data gathering activities of consortia, State and local governments, and the National Health Board"—would face a mind-bender of a task.

Supporters of Kennedy-Waxman may argue that this new regulatory structure would simply absorb some functions now lodged within the Department of Health, Education, and Welfare (HEW). But the bill involves more than a simple transfer of authority: in the process, the *scope* of this authority would be greatly broadened. Thus, while HEW may now have some leverage on doctors' fees in the narrow context of particular government programs (for example, Medicaid), the new plan would thrust HEW's surrogate—the National Health Board—into the middle of fee-setting for the entire nation. Neither the consumer nor the physician would have anywhere to go if he or she did not like the government-controlled system: *all* fees would be controlled. Moreover, federal regulation of applicant selection by the private insurance industry, far from being only a difference of degree, would launch the government into an entirely new regulatory arena.

This proposed legislation is the quintessential command-and-control approach. It would plunge federal officials deeply into day-to-day decisions on the appropriate level of doctors' fees, allowable hospital charges, and the right amount of hospital purchases of new equipment or additional beds.

Impact of the Kennedy-Waxman Bill

In spite of its elaborate web of new agencies, procedures, and controls, Kennedy-Waxman would be likely to fuel rather than dampen inflationary pressures in health-care markets and to have an adverse impact on the quality

of our health-care delivery system and the behavior of the players in that system. These effects would not take hold overnight; indeed, the short-term impact could appear to be the precise opposite.

For instance, in the short run, who besides doctors would oppose holding down doctors' fees? But what would happen over time as the government continued to "negotiate" physicians' fees? Would the government negotiate individually with the estimated 400,000 physicians in the United States? With the AMA? Of course not. Physicians would probably unionize to counterbalance the power of the government. And then, how would the American people react to the doctors in their area going on strike for higher salaries than those allowed under the prospective state budget? If fees in a state were too high, the budget's ceiling on total expenditures would force cuts in services; but if fees were too low, the best-trained physicians might boycott the state. Either way, the consumer would lose.

In fact, the very concept of these prospective budgets implies built-in tension between the remuneration of providers and the quantity and quality of health-care services. The greater the increase in doctors' fees or hospital charges permitted under a state's overall health-care budget, the lower would be the quantity (or quality) of those services that could be purchased by consumers. (If there were a prospective budget for autos sold in Kansas in 1980, in other words, and the price of autos rose after this budget had been set, the people in Kansas would have to buy fewer cars or substitute lower-priced for higher-priced cars.) While the immediate effect of imposing prospective budgets state-by-state would be to skew the geographic distribution of doctors away from low-ceiling states, the probable long-term effect would be to diminish the attraction of becoming a physician. Prospective budgeting could also have an adverse effect on insurance company offerings of health insurance and on both technological innovation and capacity in the hospital industry. In sum, rigid spending ceilings would make it more difficult to attract skilled resources to this industry.

Indeed, the problems with prospective budgeting are a microcosm of the problems of any attempt to halt economy-wide inflation through wage-price controls. Kennedy-Waxman would lead inexorably to the perennial drawbacks of price controls—deteriorating quality, distortions in consumer choices, and shortages of services. In the rush to expand health insurance coverage while holding down cost increases, the true total cost of health care would simply be disguised. Patients would still pay for the care they needed and wanted, but they would pay in the form of longer waiting times for services that would often fall below the standards they were used to, plus higher taxes and higher insurance premiums. Initially these premiums would be picked up largely by employers, but ultimately consumers would pay for more comprehensive coverage either through corresponding reductions in wage increases and fringe benefits or through the rise in inflation resulting from pass-throughs of premium increases into price increases. And the total expense would be greater because, as direct consumer outlays for health care continued to diminish, the incentive to economize on the use of health services—already quite weak—also would diminish.

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The heart of the matter is that the Kennedy-Waxman plan confuses budgeting and economizing. Economizing makes it possible to obtain the same quantities or qualities of services for *lower* total outlays. Budgeting makes it possible to achieve lower outlays, but not without some sacrifice in quantity or quality. We as a society can set any budget we want for health-care *spending*, and we can even make it stick if the controls are tight enough. But we will not necessarily be better off with lower dollar outlays and inferior services than with higher outlays and better services.

The problem with the "immediate benefits, delayed cost" approach is, of course, not limited to national health insurance. The search for a quick fix for inflation leads us to adopt policies characterized by fast but illusory improvement in our economic health coupled with

a latency period during which cost pressures build gradually, almost imperceptibly, and inexorably. We end up more sickly than we were before taking the "cure." Controls—on the overall economy or just on health spending—seem to provide a license to offer benefits (whether reduced unemployment in the case of price controls or better health insurance in the case of prospective budgets) that we otherwise would think we could not afford. Controls tempt us to stimulate demand as if indeed there were "no tomorrow."

Overemphasizing the Differences

Although it is important to distinguish among the various NHI proposals, particularly in terms of alternative strategies for financing new benefits, there is a risk in overemphasizing the distinctions. All of the major proposals call for a universal minimum set of health benefits. While the tax incentive bills would *encourage* rather than *mandate* such a package, note that the encouragement takes the form of tying the current tax status of employer contributions for health insurance to compliance with the legislation. Because the value of the exclusion of these employer contributions from employees' taxable income is substantial—currently about $9.6 billion a year—"mandatory/nonmandatory" may be a distinction without a difference. It is only fair to note also that while Kennedy-Waxman seems more complex than the other bills, this may be in part because it spells out details that the others leave vague. Any one of the alternatives, should it become law, could turn out to involve nearly as much government intervention in health-care markets.

Similarly, any difference between the catastrophic and comprehensive NHI proposals might prove to be temporary. Even a trimmed-down version of NHI (characterized by a high degree of consumer cost sharing) would be likely, once enacted, to bloom into a comprehensive program. As time passed, individual cases where deductibles or copayments had led a particular family to financial ruin would inevitably be cited as evidence of the need to lower the proportion of cost sharing for which patients were responsible. The butterfly of full-scale national health insurance could emerge from the cocoon of a catastrophic illness program.

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Even so, the differences among these bills are not entirely illusory. By altering the system of signals to which providers, insurers, and consumers respond, the tax incentives bills have a realistic chance of slowing the increase in health-care costs. At least, this approach recognizes that the major reason for the increase is the growth of insurance and the lack of incentives to select a low-cost insurance plan. Moreover, these bills would economize not simply by fostering consumer cost sharing, but primarily by stimulating competition among alternative health-care plans—and delivery systems—so as to hold down the cost level itself, irrespective of how that cost is shared between workers and firms. Finally, with the tax-incentive approach, it would be *in the interest of providers* to hold down costs (for example, by avoiding unnecessary testing and unnecessary hospitalization of patients) because people who chose such providers would reap the savings, while those who chose inefficient providers would pay the cost. The incentives approach is preferable to one that tries to wring the waste out of the system through *controlling providers'* fees and charges —but leaves the forces driving costs upward largely intact.

The Fundamental Decision

The inevitable result of overemphasizing the fine distinctions among the current NHI proposals is that too little attention is given the main issue: Is national health insurance needed *at all*? The problem with the current debate is that the spectrum of options is too narrow. We should be looking also at plans that abjure universal mandated minimum coverage—plans

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who value trial experience. Such cases lessen (if only temporarily) the dissatisfaction among attorneys who are assigned to the large, structural investigations that involve years and years of effort.

While the FTC has demonstrated its commitment to undertake large cases, it is clear, Katzmann states, that merely allocating resources to such cases does not ensure their successful prosecution. Complex structural matters require lawyers who are not only highly skillful in the law but also familiar with industrial organization—a combination that comes only with long experience. If the mammoth structural cases are to be pursued efficiently, then years of coordinated activity by a cohesive and experienced team of attorneys is demanded. The high turnover rate among FTC lawyers, lured away by the higher salaries offered in the private sector, makes prosecution of such cases especially difficult. By the time the matter reaches trial (if it does at all), the original team of attorneys (and most probably several later teams) will almost certainly have left the agency.

Katzmann disputes the twin claims that governmental decisions simply reflect the desires of agency officials to maximize their budgets, power, or convenience and that government necessarily serves the economic interest it is supposed to regulate. In his view, the FTC's behavior is not simply that of a rational, self-interested actor. Rather, the commission has struggled in the last several years to pursue actions that it perceives to be in the public interest, although it has not always been certain as to which policy course would serve that interest.

The author also discusses the commission form of governance as well as proposals for upgrading the quality of antitrust enforcement —for example, procedural reform, contracting for services from the private bar, rulemaking, the Trade Court, and shifting the FTC's antitrust duties to the Department of Justice's Antitrust Division. He argues that the latter course would not solve the difficulties involved in prosecuting the "big" case. Finally, the book assesses whether legal processes are always fit to resolve complex economic questions and examines the role of the FTC as a protector of competition.

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that would assist those who fall between the cracks of current public programs and the private insurance market and yet preserve the basic elements of our health-care system as it now exists.

The difficulty with bills like Kennedy-Waxman is not that they would improve coverage for the disadvantaged, but that they also would stifle competition in the health insurance market. Indeed, competition in this market needs *encouragement*, and the tax-incentive proposals represent a step in the right direction. But the tendency of advocates of this approach to couple it with a universal standard health package reduces the potential for moderating cost increases. While the tax incentives might induce consumers to shop for the mix of premiums, risk, and copayments that suits their preferences, the more comprehensive the accompanying universal "floor" on covered benefits, the less meaningful the consumers' actual choice. The initial benefit package might indeed represent minimum coverage that no one should be without; once the principle of a minimum is established, however, it would be easy to enrich the package regularly—and the march toward comprehensive national health insurance would surely proceed.

Whether we want to make comprehensive health coverage available to everyone in the United States is obviously a momentous policy question, and I do not seek to answer it here. What I criticize in both Kennedy-Waxman and Carter is the insistence—indeed, the fiction—that we can avoid the long-term inflationary impact of such a policy by imposing strict provider controls. This promise is misleading. If we are going to make these improvements in insurance coverage, we are going to have to pay for them. An elaborate system of provider controls may make it possible to mask this cost or temporarily divert some of it from a monetary to a nonmonetary form; but it cannot make the cost go away. And in addressing the problem of the health insurance "have nots," we must recognize the potential of all these current proposals, good intentions notwithstanding, for altering the basic character of a health-care system that, on the whole, gives American consumers what they want. ■