PART III

REGULATING THE COST-PLUS SYSTEM

10. Increasing Government Control over the Price and Quality of Medical Care

The American health care system is a cost-plus system in its cost-control stage of evolution. In this second stage, many different third-party paying institutions are engaged in a bureaucratic struggle to resist the cost-plus push of the medical care providers and to reduce their shares of the total cost. Each third-party institution is free to initiate its own cost-control strategy. But because the basic structure of cost-plus finance has not been changed, Stage II is primarily about cost shifting.

The central focus of third-party paying institutions is to eliminate waste, but they usually cannot eliminate waste without causing harm to patients. On the supply side of the medical marketplace, institutions have great resources and considerable experience at resisting change. So, in the face of a cost-control measure initiated by one institutional buyer, the suppliers attempt to shift costs to another without changing their fundamental behavior. Thus, costs are not really controlled. Although ultimately the techniques adopted in Stage II do not hold down costs, their adoption and implementation affect the quality of care that patients receive. This chapter takes a closer look at how and why that happens.

The Legacy of Cost-Plus Medicine

In a pure cost-plus system, it is inevitable that there will be unnecessary surgery, unnecessary hospitalization, and many tests and procedures that are not cost-effective. How much waste is there in the U.S. health care system? Joseph Califano, a former secretary of the U.S. Department of Health, Education, and Welfare, estimates that one out of every four dollars spent is wasteful and unnecessary.[1] If true, that would mean that we are wasting about

[1]Joseph A. Califano, Jr., *America's Health Care Revolution: Who Lives? Who Dies? Who Pays?* (New York: Random House, 1986).

3 percent of our gross national product (GNP)—an amount equal to about $700 for every man, woman, and child in the country. No one knows for sure how much waste there is, but in the cost-plus system waste grows; it does not diminish.

Rising Health Care Costs

Despite the fact that a Stage I cost-plus system was in place from the late 1940s, increases in spending on health care were surprisingly moderate until government became a major buyer of health care. Although health care spending as a percent of GNP rose throughout the 1950s, it did so gradually and was never above 6 percent until the 1960s. Over the last three decades, however, there has been a continuous, almost unbroken increase in the percent of GNP devoted to health care. That figure is now approaching 13 percent—higher than for any other nation in the world—and is expected to reach 15 percent in 1995 and 17.3 percent by the year 2000.[2]

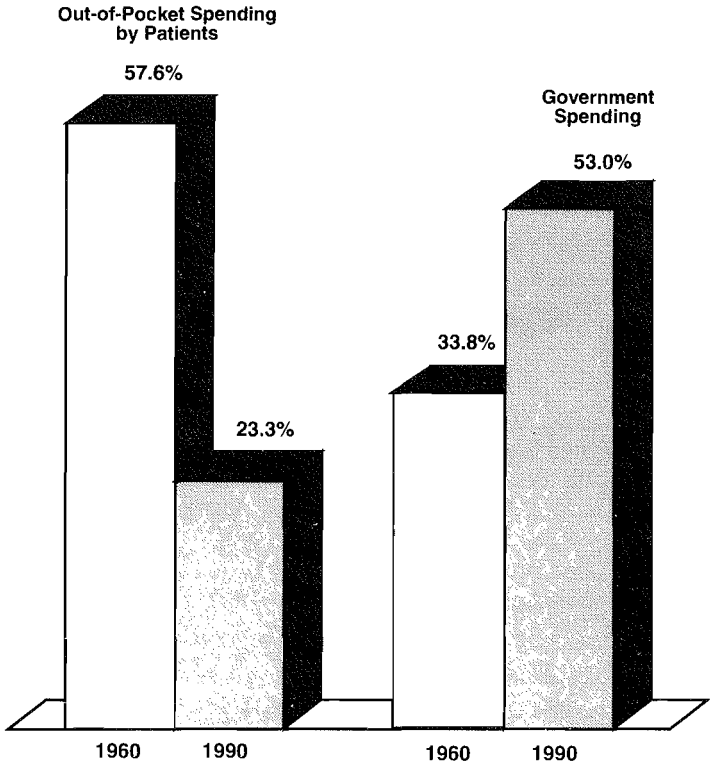
What happened? As Figure 10.1 shows, the single most important change in health care in the past 30 years has been the role of government. In 1960, most medical bills were still paid by patients out-of-pocket, and government spending on health care was only 33.8 percent of the total. Once government began to intervene in a major way, however, health care spending began to explode.

As Figure 10.2 shows, when tax subsidies for health insurance are included, government is now responsible for more than half of the nation's health care spending. By contrast, patient out-of-pocket spending now accounts for only one-fifth of the total.[3] One consequence of greater government intervention is that as public money was added to private money, more dollars were chasing limited quantities of medical goods and services. The result was medical inflation. The evidence indicates that, on the average, prior to the federal government's entry into the medical marketplace in the mid-1960s, each additional dollar of health care spending bought

[2]Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates; and Lynn Wagner, "Healthcare Spending Up Sharply," *Modern Healthcare*, April 29, 1991, p. 4.

[3]Note that Figures 10.1 and 10.2 employ two different measurements. Figure 10.2 is based on total health care spending, whereas Figure 10.1 is based on personal health care spending, which excludes research, hospital construction, and public health programs.

Figure 10.1
SHARE OF TOTAL HEALTH CARE SPENDING, 1960 AND 1990*



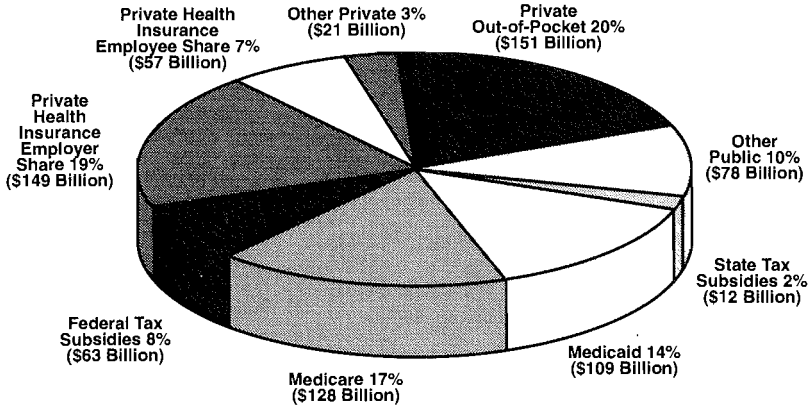
SOURCE: Gary Robbins and Aldona Robbins, Fiscal Associates.

*Personal health care spending. Note: The totals treat tax subsidies as government spending.

50 cents of goods and services, while the remaining 50 cents was consumed by inflation. After the federal government emerged as a major buyer, things got worse. Since 1965, about 67 cents of each additional dollar of spending has been consumed by inflation.[4]

[4]Estimate of Gary Robbins and Aldona Robbins, Fiscal Associates, for the National Center for Policy Analysis. Note that this estimate is similar to others. The Health Care Financing Administration estimates that since the introduction of Medicare and Medicaid, 65 cents of each additional dollar of spending has been consumed by inflation.

Figure 10.2
SOURCES OF FINANCING FOR U.S. HEALTH CARE, 1992



SOURCE: C. Eugene Steuerle, "Finance-Based Reform: The Search for an Adaptable Health Policy," paper presented at an American Enterprise Institute conference, "American Health Policy" (Washington, October 3–4, 1991).

Increasing Government Spending

The largest single buyer of health care in the United States is Uncle Sam. The federal government, through Medicare and Medicaid programs, has added to the cost-plus pressures of the U.S. health care system and driven health care costs much higher than they would have been otherwise. As Table 10.1 shows, health care spending by the federal government has been growing at a much faster rate than health care spending for the nation as a whole. From about 19 percent of total personal health care spending in 1970, for example, Medicare and Medicaid outlays grew to almost 30 percent in 1989.

Medicare is primarily designed to pay the acute (short-term) medical bills of the elderly. Although Medicaid is a health care program for the poor, the elderly consume a disproportionate and growing proportion of Medicaid dollars. That is partly because Medicaid pays for chronic (long-term) care, including some nonmedical expenses. When the market value of in-kind benefits (such as government-provided housing, food stamps, and medical care) is included in family income, the poverty rate among the elderly is

Table 10.1
MEDICARE AND MEDICAID SPENDING, 1970 TO 1989

	1970	1975	1980	1985	1987	1988	1989
Percent of total spending on personal health care	18.9%	24.5%	28.1%	29.9%	29.9%	29.7%	30.0%
Percent of total spending on hospital care	26.9	30.7	35.2	38.1	37.4	37.8	36.5
Percent of total spending on physician care	16.4	21.7	24.1	26.3	27.3	27.2	27.0
Percent of total spending on nursing home care	33.0	50.4	50.7	46.3	46.8	46.3	50.6

SOURCES: Health Care Financing Administration, *Health Care Financing Review* 8, no. 1 (1986); ibid. 11, no. 4 (Summer 1990); and ibid. 12, no. 2 (Winter 1990).

only 2.9 percent, the lowest for any population group.[5] Despite this fact, the elderly constitute 16 percent of all Medicaid beneficiaries and account for about 36 percent of all Medicaid spending.[6]

Medicare and Medicaid combined cost about $237 billion a year. They consume more than one out of every ten dollars spent by the federal government and represent about 25 percent of all income transfer payments. Despite the tremendous growth in these two programs, though, the elderly spend a larger proportion of their budgets on health care today than ever before. In the years 1960–61 (prior to Medicare), those over age 65 spent an average of 10.9 percent of their annual income on medical care; by 1980–86, that figure had jumped to 12.05 percent.[7] Medicare has not replaced private health care spending by the elderly. Rather, it has induced elderly families to spend even more.

How Regulated Is the Medical Marketplace?

In terms of rules, restrictions, and bureaucratic reporting requirements, the health care sector is one of the most regulated industries in our economy. Consider Scripps Memorial Hospital, a medium-sized (250-bed) acute care facility in San Diego, California. As Table 10.2 shows, Scripps must answer to 39 governmental bodies and 7 nongovernmental bodies, and must periodically file 65 different reports, about one report for every four beds. In most cases, the reports required are not simple forms that can be completed by a clerk. Often, they are lengthy and complicated, requiring the daily recording of information by highly trained hospital personnel. Regulatory requirements intrude in a highly visible way on the activities of the medical staff and affect virtually every aspect of medical practice.

Another California hospital, Sequoia Hospital in the San Francisco Bay area, has attempted to calculate how many additional employees are required as a result of government regulations. As Table 10.3 shows, Sequoia's staff increased by 163.6 percent between 1966 and 1990, even though the average number of

[5]Data are for 1985. See U.S. Bureau of the Census, *Statistical Abstract of the United States: 1987* (Washington: U.S. Government Printing Office, 1986), p. 446.

[6]Health Care Financing Administration.

[7]Bureau of Labor Statistics, Office of Prices and Living Conditions.

Table 10.2
REPORTS MADE TO REGULATORY AGENCIES BY SCRIPPS MEMORIAL HOSPITAL, SAN DIEGO, 1989

Agency	Number of Hospital Departments Reporting
Government	
Joint Commission of Accreditation of Hospitals	11
Occupational Safety and Health Administration	5
San Diego County Health Department	1
State Board of Equalization (hazardous waste tax return)	1
Internal Revenue Service	2
Franchise Tax Board	1
Secretary of State	1
Medicare	2
State Board of Equalization (sales tax return)	2
California Hospital Facilities Commission	1
State Board of Health	1
Environmental Protection Agency	1
Department of Transportation	1
Department of Health Services	1
Air Resources Board	1
Office of Emergency Services	1
Health and Welfare Agency	1
Air Pollution Control/Air Quality Management District	1
Regional Water Quality Control Board	1
Local Sewering Agencies	1
Local Fire Department	1
San Diego Department of Health Services	1
State Licensing Board	1
Board of Registered Nursing	2
Licensed Vocational Nursing Board	1
U.S. Department of Labor	1

(Continued on next page)

Table 10.2—Continued
REPORTS MADE TO REGULATORY AGENCIES BY SCRIPPS MEMORIAL HOSPITAL, SAN DIEGO, 1989

Agency	Number of Hospital Departments Reporting
Industrial Welfare Commission	1
Fair Employment Practice Commission	1
National Labor Relations Board	1
Immigration and Naturalization Service	1
Employment Development Department	1
Social Security Administration	1
Employee Retirement Income Security requirements	1
State Board of Pharmacy	1
Drug Enforcement Agency	1
Food and Drug Administration	1
Bureau of Narcotic Enforcement	1
California Department of Health, Radiologic Health Branch	1
Nongovernment	
American Hospital Association	2
American Conference of Governmental Industrial Hygienists	1
California Medical Association	1
Radiation Safety Organization (Syncor, Inc.)	1
National Association of Social Workers	1
American College of Surgeons	1
San Diego and Imperial Counties Organization for Cancer Control	1

SOURCE: National Center for Policy Analysis.

patients per day (250) did not change. Sequoia estimates the cost of regulations is about $7.8 million per year.[8]

In 1976, in another attempt to calculate the costs of regulation, the Hospital Association of New York State studied 148 acute care

[8]*Medical Benefits* 7, no. 15 (August 15, 1990): 1.

Table 10.3
EFFECT OF GOVERNMENT REGULATION ON SEQUOIA HOSPITAL, SAN FRANCISCO, 1966 TO 1990

Size of Staff	1966	1990
Business office and accounting	26	70
Admitting and outpatient registration	13	18
Utilization review	0	10
Social services	0	9
Medical records	17	41
Quality assurance	0	5
Data processing	0	9
Medical staff office	0	4
Administration	4	9
Nurses	374	533
Maintenance	16	28
Total	450	736

SOURCE: *Wall Street Journal*. Reprinted in *Medical Benefits* 7, no. 15 (August 15, 1990): 1.

hospitals governed by 164 different regulatory agencies. Admittedly, the method of study was not entirely objective. Hospital personnel were asked to engage in a self-evaluation of the burdens of regulation, which is a bit like asking victims to assess their suffering. Still, the study is one of the most comprehensive ever undertaken, and its results indicate the magnitude of regulatory burdens. According to the study, 25 percent of hospital costs—or $1.1 billion (in 1976 dollars)—were attributable to government regulatory requirements. About 115 million staff-hours per year were needed to meet the regulatory requirements, the equivalent to having more than 56,000 hospital employees work full-time on regulatory matters. Without such regulatory burdens, enough time would have been made available to staff 75 hospitals and thereby provide medical services for about 600,000 patients.[9]

The New York study was conducted at a time when the system of health care finance was in its pure cost-plus stage. Today, things are much worse. A new form of regulation has been added—one

[9]Hospital Association of New York State, *Cost of Regulation: Report of the Task Force on Regulation* (Albany, 1978), p. 2.

that is much more subtle, but with far more impact on the practice of medicine: government control over hospital revenues. Before looking at how those controls are established and enforced, however, it's useful to look more closely at the effect of regulatory controls on physicians.

What Increasing Regulation Means for Physicians

Most people have traditionally viewed medicine as an attractive profession, one that almost always leads to a high income and a comfortable lifestyle. But a 1989 Gallup poll revealed that 40 percent of physicians now say they would not, or probably would not, go to medical school if they had to do it all over again.[10]

Applications to medical schools reveal a similar trend. Although 35,944 students applied to medical school in 1985, that number dropped to 26,915 in 1989, reflecting a downward trend that has been under way since the mid-1970s (see Figure 10.3). There has been a 50 percent drop in the number of male applicants since the mid-1970s, and white males made up less than half of the 1989–90 freshman medical class. Medical schools are accepting a much larger percent of those who do apply and some are even recruiting applicants through advertisements in student newspapers. Although the schools won't admit it, the suspicion is that medical schools are no longer getting the same quality of student they used to get.[11]

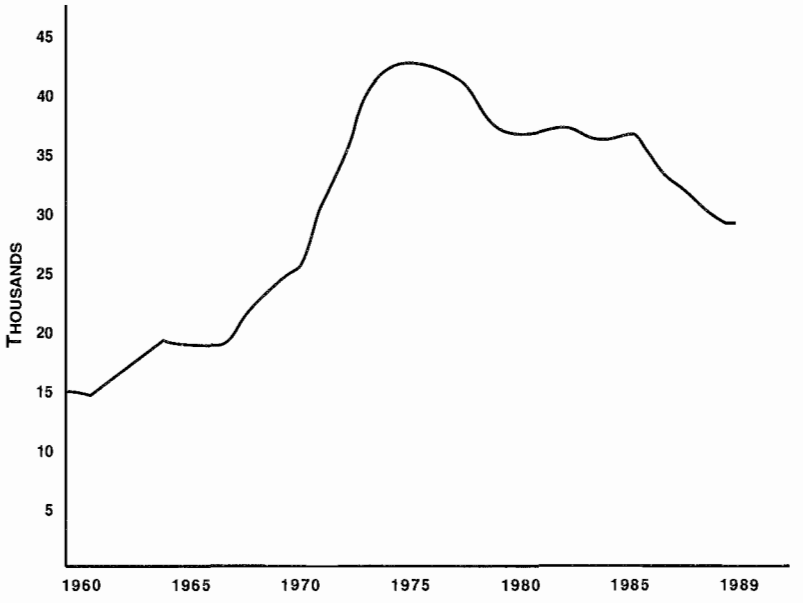
The feeling that something is going wrong is also expressed by patients. A 1989 Gallup poll of patient attitudes revealed that less than one-third felt that doctors spend enough time with them and less than half thought that "doctors usually explain things well to their patients." The public attitude about what motivates physicians has also taken a turn for the worse. According to Gallup, 57 percent of the people think that "doctors don't care about people as much as they used to" and 67 percent think "doctors are too interested in making money."[12]

[10]Reported in Lisa Belkin, "Many in Medicine Are Calling Rules a Professional Malaise," *New York Times*, February 19, 1990.

[11]Lawrence K. Altman and Elizabeth Rosenthal, "Changes in Medicine Bring Pain to the Healing Profession," *New York Times*, February 18, 1990.

[12]Reported in Gina Kolata, "Wariness Is Replacing Trust between Healer and Patient," *New York Times*, February 20, 1990.

Figure 10.3
NUMBER OF MEDICAL SCHOOL APPLICANTS, 1960 TO 1989



SOURCE: Association of American Medical Colleges. Graph reproduced from *The Trauma of Transformation in the 1990s: An Environmental Assessment of U.S. Health Care* (Minneapolis: Health One, 1989), p. 53.

So what's going wrong? Clearly a lot of it has to do with the way in which government and other third-party payers are changing the doctor-patient relationship. Among doctors who said they would not, or probably would not, go to medical school if they were in college today, the most commonly given reason (27 percent) was government and insurance regulations that "interfere with doing my job" and cause a "lack of autonomy." Doctors claim they are overwhelmed by paperwork and prohibited from delivering needed medical services by third-party payers. Of the physicians polled by Gallup in 1989, 63 percent—up from 54 percent in 1987—said they had less control over patient treatment decisions than a few years earlier.[13]

[13]Ibid.

Ironically, both doctors and patients accuse each other of being too commercial. Whereas patients say that physicians are too interested in making money, physicians complain that patients view medical care as just one more commodity. Buying medical care is like "going out and buying a new or used car," complained one physician. "Patients look at finding a doctor like they look at finding an automobile repair shop," said another.[14] But much less money is exchanged between patient and doctor than ever before. More than 80 percent of physicians' fees are paid by third parties.

If less money is changing hands, what is causing the deterioration in the doctor-patient relationship? The one thing that has changed radically in recent years is third-party regulation of the practice of medicine. The medical marketplace is becoming more impersonal and more bureaucratic because bureaucrats are increasingly making the decisions. Consider some examples:

In one case, a Tennessee physician performed emergency surgery on a young boy with heavy intestinal bleeding. But because the doctor did not obtain telephone approval prior to the operation, Medicaid refused to pay his fee. In another case, a Connecticut doctor admitted an elderly man to the hospital with a broken hip. The patient suffered numerous complications, including pneumonia and an instance of cardiac arrest, and his doctor visited him every day during his three-month hospital stay. But Medicare refused to pay for the daily visits, claiming that level of care and attention was unnecessary. The doctor can challenge Medicare's funding, but that would require his spending hours reviewing medical records and preparing detailed documents.[15]

Physicians also complain about HMO rules and restrictions. According to a female physician who had worked at several HMOs, administrators tried to intimidate doctors by regularly issuing lists comparing physicians in terms of time spent with patients, number of medications prescribed, number of lab tests, and number of x-rays ordered. The not-so-subtle message was that doctors who were high on the list were draining HMO resources. In other cases, the pressure to spend less time with patients was verbal and direct.

[14]Ibid.

[15]Belkin.

The physician left HMO practice after one administrator went so far as to schedule her restroom breaks.

Throughout the early part of this century, physician organizations struggled against the "corporate practice of medicine," under which doctors were employed by nonphysicians who could interfere with the practice of medicine.[16] The battle is being lost now, with very little protest. Although many older physicians are still self-employed, more than half of all physicians today are salaried employees, as are more than 60 percent of physicians under the age of 35.[17]

Of 200 health care careers listed by the American Hospital Association, more than one-fourth are administrative. According to the *Journal of Internal Medicine,* between 1970 and 1986, the number of health administrators increased fourfold, while the number of physicians increased by half. Increasingly, nonphysicians are telling physicians what to do.[18]

Not all of the changes are bad. Even though physicians complain about advertising, some changes seem to require it. For example, two New Jersey physicians now offer a package price for hernia operations, much as cosmetic surgeons offer a package price for cosmetic surgery. To solicit business they encourage potential patients to call 1-800-HERNIA.[19] The method may be distasteful to some, but the hospital marketplace desperately needs package prices for surgery.

Even without the growth of third-party intervention, market-based institutions surely would have evolved to solve problems. Some physicians do abuse patients and payers by overbilling. A smaller number do practice bad medicine. The federal government's solution is to publish the names of physicians who have been disciplined and of hospitals with abnormally high mortality rates.[20] This sledgehammer approach can unfairly damage reputations without even basic due process protections. Market-based

[16]Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

[17]Altman and Rosenthal.

[18]Belkin.

[19]Altman and Rosenthal.

[20]The federal government is compiling the National Practitioner Data Bank, more popularly known as "Docs in a Box," which will record the names of physicians who have been disciplined by hospitals, state medical boards, and professional societies. The data bank will also list physicians who have settled malpractice suits,

institutions might have found better ways of dealing with such problems.

If patients controlled their health care dollars and were more involved in medical decisions, there would undoubtedly be fewer instances of overbilling and unnecessary procedures. In fact, many problems arise precisely because third parties are paying the bills. When third-party payers attempt to establish price controls, physicians respond through "creative billing," often with the assistance of their patients.[21] When the cost to the patient is zero, patients frequently find ways of getting insurers to pay for extra tests and procedures, often with the help of their physicians. Under third-party payment, the self-interests of physicians and patients are automatically at odds with the self-interests of those who pay the bills.

More fundamentally, institutions that would evolve to solve problems in a market-based system would meet the needs of patients and doctors. By contrast, institutions that evolve to solve problems in a cost-plus system are responsive to third-party payers.

How the Cost-Plus Mentality Approaches the Problem of Waste

Clearly there are problems in the medical marketplace. Given the way we pay for health care and the structure of the cost-plus system, it is hard to imagine how there could not be problems. Most people who are confronted with the structure of these problems quickly identify the system of health care finance as the major culprit. If prospective bypass surgery patients were about to spend $25,000 of their own money, they would exercise far more care in making the decision than when spending Medicare's money. If physicians were primarily dealing with patients spending their own money, they would have stronger incentives to communicate the risks and

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which is very controversial since physicians may settle suits even when they have done nothing wrong. See Philip J. Hilts, "Oversight, Phase I: Keeping Records of Doctors with Records," *New York Times*, September 9, 1990. The government's current plans are to release the information only to hospitals and official regulatory bodies. However, the left-wing Public Citizen Research Group claims to have a national list of doctors who have been disciplined and is making the list available to the public. See *Medical Benefits* 7, no. 15 (August 15, 1990): 11.

[21]Some third-party payer organizations estimate that about 40 percent of physicians now engage in creative billing practices. See *Medical Benefits* 7, no. 16 (August 30, 1990): 11.

probable benefits of the patient's treatment. Moreover, if the medical marketplace were allowed to function as other markets do, there would be no reason to suppose that all people would make the same choices. From our observation of other human activities, we know that there are radical differences in attitudes toward risk among people who are otherwise similarly situated. Given that a great many choices in the medical marketplace involve risk, we would expect to see wide differences in choices—even among fully informed consumers.

In the case of diagnostic tests performed on blood, for example we know that as many as 900 tests can now be performed. If we consult the medical literature, we find considerable advice on which tests are appropriate in which circumstances. But there is no reason to suppose that fully informed consumers would make identical choices. To the contrary, their choices with regard to blood tests likely would vary as much as consumer choices in the markets for other goods and services. Risk takers would probably forgo all blood tests. Hypochondriacs might opt for all 900. The rest of the population would be distributed between these extremes.

That is not the way the cost-plus mentality views the world, however. As the cost-plus system evolved into its cost-control phase in the 1980s, the new industry buzzwords became "cost-benefit," "cost-effective," and "medical outcomes research." The idea was to evaluate alternatives by applying the well-regarded standards developed by economists.

In the literature of economics, "cost-benefit analysis" has a fairly precise meaning. Such analysis is always based on the preferences of individuals. Once the concept made its way into the medical literature, however, it acquired a completely different meaning. In the 1980s, the terms "cost-benefit" and "cost-effective" appeared with increasing frequency on the pages of the prestigious *New England Journal of Medicine.* In the hands of the cost-plus research establishment, however, cost-benefit analysis is a technical concept, devoid of any relationship to individuals' values and preferences.

Applying Cost-Benefit Analysis to the Practice of Medicine

In the hands of the professional economists who developed it, cost-benefit analysis has sensible things to say about the medical marketplace. For example, surgery is wasteful if a fully informed

consumer would rather have the money than the surgery. It is not wasteful if the patient prefers it. So, given the choice between $25,000 in cash or a $25,000 bypass operation, the operation is "cost-effective" if the patient chooses surgery instead of money. Similarly, if a fully informed consumer is given choices between having up to 900 different blood tests and taking the costs of the blood tests in the form of cash, then the cost-effective number of tests is the number the consumer chooses. This type of cost-benefit analysis makes sense unless one believes that people should be systematically denied what they want.

In the hands of the cost-plus bureaucracy, however, cost-benefit analysis has no relationship whatever to consumer choices. Applying their technocratic tools of trade, medical researchers seek to establish the "right" number of blood tests for everyone, regardless of preference. Similarly, they seek the objective conditions under which all patients should or should not have surgery, irrespective of what individual patients want.

Using Cost-Benefit Analysis to Regulate Medical Providers

In a normal marketplace, waste tends to be eliminated as people pursue their self-interest. People do not systematically spend money on things that are less valuable than other things the same money could buy. Although consumers make mistakes, they have incentives to avoid recurrent mistakes and to patronize sellers who help them to do so. The cost-plus mentality, however, does not believe that a real medical marketplace is necessary, or even desirable, and it attempts to force providers to abide by the results of technocratic cost-benefit analysis.

In its cost-control phase, then, cost-plus is a system in which medical providers face perverse incentives and third-party payers try to keep them from acting on those incentives. Third-party bureaucracies make this bad situation worse by using an approach that is totally foreign to how physicians think, what medical schools teach, and how traditional hospitals are managed. As a nation, we spent 40 years eradicating virtually every aspect of individualized cost-benefit thinking from the medical marketplace—only to reach a point at which the bureaucratized cost-benefit standard is being used to second-guess every decision medical providers make. That is why many of the cost-containment strategies of the 1980s (discussed in chapter 7) failed to work. Both private industry and

government tried to use bureaucratic rule making to repress perverse incentives rather than remove them.

Cost-benefit analysis in its sensible form (the form developed by economists) is not alien to the thinking of most physicians. They understand the concept of satisfying patient preferences. The technocratic use of cost-benefit analysis is wholly different. Not only do physicians fail to understand it, but they perceive that its misuse by third-party payers frequently conflicts with patient preferences and quality care.

The problem is significantly more dangerous when it is viewed from the perspective of the medical profession as a whole. Cost-benefit analysis is currently being used in a massive federal program to reorganize the science, as well as the practice, of medicine. This program is being conducted under the guise of "outcomes research" and the development of "practice guidelines." But its true objective is to completely define, systematize, and pass judgment on all medical knowledge. Its proponents advertise that it will review alternative treatments and see what works, what does not work, and what is cost-effective. This goal may seem sensible and consistent with the fundamental responsibility of medical research and medical education. But how long will it take for a politician to ask, "Why does Medicaid pay for something that is not cost-effective?" The end result may be that physicians will have only one way to handle every problem—the government's way.

The government does not define "cost-effective" meals for the restaurant industry or "cost-effective" designs and materials for the construction industry. But the government is taking on that task for medicine. The program will either be a multibillion-dollar blunder or it will make medicine in America even more regimented than it is in countries where it is socialized.

Regulation of Hospital Prices

In the summer of 1985, 85-year-old Leon Alger spent 19 days in a Houston hospital being treated for cerebral-spinal inflammation. On leaving the hospital, Alger was handed a 32-page bill totaling $45,797.63. Because he was a Medicare patient, Alger's share of the bill was only $257. But, furious at some of the items on the bill, he wrote to Houston newspapers complaining that neither Medicare nor anyone else should be paying the prices he saw. For example,

Alger's bill listed a daily charge of $180 for oxygen. But he happened to know that a large oxygen tank, lasting a full day, could be filled for as little as $3.80.[22]

What Alger did not know was that the bill he saw is not the bill the hospital would present to Medicare. Whether under the old system of reimbursement or the new, Medicare has never paid hospitals according to the prices they charge for services. Under the old, cost-based reimbursement, Medicare paid hospitals according to their costs, as did Blue Cross and most other private insurers. As a result, until recently about 90 percent of all hospital revenues consisted of reimbursements for hospital costs.[23]

In 1983, the federal government changed the way in which hospitals are reimbursed under Medicare. Under the new system, hospitals are paid a fixed sum for each of 492 categories[24] of illness called diagnosis-related groups (DRGs). In principle, the revenues that hospitals receive under the system are unrelated to the cost of treating any particular patient. Thus, if the hospital keeps its costs below the DRG reimbursement price, it makes a profit; if not, it suffers a loss. Take the case of Leon Alger's 32-page hospital bill. Although the total was $45,797.63, Medicare's DRG price was only $8,740. Add to that the $257 paid by Alger, and the hospital faced a shortfall of about $36,800.

On the surface, the DRG system has certain attractive features. Instead of reimbursing hospitals for waste and inefficiency, the federal government has limited its exposure; it pays a fixed fee and lets hospitals sink or swim. The system leaves certain important questions unanswered, however. If Medicare does not pay the hospital's $36,800 loss, who does? And if no one pays for it, what are the implications for future health care delivery in the United States?

[22]Janet Elliott, "Fees for Care Called Exorbitant," *Houston Post*, July 7, 1985.

[23]For a general description of cost-plus reimbursement and the difference it makes, see John C. Goodman and Gerald L. Musgrave, *The Changing Market for Health Insurance: Opting Out of the Cost-Plus System*, NCPA Policy Report no. 118 (Dallas: National Center for Policy Analysis, September 25, 1985), pp. 1–26. For an analysis of the specific reimbursement formulas, see Sylvia A. Law, *Blue Cross: What Went Wrong?* (New Haven: Yale University Press, 1973), pp. 59–114.

[24]Initially, 467 categories were established. "Report and Recommendations to the Congress," Prospective Payment Assessment Commission (Washington, DC, March 1, 1992), Appendix E, pp. 115–30.

Price Fixing

The DRG system was seen by many as an attempt by the federal government to opt out of the cost-plus system of health care finance. Some even argued that the DRG system is a market-based approach to health care. Now that the system has been in operation for several years, fewer people hold those views. Although the DRG system creates financial incentives to reduce costs, it is not structured so that government is simply one more buyer in a competitive market. Instead, it is a price-fixing scheme in which the government establishes an artificial market.

Establishing an artificial market creates perverse incentives for providers, leading to adverse health effects for patients and possibly to greater health care costs. At the most basic level, two mistakes can occur in any price-fixing scheme: Either the price can be set too high or it can be set too low. If it is too high, the system encourages too many medical procedures; if it is too low, the system encourages too few.

Incentives to Overprovide Health Care Services

Under the DRG system, physicians and hospitals receive revenues only if they perform services. As long as the DRG price compensates the hospital for its costs, health care providers have a financial incentive to perform surgery, even when the decision to operate is questionable on medical grounds. The new DRG system does encourage outpatient surgery over inpatient surgery, but it still encourages surgery. It also encourages early release after surgery and other practices that can lead to medical complications, which in turn can increase medical services and the cost to taxpayers.[25]

Incentives to Reduce the Quality of Care

In 1987 testimony before the House Government Operations Subcommittee on Human Resources and Intergovernmental Relations,

[25]For a review of these perverse incentives see John E. Wennberg, Klim McPherson, and Phillip Caper, "Will Payment Based on Diagnosis-Related Groups Control Hospital Costs?" *New England Journal of Medicine* 311, no. 5 (August 2, 1984): 296-300; and Robert S. Stern and Arnold M. Epstein, "Institutional Responses to Prospective Payment Based on Diagnosis-Related Groups: Implications for Cost, Quality and Access," *New England Journal of Medicine* 312, no. 10 (March 7, 1985): 621–27.

William Roper, then head of the Health Care Financing Administration (which administers Medicare), testified that as many as 891,000 Medicare patients received "dangerous care" each year. Those cases included 22,000 avoidable deaths; 149,000 avoidable traumas, including medication errors and the removal or "repair" of healthy organs; and 198,000 avoidable infections.[26]

It is not known to what extent those cases were directly related to the new DRG system. What is known is that the DRG system has created a serious problem of maintaining the quality of care. Once providers have performed the minimal services necessary to receive the DRG price, further care simply increases costs without increasing revenue. There have been numerous reports of patients being denied hospital admittance because of DRG rules,[27] and many more of patients being prematurely released. In one recent poll of physicians, 78 percent of the respondents reported being "pressured to discharge Medicare patients before they were ready to leave the hospital," and 88 percent reported that "the DRG program is adversely affecting the quality of medical care for Medicare patients."[28]

Despite the complaints of the physicians, there are studies that purport to show that the quality of care has not deteriorated under the DRG system. Which side is right? To some degree, both may be. Certainly the one-size-fits-all nature of the DRG pricing system creates incentives for providers to reduce the quality of care. On the other hand, the choices of patients and physicians who act as if care were free cannot be the right standard for the appropriate length of stay or choice of quality. In the absence of any real market for hospital care for the elderly, government-mandated controls and spending reductions are likely to reduce both desirable and undesirable care.

Case Study: Elderly Patients with Hip Fractures

In 1988, five years after the DRG system was introduced, a study compared the treatment of patients with similar conditions before and after the Medicare reimbursement rules changed. Studying

[26]Associated Press Wire Service, *Dallas Morning News*, October 21, 1987.

[27]See Robert A. Berenson, "Meet Dr. Squeezed," *New York Times*, July 21, 1989.

[28]These results should be taken as indicative, since the poll was not random. See *Private Practice* (October 1985), pp. 18–19.

elderly patients with hip fractures, the researchers found that the length of time patients spent in the hospital had dropped dramatically, as had the physical condition of patients at discharge.

Even more alarming, the study found a dramatic rise in the number of discharged patients who were immediately sent to nursing homes (up from 38 percent to 60 percent) and, perhaps because they entered nursing homes in poor condition, a substantial decline in their long-term recovery. Prior to the DRG system, only 9 percent of hip fracture patients sent to nursing homes remained after one year; afterward, 33 percent were still there after one year.[29] As the editors of the *New England Journal of Medicine* commented, this "provides a clear-cut demonstration, in a controlled study, of significantly poorer clinical outcomes for patients" treated after the implementation of the DRG system.[30]

Case Study: Elderly Mortality and State Government Regulation

Various studies have attempted to determine whether government policies are leading to higher mortality rates for elderly patients. A Northwestern University study surveyed the hospital records of more than 200,000 patients in 45 states.[31] It found that states with the most stringent regulation of hospital charges had a 6 to 10 percent higher mortality rate among elderly patients than states with the least stringent rate regulation. The study also found that states with the most stringent certificate-of-need (CON) regulations—controlling the ability of hospitals to expand and purchase equipment—had mortality rates 5 to 6 percent higher than states with less stringent CON regulations. The authors concluded that severe regulatory requirements "create incentives for hospitals to contain costs and may act as barriers to the development of innovative services that might otherwise improve the quality of care."[32]

[29]John F. Fitzgerald, Patricia S. Moore, and Robert Dittus, "The Care of Elderly Patients with Hip Fracture," *New England Journal of Medicine* 319, no. 21 (November 24, 1988): 1392–97.

[30]"Hospital Prospective Payment and the Quality of Care," *New England Journal of Medicine* 319, no. 21 (November 24, 1988): 1411.

[31]Stephen M. Shortell and Edward F. X. Hughes, "The Effects of Regulation, Competition and Ownership on Mortality Rates among Hospital Inpatients," *New England Journal of Medicine* 318, no. 17 (April 28, 1988): 1100–07.

[32]Ibid., 1101.

Elderly Mortality and the DRG System

Various studies have found that the DRG system apparently leads to fewer deaths in hospitals but more in nursing homes. In Hennepin County, Minnesota (which includes Minneapolis), between 1982 and 1986, the average length of stay for elderly patients in hospitals was cut in half. But because of local regulations, entry into a nursing home became more difficult. By 1987, the mortality rate for the county's elderly was more than 10 percent higher than its expected level.[33]

A Rand Corporation study for the U.S. Department of Health and Human Services disputes the contention that the DRG system has been harmful to patients. Although finding that the average length of stay in hospitals has declined by 24 percent, and patients are admitted "sicker" and released "quicker and sicker," Rand researchers maintain that the system has brought mortality down and quality up. But they also found that 12 percent of the patients received "poor care," and the death rate for these patients 30 days after discharge was double the death rate of other patients. They also found that, as a result of DRGs, more patients are being released in unstable condition, which makes them one and one-half times more likely to die within 90 days.[34]

Extending the DRG System to Other Third-Party Payers

The problems of the DRG price-fixing scheme are not limited to elderly Medicare patients. In a regulated, institutionalized market, once a method of payment becomes dominant, all third-party payers discover that they must adopt it (see chapter 3). Many state governments have adopted the DRG system in their Medicaid programs for low-income patients. Medicare and Medicaid combined represent 37 percent of all hospital revenues. Moreover, an increasing number of private insurers also are adopting Medicare's method of payment.

[33]Gregory L. Lindberg et al., "Health Care Cost Containment Measures and Mortality in Hennepin County Medicaid Elderly and All Elderly," *American Journal of Public Health* 79, no. 11 (November 1989): 1482.

[34]The Rand study was released in a series of eight reports published in *Journal of the American Medical Association* 264, no. 115 (October 17, 1990).

Table 10.4
PEDIATRIC CARE AT A NEW YORK HOSPITAL, 1985–87

Race	Average Length of Stay	Average Cost
White	7.75 days	$6,744
Hispanic	9.55 days	$8,099
Black	10.18 days	$8,408

SOURCE: Eric Muñoz, "Hospitals, Minorities Taking a Beating," *New York Times*, July 28, 1989.

Rationing Care for the Poor, the Old, and the Sick

The DRG system has other side effects, although less well recognized. For example, although it pays one fixed price for treatment of a specific condition, the actual cost to hospitals of delivering medical care can vary enormously, depending on the patient. Within a single DRG category in 1984, the cost of care ranged from a low of $5,500 to a high of $200,000. In "heart failure and shock," the DRG with the highest volume of cases, about 66 percent of the patients that year cost hospitals less than $4,000 each, whereas 7 percent cost more than $100,000 each.[35]

Who are the high-cost patients? They are the sickest and more often than not low-income and nonwhite (see chapter 3). Table 10.4 shows the length of stay and cost per treatment of pediatric patients by race. As the table shows, black children have a 31 percent longer average hospital stay and incur 25 percent higher hospital costs than their white counterparts. These cost differences are also reflected among older patients. In a cross-section of patients admitted to Long Island Jewish Medical Center between 1985 and 1987, for example, the average cost was $5,589 for white patients, $6,418 for Hispanics, and $6,753 for blacks.[36]

Among elderly patients, the young elderly are usually much less expensive to treat than the old elderly. For example, a study of

[35]Nancy M. Kane and Paul D. Manoukian, "The Effect of the Medicare Prospective Payment System on the Adoption of New Technology," *New England Journal of Medicine* 321, no. 21 (November 16, 1989): 1379.

[36]Eric Muñoz et al., "Race, DRGs and the Consumption of Hospital Resources," *Health Affairs*, Spring 1989, p. 187.

orthopedic surgical patients found that the average cost of treatment rises considerably with the age of the patient, even though the DRG price is the same for all. On patients over the age of 75, for example, hospitals lose an average of between $3,000 and $5,000 per patient for orthopedic surgery.[37]

There is increasing evidence that hospitals are responding to the financial initiatives created by the DRG system. They give care readily and quickly to the profitable Medicare patients, but slowly, reluctantly, and often with less attention to quality, to those who are unprofitable. That is especially true in the area of medical technology.

Rationing Medical Technology

Once Medicare had identified the DRG categories and prices, a reimbursement system was put into place. Medical technology, however, is changing rapidly, with new inventions and innovations coming on the market every day. A technological advance that reduces costs causes no problem and enables hospitals to make bigger profits. If a new technology causes treatment costs to rise, however, the incentives are entirely different. Unless Medicare raises the DRG price to cover the increased costs, the hospital is not able to afford the technology or may restrict its use to lower cost patients. Administrative changes in Medicare's DRG prices are made slowly if at all. Thus, many technological innovations are being rationed to Medicare patients.

Even when Medicare recognizes that an expensive technological device should be used, it often categorizes patients who need the device with those who do not in the same DRG category, and it pays an average DRG price. Hospitals with an above-average number of patients who need the device will be unable to provide it for all of them. In 1984, for example, there were 21 DRGs in which patients were combined in that way. In 18 of the 21, the DRG payment was well below the average hospital cost of providing the device. In more than half the cases, Medicare patients did not receive it.[38]

[37]Kane and Manoukian, 1381.

[38]Ibid., 1379.

Case Study: Cochlear Implants[39]

Hearing loss is the most prevalent chronic disability in the United States. It affects 30 percent of people over the age of 65 and 50 percent of people over the age of 85. Fortunately, a remarkable innovation—cochlear implants with the ability to substantially improve hearing for some patients—came on the market in 1978. The innovation prompted a congratulatory letter from President Reagan to the 3M Company, the original manufacturer, and the device won fairly prompt endorsements from the American Medical Association and the American Academy of Otolaryngology—Head and Neck Surgery. Yet, more than a decade later, most Medicare patients still cannot get a cochlear implant. In 1987, for example, Medicare reimbursed hospitals for only 69 implants.

Part of the problem is normal bureaucratic delay. But a bigger problem is the unwillingness of Medicare to pay a DRG price that covers the cost of the implant, a policy undoubtedly influenced by pressures to hold down spending. On the average, hospitals where implants are performed lose between $14,500 and $24,000 per patient.[40] One other side effect of this policy is that three of the five companies that developed and marketed the implant in the United States have now dropped out of the market, and 3M has dropped its plans to develop a new, improved implant.

Case Study: Kidney Dialysis

In 1988, Medicare paid about $3.7 billion for 147,000 patients with end-stage renal disease under a program that covers patients with kidney failure regardless of age. Since 1983, however, reimbursement for kidney dialysis (covering about 110,000 patients) has become increasingly stingy, with possible adverse effects for patients. In real terms, Medicare's payment for dialysis fell 44 percent (from $138 to $77) between 1983 and 1990. In addition, the physician's payment was frozen at about $150 per patient per month during that period. In response, many dialysis centers reduced the length of treatment time for patients, even though treatment time

[39]Ibid., 1378–83.

[40]"Proposed Rate for Prospective Payment of Cochlear Implantation," *Government Affairs Review*, September/October 1990, p. 7.

is related to a patient's odds of success.[41] According to one study, patients whose treatment sessions are less than 3.5 hours can be twice as likely to die as patients who receive longer treatments. Yet, as the study showed, the average treatment time for all dialysis patients has been falling since 1983, and about 20,000 patients now undergo sessions that last less than 3.5 hours.[42]

According to Alan Hull of Southwestern Medical School in Dallas, the United States is falling behind other countries in treatment success. Whereas U.S. patients receive about 10 hours of dialysis per week, the figure is 12 hours in Germany and 14 hours in Japan. Possibly as a result, in France, where treatment times are about 18 hours per week, the five-year survival rate is 87 percent, compared with a 47 percent U.S. survival rate.[43]

Why Haven't the Effects of the DRG System Been Worse?

Given the structure of DRG pricing, one would predict far worse results. Why haven't they occurred yet? The main reason is that pure cost-plus finance (Stage I) has by no means vanished, and most physicians still practice traditional medicine. As a result, unprofitable Medicare patients frequently receive the same quality of care administered to profitable patients. Hospital administrators make up for these losses by overcharging others, as they have done for the past 40 years.

Recently, executives at Golden Rule Insurance Company complained to a hospital administrator that the hospital's charges were unreasonable. In a letter of response, the administrator admitted that they were unreasonable, but enclosed a lengthy document explaining why that was the case. The document carefully noted the amount of "underpayment" to the hospital by Medicare, Medicaid, and preferred-provider organizations (PPOs) and furnished a complicated formula according to which these "underpayments" were made up by extra charges to all other payers. This is cost-plus finance in its pure form.

[41]Edward E. Berger and Edmund G. Lowrie, editorial, *Journal of the American Medical Association* 265, no. 7 (February 20, 1991): 909–10.

[42]Philip J. Held, *Journal of the American Medical Association* 265, no. 7 (February 20, 1991).

[43]Reported in Ron Winslow, "Cost Control May Harm Dialysis Patients," *Wall Street Journal*, February 20, 1991.

Cost shifting is becoming increasingly difficult, however. If competitive pressures continue in the hospital marketplace, hospitals will soon discover that they cannot overcharge any patient. Once that happens, the effects of the DRG system on Medicare patients will be devastating.

DRGs and the Cost-Plus System in Its Cost-Control Stage

When they were initiated, DRG prices were seen as an attempt by the federal government to opt out of traditional cost-plus finance. That image was deceptive. Far from moving toward a competitive market, the DRG system replaced one bureaucratic reimbursement scheme with another, in which patient preferences take a back seat to reimbursement rules. Currently, the federal government is attempting to set prices and monitor quality for 28 million potential patients and 5,000 hospitals. It is an impossible job. No matter what the rules, the medical marketplace is so complex that there are literally thousands of ways for health care providers to exploit them. Moreover, there is an inevitable conflict between price and quality of care. In the early years of Medicare, quality took precedence over costs. Under the new reimbursement rules, the reverse is beginning to occur.

Although individual hospitals are paid on a prospective basis, independent of their costs, the system as a whole has not escaped the pressures of cost-plus medical care. Under current practice, national DRG rates for this year are determined by last year's average hospital costs. Thus as hospital costs go up, DRG payments also go up. We still have a cost-plus system, but now it has a time lag. The federal government can, of course, resist such cost pressures by making DRG reimbursement rates increasingly stingy. But doing so would have even more adverse affects on the quality of patient care. The DRG system is already being used as a health care rationing device, and some argue that even more extensive rationing is inevitable.[44] By simply refusing to pay hospitals enough to cover the costs of expensive surgery, DRG administrators could force hospital personnel to ration health care, whether they want to or not.

[44]See David Stipp, "Medical-Cost Trend after 1990 Disputed: Growth Rate May Soar Unless Care Is Rationed," *Wall Street Journal*, January 9, 1987.

Table 10.5
REPRESENTATIVE PRICES PAID BY MEDICARE TO PHYSICIANS FOR A HOSPITAL OR OFFICE VISIT*

Reimbursement Price	Nature of Visit
$25	Brief visit; approximately 5 minutes
$35	Limited visit; brief evaluation of a chronic, stable medical problem
$50	Intermediate visit; requires adjustment of a therapeutic regime or attention to a new complaint
$70	Extended visit; requires unusual effort

*These payment schedules are being replaced by a new relative value schedule being implemented by Medicare.

Regulation of Physicians' Fees

One virtue of the DRG system is that it leaves most medical decisions up to the hospital's medical staff. In a hospital, for example, physicians do not have to answer to the federal government for ordering a diagnostic test. Quite different rules govern Medicare Part B, which pays physicians' fees and outpatient procedures.

Medicare has extensive regulations governing how physicians should practice medicine. Failure to abide by these regulations means that Medicare won't pay. If the violation is severe enough, a physician can be barred from the entire program. Some physicians try to fight the system. But they soon learn that such struggles are emotionally and financially exhausting, and no matter what the outcome, no fundamental rule is ever changed. Thus, the vast majority of physicians are working within the system, and an increasing number are providing exactly the care Medicare will pay for—no more and no less.

Table 10.5 illustrates how involved Medicare is in the practice of medicine. As the table shows, physician visits are categorized and defined, and detailed information about such visits must be supplied on Medicare reimbursement forms. Medicare also has opinions on how many visits and even what types of visits are appropriate for different medical problems. According to Medicare, for example, a certain percentage of physicians' visits to a patient's hospital room should be "brief" or "limited." There is no possibility

that only "intermediate" visits would be appropriate during a patient's hospital stay. As in the case of Medicare Part A, these rules were written with the average patient in mind, and they almost always discriminate against physicians who see sicker patients.

Medicare's intrusiveness does not end there. Medicare has opinions on whether a diagnostic test should or should not be performed and enforces its opinions through its reimbursement policies. Medicare also has opinions about what drugs a physician should inject—opinions that are often at variance with the medical literature. For example, Medicare will pay only for drugs used as approved by the federal Food and Drug Administration (FDA). Yet the FDA is notoriously slow about approvals.

Often, the FDA will approve a drug for one medical purpose but never get around to approving it for any other. In the meantime, medical researchers will discover that the drug is even more valuable when used in another way. More than half of the drugs prescribed for treating cancer, for example, are for non-FDA-approved purposes. But physicians who follow the medical literature may find that they are violating Medicare policies and cannot be paid.

Medicare policies have an impact well beyond treatment of the elderly, since many state-run Medicaid programs and private insurers are adopting the same rules. Medicare payment policies, therefore, are increasingly dictating the type of care that all patients receive (see the discussion in chapter 18).

Paying Physicians by Relative Value Scales

Operating under a $2 million grant from the Health Care Financing Administration, researchers at the Harvard School of Public Health have decided how much some physicians should get paid for different types of services.[45] Their findings will be used by the federal government to set physician reimbursement fees under Medicare. Many Blue Cross and Blue Shield plans and other private third-party payers will use the same scheme.[46]

[45]W. C. Hsiao et al., "Results, Potential Effects and Implementation Issues of the Resource-Based Relative Value Scale," *Journal of the American Medical Association* 260, no. 16 (October 28, 1988): 2429–38.

[46]See *Medical Benefits* 7, no. 16 (August 30, 1990): 10.

The Harvard group first attempted to determine how much (physical or mental) effort was required by physicians to perform various tasks. Each task was assigned a number of points, so if one task got twice as many points as another, the first task would be twice as valuable (read: cost twice as much) as the second. The official name for the point system is the resource-based relative value scale (RBRVS). To get a sense of how the RBRVS system works, let's consider a few examples. Under the system, an "office visit, limited service, established patient" is worth 62 RBRVS points. On the other hand, an "initial history and physical examination related to a healthy individual, including anticipatory guidance, adult," is worth 114 RBRVS points if done by an internist.[47] Because the medical world is very complicated and there were thousands of physician tasks to be ranked, it is not surprising that the initial rankings frequently failed the test of common sense. For example, the removal of one lobe of the parated (salivary) gland, a fairly simple procedure, had the same relative value as an extensive and difficult cancer operation. A simple diagnostic dilation and curettage (D&C) was assigned a higher value per unit of time than a hysterectomy.

In general, the approach taken by the Harvard research group is based on the labor theory of value—a theory totally discredited by economists more than 100 years ago. The theory held that one could tell the worth of something simply by looking at how much time and effort were put into it, and by forgetting supply and demand and the role of markets. Karl Marx thought this theory could be applied to an entire society to determine the value of everyone's contribution to GNP. No communist country ever succeeded in putting Marx's theory into practice. To the extent they tried, virtually every one is rejecting it and turning toward markets to allocate resources. The lessons of socialism's failure, however, have largely bypassed the Medicare bureaucracy.

How Medicare Is Attempting to Fix Prices for the Services of Physicians

Unlike the DRG program for hospitals, Medicare does not necessarily fix the total reimbursement for physicians. In principle, Medicare limits what it pays, but patients and physicians are free to

[47]These examples are taken from Jane M. Orient, "What Is a Doctor's Relative Worth?" *The Freeman* (September 1989), pp. 355–56.

agree on a higher total price, with the patient paying the balance. But the Medicare bureaucracy has created strong incentives for physicians to accept assignment—an arrangement under which Medicare pays physicians directly if they agree to accept Medicare's payment as the total fee. Moreover, once physicians opt into the assignment program, they can never opt out of it. As a result, a growing proportion of physicians who treat Medicare patients do so on an assignment basis.[48] Moreover, as in the case of hospitals, the power to set fees ultimately is the power to determine the quality of care.

Regulation of the Quantity of Medical Care

The Medicare bureaucracy also exerts control over the practice of medicine in more direct ways. The bureaucracy has many opinions about what does and does not constitute cost-effective medical practice. In the hands of the Medicare bureaucracy, cost-benefit analysis is a mechanical device, which totally ignores patients' preferences and physicians' insights.

Direct Controls over Medical Practice

In many places, a hospital must receive telephone approval from the bureaucracy before admitting a Medicare patient, a practice that is also common among private third-party payment schemes. The person giving or denying the approval will not have met or examined the patient. The decision will be based on a cost-benefit analysis using statistical averages, with little or no room for the nonaverage, abnormally sick patient. These decisions can have life or death consequences.[49]

At other times, third-party payers literally attempt to dictate how medical care will be practiced. In the case of prescription drugs, for example, the restrictions placed on physicians include: (1) therapeutic drug interchange (the substitution of a less expensive drug for a more expensive one); (2) prior authorization; (3) drug formularies (limiting choice to a list of approved drugs); (4) limited reimbursement from third-party payers for prescriptions deemed "experimental" or for "off-label" applications; (5) drug protocols (in which

[48]That proportion was 40.7 percent of all physicians as of November/December 1988.

[49]Berenson.

Table 10.6
TEN MOST FREQUENT NEGATIVE OUTCOMES RESULTING FROM DRUG COST-CONTAINMENT MEASURES

Negative Outcomes	Percent of Total
Lessened therapeutic response	28%
Therapeutic failure	24
Allergic reaction/side effects	13
Poor/loss of blood pressure	12
Heart failure/chest pain	8
Underdosed/lack potency/too strong	8
Convulsions/seizures	7
Recurring symptoms/pain/fever	5
Patient didn't recover	5
Adverse reaction/patient almost died	4

SOURCE: Oregon Medical Association, 1990. Reported in *Medical Benefits* 7, no. 17 (September 15, 1990).

drugs are prescribed in a predetermined sequence); and (6) generic substitution.

To determine the effects of these practices, Gallup polled cardiologists, internists, and general practitioners for the Oregon Medical Society. Table 10.6 shows the most frequently mentioned negative outcomes. On the average, there were 16.2 negative outcomes per physician polled, and in nine cases physicians reported that patients died because of the restrictions.[50]

Indirect Controls over Medical Practice

Even when Medicare cannot directly tell medical providers what to do, and even if it is not paying the bill, the Medicare bureaucracy can discourage what it believes is not "cost-effective" medicine by creating mountains of red tape. Medicare can require the completion of long, complicated forms even if the patient is paying out-of-pocket. Similar obstacles are created for patients who want to stay an extra day in the hospital—beyond the time that Medicare has deemed necessary.

[50]Reported in *Medical Benefits* 7, no. 17 (September 15, 1990): 10.

Potential Tools for Enforcing "Cost-Effective" Medicine

For the near future, the situation will get worse. Computerized protocols designed to instruct physicians about how to treat injuries and diseases could become powerful control mechanisms for the Medicare bureaucracy. The principle of a computerized protocol is not bad, provided it passes the market test. Imagine that a patient with a medical problem goes to see a physician. The physician types the patient's symptoms and other pertinent information into a computer. The computer's program digests the information and then recommends the most cost-effective first step—for example, a blood test. Once the results of that test are in, the program recommends the most cost-effective second step. At each stage in the process, the program recommends action based on other physicians' experiences and the costs and probable benefits of various options.

Such a system would undoubtedly have problems. So, given feedback from buyers and users, sellers would correct the errors, improve the techniques, and put out a better product. That is the way other computer programs are developed and improved in the marketplace. Such a development might be invaluable to physicians and patients who, of course, would always be free to ignore the computer program's advice. In the hands of the Medicare bureaucracy, however, computerized protocols could force physicians into a uniform practice of cost-effective medicine. Such a development would be harmful to patients for several reasons. First, a great deal of what medical science believes to be true at any point in time is shown later to be false. The progress of medical science requires experiment and innovation, and that implies different treatments for patients with similar conditions. Second, any computer program (like all other Medicare policies) will be based on statistical averages and lack the special insights and discoveries that come about in the relationship between patient and physician. Third, unlike the market for computer programs, the federal bureaucracy moves slowly, changes reluctantly, and is largely unresponsive to feedback from users (in this case, physicians and patients).

Finally, rules, regulations, and instructions developed by the federal government—unlike products sold in the marketplace—are anything but simple and efficient. Implementing price controls during World War II for example, the federal government took 21

pages to define a head of cabbage. How much more difficult will it be to define complicated medical procedures? Few people would realistically believe that government could develop cost-effective techniques to instruct auto mechanics. The prospects for achieving the same goal in the health care sector are even more remote. If Medicare tries it, delivery of medical care could become a practical nightmare.

How Medicare Attempts to Control the Quality of Care

The Medicare bureaucracy has been aware from the beginning that its payment scheme contains incentives to reduce quality. To combat this problem, the federal government set up yet another form of bureaucracy, peer review organizations (PROs), to monitor the quality of patient care. PROs are supposed to review the decisions of physicians and hospitals to make sure, for example, that sick patients are not released too early, that care does not cease simply because Medicare won't pay for it, and that unnecessary care is not given simply because Medicare will pay for it.

PROs have the authority to monitor and to impose sanctions. However, far from representing the interests of patients, they rarely communicate with patients and their deliberations are about as far removed from patients as a bureaucracy could be. In the main, PROs monitor one bureaucracy (hospitals) to serve the interests of another (Medicare). If patients in practically any city in the country are seeking information about quality care, a PRO is one of the last places they will find it.

Clearly there are problems of quality in America's hospitals. A recent study of the quality of care in New York State's hospitals, commissioned by the state government, is the most comprehensive study of the overall quality of hospital care ever conducted. The study found that, in 1986, negligence on the part of the hospital staff may have contributed to as many as 7,000 hospital deaths and 29,000 injuries. Although this represents only 1 percent of all patients, the instances of apparent malpractice are ten times greater than the number of malpractice lawsuits.[51]

[51]The report of the Harvard Medical Practice Study to the State of New York, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (Cambridge, MA: Harvard Medical Study, 1990).

Why Cost-Control Measures Do Not Ultimately Control Costs

Just as the private sector has attempted to control health care costs by opting out of the system of pure cost-plus finance since the 1980s, so the federal government has tried to accomplish the same goal over the same period of time. But U.S. medical costs are soaring and claiming an ever-increasing share of our GNP. Why are these efforts failing? The most fundamental reason is that the underlying defects in the way we finance medical care have not been corrected. When patients enter the medical marketplace, they are still spending someone else's money. Patients, physicians, and hospital administrators still have strong incentives to manipulate reimbursement rules in pursuit of their own interests.

Much of the time, when it appears that a new reimbursement policy is working, it is only because providers of medical services have found ways to shift costs to other third-party payers. As in the case of hip fracture patients, hospitals discover ways to shift costs to nursing homes and thus to Medicaid. During the brief period when the Medicare catastrophic coverage program was in force, the reverse was true. Medicaid found ways to shift nursing home costs to Medicare. Much of the so-called savings in Medicare hospital expenditures are not savings at all, but a shifting of costs to the private sector. In many cases, savings in Medicare Part A (hospital services) are realized only because costs have been shifted to Medicare Part B (physicians' services and outpatient care). Over the 1980s, Part A costs little more than doubled, while Part B costs more than quadrupled.

Yet another reason is that while some governmental bodies are trying to adopt policies that will hold down costs, others are passing laws that cause costs to rise. That phenomenon will be the subject of the next two chapters.

Needed Policy Changes

The federal government, operating principally through its Medicare program, is attempting to set prices and control quality in a very complex, multibillion-dollar market. Medicare payments are handled institution to institution, bureaucrat to bureaucrat. Virtually every Medicare rule or policy ignores the preferences and motives of patients on the one hand and the insights of physicians on the other. Medicare is a system in which it is often in everyone's

self-interest to pursue goals that are the opposite of Medicare's goals.

Because individuals can often outsmart bureaucracies, many medical providers have made a great deal of money dealing with Medicare. But because individuals are usually powerless when they confront bureaucratic obstacles, patient care has often deteriorated.

In competitive markets for most consumer products, diversity abounds in quality and in price. There is no reason to expect the medical marketplace to be any different. All doctors are not the same. All hospitals are not the same. But the current DRG system treats them as if they were and thereby attempts to enforce a single price and maintain a single standard of quality for every medical procedure, regardless of where and by whom it is performed. Other government health care programs and the many cost-management programs in the private sector are similarly structured. This approach is destined to fail. It will be replaced either by an explicit program of health care rationing or by genuine market-based institutions.

There is nothing wrong with the attempt by Medicare to limit its expenditures and thus limit taxpayer liabilities. But there is something dreadfully wrong with its attempt to control the prices of hospital services and physicians' services in the marketplace.

The only way to ensure cost-effective, high-quality medical care is to make Medicare beneficiaries active participants in the market as the primary buyers of care and the primary monitors of the services they buy. In the short run, we should redirect the DRG system toward the goal of limiting the amount that the federal government spends in the medical marketplace, rather than attempting to control price and quality. Doctors, hospitals, and patients should be free to enter into whatever financial arrangements they choose. The marketplace, not government, should determine the price and quality of health care.

Similar changes should be instituted in the Medicaid program. Where particular health care needs warrant special attention (such as prenatal care), special accounts should be created from which pregnant Medicaid women could draw funds to purchase specific types of care. The goal should be to empower poor women, enable them to escape the indigent health care system, and make them full participants in the market economy.

For the long run, our goal should be to separate medicine and politics as much as possible. Ways of reaching that goal are suggested throughout this book.

11. Regulation of Health Insurance by State Governments

Although we have described the U.S. health care system as a cost-plus system in a cost-control stage, it would be incorrect to infer that all, or even most, government policies adopted during this stage are actually holding down costs. On the whole, it is probably fair to say that they are increasing costs. This chapter examines the role of state governments, which are yielding to special-interest pressures and passing laws that relentlessly increase the price of health insurance and the amount of health care spending.

Health Insurance Benefits Mandated by State Governments[1]

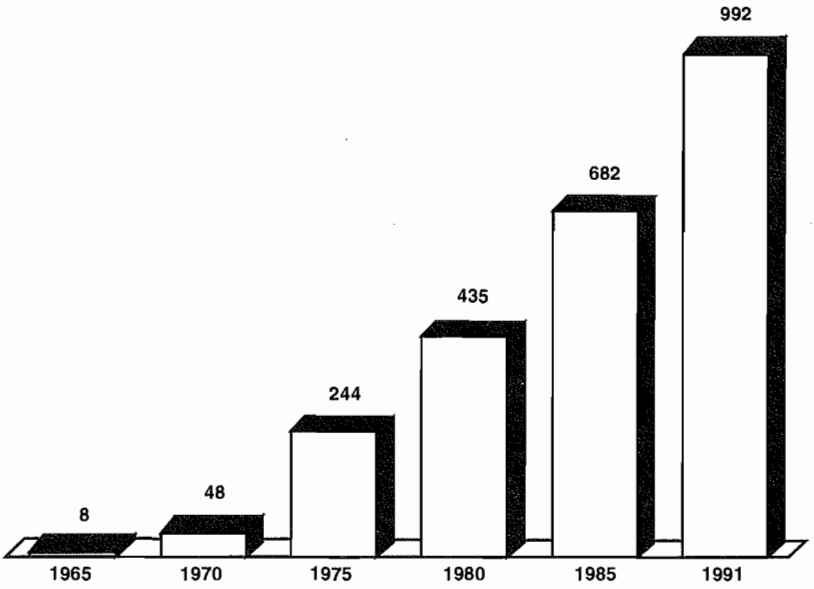
Mandated health insurance benefit laws require that health insurance contracts cover specific diseases, disabilities, and services. In some cases, laws require insurers to offer a benefit as an option for an additional premium. In 1970, there were only 48 mandated health insurance benefit laws in the United States. Yet as Figure 11.1 shows, in recent years there has been an explosion in the number of such laws, and they now total close to 1,000.[2]

Mandated benefits cover diseases ranging from AIDS to alcoholism and drug abuse. They cover services ranging from acupuncture to in vitro fertilization. They cover everything from life-prolonging surgery to purely cosmetic devices. They cover heart transplants

[1]Many of the statistics in this chapter were obtained from various sources in the health insurance industry. The interpretations of the statistics are those of the authors and do not constitute legal opinions. In many states, lawsuits currently are under way to determine the exact meaning of various statutes and regulations.

[2]Information obtained from *Health Benefits Letter* 1, no. 15 (August 29, 1991). For a discussion of the growth of mandated benefits, see Greg Scandlen, "The Changing Environment of Mandated Benefits," in Employee Benefit Research Institute, *Government Mandating of Employee Benefits* (Washington, 1987), pp. 177–83.

Figure 11.1
NUMBER OF MANDATED HEALTH INSURANCE BENEFITS ENACTED BY STATE GOVERNMENTS, 1965 TO 1991



SOURCE: Greg Scandlen, *Health Benefits Letter* 1, no. 15 (August 29, 1991).

in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in California, pastoral counseling in Vermont, and sperm bank deposits in Massachusetts. These laws reflect the politicization of health insurance. Special-interest lobbies now represent almost every major disease and disability, group of health care providers, and type of health care service. As a result, health insurance is being shaped and molded by political pressures, rather than by competition and consumer choice in a free market.

Mandated benefits legislation invariably makes health insurance more expensive. Under federal law, however, companies with self-insured health care plans are exempt from these state regulations, and virtually all large companies and many small and medium-sized ones are now self-insured. Federal employees and Medicare recipients also are exempt. State governments often exempt state employees and Medicaid recipients as well. As a result, mandated

benefits regulations fall heavily on employees of small firms and on the purchasers of individual and family policies—people who typically lack economic and political power.

The Alternatives to Mandated Benefits

Before looking at specific regulations, it is useful to first consider some alternatives. In many, or perhaps most, cases, mandated benefit laws merely represent the legislative success of special interests. In other cases, however, they address issues that many people care about, such as preventive care (including mammograms), well-child care, maternity expenses, medical expenses for adopted children, and medical expenses for AIDS patients. Legislators often mandate these benefits out of a desire to remove financial barriers to obtaining health care or to relieve families of great financial burdens.

Even if the goal is humane and desirable, the method is not. In passing mandated benefit laws, state legislators are attempting to create benefits without paying for them. The cost is then imposed on other people through higher health insurance premiums. When legislators attempt to benefit one group, they raise the cost of insurance for another. The result is a redistribution of costs and benefits that is usually highly regressive. Those most likely to gain are special groups of middle-income families. Those most likely to be harmed are lower income families that are priced out of the market for health insurance as premiums rise to cover the cost of the new mandates.

A more efficient and humane way to accomplish the same objectives is through the use of direct subsidies, funded by taxes paid by all citizens. State governments, for example, could make direct payments to low-income families with particular health disabilities. The payments could be income-related so that financial help would be targeted to those who need it most. Another technique would be to subsidize purchases of particular medical services (such as prenatal care), again with the subsidies targeted to low-income families. A third strategy is to directly subsidize the health insurance premiums of people with particular disabilities (such as AIDS), based on their income.

Each of these alternatives would permit the health insurance marketplace to continue to function, and to give people options

among different types of coverage and premiums that reflect the real cost of the options. Each alternative also would require legislators to pay for the benefits they confer and would make it more likely that the subsidies would go to people who most need them and that the costs would be borne by those who could best afford them.

Apart from more expensive medical services, there is a trend toward state mandates for relatively inexpensive preventive services such as Pap smears, mammograms, and well-child care. The vast majority of people can pay such expenses out-of-pocket and can include planning for such expenses in a family budget. Legislators are concerned, however, that when family budgets get tight, people will skimp on medical care. Yet as noted in previous chapters, using insurers to pay small medical bills is costly and inefficient. A better solution (one advanced throughout this book) would be to encourage people to establish and use Medisave accounts for small medical bills.

Misguided Attempts to Shift Costs from the Public to the Private Sector

An important principle of insurance is that the insured event must be a risky event, one that has not already occurred. In this sense, pure insurance is a gamble. Yet some states require insurers to insure people who are already known to have an illness that will generate future medical costs in excess of the premiums they pay. The result is that all other policyholders must pay higher premiums. Another important principle of insurance is that individuals must not be able to collect as a result of their intentional behavior. Yet many states require that health insurance cover treatment for alcoholism and drug abuse for those who engage in substance abuse at the time the policy is issued.[3] The result is that social drinkers, teetotalers, and nondrug users pay higher premiums to cover the costs.

[3]Whether or not alcoholism and drug abuse are properly classified as diseases, they are the consequences of purposeful behavior. Thus, insurance against alcoholism or drug abuse often is not insurance against the possibility that someone accidentally will become a substance abuser but is instead a commitment to pay medical expenses for one who already is.

Such regulations are partly a result of lobbying pressures from health care providers and high-risk groups. But they also reflect a desire on the part of state legislators to force the private sector to pay costs that would otherwise be paid by government.

AIDS

The cost of treating an AIDS patient currently runs between $75,000 and $150,000.[4] Given that most AIDS patients are unable to pay that much using their own resources, the cost often is paid by government. In an effort to shift these costs to the private sector, the District of Columbia enacted a law prohibiting insurers in the District from refusing to issue a policy or charging a higher premium to individuals already diagnosed as having AIDS.[5] Some states are also moving in this same direction. (See Table 11.1.) In California, insurers may not test insurance applicants for the presence of AIDS antibodies. Three states (Florida, New Jersey, and Wisconsin) prohibit AIDS testing for group insurance, and a similar regulation has been proposed in Rhode Island. In 12 states, insurers may not ask applicants if they have ever been tested for AIDS, and similar regulations are being proposed in 5 other states.[6]

Alcoholism and Drug Abuse

Substance abuse can be even more expensive to treat than AIDS. That is partly because the treatment is prolonged, typically takes place in an expensive facility, and requires intensive use of trained personnel. In addition, the patient often must return for further treatment. As in the case of AIDS, the government might have to bear the cost of much of this treatment unless private health insurance pays for it.

Forty states now have regulations governing health insurance for alcoholism. Of these, 29 states make such coverage mandatory and 11 require that the insurer offer it as an option. Twenty-seven states

[4]In certain managed care programs, the cost may be as low as $35,000. See Roger Rickles, "Firms Turn to 'Case Management' to Bring Down Health Care Costs," *Wall Street Journal*, December 30, 1987, p. 13.

[5]In 1989, Congress passed an appropriations bill that contained language forcing the District of Columbia to repeal this law. In effect, Congress told the District that no federal funds would be available unless the law were rescinded.

[6]With the exceptions noted above, insurers may conduct their own tests, but such testing is expensive and adds to the overall cost of insurance.

Table 11.1
RESTRICTIONS ON HEALTH INSURANCE RELATING TO AIDS*

Regulation	Number of States with the Regulation	Number of States Where Regulation Is Proposed
HIV testing prohibited for all insurance	1	0
HIV testing prohibited for group insurance	3	1
Insurers may not discriminate on basis of sexual orientation	13	4
Insurers may not use sexual orientation, occupation, age, sex, or marital status to predict whether individual will develop AIDS	10	3
Insurers may not ask questions about sexual orientation or lifestyle	13	4
Insurers may not ask if applicant has been tested for HIV or ask about results of such tests	12	5
Insurers may not ask if applicant has had blood transfusion	2	0
Insurers may not ask if applicant has been rejected as blood donor or been advised not to donate blood	2	0

SOURCE: Information compiled by Security Life of Denver.
*As of June 1, 1988.

have regulations governing health insurance for drug addiction. Of these, 19 make benefits mandatory and 8 require coverage as an option. In some cases, the regulations are ludicrous from the point of view of genuine insurance. For example, in Louisiana, group insurers are required to offer optional coverage for treatment of alcoholism or drug abuse—an option few policyholders would choose unless they intended to file claims. In Connecticut, insurers

are required to provide at least 30 days of inpatient care for the "accidental ingestion" of cocaine, marijuana, morphine, amphetamines, barbiturates, hallucinatory drugs, and other controlled substances.

Adopted Children

Twenty-five states have regulations mandating health insurance coverage for adopted children, usually requiring that adopted children be covered like other dependents. In Minnesota, however, an insurer must cover preexisting conditions. That means that if an adopted child has an expensive-to-treat condition, the insurance company (and therefore other policyholders) must bear the costs. This regulation encourages families to adopt children who might otherwise remain in state institutions at taxpayer expense. Although it saves money for some Minnesota taxpayers, the regulation raises the cost of health insurance for others.

Special-Interest Pressures from Health Care Providers

All health insurance contracts require some specification of who is authorized to diagnose and treat illness. Under traditional contracts, this authority was reserved to licensed physicians. Thus, the treatment of mental illness would include psychiatrists, but not psychologists. Diagnosis and treatment of eye diseases would include ophthalmologists, but not optometrists. In general, podiatrists and chiropractors were excluded. In recent years, however, we have witnessed a flood of regulations designed to open the market for health insurance reimbursement to scores of allied practitioners. Currently, for example, 45 states mandate coverage for the services of chiropractors. In general, chiropractors have the right to diagnose and treat diseases (including taking diagnostic x-rays) under standard insurance policies. In Nevada, insurers must reimburse chiropractors at the same rate as physicians performing similar services, even though chiropractors' fees to uninsured patients may be one-half to one-third less.

These regulations can significantly raise the cost of conventional health insurance. In general, patients of chiropractors tend to be heavy users of services. Chiropractors often will diagnose illnesses that would be dismissed by physicians and prescribe courses of treatment that would not be prescribed by physicians.

Table 11.2
MANDATED BENEFITS: SELECTED PROVIDERS[1]

Type of Provider	Number of States with Mandates[2]
Optometrists	46
Chiropractors	45
Dentists	40
Podiatrists (chiropodists)	37
Psychologists	36
Nurse midwives	24
Other types of nurses[3]	23
Social workers	22
Physical therapists	16
Psychiatric nurses	9
Speech/hearing therapists	8
Professional counselors[4]	7
Occupational therapists	5
Acupuncturists	4
Naturopaths	2

SOURCE: *Health Benefits Letter* 1, no. 15 (August 29, 1991).
[1]As of July 1991.
[2]Includes mandated coverage and mandated offerings.
[3]Includes nurses, nurse practitioners, and nurse anesthetists.
[4]Includes marriage, family, and child counselors.

As Table 11.2 shows, chiropractors are not an isolated example. In California, if an insurance policy covers the services of a psychiatrist, it must cover similar services by marriage counselors and child and family counselors. In Alaska and Connecticut, insurers must cover the services of naturopaths. In Nevada, New Mexico, and Oregon, insurers must cover acupuncture, and in California acupuncture coverage must be offered as an option. The potential for further mandates covering allied practitioners is almost endless. Currently, there are at least 142 health-related professions, with as many as 240 occupational job classifications (see Table 11.3).[7]

[7]John B. Welsh, Jr., "Legislative Review of Third-Party Mandated Benefits and Offerings in the State of Washington," in Employee Benefit Research Institute, *Government Mandating of Employee Benefits*, p. 194.

Table 11.3
MANDATED BENEFITS: SELECTED SERVICES[1]

Type of Service	Number of States with Mandates[2]
Alcoholism treatment	40
Mammography screening	39
Mental health care	29
Drug abuse treatment	27
Maternity	25
Home health care	20
Well-child care	12
TMJ disorders	12
Ambulatory surgery	12
Breast reconstruction	11
Pap smears	8
In vitro fertilization	7
Cleft palate	7
Hospice care	7
Diabetic education	5
Rehabilitation services	5
Second surgical opinions	5
Long-term care	3
Prescription drugs	3

SOURCE: *Health Benefits Letter* 1, no. 15 (August 29, 1991).
[1]As of July 1991.
[2]Includes mandated coverage and mandated offerings.

Building Constituencies for Specific Diseases and Disabilities

As in the case of AIDS, legislators frequently face pressure from people who are afflicted with a particular disease or disability or are at risk of affliction. In terms of the number of regulations, it would appear that the blind have the most effective special-interest lobby. Beyond blindness, constituencies extend from pregnant women exposed to cancer-causing substances to individuals concerned with virtually every form of mental illness. The following are some examples.

DES Mothers

In the 1950s and 1960s, a number of pregnant women took the drug diethylstilbestrol (DES) to control morning sickness. Subsequently, it was discovered that DES exposure could cause cervical

and uterine cancer in the daughters of these women. At least six states limit the ability of insurers to act on this knowledge. In California, for example, an insurer may not charge higher premiums or refuse to cover an individual either because the person has conditions attributable to DES or has been exposed to DES.

Sickle-Cell and Other Genetic Traits

Some individuals carry a genetic trait that does not affect the health of the carrier but may produce a disease or disability in the person's offspring. Examples are the sickle-cell trait (found almost exclusively in black men) and Tay-Sachs disease (almost exclusively affecting persons of Jewish descent). When an applicant is known to have such a genetic trait, many states restrict insurers from acting on this knowledge. For example, at least six states regulate the sale of insurance to individuals who have the sickle-cell trait. In California, Florida, and North Carolina, insurers may not deny coverage or charge a higher premium based on the likelihood that the trait may affect an individual's offspring. In North Carolina, the same restriction is extended to individuals with hemoglobin-C trait. In California, the restriction applies to all genetic traits.

Physical and Mental Handicaps

Most states regulate the sale of health insurance to the handicapped or disabled. For example, at least 34 states have regulations covering all physical handicaps or all general handicaps and disabilities, at least 29 have regulations specifically covering mental disabilities, and at least 35 have regulations specifically covering blindness or partial blindness. In general, such regulations inhibit insurance companies from selling policies for actuarially fair prices. As a result, the cost of insurance is higher for all other policyholders. In many states, insurers cannot refuse to cover the handicapped, but they may charge higher rates based on actuarial experience. In North Carolina, insurers have flexibility with respect to handicapped adults but must cover handicapped minors at the same rates as other children.[8]

[8]In this instance, as in most other cases discussed here, the insurer is not required to pay the cost of treating a preexisting illness. However, the insurer is precluded from charging a higher premium even when a disability increases the likelihood of future claims.

When insurers are allowed to charge higher premiums for handicapped people, the insurance company usually bears the burden and expense of proving that the rate differentials are justified. In Missouri, for example, insurance regulators assume no differential risk among classes of people unless the insurers can produce statistical evidence. In Minnesota, insurers may not charge higher premiums unless they can prove significant differences in health care costs for people who have those disabilities.

On the surface, it may seem fair to ask that differential premiums be related to differential costs of insurance. But the burden of proof may be too costly or even impossible for insurers to bear. In Louisiana, for example, insurers must cover individuals with spinal cord injuries, amputations, autism, epilepsy, mental retardation, and any other neurological impairment. A higher premium may be charged only if insurers can justify it on the basis of actuarial experience. In many cases, however, the disability is so rare that no actuarial tables exist. As a result of these restrictions, the premiums charged are less fair than they would otherwise be. Handicapped policyholders often are undercharged, and all other policyholders are overcharged to make up the difference.

Misguided Attempts at Cost Control

Some mandated benefits regulations are designed to encourage substitution of outpatient for inpatient surgery and of home care for hospital care, second and even third opinions prior to surgery, and certain types of preventive medical care. Although the regulations may have been encouraged by provider groups, some also appear to have been influenced by the states' desire to reduce health care costs. In all cases, they are misguided attempts to substitute political judgment for personal choice.

Outpatient Care

Twelve states require insurers to cover outpatient care as an alternative to inpatient care, and six of these states require that the benefits be identical. Surgery performed in an independent outpatient clinic usually costs less. But hospitals are setting up their own outpatient services, and the costs of those services may be higher than inpatient care.

Home Health Care

At least 20 states have regulations governing home health care. Coverage is mandatory in 14 of them, and must be offered as an option in the other 6. New Jersey, for example, requires coverage in the home for anything that would have been covered in a hospital on the same reimbursement basis. Yet, because it often consumes more services over a longer period, home care can cost more.

Second Opinions on Surgery

Five states require insurers to cover a second opinion prior to surgery, and Rhode Island requires coverage for a third opinion if the first two physicians disagree. Yet the experience of large corporations has been that blanket policies requiring second opinions save very little money. Second opinions are costly, and for many procedures the cost may be greater than the benefit.[9]

Preventive Medical Care

Eight states require coverage for Pap smears and 39 states mandate coverage for mammograms. Florida has mandated coverage for a specific number of physician visits for children at different ages, with a requirement that the insured not be charged any deductible in connection with the visit. Similar legislation is being considered by other states. The American Academy of Pediatrics is lobbying for 12 mandated well-child physician visits for children from birth through the age of six, implying that such an investment in preventive medicine will save Americans money. The evidence says otherwise. On the basis of cost-benefit analysis, it is hard to justify any well-child physician visits.[10] This type of preventive medicine may have important benefits for parents (relief of anxiety, reassurance, etc.), but it is not necessarily a wise way to spend scarce health care dollars. Even where preventive care can be cost-justified, paying for it through third-party insurers is almost always wasteful.

[9]See Glenn Ruffenbach, "Health Costs: Second Thoughts on Second Opinions," *Wall Street Journal*, July 27, 1988, p. 21.

[10]See Judith Wagner, Roger Herdman, and David Alpers, "Well-Child Care: How Much Is Enough?" *Health Affairs* (Fall 1989).

Case Study: Maternity and Childbirth

No issue illustrates the pressures on state legislators better than pregnancy and childbirth—in terms of both the emotional impact and the influence of medical providers and their potential patients. All 50 states have some regulation governing health insurance for newborns, and at least 45 states require that newborn care be included both in individual and group policies.[11] It's not hard to understand why. In 1986, the Sheraton Corporation spent $1.2 million (about 10 percent of its total health care costs) on three premature babies born to company employees. In 1984, Sunbeam Appliance Co. spent $500,000 (half of its entire employee health care costs) on four premature babies. That same year, Ameritrust Corporation spent $1.4 million on one premature baby.[12]

Clearly, having a child is a risky and potentially costly event. But many state regulations force health insurers to ignore that fact. For example, Arizona requires that a policy covering an insured person's dependents must also cover newborns, including premature babies and those with congenital abnormalities, but with no increase in premium. In Montana, coverage for a newborn is mandated even if other dependent children are not covered. In Minnesota and Ohio, a policy covering a dependent's daughter must also cover a newborn child of the (unwed) daughter. Since newborns are more expensive to insure than older children, the costs of these mandated benefits must be borne by other policyholders, including single men and childless women.

At least half the states also have regulations covering the costs of maternity and complications of pregnancy. At least 15 states prohibit discrimination on the basis of marital status, despite the fact that unwed mothers have a higher incidence of complications of pregnancy. In Colorado and New Jersey, for example, single and divorced women must receive the same coverage on the same terms as married women.

[11]Linda L. Lanam, "Mandated Benefits—Who Is Protected?" in Employee Benefit Research Institute, *Government Mandating of Employee Benefits*, p. 186.

[12]Rickles, p. 13; and Cathy Trust, "Corporate Prenatal-Care Plans Multiply, Benefiting Both Mothers and Employers," *Wall Street Journal*, June 24, 1988, p. 15.

Nor is that all. Even if pregnancy is viewed as a risky and unplanned event, surely the same cannot be said for in vitro fertilization. Yet five states—Arkansas, Hawaii, Maryland, Massachusetts, and Rhode Island—mandate benefits for in vitro fertilization, and in Connecticut and Texas it must be offered as an option. Moreover, because the procedure can cause multiple conceptions, leading to multiple abortions or multiple births, and because unsuccessful couples may repeat the procedure an almost endless number of times, the resulting health care expenses can be quite high.[13]

Other Types of Mandated Benefits

In addition to the medical benefits described above, some states regulate the terms and conditions under which policies may be sold. For example, some mandate that a policy must be "guaranteed renewable" for a certain period of time. That means that an insurer cannot stop covering a group of people, regardless of actuarial experience. Some also mandate that Medicare supplemental policies must be "guaranteed issued." That means that the insurer cannot refuse to sell the policy, regardless of the applicant's health. Some states refuse to permit coordination of insurance claims among companies covering the same individual. That means that an individual with coverage by more than one insurer can collect full benefits under each policy and thereby profit from being sick.

As with other types of mandated benefits, little is known about how much any single type of regulation adds to the rising cost of health insurance. However, Golden Rule Insurance Company has estimated how some regulations have increased the average policy premium in some states. Because Texas mandated that major medical plans must be guaranteed renewable for the first five years, Golden Rule's premiums in the state were increased by 15 percent. Because Georgia does not allow claims to be coordinated among insurance carriers, Golden Rule policies in that state are 15 percent higher than they otherwise would be. Maryland's requirement that

[13]It is estimated that one in six couples experiences infertility, and the nation is currently spending $1 billion a year to address the problem. Success with in vitro fertilization usually comes after two cycles. However, unsuccessful couples may try an endless number of cycles. See "Business Bulletin," *Wall Street Journal*, October 19, 1989.

Medigap[14] policies be guaranteed renewable adds 13 percent to premium prices. Michigan's requirement that Medigap policies be guaranteed renewable and guaranteed issued adds 30 percent. Because of unisex legislation prohibiting differential premiums for men and women in Montana, Golden Rule no longer markets insurance in that state.[15]

Guaranteed renewable is not a bad feature of health insurance policies—especially if people are willing to voluntarily pay a higher price to obtain it (see chapter 6). When health insurance more closely resembled real insurance instead of being prepayment for the consumption of medical care, guaranteed renewable was a common feature of policies sold in a competitive insurance market. Guaranteed issue is not a normal or natural consequence of a competitive insurance marketplace, however.

Price Regulation, Insurance Company Profits, and High-Risk Individuals

As Lloyd's of London has shown us, almost any risky event is insurable for a price. Lloyd's not only insures communications satellites headed for upper earth orbit; it also has insured Bruce Springsteen's voice and the beards (against fire or theft) of 40 members of the Whiskers Club in Derbyshire, England. When Cutty Sark offered $2 million to anyone who could capture the Loch Ness monster alive, Lloyd's insured Cutty Sark against having to honor its promise. Prior to and during Operation Desert Storm, Lloyd's wrote coverage for vessels in or near the conflict; in fact it opened its doors on Sunday for the first time in its 303-year history to accommodate new customers as hostilities broke out. If Lloyd's of London can insure endangered ships, men's whiskers, and promotional stakes, why can't many Americans buy health insurance? One answer is that in almost every state, health insurance premium prices are regulated.

Because health costs are continually rising, such state regulation usually consists of a restriction on how much premium prices may increase to cover those costs. In most states, insurance companies may not increase premium prices unless benefits paid are at least

[14]Medigap policies supplement coverage provided under Medicare.

[15]Information obtained from Golden Rule Insurance Company.

equal to a certain percentage of premium income. In all cases, regulation of premium prices translates into regulation of insurance company profits. Without sufficient annual profits, the companies cannot build reserves to cover costs that are unusual enough to occur once in every five, ten, or twenty years. This type of regulation, in turn, can make it virtually impossible for individuals with a higher than average probability of illness to obtain health insurance.

Risk and Profit

A basic principle governing all financial markets is: The higher the risk, the higher the rate of return. For example, to induce investors to purchase riskier financial assets (stocks, bonds, etc.), the sellers must convince the buyers they can earn more than on less risky assets. If we made it illegal to earn more than, say, a 10 percent return in the bond market, investors would be unwilling to purchase bonds from any but the most financially sound corporations. If we made it illegal to earn more than 8 percent on bonds, investors might be willing to purchase only government securities.

A similar principle applies to the market for health insurance: When insurers sell policies to high-risk individuals, they take on more financial risk. Other things equal, the more high-risk policyholders an insurer has, the more risky the total portfolio. Insurers voluntarily accept additional risk only if they can earn a higher return. When state governments limit the rate of return, the inevitable result is that higher risk individuals are unable to obtain health insurance at any price. One way to think of many mandated benefits laws is to see them as an attempt by state governments to force insurers to sell policies to individuals who have been regulated out of the market by state insurance regulators. Such attempts are destined to fail. When state governments force insurers to take on additional risk and forbid them to earn a higher rate of return, insurers simply quit selling policies in the state. For example, it was primarily because of the regulation of premium prices that, in September 1988, Golden Rule Insurance Company ceased marketing its policies in Alabama, Georgia, Massachusetts, Mississippi, North Carolina, New Mexico, and West Virginia.[16]

[16]Information obtained from Golden Rule Insurance Company.

Risk Pools

One way in which state governments have attempted to provide health insurance for high-risk individuals is through the use of risk pools. These are mandated benefits in the sense that all insurers operating in the state are usually forced to participate in the pool. Currently, 15 states have risk pools, and 22 others are considering similar legislation.[17] Under this arrangement, insurance is sold to individuals who cannot obtain policies outside the pool. Premium prices are regulated and generally are set as a percentage of the prices of similar policies sold in the marketplace. For example, in most states, the premium for risk pool insurance is 50 percent higher than for comparable policies.[18] In Florida, however, risk pool premiums may be twice as high; and in Montana, they may be four times as high. In Minnesota, the most generous state, risk pool insurance is only 25 percent more expensive.

Because all states cap the price of risk pool insurance, risk pools almost always lose money.[19] In most cases, losses are covered by assessing insurers, usually in proportion to their share of the market. In Maine, however, losses are covered by a tax on hospital revenues; and in Illinois, they are covered by general tax revenues. In most states that assess insurers for risk pool losses, companies are allowed to fully or partially offset their assessment against premium taxes paid to the state government.[20]

The most serious problem with risk pools is that they raise the cost of health care and/or health insurance for everyone not in the pool. When risk pool losses are paid by a tax on hospital revenues, the burden is placed on sick people. When losses are covered by assessing insurers, the burden is placed on other policyholders. And when insurers are allowed to offset their assessments against state taxes, additional pressure to maintain (or even increase) taxes on insurance premiums is created and causes further distortion in the health insurance marketplace.

[17]For a state-by-state survey of risk pools, see Aaron K. Trippler, *Comprehensive Health Insurance for High-Risk Individuals*, 2d ed. (Minneapolis: Communicating for Agriculture, 1987).

[18]Ibid., pp. 23–24.

[19]Among operating pools, Florida is the only state that has not had losses. Ibid., p. 47.

[20]Ibid., pp. 35–37.

Some Consequences of State-Mandated Benefits

The flood of mandated benefits legislation at the state level has had two major consequences. First, all those who can opt out of regulated health insurance and purchase nonregulated insurance tend to do so. Second, among those who cannot obtain unregulated insurance, an increasing number have no insurance at all. Ironically, those without insurance tend to represent both extremes on the spectrum of the potentially ill. Those who are very healthy and have a low probability of becoming ill choose to remain uninsured because the price of regulated insurance is too high. At the other extreme, those who have a high probability of becoming ill are uninsured because insurers go to considerable lengths to avoid them.

Escape from Regulation by Large and Medium-Sized Firms

On January 1, 1988, the Circle K Corporation, the nation's second largest convenience store chain, sent an interesting letter to its 8,000 employees. The letter announced that the company would no longer provide health care coverage for certain "life style-related" illnesses, including alcohol and drug abuse, self-inflicted wounds, and AIDS (unless acquired accidentally through a blood transfusion).[21] Given that Circle K Corporation operates in 27 states, it undoubtedly operates in states where health insurance benefits for the excluded diseases are required by state law. However, because the company does not purchase insurance, federal law exempts it from state regulations mandating health insurance benefits.[22]

Circle K is not alone. Just as there has been an explosion of mandated benefits legislation over the last decade, there has been an equally dramatic increase in the number of companies that self-insure and manage their own employee health care plans.[23] Today,

[21]Kenneth B. Noble, "Health Insurance Tied to Life-Style," *New York Times*, August 6, 1988, p. 1.

[22]In the fall of 1988, Circle K rescinded the policy in response to pressure from special-interest groups. Failing to comply with state mandates, however, is common practice among self-insured employers.

[23]For a description of the types of employer self-insurance and the benefits of self-insurance, see John C. Goodman and Gerald L. Musgrave, *The Changing Market for Health Insurance: Opting Out of the Cost-Plus System*, NCPA Policy Report no. 118 (Dallas: National Center for Policy Analysis, September 1985).

roughly 50 percent of all employees work for employers who are self-insured.

One reason for self-insurance is that companies are better able to manage their own health care plans and hold down rising costs. Another is that self-insured companies avoid state taxes on insurance premiums and other costly and inefficient regulations. But the most important reason may be that self-insured companies bypass the regulations and costs of mandated health insurance benefits.[24] In other words, employers who self-insure are free to tailor that insurance to the wants and needs of their employees. They are doing what any sensible consumer would do, were it not for government interference.

When companies self-insure, they usually institute cost-management techniques that are at odds with the direction of state health insurance regulations. For example, although the trend in state regulation has been to increase the number and types of services required under conventional health insurance, the tendency among self-insured companies has been to restrict and limit employee choices to certain physicians, hospitals, and types of care.[25]

With few exceptions, mandated health care benefits legislation raises the cost of conventional health insurance. Moreover, as more and more companies self-insure, the burden and costs of such legislation are being imposed on a smaller and smaller proportion of insured individuals. In some states, it is believed that as much as 75 percent of the workforce is covered by self-insured plans. That means that the full burden of mandated benefits regulation falls on the remaining 25 percent.[26]

In an effort to determine how state health insurance regulations affect the decision of firms to self-insure, health economists Jon Gabel and Gail Jensen looked at a sample of 280 firms that were not self-insured in 1981. By 1984, 24 percent chose self-insurance. Using a model that correctly predicted a firm's decision to self-insure 86 percent of the time, Gabel and Jensen found that increasing the state

[24]U.S. Office of Technology Assessment, *Medical Testing and Health Insurance*, report no. OTA-H-384 (Washington: U.S. Government Printing Office, August 1988), p. 7.

[25]Rhonda L. Rundle, "Insurers Step Up Efforts to Reduce Use of Free-Choice Health Plans," *Wall Street Journal*, May 11, 1988.

[26]Scandlen, p. 182.

premium tax from 1 percent to 3 percent increased the probability of self-insuring between 20 percent and 24 percent. Imposing a risk pool and mandating continuation of coverage increased the probability by 55.8 percent and 165.6 percent, respectively.[27]

The Gabel-Jensen study found that mandates for psychologists raised the probability of self-insuring (by 93.2 percent), as did mandates for alcohol treatment (5.9 percent) and drug dependency (58.8 percent), although the latter two mandates were not statistically significant. The impact of all state regulations taken together caused half the firms that self-insured to make that decision.[28]

Escape from Health Insurance by Small Firms

All federal employees and all people covered under Medicare also are exempted from state-mandated benefits by federal law, and states commonly exempt their own employees and all Medicaid patients. The upshot is that the burdens and costs of mandated health care benefits fall on the rest of the population: people who work for small firms, the self-employed, and the unemployed. As a result, an increasing number of small firms are discontinuing their health insurance plans for employees or choosing not to offer health insurance in the first place. Gabel and Jensen found that each new mandate lowered the probability that a small firm would offer health insurance by 1.5 percent. Raising premium taxes from 1 percent to 3 percent or imposing a risk pool lowered the likelihood of a small firm offering health insurance by at least 10 percent, and continuation of coverage mandates lowered the likelihood by 13 percent. In the absence of all regulations, Gabel and Jensen determined, 16 percent of small firms that do not now offer health insurance would do so.[29]

Higher Premiums for All Insured People

Mandated benefits legislation raises the cost of regulated health insurance in a variety of ways. Some regulations force insurers to pay for the health care of people who are already sick (for example,

[27]Jon Gabel and Gail Jensen, "The Price of State-Mandated Benefits," *Inquiry* 26, no. 4 (Winter 1989): 419–31.

[28]Ibid.

[29]Ibid.

AIDS victims); other regulations force insurers to cover procedures related to people's choices (for example, in vitro fertilization and marriage and family counseling) rather than to well-defined, risky events; and many regulations expand the definition of illness and the cost of treatment by expanding the range of covered providers (for example, by including acupuncturists and naturopaths).

In the case of chiropractors, for example, a study by Peat Marwick Main & Co. found that, under Hawaii's current practice of not mandating coverage for chiropractic services, there was no evidence that lack of chiropractic coverage resulted in inadequate care or financial hardship for people using those services. On the other hand, were Hawaii to mandate coverage, the total cost of the mandated benefit would be as high as $8.1 million per year[30] (see Table 11.4).

In a separate study, Peat Marwick found no evidence that lack of coverage for well-baby care resulted in inadequate care or financial hardship. But mandating coverage for well-baby care in Hawaii would increase health insurance costs by as much as $1.8 million.[31] Researchers also found only anecdotal evidence that lack of coverage for alcoholism and drug dependence resulted in lack of treatment. But the cost of mandating coverage for alcoholism and drug abuse in Hawaii would be as much as $2.3 million.[32] The cost of mandating coverage for inpatient mental health care in Hawaii was estimated to be as high as $12.3 million, and for outpatient treatment of mental illness, as high as $6.8 million.[33]

Further evidence of the costs of specific mandates was gathered by Gail Jensen and Michael Morrisey.[34] The Jensen-Morrisey study attempted to estimate the effect on premiums of various insurance policy provisions, whether or not they are mandated. The results

[30]Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandated Health Insurance for Chiropractic Services: A Report to the Governor and the Legislature of the State of Hawaii* (January 1988).

[31]Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandatory Health Insurance for Well-Baby Services: A Report to the Governor and the Legislature of the State of Hawaii* (January 1988).

[32]Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandatory Health Insurance for Alcohol and Drug Dependence and Mental Illness: A Report to the Governor and the Legislature of the State of Hawaii* (January 1988).

[33] Ibid.

[34]Gail A. Jensen and Michael A. Morrisey, "The Premium Consequences of Group Health Insurance Provisions" (September 1988), mimeograph.

Table 11.4
ANNUAL COST OF PROPOSED MANDATED BENEFITS IN HAWAII*

Benefit	Low Estimate	Middle Estimate	High Estimate
Chiropractic services	$2,734,000	$ 6,245,000	$ 8,089,000
Well-baby care	1,267,750	1,521,280	1,774,810
Alcohol and drug abuse treatment	284,088	414,048	2,305,308
Inpatient mental health care	948,175	2,657,315	12,325,305
Outpatient mental health care	892,164	3,556,098	6,815,627
Total	$6,126,177	$14,393,741	$31,310,050

SOURCES: For chiropractic services, Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandatory Health Insurance for Chiropractic Services: A Report to the Governor and the Legislature of the State of Hawaii* (January 1988), Table 4.2 (p. 46); for well-baby care, Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandatory Health Insurance for Well-Baby Services: A Report to the Governor and the Legislature of the State of Hawaii* (January 1988), Table 4.5 (p. 45); for alcohol and drug abuse treatment, Peat Marwick Main & Co. and the Office of the Legislative Auditor, *Study of Proposed Mandatory Health Insurance for Alcohol and Drug Dependence and Mental Illness Services: A Report to the Governor and the Legislature of the State of Hawaii* (January 1988), Appendix A (p. 108); for inpatient mental health care, ibid., Appendix B, p. 111; and for outpatient mental health care, ibid., Appendix C, p. 114.

*The estimates would be considerably higher were it not for the fact that many Hawaiian insurance policies already have full or partial coverage for the benefits.

Table 11.5
EFFECTS ON INSURANCE PREMIUMS OF SPECIFIC HEALTH INSURANCE BENEFITS

Feature	Change in Individual Premium	Change in Dependents' Premium
Front-end cost sharing[1]	− 7.6%	−11.4%
Second surgical opinion	+ 5.0[2]	+ 7.7
Home health care	+ 0.1[2]	− 5.0[2]
Extended care	− 0.4[2]	− 5.1[2]
Substance abuse treatment	+ 7.9	+ 6.2
Psychiatric hospital care	− 1.7[2]	+20.8
Psychologist visits	+10.4	+12.6
Routine dental care	+23.8	+11.8
Self-insurance[3]	+19.0	+ 8.7
Commercial insurance[3]	+ 8.6	+ 5.0[2]
1 or 2 HMOs[4]	+ 5.2	+ 6.0
3 HMOs[4]	+18.4	+ 5.6[2]

SOURCE: Gail A. Jensen and Michael A. Morrisey, "The Premium Consequences of Group Health Insurance Provisions" (September 1988), mimeograph.
[1]Presence of a deductible.
[2]Not statistically significant.
[3]Relative to Blue Cross premiums.
[4]Employee options.

of this study are presented in Table 11.5. As the table shows, second surgical opinions and home health care costs appear to have no individual statistically significant effect on premium prices of the primary insured, but second surgical opinions, in combination with other mandates, may cause premium prices for dependents to be higher than otherwise. Coverage for substance abuse is very costly, increasing premium prices by 6 to 8 percent. Coverage for outpatient mental health care is even more expensive, increasing premium prices by 10 to 13 percent. Psychiatric hospital care apparently has little effect on premium prices for employees. But if dependents are covered, premium prices can rise by as much as 21 percent.

Another interesting finding of the Jensen-Morrisey study is that self-insurance raises insurance costs by as much as 19 percent, possibly because many companies are not skilled at operating their

own health insurance programs. The additional cost may be worth it, however, if the firm saves a significant amount of money by avoiding state-mandated benefits.

Excessive Premiums for Low-Risk Individuals

A basic principle governing the health insurance marketplace is that, in any given year, a small percentage of people will generate a majority of the health care costs. For example, a survey of employers by Johnson and Higgins found that about 1 percent of all employees account for 22 percent of company health care costs, and about 5.6 percent account for 50 percent of the costs.[35]

The experience of employers undoubtedly reflects the experience of the health insurance market as a whole. Accordingly, a major objective of health insurers is to expand coverage for the vast majority who will generate few claims or small claims and avoid those likely to generate large claims. One purpose of mandated benefits legislation is to try to force insurers to cover the high-risk population. To the extent that the regulators are successful, insurers cover more and more high-risk individuals and attempt to pay for this coverage by overcharging the low-risk population. As average premiums rise, health insurance becomes less and less attractive to people who are at low risk and fewer of them buy insurance. As a result, a vicious cycle occurs: As fewer low-risk people buy insurance, the pool of the insured becomes increasingly risky—leading to higher premiums and even fewer low-risk people choosing to insure.

The Impossibility of Obtaining No-Frills Catastrophic Health Insurance Tailored to Individual and Family Needs

Another factor that encourages people (especially low-risk people) not to insure is that mandated benefits legislation prevents them from buying insurance tailored to their needs. In some states, couples who cannot have children cannot buy policies that do not provide coverage for newborn infants. Moderate drinkers and people who abstain from using drugs cannot buy policies that do not cover alcoholism and drug abuse. People who do not intend to see

[35]Reported in Rickles.

chiropractors, psychologists, or marriage counselors cannot buy policies that exclude such coverage. As a result, people cannot buy insurance for a price that reasonably reflects their wants and needs.

The Lack of Availability of Health Insurance for High-Risk Individuals

An unintended consequence of mandated benefits legislation is that it probably makes it more difficult for higher risk individuals to obtain insurance. When insurers are prevented from charging a premium that reflects the risk they incur, they will not insure. As low-risk individuals drop out of the market, insurers face even more pressure to avoid high-risk policyholders. At the extreme, insurers can refuse to sell any insurance within a state.

The Growing Number of Uninsured Individuals

From World War II until the mid-1970s, the percentage of the population covered by private health insurance grew steadily. For example, the proportion covered by private health insurance for hospital care grew from 69 percent in 1960 to 83 percent in 1978, while the proportion covered for physician care grew from 46 percent in 1960 to 78 percent in 1974.[36] Since the mid-1970s, however, this trend has been reversed. Specifically, the proportion of people with private hospital insurance fell from a peak of 83 percent to 79 percent by 1984, the proportion of people with private physician insurance fell from a peak of 78 percent to 73 percent over the same period.[37]

Different studies have arrived at different estimates of the number of people without any health insurance. One study, using the same methodology for different years, concluded that the number of people without health insurance rose from 24.5 million (11.1 percent of the population) in 1980 to 33.3 million (13.5 percent of the population) in 1990.[38]

[36]U. S. Bureau of the Census, *Statistical Abstract of the United States, 1987* (Washington: Government Printing Office), p. 89 (Table 137).

[37]Ibid.

[38]John Sheils (Lewin/ICF), testimony before the Senate Committee on Labor and Human Resources, July 24, 1991.

Why is this growth occurring? One reason may be tax reform.[39] Another may be a shift in employment from manufacturing to services and the retail trades.[40] But it's hard to escape the conclusion that an increasing number of consumers are being regulated and priced out of the market for health insurance.

To What Extent Are Mandated Benefits Causing People to Be Uninsured?

An econometric model of the health insurance marketplace has been developed by the authors.[41] To our knowledge, this is the first model that produces statistical estimates of the factors causing people to be without health insurance. Although certain information about the market for health insurance was not available to us, the model nonetheless explains 94 percent of the variation in the percent of the population without health insurance across the 50 states.

Various versions of the model were tested, and in each test the number of mandated benefits was a strong and statistically significant cause of lack of health insurance. Specifically, as many as 25.2 percent of all uninsured people lack health insurance because of mandated benefits.

The number of mandated benefits varies considerably among the states, from a low of 4 in Delaware and Idaho to a high of 32 in Maryland. Moreover, the impact of the mandates is mitigated by

[39]Under federal tax law, employer-paid premiums for health insurance are not counted in the taxable income of employees. This tax subsidy is not available to the self-employed or to people who purchase health insurance on their own, although the Tax Reform Act of 1986 does allow self-employed people to deduct 25 percent of their premium payments. The tax subsidy for employer-provided insurance becomes less important at lower marginal tax rates, however. Thus, the lowering of tax rates in the 1980s also reduced the attractiveness to employees of employer-provided health insurance. See Gary A. Robbins, "Economic Consequences of the Minimum Health Benefits for All Workers Act of 1987 (S. 1625)," testimony presented to the U.S. Senate Committee on Labor and Human Resources, November 4, 1987.

[40]More than one-half of uninsured workers in 1985 were employed in retail trade and services. See Employee Benefit Research Institute, Issue Brief no. 66, p. 15.

[41]See John C. Goodman and Gerald L. Musgrave, *Freedom of Choice in Health Insurance*, NCPA Policy Report no. 134 (Dallas: National Center for Policy Analysis, November 1988), Appendix A.

Table 11.6
EFFECTS OF MANDATED INSURANCE BENEFITS IN SELECTED STATES, 1986

State	Percent of People Who Lack Health Insurance Because of Mandates
Connecticut	64%
Maryland	60
Minnesota	60
New York	41
New Jersey	34
California	32
Maine	32
Missouri	30
Nevada	30
Virginia	30
Washington	30
Massachusetts	28
Ohio	28
Kansas	27
Nebraska	26
Montana	21
Arizona	20
Florida	18
Texas	18
New Mexico	16
Arkansas	15

SOURCE: John C. Goodman and Gerald L. Musgrave, *Freedom of Choice in Health Insurance*, NCPA Policy Report no. 134 (Dallas: National Center for Policy Analysis, November 1988), Appendix A.

other factors, such as the prevalence of employer-provided insurance and/or the ability to escape regulation through employer self-insurance. For these reasons, the impact of mandated benefits differs substantially among the states. As Table 11.6 shows, the proportion of people who lack health insurance because of mandated benefits exceeds 60 percent of the uninsured population in Connecticut, Maryland, and Minnesota, 41 percent in New York, and 30 percent in California, Maine, and New Jersey. Massachusetts is of

special interest. Legislation passed in Massachusetts at the urging of Governor Michael Dukakis was a costly attempt to make health insurance available to all Massachusetts residents (see chapter 12). However, as Table 11.6 shows, up to 28 percent of the state's uninsured population already lack health insurance because of regulations imposed by the state government.

Positive Signs of Change

Although the above discussion is pessimistic in its description of the explosion of state regulations during the 1980s and the negative impact of those regulations, there are some signs that state legislators are increasingly aware of the harmful effects of state-mandated benefits. Following the lead of Washington, Arizona, and Oregon, for example, more than a dozen states now require social and financial impact statements prior to the passage of any additional mandates.[42] In 1983, for example, because of its concern about costs, the Washington state legislature began putting the burden of proof on a mandate's proponents to show that the benefits of a proposed mandate would exceed the costs. As a result, no new mandates were adopted in Washington for several years.[43] Such requirements have clearly slowed the passage of state-mandated benefits, if only because the proponents of mandates need more time and money to overcome the new legislative hurdles.

A more positive sign is that fewer mandates are being passed and that some states have actually rolled back mandates for small business. As Table 11.7 shows, in the three years prior to 1990, state governments passed an average of 71 mandates per year. In 1990 and 1991, however, they passed only 29 and 37 mandates, respectively. Moreover, at least 24 states have now rolled back mandated benefits for small business, and a dozen other states are considering similar legislation.[44] In Washington State, for example, health insurance policies would normally be subject to 28 mandates covering

[42]"Mandated Benefits: Mixed Signals from the States," *Health Benefits Letter* 1, no. 3 (March 13, 1991).

[43]Employee Benefit Research Institute, *Employee Benefit Notes* 8, no. 9 (September 1987): 7.

[44]The discussion that follows is largely based on *Health Benefits Letter* 1, no. 8 (May 23, 1991); and ibid. 1, no. 13 (August 8, 1991).

Table 11.7
NUMBER OF NEW STATE-MANDATED HEALTH INSURANCE BENEFITS, 1987 TO 1991

Year	New Mandates
1987	62
1988	51
1989	99
1990	29
1991	37[1]

SOURCE: *Health Benefits Letter* 1, no. 15 (August 29, 1991).
[1]As of July 1991.

alcohol and drug abuse, mammographies, and the services of chiropractors, occupational therapists, physical therapists, speech therapists, podiatrists, and optometrists. Under a law passed in 1990, however, firms with fewer than 50 employees can now buy cheaper insurance with no mandated benefits.

States also have taken other actions to encourage small businesses to purchase health insurance for their employees. Several exempt small-business policies from premium taxes, and at least six states extend tax credits to companies that are first-time buyers of health insurance. Iowa, for example, exempts "bare-bones" policies from premium taxes and provides a tax credit for employers who pay at least 75 percent of the premium for a low-income employee and half of the premium for the employee's dependents. Premium taxes also have been waived for small businesses in Nevada, New Mexico, and West Virginia. Other states that give employers tax credits for the purchase of health insurance include Kansas, Kentucky, Montana, Oklahoma, and Oregon. The credit is $15 per employee per month in Oklahoma and up to $25 in Oregon.

The Threat of a Counterrevolution

Now for the bad news. In a review of the fine print of the new legislation, Greg Scandlen of *Health Benefits Letter* finds that many state reforms are less substantial than they seem.[45] Some states have

[45]Scandlen, *Health Benefits Letter* 1, no. 8 (November 1991).

repealed some mandates but not others. Missouri, for example, has repealed only 8 of its 18 mandates.

The definition of a small business is often quite restrictive. In 14 states, an employer must have no more than 25 employees. In addition, many states allow a small business to qualify only if it has been without insurance for some period of time. In seven states, the qualifying period is at least one year; in Kansas, Maryland, and Rhode Island, it's two years; and in Kentucky, it's three years. In those states, small businesses that currently provide insurance coverage are penalized for doing so. All the benefits from the new legislation go to their uninsured competitors.

In another unfortunate trend, some states have subjected bare-bones policies to new mandates while freeing them from the burdens of old ones. For example, numerous states now require coverage for mammograms and well-child care, even though the same laws allow insurers to skimp on catastrophic coverage.

Perhaps the worst development is a new set of regulations governing insurance pricing. At least five states now require insurers to sell to any small business, regardless of the health of its employees (with limits on the premiums that can be charged). Although the objective may seem humane, these laws encourage perverse behavior. If people know they can always get insurance after they are sick, they have an incentive to wait until they are sick to buy it. Yet, if only sick people buy health insurance, the premiums will be extremely high.

Another perverse development is the trend toward community rating. Virginia, for example, requires that all applicants be charged the same premium, regardless of the likelihood that they will get sick and incur medical costs. Other states have severely limited the ability of insurers to price risk accurately, causing healthier people to be overcharged and sicker people to be undercharged. States that require insurers to take all comers and prevent insurers from charging premiums that reflect real risks usually set up "reinsurance pools," under which profitable companies are forced to subsidize the losses of unprofitable ones. The net result is that all premium prices will be higher than they would have been.

Insurance industry experts estimate that the removal of all current state mandates would reduce the cost of health insurance by about 30 percent. But this gain could be totally wiped out by the cost-increasing effects of new regulations.

Furthermore, bare-bones policies often sell at a lower price, not because of reduced regulation, but because of reduced coverage for basic medical risks. Annual insurance benefits may be capped at $100,000 per employee in Arkansas and $50,000 in New Mexico and Nevada. Such policies leave people exposed for truly catastrophic medical episodes and undermine the real purpose of insurance. Because the option to reduce coverage in this way was generally permissible even before insurance reform, it's not surprising that bare-bones policies have not made much of an impact in the half-dozen states where they are now being marketed.

The Need for Real Reform

The most basic problems with insurance reform are the refusal of state governments to allow a real market to develop and the refusal of the federal government to give the currently uninsured the same tax and regulatory breaks given to employees of large companies.

Contrary to widespread impressions, most people who lack health insurance are healthy. Sixty percent are less than 30 years of age, in the healthiest segment of our population.[46] Most have below-average incomes and very few assets. As a result, they are especially sensitive to price.

Most of the uninsured have voluntarily decided not to purchase health insurance for a very good reason: The price is higher than that faced by other people for comparable benefit levels. Whereas 90 percent of insured people purchase health insurance with pretax dollars through an employer, uninsured individuals must pay with aftertax dollars. Whereas most employees of large corporations are exempt from silly state regulations, since their employers self-insure, most of the uninsured are the victims of those regulations.

What most young, healthy people need is the opportunity to buy no-frills health insurance at a fair price. Aside from giving these people the same income tax break and the same options routinely given to others, politicians could help most by repealing bad laws and getting out of the way.

[46]Jill D. Foley, *Uninsured in the United States: The Nonelderly Population without Health Insurance* (Washington: Employee Benefit Research Institute, April 1991), p. 16.

12. Mandating Employer-Provided Health Insurance

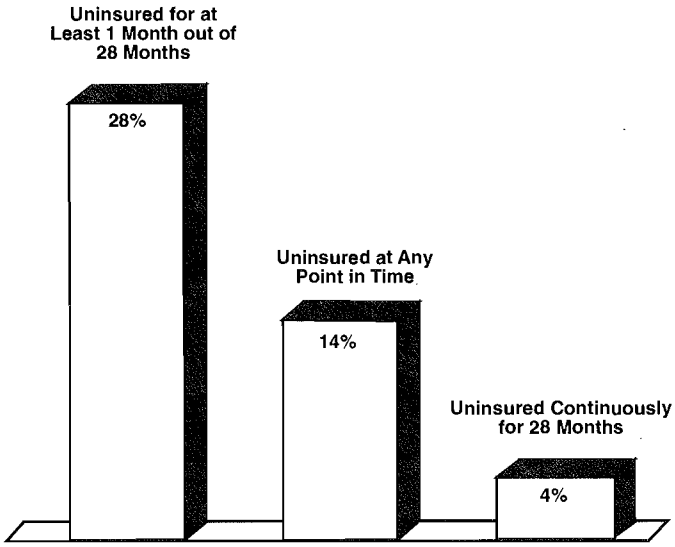
Although costly state regulations contribute to the increasing number of people who lack health insurance, lack of health insurance does not necessarily keep people from getting medical care. Nevertheless, from the perspective of the cost-plus mentality, the people who lack health insurance are a problem that demands political solutions—solutions that will put them back in the cost-plus system.

At the urging of Governor Michael Dukakis, Massachusetts passed legislation intended to provide all state residents with health insurance beginning in 1992. Other states are considering similar legislation. Several bills in Congress—including a bill introduced by Senate Democrats and one introduced by Dan Rostenkowski (D-IL), the chairman of the House Ways and Means Committee—would implement the Massachusetts plan at the national level. Other legislation to require employers to provide health insurance for all employees nationwide has been introduced in Congress by Sen. Edward Kennedy (D-MA). This chapter takes a closer look at some of the most prominent proposals to force people to have health insurance. Our general conclusion is that the principal problem addressed by these proposals is not that of unpaid hospital bills and that the proposals carry a concealed price tag many times greater than any benefits the forced insurance coverage could provide.

What Difference Does Lack of Health Insurance Make?

It is believed widely in this country, and even more prevalently in Europe, that uninsured residents of the United States are routinely denied health care. That belief is quite wrong. What is true is that the existence or nonexistence of health insurance makes a big difference in determining how care is paid for. What follows is a brief summary of how and why health insurance makes a difference.

Figure 12.1
UNINSURED AS PERCENTAGE OF NONELDERLY POPULATION



SOURCE: C. Nelson and K. Short, *Health Insurance Coverage: 1986 to 1988,* U.S. Bureau of the Census Report, p. 70, no. 17, 1989. Reported in Louis P. Garrison, Jr., "Medicaid, the Uninsured, and National Health Spending: Federal Policy Implications," *Health Care Financing Review,* 1990 Annual Supplement, p. 169.

What It Means to Lack Health Insurance

Americans have been repeatedly told that 34 million people in this country lack health insurance. But what does that mean? Most discussions of the uninsured imply that they are a well-defined class of people. But Figure 12.1 shows that is not the case. Over a 28-month period, about 28 percent of the population will be uninsured, if only for a brief period of time. On any given day, about half that number will be uninsured, however. And, over the entire 28 months, only 4 percent will be continuously uninsured. The pool of uninsured, then, is one that many people enter and leave over a period of several years. Only a small number of people remain there permanently.

In that respect, being uninsured is comparable to being unemployed. Most people will probably be unemployed at some time during their work life. At any point in time, however, only about 6 percent of the population is unemployed, and only a very small percent of people remain continuously unemployed for long periods. Like being unemployed, being uninsured is generally viewed as an undesirable state of affairs. Most people are likely to experience both, but without any serious long-term consequences.

Health Insurance and Access to Medical Care

Some apparently contradictory studies have attempted to determine how the lack of health insurance affects access to health care. Some studies claim that the uninsured get less health care. Others claim that once they see a physician or enter a hospital, the uninsured receive as much care as—or more care than—the insured. These studies are not necessarily inconsistent, but often they amount to comparing apples and oranges.

In comparing two groups of people, it is important to know much more than whether one group is insured and the other is not. For example, people with higher incomes and higher levels of education tend to place a greater value on health care and to spend more of their income on it. On the other hand, people who are sicker use more medical services than people who are healthy, and poor health tends to be correlated with low income and low levels of education.[1] Age also matters, in that younger people tend to be healthier. Interestingly, the uninsured have lower incomes and lower levels of education than the insured—and also are younger (60 percent are under the age of 30, for example).

Table 12.1 shows that if all other differences among the groups of people are ignored, there is very little difference between the insured and the uninsured in the number of physician visits (among those who see a physician) or in the number of days in a hospital (among those who enter a hospital). This generalization also applies to people known to have low health status. In fact, among people with below-average health, those without health insurance make

[1]See Attiat F. Ott and Wayne B. Gray, *The Massachusetts Health Plan: The Right Prescription?* (Boston: Pioneer Institute for Public Policy Research, 1988), pp. 26–31.

Table 12.1
USE OF HEALTH SERVICES BY NONELDERLY PEOPLE WITH AND WITHOUT HEALTH INSURANCE

Medical Service	People with Insurance	People without Insurance
Annual physician visits[1]		
1–2 visits	52.9%	51.4%
3–5 visits	24.9	22.1
6 or more visits	22.2	26.6
Annual hospital stays[2]		
1–5 days	56.9	59.8
6–10 days	22.3	19.1
11 or more days	20.8	21.2

SOURCE: National Health Interview Survey, reported in Attiat F. Ott and Wayne B. Gray, *The Massachusetts Health Plan: The Right Prescription?* (Boston: Pioneer Institute for Public Policy Research, 1988), Table 2.15 (p. 36).
[1]Refers only to people who saw a physician.
[2]Refers only to people who entered a hospital.

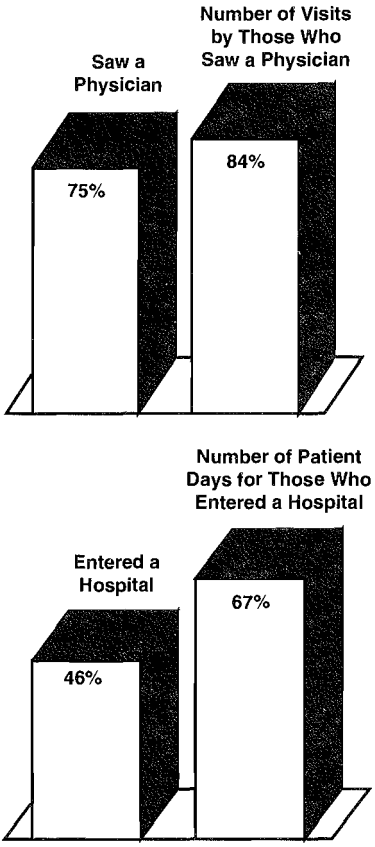
more visits to physicians and spend more days in the hospital than those with insurance.[2]

However, more detailed analysis shows that there are significant differences among the two groups, once all the relevant variables are accounted for. A study by Stephen Long and Jack Rodgers, for example, weighted the probability of using health care services by health status, age, sex, marital status, family size, income, education, employment status, and residence. The results are depicted in Figure 12.2. As the figure shows, the uninsured are about 25 percent less likely to see a physician and about half as likely to enter a hospital as are people who have employer-provided health insurance. Once in the health care system, the uninsured see physicians about 16 percent less often and spend one-third as much time in the hospital. Overall, the uninsured consume about half as much health care as the insured, when adjusted for all the variables listed above.

These results are consistent with those of the Rand Corporation study discussed in chapter 8. Whereas the Rand study showed that

[2]Ibid., Table 2.15 (p. 36).

Figure 12.2
USE OF HEALTH SERVICES BY THE UNINSURED
(as Percentage of Use by People Who Have Health Insurance)*



SOURCE: Stephen H. Long and Jack Rodgers (Congressional Budget Office), "The Effects of Being Uninsured on Health Services Use: Estimates from the Survey of Income and Program Participation," unpublished, Table 3, p. 11.

*Compares use of services over a 12-month period by those who were continuously uninsured/insured over the 12-month period. Probabilities of use are weighted by age, sex, income, health status, and other characteristics.

a deductible in the range of $1,000 to $2,500 reduces health care spending by one-third, the Long-Rodgers study showed that the absence of any health insurance reduces health care spending by one-half. The Rand study also found that, although the presence of a high deductible reduces health care spending considerably, the reduced spending has no apparent effect on people's health. Can the same be said of people who have no health insurance? That's not clear. But it seems likely that, for the vast majority of people, the absence of health insurance for brief periods has no effect on health, especially considering that most health care is elective (and therefore can be delayed) and that most people have a great deal of choice over whether to be insured or not.

According to the National Health Interview Survey (1984), more than half of those without health insurance gave "cannot afford" as the primary reason why.[3] Less than 1 percent gave "poor health" or "age" as a reason. The answer "cannot afford" should not be taken literally; better phrasing would be, "The price is too high." In Massachusetts, which recently enacted a universal health care plan, 58.1 percent of the people who lack health insurance live in families with annual incomes of $20,000 or higher.[4]

Legal Rights to Health Care

Access to medical care by those who cannot pay for it is guaranteed by numerous state and federal laws. Currently, 47 states require state, county, and/or city governments to provide care for the indigent and the uninsured, and numerous court decisions have upheld the right of hospitals to sue state and local governments for reimbursement for such care.[5] Moreover, federal law now requires all hospitals treating Medicare patients to accept all patients with emergency health problems and prohibits hospitals from transferring indigent patients unless the patient's condition is stabilized or

[3]Ibid., Table 2.11 (p. 30).

[4]Ibid., Table 2.2 (p. 17).

[5]Patricia Butler, "Legal Obligations of State and Local Governments for Indigent Care," in the Academy for State and Local Government, *Access to Care for the Medically Indigent*, pp. 13–44.

the transfer is requested by the patient or medically indicated because of superior facilities at another hospital.[6]

Health Care Rationing in the Public Sector

Most discussions (and most studies) of the uninsured make little distinction between people insured in the private sector and those insured by public programs. But if there is a major difference in access to health care in the United States, increasingly that difference is in whether or not patients rely on public hospitals and clinics—whether or not they have health insurance.

One survey of public hospital emergency rooms in large cities discovered that patients could wait up to 17 hours to see a physician. In the face of such waits, many patients leave in frustration, without receiving care.[7] Waits can also be lengthy at outpatient clinics. A pregnant woman in Chicago, for example, had to wait 125 days to see a public clinic physician for the free care to which she was presumably entitled.[8] Furthermore, anecdotal (newspaper) descriptions of conditions in public hospital emergency rooms in the United States are very similar to the descriptions of emergency rooms in Canada, Britain, and other countries with national health insurance (as discussed in chapter 18). In those countries, everyone is theoretically insured. The problem of access is created by public-sector health care rationing.

Health Insurance and the Protection of Financial Assets

If health insurance is not a prerequisite to health care for most people, why does anyone purchase it? For the same reason that people purchase life, automobile liability, and fire and casualty insurance: to protect assets. A major, catastrophic illness can wipe out a family's savings and investments. To protect their assets against unexpected medical bills, people purchase health insurance. It is hardly surprising that the more assets people have, the

[6]Deborah J. Chollet, "Financing Indigent Care," in Frank B. McArdle, ed., *The Changing Health Care Market* (Washington: Employee Benefit Research Institute, 1987), p. 188.

[7]Philip J. Hilts, "Many Leave Emergency Rooms Needing Care," *New York Times*, August 27, 1991.

[8]*Chicago Tribune*, November 25, 1990, cited in Emily Friedman, "The Uninsured: From Dilemma to Crisis," *Journal of the American Medical Association* 265, no. 19 (May 15, 1991): 2494.

more likely they are to have health insurance. If people with few assets choose not to purchase health insurance, their choice may be rational. It does, however, have social consequences. If society is committed to providing basic health care for all who need it, including the uninsured, some way must be found to pay the medical bills of the indigent uninsured. That is the reason usually given for the political support for universal health insurance.

Most proposals for mandatory health insurance, such as the Massachusetts health care plan and the Kennedy bill, are not primarily proposals to ensure access to health care. Instead, they are proposals designed to force people to purchase health insurance whether they want to or not. The argument generally used in favor of mandatory health insurance is that it will reduce the burden of hospital bad debts and charity care. For example, Susan Sherry, a spokesperson for Health Care for All (a coalition of consumer activist groups supporting the Massachusetts health care plan), explained to the *Washington Times* why individuals should not have the choice to buy or not buy health insurance: "That's not fair to the rest of us who have to pay when that person gets into an accident."[9]

Why Are People Uninsured?

Why do so many people lack health insurance? Part of the reason is that, for many, health insurance has little value. Because lack of health insurance is not a major barrier to receiving health care, health insurance is of value primarily to those who wish to protect their assets against catastrophic health care expenses. For those with few or no assets, the price of health insurance may far exceed its value.

Contrary to widespread impressions, most of the uninsured are healthy. Two-thirds of them are under the age of 30,[10] in age groups that have the lowest health care costs. Because they tend to be young and healthy and have few assets, they are likely to be sensitive to price and to voluntarily forgo health coverage if the price is too high. Nevertheless, there are at least three government policies that cause the uninsured to face higher prices than most other

[9]Michael Hedges, "Study Finds Massachusetts Health Law Will Cut Jobs, Help Non-Poor," *Washington Times*, October 6, 1988, p. A 4.

[10]Jill D. Foley, *Uninsured in the United States: The Nonelderly Population without Health Insurance* (Washington: Employee Benefit Research Institute, April 1991), p. 16.

people. First, because of the federal tax law, the self-employed, the unemployed, and some employees of small businesses face aftertax prices for health insurance that are as much as twice as high as the prices paid by people who have employer-provided health insurance. Second, because of state regulations, the uninsured face premiums that are 20 to 30 percent higher than those of many people who have health insurance. Third, because of employee benefits law, people working in the small-business sector find that health insurance is increasingly more expensive.

Ironically, our tax laws and employee benefits laws were originally designed to encourage greater health insurance coverage for more people. Today, the laws are having the opposite effect. Before imposing new costs on small businesses and creating yet another layer of bureaucracy, it would make sense to get rid of bad policies and give the market a chance to work. Instead, many are proposing more laws and more regulations.

Employer-Mandated Health Insurance in Hawaii[11]

Hawaii is currently the only state that can require all employers—even self-insured employers—to provide health insurance for their workers. Under the federal Employee Retirement Income Security Act (ERISA), companies that self-insure are exempt from state regulations. As a result, states such as Massachusetts that want to force all employers to provide health insurance have resorted to play-or-pay plans to get around the ERISA exemption. Under the play-or-pay approach, state governments impose a per-employee tax on employers who do not offer health insurance. Hawaii passed its employer mandate in 1974, and after the Supreme Court invalidated the law in 1981 (declaring it to be in violation of ERISA), Hawaii got an ERISA exemption from Congress. Under Hawaii state law, employers are required to provide a minimum package of health insurance benefits for employees, but not for their dependents. The contribution of employees is limited to 1.5 percent of wages.

It is not clear to what degree the state law forces employers and employees to do something they would not have done anyway. By one estimate, only 5,000 additional people—out of a population of

[11]This discussion is based largely on Emily Friedman, "Health Insurance in Hawaii: Paradise Lost or Found?" *Business and Health*, June 1990, pp. 52–59.

1.1 million—acquired health insurance as a result of the law. During the period from 1981 to 1983, when the law was invalidated by the Supreme Court, very few employers dropped health insurance coverage. And employer-provided benefits are commonly more liberal than the minimum benefits required by the state.

One reason why Hawaii has had fewer problems than other states could expect is that the state's population is apparently healthier and medical costs are much lower. The state has an extensive system of HMOs, and per capita hospital expenses in Hawaii in 1988 were only $506, compared to $960 in Massachusetts.

Interestingly, mandated health insurance benefits imposed by the state have been more controversial than the required minimum health care package. Over the years, the state of Hawaii has mandated in vitro fertilization, mental health, alcohol and drug abuse treatment, psychological services, and other benefits. The mandates force employees to take more of their compensation in the form of benefits they may not want or need instead of as higher wages. The state has imposed additional mandates on employers who offer optional coverage for the dependents of workers, which has undoubtedly discouraged Hawaii employers from offering dependent coverage.

Hawaii's mandates are not free. One cost is in employment growth. In the period 1980–86, Hawaii's employment grew by only 9 percent, compared with 13 percent for the nation and 20 percent for the U.S. Pacific Coast states. Another cost is reduced money wages. In 1975, when the law first went into effect, Hawaii was 25th among the states in average annual employee wages. By 1986, it had fallen to 36th.[12]

The Massachusetts Health Care Plan

On April 21, 1988, Governor Michael Dukakis signed legislation requiring employers in Massachusetts to contribute toward health insurance premiums for their employees. Perhaps because of confusion created by election year rhetoric, this plan has been widely

[12]Rita Ricardo-Campbell, "Business Health Care Costs and Competition," Working Papers in Economics no. E-91-6, Hoover Institution, Stanford University, February 1991, p. 34.

misunderstood. The following account is a brief attempt to clarify it.[13]

1. **Employees in Massachusetts are still not covered under the plan.** Despite 1988 election campaign statements that everyone in Massachusetts has health insurance, the law was not supposed to take full effect until 1992, and implementation has been subsequently delayed. Moreover, at the time of this writing, there is a reasonable chance that the law will be repealed before it is fully implemented. Currently, the Massachusetts state legislature wants to delay the entry of private business into the program until 1995, and the governor wants to kill the program altogether.
2. **The plan will require employers to spend money on health insurance for their employees but will not mandate a specific package of health insurance benefits.** Technically, employers will be assessed a state tax equal to 12 percent of salary up to $14,000 per year for each employee. However, employers may deduct from the tax any amount spent on health insurance for the employee. That means that employers must spend (either in taxes or on health insurance) $1,680 for employees earning $14,000 or more per year. Massachusetts would be in violation of federal law (ERISA) if it attempted to dictate specific benefits to self-insured plans.
3. **The plan is not universal health insurance; it will leave many uninsured people with the option of purchasing health insurance.** Technically, the only Massachusetts residents who will be forced to have health insurance will be college students. All employees not covered by employer-provided health insurance and all nonworking people will have the option of buying health insurance from the state. But they may choose not to buy the state's health insurance, just as many now choose not to buy private health insurance.
4. **Under the plan, Massachusetts residents may not all have access to affordable health insurance.** The clear intention of Massachusetts is to offer health insurance at subsidized prices

[13]This account is based largely on Ott and Gray; and Gail R. Wilensky, "The 'Pay or Play' Insurance Gamble: Massachusetts Plan for Universal Health Coverage," paper presented to the House Wednesday Group, Washington, September 26, 1988.

to low- and moderate-income families. However, as the specifics of the benefit package are unknown, the cost of the policies and the subsidies also is unknown. Nor is it known how many people will rely on the state for health insurance. Moreover, given Massachusetts' well-publicized financial troubles, the state may not be able to offer its residents affordable health insurance.

5. **Although Massachusetts intends to force the private sector to provide health insurance for employees, the system may evolve into a state-run version of national health insurance.** That is because the required contribution of employers is low relative to the cost of health insurance, and the benefits in the state insurance policy are likely to be quite liberal. According to one estimate, nationwide, the average employer contribution for an employee's health insurance in 1991 was $2,635—employers pay approximately 88 percent of individual coverage and 78 percent of family coverage for an indemnity plan.[14] Because health care costs are higher in Massachusetts, employer contributions to health insurance are likely to be $500 or $600 higher than the national average.[15] Moreover, the state insurance plan will include benefits such as mental health care and well-baby care not now included in many private plans. Thus, many employers may decide to pay the state health insurance tax (12 percent of wages) and turn the obligation of providing health insurance over to the state. Indeed, given the difficulties employers now have in managing health care plans, it would be surprising if they did not.[16]
6. **After the plan is implemented, the number of uninsured Massachusetts residents may actually increase.** Because employers have the option of paying the state tax and not providing employee health insurance, many may choose that option, including employers who currently have health insurance for their workers. Because uninsured individuals do not have to purchase insurance from the state, many may decline

[14]KPMG Peat Marwick, "Health Benefits in 1991," Montvale, NJ, 1991.

[15]Ott and Gray, p. 51.

[16]The plan does create tax-credit subsidies to encourage small business to provide employee health insurance during the first two years, however.

to do so. As a result, the number of uninsured people in Massachusetts may actually increase. The more perverse the incentives created by the state plan, the higher that increase will be.

Economists Attiat Ott and Wayne Gray have estimated the minimum costs of the plan. Based on requirements already written into law, they concluded that the plan will force Massachusetts businesses to increase spending on employee health insurance by at least 32 percent. The additional cost will be at least $642 million in the first year of operation. Because of the increased cost of employing workers, as many as 9,000 jobs will be lost, with low-paid employees the likely losers.[17] Although it is difficult to generalize about the rest of the nation on the basis of the Massachusetts plan, Wayne Gray estimates that if the Massachusetts health care plan were adopted nationally, the additional cost to business would be $23 billion and as many as 358,000 jobs would be lost nationwide.

Despite the considerable cost of the Massachusetts plan, Ott and Gray found little evidence of a problem that needed to be solved. For example, Massachusetts already has a health care risk pool, designed to spread the cost of uncompensated hospital care among all hospitals and thus among all patients. Moreover, there is virtually no evidence that the uninsured in Massachusetts lack access to adequate health care. Most of the state's uninsured are far from poor, more than 58 percent have annual family incomes of $20,000 or higher, and 15 percent have annual family incomes in excess of $50,000.[18]

Actions by Other State Governments

Many other states are considering forcing people to purchase health insurance by making health insurance a condition of employment. Often, the legislators in these states are trying to solve the problem they created by passing costly regulations. In almost every case, the natural legislative response is not to repeal bad laws but to pass more laws. Many of the legislatures that are considering forcing people to buy health insurance are the ones driving up

[17]Ott and Gray.

[18]Ibid., Table 2.2 (p. 17).

health insurance costs by mandating more and more health insurance benefits. As of this writing, California, Illinois, and Wisconsin are among the states in which employer-mandated health insurance is being taken most seriously. Wisconsin is considering following the Massachusetts model by forcing employers to purchase health insurance on behalf of their workers and by imposing statewide taxes to pay for health insurance for the uninsured unemployed. As in Massachusetts, such a plan would be costly for the private sector.

A study conducted by Aldona Robbins and Gary Robbins estimated the effect of the Wisconsin plan on that state's economy.[19] The study found that requiring private firms to provide health insurance for employees would cost businesses $417 million, reduce state output by $45 million to $100 million a year, and destroy 1,400 to 3,000 jobs annually. The study also found that creating a program of public health insurance for the uninsured with incomes below 155 percent of the poverty level would cost between $149 million and $327 million and destroy as many jobs as the mandated insurance plan.

The Kennedy Plan

Sen. Edward Kennedy has proposed legislation that would require employers nationwide to provide health insurance for their employees.[20] Although the bill is not currently before Congress, the purpose of most play-or-pay proposals is to force private employers to provide health insurance. Thus, it is useful to examine the effects of a proposal that would force employers to play, rather than pay.

[19]Aldona Robbins, Gary Robbins, and Richard Rue, *Mandated and Public Health Insurance* (Milwaukee: Heartland Institute, October 1989).

[20]At the time the legislation was proposed, Senator Kennedy circulated a very low estimate of its cost, prepared by Gordon Trapnell of the Actuarial Research Corporation. The Congressional Budget Office (CBO)—which did not make an independent premium estimate—promulgated even lower cost estimates, based on an apparent misreading of the Trapnell study. Both the Trapnell estimate and the CBO premium estimate are well below the market price of comparable coverage under the Blue Cross–Blue Shield "low option" policy made available to federal employees.

The most thorough analysis of the cost of the original Kennedy proposal was made by economists Aldona Robbins and Gary Robbins.[21] Subsequently, they reestimated the cost, based on a later version of the proposal.[22] Their later analysis forms the basis for many of the conclusions in the following discussion.[23]

Economic Effects of the Kennedy Plan

Far from being a solution to our current problems, the Kennedy bill would reduce the take-home pay of the vast majority of workers, increase the cost of health care for all Americans, increase unemployment by as many as one million people, increase production costs in every industry, increase the federal deficit, create billions of dollars of economic waste, and prevent the private sector from taking reasonable measures to control health care costs.

Lower Take-Home Pay

The Kennedy plan would impose on the private sector a cost of at least $108 billion, and possibly as much as $159 billion, in 1991 dollars.[24] Because the bill does nothing to increase productivity, its cost would fall on employees themselves.[25] That means that

[21]Aldona Robbins and Gary Robbins, *Mandating Health Insurance,* Economic Policy Bulletin no. 3 (Washington: Institute for Research on the Economics of Taxation, July 8, 1987).

[22]John C. Goodman, Aldona Robbins, and Gary Robbins, *Mandating Health Insurance,* NCPA Policy Report no. 136 (Dallas: National Center for Policy Analysis, February 1989).

[23]The Robbinses' estimate of the cost of the Kennedy mandate is considerably higher than other recent estimates, which place the cost of mandated health insurance at about $40 billion. That is close to the Robbinses' estimate of $37.3 billion to pay the Kennedy mandate for currently uninsured. However, as explained below, the Robbinses found that the mandate would require a substantial increase in benefits for those already insured—at an additional cost of about $68 billion. For a discussion of these other estimates, see Michael A. Morrisey, "Health Care Reform: A Review of Five Generic Proposals," paper presented at a policy forum, "Winners and Losers in Reforming the U.S. Health Care System," sponsored by the Employee Benefit Research Institute Education and Research Fund, Washington, October 4, 1990.

[24]For an explanation of these estimates, as well as others cited in this discussion, see Goodman, Robbins, and Robbins, appendix A.

[25]In competitive markets, labor compensation must be equal to the marginal product of labor. In other words, workers receive an income roughly equal to the value of what they produce. Because the Kennedy bill would not change worker productivity, health insurance benefits ultimately would substitute for wages, keeping total labor compensation the same.

Table 12.2
PERCENT OF EMPLOYERS WHOSE HEALTH INSURANCE POLICIES ARE NOT IN COMPLIANCE WITH THE KENNEDY PLAN

Violations of Provisions of Kennedy Plan	ICF Survey	Towers, Perrin Survey
Requires employees to pay more than 20 percent of single coverage premium	28%	28%
Requires employees to pay more than 20 percent of family premiums	54	38
Does not cover part-time workers	68	74
Waiting period of more than one month	55	46
Limitation on preexisting conditions	–	65
Does not cover seasonal or temporary workers	50	–
Does not provide full coverage for well-baby care	–	53
Does not cover physician office visits	17	–
Does not offer maternity care	16	–
Does not cover mental health care	18	–

SOURCES: ICF, Inc., *Health Care Coverage and Costs in Small and Large Businesses: Final Report*, prepared for the U.S. Small Business Administration (April 1987), Tables IV-4, IV-8, IV-9, III-10, III-12; and survey by Towers, Perrin, Forster & Crosby, reported in Jerry Geisel, "Health Plans Fail Mandate: Survey," *Business Insurance*, August 31, 1987.

employees would lose as much as $108 billion (or more) in wages and other fringe benefits.

Most discussions of the Kennedy plan focus on the problems of workers who lack employer-provided health insurance. However, about two-thirds of the cost of the bill would go to expand coverage for currently insured workers. As Table 12.2 shows, many existing employer-provided health care plans are not as generous as the Kennedy plan. The inclusion of mental health benefits is noteworthy, since mental health care is among the most expensive of all benefits. Mental health and substance abuse treatments cost over $200 per employee and account for 30 percent of the nation's health care costs.[26]

[26]*Modern Healthcare*, May 14, 1990, p. 60.

Table 12.3
COSTS OF THE KENNEDY PLAN

Cost	Amount
Direct costs for the private sector	
Cost of providing insurance for workers currently uninsured	$37.3 billion
Cost of expanding coverage for workers currently insured	$68.0 billion
Administrative costs	$3.0 billion
Total increase in insurance costs	$108.3 billion
Indirect costs for the private sector	
Number of jobs lost	1.1 million
Reduction in GNP	$27.0 billion
Increase in federal deficit	$46.5 billion
Problem the bill attempts to solve (unpaid hospital bills for uninsured workers)	$4.0 billion

SOURCE: John C. Goodman, Aldona Robbins, and Gary Robbins, *Mandating Health Insurance,* NCPA Policy Report no. 136 (Dallas: National Center for Policy Analysis, February 1989), appendix A.

Rising Health Care Costs

Passage of the Kennedy bill would result in at least $108 billion in additional spending. (See Table 12.3.) But experience shows that only about half of each additional dollar of health care spending buys additional services, while the other half is consumed by higher prices.[27] That means that as much as $54 billion of the additional spending would be consumed by medical inflation, escalating health care costs for all Americans.

Economic Waste

In the aggregate, the Kennedy bill would cost the private sector $108 billion to $159 billion per year to solve a problem estimated at $4 billion, which represents about half the total cost of uncompensated hospital care. The primary stated objective of the Kennedy bill is to cover unpaid hospital bills. But the price tag is more than 25 times the size of the problem.

[27] Robbins and Robbins, p. 21.

In 1986, uncompensated hospital care amounted to $8 billion, or about 4.4 percent of total hospital revenues.[28] That is the amount that hospitals reported as the value of care for people who would not, or could not, pay.[29] Because only two-thirds of the currently uninsured are affected by the Kennedy proposal, uncompensated hospital care would at most be reduced by two-thirds. The actual reduction would probably be much less. One of the big-ticket items contributing to hospital bad debts is the premature babies of unwed mothers, many of whom would not be covered under the Kennedy plan. Our best guess is that hospital bad debts would be reduced by $4 billion at most.[30]

Unemployment and Decreased Production

Forcing employers to pay employees with interim health benefits raises the cost of hiring unless employers can reduce wages or other fringe benefits. Often, they cannot. For example, the salaries of workers earning the minimum wage cannot legally be lowered. Yet, for part-time minimum-wage workers, the cost of mandated health insurance may be higher than the worker's salary. As many as 1.1 million fewer jobs and as much as $27 billion in reduced output for the economy as a whole would result.

Increasing the Federal Deficit

Although the Kennedy proposal purports to place the full cost of mandated health insurance on the private sector, it would affect the federal deficit in two ways. First, because the required premiums are set so high and because the bill mandates that employers pay 80 percent of them, an enormous amount of employee income would be diverted to health insurance and would not be subject to either income taxes or Social Security taxes. Second, federal tax

[28]Chollet, p. 185. When unpaid physicians' bills are included, total uncompensated care in 1986 may have been as high as $13 billion. For a discussion of the contributing factors, see Frank A. Sloan, Joseph Valvona, and Mullner Ross, "Identifying the Issues: A Statistical Profile," in Frank A. Sloan, James F. Blumstein, and James M. Perrin, eds., *Uncompensated Hospital Care: Rights and Responsibilities* (Baltimore: Johns Hopkins University Press, 1986).

[29]It is important to note that unpaid hospital bills do not necessarily mean that patients were unable to pay them. There is an important distinction between "bad debts" and "charity care," even though hospital records often do not accurately make this distinction. See Chollet, pp. 154–85.

[30]See Robbins and Robbins, pp. 11–12.

collections would be lower because employment and output would be lower. In general, federal revenues would be reduced by $17.9 billion because of lower Social Security tax collections and by $23.2 billion because of lower income tax collections. Reduced employment and reduced output would lower federal revenues by an additional $5.4 billion. The net increase in the federal deficit in 1991 would have been $46.5 billion.

Eliminating Freedom of Choice

Rather than helping the private sector forge new strategies to contain rising health care costs, the Kennedy bill would needlessly eliminate many workable programs now in place. For example, it would deny employees the right to choose high-deductible plans and keep the savings for themselves. Under the bill, the mandated employee deductible would be $250 and the cap on employee copayments would be $600. It also would force employers to pay for coverage for low-cost services such as physician office visits and well-baby care, although many employees might prefer to self-insure for such expenses. The Kennedy plan would place even greater restrictions on freedom of choice for employees of small businesses. Such firms would be grouped by region and forced to choose among plans administered by a few insurers. As a result, small firms would have even fewer options than large firms to innovate, experiment, and use new cost-control techniques.

Special Victims of the Kennedy Plan

The burden of the Kennedy bill would not be spread evenly throughout the economy. Certain groups of workers and certain types of business would be especially disadvantaged.

Low-Income Workers

The Kennedy plan would eliminate job opportunities for low-income workers. For full-time employees earning the minimum wage, the plan would increase labor costs by 21 percent for single workers and by 51 percent for workers with families. For part-time employees earning the minimum wage, the plan would increase labor costs by 48 percent for single workers and by 116 percent for workers with families.[31]

[31]Assumes 17.5 hours worked per week. About two-thirds of all workers earning the minimum wage are part-time workers.

To get a perspective on what these increases mean, consider that on April 1, 1990, federal law increased the minimum wage from $3.35 an hour to $4.25 per hour by April 1, 1991. The law increased labor costs for minimum-wage workers by 27 percent, which is much less than the economic impact of the Kennedy bill. But studies estimate that the minimum-wage increase destroyed 596,000 jobs.[32]

Minority Workers

By increasing the effective minimum wage by more than 100 percent for some workers, the Kennedy plan would be especially devastating to minorities. The impact would be greatest on minority youth, whose unemployment rate already is as high as 50 percent in many major cities.

Working Wives

As many as 48 million workers live in two-income families, and many working wives rely on the health insurance coverage provided by their husbands' employers. Under the Kennedy plan, they would be forced to carry health coverage even if they were already covered. That would raise the cost for employers of hiring such women and would make them less employable.

Workers with Families

Under the Kennedy plan, employers would be required to pay 80 percent of the cost of insuring the family members of their workers. Unless employers were able to pay employees with families a lower wage than single workers—which is highly unlikely—the cost of hiring these workers would be higher and they would become less employable.

Unemployed People with Existing Health Problems

Most existing health insurance policies exclude or limit coverage for people with preexisting health problems. The Kennedy plan would require employers to provide coverage for such conditions but would not require employers to hire such people and, indeed, would offer strong incentives not to hire them.

[32]*Job Opportunities Your State Could Lose as a Result of the New Minimum Wage Law* (Washington: U.S. Chamber of Commerce, March 1990).

Effects on Small Business

By design, the Kennedy plan would have a marginal effect on large employers with generous health insurance plans. Small businesses are a different matter. For example, in retail trade and construction (two industries with a high proportion of small businesses), 23 percent of employees are currently uninsured; and in the service industry (also dominated by small businesses), 16 percent of employees are currently uninsured.[33] Thus, it is precisely in the industries where small businesses predominate that the Kennedy bill would have its most adverse economic impact. Moreover, the cost per employee of meeting the Kennedy mandates would be highest in those industries. In durable goods manufacturing, the cost of mandated family coverage would be about 8.8 percent of labor compensation. That cost would be 11.8 percent in the service industry, 16.7 percent in retail trade, and 20.5 percent in agriculture. The new burdens would come at a time when the small-business sector is sustaining America's economic expansion, employing 48 percent of the workforce, and creating 50 to 80 percent of all new jobs.

Regressive Taxation and Uncompensated Hospital Care

Uncompensated hospital care is a serious problem for some of our nation's hospitals. Moreover, as the hospital marketplace becomes increasingly competitive, hospitals—especially rural and county hospitals with disproportionate numbers of charity patients—will face greater financial problems. If society is committed to providing health care for all, that commitment can be funded by paying for charity care with general taxes. The Kennedy bill, by contrast, would pay for charity care by imposing a highly regressive tax. Under the bill's terms, high-income workers with generous health insurance plans would experience negligible effects, whereas low-income workers would experience substantial real-income reductions and might lose their jobs.

An Invitation to Special Interests

The cost estimates presented here for the Kennedy proposal apply only to the initial package of benefits. Experience at the state level indicates that once the legislative door has been opened,

[33]Foley, Chart 4 (p. 9).

hordes of special-interest lobbyists will descend on Washington. Every group from acupuncturists to naturopaths will pressure Congress for inclusion in the federal mandates. Inevitably, the initial package of benefits will grow, and the costs will soar.[34] In the politics of health insurance at the state level, special interests exploit the politically weak—that is, those not represented by a disease lobby or a provider lobby. The Kennedy bill would elevate this process to national policy.

The Senate Democrats' Proposal[35]

A health care plan unveiled in 1991 by Sens. George Mitchell (D-ME), Edward Kennedy (D-MA), John Rockefeller (D-WV), and Donald Riegle (D-MI) combines many of the features of the Dukakis proposal and the original Kennedy proposal.

Under the senators' play-or-pay plan, employers would have a choice: Pay a federal tax, tentatively set at about 7 percent of payroll, or provide health insurance for their employees. If employers were to decide to pay the tax, the government would assume responsibility for providing health insurance. For example, a $2,500 family health insurance premium for a worker earning $20,000 a year costs 13 percent of payroll, not 7 percent. In this case, the obvious choice for the employer would be to pay the tax and turn the problem over to government. Indeed, considering that about 95 percent of all uninsured workers earn less than $30,000 a year, [36] most of their employers would have strong incentives to pay the tax and forget the problem.

Economist William J. Dennis of the NFIB Foundation has calculated what the incentives will look like for employers under different assumptions. The results are shown in Table 12.4. Because the Senate Democrats' proposal nominally requires employers to pay 80 percent of insurance premiums or 80 percent of the tax, the table illustrates the employer's share of health insurance premiums, expressed as a percentage of payroll. Thus, if the total payroll tax

[34]This process already has begun. Mental health providers successfully lobbied to get mental health benefits included in the revised committee version of the Kennedy bill.

[35]See John C. Goodman, "Wrong Prescription for the Uninsured," *Wall Street Journal*, June 11, 1991.

[36]Foley, Table 24 (p. 58).

Table 12.4

EMPLOYER'S SHARE OF HEALTH INSURANCE PREMIUMS AS PERCENT OF PAYROLL[1]

Hourly Wage ($)	$100 Premium[2]	$150 Premium[2]	$200 Premium[2]	$250 Premium[2]	$300 Premium[2]	$350 Premium[2]	$400 Premium[2]
4.00	13.3	20.0	27.6	33.3	40.0	46.7	53.3
4.50	11.9	17.8	23.7	29.6	35.6	41.5	47.4
5.00	10.7	16.0	21.3	26.7	32.0	37.3	42.7
5.50	9.7	14.5	19.4	24.2	29.1	33.9	38.8
6.00	8.9	13.3	17.8	22.2	26.7	31.1	35.6
6.50	8.2	12.3	16.4	20.5	24.6	28.7	32.8
7.00	7.6	11.4	15.2	19.0	22.9	26.7	30.5
7.50	7.1	10.7	14.2	17.8	21.3	24.9	28.4
8.00	6.7	10.0	13.3	16.7	20.0	23.3	26.7
8.50	6.3	9.4	12.5	15.7	18.8	22.0	25.1
9.00	5.9	8.9	11.9	14.8	17.8	20.7	23.7
9.50	5.6	8.4	11.2	14.0	16.8	19.6	22.5
10.00	5.3	8.0	10.7	13.3	16.0	18.7	21.3
10.50	5.1	7.6	10.2	12.7	15.2	17.8	20.3
11.00	4.8	7.3	9.7	12.1	14.5	17.0	19.4
11.50	4.6	7.0	9.3	11.6	13.9	16.2	18.6
12.00	4.4	6.7	8.9	11.1	13.3	15.6	17.8
12.50	4.3	6.4	8.5	10.7	12.8	14.9	17.1
13.00	4.1	6.2	8.2	10.3	12.3	14.4	16.4

(Continued on next page)

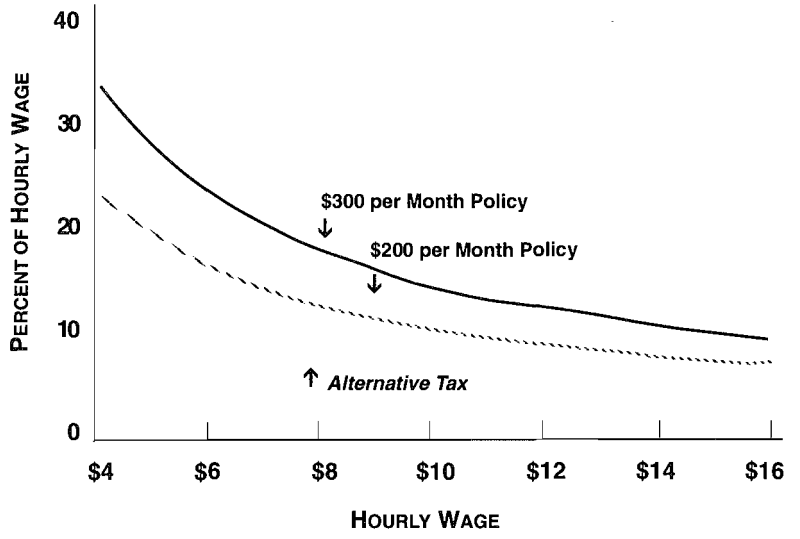
Table 12.4—Continued

EMPLOYER'S SHARE OF HEALTH INSURANCE PREMIUMS AS PERCENT OF PAYROLL[1]

Hourly Wage ($)	$100 Premium[2]	$150 Premium[2]	$200 Premium[2]	$250 Premium[2]	$300 Premium[2]	$350 Premium[2]	$400 Premium[2]
13.50	4.0	5.9	7.9	9.9	11.9	13.8	15.8
14.00	3.8	5.7	7.6	9.5	11.4	13.3	15.2
14.50	3.7	5.5	7.4	9.2	11.0	12.9	14.7
15.00	3.6	5.3	7.1	8.9	10.7	12.4	14.2
15.50	3.4	5.2	6.9	8.6	10.3	12.0	13.8
16.00	3.3	5.0	6.7	8.3	10.0	11.7	13.3

SOURCE: William J. Dennis, *It's Cheaper to Pay Than to Play* (National Federation of Independent Business, October 1991).
[1]Assumes full-time employees (37.5 hours worked per week, 4 weeks per month) and employer's share of premium equals 80 percent.
[2]Per employee per month.

Figure 12.3
EMPLOYER COST AS A PERCENT OF PAYROLL UNDER THE "PLAY" AND "PAY" OPTIONS



SOURCE: William J. Dennis, *It's Cheaper to Pay Than to Play* (National Federation of Independent Business, October 1991).

is set at 7 percent, as tentatively planned, the numbers in Table 12.4 should be compared with the employer's share of the tax, or 5.6 percent. However, if the total tax gets set at 8 percent, the employer's share would be a tax of 6.4 percent.

The results of the play-or-pay option are depicted in Figure 12.3. As the figure shows, under almost any realistic set of assumptions, employers would have a financial incentive to pay the tax and turn the problem over to government. For example, a small-business owner with eight employees earning $9 an hour and two part-time employees earning $6.50 an hour could cut health care costs in half by paying the tax. Overall, Dennis estimates that between one million and two million employers would find it cheaper to pay than to play.

In recognition of the special burdens that the Kennedy bill would create for small employers, the Senate Democrats have proposed a

25 percent tax credit on the first $3,000 of premiums for each full-time employee earning less than $20,000 a year for firms with fewer than 60 employees. Dennis examined the incentives created by the tax credit as well, and he concluded that only in a few special cases would they be sufficient to reverse an employer's decision to pay rather than play. Although employers would be able to pay the tax and forget the problem, employees would not have that freedom. Assuming they are already paid a wage roughly equal to the value of what they produce, a 7 percent payroll tax means that they would have to take a 7 percent wage cut or risk losing their jobs. As those earning the minimum wage can't take a wage cut, they stand the greatest risk of becoming unemployed.

Employers who already provide health insurance also would have to compare the 7 percent tax with the cost of a health insurance policy containing core benefits defined in Washington. A great many of them are likely to be tempted to pay the tax and drop existing coverage. Nor is this mere speculation. One Kennedy aide has said that the bill's sponsors expect that to happen.

Lee Iacocca would probably like the Senate Democrats' plan. For years, he's wanted to dump Chrysler's health care costs on government, and the Senate Democrats are offering him a chance. Instead of paying close to $4,000 per employee for private insurance, Iacocca could pay a tax of less than $3,000, have government provide each Chrysler worker with health insurance, and make a handsome profit. It is likely, however, that Chrysler workers would object to such an arrangement.

If the Democrats' plan is adopted, special interests press for expanded coverage, health insurance costs rise, and employers opt to pay the tax, what will happen to the workers? They will be required to join Medicaid and pay premiums that vary by income level.

Granted, under the Democrats' plan, Medicaid would be reorganized and take on a new name: AmeriCare. But Medicaid under any other name is still Medicaid. In most places, Medicaid pays doctors and hospitals fifty cents on the dollar, and sometimes less. Increasingly, the best doctors won't see Medicaid patients, and only charity hospitals will accept them.

Because Medicaid underpays, health care rationing is inevitable. And more severe rationing is right around the corner as the hospital

marketplace becomes more competitive, cost shifting to other patients becomes less feasible, and government at all levels has less money to spend. So far, only Oregon has admitted publicly that rationing in its Medicaid program is routine. Medical providers know the same thing is happening in every state. The Senate Democrats acknowledge this problem. To avert it, they call for reimbursing hospitals and providers at Medicare (rather than Medicaid) rates. Because of political pressures, however, they are unlikely to succeed in achieving this goal. Even if they do, Medicare itself is becoming a rationing program.

The Democrats' plan also has other problems. One is that government is inherently incapable of administering an insurance program that prices risk accurately. Witness the deposit insurance debacle at the federal level,[37] and the auto liability insurance crises in California, New Jersey, and Massachusetts. In Massachusetts, auto insurance has become so political an issue that any possibility of rational premium prices has vanished and 65 percent of all premiums now go to the state risk pool.[38]

The Senate Democrats have already signaled their lack of interest in real insurance prices. The 7 percent payroll tax has no relationship to the actual cost of health care for any particular employee. And they are proposing a quasi-cartel in the small-group health insurance market to guarantee that private insurance premiums won't reflect real risks either. That will speed the exodus of people into AmeriCare, the risk pool of last resort.

A second problem with the Senate Democrats' plan involves small business, which employs most of the noninsured workers. The Democrats' proposal to create new taxes for small business—the primary job-creating sector of the economy—came right in the middle of a recession. To avert the obvious economic harm, the plan proposes a two-year grace period for new small businesses and a five-year phase-in period for firms with fewer than 25 employees—the firms where almost half of all uninsured workers are

[37]A. James Meigs and John C. Goodman, *Federal Deposit Insurance: The Case for Radical Reform,* NCPA Policy Report no. 155 (Dallas: National Center for Policy Analysis, 1990).

[38]Simon Rottenberg, *The Cost of Regulated Pricing: A Critical Analysis of Auto Insurance Premium Rate-Setting in Massachusetts* (Boston: Pioneer Institute for Public Policy Research, 1989).

employed.[39] Like Dukakis, the Senate Democrats propose to promise now and act after the next election. Indeed, it is worth questioning whether this is a serious proposal or merely a Democratic campaign ploy.

A third problem with the plan involves health care costs which are bound to rise as more people acquire health insurance. Initially, the Senate Democrats propose "voluntary" spending limits with targets for the total amount spent on physicians' fees and hospital services throughout the country. But given that the nation's 5,000 hospitals and 500,000 doctors could not possibly agree collectively on anything, the targets will certainly be missed, and "voluntary" will soon become "mandatory."

That is precisely the approach taken in Canada, Britain, and throughout continental Europe. Governments in those countries set arbitrary budgets for hospitals and area health authorities, then force the providers to ration health care. The consequence is a lower quality of care and less—not more—efficiency (as discussed in chapter 18).

Before taxing small business to pay for an expanded Medicaid program with health care rationing required by limits on spending, Senate Democrats might listen to Lloyd Bentsen (D-TX), author of a limited program of refundable tax credits for the purchase of health insurance that was part of the budget summit agreement in 1990. Instead of pushing more people into a government rationing program, the Bentsen approach empowers low-income families and makes them real participants in the health insurance marketplace.

Mandated Employee Benefits and Lower Take-Home Pay

Health insurance is only one of various mandated employee benefits that have been proposed in Congress. Others include family and medical leave, advance notice of plant closings and of employee layoffs, and high-risk occupational disease notification. All have two characteristics in common: (1) they remove freedom of choice from the labor market and substitute the preferences of politicians for those of workers, and (2) they threaten to lower take-home pay by reducing productivity and/or requiring the substitution of fringe benefits for wages.

[39]Foley, p. 9.

A basic principle of labor economics is that employers will not hire employees unless the value of what the employees produce is at least equal to the total compensation they receive. As a result, when employers are forced to provide certain benefits, the cost of those benefits ultimately is borne by the workers through a reduction either in wages or in other fringe benefits. To the extent that mandated benefits legislation also lowers productivity, employees bear an additional cost. Lower productivity ultimately means lower compensation.

Workers already are worse off because they often are forced to accept fringe benefits instead of receiving higher wages. In addition, total labor compensation today is lower than it needs to be because of lower productivity, in part caused by legislation that purports to protect employees.[40] Mandated benefits legislation currently being considered in Congress would cause even lower productivity and lower take-home pay.

Government Regulations and Productivity

Numerous studies have shown that the goals of health, safety, and environmental legislation could be achieved at a fraction of the cost. Meanwhile, the American worker is paying for these unnecessary and wasteful policies. Between 1959 and 1969, productivity in U.S. manufacturing increased by almost 1 percent annually. Between 1973 and 1978, it fell by more than 0.5 percent annually. Regulation by the Occupational Safety and Health Administration and the Environmental Protection Agency caused about one-third of this slowdown, resulting in a cost of about $1,000 for each manufacturing worker in 1987.[41]

Fringe Benefits and Take-Home Pay

Although the U.S. economy has grown over the last 15 years, workers' paychecks have shrunk in real terms. Since 1972, total employee compensation per hour worked has increased in real terms. Yet real wages per hour worked were lower in 1982 than in 1972. In other words, employers were paying more but employees

[40]The income of workers must be roughly equal to the value of what they produce. See note 26 above.

[41]Wayne B. Gray, "The Cost of Regulation: OSHA, EPA and the Productivity Slowdown," *American Economic Review* (December 1987).

were receiving less. One reason for this anomaly is that the "wedge" created by employment taxes and fringe benefits grew from 12 percent of employee compensation in 1972 to 16 percent in 1988.[42] In many cases, workers are worse off because they are forced to take fringe benefits that they do not want and may not need.

[42]Taken from the national income and product accounts data reported in U. S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* 68, no. 7 (July 1988), Tables 6.4B, 6.5B.