OFFICE OF THE FIRST LADY
BOX 2 OF 8

LISTING OF MELANNE'S BINDERS
HEALTH CARE

economic briefing/pundits 7/22/94
the health security plan briefing book
small business and jobs 9/94
conversations on health 3/26/93 (2 binders)
conversations on health-the robert wood johnson foundation 3/15/93
pennsylvania health care conference 3/11/93

ENCLOSURES FILED OVERSIZE ATTACHMENTS 6199

NARA 4444

1/22/94

ECONOMIC BRIEFING/ PUNDITS

INSURANCE MARKET REFORM PRESENTATION

I. GOALS OF HEALTH REFORM

Message: It is universally accepted that the current system needs insurance market reform in order to achieve the goals of health reform.

- Make insurance more accessible/available
- Make insurance more affordable
- Increase coverage (reduce number of uninsured)

II. OVERVIEW OF CURRENT SYSTEM

Message: The current system, which has incentives for insurance companies to keep costs down by only insuring healthy people, leaves many insured people worried about losing insurance or not being able to pay for it and excludes others entirely from the insurance system.

- Preexisting condition exclusions lock people into jobs and insurance plans and keep others from being able to purchase coverage.
- Insurance companies can drop people from coverage as soon as they get sick and actually need their insurance.
  - It's not true insurance if you can be dropped from coverage when you finally need it.
- Experience rating means that insurance is often not affordable.
  - Insurance is the most expensive for the people who need it the most, and can increase when you get sick.
  - People in small groups can face high premium costs when someone <u>else</u> gets sick.
  - Charging different groups different rates can lead to high administrative costs

- Some people argue that charging people who use care higher prices serves as an incentive for them to use less care, but these costs are often beyond people's control.

III. REFORMS

Message: There are some frequently cited and accepted ways people think will address these problems of limited access and affordability.

- Eliminate pre-existing condition exclusions
  - Intended to eliminate job lock and free people from current insurance plans.
  - When people are locked into their insurance, insurance companies face fewer incentives to compete.
- Guaranteed issue and renewability
  - Means that insurance companies cannot deny anyone coverage and cannot drop people when they get sick.
- Community rating
  - Guarantees that everyone in a particular area is charged the same rate, regardless of health status.

IV. INCREMENTAL REFORMS

Message: Some people believe that health care reform can stop with incremental insurance market reform. But these reforms don't work without universal coverage.

- We can't get rid of pre-existing condition clauses.
  - In a totally voluntary system, people won't buy insurance until they're sick.
  - That's like selling homeowner's insurance when the house is already burning.

- So, for example, the reforms proposed by Senator Dole or the bill that was reported out of the Senate Finance Committee only prohibit pre-existing condition clauses for people who were previously insured. That leaves the uninsured or people who can't afford to keep their coverage in the lurch.

- We can't go very far with equalizing premiums through community rating.

  -Community rating is intended to provide real insurance for every individual -- insurance the provides a guarantee into the future that health costs will not change at the moment when someone gets sick or as soon as someone has another birthday. While young healthy people may see their insurance premiums increase initially, over time they will experience the benefits of steady, predictable costs that cannot be inflated at the will of individual insurers.

  - Community rating smooths out the variation in premiums, so that no one will have to pay really high premiums.

  - When everyone is charged the same premium, sick people who have not had access to affordable insurance flood into the system, increasing premiums for everyone.

  - When premiums go up, some healthy people choose to drop their insurance, further driving up premiums, which may lead even more healthy people to drop coverage.

- The likelihood that healthy people will drop their insurance when you move to community rating is even greater when insurance companies are forced to take all comers and pre-existing conditions are covered.

  - High-cost cases who have previously been denied coverage come flooding into the insurance system, which also drives up premiums.

- And let's not forget that people have less of an incentive to buy insurance when they know that they won't really be denied services and won't really have to pay their hospital and doctor bills in a desperate situation.

- So we're stuck in a Catch-22 situation, and in a voluntary system, there's no way out.

  - We could get some of those healthy people into insurance plans if we could lower the premiums.

- But we can't get the premiums down without them in the system.

V. CONCLUSION

Message: So in the name of increasing access and affordability, we may actually end up with a decrease in affordability and an increase in the number of uninsured in the system. At best, we only get marginal increases in the number of people who get coverage under these non-universal plans.

- Insurance companies will still have incentives to waste resources trying to attract the healthiest people.

- Individuals will still face incentives to free ride on the system.

AND STUDIES SHOW THAT THESE NON-UNIVERSAL PLANS JUST DON'T GET AS FAR AS THEY MIGHT CLAIM TO:

- CBO estimates that the Cooper plan -- considered the best of the incremental plans -- leaves 24 million people uninsured, 16 million of them in the middle class.

- Internal estimates show that the Dole plan will leave over 30 million Americans uninsured.

FACTS ABOUT INSURANCE REFORM

- **There is nothing new about community-rating, open enrollment, and other health insurance market reforms.**

  Blue Cross and Blue Shield plans used to sell health insurance on this basis, and they dominated the individual and small-group markets. However, as health care costs started to sky-rocket, healthy individuals and small groups began to demand lower, experience-rated premiums. As the healthier part of the community-rated pool dropped out, claims increased even faster than health care inflation. Now, hardly anyone sells community-rated insurance.

- **If you line up everyone in an insurance plan according to their predicted claims, the last 1 percent add about 10 percent to the premium.**

- **Typical individual premiums without insurance market reforms:**

  A recent newspaper article featured stories about uninsured families that were quoted premiums ranging from $300 to $500 per month for individual coverage with a $2500 deductible. (NYT 7/11/94).

  Employers generally spend about that amount for much more generous coverage, thanks to the efficiencies of group purchasing and the fact that adverse selection is avoided when employees are enrolled as a group.

- **Premium differences with unrestricted age-rating:**

  Without community-rating for nongroup insurance, a 64-year-old may pay 4 to 6 times as much for insurance as a 20-year-old. (Robert Pear, NYT 5/22/94)

- **Most of the uninsured have no access to insurance from an employer. Their only alternative is to buy coverage in the individual market, where premiums are inflated by adverse selection and insurance companies charge a lot more for marketing, administration, and risk.**

  Of Americans under 65 without employer-sponsored insurance or Medicaid, only a third buy individual insurance. The rest are uninsured. [EBRI, 1994]

9 out of 10 uninsured workers are not offered insurance by their employers. Only 1 out of 10 are actually offered coverage and choose not to take it. [Farley, Pam et. al, "The Employed Uninsured and the Role of Public Policy, Inquiry, Winter 1985]

- **CBO estimated that the cost of the HSA benefit package would be about $400 more per family in the voluntary system proposed by Representative Cooper than under a universal system like the HSA.** [CBO "Analysis of the Managed Competition Act" April 1994]

- **Some estimates suggest that up to 80 million Americans have preexisting conditions that could be excluded from any new coverage or would require payment of a higher premium.** [Economic Report of the President, Council of Economic Advisers, 1994]

ADDITIONAL NOTES ON HEALTH INSURANCE

Reinsurance and/or risk-adjustment systems are a necessary part of mandatory community-rating.

Without reinsurance or risk-adjustment, plans have a strong incentive to avoid selling to heavy users of health care at community rates. Even if the law requires plans to sell to everyone who wants to buy, plans can make themselves unattractive to heavy users by manipulating the nature and quality of the services that are offered to such people.

Without reinsurance or risk-adjustment, community-rating actually penalizes plans for providing good, effective services to the unhealthy people who need them most.

One of the biggest problems with controlling costs by underwriting (or screening out bad risks) is that it's only a temporary solution:

An insurer approaches a small group and offers an usually low premium. As part of the deal, the insurer excludes a couple of people from the plan and limits claims for some others with pre-existing conditions. Unfortunately, as time goes on, other people get sick--and the insurer can no longer cover the claims at the old premium. So either the premium goes up dramatically, or the group switches to another insurer and starts the process all over again.

The term, "**underwriting**," refers to the variety of practices aimed at screening out claims for identifiable risks (pre-existing clauses, denying coverage on the basis of medical conditions).

The term, "**underwriting cycle**," refers to the upward path of premiums after underwriting new enrollment. The initial premium is lowered by weeding out bad risks, but the effect inevitably wears off over time.

ROADMAP TO INSURANCE REFORM READING MATERIALS

1. **Insurance Market Reform section of the Economic Report of the President**

   - Provides an description of the current health insurance market and explains several terms, including adverse selection and community rating. Explains the need for universal coverage with insurance market reform.

2. **Edwin Chen, LA Times, "Peril Seen in Reform Limited to Insurance"**

   - Best article on the need for universal coverage with insurance market reform.

3. **Robert Pear, New York Times, "Pooling Risks and Sharing costs in Effort to Gain Stable Insurance Rates"**

   - Excellent discussion of issues surrounding the insurance reform debate. Includes a defense of the New York experience.

4. **Hillary Stout, Wall Street Journal, "Community-Rated Health Plans Prove Popular but Success May Depend on Universal Coverage"**

   - Makes the case for universal coverage with community rating, preexisting conditions, guaranteed issue and renewability. Uses New York as evidence for how things do not work without universal coverage.

5. **Leslie Scism, Wall Street Journal, "New York Finds Fewer People Have Health Insurance a Year After Reform"**

   - Good data on New York experience.

6. **Steven Pearlstein, The Washington Post, "Adjusting Insurance: Is It Health Reform?"**

   - Even more on insurance market reform and universal coverage.

7. **Neil Howe and Bill Strauss, "A Hidden Tax on Young People"**

   - FYI on intergenerational cost-shift with community rating.

Economic Report of the President, 1994

Box 4–1.—Moral Hazard and Adverse Selection

All insurance markets face two potential problems. The first, called moral hazard, involves incentives. Insurance may encourage those who are covered to use insured services more than they otherwise would, or it may discourage the insured from taking steps to lower their need for such services. Insurance against any kind of risk—including health risks—always involves some element of moral hazard. When people use health services more than they would without insurance, the total amount insurers must pay increases, and they in turn must increase their prices. Furthermore, because individuals pay less than the full social cost of the services they receive, too much of society's resources will be devoted to such services.

The second problem is adverse selection. People who know that they are more at risk than others of falling ill are more likely to purchase health insurance. Therefore, insurers who set their prices at the average cost for the population as a whole are likely to discover that their prices do not cover their costs, because their customers are on average sicker than the population at large. To address this problem, insurers have incentives both to charge prices that exceed the cost of covering the average person and to select risks as best they can. The higher prices of insurance that result from adverse selection have the perverse effect of discouraging some healthy people from purchasing insurance. Because of the adverse selection problem, all people must be required to purchase insurance if each of them is to be charged the average cost of providing insurance.

adverse selection

INSURANCE MARKET REFORM

Private insurance markets have a number of shortcomings that impede the realization of universal coverage

INSURING MAJOR RISKS AND PREEXISTING CONDITIONS

Economic theory suggests that at a minimum well-functioning insurance markets should insure against the expenses that accompany large medical risks because those are precisely the ones that cause the most financial hardship to individuals and families, are the least susceptible to moral hazard, and have the lowest administrative costs as a share of benefits. In our current system, however, private insurance markets often fail even when judged against this minimal standard

About 80 percent of conventional health insurance policies have limits—generally ranging from $250,000 to over $1 million—on the amount that the insurer will pay over the policyholder's lifetime. Many insurers also initially exclude coverage of "preexisting conditions"—health problems that exist before the policy takes effect. A typical rule, for example, is to exclude for 6 months a condition that was present in the 6 months prior to joining a plan. Some estimates suggest that up to 80 million Americans have preexisting conditions that could be excluded from any new coverage or would require payment of a higher premium.

pre-existing conditions

Both the exclusion of coverage for preexisting conditions and the limitations on maximum lifetime payments are ways that insurers respond to the adverse selection problem discussed in Box 4–1. Such practices also reflect the fact that insurers who know in advance about the likely health status of their potential policyholders can choose which risks they are willing to insure and which they are not, and can choose to charge different prices to different individuals based on this assessment.

Such common insurance practices may be privately optimal for individual insurers, but they are not socially efficient. People with preexisting conditions and people who have exhausted their lifetime insurance limits may still require care, and someone must bear the costs. If they cannot obtain private insurance and they have exhausted their own funds, either they will get insurance through public sector programs, such as medicaid, or the costs of their care will be shifted onto the premiums of those who are able to obtain insurance. By compelling all insurers to cover preexisting conditions and by eliminating limitations on lifetime payments, the government could reduce the adverse selection problem in private insurance markets and thereby improve how they function.

cost-shift

competition improves

COMMUNITY RATING

A second essential component of insurance reform is "community rating"—charging everyone in a large group the same price regardless of individual differences in demographic or health status. Currently, health insurance is often experience rated—the price for members of a particular group is based in whole or in part on that group's expected utilization of insured services. However, there are strong reasons for requiring community rating.

The rationale for any kind of insurance is to spread costs throughout the insured population. Complete health insurance would spread the cost of care across everyone in the population, regardless of their health status. Similarly, complete insurance would guarantee that the price paid by each individual for coverage would be the average cost of such coverage for the population. In contrast, experience rating means that the price one pays for insurance var-

ies depending on one's health status. But at least for those health problems and their associated costs that individuals cannot influence by their behavior, experience rating is at odds with the basic function of insurance—to insure against risk.

In principle, of course, one can distinguish between those health risks that individuals can influence and those that they cannot, and apply experience rating to the former. In practice, however, this is often difficult to do, because it would require detailed monitoring of personal behavior. In addition, many major health risks, with the obvious exception of those associated with smoking, are linked quite imperfectly to individual behavior, or the medical profession's understanding of the linkage remains rudimentary. Based on these considerations, community rating of health insurance, and continued public programs to deter smoking, are appropriate elements of health insurance reform.

Community rating and universal coverage

However, community rating is difficult to enact without complementary reforms. The adverse selection issue described in Box 4–1 is one potential problem, which universal coverage could address by requiring people to have coverage. A related problem stems from the fact that insurers who are compelled to charge a community rate will have incentives to seek out the healthiest consumers, because they can be covered for the lowest cost and thus are likely to yield insurers the highest profits. This risk selection may involve high administrative costs, for example in determining the medical history of each member of a group. Resources devoted to this activity increase the overall costs of health care without providing any additional health benefits.

Several steps could be taken to minimize the possibility of such selection. First, a system of "risk adjustment payments" could be designed—monetary transfers from plans that have a healthier mix of enrollees to plans with a sicker mix of enrollees. If risk adjustment perfectly compensated for true differences in health risk, it would eliminate the incentives for selection on the part of insurers.

Second, all insurers could be required to offer the same package of benefits, thereby eliminating the opportunity to use the variations in the benefits package to attract better risks. Finally, "guaranteed issue" and "guaranteed renewability" of insurance could be required—that is, people could not be denied the right to enroll initially or renew enrollment in a health plan because of demographic or health status.

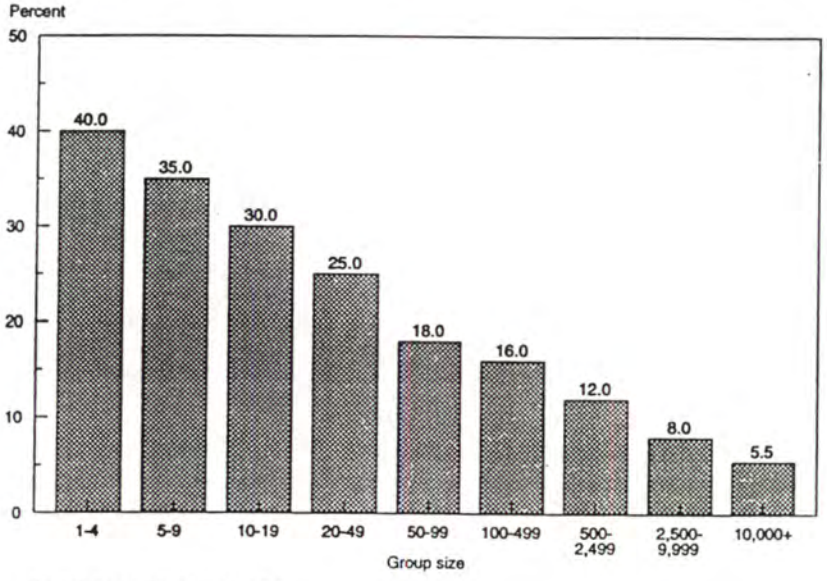
REDUCING ADMINISTRATIVE COSTS

In part because of the experience rating practices of insurance companies, there is insufficient standardization across insurers. Providers must deal with different insurers using different claim forms and covering different sets of services. Lack of standardiza-

tion results in high administrative expenses. In 1991 over 6 percent of all health care expenditures went for administrative expenses. This exceeds total spending on all public health service programs.

Standardizing benefits and billing procedures and increasing the automation of bill payment could produce substantial administrative savings. Grouping small firms and individuals into larger purchasing pools would have the same effect. As Chart 4–3 shows, the administrative load charged by commercial insurers for small groups (1 to 4 employees) averages about 40 percent of claims paid—in contrast to only about 5½ percent for large groups (over 10,000 employees).

Chart 4-3 **Administrative Expenses of Commercial Insurers as Percent of Claims Paid**
Administrative expenses are much higher in proportion to claims paid for small groups than for large groups.



Source: Hay/Huggins Company, Inc.

CREATING A MORE EFFICIENT MARKET AND CONTAINING COSTS

The third problem with the current health care system is that it appears to be far from efficient. As already noted, the United States spends a larger share of its GDP on health care than any other industrialized nation. If Americans valued medical care more

Peril Seen in Reform Limited to Insurance

■ **Health care:** Analysts warn that Congress would be shortsighted to focus only on coverage discrimination.

By EDWIN CHEN
TIMES STAFF WRITER

WASHINGTON—It sounds so simple: Ban insurers from jacking up rates on sick people and force them to accept all applicants, offering the same rates regardless of age or health status.

No single health reform proposal enjoys broader support among the public or members of Congress. And no wonder.

Ending discriminatory insurance practices would instantly allay deep-seated fears of middle-class Americans that they might lose coverage when they change jobs or be priced out of the market when they become seriously ill. In poll after poll, 60% to 80% or more of respondents favor such reforms.

But there's a big hitch.

Unless accompanied by a requirement that everyone be insured, insurance reforms would mean higher premiums for the insured and actually *increase* the ranks of the uninsured.

That's because such reforms would enable the sick and the vulnerable to buy insurance, often for the first time. Their high health costs would force insurers to increase premiums across the board.

What's more, the young and the healthy—confronted by rising rates—might drop coverage, secure in the knowledge that they could buy insurance when they needed it. That in turn would increase premiums for everyone else.

Thus would begin a vicious cycle that, experts say, would hasten the deterioration of the nation's health care financing system.

The prospect is growing that Congress will abandon comprehensive health care reform this year and instead do little more than try to remedy the apparent shortcomings of today's insurance system.

That approach could do more harm than good. Dire warnings of the unintended consequences of insurance reform are being sounded by such disparate analysts and advocates as conservative hospital lobbyist Michael Bromberg and First Lady Hillary Rodham Clinton, architect of President Clinton's agenda for change.

"Insurance reforms will solve many of the problems that the insured, voting middle class is worried about. But it won't control costs or insure the uninsured—the two biggest challenges we face," said Drew Altman, president of the Kaiser Family Foundation, a health care philanthropy based in Menlo Park, Calif.

"You buy some time, but costs will continue to escalate," added Edward F. Howard, executive vice president of the Alliance for Health Reform, a nonpartisan educational group here. "So you lay the groundwork for a bigger explosion in a few years."

Yet, as Congress prepares to begin floor debate on health reform, the appeal of insurance reforms may prove all but irresistible.

Almost every health reform bill introduced in recent years contains such measures—including all four bills reported out recently by two committees in each chamber.

Insurance reforms "solve real problems for real people. And it can happen without turning the system on its head," said Gail Wilensky, a health expert in former President George Bush's White House who now advises congressional Republicans.

Wilensky, former head of the Health Care Financing Administration, said that "it's important for Congress to say to the American people: 'We can do something, and here's one piece, signed, sealed and delivered.' "

She and other advocates of incrementalism acknowledge that insurance reforms alone will do little for the estimated 38 million uninsured Americans. But they say that such measures are a good and realistic beginning.

Opponents argue that insurance reforms alone are doomed to fail unless they are accompanied by a requirement leading to universal coverage, such as Clinton's controversial proposal to require all employers to pay at least 80% of workers' insurance premiums, with individuals picking up the rest.

Insurance reforms alone "just won't work," said Marvin B. Hall, president of the Hawaii Medical Service Assn., the largest insurance company in that state. "You'd push costs even higher."

"Insurance reforms by themselves will increase premiums substantially because you'd be allowing back into the group people who have been excluded primarily because of costs," said John Rother, legislative director of the American Assn. of Retired Persons. "And you haven't done anything at all about the cost of health care."

Among the winners of insurance market reforms, at least in the short term, would be small businesses. Most such reforms being contemplated by Congress would give them a choice of health plans by pooling them into large, voluntary purchasing groups, thus affording them lower rates enjoyed by large groups.

The biggest losers would be younger people, whose rates would rise sharply. "You'll see a bunch that's going to drop out," said Richard I. Smith, an analyst at the Assn. of Private Pension and Welfare Plans. "And what problems are we solving if we end up just producing more uninsured?"

Willis D. Gradison Jr., head of the Health Insurance Assn. of America, agreed, saying that insurance reforms "could easily have just the opposite effect of what is intended." He cited the experience of New York state as a prime example.

There, a law took effect in April of 1993 that barred insurers from setting premiums based on age, sex or health status and required them to guarantee coverage to all.

After just nine months, 40% of policyholders at Mutual of Omaha, the largest underwriter of individual policies in New York, saw their premiums drop, according to Medicine & Health, a weekly newsletter. But 60% experienced increases of as much as 60%.

Meanwhile, the number of uninsured grew by more than 25,000.

Hoping to pave the way for national insurance market reforms as a first step toward broader reforms, Reps. J. Roy Rowland (D-Ga.) and Michael Bilirakis (R-Fla.) have introduced just such a bill, saying that it is "designed to re-establish the health reform debate on a foundation of agreement rather than one of divisiveness."

"Some members have made clear that that's as far as they are willing to go," said Martin Corry, AARP's director of federal affairs. "But we think that's pretty shortsighted."

Wilensky, the Republican consultant, worries that insurance reforms could sap the will of Congress to press on with more comprehensive reforms, such as expanding coverage to the uninsured.

5/22/94

Pooling Risks and Sharing Costs in Effort to Gain Stable Insurance Rates

By ROBERT PEAR
Special to The New York Times

WASHINGTON, May 21 — Few parts of President Clinton's health plan sound so simple as the idea of charging the same insurance premiums to all people in a geographic area, whether they are young or old, sick or healthy.

The goal is to return health insurance to "what it was meant to be, a fair deal at a fair price," Mr. Clinton said last week.

But in health insurance, nothing is simple. While many Republicans agree that the Government should limit the variation in premiums, the idea of such "community rating" raises a host of political, philosophical and technical questions, like these

¶How much will rates go up for young, healthy people, whose premiums are now below the average? Are these people prepared to pay higher premiums in return for greater security?

¶Is it fair to raise premiums for young people while lowering premiums for their parents, who often have higher incomes and greater assets?

¶Is it right to charge the same premiums to smokers and nonsmokers? Should insurers be allowed to give a discount to people who take responsibility for their health, watch their diet and exercise regularly?

¶How should the Federal Government and the states divide responsibility for regulating the price of health insurance, a field long dominated by state officials?

Spreading the Risk

The move toward community rating is a reaction to the experience of the last decade, in which health insurance became prohibitively expensive for many people. Some of these people had a history of illness. Some were healthy, but were considered likely to incur high medical costs. Some were healthy, but obtained their insurance through small groups in which other people ran up high medical bills.

Insurers today charge much higher premiums to people who are old or sick. A 64-year-old may pay four to six times as much as a 20-year-old.

Community rating is an attempt to stabilize health insurance premiums by pooling risks and sharing costs. "The principle of risk spreading is essential to equitable insurance," said Salvatore R. Curiale, the Superintendent of Insurance for New York State, which has gone further toward community rating than most states.

In July 1992, Gov. Mario M. Cuomo signed a bill to establish community rating of health insurance policies for individuals and small businesses in New York. Mr. Curiale said that the law, which took effect in April 1993, had been successful.

Support of New York

"The community rating mandate did cause premiums to increase for younger people," he said. "But about 60 percent of the people affected by the change received rate decreases or increases no greater than 20 percent. Individual and small-group health insurance is more available, and it appears that premium rates are more stable."

Marilyn W. Ogden, an owner of Fritz Helmbold Inc., a meat-processing company in Troy, N.Y., said the change probably helped level off the rates her company paid. "For a small business like us, community rating is very helpful," she said. Eight of the 18 employees are over 55 years old, and the company would have to pay higher premiums without community rating.

Gail E. Shearer, manager of policy analysis at Consumers Union, described community rating as "the fairest way to share health care costs" short of a single-payer program financed by the Government with broad-based taxes.

Arthur V. Ferrara, chairman of the Life Insurance Council of New York, a trade association for insurers, gave the experiment a mixed review. "I have to agree with the superintendent to a certain degree," he said. "Thus far, community rating appears to have worked reasonably well from the Insurance Department's vantage point.

"But from the public's point of view, this law has caused tremendous strain on the younger insurance-buying population," said Mr. Ferrara, who is also chairman of the Guardian Life Insurance Company of America. "If senior members of our society pay less, someone else has to pay more. That's the younger members. Many young people have opted to drop their coverage rather than pay the high costs associated with health insurance."

Under Mr. Clinton's proposal, all people would be required to carry health insurance, including the unemployed. Insurers could not reject people because of their medical problems. Employers would pay most of the cost for their workers. The Government would help buy insurance for low-income people, including many of the unemployed.

The American Academy of Actuaries, a professional organization of insurance experts, assessed the likely effects of community rating in a recent monograph.

The academy takes no position for or against community rating, but says policymakers and the public should understand the consequences. In general, it said, "the young would subsidize the old, males would subsidize females at most ages, the healthy would subsidize the sick and the poor may subsidize the wealthy, since younger people generally earn less income than older people."

Cross subsid.

President Clinton would not allow variation in premiums because of age. But many members of Congress have concluded that some adjustment for age is needed. Many insurers say they can accept a modified form of community rating and see it as inevitable.

The Method

No Incentive To Insure the Well

Simplifying one part of the premium formula immediately creates complexity in other areas.

The idea of pure community rating is that all people with the same coverage should pay the same premiums, regardless of age, sex, medical history or occupation. But obviously it costs more to care for sick people. So most proponents of community rating, including Mr. Clinton, acknowledge that health plans enrolling sicker people should receive more money.

Thus, many experts say that if the Government requires community rating of premiums, it must also have some way of redistributing money from plans with healthy customers to plans with a less healthy clientele.

"Otherwise," said Alice F. Rosenblatt, an actuary at Coopers & Lybrand, the accounting firm, "there

risk individuals. In general, 4 percent of claimants generate 50 percent of claim costs."

Or, as Mr. Curiale said: "We don't want to penalize a company because it takes older, sicker patients. It's inappropriate to have some companies benefit because they have younger, healthier people as customers."

Taking a Regional Average

The device for redistributing money among insurance companies is called a "risk adjustment mechanism." Payments to insurers and health plans are adjusted to reflect the relative risk of their customers, the likelihood that they will incur medical costs in the future.

Under the pooling arrangement in New York, the demographic characteristics of each insurer's customers are compared with a regional average. An insurer receives money from the pool if, for example, it has a disproportionately large number of people who are old or have AIDS. An insurer must contribute to the pool if its customers are younger and healthier than the average.

Ms. Rosenblatt, the actuary, said, "If you require community rating, you must have a risk adjustment mechanism at the same time." In theory, if there were a perfect method of risk adjustment, insurers would have no incentive to seek out low-cost patients. But currently there is no such perfect method.

Under Mr. Clinton's proposal, a new Federal agency, the National Health Board, would have to develop a risk adjustment method by April 1995. The bill does not say how this should be done.

The Age Issue

Should the Young Subsidize the Old?

Older people generally use more health care than young people, but whether they should pay higher premiums is an explosive question.

Representative Nancy L. Johnson, Republican of Connecticut, said insurers must be allowed to consider age as a factor in setting premiums. "Young working people already support the retirement benefits of people over 65," she said. "It would be most unfortunate if those people were also asked to subsidize health insurance premiums of their parents, who have better-paying jobs."

Representative Bill Thomas, Republican of California, said pure community rating could provoke "a generational war." Another Republican, Senator Phil Gramm of Texas, said, "A 27-year-old with three kids shouldn't subsidize a 57-year-old in his peak earning years."

But John C. Rother, chief lobbyist for the American Association of Retired Persons, strongly defended Mr. Clinton's proposal to ban the use of age as a factor in setting premiums.

"The notion that older people are better off doesn't hold when you look at individual cases," he said. "Given early 60's make less than earlier in their careers."

Moreover, Mr. Rother said: "There is pervasive age discrimination in the workplace. Many employers try to avoid hiring older workers because of the higher health costs. Community rating should encourage employers to hire older people."

While insisting that age must be a factor, many insurers are willing to limit the variation in premiums. Mary Nell Lehnhard, senior vice president of the Blue Cross and Blue Shield Association, said the Government might stipulate that the maximum premium for older people would be two or three times the premium for young people. Older people now pay as much as five or six times as much as young people.

Community rating redistributes money in other ways, too. For example, it evens out the costs of health insurance for workers and nonworkers. Nonworkers are believed to have higher medical costs; some are out of work because of health problems.

One result of community rating is that employers would pay higher premiums to subsidize health insurance for nonworkers, said John F. Sheils, a vice president of Lewin-VHI, a consulting concern that specializes in medical economics.

Mr. Sheils said that employers, taken together, would pay $44 billion a year in subsidies for nonworkers. Federal aid for small low-wage businesses would offset $11 billion of this cost under Mr. Clinton's proposal. "The net result is that employers would provide $33 billion a year in subsidies for nonworkers," said Mr. Sheils.

New York

Confident Of Coverage

New York provides the largest demonstration of how a community rating system might work. Clinton proposed. States do not regulate large companies that serve as their own insurers; the New York law applies only to small groups with 3 to 50 workers. If a company sells insurance to such groups, it must take all applicants and set premiums through community rating.

Data compiled by Mr. Curiale's office show that, after the law took effect, premiums increased for nearly two-thirds of all people with individual or small-group coverage from commercial insurers. Premiums doubled for 5 percent of them.

Despite the increases, Mr. Curiale said that coverage was now more secure. "What you had before was an illusion," he said. "If you were young and healthy, the insurance company would accept you. As soon as something went wrong, the rate for you or your group would go sky high. With open enrollment and community rating, you may pay more, but you have stability. You have coverage that can't be taken away."

But Cecil D. Bykerk, chief actuary for the Mutual of Omaha Companies, said: "The first year is not working very well. Since the imposition of pure community rating in New York, the average age of our policyholders has gone up 3.5 years, from 41.5 to 45. That's a very significant rise. Younger people are bailing out. If you're going to have universal access to insurance, which we support, then you need some kind of mandate for people to buy."

One lesson from New York is that the shift to community rating probably ought to be gradual.

In New York, the community rating requirement was applied to all small-group contracts on April 1, 1993. "There was some panic and a lot of uncertainty as April 1 approached," Mr. Curiale said. "Insurers sent out letters telling people, 'Your contract is terminated April 1, and we can't tell you what the cost of new coverage will be.'

"If we did it over again," he said, "we'd make it effective as the old contracts expired."

FOR AND AGAINST

Community Rating of Health Insurance

What it is Requiring insurers to charge the same premiums to all people in a geographic area, regardless of factors like age, sex, medical history or occupation.

How it would work Premiums would be set by averaging the expected cost of insuring everyone in the area. Money would be redistributed among insurance companies to reflect the relative risk of their customers, that is, the likelihood that they will incur medical costs in the future. A health plan with a large share of elderly or sick patients would receive extra money from other companies through a pooling arrangement, not by charging higher premiums.

Arguments for Community rating restores insurance to its original purpose: spreading risks among diverse groups of people. In recent years, insurers have tried to insure only the healthiest people while shunning high-risk customers who most need protection. Insurers should not be allowed to charge higher rates to sick people and older people.

Arguments against Pure community rating is unworkable and inequitable. It will raise premiums for young people while lowering premiums for older people, who often have higher incomes. Insurers also ought to be free to offer discounts to nonsmokers and others with healthy habits.

Who supports it Labor unions, consumer advocates and lobbyists for the elderly favor community rating. They say the market should not be sliced up into different demographic groups.

Who opposes it Big businesses, which generally run their own health plans, do not want to be included in the community-rated pool. If their health insurance is community rated, businesses say, they will not get the benefit of savings they achieve through efficient management of their health plans and through programs promoting healthy behavior by employees.

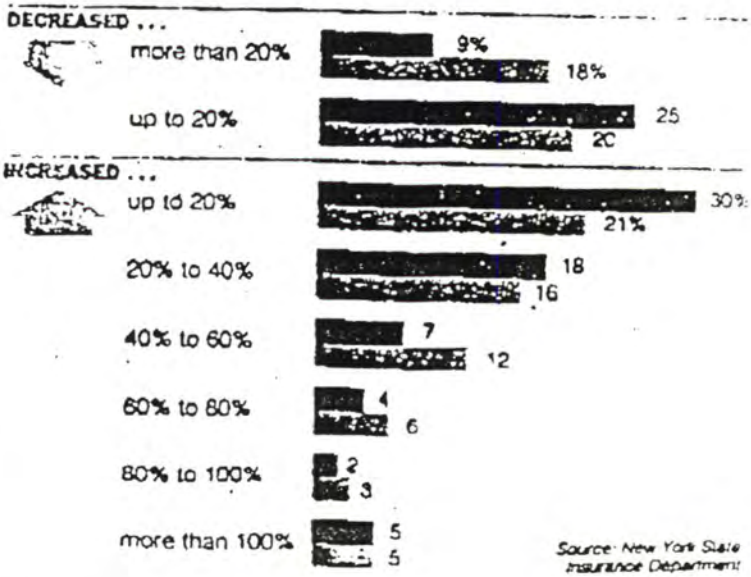
Legislative outlook Congress appears likely to limit the variation in premiums as part of any comprehensive legislation. There is wide support for a modified form of community rating, with some modest variation in premiums on account of age.

CASEBOOK

How Policyholders Fared

As part of a 1992 law regulating health insurance, New York requires community rating of premiums, so that people with the same coverage pay the same amounts without regard to age, sex, health status or occupation.

Below is the percentage of SMALL GROUP and INDIVIDUAL insurance policyholders in New York State whose rates . . .



Source: New York State Insurance Department

Community-Rated Health Plans Prove Popular, But Success May Depend on Universal Coverage

THE WALL STREET JOURNAL WEDNESDAY, JUNE 15, 199

By HILARY STOUT
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON — It's the health-care proposal everyone loves: the notion that insurance companies shouldn't be allowed to jack up rates for sick people or others at risk of piling up big medical bills.

So attractive is the concept, known as "community rating," that even many Republicans and conservative Democrats say Congress should go ahead and enact it, along with a set of other insurance-market revisions, and forget about universal health coverage for now. A new GOP television advertising campaign pushes for bipartisan insurance-market reforms to "fix health care."

There's just one problem with the idea, experts insist and real-life evidence shows. It probably won't work without universal coverage. Indeed, several of the insurance changes that reformers are clamoring for may depend for their success on bringing nearly everybody into the insurance pool.

For the past year New York state has tried community rating without a law requiring everyone to have health insurance. The result has been a rise in insurance premiums for younger, healthier people and a drop in rates for older, sicker individuals. Consequently, young people have bailed out of the system, figuring they either won't need coverage or they'll be able to get it at a reasonable price when they do.

Older, Sicker People

Now, insurers are raising prices again in order to cover the medical needs of those older, sicker people left in the pool. State insurance department figures show that as of Jan. 1, nine months after the new law took effect, 25,477 fewer people had health insurance individually or in small-employer groups. That's a 1.2% decline.

The only way to avoid this chain reaction, many experts say, is to set up a system where people can't drop out. Uwe Reinhardt, a Princeton University health economist, says that when he heard Republican calls to enact insurance market reforms alone — way to vastly improve the current system he reacted with "total disbelief." Community rating without universal coverage "will trigger the worst kind of behavior among insurers and patients," he says.

"If you can go in and out of a system at will, then the only people who will buy insurance are those who need it," says Barbara Ragle, legal counsel at Central Reserve Life Insurance Co.

Nor is community rating the only popular insurance reform that would be nearly impossible without universal coverage. The same thing is true of proposals to outlaw the common industry practice of refusing to cover people with known medical problems, so-called pre-existing conditions. Most health bills that stop short of universal coverage, such as the bipartisan Managed Competition Act championed by Democratic Rep. Jim Cooper of Tennessee, allow insurance companies to exclude coverage of a pre-existing condition for up to six months unless the prospective policy holder is switching from one policy to another. Again, the reason is that if the government requires companies to cover pre-existing conditions without requiring everyone to have insurance, people will buy policies only when they expect high medical expenses.

Seeing the Insurer's Side

Even Gail Shearer, who as manager of policy analysis for Consumers Union is usually no friend of insurance companies, says: "You can understand why the insurers want protection."

In a pure community-rated insurance system, everyone in a region would pay the same premium for the same package of health benefits, regardless of age, sex, medical history, lifestyle or place of residence, despite cancer or severe disability—or perfect health.

Some supporters of community rating are pushing to allow some adjustments, such as for age and habits that affect health, like smoking. And for all the rhetoric embracing community rating, most of the actual bills under consideration in Congress would adopt only a modified version of the concept.

"Nobody is proposing pure community rating," says Henry Aaron, an economist at the Brookings Institution in Washington. Even the sweeping Clinton proposal would allow four different types of regional risk pools, based on family type — for individuals, for single parents with children, for couples and for two-parent families with children.

The House Ways and Means Committee, under pressure from the insurance industry, is considering a bill with five different market sectors, based largely on a person's employer. Each sector would be community rated, but insurers wouldn't have to sell policies in every sector. The leading Senate Republican bill, written by John Chafee of Rhode Island, allows insurers to adjust for age and geography in some markets.

In fact, many people argue that the only legislation that guarantees a true community-rated approach are bills establishing a "single-payer" health system, where the government pays people's medical bills with tax revenues.

Other things that make community ratings work are also opposed by supporters of the concept. A successful community-rated system requires a bureaucratic structure to oversee it. Yet many of the people calling for insurance-market reforms are the same ones decrying the large regional health alliances that President Clinton has proposed.

The alliances, which would be set up by the states, would include employees of all businesses with fewer than 5,000 workers. The White House says they were conceived to establish a large pool over which to spread insurance risks. And they are also intended to take care of a difficult but critical job known as risk adjusting.

"Community rating violates basic actuarial principles," says Princeton's Prof. Reinhardt. "A community-rated system forces a competing private insurer to look at a deathly ill patient, seeing a $100,000 bill, and cheerfully enroll that person for $2,000. It goes against human nature. So in order to overcome normal human nature, you need some coercion."

That means that while everyone pays the same amount into a community-rated system, a mechanism must be set up so insurance companies receive varying amounts, depending on the risk levels of their beneficiary pools. Otherwise, a plan that for some reason was chosen by a disproportionate number of, say, HIV-positive people, would be in bad financial shape. Ultimately, health plans overloaded with bad risks who pay low premiums could collapse. Risk-adjusting basically requires plans with better risk pools to subsidize those with worse risk pools.

The administration proposed health alliances to accomplish that task. However, most of the people pushing insurance reforms are balking at alliances. Consequently, large mandatory alliances are all but dead in Congress.

Alliances aren't the only entities that could perform such functions. "It could be done through state insurance regulation," says Mr. Aaron. The virtue of alliances, Prof. Reinhardt points out, is that they also would collect the health-insurance premiums, and could then turn around and pay money out to plans in the form of "risk-adjusted premium." He says, "That's a lot different than having to go to there and fight with their lawyers."

Rating the Proposals

How the major health-reform plans deal with the issue of community rating:

- **CLINTON:** No premium variations allowed for age, medical status, geography or lifestyle. Separate pools according to family size.
- **SENATE LABOR AND HUMAN RESOURCES (approved June 9):** Same as Clinton but phased in over four years.
- **CHAFEE:** Health plans must offer a modified community rate premium for people and businesses of under 100 workers who buy insurance through a purchasing cooperative.
- **HOUSE WAYS AND MEANS (currently under consideration):** Community rating in four separate pools: individuals, employers with 2-250 employees; employers with more than 250 workers; association plans and health alliances.
- **SENATE FINANCE (currently under consideration):** Premium variations according to family size, geography and age. Highest age-adjusted premium may be no more than twice the lowest age-adjusted premium.
- **COOPER-BREAUX:** No adjustments allowed for medical status or number of past medical claims; premiums can be varied according to geography and, to some degree, age.

New York Finds Fewer People Have Health Insurance a Year After Reform

By LESLIE SCISM
Staff Reporter of THE WALL STREET JOURNAL

Almost one year after New York State adopted stiff insurance reforms, fewer people have health-care coverage than under the old system.

The surprising decline provides ammunition to supporters of nationwide mandatory insurance, and could prove troublesome for advocates pushing for incremental insurance reforms.

Under New York's system, insurers are required to offer one-size-fits-all pricing, a method that sharply decreased rates for older, sicker people but increased them for others. The law also forces insurers to take all comers, and, as a result, some insurers contend that disproportionate numbers of young, healthy people are dropping coverage on the assumption they can buy it later if needed.

With increasingly fewer healthy people counterbalancing the sick, the result, according to the insurers, is the start of an upward spiral in rates for those still in the pool. If the trend continues, insurers contend, the very people that the program was intended to help could again be priced out of the market.

Crumbling Barriers

"There should have been a substantial gain in people insured [in New York] because a number of barriers for people to be insured came down," says Robert Laszewski, a partner with Health Policy & Strategy Associates, a Washington consulting firm. But the abrupt increase in rates for young, healthy people has "affected the ability of New York to achieve a lower-cost pool. Now we may have a pool in New York skewed toward the sick, and in the long run that doesn't help the consumer."

Ronald Pollack, executive director of Washington-based Families USA Foundation, a consumer group that backs President Clinton's plan of mandated coverage, adds: "New York's experience gives very little comfort to those who just want incremental insurance reforms." Mr. Pollack insists that reforms, in isolation, "can't keep insurance affordable and available for families."

New York's effort is one of the nation's most sweeping attempts at reform and is closely watched by national policy makers. New York Insurance Department figures show that, overall, 1.2% fewer people — or 5,477 fewer people — were insured individually or in small-employer groups as of Jan. 1, nine months after the law, which covered those categories, took effect. The decline was particularly pronounced among individual policyholders — 12.4%, or 3,666 people. The figures respresents people [illegible] companies, health-maintenance organizations as well as Blue Cross/Blue Shield.

Insurance-department officials downplay the slight drop in overall enrollment, citing a "disruptive phase-in period." As for the steeper drop in individual coverage, they suggest some people previously covered individually are now in small groups, perhaps because their employers were prompted to add coverage.

'Unqualified Success'

New York Insurance Superintendent Salvatore Curiale calls the state's effort an "unqualified success" because it opened the system to those needing insurance the most. "The reason for all the effort to portray this as a failure is because the health-insurance industry is deathly afraid it will be taken up as a national policy," Mr. Curiale says. "What they're afraid of is that their profits will decrease" if they can't make money "on the backs of young, healthy people."

Many insurance companies that strongly opposed the New York law say their individual and small-group businesses have always had thin profit margins. Although they are allowed under the law to raise rates anytime they wish, the insurers contend that forcing them to take on a disproportionate number of less-healthy policyholders makes it even tougher to turn a profit, making rate increases necessary.

The insurance industry's practice of rejecting sick people, or charging them exorbitant rates, has long been one of Hillary Clinton's biggest complaints. But her calls for change have generally been in the context of sweeping reform that would bring all Americans into the health-care system, mostly by forcing employers to pay for premiums. The debate over insurance-underwriting practices has revved up recently as some leading legislators have suggested that Congress enact moderate reforms now and revisit the issue of a massive system overhaul later.

'Bailing Out'

In New York's case, the state adopted a "community rating" system, so-named because insurers must charge all people within given communities the same price regardless of such factors as age and medical condition. While considered a revolutionary effort, the state still allows insurers to refuse to cover prior medical conditions during an individual's first 12 months of coverage. The idea is that the exclusion will induce healthy people into the system before they get sick.

But Cecil Bykerk, chief actuary for Mutual of Omaha, which along with HMOs and Blue Cross/Blue Shield provides individual coverage in New York, says young, healthy people are nonetheless "bailing out." The average age of the company's New York policyholders has gone up 3.5 years under the new law, to 45 years, he says. The average New York claim more than doubled, to $7,900, while the company's claims nationally rose just $400 to $3,800.

costs in NY

The result at Mutual of Omaha: average 35% rate increases in New York this year, which come on top of increases for some young, healthy people of as much as 79% when the law took effect in April 1993. Before the reform, a 25-year-old male in Albany paid Mutual of Omaha $64.45 a month for coverage, and a 55-year-old paid $141.79; in the law's first year, each paid $107.33, and, with the newest rate increase, the bill is $145.10.

At New York Life Insurance Co., a small-group insurer, the average age of insured New York employees is up three years. Chubb LifeAmerica, a unit of Chubb Corp. that also sells small-group insurance, says people over 50 years old now represent 26% of New York enrollment, up from 20%.

"There's no question we have an adverse-selection cycle setting in," says Seymour Sternberg, a New York Life executive vice president, calling the situation "very unstable."

John Swope, president of Chubb LifeAmerica, meanwhile, speculates that some small employers with mostly young workers ended coverage because of the rate increases imposed when the law took effect, while employers with older workers "grabbed it because it was such a bargain."

At Chubb and New York Life, rates are jumping more than 20% this year. But Mr. Curiale says some small-group insurers with double-digit increases underpriced their policies last year and are playing catch-up. He says more representative increases are in the single-digit range.

For now, the state has no plans to reconsider the law, saying the problems are overdramatized. "The figures still don't show the system isn't working," Mr. Curiale says. "There's no doubt that there are younger, healthier people who decided not to pay the premium increases. But you can extrapolate that these are people who can get back into the system if they want to."

Adjusting Insurance: Is It Health Reform?

Steps Toward Expanding Coverage Could Involve 'Guaranteed Issue' and 'Community Rating'

By Steven Pearlstein
Washington Post Staff Writer

NEWS ANALYSIS

Most of what ails the U.S. health care system could be fixed with a few changes in insurance laws—that's the seductively simple suggestion made by Republicans in recent TV ads in an effort to derail President Clinton's health plan.

"Meaningless nonsense," says the White House, which is sticking by its prescription that only a comprehensive program of mandates, purchasing pools, subsidies and government regulations can restrain medical costs and extend coverage to uninsured Americans whose numbers are increasing at the rate of one million each year.

According to more than a dozen independent experts consulted last week, both sides in this highly partisan debate are guilty of health policy malpractice. Insurance reform by itself would be neither simple nor yield very dramatic results.

"A no-meat menu," said Thomas D. Pyle, who heads the health care business for Metropolitan Life Insurance Co.

"In terms of restraining prices, it won't do squat," said Brookings Institution health expert Henry Aaron.

But if insurance reform is somewhat thin policy gruel, experts also point out that the policy menu offers less elaborate options than the five-course banquet offered by the Clintons.

"We have to tell the truth about this," says Robert Patricelli, president of a health research and management firm in Avon, Conn., who chaired a health reform task earlier this year for the U.S. Chamber of Commerce. "Insurance market reform won't do much to bring 39 million uninsured into the system. At the same time, there are all sorts of useful things we can do, along with insurance reform, that stop short of the mandatory alliances and mandatory coverage of the Clinton plan."

One common element, known as "guaranteed issue," would require insurers to extend and renew coverage to people with chronic illnesses or preexisting conditions. Such a change likely would benefit about a million of the uninsured, according to the U.S. Census Bureau. At the same time, "guaranteed issue" would raise insurance premiums for everyone else, prompting some workers to go without.

But, middle-class voters like "guaranteed issue" because it gives them what they most want from health reform: protection against losing their insurance when they become sick or lose their jobs. "It takes care of the nightmare cases," said John Shiels, vice president of Lewin-VHI, a health research firm in Fairfax.

But "guaranteed issue" also invites generally healthy consumers to move in and out of the insurance system, going without insurance when they are young and healthy but signing up as soon as they get sick or get ready to have a baby. "Consumers are equally guilty as insurers of gaming the insurance system," said Uwe Reinhardt, an economist and health expert at Princeton University.

The other common element of insurance reform is "community rating," a requirement that insurers offer the same rates to all comers. Today, companies and health plans are able to hedge the risks of providing health care to customers more likely to get sick by adjusting rates based on age, occupation, health, lifestyle and other factors. But if forced to charge a single rate, insurers can try to increase their profits by seeking out the healthiest customers while avoiding the poor, the old, and the sick.

Such "cherry picking" can get quite clever. Health plans have been known to establish big programs in sports medicine, which tend to attract younger, healthier customers, while playing down specialties that are likely to attract customers with more expensive medical needs such as cancer treatment, obstetrics or heart surgery.

Other plans have gerrymandered their physician networks to focus on doctors with offices in suburban locations while excluding those with offices along urban subway lines where patients tend to be older, poorer, and sicker.

To minimize this "gaming" of the system, most "community rating" schemes are modified to allow premiums to vary by the age, sex or occupation of the insured. But Harvard University economist Joseph Newhouse said that such modifications can merely force insurers to become more sophisticated in their "gaming." The only way to eliminate it, he said, is to move to a system of universal coverage, such as advocated by the administration, in which everyone is required to have insurance.

The recent experience of New York State indicates what happens when "simple" market reforms are adopted. In the first nine months under a new law that included "guaranteed issue" and "community rating," people with unmet medical needs flocked into the insurance system while the young and healthy fled. The state insurance commissioner reported that 25,000 fewer people—a decline of 1.2 percent—had health insurance. Several insurers reported that their one-price-premiums increased more than 20 percent.

But even if insurance reform could overcome the glitches encountered in New York, according to health expert John Goodman, it still would not address three things most responsible for driving up the cost of health care.

David Brailer, a physician and professor at the University of Pennsylvania's Wharton School of Business, said insurance reform would have no impact on the key factors driving medical prices: the excess capacity in the health care system, the rate at which technology is developed and absorbed and the lack of financial incentive both patients and doctors have to control the amount of medical care that is used.

"Until you have comprehensive reform of the health delivery system—the doctors, the hospitals, the administrative apparatus—no one is going to solve the problem of escalating costs," said Ann Marie O'Keefe, policy director of the Washington Business Group on Health, a health lobbying group for large corporations.

Aaron also points out that while insurance reform addresses the biggest concern for middle-class Americans—the loss of coverage—it does little for low-income workers at firms that offer no health benefits.

"The root cause of why most people don't have coverage is that they don't have enough money," said Pyle of MetLife. "I don't see that insurance reform changes that."

Yet for all these complaints, nearly all of the experts contacted last week thought insurance reform could be the core of a compromise health plan that, while not quite achieving the goal of universal coverage or getting medical costs down to the general inflation rate, could get at most of the way toward both goals.

Harvard University economist David Cutler, who spent most of last year helping to craft the Clinton health plan, said that a less ambitious version of the administration proposal would still be a major accomplishment. Cutler ticked off an alternative plan that included insurance reforms, subsidies for the working poor, a limit on the tax exemption for health benefits, and mechanisms to ensure that employees can chose among several competing health plans.

Arthur Lifson, vice president for health policy with Cigna Corp., one of the country's largest health insurers, agreed. "The way to do it is to tie insurance reform to government subsidies to meet the obligation we have to the nation's poor and wrap them together in some sort of market mechanism that increases competition among health plans—and then I think you're a lot of the way there," he said.

"The answer is not something as simple as insurance reform, and the answer is probably not something with all bells and whistles of the Clinton plan," said O'Keefe at the Washington Business Group on Health. "The answer lies somewhere in between."

Neil Howe and Bill Strauss

A Hidden Tax on Young People

At the core of health insurance reform lies an enormous hidden tax on youth. It's called strict community rating. Politicians don't discuss it, the media don't cover it, but this multisyllabic catch-phrase threatens to move at least $40 billion a year out of the wallets of young adults (under age 35) and into the wallets of the middle-aged (age 45-64).

If strict community rating is enacted, you can ignore the talk about all the special "winners and losers" of health-care reform. The real issue will be generational. The big winners will be Clinton-aged Boomers now entering midlife; the big losers will be the young men and women now entering the labor force.

Community rating is a much-heralded reform that would prohibit insurers from charging different premiums for different individuals. In its "modified" form, it would simply ensure that no one can be charged higher premiums solely due to poor health or pre-existing conditions. This reform appeals to our sense of fairness and entails no systematic income transfer. But in its "stricter" form, it would require insurers to ignore all distinctions among individuals—including age—and charge a single community-wide fee.

Is this fair? Only if you think the federal government ought to enact a large new social insurance program that would tax the young to subsidize the middle-aged. Today, the typical 25-year-old consumes about $1,000 per year in health-care services while the typical 60-year-old consumes about $3,500. The premiums an individual pays out of pocket or the health costs companies take out of a worker's compensation generally reflect this differential. After strict community rating is enacted, however, people of all ages will pay the same premium—probably, around $2,000 per year for a single person. Presto! The 25-year-old pays 100 percent more and becomes a $1,000 yearly loser. The 60-year-old pays 40 percent less and becomes a $1,500 yearly winner. For family heads, the gap will be even wider.

If applied to everyone, strict community rating would mandate a total income transfer of at least $40 billion yearly—flowing away from the 55 million adults under age 35 and enriching the 49 million pre-Medicare adults over age 45. This "reform" would be equivalent to a 7 percent tax on a typical young couple's combined wages. That would make it about as large as their personal FICA tax (through which the young are already subsidizing the health costs of seniors).

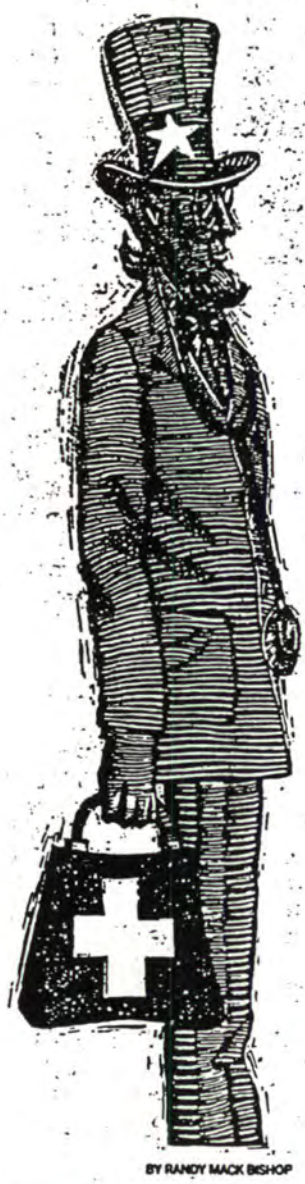
Such numbers are by no means hypothetical. Last year New York State instituted strict community rating for all small-group and individual insurers. On April 1, 1993, the price of a standard fee-for-service plan rose from $1,200 to $3,240 (a 170 percent increase) for a single 30-year-old male—while falling from $5,880 to $3,240 (a 45 percent decrease) for a single 60-year-old male.

agree on this measure, the general outlook for young people is bleak. The Clinton, Kennedy, Gibbons and McDermott plans all prohibit any age-based variation in the premium or taxes payable for all insurance policies covered by their plans. Average price tag: $1,000 per young adult. The Chafee and Michel plans allow a little variation, but would still cost young workers about $700 each. The Moynihan plan would allow an age variation up to a multiplier of two, thereby extracting roughly half as much ($500) per young worker. The Rowland plan and the Dole plan (which allows premiums to vary up to a multiplier of four, close to the actual cost variation) are the only major proposals that would hold the young harmless.

Few national leaders have bothered to bring this massive youth tax to the public's attention. President Clinton has said that premium variations are unjust. If so, why for health insurance alone? Teenage boys pay four times more than their parents for auto insurance because they're four times as reckless on the road—and nobody says that's unjust. Some politicians argue that community rating, like Social Security, won't take anything from the young that they won't get back as they grow older. But this argument assumes that such young-to-old income transfers are forever sustainable (something most twentysomethings already don't believe about Social Security). It ignores the trillion-dollar lifetime windfall that community rating will bestow on Boomers (who incurred no corresponding cost when they were young). And it implies that most 60-year-olds are economically needier than most 25-year-olds (which is patently false).

Hillary Clinton has advanced the brassiest argument for picking the pockets of the young. One of the big problems with the current system, she says, is the health costs that millions of uninsured young people shift onto insured older workers. In reality, this effect is trivial, certainly when compared with the cost shifting by seniors with Medicare discounts. It cannot justify talking about community rating as an appropriate penalty for the irresponsibility of youth.

Given the political invisibility of today's



BY RANDY MACK BISHOP

well pass Congress. If so, brace for thr consequences.

First, today's young gen ation will become even po er than they are now in re tion to the old. Alrea according to the Census B reau, the real median incor of households headed by pe ple under age 30 is 15 pe cent lower than it was wh Boomers were their age t decades ago. With strict co munity rating, their purch ing power could fall by ano er 7 percent.

Second, the new health l could defeat its own prima goal: universal coverag Since adults under age 35 a currently the least insur age group in America, t goal will only be achieved young people start purch ing more insurance. Hu premium hikes will have e actly the opposite effe (Over the past 15 mont the New York experiment community rating has caus a 30 percent rise in pol cancellations by you males.) The only practi remedy to this problem wo be to combine strict comm nity rating with univer mandated coverage—wh would seal young people i the system, force them to b vastly overpriced insuran and make them even m cynical about governm than they already are.

The final and most spect ular consequence of str community rating may be political. Right now, few you adults are paying attention health care reform. But o community rating becomes law and you wallets are emptied, that will surely chan Come 1998, people born in the '60s and '7 will comprise America's largest generation voters. Once mobilized, they will start de ing elections. That's when those who ta the young to enrich the middle-aged could run out of office by those who find themsel stuck with the bills.

Everyone knows our health-care syst needs change. Costs must be controlled. P families must gain access to doctors. Insur must be barred from discriminating aga the sick. All this can be done without forc all younger workers to pay far more for he care (and all older workers far less) than w they actually consume.

Neil Howe and Bill Strauss are co-author

"WHY UNIVERSAL COVERAGE IS ESSENTIAL FOR COST CONTAINMENT"
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"WHY UNIVERSAL COVERAGE IS ESSENTIAL FOR COST CONTAINMENT "
Fact Sheet

THE PROBLEM

A. National Health Expenditures:

- If we do nothing, health care spending will rise from 14% of GDP today to an astonishing 18% of GDP in the year 2000 -- meaning that **seven years from today, almost $1 out of every $5 earned by Americans will go to health spending**. [OMB]

- Although the U.S. Ranks first in world in per capita expenditures on health care, the nation falls short in basic indicators of health status. The U.S. ranks 19th in infant mortality rates, 21st in life expectancy for men and 16th in life expectancy for women. [*"Health United States"*, Department of Health and Human Services, 1992]

B. Deficit

- More than half of the expected $295 billion increase in federal revenue between 1996 and 2000 will be absorbed by health care cost increases. [*"The Economic and Budget Outlook"*, CBO, 1/94]

- For the next ten years, Medicaid and Medicare spending are predicted to increase by 10% or more each year -- growing significantly as a percentage of GDP. At the same time, other mandatory spending is expected to remain constant as a percentage of GDP and discretionary spending is expected to decrease. [*"The Economic and Budget Outlook"*, CBO, 1/94]

2. State and Local Budgets:

A. States

- In the last three years alone, state Medicaid expenditures have spiraled as a percentage of state budgets -- from just over 8 percent in 1990 to 12 percent in 1993. [HHS calculations from National Association of State Budget Officers data]

- State Medicaid expenditures are projected to consume nearly 18 percent of state budgets in the year 2000 -- twice as much as they had just ten years before. [HHS calculations from National Association of State Budget Officers data]

- In 1993, for the first time in history, states spent more on health care than they did on tax-financed higher education. [National Association of State Legislators]

B. Local

- In a recent study by the National League of Cities, "health care was cited as a burden by 42 percent of the cities." [AP, 7/11/94]

- For the third year in a row, health insurance costs were the biggest budget problem. Over the past three years, health insurance premiums paid by cities have increased nearly 10% in constant dollar terms. [WSJ, 7/11/94]

3. Families

- From 1988 to 1993, the average family premium for employer-based group health insurance doubled, from $2,500 to $5,200. Families wanting to buy health insurance directly from an insurer can spend as much as $10,000 a year. [HIAA (1988) and KPMG Peat Marwick (1993) in New York Times, 6/12/94]

- In 1993, families paid two-thirds (67%) of all health care payments on average or $5,190 -- three times the average family payment of $1,749 in 1980. [Lewin-VHI for Families USA, 3/94]

- Family payments for health care are consuming larger and larger portions of family incomes. In 1980, health payments consumed 9 percent of pre-tax family income, on average. By 1993, health payments by families consumed 13.1 percent of pre-tax income, on average. By 2003, without reform, this will rise to 20.1% of family income. Under the Clinton proposal in that year, it would be 18.9%. [Lewin-VHI for Families USA, 3/94]

- Cost shift to insured families:
  -- In 1991, hospitals were left with an estimated $10.8 billion in unpaid bills from uninsured patients -- up from $3.5 billion in 1981. [Lewin-ICF, Los Angeles Times, 4/12/92]

- Wage argument:
  -- If health care had been reformed in 1975, American workers would have over $1,000 in extra wages each year. [Commerce Department, Office of Management and Budget]

  -- The amount of total compensation going to health care keeps growing -- by 1993, an average of $1.10 of each worker's hourly wages went to pay for health insurance, up from 92 cents just two years before. Without reform, workers will lose another $600 per year in wages by the year 2000. [HHS, 6/94; OMB]

WHY UNIVERSAL COVERAGE WILL CONTAIN COSTS:

1. Emphasizing cost-saving preventive care and encouraging care in appropriate settings

A. Emergency Room Use:

- According to the first national survey of hospital emergency room departments, fifty-five percent of the 90 million emergency room visits in 1992 were for ailments that could have been treated elsewhere. [National Hospital Ambulatory Medical Care Survey; 1992 Emergency Department Summary; HHS, National Center for Health Statistics]

- Emergency room use increased by 19% from 1985 and 1990. Uninsured people seeking non-urgent care was the number #1 factor reported by 81% of hospitals. At the same time, there was little growth, if any, in emergency room visits by patients with private insurance. [American College of Emergency Physicians; 1993; GAO, *"Growth and Change in Emergency Room Use"*]

- Lack of primary provider was the primary reason for non-urgent emergency room use in 1990 -- far ahead of "after office hours" or "convenience". [*"Emergency Departments: Unevenly Affected by Growth and Change in Patient Use"*, GAO, 1/14/93]

- An emergency room visit costs at least three times that of a visit to a community-based physician in the same area. [Department of Health and Human Services, Inspector General Report, 1992]

B. Preventive Care:

- In 1989, only 1 in four full-time participants in health plans offered by medium and large businesses had coverage for routine physicals or immunizations. 40 to 60 percent of children under age 2 have not received the recommended immunizations. [AARP Testimony, 5/6/94]

- Immunizations work and they're highly cost effective. Every dollar spent on vaccinations for childhood diseases saves 10 to 14 dollars in long-term costs. [*"Preventive and Medical Services: Healthy People 2000"*, 11/18/92]

- A recent report indicated that one of every 10 hospital stays in Massachusetts could be avoided by better preventive medical care for conditions such as asthma, pneumonia and anemia. The study found that Massachusetts residents check in for 55,000 avoidable hospital stays each year, costing hundreds of millions of dollars. [*"1 in 10 Mass. hospital stays preventable, analysis finds,"* Boston Globe]

- At the University of California at San Diego in 1985, hospital care for babies born with no prenatal care cost an average of $2,200 more than corresponding care for babies whose mothers received adequate prenatal care. But such care cost only about $1,000 per pregnancy. [*"Opportunities for Success: Cost Effective Programs for Children."* Report of the Select Committee on Children, Youth and Families, 1988]

2. **To enable deficit reduction:**

- CBO: *"And finally, as I noted earlier . . . the proposal should make ever-increasing contributions to deficit reduction after 2004."* [Reischauer Testimony, Senate Finance Committee, 2/9/94]

3. **Families Will Pay Lower Premiums**

- CBO said the premiums under the non-universal Cooper proposal would be about 20% higher than those under the Health Security Act -- explaining that half of the difference between the two *"is largely attributable to adverse selection; the Administration's proposal would require universal participation . . . "* [CBO, 4/94, p. 18]

- New Report: ***"Coverage, Premium, and Household Spending Implications of Health Reform,"*** Lewin-VHI for Catholic Health Association, 7/18/94

  - **"Premiums are lower under universal coverage** than under insurance market reform or insurance market reform linked to subsidies."

  - **"Middle income families that currently have insurance will pay more under partial reform** than under reform that includes universal coverage."

  - With non-universal coverage, the average family who has insurance today will pay an additional $182 in 1998 on premiums compared to universal coverage.

  - Under the best incremental reform package, an average household with insurance today will spend an additional $105 in 1998. Under universal coverage, that same family would ***save*** $233.

  - In 1998, a family making between $30,000 and $40,000 will spend $472 more under a non-universal system. Under universal coverage, they would save $241. *[Note: This is without wage effects -- businesses decreasing wages to reflect higher health costs. With wage effects, the average currently insured family spends more in 1998 under universal coverage.]*

With Non-Universal Approaches

- Under a Cooper-style approach, Lewin predicts that, in 1998, *"$8.1 billion of hospital uncompensated care and the $0.5 billion free physician care would ultimately be cross-subsidized by private payers through higher patient charges and insurance premiums.* ***Partial reform will perpetuate the destabilizing effects of this costs shift as much of the care provided to the uninsured would continue to be shifted to the privately insured."*** [Lewin-VHI, 7/18/94, p. 4]

HAWAII EXAMPLE

- ***Hawaii Health Director:*** *"The secret of our success. . . is prevention. We have twice as many outpatient visits -- that is, people see their doctors several times a year -- and half as many hospital stays, as the national average. People are encouraged to go to the doctor early and often, thus minimizing the chance of costly operations for maladies that could have been prevented."* [*"Hawaii: Setting an Example for the Rest of the Nation"*, New York Times, 11/14/93]

- "Hawaii has
  - -- 70% of the national rate of acute hospital beds per 1000 population;
  - -- 90% of the national average for acute hospital utilization;
  - -- 61% of the national average for surgeries; and
  - -- 48% of the national rate of emergency department utilization.

  There is no rationing and Hawaii has the same commitment to tertiary care and new technologies as other states. We believe the economies of low inpatient utilization are a major source of Hawaii's lower costs." [*"Hawaii's Employer Mandate and Its Contribution to Universal Access,"* JAMA, 5/19/93]

- "Near universal coverage can dramatically improve overall public health, further reducing spending and leading to a more productive work force. Hawaii officials cite the infant mortality rate, which is down 50 percent from its 1974 high of 16 deaths per 1,000 births and the state's life expectancy of 78, the highest in the nation." [*"Hawaii Presents Possible Archetype for Clinton Health Plan,"* Los Angles Times, 7/8/94]

"WHY UNIVERSAL COVERAGE IS ESSENTIAL FOR COST CONTAINMENT"
Annotated Bibliography

A. Problem

1. *"The Ten-Year Budget Outlook,"* Congressional Budget Office, 1/94

   Latest Congressional Budget Office Analysis of the explosion in government health care programs -- compared to projected decreases in discretionary and other mandatory spending.

B. General Cost Containment Articles

1. Stephen Zuckerman and Jack Hadley, *"Clinton's Cost Controls Can Work,"* The Washington Post, 11/7/93

   A compelling defense of both the need to control costs and the mechanisms contained in the HSA. Explores the paradox of critics on the left saying that the cost controls "won't work" and critics on the right concluding that they "will work too well and lead to massive disruption in the provider system and the rationing of care." Concludes that *"In reality, the administration's cost containment goal is modest. . . This plan does not try to shrink health spending relative to where we are now. . . The U.S. health system is fraught with inefficiencies and excess that have no measurable health benefits."*

2. Uwe E. Reinhardt, *"Cut Costs? Of Course,"* The New York Times, 6/12/94

   Highlights percentage of national product consumed by health care costs. Challenges opponents of cost control: *"[N]o other industrialized country would even contemplate spending as much as 17 percent of its G.N.P. on health care, and none spend even 10 percent today. Why then, should the Administration be made to show 17 percent is implausible? It is the critics who should demonstrate that it is unattainable."*

C. Hawaii Example

1. 2 Page Internal Overview Of The Hawaiian System

2. Articles:
   "Hawaii is a Health Care Lab as Employers Buy Insurance", Adam Clymer, New York Times, 5/6/94

   "Hawaii Presents Possible Archetype for Clinton Health Plan," Los Angles Times, 7/8/94

Two good overviews of the Hawaiian system -- touching on both its successes and shortcomings. Will likely be the most recent articles these pundits have read on Hawaii. Primarily address the employer mandate -- its effects and implications -- but also touch on some of the benefits of universal coverage and its cost containment implications.

3. [excerpted] *"Health Care in Hawaii: Implications for National Reform,"* General Accounting Office, February 1994

Good quick summary of Hawaii's cost experience. This 5 page section of the recent GAO study on Hawaii concludes that: *"The cost experience in Hawaii is seemingly anomalous because, while per capita health care costs [and health inflation] are similar in Hawaii and the nation, insurance premiums are lower in Hawaii."*

D. Preventive / Emergency Room Studies

1. Emergency Room Studies

- [excerpted] *"America's Health Care Safety Net: Emergency Medicine,"* American College of Emergency Physicians, 1993

  Excerpts address the increased demand for emergency services and the factors contributing to this demand. Also addresses the relation between the lack of insurance and emergency room use, and the increasing use of emergency facilities for primary care. *[Note: This was released prior to the HHS study [referred to below] which shows that over half of emergency room visits were for non-emergencies. The comparable 1990 statistic referenced in this study is 42%.]*

- *"National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary,"* Centers for Disease Control and Prevention, HHS, 3/2/94

  The first national survey of hospital emergency room departments, conducted by the National Center for Health Statistics in 1992. Main conclusion is that fifty-five percent of the 90 million emergency room visits in 1992 were for ailments that could have been treated elsewhere.

2. Prevention Studies

- *"Preventive and Medical Services,"* Speech by James Mason, Assistant Secretary of Health, HHS [Under President Bush], 11/18/92

  Explores the examples of waste, inefficiency, and lack of competition in our health care system. Tried to answer the question of why we do not get our money's worth in today's system: *". . . for all our technology and all our spending, we do not have the health outcomes we might expect."*

- *"How Much Is An Ounce of Prevention Worth?"* Newhouse News Service, 12/17/94

  Good balanced overview article -- describing the Clinton proposal, the need for preventive services, and referencing the analysis that prevention may not save money in the short run.

- *"Reducing Health Care Costs by Reducing the Need and Demand for Medical Services,"* The New England Journal of Medicine, 7/29/93

  Written by the Health Project -- a well respected group of prominent doctors, including C. Everett Koop -- the study advocates funding preventive medicine as a way to lower long-term health costs. *"A comprehensive health promotion program with multiple interventions can save money both in the first years and over the long-run."* In reviewing more than 200 health promotion programs in the workplace and other studies, the researchers found evidence of significant savings.

3. Counter Prevention Argument

- *"A Costly Ounce of Prevention: Early Medical Screening May Save Lives But Not Money,"* Washington Post, 8/29/93

  Widely read article from *Outlook* section explores thesis that -- with the exception of dramatic savings in a few areas, such as childhood immunization and pre-natal cares -- preventive care will not really lead to cost reductions. Prevention can, in fact, increase costs as expensive illnesses are detected much earlier than they otherwise would have been and millions of dollars are spent to screen people who would never have gotten the disease in the first place.

- *"Prevention May Be Costlier Than a Cure,"* The Wall Street Journal, 7/6/94

  Will be the last article on prevention read by these pundits, based on a very credible study. Overall theme was that prevention may not save much money. But, the study was on much more than health care -- from requiring airbags in cars to prescribing cholesterol reducing drugs to pollution control. It concluded that most effective preventive measures are in medicine -- *"Childhood immunizations, drug and alcohol treatment programs and prenatal care are among the biggest life-saving bargains, the study shows. These lower the costs of caring for sick people, thus total costs can be more than offset by health care savings. . . "*

E. Premiums: Universal vs. Non-Universal

1. [Excerpts] *"Coverage, Premium, and Household Spending Implications of Health Reform"*, Lewin-VHI, 7/18/94

   The report compares the effects on family spending of: insurance market reforms alone, insurance market reforms with premium subsides (Managed Competition Act), and universal coverage under the President's HSA (with and without premium caps). It concludes that both premiums and household spending are lower under universal coverage than under partial reform.

COMMITTEE FOR A RESPONSIBLE BUDGET

Should be prepared to respond to 7/11/94 release

- *Members include*: Edmund S. Muskie, Warren Rudman, David Stockman, Roy Ash, William Gray III, Robert Strauss, Paul Tsongas, Peter Peterson, Paul Volcker.

- AP Story, lead: "Overhauling the entire U.S. health system would be *"premature and ill-advised"* and President Clinton and Congress should settle for less, says a bipartisan group of former government officials. *"Reforming the health system cannot be achieved in one omnibus piece of legislation,"* the Committee for a Responsible Federal Budget said in a bluntly worded, 148-worded report."

- Advocates going slowly and passing incremental reform measures to start with: Increase availability of public, tax-financed health facilities and adopting measures to increase access to affordable insurance for those who want it.

    - *"Universal coverage is a means to an end -- not the end itself."*

    - Warns of expensive new entitlements and impact on future budget.

    - *"Mandates are taxes"*

- We'll need to respond to: *"Universal coverage is not a prerequisite to global cost containment. It would assure everyone pays for health care, reducing the per capita cost of coverage. But it would increase, not reduce,* ***total*** *costs, by increasing utilization of health care."*

- *"If we cannot afford the current projected trend in health spending, then we cannot afford to reallocate every dollar saved through health care reform on health care."*

Five recommendations:

1. Require transparency in the budgetary treatment of health care reform.
2. Subject the financing for health reform to as thorough a debate and analysis as any proposal affecting taxation.
3. Recognize the potential downside risks to the Federal budget and proceed with caution.
4. Reestablish deficit reduction as an essential goal of health care reform.
5. Proceed with changes upon which there is already broad agreement.

[Answer: We agree wholeheartedly with 4 out of 5 recommendations; 5 is problem]

FAMILY SPENDING:
UNIVERSAL COVERAGE VS. INCREMENTAL REFORM

SUMMARY OF REPORT

- A Lewin-VHI report -- ***"Coverage, Premium, and Household Spending Implications of Health Reform"*** -- was released July 18, 1994 by the Catholic Health Association. The report compares the effects on family spending of: insurance market reforms alone, insurance market reforms with premium subsides (Managed Competition Act), and universal coverage under the President's HSA (with and without premium caps). It also addresses the effects of adding an individual mandate to the Managed Competition Act to achieve universal coverage.

SUMMARY OF CONCLUSIONS:

1. **Premiums are lower under universal coverage** than under insurance market reform or insurance market reform linked to subsidies

2. **Middle income families that currently have insurance will pay more under partial reform** than under reform that includes universal coverage

3. **For currently insured households earning less than $100,000 annually, health spending will decline under universal coverage** with an employer mandate and cost constraints.

OTHER INTERESTING POINTS:

Household Spending Before And After Reform

- "For the 76.5 million households that currently have insurance, we estimate that health spending is generally higher under partial reform than under universal coverage with or without wage effects." [p. v]

- "Currently insured families earning less than $10,000 a year see a net decrease in health spending under all four approaches, but middle income families that already have insurance generally see an increase in spending under the Managed Competition Act with or without universal coverage." [p. v]

- Even taking into account wage effect: "Of the three universal coverage approaches, the Health Security Act as written is the only one that reduces household spending for currently insured middle income families, with or without wage effects." [p. v]

Cost Shift To Currently Insured

- In 1998, "$8.1 billion of hospital uncompensated care and the $0.5 billion free physician care would ultimately be cross-subsidized by private payers through higher patient charges and insurance premiums. **Partial reform will perpetuate the destabilizing effects of this costs shift as much of the care provided to the uninsured would continue to be shifted to the privately insured."** [p. 4]

Box 2-1.
The Ten-Year Budget Outlook

If current policies stay unchanged, the federal deficit will climb steadily after the late 1990s, according to the Congressional Budget Office's latest look at the 10-year picture. CBO projects that the federal deficit (excluding deposit insurance) will be essentially flat in 1995 through 1998. But it climbs every year after that, ultimately topping $360 billion in 2004 (see table). Of greater concern is the deficit's trend as a share of gross domestic product: from 2.2 percent in 1998, it inches up in every year, approaching 3½ percent of GDP in 2004.

What accounts for the escalating deficits after 1999? The answer lies basically in the outlook for one fast-growing and one slow-growing area of spending: health care and discretionary spending.

Outlays for the two big health care programs, Medicare and Medicaid, climb steadily by 10 percent or more every year over the 10-year period. Thus, they also climb as a percentage of GDP: from 3.7 percent in 1994 to 6.3 percent in 2004. Discretionary spending, in contrast, sinks as a share of GDP throughout the entire period. Constrained by caps through 1998, it barely grows at all in dollar terms through then and falls from 8.2 percent to 6.7 percent of GDP--more than offsetting the climb in health care spending. But the caps expire after 1998, and appropriations are assumed to rise again in step with inflation (in keeping with standard baseline methodology). Thus, although discretionary programs continue to sink as a share of GDP in 1999 through 2004, their decline (to 6 percent in 2004) is less precipitous than in the earlier period and is not sufficient to overcome the unrelenting rise of health care spending.

Most other areas of the budget change little in relation to GDP over the 1999-2004 period. Revenues slip from 19 percent to 18.8 percent of GDP. Mandatory spending other than Medicare and Medicaid is expected to stay roughly constant as a share of GDP. The biggest such program, Social Security, remains at 4.8 percent of GDP; even by 2004, the first members of the post-World War II baby boom are still four years from eligibility for retirement. Net interest outlays hover around 3 percent of GDP, and the ratio of debt to GDP--which is basically flat in 1994 through 1999--creeps up by about 3 percentage points (from 52 percent to 55 percent) in the five years thereafter.

A year ago, CBO projected that the deficit would top $650 billion in 2003; by last September, CBO had chopped its projection to $359 billion. The enormous improvement during that six-month period was almost wholly attributable to the enactment of an ambitious deficit reduction package. The newest projection for 2003, a deficit of $324 billion, is only a minor revision in comparison. Of the $35 billion revision, two-thirds stems from higher revenues as CBO has upped its estimate of potential growth, and one-third from lower interest costs as CBO has trimmed its estimate of federal debt.

Of course, these extrapolations are not as detailed as CBO's usual five-year estimates. Rather than produce a meticulous 10-year projection for every program in the budget, CBO attempts simply to judge the likely trends in broad clusters of spending and revenues. And great uncertainties surround such long-range extrapolations. The economy's performance is a big question mark; these projections are predicated on continued growth in real GDP of 2.3 percent annually in 2000 through 2004, on inflation of 3.1 percent, and on short-term and long-term interest rates (specifically, rates on three-month Treasury bills and 10-year Treasury notes) of 4.7 percent and 6.2 percent, respectively. The economy is bound to deviate from these assumptions in ways that cannot be anticipated. And other major uncertainties abound, most notably about future trends in health care spending and about other open-ended commitments, such as the pledges for deposit insurance that proved so costly in the recent past.

The Budget Outlook Through 2004 (By fiscal year)

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
					In Billions of Dollars						
Revenues	1,251	1,338	1,411	1,479	1,556	1,630	1,706	1,783	1,868	1,958	2,054
Outlays											
Discretionary	543	541	547	547	547	564	582	600	619	638	658
Mandatory											
Social Security	318	335	352	370	388	408	429	450	473	497	523
Medicare	160	177	195	215	238	264	290	320	354	392	435
Medicaid	86	96	108	121	135	151	168	186	206	227	250
Civil Service and Military Retirement	62	65	67	70	73	78	81	85	89	92	96
Other	177	171	168	184	191	199	205	211	218	225	232
Subtotal	803	844	890	960	1,026	1,099	1,173	1,253	1,339	1,433	1,536
Deposit Insurance	-5	-11	-14	-6	-4	-4	-3	-3	-2	-2	-2
Net Interest	201	212	228	239	249	261	270	283	298	315	334
Offsetting receipts	-69	-77	-74	-78	-83	-86	-90	-94	-98	-102	-106
Total	1,474	1,509	1,577	1,661	1,736	1,834	1,931	2,039	2,156	2,282	2,419
Deficit	223	171	166	182	180	204	226	256	288	324	365
Deficit Excluding Deposit Insurance	228	182	180	189	184	208	229	258	290	326	367
Debt Held by the Public	3,462	3,642	3,822	4,021	4,218	4,441	4,686	4,961	5,268	5,611	5,995
					As a Percentage of GDP						
Revenues	18.8	19.1	19.1	19.0	19.0	19.0	18.9	18.9	18.8	18.8	18.8
Outlays											
Discretionary	8.2	7.7	7.4	7.0	6.7	6.6	6.5	6.3	6.2	6.1	6.0
Mandatory											
Social Security	4.8	4.8	4.8	4.8	4.7	4.7	4.8	4.8	4.8	4.8	4.8
Medicare	2.4	2.5	2.6	2.8	2.9	3.1	3.2	3.4	3.6	3.8	4.0
Medicaid	1.3	1.4	1.5	1.6	1.7	1.8	1.9	2.0	2.1	2.2	2.3
Civil Service and Military Retirement	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Other	2.7	2.4	2.3	2.4	2.3	2.3	2.3	2.2	2.2	2.2	2.1
Subtotal	12.1	12.0	12.1	12.3	12.5	12.8	13.0	13.3	13.5	13.8	14.1
Deposit Insurance	-0.1	-0.2	-0.2	-0.1	a	a	a	a	a	a	a
Net Interest	3.0	3.0	3.1	3.1	3.0	3.0	3.0	3.0	3.0	3.0	3.1
Offsetting receipts	-1.0	-1.1	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0	-1.0
Total	22.2	21.5	21.3	21.4	21.2	21.3	21.4	21.6	21.7	21.9	22.1
Deficit	3.4	2.4	2.2	2.3	2.2	2.4	2.5	2.7	2.9	3.1	3.3
Deficit Excluding Deposit Insurance	3.4	2.6	2.4	2.4	2.2	2.4	2.5	2.7	2.9	3.1	3.4
Debt Held by the Public	52.2	52.0	51.7	51.7	51.5	51.7	52.0	52.5	53.1	53.9	54.9

SOURCE: Congressional Budget Office.

a. Less than 0.05 percent of GDP.

The Washington Post

November 7, 1993, Sunday, Final Edition

SECTION: EDITORIAL; PAGE C7

LENGTH: 1392 words

HEADLINE: Clinton's Cost Controls Can Work

SERIES: Occasional

BYLINE: Stephen Zuckerman, Jack Hadley

BODY:

Controlling medical care spending is "Job One" for the Clinton administration's health care reform plan. System savings from successful cost control will help pay for extending insurance to the 37 million Americans who don't have it, for making sure that those who have it can't lose it and for guaranteeing that every insurance plan includes a comprehensive benefit package.

Not surprisingly, critics from both the left and right are concentrating their firepower on the administration's cost-control plan. The criticisms can be roughly divided into two camps. One is that the plan's cost-control features won't work. The other, oddly enough, is that they will work too well and lead to massive disruption in the provider system and the rationing of care.

What is the administration's cost control plan? Although often ridiculed as being of, by and for policy wonks, the basic strategy is quite simple. It has two lines of attack. The first is to promote competition among insurance plans under a cap on the average premium in an area. The second is to limit the amount of new money flowing into the system by capping the rate at which insurance premiums are allowed to increase.

The Clinton proposal requires that all insurance plans offer a comprehensive package of benefits and charge the same premium to all comers, regardless of age, health history or employment situation. According to the theory of managed competition, with the product standardized and insurance companies less able to compete by rejecting or avoiding high risks, competition will have to take the form of price and quality competition. Insurance plans will attract customers and prosper by providing value for money.

In spite of the promise of managed competition, it largely remains a theory. To put teeth into it, the Clinton plan will impose a financial penalty on any insurance plan that tries to increase its premium more than the cap allows. There is little doubt that if faced with constrained revenues, insurance plans will limit their expenses. Each plan will decide the best way to do this, including constraining the overuse of services and limiting what they pay doctors, hospitals and other health care providers. But they will have every incentive to do it in a way that doesn't drive away subscribers. One critic characterized this approach as "getting the insurance plans to do the government's dirty work." However, it seems far preferable that insurance companies that are responsible to their subscribers make these decisions than having the federal government involved in detailed price negotiations and review procedures with individual hospitals and physicians. As another critic put it, "That's like bombing from 30,000 feet. You can't see whom you kill."

In reality, the administration's cost-containment goal is modest. Its original estimate is that annual savings would be $ 136 billion in the year 2000. That's a lot of money to anyone. But let's put it into perspective. At the time this estimate was made, the Congressional Budget Office projected that health care would absorb 18.9 percent of GDP by the year 2000. The Clinton plan would bring that down to 17.3 percent. We currently spend 14.3 percent of GDP on health care, while no other industrialized country spends more than 10 percent. Thus, the Clinton plan's "draconian" cost-containment combination of more competition and caps on premium growth permits about a 3 percent increase in the share of GDP going to health. This plan does not try to shrink health spending relative to where we are now. No health care jobs will be lost, though fewer new jobs may be added in the future.

How will the system respond to these constraints? The specter of sick patients being unable to receive care is completely farfetched. The U.S. health system is fraught with inefficiencies and excesses that have no measurable health benefits. The constraints on spending growth will, for example, force more triage to reduce the estimated 15-30 percent of diagnostic tests and surgeries that may be unnecessary. Private insurers will no longer be willing to pay providers prices that are 30-40 percent above Medicare, nor should they. Providers will be able to survive with lower prices for private patients, because universal coverage will mean an end to uncompensated care and low prices for Medicaid beneficiaries.

Studies of the present system have shown that hospital costs are 10-15 percent higher than they would be if all facilities produced services more efficiently, and this excludes savings that would accrue from not producing unnecessary services. Imposing financial pressure through caps on premiums means some hospitals will scale back their investments in buildings and equipment -- which are often underutilized -- and reorganize their staffs.

Our own current research on a nationwide sample of almost 1,450 hospitals suggests that they respond to financial pressure primarily by controlling costs. The 25 percent of hospitals with the lowest profits in 1987 experienced cost increases of 13.3 percent between 1987 and 1989 compared with an average of 27.6 percent for hospitals with the highest profits. In contrast, for both groups of hospitals, total revenues grew at virtually the same rate, about 21 percent over the three years; 30-day post-admission mortality rates for Medicare patients improved slightly; and the shares of hospitals' patients covered by Medicare and Medicaid increased by about 3 percent.

Patients will also need to change. They may need to accept a less-intensive approach to diagnosis and treatment as currently practiced in the best-quality HMOs. And they may also need to consider whether a high-cost health plan is worth the extra money. If it is not, consumers will be able to choose a less costly health plan. People may not like these changes simply because change can be uncomfortable. However, Americans will no longer fear losing their coverage if they become very sick or lose their jobs.

How fast would spending growth begin to subside? If the speed with which hospitals have responded to Medicare's prospective payment system, other rate-setting systems and lowered-profits is a guide, the answer is almost immediately. When providers are paid less, they move quickly to cut their expenses and organize service delivery more efficiently. When Medicare phased in its prospective payment system between 1982 and 1984, hospitals that faced the greatest potential financial loss held their expense growth to one-third that of hospitals facing prospects of financial gain, 3.2 percent compared with 10.2 percent. Hospitals in California that faced strong competitive pressures as well as prospective losses from PPS actually cut their costs by 4.3 percent between 1983 and 1985. The annual increase in the volume of so-called "overpriced procedures" provided to Medicare beneficiaries by physicians fell from 9.3 percent in 1986-87 to 2.4 percent in 1988-89 in response to a 2.4 percent cut in average fees. Given this evidence and congressional action within the next year, the system should be able to adjust by the year 2000 without major adverse consequences.

The Clinton proposal aims to alter incentives by a combination of regulatory and market forces. Some critics would rather see much greater reliance on changes in the tax treatment of health insurance premiums as the way to change incentives. Despite its intellectual appeal to some, there is little evidence to show that this approach would succeed. On the other hand, even though strict systems of regulated spending and price controls have good track records of controlling costs, they do not have widespread political support. Many people view such systems as administratively burdensome, inflexible and likely to lead to explicit rationing.

The Clinton proposal relies on competition among plans. but limits the amount of tax-subsidized dollars that can flow into the system and requires the development of a potentially regulatory framework for limiting total spending. This is a compromise. But, its acceptability and likely success may be greater than either pure alternative.

Stephen Zuckerman is a senior research associate at the Urban Institute. Jack Hadley is co-director of the Center for Health Policy Studies at Georgetown University School of Medicine.

...ut Costs? Of Course

By Uwe E. Reinhardt

PRINCETON, N.J.

The Congressional Budget Office forecast last year that spending on health care would rise from 14 percent of the gross national product to 19 percent by the year 2000.

"Impossible!" shouted America's pundits. That level of health spending, they said, would bankrupt the country.

Then President Clinton proposed to bring that projected growth down to "only" 17 percent of the G.N.P. by the year 2000.

"Impossible!" shouted America's pundits. Such a steep decline in spending would lead to rationing of care, they argued.

While Americans are thus meandering from despair over the prospect of deprivation at 17 percent to ar... over financial collapse at 19 ..., no other industrialized nation would even contemplate spending as much as 17 percent of its G.N.P. on health care, and none spend even 10 percent today.

Why, then, should the Administration be made to show 17 percent is an implausible goal? It is the critics who should demonstrate that it is unattainable

Let us examine the projected cuts in spending on Medicare, the health insurance program for America's elderly. For that program, the President would allow annual spending to increase from $128.8 billion in 1993 to as much as $207.8 billion in the year 2000. That represents an average annual compound growth rate of 7.1 percent.

Can America's physicians really look the taxpayer in the eye and argue that even accounting for inflation, they could not treat the elderly properly for $207.8 billion in the year 2000?

To put that question in perspective, consider some fascinating data published in The New England Journal of Medicine in March 1993.

The authors of an article on Medicare spending in cities found that in 1989, after adjusting for differences in age and sex, Medicare payments for doctor's care, per beneficiary, varied from lows of $822 in Minneapolis, $872 in San Francisco and $954 in New York City to highs of $1,493 in Detroit, $1,637 in Fort Lauderdale and $1,874 in Miami.

Should not America's physicians, and the legislators from the high-cost states, be made to defend these differentials to the taxpaying public? Suppose Congress arbitrarily slashed Medicare reimbursements for Miami physicians by 20 percent. Even after this budget cut, Miami physicians would still be absorbing 57 percent more Medicare dollars per beneficiary than their colleagues in New York, and 82 percent more than their colleagues in Minneapolis.

Many critics argue that the 37 million uninsured Americans could not possibly be accommodated at spending levels of "only" 17 percent of the G.N.P. Oddly enough, some of the same critics also assert that these Americans merely lack health insurance, not health care, for they allegedly receive adequate treatment at the expense of paying patients to whom the cost of that charity care is shifted.

> No nation spends nearly as much on health as we do.

But if the uninsured already get the care they need, why should insuring them all of a sudden break the national bank? On this point, too, opponents of the President's health care plan should try harder to get their stories straight.

The Clinton Administration's proposal is complex enough to offer any would-be critic many targets of opportunity. It is puzzling that the spending forecast is chief among them. Sure, Mr. Clinton could explain his forecast better than he has done so far. But the burden of proof on this issue ought not to rest with the President. It rests on the shoulders of his critics, for it is they who have much explaining to do. □

Uwe E. Reinhardt is professor of political economy at Princeton.

50 Labs for Reform

By Jerry L. Mashaw and Theodore R. Marmor

NEW HAVEN

The debate over health care reform has reached a critical juncture. There is significant opposition in Congress to the Clinton plan without anything like consensus on an alternative.

How can a workable version of national reform be enacted when there's no majority for any single plan? The challenge for reformers is to find a strategy that reflects the political agreement on the goals of health reform as well as the disagreements on solutions.

The reformers are split into factions favoring managed competition, a single-payer system, expansion of Medicare and various hybrids of these approaches. But these divisions should not obscure the broad agreement among reformers on fundamental principles: universal coverage, reliable cost containment and radical reform of health insurance practices.

If a legislative proposal can be developed that brings together all those serious about health reform — no matter what option they favor — a majority can be created to overcome the resistance of reform's opponents. The trick, then, is to pursue legislation that builds on the reformers' common goals while recognizing their differences on how to achieve them administratively. One solution is the federalist option.

After all, the states have already achieved more on reform than Congress has. There is no reason to stop their progress, and every reason to encourage it. The federalist approach would set national standards for health insurance — that it be universal and portable (not based on residence or employment), cover all medical necessities and have effective cost-containment methods plus clear accountability for the quality of the overall system.

Having done that, the Government could promise to continue its current financial contributions to health care so long as the states met its conditions for acceptable plans. That would free states to experiment with any of the options the Administration has outlined — or any others, either existing or under development around the country.

In short, Mr. Clinton and Congress could acknowledge that medical organization and practices vary substantially in different geographical areas, as do demographics and political beliefs. They could develop a plan that motivated state experimentation, rather than mandating a single system for the entire country.

Mr. Clinton could insist that national legislation — Medicare, Medicaid, the Employee Retirement Income Security Act and the Internal Revenue Code — not get in the way of state innovation, but nonetheless impose sanctions on states that did not conform to broad national standards.

> Let the states experiment.

This approach recognizes that the nation does not yet know what works or will work everywhere. It would help the nation learn from successes and failures while avoiding the possible total failure of a plan imposed from Washington.

If Congress adopts an unproven and untested version of the Clinton plan and it turns out to be the health care equivalent of a train wreck, it would be sensible not to have the whole country on the same train at the same time. □

Jerry L. Mashaw and Theodore R. Marmor, co-authors of "America's Misunderstood Welfare State," are, respectively, professors of law and management at Yale.

THE NEW YORK TIMES, SUNDAY, JUNE 12, 1994

STATE OF HAWAII

Summary: Hawaii has moved closer to universal access than any other state through its combination of employment-based coverage, Medicaid, and a state-subsidized insurance program for the "Gap Group" -- those not qualified for either employer-provided or Medicaid coverage. State officials estimate that only about 4 percent of Hawaii's population remains uninsured -- compared to estimates of 15.3 percent nationwide.

Features:

I. Shared Employer-Employee Responsibility: The foundation of Hawaii's approach is its 1974 Prepaid Health Care Act which requires that all employers provide health insurance to their employees. Employees must elect the insurance unless they have comparable coverage from another source. Employers and employees share financing of premiums.

- The law specifies that employers must provide an extensive package of medical, hospital, and laboratory services that meets minimum standards specified in the Prepaid Health Care Act. Employers have a second option of providing a state-approved benefits package more limited than one of the standard plans and then paying half the cost of dependent coverage.

- In 1990, 88 percent of Hawaii's under-65 population were covered by employer-based insurance, provided primarily by two large insurers -- a standard fee-for-service plan from Hawaii Medical Services Association (Blue Cross/Blue Shield) and an HMO plan from the Kaiser Foundation Health Plan.

II. Medicaid Insurance: In 1990, another 7 percent of Hawaii's residents were insured through Medicaid. Hawaii has a very expansive Medicaid program, accepting a greater percentage of it low-income population than most states. In addition, Hawaii ranks third among the states for the greatest number of Medicaid service options -- with a comprehensive benefit package that covers medically necessary, and some preventive, care.

III. State Health Insurance Program (SHIP) for the Gap Group: In 1989, the Hawaii government estimated that about 5 percent of the population remained uninsured, neither covered through employer-provided insurance nor eligible for Medicaid. In response to this problem, the Hawaii legislature created the State Health Insurance Program (SHIP) to provide state-subsidized private health insurance for the low-income uninsured.

- The state purchases health insurance for SHIP enrollees from HMSA and Kaiser. The state pays the entire premium for those whose income is under the poverty level; members with incomes above poverty pay a sliding scale share of the monthly premium.

- SHIP's benefits package is very different from Hawaii's employer-provided plan and the Medicaid program. Benefits are heavily weighted toward preventive and primary care, with full coverage for prenatal, well-baby, and well-child physicians' benefits as well as coverage for health appraisals. Other physician care and hospital coverage have set limits.

Small Business: Small businesses in Hawaii pay less for health insurance that their counterparts elsewhere in the U.S. There are several reasons: (a) since most people are insured, there is less uncompensated care and therefore less cost shifting; (b) all insurers must cover all employees in a group, regardless of medical condition or risk; (c) the two dominant insurers voluntarily established an adjusted community rating system which allows small businesses to offer their employees health care benefits comparable to those offered by large employers. The Prepaid Health Care Act facilitated the use of community rating by requiring that all employees obtain insurance, thus preventing healthy people from opting out of the system.

No Strong Cost Controls: Hawaii's reforms have not shielded it from the national trend of rising health care costs, although state officials note that while Hawaii's health care spending tracked the national average, it was providing increased access to health care for all its citizens.

The New York Times

May 6, 1994, Friday, Late Edition - Final

HEADLINE: Hawaii Is a Health Care Lab As Employers Buy Insurance

BYLINE: By ADAM CLYMER, Special to The New York Times

DATELINE: HONOLULU, May 3

BODY:

The toughest question in the health care debate is whether to require employers to buy insurance for their workers.

But if members of Congress could overcome their fears of being accused of junketeering and actually visit Hawaii, they would find compelling evidence about how such a system actually works, and they would not have to rely on a range of absolute, if uninformed, opinion.

About 96 percent of Hawaiians have health insurance. Employers, regardless of the size of their work force, must pay for most of it. Nonetheless, they have thrived, despite frustration over expanding benefits and rising costs.

Moreover, Hawaiians seem healthier, and more satisfied with their health care, than other Americans.

Recent surveys by both the Northwestern National Life Insurance Company and by the American Public Health Association have rated overall health in Hawaii better than in any other state. The Federal Centers for Disease Control and Prevention ranked Hawaii at or near the top in low infant mortality, longevity and early death from heart and lung disease and cancer.

Two opinion surveys sponsored by the Kaiser Family Foundation found that 82 percent of Hawaiians, compared with 71 percent of Americans overall, were satisfied with their health care services. Only 18 percent of Hawaiians, compared with 39 percent of Americans, said their health care system worked badly.

There are no comparable surveys of doctors, many of whom complain that they make less money in Hawaii than they could elsewhere. But Jonathan R. Won, executive director of the Hawaii Medical Association, said that in a very portable profession few doctors had moved away. "Physicians really say, 'I choose to practice here,' " he said. "Nobody has come up with a better idea as yet," he said.

Hawaii is also the only state where a recent United States Chamber of Commerce survey of its members, who are mostly engaged in small business, found a majority backing compulsory payments.

Hawaii is the only state with experience with that system, but it is a little-used laboratory. Only one Congressional subcommittee has come here this year to hold a hearing. Nor is there significant academic research, even by the University of Hawaii.

Still, 20 years of Hawaiian experience does offer support for requiring employers to pay, as President Clinton has urged, but also for some of the fears that the proposal raises among small businesses.

It is clear that the "employer mandate," as the requirement to buy workers insurance is known here and in Washington, has succeeded in bringing Hawaii to the threshold of universal health insurance coverage. That seems to have helped restrain health care inflation, a serious problem here but less critical than on the mainland: health insurance premiums are about 30 percent cheaper here, while almost everything else in Hawaii is more expensive.

The state health director, John C. Lewin, argues that the system has done more than that. "By emphasizing primary care, it has improved the health status of the people of Hawaii," he said. As one example, he said, early detection of breast cancer -- despite a high rate of it in Hawaii -- had enabled the state to achieve the nation's lowest rate of mortality from the disease.

Yet Hawaiians seem rather blase about the fact that they have something unique. So they may not notice being free of the mainland fears that their employers will cancel a health plan, or that existing medical conditions will either keep them locked in their jobs, force up their rates or deny them insurance altogether.

Nor is there an echo of the intense lobbyists' argument in Washington that compelling most employers to pay for insurance will cost millions of jobs and force thousands of companies out of business. That did not happen when Hawaii's mandate took effect in 1975, nor during the worst of the recession of the 1980's, nor in the last few years, when insurance premium inflation occasionally reached double digits.

Full-Time Workers Covered

Part-time workers under 20 hours a week do not have to be insured, but no matter how small a company is, it must cover all its other workers -- and without the kind of subsidies contained in President Clinton's proposal. A report this year by the General Accounting Office, the investigative arm of Congress, said, "We found no evidence that the employer mandate resulted in large disruptions in Hawaii's small-business sector."

But a different, less shrill concern of small business heard in Washington does echo here, that Congress may include enough exemptions and subsidies to make the employer mandate bearable when it takes effect, but not forever. That has been a problem in Hawaii. As Bette Tatum, state director of the National Federation of Independent Business, put it here the other day, "Subsidies come and go; mandates last forever.".

There is no doubt that Hawaii's system is tougher on employers now than when it was enacted.

Limits on Worker Premiums

Over the years, Hawaiian officials have been prevented by Federal law from raising the ceiling on worker contributions to health care that the state law set in 1974. It is limited to 1.5 percent of a worker's salary, and no more than half the premium. For a minimum-wage worker in 1975, the limit of $5.20 a month was nearly a third of that year's $18.62 monthly cost of basic health insurance.

But health insurance costs have grown much faster than the minimum wage, which was $2 in 1975 and is $5.25 here now, or $910 a month based on a 40-hour week. The most that can be deducted from a minimum-wage worker now is $13.65 a month; that is such a small share of the $131.02 premium for a worker's basic coverage that many employers do not bother to collect it.

Though Federal law blocked Hawaii from requiring workers to pay a bigger share of their insurance premiums, Hawaii's lawmakers found a way to add benefits.

Barred from amending their 1974 Prepaid Health Care Act, Hawaiian legislators changed the basic insurance laws, requiring all health insurers and health maintenance organizations to add coverage for mental health and drug and alcohol treatment, mammograms, more well-baby care and in-vitro fertilization.

More Benefits, But Low Cost

Marvin Hall, president of the Hawaii Medical Service Association, the local Blue Cross-Blue Shield group that covers just over half of Hawaiians, says those additions amount to less than 10 percent of a premium.

Beyond the cost, the fact that the heavily Democratic, pro-labor Legislature shoved the changes down its throat rankles small business. Don Moore, who runs the hardware store in Kula, on the island of Maui, said scornfully, "They keep adding bells and whistles."

Teena Rasmussen, a wholesale flower grower who produces leis and bouquets in Kula, said the combination of new mandates and health care inflation "was not something the employer had any method of covering, except by lowering the coverage." She said foreign competition prevented her from raising her prices. While she once voluntarily

helped cover workers' families, she no longer does so and is buying the cheapest coverage she can for her nine full-time employees. But there is no business revolt. "Employers are very resigned to it over here," she said.

'Hardly Worth It'

Mr. Moore certainly fills that bill. "There are costs in any business," he said, "and certainly health insurance is one of them. It's pretty consistent that it goes up, but I wouldn't say that it has gotten out of hand." He could deduct a total $200.85 from his nine insured workers every two weeks. But, he said: "The 1.5 percent is hardly worth it. You've got an employee relationship to maintain."

One more local business gripe is a counterpart of the widespread doubt that Congress will subject itself and Federal workers to the same terms it imposes on the rest of the nation. Consider the way state government treats itself here. It pays 60 percent of the cost of insurance and requires workers to pay 40 percent.

Big business has less trouble with the system. Of the 17 percent of Hawaiians in 1974 who lacked insurance that would cover both doctor and hospital bills, most worked for small companies, in small factories, shops, restaurants and similar businesses. This is a heavily unionized state, and most union contracts had ample health insurance 20 years ago. But other big businesses, to compete for workers, matched that benefit.

Putting Theory to Work

Peter Lewis, vice president of Hawaiian Electric, the islands' major power company, said: "Speaking for most big businesses, we support the idea of the Prepaid Health Care Act. As a company, we are very much focused on the preventive end. In the long run, it will save us money."

After 1975, commercial insurers, denied the chance to avoid unhealthy clients, quickly dropped out of the market, and the H.M.S.A., the Blue Cross carrier, with about half the market, has competed ever since with Kaiser Permanente, whose H.M.O.'s have about a fifth of the market. The competition has kept prices down and encouraged the sort of preventive care that means a slightly above-average rate of doctor visits yearly but also lower hospitalization rates, shorter hospital stays and less frequent surgery.

There are disputes about how complete the insurance coverage really is. Speaking for the independent-business group, Mrs. Rasmussen, the flower grower, told Congress that 3 percent to 7 percent of Hawaiians were not covered and "many experts estimate that the numbers may be higher." Dr. Lewin often claims 98 percent coverage.

Analyses based on the Census Bureau's monthly household survey suggest that 93 percent of Hawaiians have health insurance. A much larger survey, conducted by the state Health Department, indicates that 96 percent of Hawaiians are insured.

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(ATTN: National editors) (Includes optional trims)
Hawaii Presents Possible Archetype for Clinton Health Plan (Waianae)
By Edwin Chen= (c) 1994, Los Angeles Times=

WAIANAE, Hawaii Atop a wind-swept bluff with an aquamarine vista that a resort would envy, the Waianae Comprehensive Health Clinic on Oahu's leeward coast offers a compelling view of the benefits and limitations of the employer mandate the controversial linchpin of President Clinton's health reform plan.

After 20 years under a state law that requires employers to pay a portion of their workers' health insurance, 96 percent of Hawaiians enjoy medical insurance, easily the highest percentage of any state. Yet this rural clinic still provides $1 million a year in uncompensated care to those lacking coverage, mostly people who drift in and out of odd jobs, seeking treatment only when a serious problem arises.

``Hawaii's not perfect,'' says Dr. Jack Lewin, a chief architect of the state's recent efforts to cover everyone. ``But we have powerful lessons for the future. We're not theoretical. We're real.''

Many lawmakers and analysts, the president among them, believe requiring employers to pay the lion's share of their workers' health costs is the most feasible way to achieve universal coverage and that spiraling costs cannot be contained until everyone including the nation's 38 million uninsured is covered. But others believe cost containment must come first, with the savings used to gradually extend coverage. They also believe an employer mandate would pose severe financial burdens on many businesses, costs that will only grow.

Hawaii's unique experience as the only state with an employer mandate offers lessons for all participants in the debate.

Some of the results of the state's experiment:

Hawaii has contained costs, even while expanding coverage, and is approaching universal coverage, with 96 percent of its 1.2 million residents insured. The explosive growth of insurance costs for all, especially small businesses, has been lowered by 30 percent or more.

An employer mandate alone does not guarantee that all will be insured. Other programs must be put into place to pay for the medical care of those who slip through the cracks.

Independent studies have shown that the employer mandate has not resulted in ``disruptions'' or high unemployment among small businesses here, but the costs to such firms have clearly grown over the years. The employer's share of premium payments have skyrocketed in relation to employee contributions and the state has required a slew of new benefits that must be covered, which have further driven up costs.

A Louis Harris and Associates poll, sponsored by the California-based Kaiser Family Foundation, found that 56 percent of small businesses in Hawaii cited health insurance as ``a major problem,'' more so than any other government mandate. And yet, the identical percentage also said they would support an employer mandate if one were proposed today.

Nearly universal coverage can dramatically improve overall public health, further reducing spending and leading to a more productive work force. Hawaii officials cite the infant mortality rate, which is down 50 percent from its 1974 high of 16 deaths per 1,000 births and the state's life expectancy of 78, the highest in the nation.

When Hawaii adopted the Prepaid Health Care Act in 1974, most of the state's then-million residents already were insured. The employer mandate was designed to reach the 17 percent believed to be without coverage, roughly the same percentage of Americans nationwide who now lack health insurance.

All employers were required to pay for at least 50 percent of an employee's health insurance premiums. But the state law capped a worker's contribution at 1.5 percent of wages. A minimum-wage worker in the mid-1970s, when health costs were much lower than they are now, paid almost one-third of the cost of his insurance premiums.

Over the years, insurance premiums skyrocketed, far outpacing the growth in wages. Yet the 1.5 percent cap remained, meaning that employers were forced to pay an increasingly disproportionate share.

``Workers are not being asked to share the burden. There has to be more of ared responsibility,'' said Russell R. Watanabe, president of a
1 ly-owned flower and floral supplies business in Honolulu.

(Begin optional trim)

State officials concede the point. Lewin, the former state health director who is now seeking the Democratic gubernatorial nomination, says the cap on individual contributions should be raised to ``somewhere between 3 percent and 6 percent'' to make the arrangement more equitable.

(Originally, Hawaii had intended a 50-50 split between employer and employee.)

Watanabe and many other small business owners also complained that the frequent addition of new and costly benefits such as in-vitro fertilization and mental health have forced many small business owners to reduce other benefits, to lay off employees, to hire more part-time workers, or simply to ``throw in the towel'' and close their doors.

(End optional trim)

While Clinton would require employers to pay the premiums of part-time employees working as little as 10 hours a week, Hawaii placed the cut-off at 20 hours or more per week.

Watanabe and other entrepreneurs said some business owners have attempted to duck the mandate by hiring part-timers to work only 19 hours a week. In the Harris poll, three out of 10 companies said they had engaged in the practice in the last two years, specifically to avoid the requirement. But state cials dispute such claims, noting that the percentage of part-time workers he Islands (18.2 percent) is lower than on the mainland (19.2 percent).

(Begin optional trim)

A Government Accounting Office study this year concluded that the employer mandate in Hawaii ``has not resulted in large disruptions'' among small businesses.

Despite such efforts to reach universal coverage in the state, as many as 20 percent of patients who show up at the Waianae clinic are uninsured, says administrator Richard Bettini.

And it's the same story at the bustling Queen Emma Clinic in downtown Honolulu. Of the 38,000 patients who visit the clinic each year, one in four is uninsured, according to director Chuck Duarte.

(End optional trim)

But despite some problems in achieving total coverage, officials here generally agree that the employer mandate is the essential building block of universal coverage.

``Without it,'' says Marvin Hall, Hawaii's top private health insurance executive, ``you are just not going to do the job.''

-END-OF-AUTOBREAK(1)-

-AUTOBREAK(2)-FOLLOWS

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United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

February 1994

HEALTH CARE IN HAWAII

Implications for National Reform

RESTRICTED--Not to be released outside the General Accounting Office unless specifically approved by the Office of Congressional Relations.

GAO/HEHS-94-68

demographic characteristics of the communities they serve. In addition, the representatives are concerned about the centers' financial viability under QUEST.

Center representatives believe that some of these problems would be alleviated if an individual or a group of community health centers could successfully bid to become a QUEST managed care plan administrator. However, they believe QUEST performance-bond and geographic-coverage requirements are significant barriers to successful center bids.[24]

Overall Costs Parallel National Trend but Premiums Are Lower

The cost experience in Hawaii is seemingly anomalous because, while per capita health care costs are similar in Hawaii and the nation, insurance premiums are lower in Hawaii. PHCA was intended to expand access to coverage, but it did not include explicit efforts to control health care costs.[25]

Per capita expenditures in Hawaii have been very similar to the national average since 1974, and both have increased more rapidly than the overall rate of inflation. The same factors in the health care economy have influenced this trend in Hawaii and the rest of the nation. At the same time, however, health insurance premiums are generally lower in Hawaii than in the nation as a whole and have risen at a slightly slower rate than nationally.

Hawaii Per Capita Expenditures Track National Average

Hawaii's per capita health care expenditures continue to be similar to national levels. We reported earlier that Hawaii's per capita health care expenditures from 1974 to 1982 tracked the national average at the same time the state widened access to coverage through its employer mandate.[26] Similarly, from 1980 to 1991, Hawaii's per capita expenditures for hospitals, physicians, and prescription drugs tracked the national average

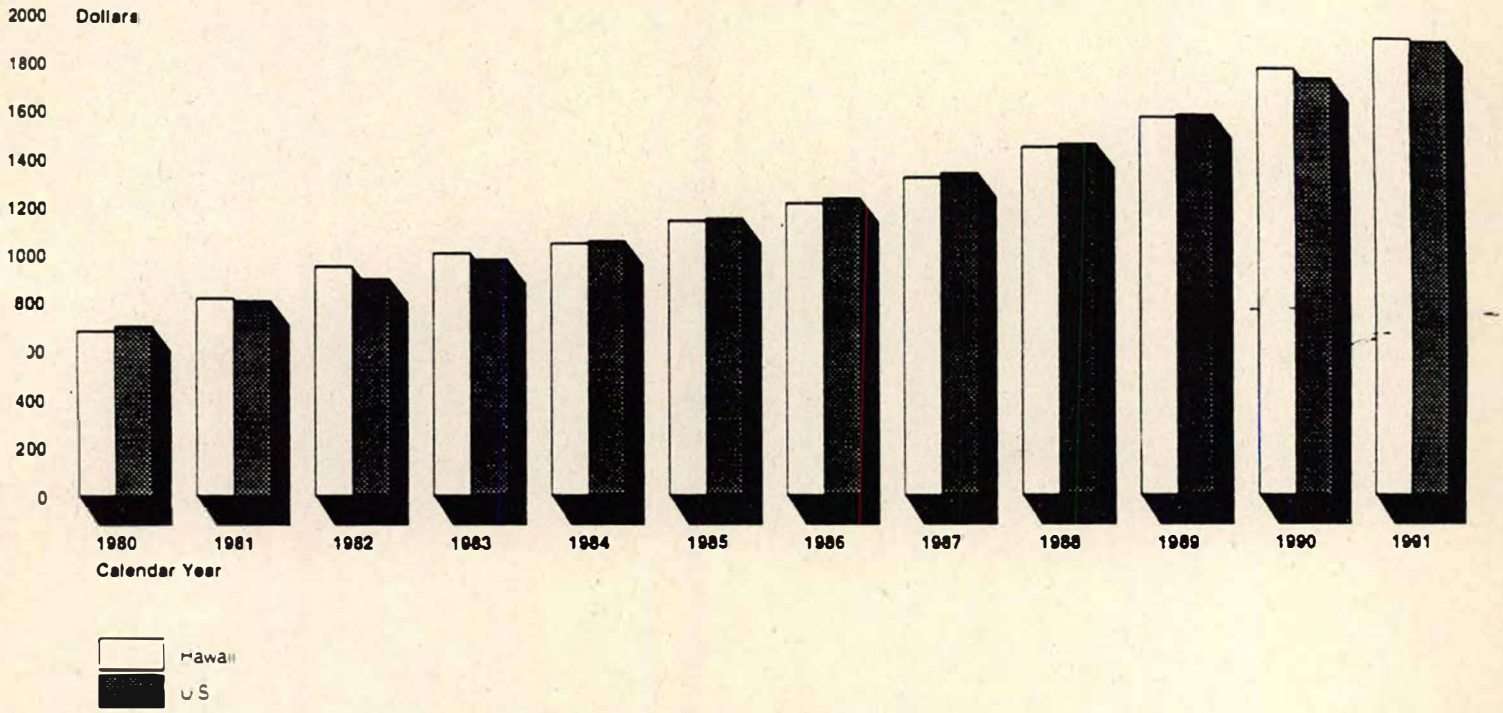
[24]The QUEST request for proposals requires successful bidders to obtain a $1 million performance bond for the state to hold as security against the proper performance of the contract. The bond will be adjusted according to the number of recipients enrolled. After adjustment, the bond must be sufficient to cover approximately 2 months of capitated payments. A center representative estimated that this would require a $2 million to $3 million bond. Regarding geographic coverage, successful bidders must accept recipients from all geographic areas on a particular island, except on the island of Hawaii, which due to its size is divided into two geographic regions.

[25]Hawaii, however, does have certificate-of-need requirements for hospital construction; changes in service; and major capital equipment purchases, such as magnetic resonance imaging machines.

[26]Access to Health Care: States Respond to Growing Crisis (GAO/HRD-92-70, June 16, 1992).

(see fig. 1). Between 1980 and 1991, those expenditures increased at an average annual rate of 9.8 percent in Hawaii and 9.4 percent in the nation.

Figure 1: Hawaii and U.S. Per Capita Expenditures for Hospitals, Physicians, and Prescription Drugs (1980-91)



Source: Health Care Financing Administration

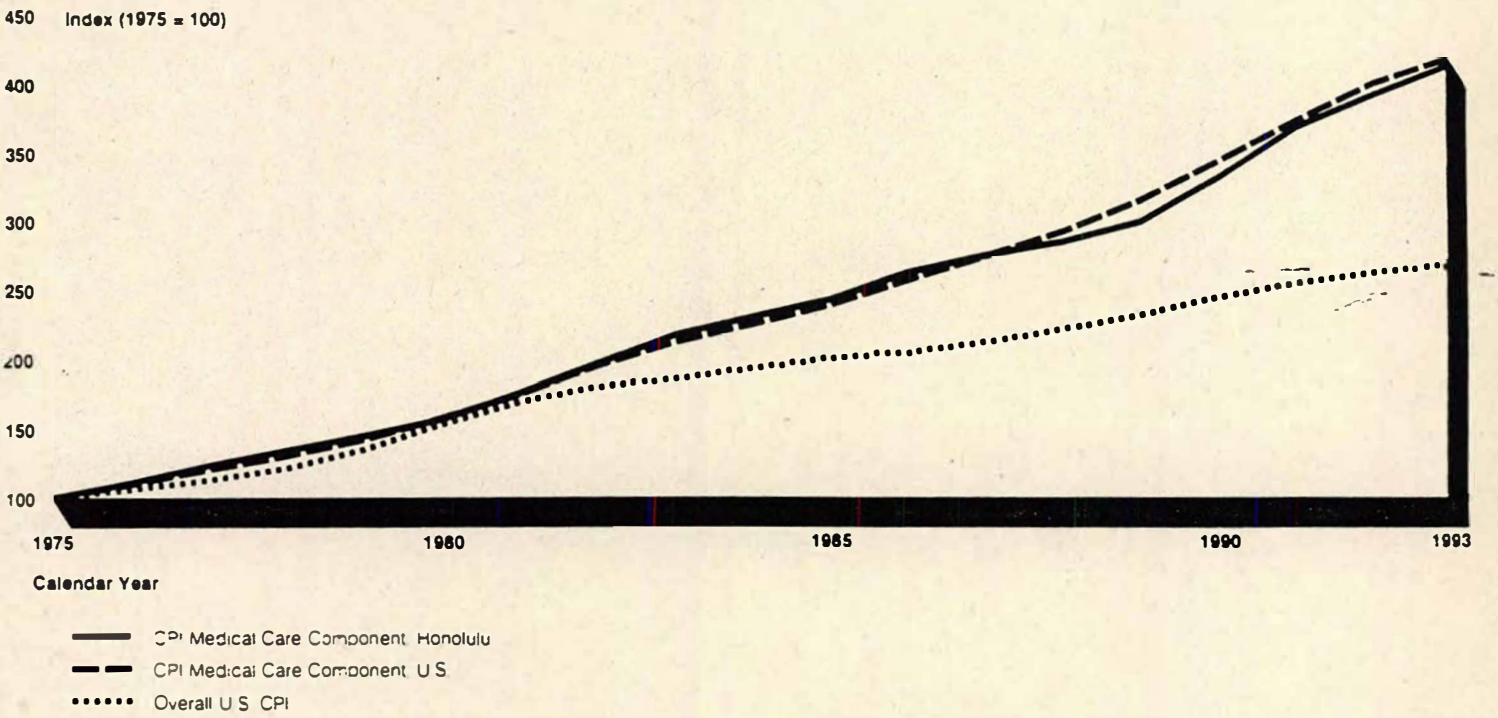
Same Factors Drive Up Health Care Costs in Hawaii and the United States

In both Hawaii and the nation as a whole, health care costs have been rising more rapidly than the average rate of inflation for other goods and services (see fig. 2).[27] State officials, insurers, and health care providers told us that Hawaii is not immune to the factors that have driven up health care costs nationally. These officials said that administrative costs are high and rising; wages for health care professionals, particularly nurses and

[27]Figure 2 uses the rate of inflation for Honolulu because statewide data are not available. The Honolulu data are representative of Hawaii's experience because 75 percent of Hawaii's population resides there.

some technical specialists, have risen significantly in recent years; and medical equipment costs are rising due to advances in technology.[28]

Figure 2: Consumer Price Index (CPI) Medical Care Component for Honolulu and the United States Compared to Overall CPI (1975-93)



Note: The 1993 data are based on the first 6 months of the year.
With 75 percent of Hawaii's population, Honolulu is representative of the entire state.

Cost of Medicaid Program Has Escalated

The cost of Hawaii's Medicaid program has increased significantly in the past few years. During this period, Medicaid expenditures nationwide also rose dramatically (see table 1).[29]

[28]We reported on the roles of technological advances and administrative costs in the growth of hospital costs nationwide in Hospital Costs: Adoption of Technologies Drives Cost Growth (GAO/HRD-92-120, Sept. 9, 1992).

[29]Nationwide, Medicaid enrollment increased by 2.7 million beneficiaries from fiscal year 1990 to fiscal year 1991; the largest single-year increase in the program since the mid-1970s.

Table 1: Growth in Hawaii and U.S. Medicaid Expenditures

	Fiscal year		
	1990	1991	1992
Hawaii	17%	10%	32%
U.S.	18%	27%	30%

Source: Hawaii State Department of Human Resources, Health Care Financing Administration (HCFA).

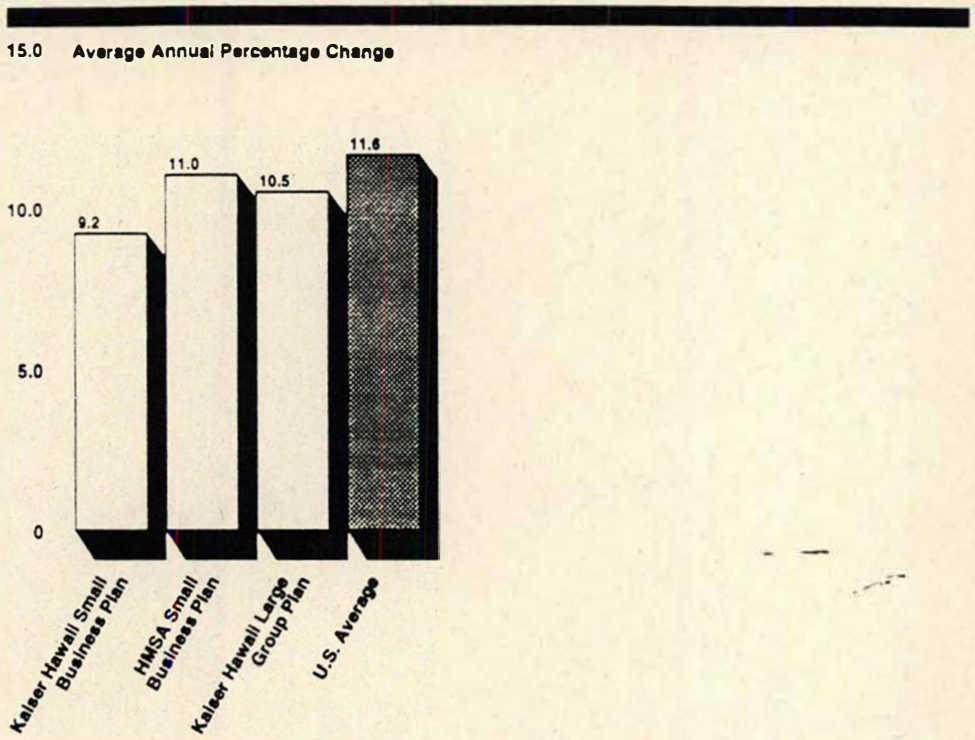
In fiscal year 1992, Hawaii experienced a shortfall in its Medicaid budget, requiring the state legislature to appropriate an additional $64 million to cover costs. Most of the upsurge in Hawaii's Medicaid costs occurred because of increased enrollment prompted by expanded federal program eligibility, Hawaii's recent economic downturn, and the SHIP outreach program, which enrolled additional eligible people in the Medicaid program. The cost per Medicaid beneficiary also increased; from fiscal year 1989 to fiscal year 1991, Hawaii's average cost per recipient rose between 7 and 9 percent each year,[30] primarily due to the escalating cost of health care. (See app. II for additional information on the costs of Hawaii's Medicaid program.)

Health Insurance Premiums Lower in Hawaii

Health insurance premiums are lower and have been rising less rapidly in Hawaii than in the nation as a whole (see fig. 3). In 1991, annual premiums for three of the most prevalent health plans in Hawaii—one large-business plan and two small-business plans—were lower than the U.S. average cost of $1,604 for comparable coverage by $358 to $396 (see fig. 4). Because the figure for the national average includes costs for both large and small companies—and premiums for large companies typically cost less than those for small companies—the lower cost for the two Hawaii small-business plans is especially notable. Moreover, insurance officials in Hawaii told us that premiums for small businesses in Hawaii are not much different from those for large businesses.

[30]From 1988 to 1991, nationwide Medicaid expenditures per capita grew at an average annual rate of 12.3 percent.

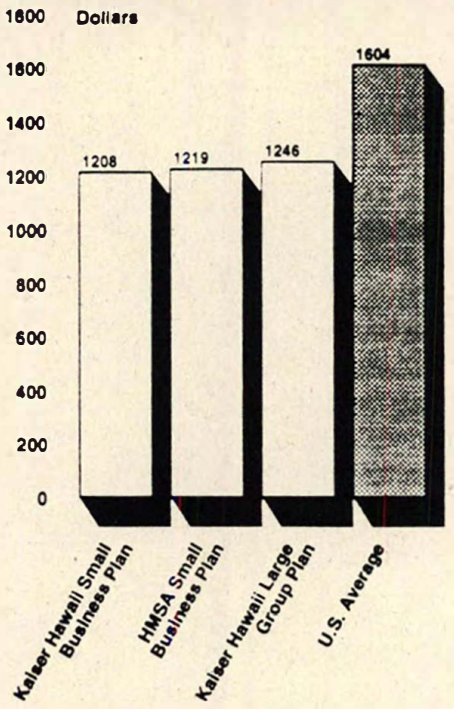
Figure 3: Average Annual Increases in Kaiser Hawaii and HMSA Premiums Compared to the United States
(1984-92)



Note: Data for Hawaii are based on annualized changes for single coverage plans for 1984-92.

Sources: Kaiser Foundation of Hawaii, HMSA, and Foster Higgins Health Care Benefits Survey for 1984-92.

Figure 4: Annual Medical Plan Costs for Single Coverage in Hawaii Compared to the United States in 1991



Source: Kaiser Foundation of Hawaii, HMSA, and 1991 Wyatt COMPARE Data Base.

Several factors may contribute to Hawaii's lower premium costs. One is the reduced amount of cost shifting in Hawaii. In general, health care providers pass on the cost of providing uncompensated care to patients with private insurance coverage. Because relatively few Hawaii residents are uninsured, the need for people with insurance to cover such extra costs is minimized. As a result of the state's requirement that all eligible employees accept health insurance, healthy people cannot opt out of the system. Total health care costs, therefore, are spread over wider risk pools that include both healthy and less healthy people. An additional factor that lowers costs for many small businesses is the major insurers' use of

modified community rating for small businesses.[31] (See app. III for detailed information on health insurance premiums in Hawaii.)

Small Businesses Report Little Adverse Impact From Employer Mandate

Most small businesses in Hawaii expressed general satisfaction with the Hawaii health insurance system, but they regard the mandatory provision of insurance as a burden. We found no evidence that the employer mandate resulted in large disruptions in Hawaii's small business sector.[32]

Preliminary results from a Louis Harris and Associates, Inc. survey of small businesses[33] in Hawaii conducted for the Kaiser Family Foundation[34] found that taxes and health insurance are viewed as the top two problems facing small business. Fifty-six percent of small businesses that were surveyed considered the cost of health insurance to be a major problem—more than any other government requirement.[35] However, more small businesses in Hawaii considered the inflation of their health care costs to be under control (54 percent) rather than out of control (41 percent).[36] This is a more favorable view than the view of small businesses in the rest of the country, 62 percent of which characterized the inflation of their health care costs as somewhat or totally out of control.

[31] When insurers use community rating, they base premiums on the anticipated health care utilization of all subscribers in a particular geographic area or other broad grouping. This contrasts with the more common practice of experience rating, in which insurers base premium rates on the medical experience of each insured group. The major fee-for-service insurer in Hawaii uses a system of modified community rating for businesses with fewer than 100 employees. Small businesses are placed in one large risk pool, but their premiums may be adjusted up or down by up to 20 percent, depending on their utilization. For large businesses, however, Hawaii's major insurers determine rates from a company's experience. This results in a wider range of insurance premiums for large companies, with some large businesses paying higher premiums than small ones.

[32] State officials point to the limited use of a State Premium Supplementation Fund as evidence that Hawaii's employer mandate has not overburdened small businesses. PHCA established the fund to subsidize employers with fewer than eight employees, and to pay health care benefits for employees of bankrupt or noncompliant employers. Since July 1975, the state has paid less than $110,000 from this fund. However, business leaders told us that few businesses knew of the existence of the fund until recently, and state officials said that the limitations on the use of the fund are very restrictive. Consequently, the use of the fund may not be a good indicator of the effect of the mandate on small businesses.

[33] These were businesses with 100 or fewer employees; firms of this size employ over half of the state's work force.

[34] Kaiser/Harris Survey of Small Business Owners in Hawaii, 1993 (preliminary findings).

[35] Other requirements include worker's compensation, unemployment compensation, and occupational safety and health requirements.

[36] Forty-six percent of the companies surveyed in Hawaii considered health care cost inflation to be somewhat under control and 8 percent considered these costs to be completely under control.

Premium History of Prevalent Insurance Plans in Hawaii (1984-93)

	Kaiser[a] Small Business Plan B		HMSA[b] Small Business Plan 4		Kaiser[a] Large Group Plan B	
	Monthly premium	Percent change	Monthly premium	Percent change	Monthly premium	Percent change
1984	$52.92		$47.52		$52.92	
1985	67.92	28.34%	47.52	0.00%	67.92	28.34%
1986	61.62	-9.28	55.72	17.26	61.62	-9.28
1987	63.88	3.67	64.70	16.12	63.88	3.67
1988	66.24	3.69	73.12	13.01	66.24	3.69
1989	72.68	9.72	87.58	19.78	72.68	9.72
1990	90.36	24.33	94.62	8.04	90.36	24.33
1991	100.70	11.44	101.58	7.36	103.80	14.87
1992	107.20	6.45	109.72	8.01	117.65	13.34
1993	115.49	7.73	128.38	17.01	130.49	10.91

Note: All premiums are for individual coverage.

[a]Kaiser Foundation Health Plan

[b]Hawaii Medical Service Association

Source: Kaiser Foundation Health Plan and Hawaii Medical Service Association

America's Health Care Safety Net

Emergency Medicine: 1968-1993 and Beyond

American College of Emergency Physicians

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

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

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

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

In 1990, there were 92 million ED visits to the 93.4 percent of hospitals with emergency departments, compared to 30 million in 965. At the same time, the overall number of hospitals fell from ,123 to 6,649.[24]

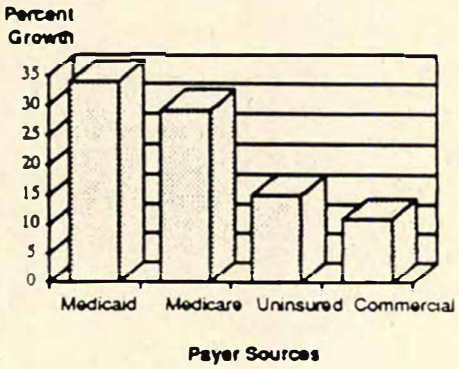
Overcrowding threatens emergency care system

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

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

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

Growth in ED Use (1985-1990)



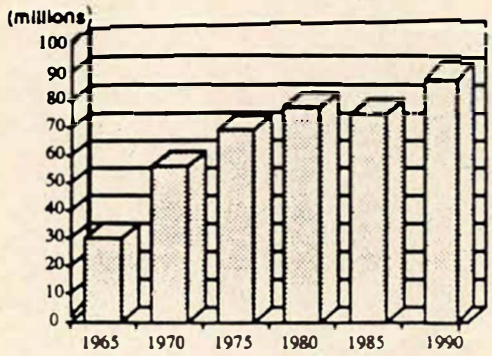
Reference: GAO/HRD-93-4
Growth and Change in Emergency Department Use

Factors Increasing ED Visits (1985-90)

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

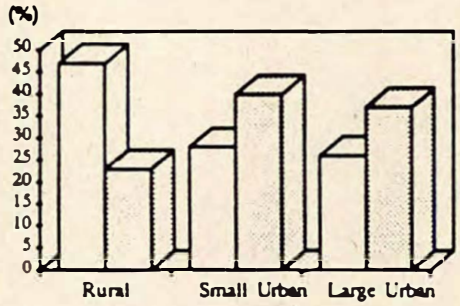
Reference: GAO/HRD-93-4
Growth and Change in Emergency Department Use

Emergency Department Visits



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

Most ED Patient Visits Were In Urban Hospitals (1990)



☐ Emergency Departments
☐ Emergency Department Visits

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

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

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

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

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

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

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

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

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

Inadequate insurance impacts emergency care

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

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

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

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

Stressful conditions lead to burnout

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

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

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

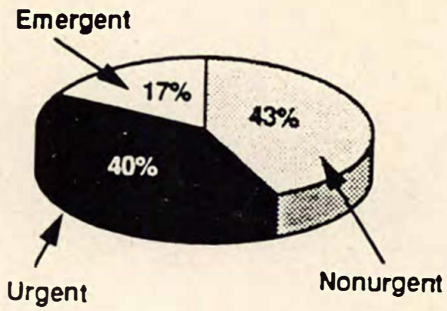
Adds Dr. Anderson Jr.: "AIDS and tuberculosis are giving people pause. On the other hand, you have to understand that the breed of emergency physician is a different one. The excitement, variety and challenges are very appealing."

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

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

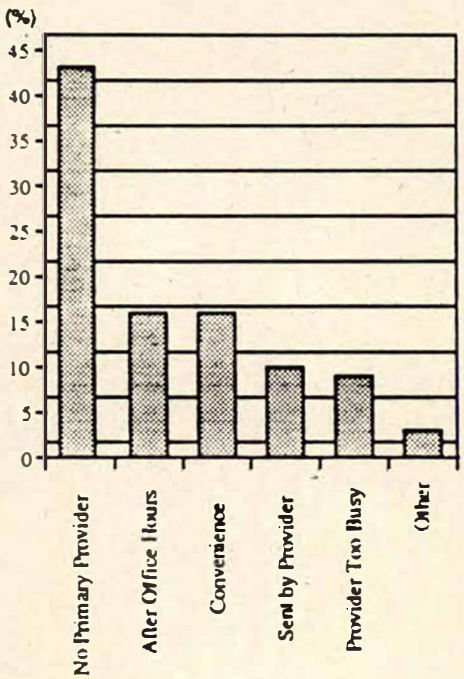
Diana Williams, MD

Types of ED Visits (1990)



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

Reasons For Nonurgent ED Use (1990)



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

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

Primary Care in the Emergency Department

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

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

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

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

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

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

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

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

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

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

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

Arthur Kellermann, MD

Subspecialization in Emergency Medicine

Emergency medicine is not just "emergency department medicine." The delivery of acute, episodic care encompasses areas of medicine including disaster response and toxicology. ACEP membership sections cover such areas as pediatric emergency medicine, disaster medicine, rural emergency medicine, health policy, and emergency medical services.[5e]

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

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

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

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

Number 245 • March 2, 1994

Advance Data

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

National Hospital Ambulatory Medical Care Survey: 1992 Emergency Department Summary

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

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

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

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

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

Patient characteristics

During the 12-month period from January–December 1992, an estimated 89.8 million visits were made to ED's of non-Federal, short-stay, or general hospitals in the United States—about 35.7 visits per 100 persons. ED visits by patient's age, sex, and race are shown in table 1. Persons 75 years of age and over had a higher ED visit rate (55.8 visits per 100 persons) than persons in the five other age categories. Females made 51.9 percent of all ED visits. There was no significant difference in total visit rates by sex.

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

Emergency department visit characteristics

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

Urgency of visit

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

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

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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

OMB No. 0920-0278

CDC 64.53

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

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
EMERGENCY DEPARTMENT
PATIENT RECORD

3. DATE OF VISIT
Month / Day / Year

4. DATE OF BIRTH
Month / Day / Year

5. SEX
1 ☐ Female
2 ☐ Male

6. RACE
1 ☐ White
2 ☐ Black
3 ☐ Asian/Pacific Islander
4 ☐ American Indian/Eskimo/Aleut

7. ETHNICITY
1 ☐ Hispanic
2 ☐ Not Hispanic

8. EXPECTED SOURCE(S) OF PAYMENT *(Check all that apply)*
1 ☐ Medicare
2 ☐ Medicaid
3 ☐ Other government
4 ☐ Private/Commercial
5 ☐ HMO/Other prepaid
6 ☐ Patient paid
7 ☐ No charge
8 ☐ Other

9. MAJOR REASON FOR THIS VISIT *(Check one)*
1 ☐ Injury, first visit
2 ☐ Injury, follow-up
3 ☐ Illness, first visit
4 ☐ Illness, follow-up
5 ☐ Other reason

10. CAUSE OF INJURY *(Complete if injury is marked in 9. Describe cause and place of injury.)*

11. PATIENT'S COMPLAINT(S), SYMPTOM(S), OR OTHER REASON(S) FOR THIS VISIT *(In patient's own words)*
a. Most important:
b. Other:
c. Other:

12. PHYSICIAN'S DIAGNOSES
a. Principal diagnosis/problem associated with item 11a.
b. Other:
c. Other:

13. URGENCY OF THIS VISIT *(Check only one)*
1 ☐ Urgent/Emergent
2 ☐ Non-urgent

14. IS PROBLEM ALCOHOL- OR DRUG-RELATED?
1 ☐ Neither
2 ☐ Alcohol-related
3 ☐ Drug-related
4 ☐ Both

15. DIAGNOSTIC/SCREENING SERVICES *(Check all ordered or provided.)*
1 ☐ None
2 ☐ Blood pressure check
3 ☐ Urinalysis
4 ☐ HIV serology
5 ☐ Other blood test
6 ☐ EKG
7 ☐ Mental status exam
7 ☐ Chest x-ray
9 ☐ Extremity x-ray
10 ☐ CT scan/MRI
11 ☐ Other diagnostic imaging
12 ☐ Other (Specify)

16. PROCEDURES *(Check all provided on this visit)*
1 ☐ None
2 ☐ Endotracheal intubation
3 ☐ CPR
4 ☐ IV fluids
5 ☐ NG tube/gastric lavage
6 ☐ Wound care
7 ☐ Eye/ENT care
8 ☐ Orthopedic care
9 ☐ Bladder catheter
10 ☐ Lumbar puncture
11 ☐ Other(s) (Specify)

17. MEDICATION
(Record all new or continued medication ordered, administered, or provided at this visit. Use the same brand name or generic name entered on any Rx or medical record. Include immunizations and desensitizing agents.)
☐ None
1.
2.
3.
4.
5.

18. DISPOSITION THIS VISIT *(Check all that apply)*
1 ☐ Return to ED PRN
2 ☐ Return to ED - appointment
3 ☐ Return to referring physician
4 ☐ Refer to other physician/clinic
5 ☐ Admit to hospital
6 ☐ Transfer to other facility
7 ☐ DOA/died in ED
8 ☐ Left AMA
9 ☐ No follow-up planned
10 ☐ Other (Specify)

19. PROVIDERS SEEN THIS VISIT *(Check all that apply)*
1 ☐ Resident/Intern
2 ☐ Staff physician
3 ☐ Other physician
4 ☐ Physician assistant
5 ☐ Nurse practitioner
6 ☐ Registered nurse
7 ☐ Licensed practical nurse
8 ☐ Nurse's aide

Figure 1. Patient Record form.

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

Characteristic	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Number of visits per 100 persons per year[1]
All visits	89,796	3,202	100.0	—	35.7
Patient characteristic					
Age:					
Under 15 years	22,523	1,485	25.1	1.3	39.9
15–24 years	14,848	702	16.5	0.4	43.2
25–44 years	27,240	1,097	30.3	0.7	33.5
45–64 years	12,509	528	13.9	0.4	25.8
65–74 years	5,806	267	6.5	0.2	31.4
75 years and over	6,871	313	7.7	0.3	55.8
Sex and age:					
Female	46,612	1,688	51.9	0.4	36.1
Under 15 years	10,196	640	11.4	0.6	37.0
15–24 years	8,051	421	9.0	0.3	46.6
25–44 years	14,045	615	15.6	0.4	34.0
45–64 years	6,629	302	7.4	0.3	26.3
65–74 years	3,350	175	3.7	0.2	32.9
75 years and over	4,342	216	4.8	0.2	56.4
Male	43,184	1,605	48.1	0.4	35.3
Under 15 years	12,327	878	13.7	0.8	42.7
15–24 years	6,797	336	7.6	0.2	39.8
25–44 years	13,195	560	14.7	0.4	33.0
45–64 years	5,880	279	6.5	0.2	25.2
65–74 years	2,456	121	2.7	0.1	29.7
75 years and over	2,529	148	2.8	0.1	54.8
Race and age:					
White	70,478	3,006	78.5	1.3	33.6
Under 15 years	16,878	1,028	18.8	0.8	37.5
15–24 years	11,598	628	12.9	0.4	42.2
25–44 years	20,579	945	22.9	0.6	30.4
45–64 years	10,134	477	11.3	0.4	24.3
65–74 years	5,017	252	5.6	0.2	30.7
75 years and over	6,272	299	7.0	0.3	56.2
Black	17,150	1,062	19.1	1.2	54.5
Under 15 years	5,132	761	5.7	0.9	57.3
15–24 years	2,877	214	3.2	0.2	56.4
25–44 years	5,840	437	6.5	0.5	59.6
45–64 years	2,111	190	2.4	0.2	42.3
65–74 years	685	86	0.8	0.1	41.6
75 years and over	505	64	0.6	0.1	51.7
All other races:					
Asian/Pacific Islander	1,400	247	1.6	0.3	---
American Indian/Eskimo/Aleut	*769	315	*0.9	0.4	---
Emergency department characteristic					
Geographic region:					
Northeast	16,950	1,108	18.9	1.2	33.9
Midwest	25,790	2,051	28.7	1.9	42.0
South	29,542	1,778	32.9	1.8	35.0
West	17,515	1,546	19.5	1.6	31.5

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

were urgent/emergent (table 2). When compared with all other age categories, persons 75 years of age and over had the highest urgent visit rate (36.6 visits per 100 persons). Persons 15–24 years of age had a higher rate of nonurgent visits (26.3 visits per 100 persons) than any other age group except children less than 15 years of age. There was no significant difference between urgent or nonurgent visit rates by sex.

Type of visit

The majority of ED visits (58.5 percent) were made for illness and 35.2 percent were made for injury (table 3). Eighty-seven percent of all ED visits were first visits for the presenting problem.

Injury-related visits

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

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

Patient characteristic	Number of urgent visits in thousands	Standard error in thousands	Number of urgent visits per 100 persons per year[1]	Number of nonurgent visits in thousands	Standard error in thousands	Number of nonurgent visits per 100 persons per year[1]
All urgent/emergent visits	40,079	1,803	15.9	49,718	2,175	19.8
Age						
Under 15 years	8,674	1,030	15.7	13,649	756	24.2
15–24 years	5,300	353	16.9	9,048	499	26.3
25–44 years	11,080	514	13.6	16,160	818	19.9
45–64 years	6,379	321	13.2	6,131	334	12.8
65–74 years	3,434	193	18.6	2,371	164	12.8
75 years and over	4,513	236	36.8	2,358	148	19.1
Sex and age						
Female	20,338	904	15.7	26,275	1,216	20.3
Under 15 years	3,842	418	13.9	6,353	348	23.1
15–24 years	2,392	213	17.3	5,059	299	29.3
25–44 years	5,573	295	13.5	8,472	434	20.5
45–64 years	3,159	174	12.5	3,471	226	13.8
65–74 years	1,943	114	19.1	1,407	119	13.8
75 years and over	2,829	161	36.7	1,513	106	19.6
Male	19,741	945	16.2	23,443	1,067	19.2
Under 15 years	5,031	628	17.4	7,296	448	25.3
15–24 years	2,807	181	16.4	3,990	241	23.3
25–44 years	5,506	258	13.8	7,689	422	19.2
45–64 years	3,220	187	13.8	2,660	164	11.4
65–74 years	1,492	109	18.0	964	74	11.7
75 years and over	1,684	107	36.5	845	73	18.3
Race and age						
White	32,097	1,560	15.3	38,381	2,005	18.3
Under 15 years	6,629	589	14.7	10,250	664	22.8
15–24 years	4,662	325	17.0	6,936	437	25.2
25–44 years	8,473	452	12.5	12,106	692	17.9
45–64 years	5,206	300	12.5	4,928	286	11.8
65–74 years	2,997	180	18.3	2,020	160	12.3
75 years and over	4,131	222	37.0	2,141	143	19.2
Black	7,158	632	22.8	9,992	703	31.8
Under 15 years	2,067	531	23.3	3,045	330	34.0
15–24 years	1,030	99	20.2	1,847	178	36.2
25–44 years	2,271	191	23.2	3,569	307	36.4
45–64 years	1,035	109	20.7	1,076	111	21.6
65–74 years	396	56	24.1	289	40	17.6
75 years and over	339	51	34.7	166	25	17.0

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

item 9. Almost 31.6 million ED visits were made for injury (table 4). Persons 15–24 years of age had a higher injury-related visit rate (18.9 visits per 100 persons) than persons in each of the other five age categories. Males had higher injury-related visit rates (14.8 per 100 persons) than females (10.5 per 100 persons) overall and in each age category except for 65–74 years and 75 years and over, where females had higher rates. There was no significant difference between injury-related visit rates by race. However, black people had a higher rate than white people among persons 25–44 years of age, while white people had a higher rate than black people in the 75 years and over age category.

Cause of injury

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

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

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

Visit characteristic	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits	89,796	3,202	100.0	...
Major reason for this visit				
All illness visits	52,528	2,128	58.5	0.9
Illness, first visit	49,691	2,033	55.3	0.9
Illness, follow-up	2,837	229	3.2	0.2
All injury visits	31,567	1,210	35.2	0.7
Injury, first visit	28,389	1,046	31.6	0.7
Injury, follow-up	3,178	241	3.5	0.2
All visits for other reasons	4,430	511	4.9	0.6
Unknown	1,271	165	1.4	0.2

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

Patient characteristic	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Number of visits per 100 persons per year[1]
All injury-related visits	31,567	1,210	100.0	...	12.6
Age					
Under 15 years	8,162	426	25.9	0.9	14.5
15–24 years	6,489	307	20.6	0.5	16.9
25–44 years	10,500	446	33.3	0.6	12.9
45–64 years	3,681	207	11.7	0.5	7.6
65–74 years	1,305	98	4.1	0.3	7.1
75 years and over	1,430	100	4.5	0.3	11.6
Sex and age					
Female	13,540	539	42.9	0.6	10.5
Under 15 years	3,290	181	10.4	0.4	11.9
15–24 years	2,442	148	7.7	0.3	14.1
25–44 years	4,305	237	13.6	0.6	10.4
45–64 years	1,647	101	5.2	0.3	6.5
65–74 years	852	69	2.7	0.2	8.4
75 years and over	1,004	77	3.2	0.2	13.0
Male	18,027	734	57.1	0.6	14.8
Under 15 years	4,872	278	15.4	0.6	16.9
15–24 years	4,048	206	12.8	0.4	23.7
25–44 years	6,195	280	19.6	0.6	15.5
45–64 years	2,034	151	6.4	0.4	8.7
65–74 years	453	49	1.4	0.1	5.5
75 years and over	426	50	1.3	0.2	9.2
Race and age					
White	26,271	1,180	83.2	1.1	12.5
Under 15 years	6,794	372	21.5	0.7	13.1
15–24 years	5,456	293	17.3	0.5	19.9
25–44 years	8,405	418	26.6	0.7	12.4
45–64 years	3,096	197	9.8	0.5	7.4
65–74 years	1,160	93	3.7	0.3	7.1
75 years and over	1,359	101	4.3	0.3	12.2
Black	4,556	304	14.4	1.0	14.5
Under 15 years	1,214	138	3.8	0.5	13.6
15–24 years	903	82	2.9	0.3	17.7
25–44 years	1,783	151	5.6	0.5	18.2
45–64 years	490	61	1.6	0.2	9.8
65–74 years	111	23	0.4	0.1	6.8
75 years and over	54	12	0.2	0.0	5.5

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

Alcohol- or drug-related problem

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

Reason for visit

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

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

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

Principal diagnosis

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

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

Cause of injury and E code[1]		Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits with an E code entered		28,812	1,127	100.0	...
Other accidents	E916–E928	10,309	477	35.8	0.7
Accidental falls	E880–E888	7,669	348	26.6	0.8
Motor vehicle accidents, traffic and non-traffic	E810–E825	4,130	196	14.3	0.5
Homicide and injury purposely inflicted by other persons	E960–E969	1,553	119	5.4	0.4
Accidents due to natural and environmental factors	E900–E909	1,374	110	4.8	0.3
Accidents caused by submersion, suffocation, and foreign bodies	E910–E915	1,040	84	3.6	0.3
Other road vehicle accidents	E826–E829	635	71	2.2	0.2
Surgical and medical procedures as the cause of abnormal reaction of patient or later complication without mention of misadventure at the time of procedure	E878–E879	404	49	1.4	0.2
Drugs, medicinal and biological substances causing adverse effects in therapeutic use	E930–E949	370	52	1.3	0.2
Accidental poisoning by drugs, medicinal substances, and biologicals	E850–E858	332	50	1.2	0.2
Accidental poisoning by other solid and liquid substances, gases, and vapors	E860–E869	192	35	0.7	0.1
Suicide and self-inflicted injury	E950–E959	160	38	0.6	0.1
Accidents caused by fire and flames	E890–E899	127	25	0.4	0.1
Late effects of accidental injury	E929	52	13	0.2	0.0
Injury undetermined whether accidentally or purposely inflicted	E980–E989	39	10	0.1	0.0
Other[2]		109	21	0.4	0.1
Unknown[3]		315	45	1.1	0.2

[1] Based on the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM) (3).
[2] Includes railway accidents (E800–E807); water transport accidents (E830–E838); air and space transport accidents (E840–E845); vehicle accidents not elsewhere classifiable (E846–E848); misadventures to patients during surgical and medical care (E870–E876); legal intervention (E970–E978); and injury resulting from operations of war (E990–E999).
[3] Includes uncodable E codes and illegible E codes.

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

The 20 most frequently reported principal diagnoses are shown in table 10. These are categorized at the three-digit coding level of the ICD–9–CM and account for 38.4 percent of all ED visits. The most commonly recorded diagnosis was suppurative and unspecified otitis media, occurring at 3.5 percent of all visits.

Diagnostic and screening services

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

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

Visit characteristic	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits	89,796	3,202	100.0	...
Alcohol- or drug-related visit				
Neither	86,015	3,026	95.8	0.2
Alcohol-related	2,459	196	2.7	0.2
Drug-related	996	91	1.1	0.1
Both	327	44	0.4	0.0

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

Procedures

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

Expected source of payment

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

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

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

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

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

Thank you.

Preventive and Medical Services

HEALTHY PEOPLE 2000

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

Delivered to the Association of Military Surgeons of the United States, 99th Annual Meeting, Nashville, Tennessee, November 18, 1992

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

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

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

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

Americans have developed a faith in the magic of medicine. We expect miracles – but the world of science isn't always able to deliver. The impossible takes a little longer. AIDS provides us an example. We're in the 12th year of this disastrous epidemic. There is still no vaccine and although medicines extend life, there is no cure – even on the horizon. There is a gap between what we want and what science can deliver.

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

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

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

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

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

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

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

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

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

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

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

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

We know cigarette advertising influences our nation's youth.

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

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

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

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

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

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

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

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

In most areas of our economy. a competitive market exists where price is influenced by the consumer's willingness and ability to pay. In such a competitive market place. over production, poor quality and high cost lead to inefficient enterprises that ultimately close and lock their doors. However. in the medical marketplace. even when there is an over supply – too many beds. too many doctors. too many MRIs. n. one fails and prices rise rather than fall. Surgeons generate their own demand. The number of hysterectomies performed in a population is not related to the number of women in the population, but instead to the number of OB/GYNs practicing in the community.

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

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

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

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

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

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

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

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

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

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

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

At a time when we need more primary care physicians we have fewer. In the last 25 years the percentage of primary care doctors has dipped from 50 percent to 33 percent in 1991. In 1981, about 40 percent of the graduating medical class planned to become board certified in primary care specialties. By 1989, the percent had dropped to 25. This disastrous trend continues. If we set a goal of 50 percent primary care physicians in each graduating class it would take until some time between 2020 and 2030 to correct our problem. Can we wait?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I'm optimistic!

BC-HEALTH-WELLNESS-NNS
How Much Is an Ounce of Prevention Worth?
Two optional trims to 1,100 words
By MILES BENSON
c.1993 Newhouse News Service

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(FIRST OPTIONAL TRIM BEGINS)

Not everyone believes that promoting wellness would reduce health costs.

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

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

But many doctors and other experts disagree.

(FIRST OPTIONAL TRIM ENDS)

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

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

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

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

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

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

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

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SPECIAL ARTICLES

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

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

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

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

If there were no illness and no accidents, health care costs for a society would theoretically be zero. For much of this century, the decrease in acute illness and the proportional increase in chronic disease have fueled inflation in medical costs.[11] Preventing chronic illness would offer hope of a reduction in demand: if a coronary-artery bypass graft procedure costs $50,000, then avoiding that procedure could save up to $50,000, depending on the cost of the intervention, on whether the procedure is postponed or prevented, and other offsetting factors.[12] Approaches involving self-management could potentially yield similar benefits: if a visit to the emergency department for a cold, including cultures, x-ray films, and antibiotics, costs $130, then that amount is saved if the visit is not made. If they are based on well-documented and proved interventions, health policies directed at reducing the burden of illness constitute a positive approach: individuals become healthy and society may save money.[13,14]

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

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

THE POTENTIAL FOR REDUCING DEMAND

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

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

Much Disease Is Preventable

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

Risky Behavior Costs Money

Lifetime medical costs, which average approximately $225,000 per person, are clearly linked to health habits.[22-24] For example, the lifetime costs for smokers, despite their shorter lives, are higher than those for nonsmokers[22,25] by approximately one third.[20,22] Breslow and Breslow[23] have demonstrated that poor health habits are strongly associated with greater burdens of illness and that these effects are similar in magnitude to the effects on mortality. Yen et al.[26] showed that self-reported health habits strongly predicted annual claims costs over the next three years; people at low risk had average claims of $190, whereas those at high risk had claims averaging $1,550. Using cross-sectional data from the National Health Interview Survey, Wetzler and Cruess found that increased physical activity was associated with fewer visits to the doctor.[27] Tsai et al. confirmed statistically significant associations between smoking habits and overall morbidity; overall morbidity was higher by 60 percent among smokers.[28] Sokolov demonstrated that in a large corporate setting, people with three or more risk factors on a list that included smoking, obesity, hypertension, hypercholesterolemia, and diabetes had claims costs that were double those of people who had no risk factors.[29,30]

Variability in Regional Costs Implies Slack in the System

Wennberg and others have documented striking regional differences in the use of services.[31,32] Cesarean-section rates in the United States have risen from 5 percent in 1965 to over 25 percent in 1988; moreover, current rates range from 9.6 to 31.8 percent in different settings.[33] Hospital expenditures per capita are twice as high in Boston as in New Haven. In some communities in Maine, over 50 percent of men undergo prostatectomy, as compared with only 15 percent in nearby communities, yet the health outcomes in these men appear similar.[31,32,34] In the case of elective hospitalizations, admission rates correlate with the number of hospital beds per capita rather than the incidence of illness.[35,36] Educating the consumer so that more informed decisions are made decreases the frequency with which certain procedures are performed.[31,32] When patients are given information and alternatives, they have been shown, on average, to select less invasive (and less expensive) strategies than their physicians.[32] Health maintenance organizations cost as much as 20 percent less than traditional programs of health care delivery, with no discernible negative effects on health outcomes.[37]

Self-Management Can Result in Savings

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

Care for Terminal Illness Has Become Extraordinarily Expensive and Inhumane

The costs of medical care in the last year of life are high, and a portion of them represent overly intensive services in terminal illness.[44] Some 18 percent of lifetime costs for medical care, or over $40,000, is estimated to be incurred in the last year,[45] and 29.4 percent of Medicare and Medicaid payments for those over the age of 65 are for people in the last year.[46] Imminent death is not always predictable, but sometimes the reality is clear. Seventy percent of people request no life-sustaining treatments for themselves when they are dying, and 89 percent desire living wills and other advance directives. Yet only 9 percent have made such directives.[47-49] Schneiderman and colleagues[50] point out that not only signed documents but also physician–patient communication is important if dying patients are to receive less unwanted care. Roos and colleagues have discussed the factors associated with expensive and inexpensive terminal care.[51]

Health Promotion at Work Has Successfully Reduced Costs

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

A recent review of 28 separate studies of health promotion in the workplace emphasized the effects on documented cost reduction, with the savings generally being three or more times greater than the program costs.[56] A low-cost intervention delivered by mail[61,62] had a higher percentage return. A well-executed study sponsored by the National Institutes of Health in Birmingham, Alabama, showed a 10-to-1 return and held costs to the city constant over a five-year period.[67] Increasing collaboration by universities and corporations has substantially improved the quality of recent studies.[70] There already are model programs that improve health and decrease costs. It is not knowledge that is lacking, but penetration of these programs into a greater number of settings.

Redefining Health Promotion

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

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

Who Will Pay?

Widespread dissemination of programs such as those described here costs money — not a great deal of money in comparison with overall health costs, but some money. The costs should be borne by those who will ultimately have the savings — that is, those now paying the costs. Insurers, industry, and government can pay out of their potential savings. What is required is a widespread conviction that appropriately designed programs directed at reducing need and demand can actually save money.[13,14,69]

The Health Project

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

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

Problems and Caveats

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

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

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

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

Conclusions

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

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PREVENTIVE HEALTH

A Costly Ounce of Prevention

Early Medical Screening May Save Lives, but Not Money

By Spencer Rich

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

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

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

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

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

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

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

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

"Cost-effectiveness studies, which estimate the net costs and net health benefits of interventions, show that preventive care usually increases medical expenditures," said Louise B. Russell of Rutgers University, who has studied prevention economics for many years, in the July 29 issue of the New England Journal of Medicine. Elsewhere she has said, "Prevention adds billions of dollars to health care spending."

Spencer Rich covers health issues for The Washington Post.

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

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

- Annual manual breast cancer screening recommended for all women 55 to 65 was estimated in 1985 by David Eddy, a leading researcher, as having a net cost of $15,500 for every one-year extension of life for one woman—even after considering how much would be saved by finding the disease early. If, in addition, every woman in this age group got yearly mammograms (as some authorities recommend), more cases would be found but the net incremental cost for each additional year of life saved for one woman would rise to $84,000.
- Pap smears for cervical cancer conducted every three years for all women age 20 to 75 would have cost a net of $13,300 in 1985 for every year of life saved for one woman, according to estimates by Eddy, who said that the cost is "well worth it." His study also found that if the smears were done every two years instead of three, the extra cost for every additional life-year saved for one woman would be $419,000; and if done annually, the incremental cost compared to the two-year strategy would be more than $1 million for each additional life-year saved.
- Cholesterol screening of healthy adults to ward off heart problems does not save money, according to a 1991 OTA study by Judith Wagner and Alan M. Garber of Stanford Medical School. They based the study on guidelines endorsed by the American Heart Association that call for cholesterol screening of all persons over 20 at various intervals, dietary guidelines for those found to have high cholesterol and costly drug therapy when appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prevention May Be Costlier Than a Cure

By David Stipp

Staff Reporter of The Wall Street Journal

Which saves lives more cheaply, heart transplants or curbing industrial pollution to prevent cancer?

If you picked ounces of cancer prevention over pounds of heart cure, ponder this: Each year of life bought by a heart transplant costs, on average, $104,000. But a life-year saved by preventing factories from releasing carcinogenic substances like formaldehyde and benzene generally costs more than $2.5 million.

That's what a sweeping study of cost-benefit estimates by the Harvard School of Public Health's Center for Risk Analysis shows. The ongoing lifesaving study is the most ambitious effort to date to [illegible] estimated [illegible] of [illegible] avert premature deaths.

Findings so far suggest that:

- Medical care generally saves lives at less cost than workplace-safety or environmental measures.
- Extravagantly large sums are spent to alleviate minor cancer risks.
- Oregon's ranking of Medicaid services — touted as a possible national model for setting medical priorities — falls far short of maximizing cost-effectiveness.
- Some [illegible] deaths could be averted annually in the U.S. if the $21.2 billion spent on [illegible] major life-preserving programs were reallocated so more went to the most beneficial measures and less to the others. Cost-effective spending could cut about $31 billion in health-care and other costs without increasing the death rate.

Lifesaving Costs

Median cost of a year of life saved by various interventions

	COST
Childhood immunizations	Less than zero
Prenatal care	Less than zero
Flu shots	$600
Water chlorination	$4,000
Pneumonia vaccination	$12,000
Breast cancer screening	$17,000
Construction safety rules	$38,000
Home radon control	$141,000
Asbestos controls	$1.9 million
Radiation controls	$27.4 million

Source: Harvard Lifesaving Study

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

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

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

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

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

Medical treatments sometimes cost surprisingly little in the study's analysis because they are used on a small target group — sick people. For example, kidney dialysis typically saves a life-year for about $46,000. But broad-brush prevention, such as installing seat belts in all school buses ($2.8 million per life-year), generally pays off for only a small fraction of the population.

But the Harvard study doesn't factor in the myriad considerations that might make spending effective or ineffective. For example, a school district where children died in a bus without seat belts might pay huge legal settlements, as well as incur adverse publicity that might cost the schools voter support for tax levies.

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

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

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

Dr. Tengs notes that selective anticancer prevention can be cost-effective. A life-year saved by screening women over 20 annually for cervical cancer costs $224,000, compared with $11,000 for annually screening women over 60.

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

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

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

[illegible] between 1990 and 1993, the state put increasing weight on cost-effectiveness. [illegible] of the Harvard study. [illegible] the commission revised the rankings of about 40 of the 709 items on the [illegible] list.

THE WALL STREET JOURNAL, WEDNESDAY, JULY 6, 1994

EXECUTIVE SUMMARY

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

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

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

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

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

Insurance Coverage

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

Table ES-1

Number of Persons Remaining Uninsured Under Selected Approaches in 1998

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

a Insurance market reform includes guaranteed renewability and portability, limits on pre-existing condition exclusions and community rating for individual and small group (under 100) markets.

b As specified in the Managed Competition Act, 100 percent premium subsidy for persons with income below poverty and sliding scale subsidies for persons up to 200 percent of poverty. The Act also includes changes in the tax deductibility of premium payments.

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

Expenditures For The Remaining Uninsured

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

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

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

Changes In Insurance Premiums For The Currently Insured

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

Table ES-2
Number of Persons and National Average Premiums for Persons Under Alternative Reform Scenarios in 1998

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

a Insurance market reform includes guaranteed renewability and portability, limits on pre-existing condition exclusions and community rating for individual and small group (under 100) markets.

b As specified in the Managed Competition Act, 100 percent premium subsidy for persons with income below poverty and sliding scale subsidies for persons up to 200 percent of poverty. The Act also includes changes in the tax deductibility of premium payments.

c For consistent analysis, universal coverage is based on the Managed Competition Act expanded to include an individual mandate. An employer mandate could be used to attain universal coverage as in the Health Security Act. The premium changes shown in this analysis would be the same under either mandate because we focus only on premium amounts regardless of payer.

d Change in average premium compared to premium without reform. All premiums have been standardized to the Health Security Act benefits package.

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

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

- Without reform, the overall average monthly premium for currently insured persons would be $172 per person in 1998.[ES-3]

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

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

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

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

CHANGES IN HOUSEHOLD HEALTH SPENDING

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

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

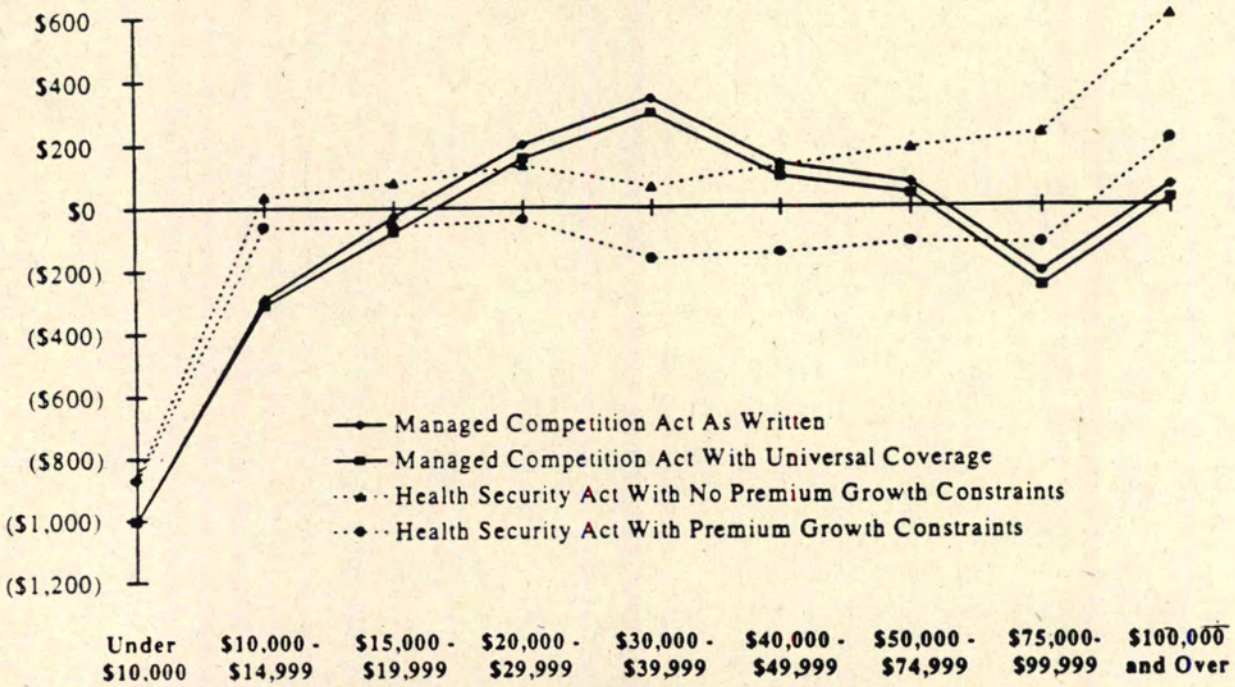
For the 76.5 million households that currently have insurance, we estimate that health spending is generally higher under partial reform than under universal coverage with or without wage effects.[ES-4] ***Figure ES-1*** shows the net changes in household health spending for the currently insured population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

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

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

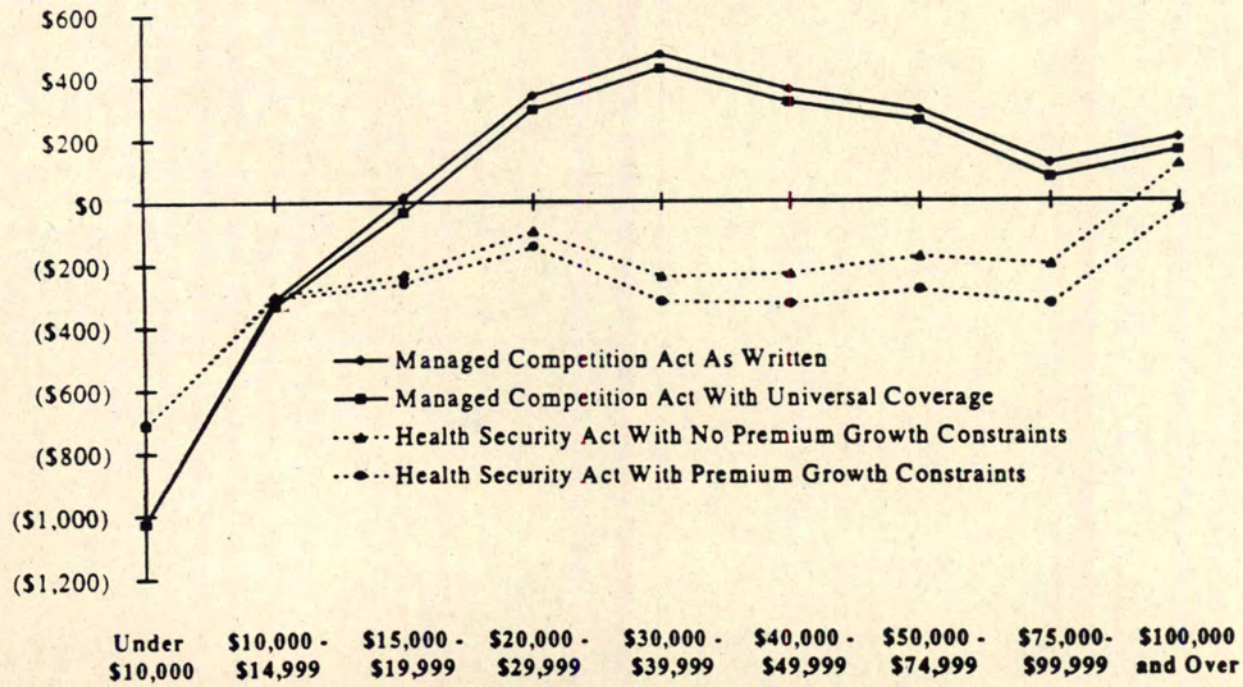
ES-4 To estimate the wage effect, we assume that 88 percent of new employer costs (based on econometric studies) are eventually passed on to employees in the form of wage reductions, ***and*** that 88 percent of new employer savings are generally passed on to employees in the form of wage increases.

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



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

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



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