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UNIVERSAL COVERAGE AND THE

CONSERVATIVE WAY

by Alain C. Enthoven and Sara J. Singer

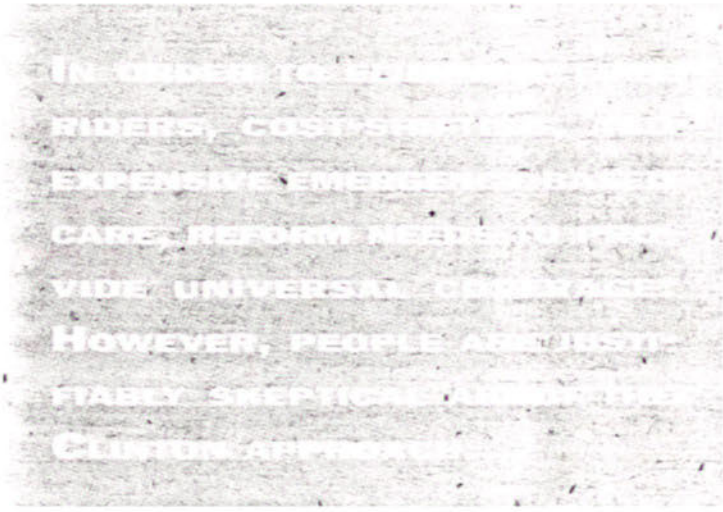
If Congress does not institute a health care reform proposal that effectively contains escalating health care costs, the need to raise taxes to finance growing federal, state, and local budgetary needs will intensify. The United States will spend more than $1 trillion ($1,060 billion) on health care in 1994, according to the Department of Commerce—almost 16 percent of the gross domestic product. That dollar figure in real terms exceeds by about two-thirds what this country spent in 1987. Directly or indirectly (through tax breaks) government pays for about half of it. For those who care about public finances, health care costs are reaching crisis proportions.

Conservative Republican proposals will not solve the cost problem. In general, conservative Republicans would address the health care cost problem by making individuals conscious of the cost of health care at the "point of service." They would accomplish this by giving individuals the option to purchase "catastrophic" coverage with a high deductible and encouraging them to establish tax-free medical savings ("Medisave") accounts, like individual retirement accounts, to use for annual out-of-pocket medical expenses up to the deductible level—approximately $3,000. While this might make individuals cost-conscious up to the level of the deductible, it will make very little difference to the problem of overall health costs.

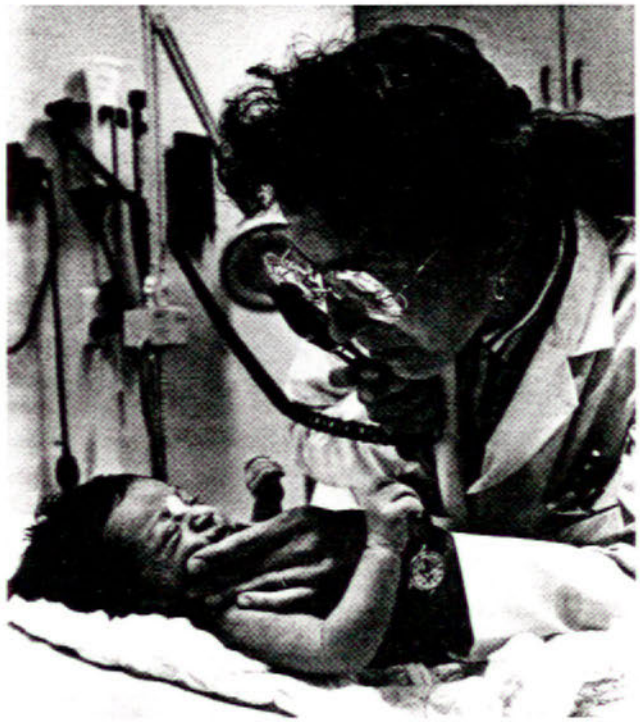
First, healthy individuals, who generally make little use of health care services, will choose the catastrophic option, while unhealthy individuals, if they can, will choose plans with comprehensive benefits, no deductibles, and low cost-sharing requirements. In that case, any cost-containing incentives of a Medisave account would have no impact on unhealthy people, who use the health care system most. Second, individuals who choose the catastrophic coverage option would have an incentive to avoid primary care like prenatal care and preventive services like immunizations. Some of these people may end up with higher health care costs in the long run. Third, most expense is concentrated on relatively few sick people. In 1992, 83 percent of total national health care expenditures were spent on 15 percent of the population for whom the cost of health care was greater than $2,500. In any year, anyone with a chronic disease, pregnancy, or hospital episode will have reached or come close to the deductible. For them, the expected marginal cost of more care under a traditional catastrophic policy will be zero. Neither patient nor doctor will have an incentive for cost-

conscious choice, so the incentive of a $3,000 deductible would really have little effect.

Ironically, the conservative Republican proposals most resemble proposals on the opposite end of the political spectrum. Liberal Democrats advocate a single-payer system that would control costs by eliminating the health insurance industry and turning control of health care purchasing over to the government with the hope of saving money on administrative costs. Such proposals, like the conservative Republican proposals, would do nothing to solve the fundamental problems in the system. So, assuming that the government will continue to be an inefficient and ineffective purchaser of whatever it buys (the federal government has not been able to do a very good job with Medicare and Medicaid), it is most unlikely that such proposals would contain costs either.



The problem with the traditional system of "fee-for-service," solo practice, "remote-third-party payment," and the reason that costs are increasing so dramatically, is that the people who control most of the dollars in health care—doctors—have a financial incentive to drive up costs. In the traditional system, doctors are paid more for providing more, but not necessarily better, care. Insurers are simply remote third-party payers that pay the bills. As costs have become increasingly a problem, insurers have tried unsuccessfully to control costs through utilization review which has succeeded only in driving up administrative costs and in creating an adversarial relationship with doctors.



Universal coverage under the Clinton plan is intended to cover prenatal care through Medicare/Medicaid benefits.

Instead, national health system reform must fundamentally change the incentives in the system by creating powerful market forces that reward doctors and hospitals for forming and operating increasingly efficient comprehensive care organizations, through a long-term continuing process of quality and productivity improvement. The system must hold providers accountable for cost and quality; it must reward physicians who "do it right the first time"; it must reward innovation.

Reform must also eliminate "free riders"—those who choose not to purchase health care coverage because they know the system will provide for them if they become ill. Unfortunately, emergency room–based care is inefficient and expensive care. In many cases, problems could be avoided through early detection or prevention. In all cases, billing and credit costs are wasted. The cost of free riders is passed on through "cost-shifting" to those who do purchase coverage.

Conservative Democratic and moderate Republican proposals come closest to achieving these goals. The proposals call for "accountable health plans" that would integrate the financing and delivery components of the health care system. Accountable health plans would be paid a fixed price per member per month and would be responsible for the comprehensive care of the populations they serve. This gives an accountable health plan an incentive to keep people healthy or to get them well as efficiently as possible once ill. Accountable health plans would be held accountable by individuals, armed with information on the basis of which to compare and with incentives to choose value for money.

To maximize the incentive to choose the most efficient competing health plans, individuals must pay the full difference in cost between the low-cost plan and the plan they choose. Therefore, an important component of a health reform plan must be a limit on the exclusion of employer-paid health benefits from taxable incomes. Such a limit, or "tax cap," would stop subsidizing the choice of more expensive health plans through the tax code. In 1994, the federal budget lost $74 billion in tax revenue to this tax break. In 1995, it will lose $90 billion. A country that desperately needs money to fund subsidies to help low-income people buy coverage cannot afford this rate of increase.

More importantly, once individuals must pay the full difference in cost, health plans will have an incentive to lower their prices. Rather than offering enhanced benefits and reduced cost-sharing requirements as health plans

do now to attract customers, health plans will focus on finding ways to innovate and to become more efficient so they can pass on the savings.

In order to eliminate free riders, cost-shifting, and expensive emergency-based care, reform needs to provide universal coverage. However, people are justifiably skeptical about the Clinton approach of creating an up-front universal entitlement to a comprehensive set of benefits and deferring payment until uncertain future "savings" are realized. A better way to proceed would be to create a step-by-step approach to universal coverage that allows reform to adapt to observations and experience, but requires government financing to be in balance.

An integral component of such an approach would be a "balanced health security budget" that guarantees that federal coverage costs do not grow faster than revenue. The budget would be similar to the existing limit on discretionary federal spending. It would include direct subsidies for low-income individuals (including the current Medicaid population), Medicare, and the Federal Employee Health Benefits Program, and would count the revenue lost from the exclusion of health benefits from taxable incomes. Public programs would be included in a reformed system with appropriate incentives in order to achieve savings and increase federal revenues available for subsidies. States would also be required to continue their financial participation.

Government health expenditures would be disbursed on a pay-as-you-go basis: no more would be spent on health care than there are funds available. Each year, if savings are not sufficient, legislators would agree either (1) to raise more money to pay for benefits for the federally covered population, (2) to limit the scope of the benefits package to cover only the services clearly shown to have positive treatment outcomes, or (3) to limit the health coverage subsidies available to individuals. In this way, the federal budget would not be at risk for open-ended entitlements and specific segments of the population would not bear excessive cost-shifting.

Rather than ignoring the fundamental problem and supporting incremental reforms that do not change current cost-increasing incentives, conservatives and liberals should join moderates and unite behind a health system reform proposal that would rely on market forces to contain costs. ■

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