

Reform: Medicare

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*Health Affairs*, July/August 1999

# Purchasing Medicare Prescription Drug Benefits: A New Proposal

*It is possible for Medicare to offer an affordable prescription drug benefit without resorting to national price controls.*

by Lynn Etheredge

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Prologue  
Abstract  
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**PROLOGUE:** Almost thirty-five years ago, Congress modeled Medicare's original package of medical benefits after those offered by Blue Cross and Blue Shield plans at the time. Few benefits have been added since then, although the nature of the illnesses that afflict Medicare's 38.4 million beneficiaries have changed considerably, as has the capacity of medicine to cope with them. On 1 July 1988, when President Ronald Reagan signed into law the Medicare Catastrophic Coverage Act, the federal government corrected what many elderly people believed was the program's most serious missing benefit: the coverage of outpatient prescription drugs. However, less than two years later Congress repealed the law in response to opposition vociferously expressed by some elderly people and some pharmaceutical companies. Now, as prescription drugs consume a larger share of the health care dollar, political pressure is building again for adding an outpatient drug benefit. Whether Congress takes definitive action may depend largely on whether it can forge a private/public collaboration that is acceptable to the competing parties.

In this lead paper Lynn Etheredge, an independent consultant widely respected for his policy acumen, proposes an approach that seeks to accommodate the concerns of both government and the private sector regarding a new drug benefit, and two leading stakeholders respond with perspectives that follow. Etheredge directed the professional health staff of the president's Office of Management and Budget during the administrations of Jimmy Carter and Ronald Reagan. He is now a consultant with the Health Insurance Reform Project at the George Washington University, a project that is supported by the Robert Wood Johnson Foundation.

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**ABSTRACT:** Medicare policymakers are considering using private-sector firms to offer and manage a prescription drug benefit. In such arrangements Medicare and its potential contractors will need to consider four major areas of risk: selection risk, cost management risk, risks of government as a business partner, and risks that new Medicare benefits will change competitive advantages. This paper considers these risk factors and suggests a model for Medicare prescription drug coverage. By adapting private-sector purchasing practices and using competitive markets, Medicare could offer prescription drug benefits-at affordable premiums for beneficiaries-without resorting to national price controls for pharmaceutical products.

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Political leaders are showing an increased interest in expanding Medicare's benefits to include

outpatient prescription drugs. In contrast to the usual legislative practice of establishing national price controls for Medicare-paid services, much of the discussion now contemplates offering prescription drug benefits through existing private entities such as Medicare+Choice plans, employer retiree plans, Medigap plans, and competing pharmacy benefit management (PBM) companies. This new Medicare strategy would adapt the best practices of private-sector employers and health plans in managing drug benefits. PBM companies, for example, typically assemble purchasing pools of millions of persons; they obtain large drug price discounts, offer broad networks, and operate at low administrative costs. The Federal Employees Plan (FEP), which is the nation's largest employee health benefits plan, purchases its drug benefits through competitive contracts with two of these companies.<sup>1</sup>

The federal government has been on a steep learning curve about how the Medicare program can best use health care markets. In structuring the Medicare+Choice arrangement in the Balanced Budget Act (BBA) of 1997, for example, decisionmakers were aiming for a major expansion in the role of private health plans. But health plans assessed the risks and rewards of the emerging Medicare market and government's contractual terms differently-and dropped 450,000 Medicare beneficiaries.

If the federal government is going to succeed in using competitive markets for Medicare drug benefits, its policymakers will need to understand how to (1) structure a market and (2) define contractual terms that both accomplish government's purposes and create viable business opportunities for insurers and benefit administrators. To explore these issues, in April 1999 the Health Insurance Reform Project at the George Washington University and *Health Affairs* convened a small group of actuaries, insurance executives, pharmacy benefit managers, public-sector purchasers of prescription drugs, and other experts.<sup>2</sup> This paper draws from that dialogue, as well as from other discussions. It seeks to identify the most important concerns of potential insurers and administrators who would compete to offer Medicare drug benefits, and to consider how Medicare policies could be designed to address these concerns. It also suggests a prototype, evolving from this market-oriented focus, for Medicare outpatient drug coverage.

## Major Areas Of Risk

The subject of risk emerged at the April 1999 meeting as the central, pervasive issue in how private-sector experts size up various models for Medicare prescription drug coverage. This is a distinctly different focus than most public policy theorists have taken for designing Medicare markets; it has often been assumed that the size alone of the \$200 billion potential Medicare+Choice market or the \$20-\$40 billion Medicare prescription drug market will almost automatically guarantee that private-sector firms will rush forward to do business with the government. Private-sector firms see opportunities for gain, of course-although they tend to believe that government will cut their profit potential sharply once it has lured them into the market-but they see many unknowns and risk for losses as well. Indeed, for private insurers, assessment of such market risk is a core business competence.

Insurance company actuaries quantify risk, based on known facts, and uncertainty adds to risks. The greater the risk, the higher the premium the company will charge-over and above expected benefit costs-to cover the risk, or the higher the level of reserves an insurance company will need to cover potential losses. If the reward/risk balance is not a good one in relation to other business opportunities, a well-managed insurer will stay out of a market or drop a product. When subjected to disciplined business analysis, several often-discussed ideas about Medicare drug benefits are distinctly unattractive business opportunities. Such ideas include the notion that Medicare drug benefits could be offered by PBMs competing on a fully capitated basis, or that affordable coverage could be offered by Medigap plans through voluntary high options. With well-designed markets and good risk-sharing contracts, however, Medicare and the private sector can do business together.

Business enterprises always involve some risks, such as performance risk of whether a company will be able to deliver on its contracts and risks that a competitor will have better products or market strategies. But four major sources of risk stand out for firms as they consider the business opportunities presented by a new Medicare outpatient pharmacy market: selection risk, cost management risk, the risks of having government as a business partner, and the risks that Medicare prescription drug coverage will rearrange current competitive positions.

**Selection risk.** Selection risk is the largest risk factor that an insurer or a PBM company would need to consider in deciding whether to offer a Medicare pharmaceutical benefit for a capitated premium or other at-risk basis. Selection risk arises because Medicare drug benefit use is unevenly distributed and is predictable for many higher-expense patients.<sup>3</sup> About 32 percent of enrollees incur about 60 percent of expenses.<sup>4</sup> Among Medicare's highest-cost patients are those receiving transplants and cancer chemotherapy, as well as patients with kidney disease, congestive heart disease, and chronic obstructive pulmonary disease. If drug coverage is offered on a voluntary, individual-choice basis (and premiums are not allowed to reflect health risk), higher-cost beneficiaries are much more likely than lower-cost beneficiaries are to enroll, premiums will need to rise to cover their costs, and lower-expense Medicare enrollees will not find it economical to purchase coverage.

Today's Medigap market illustrates the unworkability of a voluntary enrollment option in achieving widespread coverage. Of the ten standard Medigap plans, Plans H, I, and J include prescription drug coverage. They are subject to high risk selection. A recent study compared Plan C (no prescription drug benefit) with Plan I (\$1,250 maximum drug benefit) for five cities (Dallas, Denver, Los Angeles, Miami, and Manchester, New Hampshire). Although the major difference between the plans was the \$1,250 prescription drug benefit, premiums for a sixty-five-year-old averaged \$1,534 more in Plan I than in Plan C (\$2,724 versus \$1,190), and premiums for a seventy-five-year-old averaged \$1,984 more (\$3,474 versus \$1,490).<sup>5</sup>

Apparently, drug coverage is a "supermagnet" for adverse selection by persons with high drug and nondrug health care costs. Plans H, I, and J are now open at age sixty-five. Thereafter, only persons accepted by the insurance company can enroll.<sup>6</sup> If a national Medicare drug benefit were available in an annual open-enrollment period, so that persons could defer enrollment until they expected high drug costs (for example, after a diagnosis of cancer or congestive heart failure), selection risk for an insurer would be even more severe.

An insurer that started to offer Medicare pharmacy benefits (or a Medicare+Choice health plan) also would be at greater risk as a "pioneer" with a new Medicare product offering drug benefits. There likely would be latent demand, such as uninsured persons who have high drug expenses, including high-cost patients who have been denied coverage by current Medigap insurers or who have found those policies to be too expensive. Individuals also could shift from high-premium Medigap plans to new insurance offerings. Since one-third of Medicare enrollees now lack prescription benefits, it is particularly difficult to make confident estimates of an individual insurer's costs for the new enrollees who would select its plan. The early market entrants could get most of the high-risk patients. The problems of risk selection multiply when competing health plans are allowed to offer features that strongly encourage or discourage high-risk enrollment; competition on that basis could occur through lowering out-of-pocket limits, by not covering drugs in therapeutic classes needed by high-cost patients (such as chemotherapy) or selectively charging higher copayments for them.

*Policy implications.* Medicare policy could be designed to address these issues. The most important factor would be to assure that there was universal (or near-universal) coverage for a basic pharmacy benefit. Knowing that a risk pool would include the many good risks (low users) as well as high users, potential insurers could more confidently quote premiums that were closer to community-rated premiums and expect to have a representative risk pool. Having a large potential market also would encourage many new entrants. Broad coverage could be achieved through a universal Medicare entitlement, inclusion of a drug benefit in Medicare Supplementary Medical Insurance (SMI, Part B), and/or a combination of SMI, Medigap plans, Medicare+Choice health plans, employer retiree benefit plans, and expanded Medicaid coverage.

A second implication of selection risk is the need to standardize (or limit variations in) the pharmacy benefit and how it is administered. Standardization helps consumers to make informed comparisons in a competitive market, as well as to lessen risk-selection competition. Among the frequently suggested elements to be standardized for a well-functioning market-for beneficiaries, Medicare, and pharmacy benefit offerers-are guaranteed issue, guaranteed renewal, open-enrollment periods, waiting periods and "lock-in" rules, prohibition of medical underwriting, basis of premium (community or age rating), "report cards" for consumers, deductibles, copayments (including "tier copayments" for different drugs),

days' supply limits, and upper limits on benefits (and how expenses are counted in meeting deductibles and upper limits).<sup>7</sup>

Areas in which insurers or pharmacy benefit administrators need to have flexibility to manage include formularies, premiums, better services (such as mail order), purchasing from pharmaceutical manufacturers and pharmacies, pharmacy networks, point-of-sale and other utilization review, use of generics, and prior authorization of expensive drugs. Formularies need some standards to avoid competition-induced misbehavior, but it may suffice to require that they include at least two drugs in each therapeutic class. Of course, any prescription written by a physician as "DAW" (dispense as written) would need to be supplied.<sup>8</sup>

Risk adjusters also should be developed for Medicare pharmacy benefits. Risk adjusters, particularly as they incorporate information on the uninsured population, will lessen the risk associated with offering Medicare pharmacy benefits so that insurers would be more likely to offer them. Since outpatient pharmacy benefits are good indicators for presence and severity of illness for nonhospital care, pharmacy risk adjusters also could improve the overall risk adjustment for Medicare+Choice plans.

**Cost management risks.** The second-largest risk factor is whether an insurer or pharmacy benefit administrator can control costs well enough to enter into a capitation or other kind of risk-sharing contract. This has become an increasingly important risk factor since drug spending, driven mostly by volume, has accelerated to double-digit rates for the past several years-even in managed care plans. Although the near-term causes are not well understood, the implicated factors include more new products, direct-to-consumer (DTC) advertising, greater use of drugs as preferred clinical practice by managed care plans, and low cost-sharing rates in many benefit plans. Pharmacy industry leaders also speak of a full pipeline for new drugs and of future products based on genetic knowledge and molecular engineering that will transform much of clinical practice, making it possible to cure or even prevent many health problems. Such possibilities make it even more important for Medicare to cover drug benefits. In such a volatile market, however, the Medicare program will find no interest among PBMs or Medigap insurers in proposals to shift Medicare's insurance risks for pharmacy benefits to them through full capitation contracts.

As drug benefit managers for large employers and health plans, PBMs bring a number of important capabilities. They offer negotiated discount pricing on pharmacy products and networks, formularies, generic substitution, claims processing, quality and utilization review, and other services; and they may enter into incentive and penalty arrangements for various aspects of contract performance. Unlike managed care plans, which have contractual relations with physicians-and which can benefit from reduced hospital use from better ambulatory care therapies-PBMs seldom take full capitation contracts themselves. They do not have risk arrangements with physicians, nor can they benefit from the trade-offs of drug versus medical costs. They have only indirect influence on volume, such as calling physicians to change a prescription or lower/higher consumer cost sharing. PBMs also are not in the insurance business; many would need to acquire an insurance license, expertise, and reserves or partner with insurers. Most Medigap plans are even more limited in their capabilities to influence drug costs; they would need to develop PBM capabilities or partner to gain them.

The limited potential for using stand-alone capitated contracts for carve-out pharmacy benefits is not necessarily a problem for Medicare. The program now lacks the data to set accurate capitation rates for its uninsured beneficiaries. Even with good information, however, capitation contracts can be a suboptimal payment method for health services-for patients, service providers, and health plans. Whereas fee-for-service encourages use of too many services, capitation can lead to use of too few services, particularly for higher-cost patients. As reflected in the Medicare+Choice experience, capitation may produce risks that are too high in relation to potential market earnings and deter market entry. A recent study suggested that risk-sharing contracts may be preferable to capitation as the best method for Medicare to use in contracting for services.<sup>9</sup> Indeed, Medicare and other large payers actually pay more-a "risk premium"-for transferring risk to an insurance company through a capitation contract; large self-insured companies often save money by keeping risks and contracting with third-party administrators to manage benefits with performance incentives and perhaps limited risk sharing.

*Policy implications.* Government can design a Medicare benefit that includes the best practices of purchasing drug benefits by using the same kinds of performance contracts and limited risk-sharing contracts that are now common for large employers and health plans that use PBMs in the private sector. Such arrangements could be part of Medicare contracts with all who offer drug benefits for Medicare enrollees, including Medicare+Choice plans, Medigap insurers, employers, Medicaid programs, and PBMs for Medicare's fee-for-service program. Cost management risks also can be lessened by having a basic benefit package, which reduces insurers' financial exposure, and by cost sharing, which shares risks (expenses) with consumers. Government also could lessen private-sector and consumer risks by picking up high-cost patients itself through a Medicare catastrophic pharmacy benefit or reinsurance. Indeed, such a benefit, with its own contract terms, could facilitate developing better case management and disease management services for high-cost Medicare beneficiaries with chronic or terminal illnesses.<sup>10</sup>

Although Medicare could make effective use of private-sector markets and firms—which are particularly good at negotiating prices and administrative services—the payers for Medicare prescription benefits (such as the Health Care Financing Administration [HCFA], Medicare+Choice plans, employers, Medigap plans, or individuals) would still bear much of the risk for higher drug-use volume, for which there are not yet adequate clinical data to draw lines on medically appropriate use. But the sensible way to address the problem of inadequate knowledge is for the federal government to invest in more research about drug therapies for Medicare's elderly and disabled patients. In the long run, this would assist in better management of pharmacy benefits, as well as in development of a stronger clinical science base for treating the medical problems of Medicare's thirty-nine million enrollees.

**Government-partnership risk.** A third major source of risk for potential business partners with the Medicare program is that many just do not trust government to be a good business partner. Whatever the initial legislation or contracts may provide, they believe that government will increasingly squeeze their profit opportunities and regulate how they run their businesses. For example, they are afraid of getting into the kinds of capitation arrangements that government has decreed for some of its Medicare+Choice "partners" that will raise their government-paid premiums only 2 percent per year. The kinds of actions pharmacy benefit administrators would need to take to live within such constraints would involve tightly closed formularies and highly intrusive programs of utilization controls, with frequent calls to physicians and patients, which would lead toward public backlash and more regulation. Once government became a large customer, it would be difficult to walk away from the Medicare market. The risks for pharmacy benefit insurers and contractors likely would increase with the amount of prescription drug benefits paid by the federal budget, particularly if such costs increase rapidly and thus call forth tough cost-control efforts.

*Policy implications.* Despite these views about "government-partnership risk," few health care providers today would turn away more Medicare business. The health sector and Medicare's business partners have usually done quite well over the past thirty years, as Medicare spending has risen to more than \$200 billion annually. Nevertheless, these types of perceived risks can be addressed in designing a new Medicare drug benefit by maintaining multiple public and private funding sources for Medicare drug benefits. Specifically, such considerations suggest maintaining many of the existing arrangements whereby about two-thirds of senior citizens now obtain some drug coverage or other supplemental benefits, such as retiree health benefits and Medicaid and Medigap plans. A government catastrophic benefit payable for employer coverage could encourage employers not to drop their current benefits and shift all costs to Medicare. Such arrangements—which avoid refinancing all of the existing financing of prescription drug benefits through the federal budget—also could be favored for fiscal reasons.

A Medicare advisory committee on pharmacy benefits contracting also might help to ensure balanced consideration of government/private-sector contracting issues, much as the Medicare Payment Advisory Commission (MedPAC) does for regulated pricing issues.

**Market risk.** A fourth area of risk is how the introduction of Medicare prescription drug benefits would work to the competitive advantage or disadvantage of current health care system actors. A central question is whether a Medicare pharmacy benefit would help or hurt Medicare+Choice plans. One line

of reasoning is that since pharmacy benefits are one of the attractive features that draw beneficiaries to Medicare+Choice plans, the offering of these benefits by their competitors would detract from health plans' enrollment growth and thus be to their market disadvantage. But risk analyses point to a different conclusion: If all persons have prescription drug benefits, then Medicare+Choice plans face less risk that offering drug benefits will produce unfavorable selection; health plans also will obtain higher government adjusted average per capita cost (AAPCC) payments for drug therapies that they use more than fee-for-service medicine and that help to reduce their inpatient costs.

*Policy implications.* Adding a Medicare drug benefit will cause many Medigap plans and PBM companies to rethink products, strategies, marketing, and business alliances. Also, a number of firms with PBM capabilities, including insurers (such as Aetna and some Blues plans) and claims processors (such as EDS), may well enter a new Medicare market. For government policymakers, such competitive factors are most likely to play out in pressures to allow a lot of pharmacy benefit administrators to participate in new contracts for Medicare fee-for-service benefits. Federal policy also may be called upon to resolve the premium structures of age-rated Medigap (for example, some Blues plans), community-rated Medigap (for example, United/AARP), and community-rated Medicare+Choice. To foster cost-based (rather than selection-based) competition, it would be desirable to have all of the plans offering Medicare drug benefits use either age or community rating.

## A Prototype

The above discussions suggest that with proper attention to risk issues, government and the private sector can do business together to assure good drug benefits for the Medicare population. Drawing on these analyses, a Medicare pharmacy benefit could have the following characteristics.

**Coverage.** All Medicare-eligible elderly and disabled persons would be covered for outpatient prescription drugs through one of five mechanisms: a Medicare+Choice plan, employer-based retiree benefits, redesigned Medigap plans, Medicaid, or fee-for-service Medicare. Persons who select one of the first three options would pay premiums directly to those plans. Persons with incomes below 135 percent of poverty would be "bought in" by Medicare to Medicaid drug coverage. Persons not covered through these means would pay a higher SMI premium for direct Medicare coverage.<sup>11</sup> **Basic benefits.** Medicare pharmacy coverage would consist of basic benefits, paid by individuals, and catastrophic (or "stop-loss") benefits, paid by government. The basic benefits would be standardized with a specified deductible. Medicare beneficiaries also could have a "discount card" that offers a negotiated savings on drug purchases to reduce their out-of-pocket or uncovered prescription drug expenses.

Pharmacy benefit plans open to individual choice (Medicare fee-for-service, Medicare+Choice plans, and Medigap) would be standardized with respect to guaranteed issue and renewal, open-enrollment periods and lock-ins, prohibition of medical underwriting, basis of premium, report cards for consumers, deductibles, copayments (including "tier copayments" for different drugs), days' supply limits, upper limits on benefits, and how expenses are counted in meeting deductibles and upper limits. Health plans would be able to compete with respect to formularies (subject to basic standards), premiums, better services, purchasing from pharmaceutical manufacturers and pharmacies, pharmacy networks, point-of-sale and other utilization review, generic drug use, and prior authorization of expensive drugs.

**Catastrophic benefits.** Medicare would cover drug expenses above a stop-loss limit per person. The deductible and copayment features of basic coverage (paid by beneficiaries) and stop-loss benefits (paid by government) would be designed to split the total insurance costs about fifty-fifty between individual enrollees' premiums and government costs. This split was the original financing formula for the SMI program, and more than 95 percent of eligible enrollees signed up. Medicare would pay for stop-loss benefits of its enrollees in Medigap plans, Medicare+Choice plans, and employer retiree benefit plans and qualifying disease management, high-cost case management, hospice, and other programs.

The National Academy of Social Insurance recently published estimates for five Medicare prescription drug packages. The benefit designs include various combinations of deductibles from \$200 to \$500, coinsurance rates of 20 percent to 50 percent, and stop-loss benefits of \$1,000 to \$3,000. The total cost per beneficiary ranges from \$443 to \$609 in 1999. These estimates suggest that good Medicare drug

coverage using a fifty-fifty financing split would cost individuals and government each about \$200-\$300 per person in 1999.<sup>12</sup> For his or her \$200-\$300 premium payment, a Medicare enrollee thus would receive both basic and catastrophic outpatient prescription drug coverage.

**Medigap redesign.** Medigap plans would be restructured to add the basic prescription drug coverage and to increase cost sharing for other Medicare benefits. Today's requirements that Medigap plans must fill in deductibles and coinsurance not only do not add much value as insurance-individuals probably pay \$104 to fill in a \$100 deductible-but also make most of Medicare's hospital and physician services free to an individual, thereby raising total program spending.<sup>13</sup> This kind of redesign also would lessen the (net) premium increase for Medigap enrollees of adding prescription drug benefits.

**Contract mechanisms.** Medicare would use the best practices of private-sector purchasers rather than capitation. PBMs for fee-for-service Medicare enrollees would be selected competitively, at least two in each region. They would be paid through performance contracts or with risk sharing for both basic and catastrophic benefits. Medicare+Choice plans, Medigap plans, employer retiree benefit plans, disease management firms, hospices, and others could be paid under performance or risk-sharing contracts for catastrophic drug benefits. A pharmacy benefits committee could advise HCFA on writing contracts for drug benefits.

Having these types of arrangements to use the private sector's capabilities, the federal government would be responsible for paying for Medicare catastrophic drug benefits and Medicaid buy-ins, contracting for Medicare fee-for-service drug benefits and catastrophic benefits, developing a pharmacy benefits risk adjuster (for Medicare+Choice plans and for other contracting if needed), and expanding national investments in pharmaceutical and disease management studies. By adapting private-sector purchasing practices and using competitive markets, Medicare could offer prescription drug benefits at affordable premiums for beneficiaries, without resorting to national price controls for pharmaceutical products.

*The author thanks Stanley Jones and Sandra Foote for many discussions of insurance issues and comments on the paper. This paper was supported by a grant from the Robert Wood Johnson Foundation to the Health Insurance Reform Project at the George Washington University.*

## NOTES

1. The FEP is operated by the Blue Cross and Blue Shield Association as part of the Federal Employees Health Benefits Program (FEHBP).
2. The meeting was held 9 April 1999 in Washington, D.C. Participants, in addition to the author, included Anthony Barrueta (Kaiser Foundation Health Plans), John Bertko (Reden and Ander), Elizabeth Dichter (PCS Health Systems), Sandra Foote (Health Insurance Reform Project), Peter Fox (PDF, Inc.), John Iglehart (*Health Affairs*), Stanley Jones (Health Insurance Reform Project), J.D. Kleinke (Health Strategies Network), Terry Latanich (Merck-Medco), Patricia Norton (Massachusetts Division of Medical Assistance), Michael Pollard (Michaels, Wishner, and Bonner), Edward Sellers (Blue Cross and Blue Shield of South Carolina), David Smith (United Health Care), and Robin Strongin (National Health Policy Forum). The contributions of these persons are gratefully acknowledged; they are absolved from responsibility for the author's views expressed in the paper.
3. To the extent that high expenses for some patients are predictable, it is easier for insurance companies to screen out or avoid such patients, and it is also easier for such persons to see if their expected insurance benefits will exceed their premiums.
4. PCS Health Systems estimates from Elizabeth Dichter, personal communication, 13 May 1999.
5. M. Gluck, *A Medicare Prescription Drug Benefit* (Washington: National Academy of Social Insurance, 1999), Table 3.
6. Only about 8 percent of Medicare enrollees obtain primary prescription drug coverage through Medigap plans or other individual insurance. See M. Davis et al., "Prescription Drug Coverage, Utilization, and Spending among Medicare Beneficiaries," *Health Affairs* (January/February 1999): 231-243.
7. A study that informed these suggestions is P.D. Fox et al., "Should Medicare HMO Benefits Be Standardized?" *Health Affairs* (July/August 1999): 40-52.
8. Higher copayments, subject to limits, would be allowed for off-formulary products.
9. *Structuring Medicare Choices: Final Report of the Study Panel on Competition and Choice*

(Washington: National Academy of Social Insurance, February 1998). Risk sharing can include mixes of capitation and fee-for-service, cost corridors (a contractor bearing the risk for the first 5 percent of gains or losses, with eighty-twenty payer sharing in larger gains or losses), and other contracting arrangements. See J. Newhouse, "Reimbursing Health Plans and Health Providers: Selection versus Efficiency in Production," *Journal of Economic Literature* (September 1996): 1236-1263; and J.P. Newhouse, M.B. Buntin, and J.D. Chapman, "Risk Adjustment and Medicare: Taking a Closer Look," *Health Affairs* (September/October 1997): 26-43. Capitation for prescription drugs alone also risks rationing of drug benefits, possibly with higher hospital or physician expenses.

10. P.D. Fox, L. Etheredge, and S.B. Jones, "Addressing the Needs of Chronically Ill Persons under Medicare," *Health Affairs* (March/April 1998): 144-150; and S.B. Jones, "Why Not the Best for the Chronically Ill?" Research Agenda Brief (Washington: Health Insurance Reform Project, George Washington University, January 1996).

11. A practical way to administer this arrangement would be to continue the current "default" that all Medicare enrollees are enrolled in SMI and have SMI premiums subtracted from their Social Security benefit unless they specifically decline coverage. For coordinating prescription drug coverage, employers offering prescription drug benefits, Medigap plans, and Medicare+Choice plans would advise HCFA of their Medicare enrollees, and Medicare would not subtract the SMI premium for prescription drug benefits from Social Security checks for these persons.

12. Gluck, *A Medicare Prescription Drug Benefit*, Table 4. Estimates developed by Actuarial Research Corporation based on 1995 Medicare Current Beneficiary Survey data. The estimates assume a 10 percent savings compared with what beneficiaries now pay for prescription drugs. Market research would be useful to determine which combination of features would be preferred by beneficiaries, and further analysis would be needed to determine the stop-loss level to produce a fifty-fifty financing split.

13. The Congressional Budget Office (CBO) estimates that Medigap policyholders use at least 25 percent more services, on average, than they would if they did not have first-dollar coverage. Congressional Budget Office, *Maintaining Budget Discipline: Spending and Revenue Options* (Washington: CBO, April 1999), 172.

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# Medicare Reform

HEALTH AFFAIRS

## ***Purchasing Medicare Prescription Drug Benefits: A New Proposal***

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Lynn Etheredge

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Medicare policymakers are considering using private-sector firms to offer and manage a prescription drug benefit. In such arrangements Medicare and its potential contractors will need to consider four major areas of risk: selection risk, cost management risk, risks of government as a business partner, and risks that new Medicare benefits will change competitive advantages. This paper considers these risk factors and suggests a model for Medicare prescription drug coverage. adapting private-sector purchasing practices and using competitive markets, Medicare could offer prescription drug benefits-at affordable premiums for beneficiaries-without resorting to national price controls for pharmaceutical products.

## ***PERSPECTIVE: A Drug Benefit: The Necessary Prescription For Medicare***

John Rother

The question is not whether to include a drug benefit, but rather how to structure such a benefit, says the AARP's legislative director.

## ***PERSPECTIVE: Covering Prescription Drugs Under Medicare: For The Good Of The Patients***

Alan F. Holmer

Let's improve prescription drug coverage for Medicare beneficiaries now-the right way, says a drug industry representative.

## ***Moving Medicare To The FEHBP Model, Or How To Make An Elephant Fly***

Harry P. Cain II

Transforming Medicare into a Federal Employees Health Benefits Program (FEHBP)-type program holds the promise of more choice, lower costs (in the long term), and higher quality-a fine concept that will collapse in its implementation unless at least three conditions are met. (1) Congress gets the regulatory structure right and then refrains from annual tinkering, (2) Congress does not set unrealistic expectations regarding "cost savings," especially if a prescription drug benefit is added, and (3) administrative agency staff have the requisite training and a "privatizing" orientation. Given Medicare's history and the "Medicare-industrial complex," none of those conditions is likely to be met.

## ***Should Medicare HMO Benefits Be Standardized?***

Peter D. Fox, Rani Snyder, Geraldine Dallek, and Thomas Rice

Legislation enacted in 1990 standardized Medigap benefits but not the benefits of health maintenance organizations (HMOs) that serve Medicare beneficiaries. An examination of marketing materials in two large counties reveals the potential for

enormous confusion among beneficiaries because of differences in wording to describe the same benefit, health plans' failure to list Medicare-covered services, and the differences in the benefits themselves. To date, the Health Care Financing Administration (HCFA) has not been able to overcome this confusion through the comparative material distributed on its Web site; indeed, significant errors were found, reflecting to some extent the underlying difficulties in characterizing benefits. Ways of ameliorating the situation are discussed.



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## State of the Debate DR. BUSINESS

Arnold S. Relman

### WORKS DISCUSSED IN THIS ESSAY

George Anders,  
*Health Against  
Wealth: HMOs  
and the  
Breakdown of  
Medical Trust*  
(Houghton  
Mifflin, 1996).

Regina  
Herzlinger,  
*Market-Driven  
Health Care: Who  
Wins, Who Loses  
in the  
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**H**ealth care remains one of the most intractable domestic problems facing the United States today. To compound the issue, there isn't even agreement on what health care really is, or what it ought to be. To most physicians, like me, it involves at its core a professional relationship between patients who are sick or injured and the physicians to whom they entrust their care. But to a business school professor, like Regina Herzlinger, it is a "service industry," the products of which ought to be selected by consumers (let's not call them "patients") in a competitive marketplace, on the basis of price, convenience, and quality.

Herzlinger, who teaches at Harvard University, is on one side of a profound debate about health care and the marketplace. Can the disciplines of the market be brought to bear to control medical costs while assuring access, choice, and quality—as they do in ordinary industries? Or is health care such a far cry from a free market to begin with that recourse to the marketplace only makes its problems worse?

The market view is currently ascendant. We have been witnessing a massive shift in the control and ownership of medical care to private, for-profit businesses. Most of the control is indirectly exercised through investor-owned, managed care insurance plans, but an increasing number of inpatient and outpatient medical facilities are also being acquired and managed by investor-owned corporations. These medical care businesses have become one of the largest sectors of the U.S. economy.

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## HEALTH SHOPPERS

Herzlinger's new book is a blueprint for transforming the health care system into a more explicitly consumer-driven market. As she sees it, buying medical care is like buying any other service or commodity the market economy offers. Smart shoppers, properly armed with information from the medical equivalent of *Consumer Reports*, should be able to seek out the vendors of the services they have decided they need and choose from among them based not only on price but on quality and convenience. Seeking to gain new customers, competing medical vendors would make every effort to provide a satisfactory product. If the market worked its usual magic, consumers would get what they wanted, efficient producers of medical services would be rewarded, prices would be kept down, and quality and innovation would be encouraged.

There are multiple problems with this general view. For one thing, most

medical consumers are not free to shop around. In the age of managed care and medical underwriting, a patient with a serious illness who doesn't like her care is often simply stuck, because no other insurer will take her. For another, tens of millions of consumers cannot afford to buy health coverage. Further, most experienced physicians will question Herzlinger's breezy assertion that consumers of medical care are like consumers of other services who, given enough information, can shop for the services they desire.

People may be "consumers" when they are well and are shopping for elective or routine medical services, but they are "patients" when they get sick. Those with major illnesses or injuries do not and cannot shop around for what they want. They rarely know enough to choose their own treatment. They are dependent on professional help, and they rely on their physicians to provide it. Even very intelligent, well-informed people know better than to attempt self-diagnosis when they are in serious trouble. There are few "consumers" or "smart shoppers" in hospital emergency rooms or intensive care units. Healthy economists and MBAs who talk about medical care as if it were just another business haven't yet learned that lesson.

It is fine to encourage people to become better-informed "health consumers" in the choices they make in their physicians and their treatments. But Herzlinger pushes the point beyond its logical limits. The essence of the relationship between a sick patient and a physician is trust by the patient in the competence and beneficence of the physician, and a commitment by the physician to meet his or her professional fiduciary obligations to the patient. There is nothing like that in the commercial transactions between customers and vendors that take place in service industries, even when the service is technical and beyond the understanding of most customers. "Caveat emptor" may be the watchword in commerce, but it cannot apply in medicine.

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## **"FOCUSED FACTORIES"**

Herzlinger offers another idea that conforms more to ordinary commerce than to medical care—single-service firms and facilities. She recommends that general care hospitals and large integrated managed care companies be replaced wherever possible by what she calls "focused factories," specialized facilities and clinics devoted to one particular disease or surgical procedure—like diabetes or asthma, or hernia repairs or open-heart surgery. She claims these "carve-out" organizations would provide care more efficiently and cheaply than the old-fashioned multipurpose hospitals and clinics, and she believes they would make shopping for health care more convenient for customers. As Herzlinger envisions the future, these "focused factories" would compete vigorously for customers and, through market forces, would transform health care into a more consumer-friendly and affordable system. This new era is almost at hand, she says, despite the resistance of stuffy old medical school professors (she names me as an example), who resent outside interference in their traditional domain.

But Herzlinger's vision of "focused factories" for medical care will be criticized not just by old professors but by most clinicians. They know that diseases are usually not compartmentalized and that the sicker the patient is, the more important it is to deal with him or her as a whole human being, rather than as an ailing body part or organ. Patients often have more than one disease or, even when they have only one disease, they often have complications involving several organ systems. They cannot be properly

treated without considering the interrelations among the several parts and dealing with the whole person. Herzlinger briefly acknowledges this problem by suggesting that each "focused factory" should have on hand the specialists and facilities needed to manage the common complications of the disease upon which the institution is focused. But that simply integrates the care of one disease at the cost of fragmenting and duplicating the resources needed for the care of other diseases. Seriously ill patients are best treated by multispecialty teams of doctors, including primary care physicians and different kinds of specialists, and these teams should work together in one multipurpose inpatient facility.

While it may make sense to integrate care for particular problems within a general hospital, freestanding specialized institutions for single diseases or procedures are of dubious value, particularly when they separate inpatients from the hospital facilities they may need in unexpected emergencies. Every large hospital center has wings or floors that can function as "focused factories" for particular diseases, but they are still an integral part of a general hospital that can deal with any complication, whether or not it is based on the condition for which the patient first sought treatment. Narrowly specialized freestanding institutions are inherently risky for sick patients. This is not to say that no freestanding specialized facilities make clinical sense. Some kinds do, particularly those that treat relatively low-risk problems on an ambulatory basis. A few of the largest and most completely staffed cancer hospitals also can provide comprehensive care when it is needed. But if Professor Herzlinger means to suggest that most general care hospitals should be broken up into physically separated and independently managed "focused factories," she doesn't understand the medical purposes of a general hospital.

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## MEDICAL GENTRIFICATION

Having devoted most of her book to extolling the virtues of "market-driven" health care, Herzlinger spends only one chapter at the end on how to change the current private health insurance system to establish the market she envisions. Ironically, Herzlinger's market system is heavily dependent on government. She recognizes, quite correctly, that the present system of managed care does not allow the consumers of medical services to make their own choices with their own money. She is opposed to employers holding the money and making most of the choices of managed care plans for their employees. I share that view.

What she proposes, therefore, is a "tax-neutral," government-regulated transfer of health benefit funds from employers to employees ("based on the employee's health characteristics"), and a government requirement that employees use these funds to purchase a catastrophic health insurance policy to pay for all expenses beyond "what they can reasonably afford to pay out of their pockets." Government would also "assure the quality and availability of information about health care providers; and it would prosecute consumer and provider fraud." Large deductibles would encourage employees to shop carefully for their initial medical services each year because they would be spending their own money. Beyond that initial outlay, they would be comprehensively insured by policies they would choose themselves, using the funds paid to them by their employers.

Herzlinger gives only sketchy outlines of how her "consumer-controlled health insurance system" might work, and leaves many important questions

unanswered. Many of these questions are probably unanswerable. For example, how would government carry out all the complicated regulatory functions she lists? How would it adjust transfers according to the "health status" of an employee and his or her family? Risk adjustment for health status is not developed enough to ensure fair payment of this kind for coverage of an individual employee, let alone a family. How would government discourage low-income employees from delaying necessary care simply to avoid out-of-pocket expenses? And, once the deductible had been exceeded, what would prevent employees who chose an indemnity type of plan from overusing the insurance benefits and driving up premium costs? In short, Herzlinger fails to explain how the wide-open insurance market she advocates could be expected to work without extensive cost and quality controls by government that would inevitably constrain free choice by consumers. She cites the Federal Employees Health Benefits Program (FEHBP) as a model of what informed consumer choice can achieve, but she neglects to mention that the majority of the choices offered to federal employees (after careful screening by the government) are managed care plans—to which she is opposed.

Professor Herzlinger's book is unpersuasive largely because the consumer-driven market she envisions simply isn't compatible with the realities of medical care. Her proposal for reform also falls short because it doesn't deal with the whole health care system. Not surprisingly, given her profession, she focuses on the part of the system that is funded through employment-based insurance (by now, almost entirely under managed care). The other part, including Medicare and Medicaid and the growing army of the uninsured, is barely mentioned. This omission means that the book is mostly about medical services for the relatively young, healthy, educated, and employed members of society—like the author herself. Herzlinger's book is therefore not a proposal for general health care reform. It is instead a call for a kind of medical "gentrification"—a reconfiguration of the system to make it more accessible and convenient for those able to shop for what they want, and able to pay for it out of pocket.

Despite its obvious limitations, Herzlinger's book will probably appeal to the growing number of free-market enthusiasts who are becoming uncomfortable with the restraints and aberrations of the present managed care market. Managed care, in one form or another, may be the only viable alternative to the fee-for-service, indemnity-insured system it is replacing, but its present configuration is certainly not consumer-friendly. Furthermore, managed care plans have an inherent conflict of interest with the employees they are supposed to be serving. The less medical care a plan provides, the more of the premium the plan gets to keep. It is easy to understand why a backlash against managed care is growing so rapidly. Herzlinger's book will add strength to that protest, although it offers little in the way of practical solutions to the problem.

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## HEALTH V. WEALTH

The best current book about managed care is George Anders's *Health Against Wealth*. The author, a *Wall Street Journal* medical reporter, tells the story of "HMOs and the Breakdown of Medical Trust." He describes how physicians, unable to contain rising health care costs, lost control of the medical care system to a rapidly expanding managed care industry. That industry, increasingly owned by for-profit corporations, acts as a middleman between employers and the providers of health care. Employers have negotiated lower premiums with the HMOs, but the latter have drastically reduced payments to providers, thereby assuring high profits to themselves. The winners in this new system are the employers and the HMOs. The losers are the providers and the employees.

***Health Against Wealth* explains that the winners in the managed care industry are the employers and the HMOs. The losers are the providers and the employees.**

Managed care is often described as a "market" solution to the problem of health care costs, but it isn't much like the consumer-oriented market Herzlinger advocates. As Anders explains, the "market" in managed care is largely limited to the negotiations between employers and the managed care plans they choose for their employees. The real consumers of health care, employees, have little or no choice of plan, limited choice of physician, and—unless they want to pay the costs of seeking care outside their plan—virtually no opportunity to shop for the services they think they need.

Anders illustrates all of these limitations and predicts that the system will inevitably change. He is probably right. What will replace it is not at all clear at the moment. Anders suggests the next phase may be direct negotiation of managed care contracts between employers and the providers of medical care (physician groups and hospitals), thus bypassing the HMO companies. That would be an improvement over the present system, but it would still not allow the consumers of care to choose their own providers. Why should employers decide which doctors and hospitals their employees can use? Herzlinger is right in her objection to that arrangement, although the rest of her proposal for a consumer-driven, price-competitive market for medical care is unconvincing.

Both books make clear how far we still are from an equitable and workable health care system. To solve the manifold problems of health care in America, we will have to develop a system that deals with economic and medical realities while moving the responsibility for ownership back into the community and putting the reins of management in the hands of those who deliver and receive the care. Before we can reach that goal, we will have to accept the notion of health care as a social good rather than an economic commodity. What the public and the medical profession are learning from their current unhappy experience with commercialized medical care is that the free market cannot by itself produce the system we need. Sooner or later, we will realize that more regulation and new policies are required. What then happens will depend on how strongly physicians, patients, and not-for-profit community health care institutions press for real reform.

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# Protection of the Health Care Consumer: *The "Truth" Agency*

Regina Herzlinger

PPI Policy Report  
March 1999

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## 1. A Health Care SEC

I was stunned. Why were the frequent flyers on my plane applauding a movie? When I looked up, the answer was clear: the screen showed Helen Hunt's famous tirade against the HMO that denied adequate care to her sick son and ignored her suffering.<sup>1</sup>

The managed care backlash I had long predicted had clearly arrived.<sup>2</sup> Earnest elected representatives rushed to the rescue. Their remedies ran the gamut from mandated benefits to national health care quality standards.

Well intentioned? Sure. But in the light of day, reality strikes: Regulation is no sure-fire problem solver. Will new regulations solve the perceived managed care problems of inadequate care, excessive costs, and financial fragility? One can doubt their efficacy. Regulations can ossify institutions and suppress much-needed innovation, and they can be politicized.

Fortunately, another sector of the economy offers valuable lessons for effective resolution of similar problems. Although at one time it, too, suffered from lack of public trust and was thought to damage American consumers, it is now among the most admired parts of the U.S. economy, widely held up as an international model.<sup>3</sup>

"It" is the U.S. securities markets. They are appropriate reform models because both securities and health insurance policies are complex and purchased in similar ways--either directly, from the firm or broker, or indirectly, through a mutual fund or the employer. But while the markets for health insurance are widely viewed as failures, those for securities are viewed as successes. Why?

To my mind, the U.S. government's Securities and Exchange Commission (SEC) served as the handmaiden for the transformation of the securities markets. It did so by providing information and oversight, not through evaluation and micromanagement. A health insurance SEC that contains the essential features described below would replicate this success. With such an agency

in place, the health insurance markets would:

- **Disclose complete and reliable information.**
- **Contain fair prices for health insurance policies in the sense that they reflect all publicly available information.**
- **Protect consumers with information that helps them to redirect money from ineffective insurers that provide too little medical care for their price to insurers that give customers the quality and price they want.**
- **Lower the transaction costs of buying health insurance.**

These potential benefits would be enhanced if the choice of health insurance were in the hands of consumers instead of employers. In other publications, the Progressive Policy Institute and I have described reforms to increase consumer choice.<sup>4</sup>

In what follows, I will analyze the deficiencies of current efforts to protect health care consumers, the causes for the SEC's success, the characteristics of regulations most likely to replicate its salubrious effects in health insurance, and the transformation of the health insurance market that appropriate regulation can create.

I will discuss the characteristics of the SEC and its related private sector organizations in great detail because they are frequently misunderstood. God is in these details. Those who misunderstand them may convert the SEC from a positive overseeing organization that enhances disclosure to a negative evaluating agency that micromanages private sector organization

## **2. The Pipe Dreams of Patient Protection Legislation**

The many current patient protection bills, to varying degrees, rely on three mechanisms to solve the problems of managed care: Government-controlled information disclosure, standards for medical care, and mandated benefits. Superficially, they appear benign, even reassuring; but, as presently drafted, some pose a worrisome potential to cause harm.<sup>5</sup>

### **Government-Controlled Disclosure**

Substantial problems exist with providing consumer information in a sector that has little experience with public disclosure and that lacks widely accepted standards of measurement.

Many agree that, despite a firm scientific foundation, the art of health care quality measurement is in its infancy.<sup>6</sup> What to measure, how to measure and disseminate it, how to adjust for individual characteristics and severity of illness--these are but a few of the fundamental unresolved issues.<sup>7</sup> Small wonder then that consumers simply ignore presently available data. They correctly suspect the statistical reliability and data integrity of the measures.<sup>8</sup> Some data are irrelevant or deficient; for example, pooling all of us into a vast sea that neglects the significant differences among the information needs of the chronically ill, women, and the elderly,<sup>9</sup> or focusing exclusively on the clinical aspects of medical care and ignoring the busy U.S. consumer's interest in service convenience.<sup>10</sup> Moreover, consumers want specific, timely information so, when needed, they can readily identify the health professionals who can best treat them.

Such novel information will require many perspectives and considerable experimentation. It is unlikely to emanate from the agencies designated to implement an information policy under both Democratic and Republican proposals, such as the Departments of Labor and Health and Human Services. Because they both regulate and buy health care services, these agencies have an intrinsic conflict of interest. For example, regulators may unintentionally bias the information to focus only

on the intended impact of their regulations and not on unexpected, possibly pernicious, side effects. Moreover, government organizations often politicize standards. For example, in 1998, to mollify the powerful teachers union, the Massachusetts government lowered the "standard grade" it initially required of new teachers on a statewide examination to include 263 teachers who had failed the exam.<sup>11</sup>

Further, designation of any one agency as the sole source of information about health care is downright chilling. Consumers want multiple perspectives for their information. Investors, for example, choose from hundreds of excellent sources of information, ranging from Morningstar for mutual funds to easily available public media analysts. No one source is sufficient: even the estimable Consumer Reports' automobile ratings are unlikely to meet the needs of Harley-Davidson drivers. Similarly, consumer ratings of HMOs differed substantially from those of physicians.

## Medical Care Standards: Science v. Art

More worrisome is the insistence on national standards for the appropriate medical care for each patient. Some managed care plans are no doubt guilty of arbitrarily overruling doctors' judgments about patient care; but the proposed federal rules that purport to put providers back in charge of patient care may well have the opposite effect, creating more pressure to comply with increasingly rigid standards.

Useful standards are typically based on replicable empirical experiments and sound theoretical footings; for example, standards for metal fatigue, although imperfect, are, nevertheless, useful because of the advanced theory and practice of materials science. But, because many agree that present-day medicine is art more than science,<sup>12</sup> the requirement for standards is akin to specifying the width of Van Gogh's brush strokes.

Indeed, the insistence on national standards may curb critical innovation in the practice of medicine, such as the efforts of many research groups and professional societies to develop and disseminate standards of care and best practices.<sup>13</sup> Notes Dr. Robert Waller, the distinguished CEO of the Mayo Foundation, "Regulations put a stake in the ground that says, 'You have to meet that standard.' But what's quality on Monday is not what's quality on Tuesday."<sup>14</sup>

## Mandated Benefits

Many pieces of legislation contain a shopping bag full of mandated benefits, such as direct access to specialty care for women and children, to overcome a perceived reluctance by managed care to provide important needed services. The overseers of managed care know they must tackle the 20 percent of events that account for 80 percent of the costs.<sup>15</sup> For example, their 24-hour limit on a new mother's hospital stay may have been partially motivated by the 80-20 rule: There are four million births annually in the United States.<sup>16</sup>

These legislative mandates were primarily induced by consumer activists.<sup>17</sup> On an anecdotal basis, individual mandated benefits appear perfectly reasonable. Take Mary Jo Sadosky's complaint when, exhausted and in pain, she was asked to leave a hospital 12 hours after giving birth to twins. No wonder she fought for a ban against "drive-through deliveries."<sup>18</sup>

While one cannot argue with individual complaints like these, the overall strategy has undesirable effects. A one-size-fits-all medical care strategy is unlikely to prove cost effective because Mother Nature designed us in infinite variety. Worse yet, mandated benefits may suppress the innovations in medical care delivery that offer the best hope for improving its cost-effectiveness. For example, according to a 15-year study, a program of frequent, at-home visits by a nurse for low-income mothers lowered their rates of drug and alcohol abuse and dependency on welfare and the abuse rates of their children.<sup>19</sup> Will a health insurer that is forced to follow a one-size-fits-all mandate

invest in innovative programs to supplant it? Do not count on it.

To consider the pernicious impact of mandates on innovation, think about Dick Fosbury, the 1968 Olympic Gold Medalist in the running high jump. Unlike other jumpers who faced the bar, Fosbury backed into it and flopped 7 feet and 4-1/4 inches over it.<sup>20</sup> His unlikely innovation, the Fosbury Flop, is now routinely used.

But, imagine if well-intended Olympic officials had mandated forward-facing high jumps. Although they might have plausibly reasoned that backward jumps increase the chances of injury or are aesthetically unpleasing, the resulting bottom line--or, more correctly, the top line--no Fosbury flopping, no innovation.

### 3. What Works: Information Disclosure

Fundamentally, the primary complaint about the health insurance market is that consumers are not getting a good deal because they do not really know what they are buying. As a result, health insurers allegedly can offer too little health care for the money, skim off too much for themselves, or operate with excessively risky infrastructures. The paucity of information enables insurers that offer a bad buy to flourish. In contrast, many experts agree that the prices of publicly traded securities are fair, in the sense that they fully reflect the impact of all publicly available information.<sup>21</sup> The information reflected in these prices serves to redirect capital from ineffective firms to effective ones.<sup>22</sup> If health insurance markets operated like these "efficient" securities markets, consumers would have access to complete, reliable information and the prices of health insurance policies would reflect that information. Bad buys would become good ones.

#### Efficient Markets

The conclusion that securities prices reflect the impact of all information is surprising. After all, many individual owners of securities are incapable of fully evaluating the complex, publicly available information. How can they incorporate this information into the price?

At least two explanations for this seeming paradox exist.<sup>23</sup> First, the consensus estimate of a group on say, football game results, is generally better than the average knowledge of the individuals within the group. As Stanford's William Beaver explains, our individual evaluations are based on some kernel of valid knowledge and some idiosyncratic opinions. When we are grouped, our idiosyncratic opinions have little impact because they are not widely shared by other group members, while the kernel of truth within us is culled out as the group's consensus because it is shared by many other group members.<sup>24</sup>

Additionally, experts in the interpretation of information help investors to evaluate the price. Some experts' analyses are freely available through the mass media--TV, radio, newspapers, the Internet, and magazines--and to the clients of brokerage houses. The experts are themselves rated. For example, *The Wall Street Journal's* annual "All-Star Analysts" section evaluates the performance of analysts who specialize in different industries and the overall performance of their brokerage houses.<sup>26</sup> Other experts offer their skills through the mutual funds they manage. These experts, too, are rated in readily available and understood information such as the mutual fund ratings of *Forbes* and *Consumer Reports*.<sup>27</sup> Investors use this to reward recent good performers, by allocating more money to them, and less to poor performers.<sup>28</sup>

The growth in information retrieval services, especially the electronic information retrieval component which increased by over 100 percent in one year,<sup>29</sup> will support the continued efficiency of the market. These services are estimated to grow from their 1997 level of \$19.8 billion to \$42.4 billion in 2002.<sup>30</sup>

#### The SEC: The "Truth" Agency

Many knowledgeable observers contend the U.S. Securities and Exchange Commission (SEC) is a critical element of the efficiency of the securities markets.<sup>31</sup> (While the issues of state insurance commissioners and state vs. federal regulations are important, they are beyond the purview of this report.) (See Sidebar A.)

The SEC was created in 1934, to much fanfare, during the administration of U.S. President Franklin Delano Roosevelt, to correct the woeful abuses of small investors in the markets: insider trading, stock watering, nonexistent or misleading information, and outright fraud.<sup>32</sup> The hope was that the SEC would restore public confidence in the markets and succeed where lax, inconsistent, inadequately funded state "blue sky" regulations-- meant to check promoters who would sell "building lots in the blue sky"--had failed.<sup>33</sup>

Regulation of securities was not a new idea. As early as 1285, the English King Edward I required licensure of London brokers.<sup>34</sup> Much of this early regulation relied on authorities to evaluate the worthiness of a security before permitting its public sale.<sup>35</sup> But, from its inception, the SEC, unlike its predecessors, was not a "merit" agency. As Roosevelt noted: "The Federal Government cannot and should not take any action that might be construed as approving or guaranteeing that . . . securities are sound. . . ." Rather, the SEC was to insure full disclosure of all material facts about the securities. In Roosevelt's words, "It puts the burden of telling the truth on the seller."<sup>36</sup>

There was plenty of truth waiting to be told. At the time of the SEC's creation, there were minimal requirements for listing of securities on the stock exchange and no source of generally accepted accounting principles. Information disclosure was limited and not subject to oversight. In 1923, only 25 percent of the New York Stock Exchange firms provided reports to their shareholders.<sup>37</sup> Sound familiar?

To put teeth in its mission, the SEC was given the power to enforce "truth in securities" (the Securities Act of 1933) and to regulate the trading of securities in markets through brokers and exchanges (the Securities Exchange Act of 1934). Firms that trade their securities in inter-state markets must register with the SEC and file regular information reports. Exchanges and inter-state brokers must also be registered. The SEC also reviews the rules for market operations and requires that brokers meet minimum capital requirements and submit information about their transactions. The 1934 act also protects investors against deceptive practices.<sup>38</sup>

These SEC powers to regulate information and the functioning of the securities markets are key elements of the efficient U.S. markets.

### **The Private Sector Sources of Information**

The information that lies at the heart of the efficiency of the markets wells from the delicately balanced interaction among three private sector groups: the firms, the FASB (Financial Accounting Standards Board, the accounting information standards promulgator), and the accounting profession.

The presence of three different groups provides checks and balances and fuller consideration of diverse points of view. Unlike a government agency, this troika does not sing out of one hymnal. And their private-sector nature requires political and financial support for their continued existence. If they hit a sour note with their diverse supporters, they can, and have been, forced to change their ways.

The SEC recognized the following advantages of ceding some of its authority to disclose information to the private sector:<sup>39</sup>

- Practicing accountants were closer to the firms and thus could more accurately identify

emerging issues.

- The involvement of the private sector in creating disclosure requirements would encourage greater compliance than government mandates.
- The SEC could more readily audit the work of the private sector information disclosers than its own. Involvement of the private sector in disclosing information would resolve a conflict of interest for the SEC.<sup>40</sup>

## The Firm

Much of the information emanates from the firm itself: Organizations registered with the SEC must disclose both financial and nonfinancial information in routine reports, including the firm's financial statements; management's discussion and analysis of performance; disclosure of the top executives' compensation; and evaluation of the firm's various lines of business.

Although the firm's managers prepare this information, they must use the methods promulgated by the FASB and its predecessors to measure some financial statement items. (The SEC had legal authority to specify these accounting standards but, with active oversight, it generally relies on the FASB to do so.)<sup>41</sup> The managers hire an independent accounting firm to audit whether the financial statements have been prepared in accordance with the generally accepted accounting principles (GAAP) as defined by the FASB and others. The generally accepted auditing standards that guide the auditing process have been defined by the American Institute of Certified Public Accountants' Auditing Standards Board.<sup>42</sup> The auditors render a formal opinion of the firm's financial statements. If the information deviates from GAAP, or if the auditor cannot issue a clean opinion for other reasons, the SEC may well suspend trading in the stock and thus bar the firm from access to the capital markets.

## The FASB

Because the FASB is a private, nonprofit organization, it lacks the stability of tax-financed government organizations. To survive, it must earn sufficient revenues to cover its expenses and the respect of its constituency. These results are not so easily achieved: Two predecessor organizations to the FASB folded in part because they could not reach a politically acceptable consensus on specific accounting standards.<sup>43</sup>

The FASB was designed to remedy some of the structural problems of its predecessors.<sup>44</sup> Unlike them, it was an independent, well-funded organization, sponsored by a nonprofit foundation whose board represents auditors, businesses, users, and the public.<sup>45</sup> Its \$16 million in 1997 operating revenues were derived primarily from publication sales and secondarily from contributors, such as accounting groups and private sector businesses.<sup>46</sup> To provide independence, the FASB's board members serve a full-time, five-year term at handsome rates of pay.<sup>47</sup> Although they are all well-versed in accounting, they come from diverse backgrounds, including large and small accounting firms, financial analysts, accounting academics, and industry.<sup>48</sup>

In recognition of the political, consensus-building nature of its mandate, the FASB's process for issuing an accounting standard elicits widespread, thoughtful responses. The process is completely public and repeated rounds of exposure drafts encourage wide participation.

As a result of the open, elaborate standard-setting process, FASB's standards incorporate diverse points of view in an acceptable political consensus. This process is crucial to the FASB's success. Although accounting techniques were codified in 1494 by the mathematician Luca Pacioli,<sup>49</sup> as in health care, a conceptual foundation that can clearly adjudicate all measurement disputes still does not exist.<sup>50</sup> As a FASB chairman noted, "Accounting, like law, is an art whose rules are not

susceptible to. . . tests of validity. . . accounting is rather a convention supported by general acceptance, consensus."<sup>51</sup>

## **The Accounting Profession**

The independent accountants who audit the financial statements represent yet another important check and balance in the process of providing market information.

Certified accountants are professionals who must fulfill stringent examinations and educational requirements.<sup>52</sup> They frequently work in one of the Big Five accounting firms which, in 1996, audited nearly 80 percent of publicly traded firms.<sup>53</sup> Accounting firms can be held legally liable for negligence, fraud, and breach of contract.<sup>54</sup> One firm, for example, was required to pay up to \$110 million to the creditors of the bankrupt DeLorean Motor Co. for negligent auditing, on top of a private \$35 million payment to the British government.<sup>55</sup> Accountants have been found criminally liable for misstatements in cases even where they did not directly benefit from them.<sup>56</sup>

Accountants are thus subject to three powerful pressures: Their profession's standards of ethics,<sup>57</sup> the marketplace (accountants must satisfy their clients, the corporations that hire them), and their legal liability.

## **Impact of the Private Sector on the Quality of Information**

The managers who prepare a firm's information disclosures are subject to many checks and balances. On the one hand, they may prepare financial statements and other information disclosures that reflect their distinctive economic circumstances. Although they must use FASB standards, these are typically not straitjackets: Similar firms may account for similar circumstances in substantially different ways.<sup>58</sup> On the other hand, corporate executives face substantial legal liabilities and the wrath of the SEC for failure to disclose material events. And if their auditor decides to resign or they decide to switch auditing firms, the SEC requires a public filing and explanation of the reason for the change.<sup>59</sup>

Although this process can, and likely will, be altered, two characteristics are central to its success.<sup>60</sup> First, the private sector organizations must satisfy their constituencies or, like the FASB's predecessors, they will cease to exist. Second, the many participants in the process serve to promote the perspectives of diverse interest groups that are essential for fair and complete information disclosure.

## **4. The Users of Information: The Markets**

The SEC's oversight of the markets in which securities are traded also helps to promote their efficiency. These markets are roughly analogous to the markets in which employers purchase insurance on behalf of employees because, as in the health insurance markets, people invest through registered brokers. The analogy is limited, of course, because unlike investors who could choose their own brokers and the securities they wish to purchase, most employees currently have only a limited choice of insurance options. Nonetheless, employers run the risk of an unhappy workforce if they ignore their employee's preferences when selecting coverage.

### **Different Strokes for Different Folks**

The securities markets' efficiency has not been achieved through cookie-cutter SEC market requirements. The many markets in which securities are traded have traditionally differed considerably in their operations. For example, prior to their merger, the American Stock Exchange (Amex) used a central specialist auction system of trading, while the Nasdaq relied on dealers networked by computers. The rules for market participation differed too.<sup>61</sup> Not

surprisingly, the exchanges differ in their successes. The Nasdaq options trading foray failed but its 1997 stock trading volume amounted to 648 million shares daily. Conversely, the Amex accounted for a whopping 25 percent share of the options market, but traded only 25 million shares daily.<sup>62</sup>

The vast amount of public information about these markets enables the intensive scrutiny that improves their efficiency. For example, a critical academic analysis of the bid-ask price spread on the Nasdaq prompted an SEC investigation and ultimately findings of price rigging. In response, the Nasdaq agreed to spend \$100 million to improve its regulation<sup>63</sup> and investors are likely to reap more than \$1 billion in settlement of a class-action suit.<sup>64</sup> The information also helps Congress to monitor the markets. U.S. Rep. John Dingell's (D-MI) investigation of a Nasdaq company whose stock price plummeted ultimately caused the SEC and Nasdaq to improve their operating procedures.<sup>65</sup> The best, and most important, monitor is the public. As the New York Times noted, ". . . It is the rising power of [average amateur American investors pouring their money into mutual funds and retirement accounts that have made] the fairness of stock trading systems a populist political issue. . . . Advances in technology have made it far easier for regulators, professional investors, and even amateurs to figure out who is getting a fair shake."<sup>66</sup> By August of 1998, the SEC received 120 daily e-mail messages from the suspicious on-line investors who were the agency's largest source for Internet investigations.<sup>67</sup>

## Competition

Competition among sellers of securities also increases the fairness of the prices on the markets, abetted by the SEC's deregulation of fees.<sup>68</sup> For example, when the firm E\*Trade first established its own Web site for on-line stock trading, its low \$14.95 commission quickly attracted millions of trades. But, by April of 1998, E\*Trade's on-line competitors had cut commissions to less than \$10 a trade.<sup>69</sup> And when the SEC forced the Nasdaq to open its data systems on bid-ask spreads and to permit private trading systems to post their prices on Nasdaq's system, a new breed of "guerrilla marketmakers" emerged. As the profit margins of traditional marketmakers plunged, decreasing by nearly 50 percent in the period 1993- 1997, investors saved \$20 billion in 1997.<sup>70</sup>

Such competition is spurred by comprehensive, easily available evaluations of transaction costs. For example, SmartMoney's Interactive Web site recently ranked Brown & Co. the "best on price," with a commission charge of only \$5 a trade, while Charles Schwab was rated the "worst" with a commission of \$116.06 for the same transaction. Nevertheless, in the first quarter of 1998 Schwab claimed that it grew probably more than all the discounters and on-line firms added together.<sup>71</sup> Why? Likely because consumers value the research and other services it offers.<sup>72</sup>

The impact of information on these favorable market characteristics is highlighted by an analysis of security markets in developing countries. It revealed that in early stages of market development, improvements in information convinced creditors to lend more. As the markets matured, firms substituted equity for debt financing. The overall impact of the information was to lower the cost of both debt and equity capital.<sup>73</sup>

## 5. How to Make it Happen: Translating the Lessons of the SEC to the Health Insurance Market

The U.S. securities markets are successful in precisely the ways that health insurance markets should replicate:

- Prices are fair in the sense that they reflect all publicly available information, despite the inability or unwillingness of many buyers to avail themselves of this information.
- Buyers use this information to redirect capital so that it rewards productive firms and

penalizes unproductive ones.

- Information and competition continually reduce the transaction costs of buying securities.

## Societal Consequence of SEC-like Regulation

The presence of these characteristics in the health insurance market would achieve two important social goals:

*First*, they would divert capital from health insurers that offer a bad buy to those that offer a good one. The bad buy insurers would shrink or improve. The good buy insurers would flourish.

Currently, many complain that health insurance is a bad buy. The allegations take a number of forms: Too little is expended for medical care and service <sup>74</sup> --unfair, inconvenient, horrific restrictions abound; too much is spent on administrative salaries and returns to capital; and, paradoxically, too little is returned to capital.

These complaints cannot be easily evaluated. Wharton's Professor Patricia Danzon convincingly pegs the administrative costs of large-firm insurers at 5.5 percent to 30 percent or more for firms with 20 or fewer employees. Are these excessive? Single-payer advocates maintain that administrative expenses, which they estimate at 25 percent-48 percent, are a dead loss; but Danzon contends that competition among insurers likely lowers costs and inhibits adjustment of premiums at the consumers' expense.<sup>75</sup> (Although the appropriateness of administrative expenses appears moot, the hefty compensation of some HMO executives takes one's breath away. While Oxford Health Care's providers were left languishing for payment,<sup>76</sup> the 1996 compensation of its CEO was \$29 million and the total compensation of the top five executives was \$58 million, exclusive of unexercised stock options.<sup>77</sup> A study by Graef Crystal, a noted compensation expert, concluded that managed care companies paid their CEOs 62 percent more than other comparable-sized firms and 35 percent more than their stockholder performance warranted.<sup>78</sup>)

Complaints about the industry's excessive profitability ignore the industry's risk--after all, a deep sea diver should be paid more than a bank clerk to compensate for risk--and were not as relevant recently when many managed care organizations were operating at a loss, as in 1994 when the ostensibly nonprofit Kaiser Permanente earned a 6.7 percent profit and, in 1995, when Oxford earned a 5.2 percent rate.<sup>79</sup> And yet, paradoxically, some health insurers were severely undercapitalized.<sup>80</sup> For example, the \$39 million 1992 capital balance of New York's mammoth \$7 billion Empire Blue Cross- Blue Shield <sup>81</sup> was comparable to an elephant's balancing on the edge of a razor blade.

Complaints like these are not unique to the health insurance sector. The U.S. automobile sector, too, was characterized by years of poor quality ratings; doubt about its leadership; and serious concerns about the financial stability of Chrysler.<sup>82</sup> But U.S. automobile consumers could act more decisively than health insurance consumers because of the widespread availability of quality and price information. The information redirected capital from bad buys (U.S. cars) to better buys (foreign ones). Nor was the process static. Poor results caused dramatic improvement in the quality-to-price ratio of U.S. cars, Chrysler became a strong company,<sup>83</sup> and weak dealers disappeared.<sup>84</sup> All in all, information improved the entire sector.

Similar results were obtained when New York State required the collection and dissemination of risk-adjusted mortality rates for hospitals and surgeons for coronary bypass surgeries. As a result, statewide mortality rates dropped.<sup>85</sup> Widespread availability of information will similarly impact the health insurance market. Insurers that offered inappropriate quality or risk relative to their cost would shrivel or improve; health insurers that offered good buys would flourish.

*Second*, they would reward and punish effective and ineffective purveyors of health insurance.

Currently, the magnitude of transaction costs for purchasing health insurance is a bit of a mystery. One health insurance broker estimates the expense of designing policies, communicating and advising enrollees, and handling renewals for a 40-person company between 2 percent to 2-1/2 percent of the total costs. When pressed for more specific data, he said, "Asking about this kind of stuff is like asking the military for their nuclear weapons plans. It is not top secret--or it should not be--but it is treated that way."<sup>86</sup> Tracking down comparable prices for health insurance policies is also a major research undertaking.

Contrast this mysterious effluvium with the clarity of information about the transaction costs and prices of securities. For example, the online broker E\*Trade openly compares its transaction costs with those of other brokers.<sup>87</sup>

In the securities markets, investors can readily evaluate the services offered by their brokers relative to their costs. As a result, discount brokers flourished and full-price brokers were forced to offer their customers additional services, such as proprietary research and analysis.<sup>88</sup>

If purchasers of health insurance could readily access comparable transaction cost and price information, they, too, would benefit from competition among brokers. Some would offer only low prices, while others would provide extensive research analysis of the merits of various policies, among other services, to justify their fuller price. If these analyses were publicly available, the health insurance analysts would be rated with evaluations comparable to the *Wall Street Journal's* "All-Star Analysts" list.

## How To Make It Happen

The key to achieving these desirable characteristics in the health insurance market is legislation that replicates these essential elements of the SEC model:

- **Registration:** The SEC requires firms that want to trade their securities in interstate markets and all such market-makers to register with the agency. A corresponding health care agency would oversee the integrity and require the public disclosure of information for health insurers, the policies they issue, the services they provide, and the interstate markets in which such insurance policies are sold. It would be armed with powerful penalties for undercapitalized, unethical, misleading, and fraudulent market participants.
- **Private Sector Disclosure and Auditing:** The SEC relies heavily on private sector organizations to supply financial and nonfinancial information, standardize its measurement, and audit its integrity. The new health care agency would delegate the powers to derive measurement principles to an independent, private nonprofit organization that, like the FASB, represents a broad constituency. The agency would require auditing of the information by independent professionals, who would render an opinion of the information and bear legal liability for misstatement and full disclosure.
- **Private Sector Analysis:** The evaluation process is primarily conducted by private sector analysts, who disseminate their reasoning and frequently divergent ratings. To encourage similar private sector analysts, the new health care agency would require public dissemination of all health insurance prices and related transaction costs, and the characteristics of the policies, such as quality and customer satisfaction.

## How Not to Make It Happen

Unfortunately, many of the well-intended proposals to achieve patient protection undermine one or more of these essential characteristics. (See Sidebar B: *The Real McCoy*.) All too often, the health care regulator(s) would evaluate and micromanage health insurers and the markets in which they operate. Many would grant the government regulator substantially greater powers

than those exercised by the SEC.

- **Government-controlled Disclosure:** Disclosure requirements would be prepared by governments, not the private sector. The open FASB process that incorporates professional criteria and the perspectives of many different interest groups would likely be compromised with government promulgation of the measurement yardstick. After all, while the FASB's private sector status requires the respect and financial support of many constituencies for its continued survival, these are much weaker motivational forces for a government agency.

*One voice may be substituted for many.*

- **Government-controlled Analysis:** In many proposals, the agency will prepare benchmarks or standards of achievement, sometimes even a report card. When health insurers and brokers are thus required to sing out of the same hymnal, innovations in health care may not be recognized and may well be discouraged. And the importance of the many analysts who provide evaluations to investors will be curtailed.

*One perspective may override those of many.*

- **Government Micro-management:** Many proposals require health insurers and insurance markets to comply with enormously detailed managerial requirements. The likely result? Lack of innovation. Wave good bye to the Dick Fosburys of health services and insurance.

*One managerial vision will be substituted for many entrepreneurial ones.*

All of this is not to say that government action is not required. To the contrary, the much-abused U.S. health care consumer needs, and wants, government protection.<sup>89</sup>

But the present crop of patient protection bills is unlikely to fully achieve the results in the health insurance markets that the SEC legislation achieved in the securities markets. Indeed, it may inadvertently cause government protection to cross the line from providing helpful information and oversight to causing paralyzing evaluation and micromanagement.

God is in the details.

## **Sidebar A:**

### **Is Government Needed for an Efficient Market?**

Is government regulation of information disclosure essential to the efficiency of markets?

In a classic 1964 article, the great University of Chicago economist George Stigler answered that question with a resounding "no."<sup>a</sup> In this view, information is like any other competitive asset: If it is beneficial to the firm, its managers will advertise it; if it is detrimental, the firm's competitors will trumpet it; and, if it exists, whether good or bad, analysts will ferret it out. No need for the government in this arena.

As is usual in works of such significance, Stigler's and similar analyses were widely criticized<sup>b</sup> and other credible studies reinforced the important role of the SEC. For example, an analysis of the pricing of initial public offerings of stocks demonstrated that SEC requirements had a significant downward effect on the prices.<sup>c</sup> Despite the unusually abundant presence of intelligent research, this issue cannot be settled solely on the basis of empirical analyses. Is there a theoretical basis for government's presence in the information market?

To my mind, two compelling reasons exist. First, the public good nature of information disclosure enables free riders to benefit without paying its costs. When information is disclosed to the public, everyone can benefit from it. Because the disclosers cannot price the information on the basis of the benefits that these users derive from it, they lack incentives for full disclosure.<sup>d</sup> As an example, some corporate executives have complained that the competitive information in FASB's line-of-business disclosure benefits the firm's rivals, with little net benefit to the stockholders.<sup>e</sup> Clearly, if left to their own devices, these executives may not disclose this important information. Absent government regulation, the quantity of publicly available information will be undersupplied.

Then too, absent regulation, disclosure may favor some recipients and exclude others.<sup>25</sup> Such selective discrimination, however temporary, violates our national notions of equity. Regulations that penalize insider activity and require simultaneous dissemination of information level the playing field.

Some also argue that the government disclosure of public information may cost less than the sum of the costs of many private disclosures of the same information. But if the economies of collective action are so powerful, an industry group could attain them as well as a government organization. f

### Endnotes for Sidebar A

a. George J. Stigler, "Public Regulation of the Securities Market," *Journal of Business*, April 1964, pp. 117-142. Reprinted in Gary John Previts, *The Development of SEC Accounting* (Reading, Mass.: Addison-Wesley, 1981), pp. 143-170.

b. For a similar analysis see George Benston, "Required Disclosure and the Stock Market: An Evaluation of the Securities and Exchange Act of 1934," *American Economic Review*, vol. 63, no. 1 (March 1973), pp. 132-155. For critiques, see, for example, Nicholas Dopuch, "The Capital Market, The Market for Information, and External Accounting," *Journal of Finance*, vol. 31, no. 2 (May 1976), pp. 611-630 and Edward Deakin, "Accounting Reports, Policy Interventions, and the Behavior of Securities Returns," *Accounting Review*, vol. 51, no. 3 (July 1976), pp. 590-603.

c. Sela Tinic, "Initial Public Offerings," *The Journal of Finance*, vol. 43, no. 4 (September 1988), pp. 818-819.

d. Joseph E. Stiglitz, Jaime Jaramillo-Vallejo, Yung Chal Park, "The Role of the State in Financial Markets," *World Bank Research Observer*, 1993, pp. 16-61.

e. Jill Dutt, "Unlikely Adversaries: Top Regulators in Dispute Over Plan to Change Accounting Rule on Derivatives," *The Washington Post*, August 24, 1997, p. H1.

f. William H. Beaver, *Financial Reporting: An Accounting Revolution* (Englewood Cliffs, N.J.: Prentice Hall, 1989), p. 191.

## Sidebar B: The Real McCoy

For example, in "Promarket Regulation: An SEC-FASB Model," Lynn Etheredge proposes a SEC-FASB mechanism for the health care market.<sup>a</sup> While his general proposal is fine--health information is virtually an oxymoron today and markets cannot function efficiently in the absence of information--his detailed specifications for the health care analogue to the real SEC may not replicate the results achieved in the securities markets.

The SEC provides the environment for what I dubbed **DADS** in a *Harvard Business Review* article, "Can Public Trust in Nonprofits and Governments Be Restored?": It facilitates the **d**isclosure of information, the **a**nalysis of that information by management, and the ready **d**issemination of that information to all market participants through its power to inflict painful sanctions against corporations that seek capital but that fail to disclose, analyze, and disseminate information about their performance.<sup>b</sup> Etheredge's version of the SEC-FASB model blurs the distinctions between information and evaluation, between oversight and micromanagement. For example, as his analogue to the FASB, he proposes a Health Care Quality Assessment Board to evaluate quality, and he would require his analogue to the SEC to evaluate health care benefits and problems in coverage.<sup>c</sup> But the real FASB does not assess the quality of the output produced by corporations, nor does the real SEC evaluate whether the markets for the products that corporations sell yield effective, efficient outputs. Instead, they ensure the provision of reliable, useful information that participants in the market can use to perform their own analyses.<sup>d</sup>

This misinterpretation is more widely held. For example, a senior health plan official said: "If a FASB-like board had been around during the furor over how long new mothers can stay in the hospital . . . we would have brought forth research, looked at the pros and cons and had a much more reasoned debate. . . ." <sup>e</sup> Notes a leading accountant: "To think that the FASB would have something to say about length of stay is pretty farfetched."<sup>f</sup>

## Sidebar B: Endnotes

a. Lynn Etheredge, "Promarket Regulation," *Health Affairs*, vol. 16, no. 6 (December 1997), pp. 22-25.

b. Regina E. Herzlinger, "Can Public Trust in Nonprofits and Governments Be Restored?", *Harvard Business Review*, vol. 74, no. 2 (March/April 1996), pp. 97-107.

c. Lynn Etheredge, op. cit.

d. See, for example, Regina E. Herzlinger and Denise Nitterhouse, *Financial Accounting and Managerial Control for Nonprofit Organizations*, (Cincinnati, Ohio: South-Western, 1994).

e. Marilyn Werber Serafini, "Micromanaged Care?" *National Journal*, vol. 29, no. 50 (December 17, 1997), p. 2506.

f. Correspondence, Robert Forrester, Pricewaterhouse Coopers, to Regina E. Herzlinger, January 18, 1998.

## Endnotes

1. Regina E. Herzlinger, "Healthy Competition," *The Atlantic*, vol. 268, no. 2 (August 1991), pp. 69-81, and "The Quiet Health Care Revolution," *The Public Interest* (Spring 1994), pp. 72-90.

2. *Ibid.*

3. William H. Beaver, *Financial Reporting: An Accounting Revolution* (Englewood Cliffs, N.J.: Prentice Hall, 1989), pp. 130-162.

4. Regina E. Herzlinger, op. cit., and David B. Kendall, "Better Luck Next Time: Moving Beyond Partisan Posturing over Patients' Rights" and "President Clinton's Medicare Buy-in: Right Goal, Wrong Program," (Washington, DC: Progressive Policy Institute, October, 1998 and February, 1998).

5. While my purpose is to specify the desirable characteristics of government regulation and not to criticize individual pieces of legislation, I would like to identify the leading bills introduced in the 105th Congress: "Patients' Bill of Rights Act of 1998" (H.R. 3605 and S. 1890), Rep. Dingell (D-Mich) and Sen. Daschle (D-S.D.); "Patient Protection Act of 1998" (H.R. 4250), Rep. Hastert (R-Ill); "Patients' Bill of Rights Act" (S. 2330), Sen. Nickles (R-Okla); "Promoting Responsible Managed Care Act of 1998" (S. 2416), Sen. Chafee (R-R.I.).

6. Mark R. Chassin and Robert W. Galvin, "The Urgent Need to Improve Health Care Quality: Institute of Medicine National Roundtable on Health Care Quality," *Journal of the American Medical Association*, 280, no. 11 (September 16, 1998), p. 1000.

7. See, for example, Steve Isaacs, "Consumers' Information Needs: Results of a National Survey," *Health Affairs*, vol. 15, no. 4 (Winter 1996), pp. 31-41.

8. Susan Edgman-Levitan and Paul Cleary, "What Information Do Consumers Want and Need?," *Health Affairs*, vol. 15, no. 4 (Winter 1996), p. 45.

9. Anne Tumlinson, Hannah Bottigheimer, Peter Mahoney, Elliot M. Stone, and Anne Hendricks, "Choosing a Health Plan: What Information Will Consumers Use?," *Health Affairs*, vol. 16, no. 3 (May/June 1997), pp. 229-238.

10. See Regina E. Herzlinger, *Market-Driven Health Care* (Reading, Mass.: Addison-Wesley, 1997), Chapters 1 through 4, for descriptions of busy and intelligent health care consumers and Edgman-Levitan and Clearly, op. cit., for their information interests, pp. 45 and 52-53. Linda O. Prager, "Fee-for-service Plans Tops Among Doctors in Most Markets," *American Medical News*, October 12, 1998, p. 13.

11. Carey Goldbert, "Massachusetts Retreats on Threshold for Teacher Test, Flunking Nearly 600," *New York Times*, July 2, 1998, Sec. A, p. 12, col. 1.

12. Regina E. Herzlinger, op. cit., "Medicine: Art or Science?," *Market-Driven Health Care*, pp. 71-76.

13. Michael L. Millenson, *Demanding Medical Excellence* (Chicago, Ill.: University of Chicago Press, 1997).

14. Geri Aston, "Congress At Odds Over Managed Care," *American Medical News*, March 23/30, 1998, p. 12.

15. Regina E. Herzlinger, op. cit., *Market-Driven Health Care*, pp. 184-186.

16. Health United States 1996-97 (Washington, D.C.: Government Printing Office, 1998), p.83.

17. George J. Annas, "Women and Children First," *New England Journal of Medicine*, vol. 3, no. 24 (December 14, 1995): 1647-51.

18. Julie Miller, "Mother and Newborn: How Long in the Hospital," *New York Times*, August 20, 1995, Section 13CN, p. 1.

19. Harriet Kitzman, David L. Olds, Charles R. Henderson, Carole Hanks et al., "Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing," *Journal of the American Medical Association*, vol. 278, no. 8 (August 27, 1997), pp. 644-652. David L. Olds, John Eckenrode, Charles R. Henderson, Harriet Kitzman et al., "Long Term Effect of Home Visitation on Maternal Life Course and Child Abuse and Neglect," *Journal of the American Medical Association*, vol. 278, no. 8 (August 27, 1997), pp. 637-643.

20. *The Information Please Almanac*, "Sports--The Summer Olympic Games" (Boston: Houghton-Mifflin, 1993), p. 898.

21. In statistical terms, the concept of the efficient market hypothesis assumes that investment returns are serially independent and that their probability distributions are constant through time. The interpretation of the efficient market hypothesis has evolved to mean that if a market is efficient with respect to information, an investor is playing a fair game, meaning that prices behave as though everyone had access to the same information. (Eugene Fama, "Efficient Capital Markets: A Review of Theory and Empirical Work," *Journal of Finance*, vol. 25, no. 1 (1970), pp. 383-417. William H. Beaver, *Financial Reporting: An Accounting Revolution* (Englewood Cliffs, N.J.: Prentice Hall, 1989), pp. 130-152. Burton Malkiel, *A Random Walk Down Wall Street: Including a Life-Cycle Guide to Personal Investing* (New York: W.W. Norton & Company, 1996), p.3. William H. Beaver, *Financial Reporting: An Accounting Revolution* (Englewood Cliffs, N.J.: Prentice Hall, 1989), pp. 130-162.

22. This is not to say that the market is always right, but rather that it reflects all the information publicly available at that time.

23. Eugene Fama first proposed three definitions or standards to test the efficient market hypothesis: weak, semi-strong, and strong. The strongest form of the efficient markets hypothesis asserts that all information known by market participants is fully reflected in market prices so it is impossible for insiders who trade on private information to earn abnormal profits. (Maurice A. Joy, "Hunting the Stock Market Snarks," *Sloan Management Review*, vol. 3, no. 28 (Spring 1987), p. 22. Eugene Fama, "Efficient Capital Markets," op. cit.) While it is not impossible for insiders to profit from information, for the most part, the stock market comes very close to meeting the strongest standard for efficiency (Joy, op. cit. See also, for example, Michael Jensen, "The Performance of Mutual Funds in the Period 1945-1964," *Journal of Finance*, vol. 42, no. 2 (May 1968): 389-416; and Michael Jensen, "Risk, the Pricing of Capital Assets, and the Evaluation of Investment Portfolios," *Journal of Business*, vol. 42, no. 2 (April 1969): 167-247).

24. "Here's How Our Staff Picks em," *Chicago Daily News*, November 25, 1996, p. 43; November 24, 1967, p. 38), and November 29, 1968, p. 43. As cited by Beaver, *Ibid.*, p. 150.

25. Eventually investors will share this information. For example, if you have special knowledge of IBM's rosy future and buy a large amount of its stock, I can learn about your purchase. I can then judge what circumstances motivated you and buy the stock for myself. But you will have a temporal advantage over me, because you learned this special information before I did.

26. "All-Star Analysts," *Wall Street Journal*, June 30, 1998, pp. R1-R15.

27. Interested investors can compare annual evaluations of mutual funds published in financial and consumer magazines such as *Forbes* (February 10, 1997), *Money* (March 1998), and *Consumer Reports* (March 1998) or they can turn to mutual fund newsletters such as "Morningstar" and "Valueline" for quarterly updates.

28. Richard A. Ippolito, "Consumer Reactions to Measures of Poor Quality: Evidence from the Mutual Fund Industry," *Journal of Law and Economics*, vol. 35, no. 1 (April 1972), pp. 45-70. Burton G. Malkiel, *A Random Walk Down Wall Street* (New York: W.W. Norton & Company, 1996), pp. 443-444. Also, Michael Jensen. "The Performance of Mutual Funds in the Period 1945-64," *Journal of Finance* 23 (May), pp. 389-416.

29. *U.S. Industry and Trade Outlook 1998: Information Services* (Washington, D.C.: U.S. Department of Commerce, 1998), pp. 26-28.
30. U.S. Department of Labor, *SIC Description for 7375: Information Retrieval Services*, [www.osha.gov/cqi-bin/sic/sicser7375](http://www.osha.gov/cqi-bin/sic/sicser7375).
31. See, for example, Joel Seligman, *The Transformation of Wall Street* (Boston: Northeastern University Press, 1995), pp. 561-568.
32. Fred Skousen, *An Introduction to the SEC* (Cincinnati, Ohio: South-Western Publishing, 1991), p. 118. U.S. Securities and Exchange Commission, "Good People, Important Problems and Workable Laws: 50 Years of the Securities and Exchange Commission" (Washington, D.C.: The Commission, 1984).
33. Joel Seligman, *op. cit.*, pp. 44-46.
34. Fred Skousen, *op. cit.*, p. 2.
35. Arguably the most famous, or notorious, of this kind of regulation was the 1720 Bubble Act that required the personal approval of the English monarch for all corporate charters. The act resulted from the financial panic induced by the pricking of a speculative bubble that had buoyed the stocks of many newly incorporated English firms. In 1720, the South Sea Company's stock, for example, rose from £130 to more than £1,000, only to collapse when the company's directors began to sell their shares (Burton G. Malkiel, *op. cit.*, pp. 40-44).
36. Joel Seligman, *op. cit.*, pp. 54-55.
37. Joel Seligman, *op. cit.*, pp. 43-48.
38. Fred Skousen, *op. cit.* pp. 22-28.
39. Richard E. Baker, "Accounting Rule-Making--Still at the Crossroads," *Business Horizons*, vol. 19, no. 5, October 1976, p. 66.
40. Nevertheless, although the SEC *does not* dictate substance, it *does* have substantive gatekeepers who oversee the integrity of the firms, their securities, and the markets in which they sell their securities and severely penalize those that transgress. For example, to enforce the probity and integrity of securities and those who sell them, the SEC required one stock-one vote and anti-dilution rules and full disclosure of the riskiness of securities to vulnerable investors.
41. Paul W. Miller, Rodney J. Redding, and Paul R. Bahnson, *The FASB: The People, the Process, and the Politics* (Burr Ridge, Ill.: Richard D. Irwin, 1994), pp. 20-21.
42. Coopers & Lybrand, "Independence Standards Board," *Audit Committee Update 1998* (Jersey City: Coopers & Lybrand, 1998), pp. 20-21.
43. The Accounting Principles Board (APB), the FASB's immediate predecessor, collapsed in 1973, in some measure because of disagreement with its proposed accounting treatment for business combinations and an earlier opinion on tax credits. In the latter case, the APB proposed to defer recognition of some of the benefits of the credit. Although the APB's standard conformed with accounting theory, three accounting firms announced they would not comply with the opinion. Even the SEC decided that its registrants need not follow it. Absent the support of business, the accounting community, and the SEC, the APB found its authority to set accounting standards severely eroded (Gary John Previts and Barbara Dubis Marino, *A History of Accounting in America* (New York: John Wiley, 1979), pp. 290-291). Some also worried about the APB's excessively close ties to the accounting institute; its sponsors; its large, 17-member board; and the continued allegiance of its part-time board

members to their employers or clients (Paul W. Miller, Rodney J. Redding, and Paul R. Bahnson, *The FASB* (Burr Ridge, Ill.: Richard D. Irwin, 1994), p. 56. Marshall S. Armstrong, "The Politics of Establishing Accounting Standards," *The Government Accountants Journal*, vol. 25, no. 2, Summer 1976, pp. 8-13.

44. Paul W. Miller et. al., *op. cit.*, pp. 30-58.

45. Paul W. Miller et al., *op. cit.*, p. 35.

46. Financial Accounting Foundation (FAF), *Annual Report 1997* (FAF: Norwalk, Connecticut, 1998); *Guide Star--Financial Report* (Washington, D.C.: Philanthropic Research Inc., 1998). Stephen Barr, "FASB Under Siege," *CFO*, vol. 10, no. 9 (September 1994), pp. 34-46.

47. Financial Accounting Foundation, *op. cit.*, p. 24.

48. Stephen Barr, *op. cit.*

49. Gary John Previts and Barbara Dubis Merino, *A History of Accounting in America: An Historical Interpretation of the Cultural Significance of Accounting* (New York: Wiley, 1979), p. 6.

50. Although such a conceptual foundation theoretically exists--currently, it takes the form of six concept statements that cover issues such as the Elements of Financial Statements (Cheri L. Reither, "How the FASB Approaches a Standard-Setting Issue," *Accounting Horizons*, vol. 11, no. 4 (December 1997), pp. 91-104) in practice, debates about fundamental accounting issues--such as current vs. historical costs value or capitalization vs. expensing--continue to roil the profession (Miller, *op. cit.*, "Some Recurring Accounting Controversies," pp. 114-127).

51. Marshall Armstrong, *op. cit.*, p. 10.

52. U.S. General Accounting Office (GAO), *The Accounting Profession* (Washington, D.C.: Government Printing Office, September 1996), pp. 89-90.

53. GAO, *Ibid.*, p. 2.

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## About the Author

Regina E. Herzlinger is the Nancy R. McPherson Professor of Business at the Harvard Business School and an expert in both health care and accounting. Her current events best seller, *Market-Driven Health Care* (Boston: Addison Wesley, 1997), won the 1998 Book of the Year Award from the American College of Healthcare Executives. Her latest accounting book is *The Four Report: A Practical Guide for Effective Oversight of Nonprofit Organizations* (San Francisco: Jossey Bass, forthcoming). Professor Herzlinger has chaired the Audit and Pension Committees of the Board of Directors of a number of large, publicly traded firms.

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### *Seeking Quality in Health Care: Preventive Services Lag Far Behind Target Rates, Vary Widely with Geography*

An ounce of prevention may be worth a pound of cure, but that adage does not carry much weight in many sectors of the US health care system. That's the message of *The Dartmouth Atlas of Health Care in the United States, 1999 Edition* – "The Quality of Medical Care in the United States: A Report on the Medicare Program," which uses quantifiable measures of quality to evaluate the delivery of health care in this country. The 1999 *Atlas* finds that fundamental preventive services fall far below recommended levels and vary widely from place to place.

The 1999 *Atlas* goes beyond previous analyses of local and regional patterns of health care to include measures of quality based on adherence to established guidelines for preventive care, and the quality of surgical decision making and care at the end of life. By focusing on indicators of quality, the *Atlas* appraises the "vital signs" of health care delivery systems, making it required reading for decision makers, employee benefits managers, policy planners, and all those concerned with improving health care in the United States.

## The Lag in Compliance with Preventive Services

The 1999 *Atlas* analyzes the frequency of use of preventive services recommended by the U.S. Preventive Services Task Force. This group used a conservative evidence-based approach to endorse three preventive services for routine use among Medicare enrollees -- immunization to reduce the risk of pneumococcal pneumonia; mammography to detect early-stage breast cancer; and fecal occult blood tests or sigmoidoscopy to detect early-stage colon cancer.

The 1999 *Atlas* findings are hardly encouraging:

- Pneumococcal pneumonia is associated with high morbidity and mortality in the elderly population. Despite recommendations that Medicare enrollees be re-immunized at least every 10 years, the *Atlas* finds that actual compliance ranged from 7.5 percent to less than 1.8 percent. Only five of the nation's 306 hospital referral regions were at 7 percent or higher.
- Mammographic screening for breast cancer is recommended every one or two years for women age 50 to 69. Yet for female Medicare enrollees between 65 and 69, the average rate of mammography in 1995-96 was just 28.3 percent, ranging from less than 12.5 percent to slightly more than 50 percent.

Regionally, a woman living in the Northeast, Florida, or Michigan was much more likely to have a mammography than a woman living in the Southeast or in several parts of the Southwest.

- One recent study found that fecal occult blood screening conducted once every one to two years can reduce cancer deaths in older individuals by almost one-third. Yet the percentage of Medicare enrollees receiving annual screening in 1995-96 varied by a factor of almost 10, from 2.4 percent in the Terre Haute, Indiana hospital referral region, to 22.2 percent in Takoma Park, Maryland.

The same disturbing picture emerges in the *Atlas*' evaluation of preventive services for people with insulin-dependent and non-insulin-dependent diabetes. People with both forms of the disease are at significant risk of morbidity and mortality, including retinal disease, kidney disease, and coronary artery disease.

The Diabetes Quality Improvement Project recommends annual eye examinations and regular measurement of glucose markers and LDL blood lipid levels. The 1999 *Atlas* finds that all hospital referral regions fell short of the recommended levels for each of these screening services in the 1995-96 period:

Annual eye examinations for Medicare enrollees varied by a factor of more than 2.5, from 25.1 percent in Terre Haute, Indiana, to 66.1 percent in Fort Lauderdale, Florida. Routine monitoring of HgbA1c, a marker of glucose, ranged from 8.9 percent of eligible Medicare enrollees in York, Pennsylvania, to 70.2 percent in Idaho Falls, Idaho.

Compliance with the guideline for blood lipid testing also fluctuated widely, from a high of 68.9 percent in Bradenton, Florida, to a low of 6.8 percent in York, Pennsylvania.

Do regions with more primary care physicians, often viewed as gatekeepers and first-line diagnosticians, show more frequent use of recommended screening and preventive services? Not at all. The 1999 *Atlas* discerns almost no association between the level of the generalist physician workforce and the use of mammography, vaccination against pneumococcal pneumonia, or eye examinations for diabetics. Indeed, most measures of the capacity of the health care system appeared to have little impact on the use of preventive clinical services.

Continuity of care -- seeing the same physician for a majority of ambulatory care visits -- might also be expected to yield increases in the use of appropriate diagnostic testing. Yet, looking at patients who received at least 50 percent of their ambulatory care visits from one physician, the 1999 *Atlas* actually finds an inverse relationship between continuity of care and use of mammography, screening for colorectal cancer, and blood lipids testing for diabetics.

The 1999 *Atlas* shows that as a nation we are not doing as well as we can -- and that there continues to be a wide variation in the proportion of people who receive appropriate care.

The new edition builds on a key finding in the 1998 *Atlas*: in certain aspects of health care delivery, capacity is destiny. The capacity of the local health care system, in particular the supply of hospital beds, appears to wield a powerful influence on both general medical admissions and admissions for ambulatory care conditions.

Similarly, last year's *Atlas* concluded that characteristics of the local health system -- most notably the size of its acute care hospital sector -- were strongly linked to where people die. Acute care bed capacity was a more significant predictor of place of death than patient characteristics or expressed preferences for dying at home. Paradoxically, some of the places that spent the most on acute care hospital services during the six months of life were also those with greater spending on hospice or home health care. But even holding these and other factors constant, acute care bed capacity rather than demand or patient preference loomed as the primary factor predicting whether a person died in the hospital.

### **A Wealth of Data Available, Including National, Regional, and Local Comparisons**

Developed by the Center for the Evaluative Clinical Sciences at Dartmouth Medical School and published by Health Forum, a subsidiary of the American Hospital Association, *The Dartmouth Atlas of Health Care* series has become an invaluable resource for all those concerned about the state of health care in their region or the future of health care in the United States. Since its first publication in 1997, the *Atlas* has revealed the broad differences in health care delivery systems, the influence of geography on medical practice and the frequency of certain surgical procedures, and the impact of hospital bed capacity on end-of-life issues and general hospital admissions. The series analyzes the country's 3,436 local health care markets, referred to as hospital service areas (HSAs), and 306 hospital referral regions (HRRs), making it the only national analysis of how resources are distributed and services are used at the community level. To insure accurate comparisons across regions, *Atlas* data are adjusted to account for regional differences in the age and sex composition of the population and cost of living. This wealth of information is available in book and in a database. To find out more information or to order *The Dartmouth Atlas of Health Care 1999* [click here](#).

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## "AN OUNCE OF PREVENTION" NOT GIVEN ENOUGH WEIGHT IN THE U.S. HEALTH CARE SYSTEM, NEW REPORT SHOWS

*Mammography, Colorectal Cancer Screening and Diabetic Preventive Services Examined*

**SAN FRANCISCO (April 19, 1999)** - Despite the known benefits of such preventive services as screening for breast cancer and eye exams for diabetics, a large proportion of senior citizens are not receiving this type of care, according to a new report. *The Quality of Medical Care in the United States: A Report on the Medicare Program*, the third national release of the *Dartmouth Atlas of Health Care*, shows that even though the Medicare program pays for these tests, and panels of experts have documented their effectiveness in preventing complications and premature deaths, compliance with the recommended tests is extremely erratic. For example, in some parts of the country as few as 12.5 percent of elderly women receive recommended annual mammograms.

"We should be striving for close to 100 percent use of these

specific preventive services considering what we know about prevention and early detection, but we are nowhere near that goal," said the Atlas' principal investigator, John E. Wennberg, M.D., M.P.H., of the Dartmouth Medical School. "Prevention of complications and early detection of treatable disease are among the most important goals of medicine and should be a top priority for the health care field."

"Preventing disease using reliable screening methods should be a no-brainer - and most importantly, Americans want these benefits," said Jonathan T. Lord, M.D., chief operating officer and quality expert at the American Hospital Association (AHA). "Physicians and other providers should see these data as an opportunity to make improvements and to work together with their patients to make sure everyone is receiving what are often life-saving preventive services." The AHA subsidiary Health Forum publishes the Atlas.

Highlights include the following:

- **Screening for breast cancer:** Mammograms are recommended at least once every two years for women age 65-69. However, in 1995-96, only 28.3 percent of women in this age group received at least one mammogram; compliance with recommended guidelines varied from a low of 12 percent to a high of 50 percent. Women in the Northeast, Florida and Michigan were more likely to receive mammography than women elsewhere.
- **Screening for colorectal cancer:** Screening by either fecal occult blood test or colonoscopy is recommended annually, but on average, only 12 percent of the 29.4 million Americans enrolled in Medicare in 1995-96 received one preventive test. Compliance with the screening was higher in the Northeast and Southeast.
- **Immunization for pneumococcal pneumonia:** Vaccinations every 10 years are advised for the elderly, but the rates for those receiving the vaccine ranged from nine to 38 percent.
- **Preventive services for diabetics:** About 1.7 million Medicare patients with diabetes are "underserved," according to the Atlas. Because of complications that can result from the disease, annual eye exams, annual monitoring of glucose markers, and semi-annual cholesterol readings are recommended. Percentages of the population receiving the eye exam annually ranged from 25 to 60 percent.

"How preventive services are used seems to reflect local physicians' opinions and practice styles," Wennberg says. "The underuse of these services and the haphazard nature of compliance with recommended guidelines indicate there is substantial opportunity to improve the quality of care. The 'cure' appears to be better management of resources, rather than more spending."

In addition to findings on preventive services, the 1999 Atlas

continues to show wide geographic variation in the numbers and types of physicians, surgical procedures, hospital beds and Medicare dollars spent on various procedures. For example, residents of some parts of the country are as much as 10 times more likely to receive particular surgical procedures than people with the same disease who live elsewhere. The Atlas shows variation in 10 surgical procedures - repair of hip fracture, colectomy for colorectal cancer, cholecystectomy, angioplasty, coronary artery bypass surgery, hip replacement, lower extremity bypass surgery, carotid endarterectomy, back surgery and radical prostatectomy - representing approximately 42 percent of surgeries received by Medicare patients.

Last year's Atlas revealed that the American experience with death varied greatly from one community to the next, which the 1999 Atlas confirms. The Atlas explored the "intensity of care in the last six months of life" showing the number of physicians involved in patients' care varied substantially. In some regions, more than 30 percent of patients saw 10 or more physicians during their last six months while in others fewer than three percent were treated by that many different physicians.

"The Atlas once again raises questions about what level and type of health care is right for our country, and it presents an opportunity for health care leaders to create change in the system for everyone's benefit," said Steven A. Schroeder, M.D., president of the Robert Wood Johnson Foundation, which funded the Dartmouth research.

The 1999 Dartmouth Atlas is based on research by Dartmouth medical epidemiologist Wennberg and colleagues at the Center for the Evaluative Clinical Sciences. It is a volume of text, graphs and maps showing the geographic distribution of health care resources in the United States based on how health care is used by defined populations, rather than the physical location of health care resources. The Dartmouth Atlas data are based on 1995-96 Medicare statistics and other health care databases.

Dartmouth research identified 3,436 hospital service areas in the United States, and 306 hospital referral regions -- aggregates of hospital service areas that are the natural markets for tertiary care such as open heart surgery and neurosurgery. Dartmouth researchers used the technique called "small area analysis" to compare different populations' consumption of health care services, taking into account the difference in populations' composition by age, sex, race and other factors that affect demand for health care.

The Atlas findings are already being used by employers. The AHA and the Midwest Business Group on Health recently released a study, funded by the Robert Wood Johnson Foundation, on how employers will use the Dartmouth Atlas to make sure the health care services their employees receive are effective. As a result of the study, physicians in these groups are working more closely with colleagues from different cities and are working more directly with patients to involve them in the decision-making process about their health care treatment.

choices.

State hospital associations are beginning to develop state versions of the national Atlas that go beyond Medicare data and compare patients in all age categories. The Hospital and Healthsystem Association of Pennsylvania recently published the *Dartmouth Atlas of Health Care in Pennsylvania*. And atlases specific to surgical specialties - cardiovascular, orthopedic and vascular surgery -- are in development.

The Center for the Evaluative Clinical Sciences at Dartmouth is a multidisciplinary group of researchers - epidemiologists, economists, clinicians, statisticians, sociologists and others - investigating a variety of issues related to medical care and its outcomes.

The American Hospital Association is a not-for-profit association of health care provider organizations and individuals that are committed to health improvement of their communities. The AHA is the national advocate for its members, which includes 5,000 hospitals, health care systems, networks, and other providers of care, and 37,000 individuals. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA web site at [www.aha.org](http://www.aha.org).

The Robert Wood Johnson Foundation, based in Princeton, N.J., is the nation's largest philanthropy devoted exclusively to health and health care. The Foundation concentrates its grantmaking in three areas: (1) to ensure that all Americans have access to basic health care at reasonable cost; (2) to improve care and support for people with chronic health conditions; and (3) to reduce the personal, social and economic harm caused by substance abuse - tobacco, alcohol and illicit drugs.

The *Dartmouth Atlas of Health Care* is available in hardcover (catalog #044401) for \$295 for AHA members; \$350 for non-members; in a Data Viewer on CD-ROM (catalog #044452) for \$1,095 for AHA members; \$1,295 non-members; a package of both the book and CD-ROM (catalog #044453) are available for \$1195 for AHA members; \$1395 non-members. Order by calling 800-AHA-2626 or [click here](#).

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**Targeting Long- and Short-Term Gaps in  
Health Insurance**

Pamela Farley Short\* and Jacob Alex Klerman\*\*

\*Pennsylvania State University

\*\*RAND Corporation

July 1998

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to the The Commonwealth Fund or its directors, officers, or staff.

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Since the demise of debates on how to achieve universal health insurance coverage, Congress and the states have turned to a strategy of expanding health insurance incrementally. These efforts have included market reforms to make coverage more accessible as well as expansions of federal public subsidies for children's health insurance and, in some states, subsidies for working families.

Expanding coverage incrementally raises a host of issues and choices for public policy, with likely differential impacts on the extent to which efforts succeed in reducing either the number or proportion of uninsured. Different approaches are likely to be more or less successful depending on the extent to which they reduce financial barriers to coverage and reach out to those who are currently uninsured.

To explore a range of issues related to incremental expansion, The Commonwealth Fund has commissioned a series of papers to be published sequentially. The first paper in the series, *The Financial Burden of Self-Paid Health Insurance on the Poor and Near-Poor*, by Jon Gabel, Kelly Hunt, and Jean Kim of KPMG Peat Marwick, LLP, examines the issue of affordability and the need for subsidies for the uninsured living on poverty or near-poor incomes. Using KPMG's data base on employer premium costs across the country, the authors calculate the share of income that would be required if the near-poor or poor attempted to buy

insurance on their own. The paper then estimates subsidies necessary to hold premium costs to no more than 5 percent of pre-tax incomes.

The second paper in the series, *State-Subsidized Health Insurance Programs for Low Income Residents: Program Structure, Administration, and Costs*, by Laura Summer of the National Academy on an Aging Society, conveys the results of extensive case studies of 12 states' programs to cover uninsured populations. Summer examined states' administrative structures, use of managed care, eligibility rules, and application and enrollment processes, and found that while many administrators would like to improve their programs to cover more people, they lacked much of the information that would enable them to do so. The author shares several overarching lessons gleaned from her case studies, and suggests that states' systematic examination of their public insurance programs can greatly influence their success in covering uninsured populations.

The third paper, *Covering Uninsured Children and Their Parents: Estimated Costs and Number of Newly Insured*, by Kenneth E. Thorpe and Curtis S. Florence of Tulane University, examines the likely impact of recent federal legislation to expand health coverage to more uninsured children and explores the costs of covering these children and their parents. The authors find that 11.3 million children under age 19 are uninsured, and that four of five of their parents are also uninsured. Thorpe and Florence conclude that the Child Health Insurance Program (CHIP) and Medicaid hold the potential for covering eight of ten uninsured children, and that CHIP may prove to be a base on which to expand coverage for both children and their parents.

This fourth paper, *Targeting Long- and Short-Term Gaps in Health Insurance*, written by Pamela Farley Short, director of the Center for Health Policy Research at Pennsylvania State University, and Jacob Klerman, senior economist at the RAND Corporation, explores the types and numbers of families who would be helped by approaches to extend coverage based on different lengths of time spent without insurance. Using the federal Survey of Income and Program Participation, which tracked the insurance coverage and incomes of families over a period of nearly three years, the authors find that policies targeted toward those with the longest and shortest spells spent without insurance would reach quite different populations.

Requiring a substantial period of time spent uninsured would, in general, provide subsidies to a poorer segment of the uninsured population and cover more people than would policies targeting people with short-term insurance gaps. For example, an option that would require the applicant to have been uninsured for at least 12 months would cover an estimated 26 million people. Forty percent of these long-term uninsured individuals would be poor. An option that would require the applicant to have had insurance for at least a year and half previously, and that would offer insurance for only a six-month period, would reach 11 million people who are currently uninsured. Thirty-two percent of this short-term uninsured group would have incomes above 250

percent of the poverty level, and only 18 percent would be poor.

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## EXECUTIVE SUMMARY

Twenty-six million Americans have not had health insurance for more than a year, primarily because they have low incomes and cannot afford to pay the premiums. In this report, we explore the types of families who would be helped by various approaches to extend insurance coverage based on different lengths of time spent without insurance. We also estimate the number of uninsured families who would be covered under specific options. Using the federal *Survey of Income and Program Participation*, which tracked the insurance coverage and incomes of families over a period of nearly three years, we find that policies targeted toward those with the longest and shortest spells spent without insurance would reach quite different populations.

Requiring a substantial period of time spent uninsured would, in general, provide subsidies to a poorer segment of the uninsured population and cover more people than would policies targeting people with short-term insurance gaps. An option that would require the applicant to have been uninsured for at least 12 months, for example, would cover an estimated 26 million people. Forty percent of these long-term uninsured individuals would be poor, and 78 percent would live in families with incomes below 200 percent of federal poverty standards (a two-person family with an income of less than \$20,000). By contrast, only 24 percent of the uninsured who would have qualified for a short-term program of similar size (requiring three months of prior coverage, with a 12-month limit on eligibility) would be poor. Sixty-two percent would live in families with incomes below 200 percent of the poverty line.

Some states have implemented programs that target people who have met requirements for uninsured gaps of specific durations. Minnesota, for example, extends coverage to applicants who have not have been insured for the past four months or who have not been eligible for employer-subsidized coverage for the past 18 months. In Vermont, applicants qualify if they have not had insurance for 12 months prior to application.

Other proposed programs, which would cover unemployed individuals, typically offer only short-term coverage and require the person to have had prior coverage. A program that would require the applicant to have had insurance for at least a year and half previously, and that would offer insurance for only a six-month period, would reach 11 million people who would be currently uninsured. This short-term uninsured group has generally higher incomes than the long-term uninsured group: 32 percent have incomes above 250 percent of the poverty level, and only 18 percent are poor. In this report, we specify several stylized examples of programs that target the short- and long-term uninsured and simulate eligibility for each. For the short-term approach, we consider programs with time limits of six months and 12 months, and the examples we simulate require either three months or 18 months of prior coverage. In total, we consider four short-term programs, involving two time limits and two prior coverage requirements. For the long-term approach, we consider programs that cover the uninsured only after waiting periods of six months, 12 months, and 18 months.

Across the programs we simulate, those for the long-term uninsured cover more people and a larger share of uninsured person-years. The largest, most broadly conceived short-term program that we considered (requiring only three months of prior coverage and offering 12 months of eligibility) would have covered about 23 million people during the year and 11 million person-years. The smallest, most narrowly targeted long-term program (requiring an 18-month waiting period) would have covered about 18 million people during the year and 14 million uninsured person-years. Thus, even this smallest long-term program covers almost as many people and more person-months as the largest short-term program.

These analyses indicate that targeting the long-term uninsured is likely to both cover more of the uninsured and to cost more than targeting the short-term uninsured. Targeting the long-term uninsured has the virtue of directing public assistance to uninsured people who, given their low incomes and history of being without insurance, are unlikely to obtain insurance on their own. Targeting the long-term uninsured, however, presents other difficulties. Eligibility rules that are based on lack of insurance for a specified time are difficult to enforce. Such rules also run counter to the principles of insurance by allowing and encouraging people to remain uninsured until they have a need for medical care.

Short-term programs, on the other hand, encourage people to buy insurance and protect the insured against lapses in coverage. However, many of the uninsured who would qualify for short-term

programs are not poor, and many people in these circumstances would likely find ways to continue their coverage. Accordingly, short-term programs are likely to replace—not augment—existing private insurance arrangements. Much of the money for such programs is likely to provide financial relief for the insured rather than offering new coverage for the uninsured.

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## I. INTRODUCTION

Most Americans—about 85 percent—have health insurance. Their insurance is provided through a complex and interlocking set of arrangements that involves employers, government-sponsored programs, and individually purchased coverage. As demonstrated by the failed effort to enact comprehensive health reforms, voters and their representatives are reluctant to make wholesale changes in a very complicated system that serves most Americans fairly well.

The enactment of a limited set of private health insurance reforms in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the creation of a new federal program to cover uninsured children in 1997 indicates the current political inclination to proceed a step at a time in extending coverage to the uninsured. Because of the complexity of arrangements for covering the insured, and the many reasons why some people lack health insurance, incremental reform is likely to involve a variety of approaches, targeting different subgroups of the uninsured with different types of assistance.

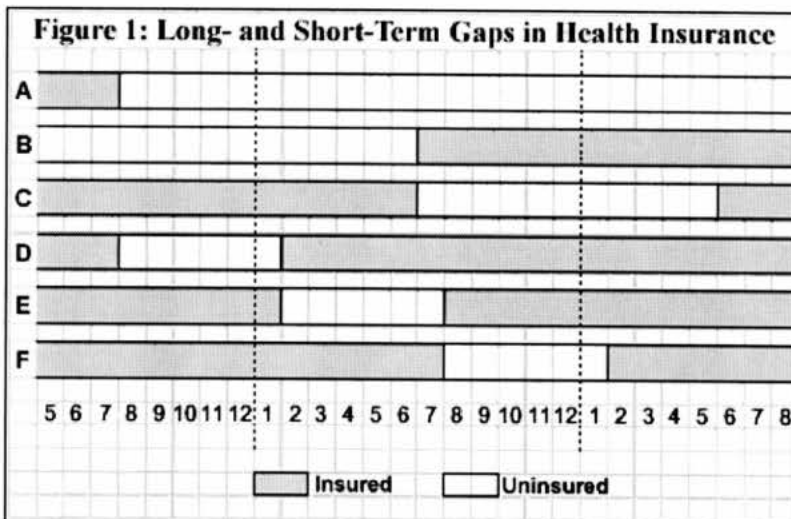
As we discuss in detail in the next section, pilot projects, reform proposals, and recent legislation at the state and federal levels have targeted subgroups of the uninsured according to the length of time that they have been uninsured. Some proposals target short-term gaps in health insurance, covering people who have recently lost their insurance or who would have lost their insurance in the absence of reform. Other proposals target long-term gaps in insurance, covering people who have been uninsured for some time. In this report, we contrast the two approaches and show that they reach target populations with different demographic and income profiles.

The second section of this report provides an overview of the issues, describing the uninsured according to their time without coverage and reviewing examples of programs that either explicitly or implicitly base eligibility on this criterion. The third section discusses our methodology and data source, the *Survey of Income and Program Participation* (SIPP). The fourth section presents our estimates of the proportion of the uninsured who would be eligible for stylized examples of programs targeting the short- and long-term uninsured, and a comparison of the target populations. The concluding section summarizes the findings and considers the implications for incremental health insurance reform.

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## II. SHORT GAPS, LONG GAPS, AND INCREMENTAL REFORM

The concepts involved in targeting the uninsured by duration of uninsured status are inherently dynamic and can be confusing, so we begin with a short review of the measurement issues. The simplest way of looking at the uninsured in a dynamic context is to focus on the stock of uninsured individuals at a given point in time.



For example, we might focus on the first month of the calendar year as indicated in [Figure 1](#) by the dotted vertical lines. Considering the cross-section of people who are uninsured in Month 1 of this year, we can ask how long each person has been without coverage as of that month. What we call a short-term program would cover everyone who, as of that month, had been uninsured for less than, say, six months. What we call a long-term program would cover everyone who, as of that month, had been uninsured for more than, say, 12 months. Absent behavioral responses to the introduction of a new program, the number of uninsured in Month 1 would drop by the number of people whose elapsed time without insurance is either short enough or long enough to qualify for a new, targeted program.<sup>1</sup> Such counts of monthly enrollment correspond to a familiar concept: the program's caseload.

Aggregating 12 monthly cross-sections over a year produces an estimate of the number of person-months that are uninsured or eligible for a program during a year, which is often the accounting period of interest. If no seasonal changes or other trends occur, so that the proportions of uninsured or eligibles for the program are identical in each cross-section, then any one cross-section indicates the aggregate proportion of person-months that are uninsured or eligible over the longer accounting period. For this reason, cross-sectional estimates of eligibility and annual person-months of eligibility are closely related.

Person-months, in turn, are closely related to annual program costs. Multiplying the average cost of insuring someone for a month by the total number of insured person-months yields an estimate of total costs. For this reason, estimates of person-months of eligibility are quite useful in the evaluation of

alternative policy approaches.

Note, however, that the number of uninsured who qualify for either short- or long-term programs at a given point in time will always be less than the number who qualify over a period of time, such as a year. As illustrated in [Figure 1](#), all of the uninsured spells that start during the year (C, E, and F) will qualify for a short-term program, but are not counted in the cross-section for Month 1. As time passes, several people who did not qualify for a long-term program at the beginning of the year will become eligible when they reach the end of the waiting period (Person B, for example, with a six-month waiting-period). Consequently, more people will benefit over time from either a short- or long-term program than statistics for a cross-section imply.

Finally, as [Figure 1](#) suggests and a more formal analysis could demonstrate, cross-sectional estimates (or estimates involving person-months) give relatively less weight to the short-term uninsured than estimates involving people who have ever been uninsured over time. For example, the person with the very long spell spent uninsured (A) would be counted as uninsured by looking at either a cross-section or a year. However, three other people with shorter spells spent uninsured (C, E, and F) are added during the year to the two people counted in the initial cross-section (B and D). Only two-thirds of the uninsured have shorter spells in the cross-section, compared with five out of six over the year. To put it another way, by counting people, each person is considered equally, while counting person-months without insurance adjusts for time, giving greater weight to long spells that are in progress for a larger proportion of the year.

Working through these measurement issues is important in evaluating programs that explicitly or implicitly target the uninsured according to their length of time without coverage. To demonstrate well-established precedents for targeting the uninsured in this fashion, we turn now to examples of programs or proposals that target short- and long-term gaps in health insurance. Part of our intent here is to call attention to the design features that are typical of each approach.

### **Programs That Target Short-Term Gaps**

We begin this part of our discussion with one of the most active areas of insurance reform: programs that have targeted short-term gaps in health insurance. For example, going back as far as 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) granted employees leaving medium-size and large firms (20 or more employees) the right to continue buying health insurance from their previous employer at 102 percent of the employer's group rate for 18 months. HIPAA, which was enacted in 1996, guaranteed the right to buy insurance in the individual market to employees leaving firms small enough to be exempt from COBRA and former employees of larger firms who have exhausted their COBRA eligibility. HIPAA also imposed limits on exclusions of pre-existing conditions to eliminate gaps in coverage for people who change plans. In addition, proposals have regularly been made to subsidize health insurance purchases for the temporarily uninsured and unemployed, defined most recently

as those who left an insured job within the past six months and are still collecting unemployment insurance.

As these examples illustrate, eligibility for many short-term programs is subject to time limits and prior coverage requirements. The proposal to subsidize health insurance for the unemployed, for example, was limited to people with at least 12 months of continuous insurance before they lost their jobs. The guarantee of group-to-individual conversion in HIPAA is limited to people with at least 18 months of prior continuous group coverage.

Short-term programs require prior coverage because time limits must necessarily be defined in relation to the loss of some other type of coverage. Figure 1 shows that targeting short-term gaps in health insurance means targeting people as they lose (or have recently lost) their health insurance. If the intent is to protect against occasional, unexpected gaps in coverage, as opposed to a continuing pattern of intermittent coverage, then prior coverage requirements are necessary to enforce the time limits. Without prior coverage requirements, people could obtain subsidized or continuation coverage over the long term from a short-term program. When they reached the time limit, they would merely have to buy insurance for a month or so in order to requalify.

### **Programs That Target Long-Term Gaps**

The long-term uninsured have also been targeted in recent legislation and proposals for reform. This approach is most prominent in states' subsidized insurance programs. A recent survey of 16 state-subsidized insurance programs by the Alpha Center (Lipson and Schrodell, 1996) notes that nearly all state programs exclude individuals who are insured at the time of application so that people cannot drop their current coverage in order to qualify for subsidized coverage. Nearly half of the 16 state programs further restrict eligibility to those who have been uninsured for a minimum period of time. Some states even specify that the uninsured may not have access to employer-sponsored insurance for the specified waiting period. Other states have effectively imposed a waiting period by restricting eligibility to those who were uninsured on a date prior to the enactment of the legislation. Examples of these state requirements include:

- New Hampshire's Healthy Kids program, which excludes children who have been enrolled in an employer plan within the past three months.
- Minnesota's MinnesotaCare, which requires individuals to have been uninsured for four months and to have had no access to coverage for which an employer would pay at least half.
- Vermont's Health Access Plan program, which excludes people with insurance in the preceding 12 months (although this requirement may be waived under special circumstances).

- New Jersey's Health Access program, which excludes people who had employer-based insurance in the last 12 months.
- Oregon's Family Health Insurance Assistance Program, which requires individuals to have been uninsured for 12 months prior to application.
- New York's Regional Pilot Projects, which require individuals to have been uninsured on some earlier date.
- Tennessee's TennCare, which requires individuals to have been uninsured on some earlier date.

Similar restrictions were included in 11 state demonstration programs involving employers who did not offer insurance that were sponsored by the Robert Wood Johnson Foundation. These demonstrations were targeted toward the "chronically uninsured" according to Helms, Gauthier, and Champion (1992). All but one were restricted to employers who had not offered health insurance for a minimum of six months to a year.

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### III. METHODS AND DATA

Drawing on these precedents, we specify several stylized examples of programs that target the short- and long-term uninsured. Then, in order to compare and contrast these approaches, we simulate eligibility for each program. We consider four examples of the short-term approach with time limits of six months and 12 months that also require either three or 18 months of prior coverage under a private insurance policy. The three-month requirement was selected as a bare minimum for requiring any prior coverage at all; 18 months is the longest requirement that we found in any of the proposals or programs that we reviewed.<sup>2</sup> For the long-term approach, we consider programs that cover the uninsured only after waiting periods of six months, 12 months, and 18 months.

In each instance, the simulation proceeds by looking back in time from each month in which a person is uninsured to determine whether the person meets the eligibility criteria for each of the short- and long-term programs. Having made this calculation for each month in the one-year period, we estimate how many uninsured people would be covered by the program at some point in the year and how many uninsured person-months would be covered.

We also characterize the covered people and person-months in terms of their percent distribution by family income, age (adult or child under age 19), family type, and family employment. For these purposes, "family" refers to a "health insurance unit" (a married couple or single adult and dependent children). This nuclear family concept corresponds to the group of people who would typically qualify for family coverage under a single private insurance policy.

We characterize people according to their status at the start of

the year for our estimates of those who were ever uninsured or eligible for one of the model programs over a year. We use the monthly data for estimates involving person-months for these characteristics.

The data source for these simulations and tabulations is the 1991 panel of the *Survey of Income and Program Participation* (SIPP). SIPP is a panel survey, conducted by the U.S. Bureau of the Census, that follows a nationally representative sample of the U.S. population over a period of nearly three years. At every interview, the survey collects information on monthly health insurance status (including source of coverage) and employment status during the preceding four months. In addition, a supplement to the second interview collects retrospective information on how long each insured person had been covered at the start of the panel and the last time that each uninsured person was insured.

The 1991 panel has a sample of 37,529 persons. We make estimates for a one-year period at the end of the panel, roughly corresponding to the period from mid-1992 to mid-1993, depending on the calendar months when each respondent was interviewed.<sup>3</sup> The estimates are restricted to the subgroup of individuals in the sample who responded for their entire period of eligibility during the panel, were under age 65 during any of the last 12 months, and were in-scope for the survey in any of the last 12 months. These restrictions yield a sample of 5,135 people who were ever uninsured during the 12-month period.

For our analysis, the crucial variable is the length of time that a person has been uninsured. In mimicking some proposals, we also consider length of enrollment in private insurance at the time someone became uninsured. Because retrospective recall of such durations is known to be less than perfect, we base our estimates as much as possible on durations that are captured within SIPP by tracking respondents over time. More specifically, we make estimates for people who were uninsured in each of the last 12 months of the panel so that we can use the data collected at each of the earlier interviews to calculate the prior duration of uninsured or privately insured spells.

In some instances, we need to look back more than 20 months and use the retrospective data from the second interview. That interview includes several retrospective questions that are relevant to our analysis. Respondents who had private insurance at the second interview were asked: "For how long has \_\_\_\_\_ been covered by health insurance without interruption?" Respondents who did not have private insurance were asked: "When was the last time \_\_\_\_\_ was covered by private health insurance?" And everyone was asked if they had ever received either Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI); if so, they were asked the date when they last received this assistance. Because AFDC and SSI automatically qualify recipients for Medicaid, we assign the last date of private insurance enrollment or AFDC/SSI reciprocity, whichever was most recent, as the starting date of uninsured

spells that were in progress at the beginning of the SIPP panel.<sup>4</sup>

#### IV. FINDINGS

Because the goal of both short- and long-term programs is to reduce the number of uninsured, we begin with estimates from SIPP of the magnitude of the problem. For this purpose, we also begin with the larger estimate of the uninsured—namely the proportion of the population that was ever uninsured during the year. As shown in the first row of [Table 1](#), 20.3 percent of the population under age 65 was uninsured at some point in the one-year period that we studied.<sup>5</sup> This percentage varied markedly by income, ranging from 43.1 percent of those under the poverty line to 6.6 percent of those with family incomes of 250 percent of the poverty line or more.<sup>6</sup>

| <b>Table 1</b><br><b>Percent of U.S. Population Under Age 65 Who Are Uninsured in 12 Months and Their Eligibility for Programs Targeting Long- and Short-Term Gaps in Insurance (1992-1993)</b> |       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| Percent of population that is uninsured                                                                                                                                                         | 20.3% |
| Percent of uninsured <sup>a</sup> who are eligible for program targeting:                                                                                                                       |       |
| <b>Long-term uninsured</b>                                                                                                                                                                      |       |
| 6-month waiting period                                                                                                                                                                          | 72.4% |
| 12-month waiting period                                                                                                                                                                         | 56.0% |
| 18-month waiting period                                                                                                                                                                         | 39.8% |
| <b>Short-term uninsured</b>                                                                                                                                                                     |       |
| 3-months prior coverage                                                                                                                                                                         |       |
| 6-month limit                                                                                                                                                                                   | 45.5% |
| 12-month limit                                                                                                                                                                                  | 50.7% |
| 18-months prior coverage                                                                                                                                                                        |       |
| 6-month limit                                                                                                                                                                                   | 24.0% |
| 12-month limit                                                                                                                                                                                  | 21.1% |
| <sup>a</sup> People who are ever uninsured in a year and ever eligible for targeted programs.                                                                                                   |       |
| Source: <i>Survey of Income and Program Participation</i> , 1991 panel.                                                                                                                         |       |

Similar percentages of adults and children were uninsured. Persons in families headed by single adults, either with or without children, were especially likely to be uninsured. The uninsured rate at the beginning of the year was closely associated with family employment, varying from a high of 59.0 percent of the unemployed and their families to a low of 16.4 percent in families with at least one full-time worker.

Focusing on the long-term program with a 12-month waiting period, which would have covered about half the people who were ever uninsured, it is evident that such a program is implicitly

directed at uninsured people in lower income groups (Table 2). Sixty-three percent of the poor uninsured (i.e., those with family incomes below the poverty line) would have qualified for a program with a 12-month waiting period. By comparison, only 42.2 percent of the uninsured at 250 percent of the poverty line and above would have qualified. Because of differences in the eligibility of children and adults in single-parent families, this long-term program would have covered a larger share of uninsured adults (58.0 percent) than children (51.0 percent).<sup>7</sup> Although a somewhat smaller share of the uninsured in families with a full-time worker would have satisfied the 12-month requirement, the differences by employment are not as extreme as the differences by income. Relaxing the targeting by shortening the waiting period narrows the differences across subgroups; targeting even more narrowly by lengthening the waiting period inflates the differences across subgroups. (See Table A1 in the Appendix.)

As illustrated by the short-term program that would have covered about half the people who were ever uninsured (with a 12-month limit and a three-month prior coverage requirement), a short-term program benefits a larger proportion of the uninsured at higher income levels than at low income levels. About 73 percent of the uninsured with family incomes at 250 percent of the poverty line or more would have qualified for this short-term program during the 12 months that we studied, compared with 34.8 percent of the uninsured below the poverty line. Shortening the time limit but keeping some kind of private insurance requirement does not appreciably narrow the differences by income. (See Table A1 in the Appendix. Two-thirds of the uninsured with incomes of 250 percent of the poverty line or more would have qualified with a time limit of six months, compared with less than one-third of the uninsured who were poor.

Uninsured, married adults were more likely to benefit from a short-term program than children or adults in single-parent families or even their own children. Fifty-seven percent of married adults without children and 53.8 percent of married adults with children would have qualified for a program offering 12 months of coverage after a minimum of three months of prior coverage. The uninsured who were in families with at least one full-time worker were also more likely to qualify for such a program.

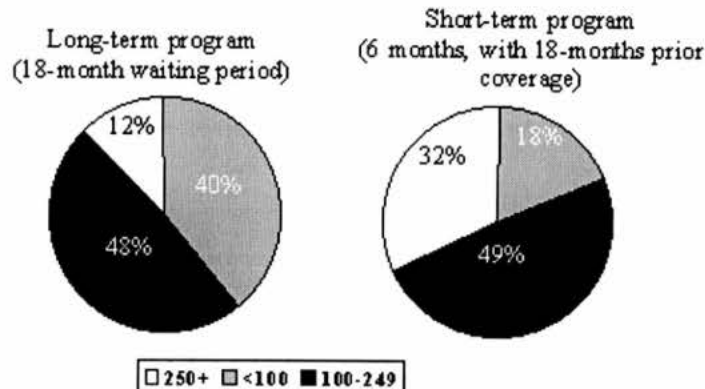
**Table 2**  
**Percent of People Who Are Ever Uninsured in 12 Months Who**  
**Are Eligible for Long-Term**  
**and Short-Term Programs of Approximately Equal**  
**Size(1992-1993)**

|                                               | Long-Term<br>Program<br>(12-month<br>waiting period) | Short-Term<br>Program<br>(3 months prior<br>coverage,<br>12-month<br>limit) |
|-----------------------------------------------|------------------------------------------------------|-----------------------------------------------------------------------------|
|                                               | Percent of uninsured who are<br>eligible             |                                                                             |
| <b>All under age 65</b>                       | 56.0%                                                | 50.7%                                                                       |
| <i>Family Income (percent of<br/>poverty)</i> | 63.1%                                                | 34.8%                                                                       |
| < 100                                         | 55.7%                                                | 54.4%                                                                       |
| 100-249                                       | 58.2%                                                | 47.3%                                                                       |
| 100-149                                       | 56.0%                                                | 56.3%                                                                       |
| 150-199                                       | 49.9%                                                | 66.7%                                                                       |
| 200-249                                       | 42.2%                                                | 72.8%                                                                       |
| 250                                           |                                                      |                                                                             |
| <i>Age</i>                                    |                                                      |                                                                             |
| Adult                                         | 58.0%                                                | 52.9%                                                                       |
| Child under 19                                | 51.0%                                                | 45.1%                                                                       |
| <i>Family type and age</i>                    |                                                      |                                                                             |
| Single adult                                  | 61.1%                                                | 52.3%                                                                       |
| Adult couple                                  | 57.0%                                                | 57.0%                                                                       |
| Single parent                                 |                                                      |                                                                             |
| Adult                                         | 58.0%                                                | 46.3%                                                                       |
| Child                                         | 45.4%                                                | 44.9%                                                                       |
| Two parents                                   |                                                      |                                                                             |
| Adults                                        | 53.4%                                                | 53.8%                                                                       |
| Child                                         | 55.1%                                                | 45.1%                                                                       |
| <i>Family employment</i>                      |                                                      |                                                                             |
| Any full-time wage earner                     |                                                      |                                                                             |
| Only part-time or<br>self-employed            | 52.3%                                                | 56.7%                                                                       |
| 60.5%                                         |                                                      | 46.3%                                                                       |
| No workers                                    |                                                      |                                                                             |
| Any unemployed                                | 60.9%                                                | 40.1%                                                                       |
| Other                                         | 63.0%                                                | 37.9%                                                                       |

Source: *Survey of Income and Program Participation*, 1991 panel.

A long-term program with an 18-month waiting period (the most targeted that we considered) would have served about 18 million people over the course of a year. The most targeted short-term program (limited to six months and people with 18 months of prior coverage under a private plan) would have served about 11 million people. The differences between the two programs are not limited to the number of people they would cover; they also serve noticeably different groups of people, as shown by considering these polar examples.

**Figure 2**  
**Percent Distribution of Persons Eligible for Long- and Short-Term Programs by Family Income as a Percent of the Poverty Line**



In particular, as shown in [Figure 2](#), 40.0 percent of the people eligible for the larger program targeting the long-term uninsured were poor, compared with 18.3 percent of the people eligible for the smaller program targeting the short-term uninsured. Just 12.3 percent of those qualifying as long-term uninsured were in the higher income group with family incomes of 250 percent of the poverty line or more, while virtually a third of those qualifying for the short-term program were in this income range. When the unit of analysis is shifted from persons in a year to person-months ([Table 3](#)), the percentage of uninsured is considerably lower, for reasons that we discussed in relation to [Figure 1](#). Only 14.0 percent of all person-months were uninsured, compared with 20.3 percent of all people who were ever uninsured during a year. Nevertheless, while calculated on different denominators, similar percentages of the uninsured were eligible for each of the long-term programs according to either measure. For example, 43.5 percent of uninsured person-months were eligible for the long-term program with an 18-month waiting period, compared with 39.8 percent of persons ever uninsured. This is because long-term programs tend to cover people who qualify for the entire year, if they qualify at all.

For the short-term programs, however, a greater disparity is found between the two measures. For example, while 45.5 percent of uninsured people would have qualified at some point in the year for the program with a six-month time limit and a three-month prior coverage requirement, only 22.9 percent of uninsured person-months would have qualified. For the program with the shortest time limit, the eligibility of people and person-months diverges because the time limit on eligibility for the short-term program causes many people not to qualify during all the months when they are uninsured. The percentage of persons who qualified for the short-term programs with a six-month limit was about twice the percentage of person-months. That ratio falls from about 2:1 to 3:2 with a 12-month limit.

While the distinction between persons and person-months is important in quantifying the size of the uninsured "gap" and the proportion of the gap that would be filled by a short-term program, it has little effect on comparisons across population subgroups. (See the relevant Appendix tables.) By either measure, the long-term programs fill relatively more of the gap at low income levels and the short-term programs fill relatively more of the gap at higher income levels. Furthermore, the composition of the uninsured group that is eligible for the different programs varies across program designs by income and other population characteristics in similar ways according to either measure. For example, the poor accounted for 26.4 percent of the person-months eligible for the short-term program with a six-month time limit and a three-month prior coverage requirement (data not shown). The poor accounted for 23.9 percent of the persons who are eligible for this program during a year.

**Table 3**  
**Percent of U.S. Population Under Age 65 Who Are Uninsured in 12 Months and their Eligibility for Programs Targeting Long- and Short-Term Gaps in Insurance (1992-1993)**

|                                         | People <sup>a</sup> | Person-Months |
|-----------------------------------------|---------------------|---------------|
| Percent of population that is uninsured | 20.3%               | 14.0%         |
| <b>Long-term uninsured</b>              | 72.4%               | 73.2%         |
| 6-month waiting period                  | 56.0%               | 55.6%         |
| 12-month waiting period                 | 39.8%               | 43.5%         |
| 18-month waiting period                 |                     |               |
| <b>Short-term uninsured</b>             |                     |               |
| 3-months prior coverage                 |                     |               |
| 6-month limit                           | 45.5%               | 22.9%         |
| 12-month limit                          | 50.7%               | 35.0%         |
| 18-months prior coverage                |                     |               |
| 6-month limit                           | 24.0%               | 11.1%         |
| 12-month limit                          | 27.1%               | 16.6%         |

<sup>a</sup>People who were ever uninsured in a year and were ever eligible for targeted programs.

Source: *Survey of Income and Program Participation*, 1991 panel.

## V. DISCUSSION

Within the range of program designs for which there is precedent, the programs that target long-term gaps in health insurance provide more person-months of coverage over a fixed accounting period (such as a year) than programs that target short-term gaps in coverage. Given the link between subsidy costs and person-months of coverage, subsidies for the long-term programs also cost more. The differences between the short- and long-term approaches are somewhat smaller when measured in terms of the number of people who would benefit over time. However, as a general rule, the long-term programs will cover more people as well.

Specifically, according to our estimates for a 12-month period from mid-1992 to mid-1993, about 46 million people under age 65 were uninsured for at least part of the year. Because a significant proportion of these people were uninsured for only part of the 12-month period, the shortfall in their health insurance coverage amounted to 375 million uninsured person-months or, dividing by 12, 31 million uninsured person-years. If implemented in the 1992-1993 time period, the most broadly conceived short-term program (requiring only three months of prior coverage and offering 12 months of eligibility) would have targeted about 23 million people during the year and 11 million person-years. The smallest and most narrowly targeted long-term program (with an 18-month waiting period) would have reached 18 million people. However, the smallest long-term program would have targeted more person-years—14 million—than the largest short-term program.<sup>8,9</sup>

As measures of the uninsured “gap” and program eligibility, both people and person-years have policy relevance. Counts of people show how many lives are affected by lack of insurance and could benefit from an incremental expansion of coverage. Because of the link between costs and person-years, counts of person-years come close to measuring costs and benefits in accounting terms.

Our results also show that programs targeting short- and long-term gaps in health insurance would cover different segments of the uninsured population. In particular, the long-term uninsured tend to be from low income families. The short-term uninsured (who recently had private insurance to lose) tend to be from higher income families. The composition of these groups differs as well.

Our findings indicate that many of the uninsured who would benefit from short-term programs are people who are not poor and, in some cases, are well above the poverty line. Consequently, it seems reasonable to expect many of the short-term uninsured to pay for their own coverage. That was apparently the logic behind both COBRA and HIPAA, programs that targeted short-term gaps but did not offer subsidies.

Many people in the same circumstances—for example, people who have lost a job that offered employer-sponsored insurance—do indeed pay for continued coverage (Klerman 1997). That observation not only raises the question of whether subsidies are really necessary to close the remaining short-term gaps in coverage, it also means that a broad subsidy program to cover the short-term uninsured would assist many people who would have obtained and paid for health insurance anyway. This is a significant reason to steer away from subsidies for the short-term uninsured.

Implicit in the current emphasis on targeted health care reforms is the policy goal of reducing the number of uninsured with a modest investment of public money and political capital. Offering subsidies to the short-term uninsured is unlikely to meet this goal because of the likelihood that many of the subsidies would go to

people who would have obtained insurance through private means. Subsidies to such people give them financial relief but do not reduce the number of uninsured.

The Medicaid expansions of the last decade have been closely scrutinized for evidence that they replaced (or "crowded out") private insurance in this fashion. Despite agreement that some substitution of public insurance for private insurance occurred, the magnitude of that substitution is still a matter of controversy (Curtis, Merlis, and Page, 1997; Cutler and Gruber, 1996; Cutler and Gruber, 1997; Dubay and Kenney, 1997). In any event, compared with Medicaid expansions directed primarily at children below the poverty line, a subsidy program that targets the short-term uninsured (and specifically singles out people with a recent history of private insurance) is likely to pay an even larger share of its subsidies to people who would have bought health insurance on their own.<sup>10</sup>

While subsidies may not be the best way to close the gap for many of the short-term uninsured, directing some time-limited subsidies to low income individuals and families who lose their insurance might be necessary to encourage them to obtain insurance. For the rest of the short-term uninsured, other ways could help make insurance more affordable. For example, unemployment insurance might be redesigned to allow workers to insure against the cost of health insurance during periods of unemployment. And the development of less expensive alternatives to employer-sponsored insurance that individuals could buy on their own would also help to fill and avoid short-term lapses in coverage.

Nearly by definition, the long-term uninsured are unlikely to obtain private insurance. By satisfying a long waiting period requirement, people reveal that they have little ability or desire to obtain insurance—a reflection of some combination of lack of access, high premiums, low incomes, or little perceived need for insurance. Empirically as well, hazard modeling of the probability of ending an uninsured spell suggests that people who are uninsured for more than a year are quite unlikely to acquire insurance in the near future (Swartz and McBride, 1990). Consequently, targeting subsidies at the long-term uninsured has the virtue of avoiding a significant displacement of private insurance. Given the income distribution of the long-term uninsured, offering significant subsidies to encourage a large proportion of these people to obtain insurance would likely be necessary.

Targeting the long-term uninsured, however, presents its own difficulties. For one, rules that base eligibility for subsidies on lack of insurance for a specified time are difficult to enforce. Lipson and Schrodel (1996) report that Florida's Healthy Kids program had a waiting period (six months without health insurance), but dropped it because of enforcement difficulties.

The reverse case, in which eligibility depends on establishing a history of insurance, offers an instructive contrast. HIPAA grants a variety of continuation and portability rights to former employees

with a minimum history of continuous coverage. To identify employees who qualify for these rights, the legislation requires employers to provide written certificates of prior coverage.

How would one develop a similar certification program to establish how long a person has been uninsured? No single institution has the information to certify this information. A national registration system for health insurance coverage will not likely be established merely to enforce the waiting period for a subsidy program. Thus, long-term programs are left to fall back on requiring people to swear or sign that they are eligible. That enforcement mechanism is obviously weak and prone to fraud.

Requiring long periods without insurance also raises a moral issue. Program administrators in Washington and Florida noted that the "right thing" for the uninsured to do is to buy insurance for themselves in the private market (Gauthier and Schrodell, 1997). Requiring participants to be uninsured for a minimum length of time penalizes people who did the right thing by being prudent and buying insurance out of their own pockets. This rule also encourages people to do the wrong thing: remain uninsured in order to satisfy the waiting period requirement.

Put in another way, in an ideal world consumers would buy health insurance policies that would cover them for a lifetime (Cochrane 1995). Lifetime insurance contracts, which obligated purchasers to pay premiums and insurers to pay claims over a lifetime, would protect consumers against the risk of changes in health status that make them "uninsurable." Lifetime insurance contracts would also hold down the cost of health insurance by preventing people from waiting to buy insurance until they were ready to file a significant claim. Coverage programs with long waiting periods encourage the latter sort of behavior and move away from the ideal. Short-term programs, especially those that target people who have already paid for insurance for a significant time, move closer to the ideal. But short-term programs are also the most likely to replace, and not augment, existing insurance arrangements.

As this discussion demonstrates, targeting either the long-term uninsured or the short-term uninsured has advantages and disadvantages, as does any program to extend coverage to the uninsured. Our principal intention here is to call attention to the difference in the size and composition of the groups that are targeted when incremental programs focus on short- and long-term gaps in health insurance. Programs focused on short-term gaps will usually reach fewer of the uninsured, will particularly benefit people with middle and high incomes, and should probably emphasize strategies other than subsidies to encourage more health insurance purchases. Programs focused on long-term gaps will usually cover more of the uninsured, will particularly benefit people at the bottom of the income distribution range, and for that reason will almost inevitably require public financing for many of the newly insured.

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#### APPENDIX TABLES

| <b>Table A1</b>                                                                                                         |                             |                        |                                                                               |           |           |
|-------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------|-------------------------------------------------------------------------------|-----------|-----------|
| <b>Percent of Persons Ever Uninsured in a Year Who Are Eligible for a Program Targeting Long-Term Gaps in Insurance</b> |                             |                        |                                                                               |           |           |
|                                                                                                                         | Total Population (millions) | Percent Ever Uninsured | Percent of Uninsured Who Are Eligible (by length of uninsured waiting period) |           |           |
|                                                                                                                         |                             |                        | 6 Months                                                                      | 12 Months | 18 Months |
| All under age 65                                                                                                        | 224.8                       | 20.3                   | 72.4                                                                          | 56.0      | 39.8      |
| <i>Family Income (percent of poverty)</i>                                                                               |                             |                        |                                                                               |           |           |
| <100                                                                                                                    | 37.2                        | 43.1                   | 78.1                                                                          | 63.1      | 45.2      |
| 100–249                                                                                                                 | 69.7                        | 31.1                   | 72.3                                                                          | 55.7      | 39.9      |
| 100–149                                                                                                                 | 22.5                        | 43.9                   | 73.7                                                                          | 58.2      | 42.5      |
| 150–199                                                                                                                 | 23.9                        | 30.1                   | 74.2                                                                          | 56.0      | 40.0      |
| 200–249                                                                                                                 | 23.3                        | 19.9                   | 66.5                                                                          | 49.9      | 34.0      |
| >250                                                                                                                    | 117.9                       | 6.6                    | 61.1                                                                          | 42.2      | 28.6      |
| <i>Age</i>                                                                                                              |                             |                        |                                                                               |           |           |
| Adult                                                                                                                   | 159.3                       | 20.4                   | 74.5                                                                          | 58.0      | 42.3      |
| Child under 19                                                                                                          | 65.5                        | 20.1                   | 67.3                                                                          | 51.0      | 33.8      |
| <i>Family type and age<sup>a</sup></i>                                                                                  |                             |                        |                                                                               |           |           |
| Single adult                                                                                                            | 45.3                        | 31.3                   | 76.9                                                                          | 61.1      | 46.0      |
| Adult couple                                                                                                            | 42.0                        | 12.1                   | 73.7                                                                          | 57.0      | 43.2      |
| Single parent                                                                                                           |                             |                        |                                                                               |           |           |
| Adult                                                                                                                   | 12.3                        | 26.8                   | 73.1                                                                          | 58.0      | 36.3      |
| Child                                                                                                                   | 16.7                        | 25.9                   | 61.5                                                                          | 45.4      | 24.3      |
| Two parents                                                                                                             |                             |                        |                                                                               |           |           |
| Adults                                                                                                                  | 60.1                        | 16.6                   | 71.5                                                                          | 53.4      | 37.8      |
| Child                                                                                                                   | 47.2                        | 17.2                   | 70.9                                                                          | 55.1      | 40.0      |
| <i>Family employment</i>                                                                                                |                             |                        |                                                                               |           |           |
| Any full-time wage-earner                                                                                               | 166.2                       | 16.4                   | 70.2                                                                          | 52.3      | 36.7      |
| Only part-time or self-employed                                                                                         | 19.9                        | 36.1                   | 73.8                                                                          | 60.5      | 45.8      |
| No workers                                                                                                              |                             |                        |                                                                               |           |           |

|                |      |      |      |      |      |  |
|----------------|------|------|------|------|------|--|
| No workers     |      |      |      |      |      |  |
| Any unemployed | 7.0  | 59.0 | 77.8 | 60.9 | 43.3 |  |
| Other          | 31.7 | 22.0 | 76.5 | 63.0 | 43.8 |  |

<sup>a</sup> Total includes "children" under age 19 who did not live with parents or relatives, who are not shown separately.

**Table A2**  
**Percent of Persons Ever Uninsured in a Year Who Are Eligible for a Program Targeting Long-Term Gaps in Insurance**

|                                           | Total Population (millions) | Percent Ever Uninsured | Preceded by 3 Months of Private Insurance, Covered for: |           | Preceded by 18 Months of Private Insurance, Covered for: |           |
|-------------------------------------------|-----------------------------|------------------------|---------------------------------------------------------|-----------|----------------------------------------------------------|-----------|
|                                           |                             |                        | 6 Months                                                | 12 Months | 6 Months                                                 | 12 Months |
| All under age 65                          | 224.8                       | 20.3                   | 45.5                                                    | 50.7      | 24.0                                                     | 27.1      |
| <i>Family Income (percent of poverty)</i> |                             |                        |                                                         |           |                                                          |           |
| <100                                      | 37.2                        | 43.1                   | 30.9                                                    | 34.8      | 12.5                                                     | 14.3      |
| 100-249                                   | 69.7                        | 31.1                   | 48.7                                                    | 54.4      | 25.0                                                     | 28.6      |
| 100-149                                   | 22.5                        | 43.9                   | 41.8                                                    | 47.3      | 19.3                                                     | 22.7      |
| 150-199                                   | 23.9                        | 30.1                   | 51.4                                                    | 56.3      | 27.5                                                     | 31.0      |
| 200-249                                   | 23.3                        | 19.9                   | 59.3                                                    | 66.7      | 33.2                                                     | 37.6      |
| >250                                      | 117.9                       | 6.6                    | 66.8                                                    | 72.8      | 45.0                                                     | 49.0      |
| <i>Age</i>                                |                             |                        |                                                         |           |                                                          |           |
| Adult                                     | 159.3                       | 20.4                   | 47.3                                                    | 52.9      | 25.7                                                     | 29.2      |
| Child under 19                            | 65.5                        | 20.1                   | 41.2                                                    | 45.1      | 19.9                                                     | 21.9      |
| <i>Family type and age<sup>a</sup></i>    |                             |                        |                                                         |           |                                                          |           |
| Single adult                              | 45.3                        | 31.3                   | 46.8                                                    | 52.3      | 23.6                                                     | 27.7      |
| Adult couple                              | 42.0                        | 12.1                   | 49.4                                                    | 57.0      | 30.6                                                     | 35.4      |
| Single parent                             |                             |                        |                                                         |           |                                                          |           |
| Adult                                     | 12.3                        | 26.8                   | 41.7                                                    | 46.3      | 21.5                                                     | 23.2      |
| Child                                     | 16.7                        | 25.9                   | 42.1                                                    | 44.9      | 18.5                                                     | 19.8      |
| Two parents                               |                             |                        |                                                         |           |                                                          |           |
| Adults                                    | 60.1                        | 16.6                   | 48.7                                                    | 53.8      | 27.7                                                     | 30.2      |
| Child                                     | 47.2                        | 17.2                   | 40.8                                                    | 45.1      | 20.6                                                     | 23.1      |
| <i>Family employment</i>                  |                             |                        |                                                         |           |                                                          |           |
| Any full-time wage-earner                 | 166.2                       | 16.4                   | 51.9                                                    | 56.7      | 27.9                                                     | 30.8      |
| Only part-time or self-employed           | 19.9                        | 36.1                   | 41.6                                                    | 46.3      | 20.2                                                     | 22.9      |
| No workers                                |                             |                        |                                                         |           |                                                          |           |
| Any unemployed                            | 7.0                         | 59.0                   | 33.1                                                    | 40.1      | 18.1                                                     | 22.8      |
| Other                                     | 31.7                        | 22.0                   | 32.2                                                    | 37.9      | 16.3                                                     | 19.6      |

<sup>a</sup> Total includes "children" under age 19 who did not live with parents or relatives, who are not shown separately.

**Table A3**  
**Percent Distribution of Total Population, Persons Ever Uninsured in a Year, and Uninsured Persons Eligible for a Program Targeting Long-Term Gaps in Insurance**

|                                           | Total Population | Uninsured | Ineligibles | Uninsured Who Are Eligible<br>(by length of uninsured waiting period) |           |           |
|-------------------------------------------|------------------|-----------|-------------|-----------------------------------------------------------------------|-----------|-----------|
|                                           |                  |           |             | 6 Months                                                              | 12 Months | 18 Months |
| All under age 65 (millions)               | 224.8            | 45.6      | 12.6        | 33.0                                                                  | 25.5      | 18.1      |
| Percent distribution                      |                  |           |             |                                                                       |           |           |
| All under age 65                          |                  |           |             |                                                                       |           |           |
| <i>Family Income (percent of poverty)</i> |                  |           |             |                                                                       |           |           |
| <100                                      | 16.6             | 35.2      | 27.9        | 38.0                                                                  | 39.7      | 40.0      |
| 100-149                                   | 10.0             | 21.7      | 20.7        | 22.1                                                                  | 22.5      | 23.1      |
| 150-199                                   | 10.6             | 15.8      | 14.8        | 16.1                                                                  | 15.8      | 15.8      |
| 200-249                                   | 10.4             | 10.2      | 12.4        | 9.3                                                                   | 9.1       | 8.7       |
| >250                                      | 52.4             | 17.2      | 24.3        | 14.5                                                                  | 13.0      | 12.3      |
| <i>Age</i>                                |                  |           |             |                                                                       |           |           |
| Adult                                     | 70.9             | 71.1      | 65.7        | 73.2                                                                  | 73.7      | 75.5      |
| Child under 19                            | 29.1             | 28.9      | 34.3        | 26.8                                                                  | 26.3      | 24.5      |
| <i>Family type and age<sup>a</sup></i>    |                  |           |             |                                                                       |           |           |
| Single adult                              | 20.2             | 31.1      | 26.1        | 33.0                                                                  | 34.0      | 35.9      |
| Adult couple                              | 18.7             | 11.1      | 10.6        | 11.3                                                                  | 11.3      | 12.1      |
| Single parent                             |                  |           |             |                                                                       |           |           |
| Adult                                     | 5.5              | 7.2       | 7.1         | 7.3                                                                   | 7.5       | 6.6       |
| Child                                     | 7.4              | 9.5       | 13.3        | 8.1                                                                   | 7.7       | 5.8       |
| Two parents                               |                  |           |             |                                                                       |           |           |
| Adults                                    | 26.7             | 21.9      | 22.7        | 21.6                                                                  | 20.9      | 20.8      |
| Child                                     | 21.0             | 17.8      | 18.8        | 17.4                                                                  | 17.5      | 17.9      |
| <i>Family employment</i>                  |                  |           |             |                                                                       |           |           |
| Any full-time wage-earner                 | 73.9             | 59.8      | 64.7        | 58.0                                                                  | 55.8      | 55.1      |
| Only part-time or self-employed           | 8.8              | 15.7      | 14.9        | 16.0                                                                  | 17.0      | 18.1      |
| No workers                                |                  |           |             |                                                                       |           |           |
| Any unemployed                            | 3.1              | 9.1       | 7.3         | 9.8                                                                   | 9.9       | 9.9       |
| Other                                     | 14.1             | 15.3      | 13.1        | 16.2                                                                  | 17.3      | 16.9      |

<sup>a</sup> Total includes "children" under age 19 who did not live with parents or relatives, who are not shown separately.

**Table A3 Children**  
**Percent Distribution of Total Population, Persons Ever**  
**Uninsured in a Year, and Uninsured**  
**Persons Eligible for a Program Targeting Long-Term Gaps in**  
**Insurance**

|                                           | Total<br>Population | Uninsured | Ineligibles | Uninsured Who Are<br>Eligible<br>(by length of uninsured<br>waiting period) |              |              |
|-------------------------------------------|---------------------|-----------|-------------|-----------------------------------------------------------------------------|--------------|--------------|
|                                           |                     |           |             | 6<br>Months                                                                 | 12<br>Months | 18<br>Months |
| All under age 65<br>(millions)            | 65.5                | 13.2      | 4.3         | 8.9                                                                         | 6.7          | 4.4          |
| Percent distribution                      |                     |           |             |                                                                             |              |              |
| All under age 65                          | 100.0               | 100.0     | 100.0       | 100.0                                                                       | 100.0        | 100.0        |
| <i>Family Income (percent of poverty)</i> |                     |           |             |                                                                             |              |              |
| <100                                      | 23.4                | 42.4      | 40.2        | 43.4                                                                        | 44.0         | 42.0         |
| 100–149                                   | 11.3                | 23.9      | 24.8        | 23.5                                                                        | 24.7         | 27.5         |
| 150–199                                   | 11.4                | 15.1      | 13.3        | 16.1                                                                        | 15.7         | 15.2         |
| 200–249                                   | 10.3                | 8.2       | 9.4         | 7.6                                                                         | 7.9          | 8.0          |
| >250                                      | 43.6                | 10.4      | 12.3        | 9.5                                                                         | 7.7          | 7.2          |
| <i>Family type and age<sup>a</sup></i>    |                     |           |             |                                                                             |              |              |
| Single parent                             | 25.5                | 32.9      | 38.7        | 30.1                                                                        | 29.3         | 23.7         |
| Two parents                               | 72.1                | 61.6      | 54.8        | 65.0                                                                        | 66.6         | 73.0         |
| No parent                                 | 2.4                 | 5.5       | 7.5         | 4.9                                                                         | 4.1          | 3.3          |
| <i>Family employment</i>                  |                     |           |             |                                                                             |              |              |
| Any full-time<br>wage-earner              | 76.6                | 62.9      | 58.4        | 65.1                                                                        | 64.3         | 66.4         |
| Only part-time<br>or<br>self-employed     | 7.0                 | 12.0      | 14.0        | 11.1                                                                        | 12.1         | 12.2         |
| No workers                                |                     |           |             |                                                                             |              |              |
| Any<br>unemployed                         | 3.2                 | 7.1       | 6.6         | 7.4                                                                         | 6.7          | 6.2          |
| Other                                     | 13.3                | 17.9      | 21.0        | 16.4                                                                        | 17.0         | 15.2         |

<sup>a</sup> Total includes "children" under age 19 who did not live with parents or relatives, who are not shown separately.

| <b>Table A3 Adults</b><br><b>Percent Distribution of Total Population, Persons Ever Uninsured in a Year, and Uninsured Persons Eligible for a Program Targeting Long-Term Gaps in Insurance</b> |                  |           |             |                                                                       |           |           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------|-------------|-----------------------------------------------------------------------|-----------|-----------|
|                                                                                                                                                                                                 | Total Population | Uninsured | Ineligibles | Uninsured Who Are Eligible<br>(by length of uninsured waiting period) |           |           |
|                                                                                                                                                                                                 |                  |           |             | 6 Months                                                              | 12 Months | 18 Months |
| All under age 65 (millions)                                                                                                                                                                     | 159.3            | 32.4      | 8.3         | 24.2                                                                  | 18.8      | 13.7      |
| Percent distribution                                                                                                                                                                            |                  |           |             |                                                                       |           |           |
| All under age 65                                                                                                                                                                                | 100.0            | 100.0     | 100.0       | 100.0                                                                 | 100.0     | 100.0     |
| <i>Family Income (percent of poverty)</i>                                                                                                                                                       |                  |           |             |                                                                       |           |           |
| <100                                                                                                                                                                                            | 13.8             | 32.3      | 21.5        | 36.0                                                                  | 38.1      | 39.3      |
| 100-149                                                                                                                                                                                         | 9.5              | 20.8      | 18.6        | 21.6                                                                  | 21.8      | 21.7      |
| 150-199                                                                                                                                                                                         | 10.3             | 16.0      | 15.6        | 16.2                                                                  | 15.8      | 16.0      |
| 200-249                                                                                                                                                                                         | 10.4             | 11.0      | 13.9        | 10.0                                                                  | 9.5       | 8.9       |
| >250                                                                                                                                                                                            | 56.1             | 19.9      | 30.5        | 16.3                                                                  | 14.9      | 14.0      |
| <i>Family type and age<sup>a</sup></i>                                                                                                                                                          |                  |           |             |                                                                       |           |           |
| Single adult                                                                                                                                                                                    | 28.2             | 43.3      | 39.0        | 44.7                                                                  | 45.9      | 47.4      |
| Adult couple                                                                                                                                                                                    | 26.3             | 15.5      | 15.6        | 15.5                                                                  | 15.3      | 15.9      |
| Single parent                                                                                                                                                                                   | 7.7              | 10.2      | 10.8        | 10.0                                                                  | 10.2      | 8.8       |
| Two parents                                                                                                                                                                                     | 37.7             | 30.8      | 34.5        | 29.5                                                                  | 28.3      | 27.6      |
| <i>Family employment</i>                                                                                                                                                                        |                  |           |             |                                                                       |           |           |
| Any full-time wage-earner                                                                                                                                                                       | 72.8             | 58.6      | 67.9        | 55.4                                                                  | 52.8      | 51.5      |
| Only part-time or self-employed                                                                                                                                                                 | 9.6              | 17.2      | 15.4        | 17.8                                                                  | 18.8      | 20.0      |
| No workers                                                                                                                                                                                      |                  |           |             |                                                                       |           |           |
| Any unemployed                                                                                                                                                                                  | 3.1              | 9.9       | 7.7         | 10.7                                                                  | 11.1      | 11.2      |
| Other                                                                                                                                                                                           | 14.5             | 14.3      | 8.9         | 16.1                                                                  | 17.4      | 17.4      |
| <sup>a</sup> Total includes "children" under age 19 who did not live with parents or relatives, who are not shown separately.                                                                   |                  |           |             |                                                                       |           |           |

**Table A4**  
**Percent Distribution of Uninsured Persons Who Are Eligible**  
**for a Program Targeting Short-Term Gaps in Insurance**

|                                           | Preceded by 3 Months of<br>Private Insurance, covered<br>for: |              | Preceded by 18 Months of<br>Private Insurance, covered<br>for: |              |
|-------------------------------------------|---------------------------------------------------------------|--------------|----------------------------------------------------------------|--------------|
|                                           | 6<br>Months                                                   | 12<br>Months | 6<br>Months                                                    | 12<br>Months |
| All under age 65<br>(millions)            | 20.8                                                          | 23.1         | 10.9                                                           | 12.3         |
| Percent distribution                      |                                                               |              |                                                                |              |
| All under age 65                          | 100.0                                                         | 100.0        | 100.0                                                          | 100.0        |
| <i>Family Income (percent of poverty)</i> |                                                               |              |                                                                |              |
| <100                                      | 23.9                                                          | 24.1         | 18.3                                                           | 18.6         |
| 100–149                                   | 19.9                                                          | 20.3         | 17.4                                                           | 18.2         |
| 150–199                                   | 17.8                                                          | 17.5         | 18.0                                                           | 18.0         |
| 200–249                                   | 13.3                                                          | 13.4         | 14.1                                                           | 14.1         |
| >250                                      | 25.2                                                          | 24.7         | 32.2                                                           | 31.1         |
| <i>Age</i>                                |                                                               |              |                                                                |              |
| Adult                                     | 73.9                                                          | 74.3         | 76.0                                                           | 76.6         |
| Child under 19                            | 26.1                                                          | 25.7         | 24.0                                                           | 23.4         |
| <i>Family type and age<sup>a</sup></i>    |                                                               |              |                                                                |              |
| Single adult                              | 32.0                                                          | 32.1         | 30.6                                                           | 31.8         |
| Adult couple                              | 12.1                                                          | 12.5         | 14.2                                                           | 14.6         |
| Single parent                             |                                                               |              |                                                                |              |
| Adult                                     | 6.6                                                           | 6.6          | 6.5                                                            | 6.2          |
| Child                                     | 8.8                                                           | 8.4          | 7.3                                                            | 7.0          |
| Two parents                               |                                                               |              |                                                                |              |
| Adults                                    | 23.4                                                          | 23.3         | 25.3                                                           | 24.5         |
| Child                                     | 15.9                                                          | 15.8         | 15.3                                                           | 15.2         |
| <i>Family employment</i>                  |                                                               |              |                                                                |              |
| Any full-time<br>wage-earner              | 68.2                                                          | 67.0         | 69.5                                                           | 68.0         |
| Only part-time<br>or<br>self-employed     | 14.4                                                          | 14.4         | 13.3                                                           | 13.3         |
| No workers                                |                                                               |              |                                                                |              |
| Any<br>unemployed                         | 6.6                                                           | 7.2          | 6.9                                                            | 7.7          |
| Other                                     | 10.8                                                          | 11.5         | 10.4                                                           | 11.1         |

<sup>a</sup> Total includes "children" under age 19 who did not live with parents or relatives, who are not shown separately.

| <b>Table A4, Children</b>                                                                                                     |                                                         |           |                                                          |           |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------|----------------------------------------------------------|-----------|
| <b>Percent Distribution of Uninsured Persons Who Are Eligible for a Program Targeting Short-Term Gaps in Insurance</b>        |                                                         |           |                                                          |           |
|                                                                                                                               | Preceded by 3 Months of Private Insurance, covered for: |           | Preceded by 18 Months of Private Insurance, covered for: |           |
|                                                                                                                               | 6 Months                                                | 12 Months | 6 Months                                                 | 12 Months |
| All under age 65 (millions)                                                                                                   | 5.4                                                     | 5.9       | 2.6                                                      | 2.9       |
|                                                                                                                               | Percent distribution                                    |           |                                                          |           |
| All under age 65                                                                                                              | 100.0                                                   | 100.0     | 100.0                                                    | 100.0     |
| <i>Family Income (percent of poverty)</i>                                                                                     |                                                         |           |                                                          |           |
| <100                                                                                                                          | 29.1                                                    | 29.6      | 20.2                                                     | 20.2      |
| 100–149                                                                                                                       | 21.5                                                    | 21.4      | 19.8                                                     | 20.5      |
| 150–199                                                                                                                       | 19.6                                                    | 18.6      | 22.8                                                     | 21.3      |
| 200–249                                                                                                                       | 11.5                                                    | 11.8      | 12.0                                                     | 12.7      |
| >250                                                                                                                          | 18.4                                                    | 18.6      | 25.2                                                     | 25.3      |
| <i>Family type and age<sup>a</sup></i>                                                                                        |                                                         |           |                                                          |           |
| Single parent                                                                                                                 | 33.6                                                    | 32.7      | 30.6                                                     | 29.8      |
| Two parents                                                                                                                   | 61.0                                                    | 61.6      | 63.7                                                     | 65.0      |
| No parent                                                                                                                     | 5.4                                                     | 4.2       | 6.7                                                      | 5.2       |
| <i>Family employment</i>                                                                                                      |                                                         |           |                                                          |           |
| Any full-time wage-earner                                                                                                     | 69.1                                                    | 68.3      | 70.6                                                     | 70.4      |
| Only part-time or self-employed                                                                                               | 11.7                                                    | 11.3      | 8.8                                                      | 8.2       |
| No workers                                                                                                                    |                                                         |           |                                                          |           |
| Any unemployed                                                                                                                | 4.6                                                     | 5.6       | 5.3                                                      | 6.2       |
| Other                                                                                                                         | 14.6                                                    | 14.8      | 15.3                                                     | 15.1      |
| <sup>a</sup> Total includes "children" under age 19 who did not live with parents or relatives, who are not shown separately. |                                                         |           |                                                          |           |

| <b>Table A4, Adults</b>                                                                                                       |                                                         |           |                                                          |           |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------|----------------------------------------------------------|-----------|
| <b>Percent Distribution of Uninsured Persons Who Are Eligible for a Program Targeting Short-Term Gaps in Insurance</b>        |                                                         |           |                                                          |           |
|                                                                                                                               | Preceded by 3 Months of Private Insurance, covered for: |           | Preceded by 18 Months of Private Insurance, covered for: |           |
|                                                                                                                               | 6 Months                                                | 12 Months | 6 Months                                                 | 12 Months |
| All under age 65 (millions)                                                                                                   | 15.3                                                    | 17.2      | 8.3                                                      | 9.5       |
|                                                                                                                               | Percent distribution                                    |           |                                                          |           |
| All under age 65                                                                                                              | 100.0                                                   | 100.0     | 100.0                                                    | 100.0     |
| <i>Family Income (percent of poverty)</i>                                                                                     |                                                         |           |                                                          |           |
| <100                                                                                                                          | 22.1                                                    | 22.3      | 17.8                                                     | 18.1      |
| 100–149                                                                                                                       | 19.3                                                    | 19.9      | 16.6                                                     | 17.5      |
| 150–199                                                                                                                       | 17.1                                                    | 17.1      | 16.5                                                     | 17.1      |
| 200–249                                                                                                                       | 13.9                                                    | 13.9      | 14.7                                                     | 14.6      |
| >250                                                                                                                          | 27.6                                                    | 26.8      | 34.4                                                     | 32.9      |
| <i>Family type and age<sup>a</sup></i>                                                                                        |                                                         |           |                                                          |           |
| Single adult                                                                                                                  | 42.8                                                    | 42.8      | 39.5                                                     | 40.9      |
| Adult couple                                                                                                                  | 16.3                                                    | 16.8      | 18.6                                                     | 18.9      |
| Single parent                                                                                                                 | 9.0                                                     | 8.9       | 8.6                                                      | 8.1       |
| Two parents                                                                                                                   | 31.7                                                    | 31.3      | 33.2                                                     | 31.9      |
| <i>Family employment</i>                                                                                                      |                                                         |           |                                                          |           |
| Any full-time wage-earner                                                                                                     | 67.9                                                    | 66.5      | 69.1                                                     | 67.2      |
| Only part-time or self-employed                                                                                               | 15.3                                                    | 15.4      | 14.7                                                     | 14.8      |
| No workers                                                                                                                    |                                                         |           |                                                          |           |
| Any unemployed                                                                                                                | 7.3                                                     | 7.8       | 7.4                                                      | 8.1       |
| Other                                                                                                                         | 9.5                                                     | 10.3      | 8.9                                                      | 9.9       |
| <sup>a</sup> Total includes "children" under age 19 who did not live with parents or relatives, who are not shown separately. |                                                         |           |                                                          |           |

**Table A5**  
**Percent of Uninsured Person-Months Who Are Eligible**  
**for a Program Targeting Long-Term Gaps in Insurance**  
**(Annual)**

|                                               | Total<br>Person-<br>Months<br>(millions) | Percent<br>Uninsured | Percent of Uninsured Who Are<br>Eligible<br>(by length of uninsured waiting<br>period) |              |              |
|-----------------------------------------------|------------------------------------------|----------------------|----------------------------------------------------------------------------------------|--------------|--------------|
|                                               |                                          |                      | 6 Months                                                                               | 12<br>Months | 18<br>Months |
| All under age 65                              | 2675.9                                   | 14.0                 | 73.2                                                                                   | 55.6         | 43.5         |
| <i>Family Income (percent of<br/>poverty)</i> |                                          |                      |                                                                                        |              |              |
| <100                                          | 447.5                                    | 32.2                 | 76.6                                                                                   | 59.4         | 46.8         |
| 100–249                                       | 832.3                                    | 21.5                 | 72.6                                                                                   | 54.9         | 43.0         |
| 100–149                                       | 271.3                                    | 31.1                 | 73.1                                                                                   | 56.1         | 44.1         |
| 150–199                                       | 283.4                                    | 21.2                 | 74.2                                                                                   | 55.9         | 43.9         |
| 200–249                                       | 277.6                                    | 12.4                 | 68.4                                                                                   | 50.4         | 38.7         |
| >250                                          | 1396.1                                   | 3.7                  | 65.8                                                                                   | 47.3         | 36.2         |
| <i>Age</i>                                    |                                          |                      |                                                                                        |              |              |
| Adult                                         | 1909.9                                   | 14.4                 | 74.7                                                                                   | 57.6         | 45.8         |
| Child under 19                                | 766.0                                    | 13.0                 | 68.9                                                                                   | 49.9         | 37.2         |
| <i>Family type and age<sup>a</sup></i>        |                                          |                      |                                                                                        |              |              |
| Single adult                                  | 543.4                                    | 23.4                 | 76.8                                                                                   | 61.3         | 49.8         |
| Adult couple                                  | 494.2                                    | 8.3                  | 74.6                                                                                   | 57.6         | 47.0         |
| Single parent                                 |                                          |                      |                                                                                        |              |              |
| Adult                                         | 149.6                                    | 19.0                 | 71.2                                                                                   | 49.9         | 34.5         |
| Child                                         | 196.8                                    | 16.6                 | 60.1                                                                                   | 38.0         | 25.7         |
| Two parents                                   |                                          |                      |                                                                                        |              |              |
| Adults                                        | 726.2                                    | 10.9                 | 72.2                                                                                   | 54.0         | 42.6         |
| Child                                         | 551.2                                    | 11.5                 | 74.0                                                                                   | 57.1         | 44.4         |
| <i>Family employment</i>                      |                                          |                      |                                                                                        |              |              |
| Any full-time<br>wage-earner                  | 1982.9                                   | 10.7                 | 71.6                                                                                   | 53.9         | 42.2         |
| Only part-time<br>or<br>self-employed         | 237.9                                    | 27.7                 | 76.8                                                                                   | 60.3         | 48.7         |
| No workers                                    |                                          |                      |                                                                                        |              |              |
| Any<br>unemployed                             | 80.9                                     | 44.0                 | 71.9                                                                                   | 53.4         | 40.5         |
| Other                                         | 374.1                                    | 16.1                 | 75.3                                                                                   | 57.5         | 44.5         |

<sup>a</sup> Total includes "children" under age 19 who did not live with parents or relatives, who are not shown separately.

**Table A6**  
**Percent of Uninsured Person-Months Who Are Eligible**  
**for a Program Targeting Short-Term Gaps in Insurance**  
**(annual)**

|                                           | Preceded by 3 Months of<br>Private Insurance, covered<br>for: |              | Preceded by 18 Months of<br>Private Insurance, covered<br>for: |              |
|-------------------------------------------|---------------------------------------------------------------|--------------|----------------------------------------------------------------|--------------|
|                                           | 6<br>Months                                                   | 12<br>Months | 6<br>Months                                                    | 12<br>Months |
| All under age 65                          | 22.9                                                          | 35.0         | 11.1                                                           | 16.6         |
| <i>Family Income (percent of poverty)</i> |                                                               |              |                                                                |              |
| <100                                      | 15.8                                                          | 25.1         | 6.3                                                            | 10.2         |
| 100–249                                   | 24.8                                                          | 38.1         | 11.8                                                           | 17.7         |
| 100–149                                   | 21.4                                                          | 33.5         | 10.0                                                           | 15.1         |
| 150–199                                   | 25.4                                                          | 39.0         | 11.7                                                           | 18.4         |
| 200–249                                   | 32.2                                                          | 47.9         | 16.6                                                           | 22.9         |
| >250                                      | 36.1                                                          | 52.0         | 22.1                                                           | 30.3         |
| <i>Age</i>                                |                                                               |              |                                                                |              |
| Adult                                     | 23.5                                                          | 36.3         | 11.8                                                           | 17.6         |
| Child under 19                            | 21.2                                                          | 31.6         | 9.1                                                            | 13.6         |
| <i>Family type and age<sup>a</sup></i>    |                                                               |              |                                                                |              |
| Single adult                              | 22.8                                                          | 35.0         | 11.4                                                           | 17.2         |
| Adult couple                              | 26.2                                                          | 40.2         | 15.2                                                           | 23.0         |
| Single parent                             |                                                               |              |                                                                |              |
| Adult                                     | 23.3                                                          | 35.9         | 10.8                                                           | 15.2         |
| Child                                     | 24.6                                                          | 34.5         | 10.2                                                           | 14.1         |
| Two parents                               |                                                               |              |                                                                |              |
| Adults                                    | 23.7                                                          | 36.8         | 11.4                                                           | 16.9         |
| Child                                     | 18.8                                                          | 29.2         | 7.9                                                            | 12.5         |
| Child                                     | 25.7                                                          | 36.6         | 11.8                                                           | 16.5         |
| <i>Family employment</i>                  |                                                               |              |                                                                |              |
| Any full-time wage-earner                 | 24.9                                                          | 37.5         | 11.8                                                           | 17.2         |
| Only part-time or self-employed           | 20.0                                                          | 31.7         | 9.2                                                            | 14.4         |
| No workers                                |                                                               |              |                                                                |              |
| Any unemployed                            | 24.5                                                          | 37.6         | 13.2                                                           | 20.7         |
| Other                                     | 18.0                                                          | 28.3         | 9.5                                                            | 14.3         |

<sup>a</sup> Total includes "children" under age 19 who did not live with parents or relatives, who are not shown separately.

#### Footnotes

<sup>1</sup>In reality, the proportion who would qualify could be much larger than these estimates, which were made in the absence of the program, imply. Once the new program is in place, some people will change their behavior, dropping their coverage or staying uninsured longer in order to take advantage of the new program.

<sup>2</sup>We concentrate on the loss of private insurance because the issues surrounding the loss of Medicaid are quite different, as are the policy options. In other words, we assume that reducing the number of Medicaid recipients who become uninsured would require a separate policy initiative.

<sup>3</sup>The SIPP sample is divided into four "rotation groups." Each rotation group is interviewed in successive months, so that a cycle of interviews is completed every four months.

<sup>4</sup>Notice that the question asked of the privately insured does not, strictly speaking, refer to the onset of their private insurance. If the question is taken literally, the answer corresponds to the time when the person was last uninsured.

<sup>5</sup>This percentage translates into 45.6 million people who were ever uninsured during the year. The most comparable figure from the 1991 SIPP panel that has been published by the Census Bureau (Bennefield 1995) is that 20.3 percent of the total U.S. population was uninsured for at least one month in calendar year 1992. As this percentage refers to the entire population, it corresponds to 50.75 million people. There are several methodological differences between our estimate and that of the Census Bureau, which may explain the discrepancy. First, we analyze the last 12 months of the 1991 panel, roughly corresponding to the period from mid-1992 to mid-1993. As the economy was recovering from a recession during the period corresponding to our estimates, the later time frame may explain higher rates of insurance. Second, we attribute Medicaid coverage to SIPP respondents who report AFDC or SSI, even if they do not report Medicaid, because AFDC and SSI automatically qualify recipients for Medicaid. Third, we include people who moved into military barracks, died, or left the scope of SIPP for other reasons during the 12-month period in both the numerator and denominator of our estimates-if they responded for the full period of their eligibility for the panel survey. These part-year respondents are excluded from both the numerator and the denominator in the Census Bureau's estimates. Finally, we use the estimation weights developed by the Census Bureau for the panel file. These weights correct for differential attrition along some dimensions. Nevertheless, because our estimates are drawn from somewhat later months of the panel, it is possible that our estimates are subject to more attrition bias than the Census Bureau's.

<sup>6</sup>Unless otherwise specified, these and other statistics that are not shown in tables in the body of the report can be found in the Appendix tables.

<sup>7</sup>Because children in low income families are eligible for Medicaid, while their parents are not, children in single-parent families (which are disproportionately low income) are less likely to be uninsured for prolonged periods.

<sup>8</sup>Conceptually, these differences could be equalized by considering short-term programs with longer time limits, but long time limits are inconsistent with the concept of a short-term program. The size of the long-term programs could be reduced by imposing longer waiting periods, but longer waiting periods would exacerbate the enforcement and fairness issues associated with the long-term approach that we raise below.

<sup>9</sup>Another way to expand the reach of the short-term programs that we considered is to expand the effort to eliminate gaps in coverage when people leave Medicaid.

<sup>10</sup>In our analysis, because we determined eligibility for the short-term programs by counting back to the start of uninsured spells, we implicitly assumed that it is possible to target people who are about to become uninsured. In actual practice, one has to target events that are likely to trigger a loss of insurance (such as a change in employment). Then the problem is that some of the people who experience such an event would have remained insured without falling back on the public program.



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