

Changing the U.S. health care system: How difficult will it be?

by Barbara L. Wolfe

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Issues of health care reform are gaining increasing attention and are now very high on the list of current public policy concerns in the United States. Two central problems face the U.S. health care system. One is the increasing cost of medical care; the other is the lack of health insurance for growing numbers of citizens. Yet major change is unlikely in the near future. Why is this?

Problems of the U.S. health care system

Costs

The United States spends more money per capita on health care than any other country.¹ Furthermore, health care costs continue to increase at a high rate: in the last decade, every 40 months the share of the Gross National Product (GNP) spent on health care went up by 1 percent. It was 12.3 percent in 1990 and, according to some experts, is expected to be 14 percent this fiscal year.² Even if the rate of increase remained constant, by the year 2000 the United States would be spending at least 15 percent of its GNP on health care.

Most of the costs for health care are paid by so-called third parties—private insurers, public insurance, public direct provision. Only about 25 percent of the costs are paid directly by consumers.

The dominant form of health insurance in the United States is private insurance. Approximately three-quarters of U.S. citizens are covered by private plans (two-thirds of these are covered by employer-based plans); 18 percent are covered by public plans (Medicaid and Medicare), and 13.9 percent have no coverage.³ Many people—particularly the elderly—are covered by both private and public plans.

About 9.7 percent of the population, including more than 15 percent of all children, are covered by Medicaid,⁴ a joint federal-state public program that pays for the health care of low-income and disabled citizens. The greatest outlay of Medicaid funds, however, goes to the elderly. In 1990, 27 percent of total Medicaid spending was for nursing home care (excluding care for the mentally retarded).⁵ The largest public program to provide health insurance is Medicare, a federal program providing coverage to those 65 and over and the disabled who qualify to receive Social Security.⁶

For businesses, the cost of health care is escalating rapidly, more rapidly than inflation and their profits from increased productivity combined. This situation limits a firm's ability to shift the increase in premium costs to employees.⁷ Instead, businesses are offering less generous plans: They are increasing deductibles and/or the co-insurance rate and, more important, they are reducing coverage of the dependents of workers. Coverage for part-time employees has been cut, as have benefits for temporary employees.

One aspect of health care costs that has become increasingly important to U.S. firms is the liability to pay for health care benefits promised to retirees. Beginning this year, firms have to report on their financial statements the unfunded liability of health insurance benefits promised—the estimated amount they owe their retirees in health benefits. One early estimate is a \$227 billion liability in 1988 dollars.⁸

Health care expenditures are also an increasing problem for the public sector. Medicaid continues to grow as a share of state budgets, reflecting both price increases and increases in benefits and eligibility mandated by the federal government. Similarly, health care spending is a major problem for the federal government—it is the second fastest growing component of the federal budget (outpaced only by the growth in the public debt). At both levels of government, health care spending accounts for at least 14 percent of total expenditures.⁹ These costs create fiscal pressures on the governments and limit their ability to respond to other needs, including reducing their budget deficits.

The uninsured

The other major aspect of the health care dilemma is the increasing numbers of persons without health insurance. This problem has grown as firms have cut back on private coverage, as persons have become unemployed, as increasing numbers have taken jobs in industries that tend not to provide coverage (such as the service sector), and as states have attempted to reduce their Medicaid expenditures by restricting eligibility for Medicaid (and welfare). Approximately 34.6 million U.S. citizens do not have any health insurance coverage,¹⁰ and millions more have too little health insurance to cover the costs of catastrophic illnesses or serious injuries.

The probability of being uninsured is far greater among persons who live in families with incomes below the poverty line or just above it compared to those who live in families with higher incomes. Young persons are much more likely to be uninsured than older persons, and those living in single-parent households are less likely to be protected than childless couples.

Strong evidence exists of a link between insurance coverage and utilization of medical care.¹¹ Those with insurance use more care, controlling for health, age, and location, than those without coverage; those with more extensive coverage use more care (at least outpatient care) than those with limited coverage. The lack of coverage causes financial insecurity, inequitable burdens across communities, increased costs for businesses (which must pay higher premiums to cover the costs to medical facilities of care for uninsured and underinsured persons), and increased participation in welfare programs such as Aid to Families with Dependent Children, in addition to delayed and forgone medical care.

Proposed alternative health care plans

Many economists, policy analysts, and politicians have proposed alternative health care plans. These plans can be classified into four categories: employer mandates, expansion of current arrangements, tax incentives, and nationalized health insurance. The employer mandate, the so-called pay-or-play plan, requires employers to provide some minimum level of coverage to all employees and their dependents. Employers could either provide insurance to employees directly, following set specifications both on the breadth and depth of insurance coverage and the "proportion of the premium paid for by the employer,"¹² or they could pay a fixed percentage of their payroll (or a fixed percentage up to a maximum per employee) into a pool, the funds from which would cover the cost of insurance for their employees and their dependents. The insurance pool would be organized by (but not necessarily run by) the public sector and would also offer insurance to those not otherwise covered.¹³ Individuals insured through this ar-

range are likely to pay a significant portion of the cost of coverage. Firms having few workers may be exempted from this mandate. The current plan in Hawaii is an example of pay-or-play. All employees (but not their dependents) who work twenty or more weeks in a year are covered.

The second set of plans—to expand the current public programs—would permit various persons with specific characteristics to "buy into" Medicare or Medicaid, at a cost that is related to their income. For example, all pregnant women, infants, and young children; disabled persons; and/or those who retire before age 65 (the current age for eligibility for Medicare) might be given access to one of these public programs. The current 24-month waiting period for Medicare coverage of the severely disabled is likely to be reduced or eliminated.

A third set of plans would modify the two tax incentives currently in place regarding health insurance. The first is a tax subsidy for the purchase of employer-based coverage. This subsidy, by omitting the employer's contribution to health insurance from the employee's reported income, eliminates both payroll and income taxes on this component of compensation.¹⁴ The second tax subsidy is included in the federal income tax: One can claim a tax deduction for medical care expenditures (including privately paid insurance premiums), for amounts greater than 7.5 percent of adjusted gross income.

The current set of incentives is worth more to higher-income persons, since the value of the incentives depends on one's marginal tax bracket.

Proposed modifications would provide refundable tax credits¹⁵ to low-income families,¹⁶ and/or set a maximum on the amount of the employer-based premium that can be excluded from the employee's tax base.¹⁷ This maximum could be based on an actuarial cost of a basic insurance plan for families of specified sizes and ages (with an adjustment for disability). A third alternative would combine employer-based insurance incorporating a high deductible (say a family would have to pay \$36,000 per year before receiving reimbursement) with an employer contribution to a tax-free medical savings account to cover deductibles and other health costs. The savings account would work like an Individual Retirement Account (IRA). The employer contribution would be based on the savings from shifting to a new insurance plan with a much higher deductible. The funds could be used for deductibles, for insurance premiums (should the individual not be employed), or for long-term care. The employee would keep any savings amounts not spent, subject to certain limitations on withdrawals.

President Bush's proposal is an example of a plan that uses tax incentives. His proposed plan would provide a refundable tax credit to those with family incomes below the poverty line; a sliding-scale nonrefundable tax credit to

families with incomes up to \$80,000 (in 1992 dollars) and to single persons with incomes up to \$50,000; and a tax credit to all the self-employed without regard to income. For 1992, the tax credit would be \$3750 for a family or \$1250 for an individual, usable only to purchase health insurance. The value of the credit would increase by the rate of overall price inflation.

The final set of policies being discussed is some form of nationalized health insurance. They range from combining the expansion of public programs with mandated coverage to full-blown single-payer systems (in which the government pays for all medical care) like that of Canada (see below). Providers of care remain private, but the financing is public. One primary focus of these plans is to eliminate the high cost of overhead caused by the duplication of forms, administration, etc., of multiple payers.

The German system of medical care resembles that of the United States in some ways: care outside of hospitals is provided by private practitioners who are paid on a fee-for-service basis and who provide care to patients who choose them; hospital care, however, is provided by doctors who work for the hospital and are paid a salary. (The fees paid to physicians are based on a negotiated fee schedule,¹⁸ whereas the hospital payment is based on a negotiated per diem rate.)¹⁹ Most persons receive insurance through their place of employment (many plans are based on occupation), and health insurance is offered by numerous insurers. Unlike the situation in the United States, 90 percent of these insurers are nonprofit and are known as sickness funds. These sickness funds are more heavily regulated than U.S. insurers: they must offer a minimum plan; employees and the self-employed (except those with high incomes) must enroll in a plan; dependents must be covered; unemployed and retired persons (and their dependents) must be covered by the sickness fund that covered them while employed; no deductibles are permitted; and there is cost-sharing only for hospital care and prescription drugs. Financing is via mandatory payroll contributions of about 13 percent of wages, subject to a ceiling. These payroll taxes cover the costs of the entire system.

The Canadian plan combines private fee-for-service practitioners with hospitals that operate on a budget that is set annually. Long-term care is provided as part of the system. Providers are paid according to a fee schedule and patients cannot be charged directly—there are no co-payments. All citizens of Canada are covered; the central government covers a share of the cost of the plan, the provinces, the rest. Each province has its own plan to provide additional financing, determine fee schedules, regulations, etc. Compared to the United States, fewer practitioners are allowed to practice (in a number of the provinces); there is far less investment in new capital and less diffusion of new technology; there is more queuing and more denial of care. On the plus side, greater contact exists between physicians and patients, and financial insecurity caused by the uncertainty

of the costs of future medical care and insurance coverage has all but been eliminated.

Why is change difficult?

It is unlikely that the United States will change its health care system substantially in the next few years. Minor reforms may occur on the state or local level; tax incentives may well be altered to subsidize the cost of buying insurance for those not insured at their place of employment; but no major national change can be expected. There are several reasons for this:

1. It is generally assumed (and feared) that extending coverage to those who are currently uninsured will substantially increase the costs of medical care. This may not, in fact, be true. About half of those uninsured at any point in time will have coverage within about eight months,²⁰ and their overall utilization of the system is unlikely to increase substantially if they have coverage all of the time rather than intermittently. In addition, most persons without insurance do receive care when they become seriously ill. The cost of this care is already included in medical care expenditures. Some increase in expenditures on medical care can be expected, at least in the initial period in which coverage is extended, but the total cost of such increased coverage will be smaller than is publicly perceived.

2. Entrenched interest groups wish to avoid any change that might penalize them. The private insurance sector, including its employees, for example, is bound to fight against the shift to public provision of health coverage or mandated private coverage of high-risk persons. Private health providers (depending on the proposed plan) may fear reduced compensation and further regulation of their services. Suppliers of medical equipment—a broad spectrum of companies—may fear loss of business. Employees and their dependents who are currently covered by plans provided at their place of employment with little cost-sharing required of them also have an interest in maintaining the status quo, as do employees covered by the policy of other family members. Employers in firms that do not offer insurance or offer only limited coverage may fear the increase in costs. And low-income earners may place a smaller value on health insurance than the cost to them of proposed plans.

Parties who might gain tend to be more diffuse and may not coalesce to lobby for a proposed change. These groups include employers who now provide extensive coverage to their employees and the dependents of their employees; providers who primarily serve low-income people, especially those who are uninsured; individuals who are not covered because they are high risk and/or do not have the option of obtaining coverage at their place of employment; employees who see their cash compensation eroding as the cost of insurance coverage takes a larger and larger share out of their paychecks; and, finally, employees who fear the

loss of coverage either because of anticipated reductions in breadth of coverage or loss of their job.

3. Mandating coverage may increase unemployment, particularly for low-skilled workers, and may force some small businesses into bankruptcy. At this time of relatively high unemployment, this is a serious danger. It is a problem, however, primarily for the employer-provided pay-or-play plans.

4. Many citizens (employers, employees, and others with private income) fear that a number of these plans will lead to higher taxes—and hence reduce their net income. Whether net income is reduced depends on the plan adopted, its financing, and the individual's current situation. Most of the new plans appear more costly to employees than the system in place, because few employees fully understand that they are now paying (albeit with pretax dollars) for most of their health insurance. Furthermore, employees are not likely, at least immediately, to obtain the full value of their current contribution to health insurance (this refers to the component now known as the employer's contribution) in their paychecks if coverage is removed from their place of employment.²¹ Under any scenario, some persons will lose (pay more, get less coverage) and others gain (obtain coverage, pay less). But it is difficult to predict accurately what sort of redistribution of costs and benefits will occur. (We really do not fully understand who actually pays for medical care today.)

5. Although there is little willingness to provide the highest quality care to those publicly insured (for example, to those on Medicaid), there is also an unwillingness to "bite the bullet" and ration health care or to set up clearly defined dual standards of care. Many are also reluctant to hold down the rate of improvement in technology or to move away from the so-called technological imperative (do all that is technologically possible to save a life). But at least some members of the public may no longer hold this position. The rapid spread of living wills demonstrates that individuals sometimes choose to limit major life-saving efforts when there is little chance of long-term survival or for a high-quality life. The state of Oregon has also moved away from the goal of providing all possible health services to a limited number of Medicaid recipients. It is attempting instead to provide coverage to a greater number of persons by establishing a list of medical priorities and allocating a specified level of dollars according to that priority list. Other care will not be provided under the Oregon Medicaid plan.²²

What can be done?

What all of this suggests is that major change is unlikely in the next few years, but that more realistic attitudes toward medical care are likely to increase the probability of change in the more distant future. More accurate information would be a first step in evolving more realistic attitudes. If

people had an accurate picture of how much they are paying—and for what—they could better assess proposed changes. The United States has a good deal to learn about its health care system and a good deal to teach its citizens if productive change in its health care system is to take place.

Absent any major shift, however, steps can be taken to patch the current health care system. One such step would be to provide coverage for a specific set of services to *all* children under the age of nineteen under what I call a Healthy-Kid program. Primary care would be provided in community care centers, where parents and children would go for children's care. Further medical care would be referred to other private providers, but with the community care center as the manager of the care for all children who live in the area.²³ Certain basic care, such as immunizations, would be provided to all children without charge; specific additional care would require co-payments which would be income conditioned. That is, higher-income families would pay higher charges. The plan would also cover pregnant women—again with co-payments tied to income. The plan would be operated through the Health Care Financing Administration (HCFA), which now runs Medicare. The payments to the community providers would be in the form of a prepayment for all specified services (similar to payments to a Health Maintenance Organization), except for required co-payments. The payments to providers would not depend on the income of the child's family but only on geographic location (and, perhaps his or her underlying health status for those with a chronic condition).²⁴ The (group of) community providers would be responsible for paying all of the additional costs of care for children in their jurisdiction; HCFA would provide reinsurance above a set limit (that is, they would cover medical expenses over a very high amount, say \$100,000).

Children are relatively inexpensive to cover. Including all of them in one program would avoid a dual-quality system, ensure access to basic preventive services, and provide access to family planning and prenatal care for teenagers, who would know where to go to receive assistance. Providing coverage for children would reduce the cost of employer-based and other private coverage, increasing thereby the probability of greater private coverage for adults.²⁵ Locating programs in communities would increase the likelihood that residents would use the appropriate clinic rather than emergency rooms and other expensive and inefficient forms of care. Providing coverage for pregnant women in their communities should encourage the early use of prenatal care and hence decrease the need for high-cost care such as intensive care for infants with low birth weights.

A second step that could be taken would be to cap the tax subsidy on employer-based health insurance. If a cap is enacted, it is likely to lead to a redesign of policies to provide protection for major health problems. Insurance companies would have an incentive to design policies to provide full coverage for care that is cost-effective (immu-

nizations, certain screening programs) but would require significant co-payments for other care. Insurers would face a new incentive: to provide coverage such that the premium was not much beyond the cap, thereby reducing the cost of the plan. Employees would become aware of the cost of their insurance, for they would directly pay any amount over the cap with posttax dollars and would have increased co-payments as well.

A cap on the tax subsidy for health insurance and the introduction of Healthy-Kid are useful first steps, therefore, both toward improving the current U.S. health care system and toward forcing us to realize what it costs. ■

¹As of 1990, the United States spent \$2,566 per person, or \$666.2 billion, on health care (U.S. House of Representatives, Committee on Ways and Means, *1992 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means* [Washington, D.C.: GPO, 1992], pp. 288–289).

²The increase has several causes, including the aging of the population (older persons use far more medical care than younger persons); the improvements in technology, which extend life and improve the quality of life but are expensive in terms of real resources; and the third-party payer system (see text), which makes possible the rapid spread of new technology but reduces the incentive of consumers to search for lower-priced care and increases the probability that they will demand care for any given health problem.

³*1992 Green Book*, pp. 312–313.

⁴*Ibid.*, p. 1646.

⁵*Ibid.*, p. 281.

⁶Persons on end-stage renal dialysis are also eligible, regardless of their eligibility for Social Security.

⁷It is difficult for firms to reduce nominal wages. Hence, if there is little growth in productivity or little increase in prices, firms are constrained in their ability to shift to employees the burden of paying for increases in health insurance. Over time, as prices increase and as productivity increases, the increased cost of health insurance can be passed on to employees.

⁸Estimate from the U.S. General Accounting Office, HRD-89-51.

⁹According to K. Levit and C. Cowan, “Business, Households, and Government: Health Care Costs, 1990,” *Health Care Financing Review*, 13 (Winter 1991), 83–93, Table 5, including expenses for employees, 17.2 percent of federal revenue and 16.3 percent of state and local revenue go for health care.

¹⁰*1992 Green Book*, p. 311.

¹¹See for example, K. J. Arrow, “Uncertainty and the Welfare Economics of Medical Care,” *American Economic Review*, 53 (1963), pp. 941–973.

¹²This is in quotes, for most economists believe that, with the exception of workers at a mandated minimum wage, employees bear the bulk of the cost of insurance in terms of forgone earnings. However, if there is a

sudden increase in coverage, it may take time for the full share to be shifted to employees. This occurs because it is difficult to reduce nominal wages.

¹³The public sector would also provide a subsidy toward the purchase of health insurance for those with low incomes. However, if the “pay” part of the pay-or-play plan were large enough, this would not be necessary.

¹⁴Employees of certain types of firms can also set up a special account which allows them to omit their own expenditures for health care from their income for income tax purposes. Once a year, a decision can be made to put an amount they specify into an account set up for the purpose of paying for health care expenditures. If funds remain at the end of the year, they are not returned to the individual.

¹⁵Under a refundable tax credit, the government refunds to the taxpayer any amount of the credit remaining after taxes are paid.

¹⁶The formation of risk pools is another alternative that is sometimes discussed in conjunction with refundable tax credits. Single individuals, families, or small firms generally must pay far more for the same insurance coverage than persons in large groups. Risk pools combine groups of individuals or small groups of employees to reduce the surcharge insurance companies charge small groups or individuals. (The surcharge reflects both higher costs of selling to small groups and the fear of adverse selection—that only those with the greatest expected medical expenditures will purchase individual policies.)

¹⁷A proposal to reduce the tax subsidy to high-income persons is a more limited form of such policies.

¹⁸These fee schedules are based on a relative-value scale similar to that being introduced for Medicare. The actual schedule differs across regions and is the result of negotiations between regional associations of physicians and the nonprofit insurers. They can be lowered toward the end of the year if expenditures on physicians are high relative to a goal or cap.

¹⁹These rates are based on annual global (all-inclusive) budgets set for each hospital, the result of negotiations between each hospital and the regional association of insurers.

²⁰K. Schwartz and T. McBride, “Spells without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured,” *Inquiry*, 27 (1990), 281–288.

²¹Firms are likely to wait to see how much they will have to contribute under any new financing plan, and they may seek to establish alternative fringe benefits to promote employee loyalty. Both of these likelihoods reduce the amount firms are willing to offer employees as cash compensation.

²²The plan must be approved (i.e., granted a waiver) by the federal government before it can be put into effect. In its present form, the waiver has been rejected by the Bush administration.

²³The providers in the community care center would be either private providers who contract to provide care at the center as well as manage all additional care for the children served by the center or, in certain limited cases, publicly employed providers.

²⁴The conditions covered would be limited and might include certain cancers, AIDS, and a few other expensive chronic conditions. The adjustment would be a multiplicative factor such as 1.5 times the basic prepayment.

²⁵For private insurance companies, Healthy-Kid may represent a trade-off: a loss of the market for children and pregnant women but an increase in the market for adults.