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What's the Problem?

With all the talk about the health-care “crisis” facing the United States, it is useful to note that people are ambivalent. According to a 1992 poll, 75 percent of American people are happy with their own medical care. But they are worried about the system. A similar percentage thinks the health system needs a complete overhaul.

There are two basic problems. Lack of coverage is serious. Approximately 15 percent of people under 65 are not insured. We hear a lot about people being turned down for health insurance. Surely, being turned down hurts. But less than 1 percent of people under 65 are uninsurable due to preexisting conditions.

Ballooning national health-care cost is a second public policy problem. Health care, by far, is the fastest growing part of the federal budget. It was 3 percent of the total in 1965. Federal health expenditures rose to 10 percent in 1980, and to 16 percent in 1992.

Similarly, health-care spending comprises a rapidly rising share of the entire economy. From 5 percent of Gross Domestic Product (GDP) in 1960, these outlays rose to 9 percent in 1980 and to 15 percent in 1993. The Congressional Budget Office estimates that medical expenses will comprise 19 percent of the U.S. economy in the year 2000 — with no change in policy. The status quo does not seem to be sustainable. Before examining proposed cures, let us analyze the causes.

What Causes the Problem?

As for the lack of coverage, it is mainly a small business phenomenon. About 80 percent of those uncovered are workers in small firms or their families. A key factor is that

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small employers do not enjoy the economies of scale that benefit larger enterprises. For example, overhead eats up 40 percent of the premiums paid by firms with 1-4 employees. The ratio falls to 25 percent for employers of 20-49 and to 12 percent for employers with 500-2,500 workers. For the largest firms (10,000 or more), the overhead ratio is a modest 5-1/2 percent.

A complicating factor is that young people account for 40 percent of the uncovered, and many of them have voluntarily turned down the coverage. They tend to be healthy but do not have the financial strength of people who have been working longer. Also, the lack of coverage is often a short-term problem. On average, the problem has a six-month duration. A further complication is that small companies cannot buy a modest health-care plan. State insurance commissions dictate the composition of these plans and they are very amenable to lobbying by special interests. Thus, in some states, the plans must include hair transplants and other optional items. In effect, the small employer cannot buy a Ford. It must be a Lincoln — or nothing. As Voltaire said it, the best is the enemy of the good.

The problem of high and rising medical costs is an extremely complicated issue. A fundamental factor is the strategic shift in who pays. Back in 1960, people paid 56 percent of their health-care costs, while government agencies and insurance companies each paid 21 percent. A complete reversal has occurred in the intervening years. By 1991, people paid only 22 percent of their medical costs. The lion's share was borne by government (43 percent) and insurance (32 percent).

For hospital service, as an example, the patient now pays only 3 percent. For doctor bills, the average patient payment is 18 percent of the total.

Another factor contributing to rising medical bills is that we live longer. Therefore, expensive-to-treat diseases like cancer that usually hit older people are more prevalent. A key reason we live longer is the use of expensive new medical technology — which, in turn, contributes to higher medical costs in many ways. Thus, we now use less of the available hospital capacity. Nearly 40 percent of hospital beds are empty. The United States has the lowest death rate for stomach, cervical, and uterine cancer — and the second lowest rate for

breast cancer and heart attacks. As for our high infant mortality rates, in large part they reflect the high incidence of drug usage and crime.

Economic illiteracy is another factor pushing up health-care costs. Employer-paid insurance means to many people that health care is free. Of course, that is not how economists look at it. As employees are beginning to realize, fringe benefits such as employer-paid health insurance are part of the worker's total compensation package. More for health care means less for direct wages. That is what has been happening.

Finally, we must acknowledge the widespread attitude, "nothing's too good for me if I don't have to pay for it." Few Americans know the origin of this particular fringe benefit. After all, employers do not provide food stamps — or rent stamps. Employer-paid insurance is a side-effect of World War II wage controls. The lid on wages did not extend to fringe benefits, which became the major loophole. But when the controls were lifted, workers had become used to this "freebie."

What Cures Are Available?

Everyone favors the attractive solution of reducing paperwork and overhead. But if we were really serious about it, we would pay the routine bills ourselves. Sadly, that is viewed as too "extreme" a solution. But we follow that practice in the case of auto insurance. There the motorist pays for small items and the insurance companies pay for the big ones. We know that keeps our insurance bills down and nobody gripes about being "unfair" to poor people.

But because we do not view health insurance as insurance, but as a benefit, the patient does not pay for the small items (which are so costly to administer) and often runs out of coverage for the really big items.

In one response to high medical costs, the Clintons want to cut profiteering. Both the President and Mrs. Clinton have repeatedly threatened to "crack down" on the "profiteers" who make a "killing" off the current system. Aside from not sounding presidential, that

approach avoids making hard choices. Thus, they pick on the pharmaceutical companies. Yes, many of the companies have been quite profitable. But, yes, they also plow back unparalleled amounts of retained earnings into R&D. The result is that the United States leads the world in developing new and better medicines. The Administration ignores the fact that prescription medicines have declined from 10 percent of the health-care dollar in 1960 to 5 percent in 1992.

But pharmaceuticals *are* different. As we have seen, insurance or government pays for most doctor and hospital bills. But the patient pays the drug store most of the time. Drugs are a large share of the patient's out-of-pocket cost, and therefore politically vulnerable. Also, the "villain" is big business, always a much easier target than non-profit hospitals or the family doctor.

A standard proposal is to control health-care prices. Because of past failures with price controls, no one is suggesting something *called* price controls. So, instead, the Clinton Administration proposes boards to set dollar ceilings on health costs. That is supposed to force the medical system to become more efficient. Personally, this suggestion arouses my cynical feelings. Here's a parallel: The public debt limit was supposed to limit federal deficits. In practice, Congress just raises the debt ceiling from time to time to accommodate more federal spending.

Now, I reluctantly turn to the most controversial aspect of controlling health-care costs — the hot potato that politicians in both parties try to ignore. The really big potential cost saving is from controlling *usage*. The Canadians do it by making people wait longer. On average, it takes five months to get a pap smear and nine months for a hip replacement. You are more likely to die while waiting for a heart operation than on the operating table.

If we are serious about controlling health-care costs, sooner or later we will have to think about the unthinkable: the issue of bodies in prone vegetative state. The hard fact is that we prolong life support beyond other nations. They often have age limits on types of surgery. A key question — so difficult to answer — is "who should hold the plug?"

Consider the case of the mother who did not have the heart to pull the plug on her immobile child. It was an episode on *60 Minutes*. She knew the situation was hopeless, but tearfully she said that she knew that she should pull the plug, but did not have the heart to. More objective people must ask, “Why is the plug in her hand?” She is not paying the bills, nor is she in a position to make a sound judgment.

A related issue is the right-to-die. A recent case in Philadelphia involved a 43-year-old who had spent the past 22 years in a “persistent vegetative state.” Only the brain stem — the part of the brain that runs the body’s organs — still functions. The State Superior Court rejected the mother’s request to let her son die in peace. The lower courts must now retry the case keeping in mind that, in the words of the majority opinion, “First and foremost, our actions are motivated by the desire to preserve life.”

Whatever our views on the legal, ethical, religious, and moral aspects of such cases may be, the fact is that the status quo drives up health-care costs.

The Clinton Proposal

The Clinton health-care reform proposal is a complicated matter. Turning to the mechanics of the plan, five levels can be identified. Whatever their merits, it surely is hard to agree with the argument that no new bureaucracy is contemplated. At the top of the health-care system pyramid will be a *new seven-member National Health Board*. It will oversee state plans and the functioning of health alliances. The Board also will administer and update the package of benefits guaranteed each person. As presently envisioned, that is substantial.

- For hospital stays, a semi-private room plus ambulance and outpatient services.
- Visits to the doctor, lab tests, prescription medicines, and eyeglasses (but for children only). Excluded from coverage will be hearing aids, contact lenses, sex-change surgery, cosmetic orthodontia, and in-vitro fertilization.
- Outpatient physical or occupational therapy — but only where necessary to restore skills lost from illness or injury.

- Home care, but only where it is an alternative to hospitalization (the idea is that it will be a lower-cost substitute).
- Hospice care for the terminally ill.
- Dental care: most care for children and adult prevention benefits (latter to be phased in).
- Nursing homes as an alternative to hospital stays — but no more than 100 days a year.
- Mental health, including limited psychotherapy, limited inpatient services, and limited psychiatric hospital stays.
- Preventative care, such as immunizations, mammograms, pap smears, prenatal care, and cholesterol screening.
- Substance abuse, limited inpatient services, and limited outpatient services.

The National Health Board will also enforce the national health-care budget. A committee of the board will monitor drug prices, fining those they consider “unreasonable.”

A presidentially appointed National Quality Management Council will also be set up. It is to be comprised of 15 members “broadly representative” of the U.S. population. The Council will develop measures of “quality” in order to standardize the measurement of the performance of health plans. Also, a 15-member advisory committee will be set up to help develop the methodology for a national risk adjustment mechanism and to guide changes in insurance premiums.

It is hard to take seriously the White House talk about reducing the health-care bureaucracy. The added personnel I’ve covered thus far are the top of the pyramid; the federal role. *Each state* will be required to set up its own bureaucracy to carry out a host of new functions that will be imposed on it. These will include: establishing and overseeing new health-care alliances (one or more per state), qualifying health plans and overseeing their financial viability, and establishing “capital” standards for health plans to meet federal standards.

If the states do not meet their new “responsibilities,” the Feds will punish them or take over the responsibility. Each state will also operate a guaranty fund. In practice, healthy plans will bail out sick ones, as we will see.

Health-care alliances are the third level. Each state will determine the structure of its alliances. They could be state agencies or nonprofit corporations. Consumers and employers are to be equally represented in the management of each alliance. That sounds like a political football or amateur hour — or both. An employer of more than 5,000 can set up its own alliance.

Each alliance negotiates with health-care plans to determine who will provide the comprehensive benefits package. The alliances will enroll members in health plans — and everyone must join. Each alliance sets fee schedules for doctors and provides information on quality and costs of the different plans.

Alliances can borrow from the U.S. Department of Health and Human Services (HHS) to cover cash shortfalls. Thus, a new credit program is in the making. The Council of Economic Advisers estimates that the regional alliances will need 50,000 new hires. That is at least \$1 billion in additional overhead.

Health plans are the fourth level. They may be organized by insurance companies, hospitals, or other health-care providers. Each plan must accept any eligible member — unless oversubscribed. The plan may charge a standard fee for each member, a fee for service, or a combination. Fee for service means choosing your own doctor, as at present. (We’ll examine that alternative a little later.)

Finally, at the fifth and bottom level of the pyramid we come to *health-care providers*. They actually take care of sick people. But only if the provider is part of a health plan approved by a health-care alliance.

Who Pays?

The simple answer to the question is that everyone pays for the Clinton health plan. I’ve identified at least six categories. First of all, *employers* must pay at least 80 percent of the

average cost of health-insurance premiums in their region. They also must support family coverage for married workers. There will be a limit of 7.9 percent of payroll for large companies and 3.5 percent for small companies. The federal government will subsidize some small businesses. There is a catch here (there are a lot of catches or sand traps in the details). The health-insurance premiums also will finance the regional alliances — up to 2.5 percent of premiums — as well as the HHS programs of aid to medical education (another 1.5 percent). A hidden employer tax is discussed below, for early retirees.

Employees will contribute an average of 20 percent, according to the White House materials. However, the arithmetic seems to be faulty. If employers must pay *at least* 80 percent and can pay more (as many now do), it is hard to come up with an employee average of 20 percent.

The *self-employed and those not working* will have to buy insurance and pay full cost — unless they qualify for government subsidy. The total cost will be tax deductible, which is more generous than the current tax treatment.

Government (e.g., general taxpayers) will also pay some of the cost. After all, the federal government will be subsidizing many small and low-wage businesses, as well as individuals with incomes below 150 percent of the poverty line.

Medicaid payments will be made through health alliances, but Medicare for the elderly and disabled will continue as at present. The federal government also will pay 80 percent of the health-care benefits for those retiring between 55-65, the years before Medicare kicks in. This new burst of generosity is to be financed via a one-time tax on affected companies, based on their financial gain from government assuming the costs. A one-shot tax payment offsetting a long-term benefit involves a painful cash outflow; that is one of the many repercussions that seems to be ignored.

Patients constitute a category of health-care payers that is softpedaled. Those who sign up for an HMO (standard fee for each member) will pay \$10 per office visit or outpatient service. However, those enrolled in fee-for-service plans will pay much more. They will have

to bear out-of-pocket 20 percent of the cost of office visits and hospitalization. There will be deductibles of \$200 a year for individuals and \$400 for families. Annual payments will be limited to \$1500 for individuals and \$3000 for families. On the positive side, those enrolled in fee-for-service can go to any doctor.

Cigarette smokers will help to pay for the medical costs. Higher excises will help to finance government subsidies.

There is a sleeper in the state role. If a state does not take on its "responsibility," the Department of Health and Human Services takes over. It can levy a 15 percent surcharge on all health-insurance premiums to finance its new bureaucracy.

Major Criticisms

Let us examine four major criticisms of the Clinton Plan.

1. *Patients lose choice of doctor.* The White House denies this vehemently. But if your physician is not a member of an approved plan, you will pay for services out of your own pocket. Ironically, an Administration so visibly concerned with fairness provides real choice only to those rich enough to pay extra.

2. *Introduces costly new layers of bureaucracy.* We have seen the details on the new federal control apparatus and have noted that each state will have to set up an operation to choose and monitor the alliances. Moreover, each alliance will be a new administrative activity. The individual health-care plans will be more bureaucratic than the typical situation now facing the individual patient.

A federal agency will have to set and pay out a variety of subsidies — to small businesses, to employers of low-income labor, to the unemployed not on Medicaid, and to those taking early retirement.

3. *It will raise, not lower, the rising trend of medical costs.* Even the White House estimates that, for the first few years, total health outlays will rise above the CBO "baseline."

By 1998, however, total costs are supposed to slow down. Giving more people more health coverage sounds as if it will be expensive, even if economies and efficiencies offset the new bureaucracies. Of course, there are many opportunities for greater efficiency.

The dollar ceilings — via limits on insurance premiums and on doctors' fees — are supposed to keep medical prices down. But, if dollar ceilings are kept, will quality of care suffer? That does seem likely. After all, rich and influential Canadians come to the United States for serious health care.

4. *The Clinton Plan has lots of punitive provisions.* Even though the talk is all about patient choice, the substantial expansion in the federal role in the entire health-care sector will be accompanied by the exercise of governmental power. For example, if a person does not want to enroll in any plan, the regional alliance will do it for him or her — and *double* the regular premium.

If a plan has generous provisions — costing 20 percent or more above the regional average — it will be excluded. Thus, the plan will not be available to anyone, even if people want to pay for it out of their own pockets. So much for the alternative of “fee for service” plans and patient choice. Clearly, the Clinton Plan contains price controls, but under different names. Doctors will be fined for departing from “targets” set by alliances and the National Health Board. Ditto for health-insurance plans. The notion that the Clinton Plan avoids price controls by calling the result “targets” is, to put it mildly, ingenuous. Similarly, it converts what are now voluntary insurance premiums to compulsory taxes, but avoids changing the label. In addition, the Secretary of Labor can assess each corporate alliance up to 2 percent of its insurance premiums to finance a new Corporate Alliance Health Plan Insolvency Fund. But it won't be a “tax”!

Outlook for Enactment of Health-Care Reform

Rarely does Congress enact a major program without making many changes. Moreover, no recent president has been able to deliver on all of his campaign promises. Thus,

quick passage of the health package is not likely. Each House will hold extended hearings and make major changes in the plan. Passage is not expected before the fall of 1994. One bipartisan lesson emerges from the past. Enacting an ambitious new program is very difficult. Doing so under great time pressure virtually guarantees serious mistakes. It is much harder to revise programs of this sort than to do it right the first time, because revision usually means taking benefits away from somebody. The "easy" way out is to spend more federal money than originally envisioned. Medicare and Medicaid are excellent examples.

Meanwhile, changes are being made in health care voluntarily, and often in anticipation of federal legislation. The largest insurance companies are beginning to set up "community care" networks. They are acquiring hospitals and clinics, so that they can offer a full spectrum of treatment for a fixed price.

Ultimately, these conglomerates may include, in addition to insurance companies and hospitals, outpatient clinics, doctors' offices, nursing homes, hospices, home health-care services, pharmacies, drug treatment centers, and medical equipment suppliers.

The Michigan health-care network is a pioneer. It is vertically integrating the Henry Ford Health System, Mercy Health Services, and Michigan Blue Cross/Blue Shield. The network of 13 hospitals offers health care to groups of 100 employees or more. It requires a fixed monthly payment averaging \$200 for an individual and \$466 for a family. The Michigan network promises that premiums will not rise more than 5 percent in 1994 or 1995.

The South Carolina Medical Association is developing an alternative. It is forming a statewide network of doctors to negotiate contracts with employers and take responsibility for controlling their health costs. The Association intends to negotiate an annual health-care spending goal for each company, sharing any savings as well as any overruns.

Health-care networks already dominate Southern California. Hospitals, physicians, and insurance companies all have established health-care networks. Solo practitioners are getting rare. One byproduct seems to be the creation of a new class of millionaire entrepreneur-physician.

Elsewhere, perhaps insurance companies and hospitals will get together. Between them, they have the large organizational skills and recordkeeping that will be necessary. The hospitals have the patients and the insurance companies have the market — the willingness of employers to pay for the health care of the employees.

Meanwhile, pharmacies are increasingly becoming members of chains, franchises, and other group efforts. Stepping back from the concern with health care, important as it is, we have to ask, “Is the day of the small ‘business’ in services over?”