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TOWARD A NATIONAL HEALTH PLAN

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ABSTRACT

Medical care in the United States is very expensive. The goals of a national health plan are therefore clear: to make needed care affordable and to create cost controls. In the past these problems have been attacked separately. The purpose of this paper is to discuss these two goals.

The focus of the American way of health is "intervention." A problem occurs, it is diagnosed, and it is treated in an acute care facility. Very little money is spent on prevention and education. In addition, maximum care is often used where "less" would be equally effective. In the formulation of health plans in this paper, this focus is redefined to a more middle-of-the-road position. This may not always be obvious, but it is important.

Four distinct areas of undercoverage exist in today's combination of insurance and government health cost protection: lack of basic benefits for the poor; lack of acute catastrophic coverage for many workers and their dependents; lack of long-term care coverage (nursing homes) for the elderly; and lack of protection for the elderly from high expenses arising from non-covered items such as prescriptions and dentistry.

Four basic causes of the current high medical inflation can be identified: emphasis on acute care; lack of concern about costs on the part of patients and doctors (due in part to the major role of third-party payments without coinsurance); lack of competition in the medical industry; and the combination of malpractice and defensive medicine.

Given information as to who is not adequately covered and why expenses are high, a national health plan can be designed. While this paper does not develop a specific health plan, it does analyze the problems and give direction.

INTRODUCTION

THE purpose of this paper is to discuss the major health issues facing the United States and to relate them to one another. Only by looking at all of the issues can we evaluate previously proposed solutions and suggest modifications.

The health crisis of the 1980s is not that of the 1970s. The 1970s began with a recognition that, despite the fact that record numbers of people were covered by private health insurance, significant numbers of people did not have adequate coverage. America's social conscience was touched by stories of the poor and near-poor not being able to afford basic medical care. But there was more. Middle-class America was able to relate to the horror stories of catastrophic illnesses destroying in one year the savings of a lifetime. The problem was easily stated—there were major gaps in health protection. The solution seemed equally easy—the government would step in with a comprehensive health plan.

As the 1970s progressed, it became apparent that, for two reasons, the health crisis was not simply one of inadequate coverage, which could be corrected by government action. First, medical costs had gotten out of control. Second, it was recognized that the government had become very big and clumsy. The health crisis seemed infinitely more complex than it had seemed originally. Some people worried about inadequate coverage. Others worried about cost. And both groups worried about how best to use government in solving these problems.

While Senator Kennedy still championed comprehensive care, less liberal senators, such as Dole, Schweiker, and Durenberger, talked of "catastrophic insurance." The term is something of a misnomer. The basic premise of these programs is that private insurance is doing a good job—in fact, a better job than the government can do. Moreover, federal, state, and local governments are already spending substantial amounts of money on medical care. Since much of this money already goes to the poor, some advocates of catastrophic insurance argue that there are already sufficient public funds expended to provide for almost all of the basic needs of the poor. They argue that what the government really must do is allocate its resources to where they can do the most good in an efficient manner. In other words, if the existing hodgepodge of programs were replaced with a single program with clear guidelines, the poor would be far better off, and at very little additional cost to the government. This would leave the government free to handle the problem of most concern to the average American—the rare but devastating illness. Thus, catastrophic plans can be viewed as filling in the gaps in the current system, with special emphasis on catastrophic illnesses, and doing it with as little government and as low a price tag as possible.

It is clear that if the United States adopts national health insurance, the foundations of the plan will rest on the catastrophic program, not on the comprehensive program. It is essential, therefore, to understand exactly

what a catastrophic program will and will not do, and what secondary effects it will cause.

THE ISSUES

There are two conflicting goals in any potential national health program: first, to cover those expenses that would otherwise be a major financial burden, and, second, to dampen the increase in medical costs.

In connection with the first of these goals, we have already identified two major gaps in the current combination of private insurance, government insurance, and government assistance. These are in the areas of catastrophic illnesses and the lack of basic coverage for poor or near-poor persons.

In addition, some catastrophic proposals have recognized that people have temporary needs caused by changes in circumstances. Such persons suddenly are without protection they previously had and are highly vulnerable. Senator Durenberger, in S. 1968 ([13], p. 29), listed the following conditions causing such temporary needs: termination of employment, death of an employed family member who had dependents, and divorce.

Current proposals, however, have avoided the two key problems of the elderly, namely, catastrophic expenses caused by nursing-home stays, and burdensome expenses (usually not requiring hospitalization) that are not covered by medicare but that can add up to a high percentage of retirement income.

Thus, there are five major gaps in coverage that need to be considered in designing a national health plan:

1. Medical treatment of acute catastrophic illnesses;
2. Expenses of the poor and near-poor;
3. Temporary lack of coverage;
4. Long-term nonhospital care for the infirm, especially the elderly; and
5. "Nonmedicare" expenses, when they reach a threshold level.

The second major goal of a national health program is to control increases in health costs. Proposed legislation has generally depended on two tools—government encouragement of medical-cost competition among doctors and hospitals, and increased use of deductibles and coinsurance before the catastrophic threshold is reached. Noticeably absent are even the most modest cost-sharing provisions once the catastrophic threshold is reached.

Alluded to, but never fully developed, is the recognition that, in the long run, preventive medicine can reduce medical costs and at the same time prevent suffering. Preventive medicine consists of diagnostic clinics, incentives to seek regular medical care, the education of the public (including

medical-cost education), and special attention to pediatric problems (inoculations and regular examinations).

Almost ignored, but having a potentially significant impact on future medical costs, are two controversial concepts:

1. *Malpractice cost control.* An individual would be allowed to "elect" an arbitration alternative to the current legal system. In return, he or she would get lower insurance premiums and quicker awards.
2. *A larger supply of physicians.* The government would redefine its current goal of actively reducing medical school enrollments (to ensure that there is no surplus) to one of actively attempting to create a "slight" surplus of physicians (not surgeons) to stimulate competition.

While the two preceding concepts might or might not be positive ones when looked at as a whole, one thing is clear: providers of legal care would be hurt by malpractice cost control, and providers of medical care would no longer be "automatically" guaranteed a good living should a large enough surplus occur to cause active competition.

In order to decide whether the preceding concepts might prove effective, it is necessary to examine the basic controllable causes of medical-cost inflation. Malpractice awards obviously are one such cause. Other key causes are as follows:

1. *Lack of competition.* Because of the inelastic demand for medical services, a shortage of medical personnel has led to "cost plus" pricing. The provider has no incentive to control costs.
2. *Third-party payments.* Private insurance and government payments create a situation where it is logical for the patient to be concerned not with cost but solely with care. Marginal procedures are agreed to because, while they may result in no benefit, the cost to the patient is negligible.
3. *Emphasis on expensive acute care.* The preferred method of treating patients is in hospitals. This preference is reinforced by conditions in insurance policies and government programs requiring hospital stays for reimbursement. Many procedures that could be performed without hospitalization are performed (more expensively) in hospitals, simply because this is the only way the patient can be reimbursed.
4. *Emphasis on expensive high-technology equipment.* While hospitals do not compete on a cost basis, they do compete on an equipment basis. Once installed, the equipment tends to be used, justifying its expense. Patients agree to use of the equipment, even when little benefit is expected, because third parties will pay for the procedure.
5. *Defensive medicine.* The reward-punishment system punishes the doctor for doing too little (the threat of malpractice) but rarely punishes him for spending money

on unnecessary or marginal procedures. In fact, when patients are billed on a cost-plus basis, overly defensive medicine is actually rewarded.

In addition to the above controllable causes of medical inflation, there is one major uncontrollable cause. Medicine is heavily service-oriented. Like other service industries, productivity has increased only marginally over the past ten years. Thus, any increases in compensation have necessarily resulted in an almost equal increase in medical care costs.

In summary, five major controllable causes of medical-cost inflation have been identified, namely, (1) lack of competition, (2) lack of concern about costs on the part of both patients and physicians, (3) emphasis on expensive acute care, (4) emphasis on new high-cost technology, and (5) malpractice and the resulting defensive medicine. To deal with these problems, six major measures have been suggested: (1) competition should be increased; (2) patients should pay a portion of each medical procedure; (3) emphasis should be shifted away from acute, high-technology care to preventive medicine and outpatient care: (4) malpractice awards should be limited; (5) controls should be placed on unnecessary or marginal treatments, especially when high costs are involved (i.e., defensive medicine should be controlled); and (6) medical consumer education should be increased.

DIMENSIONS OF THE PROBLEM

Statistics help to define problems. The numbers quoted below are designed to give the reader a feel for what the government is doing now, what is not covered, the potential effect of tools, and what it all means.

1. *Extent of current government involvement.* Statistics compiled by the Health Care Financing Administration show that, in 1979, $212 billion, or 9 percent of gross national product, was spent on health care. Of this amount, $91 billion (43 percent of the total) came from federal, state, or local governments. Of particular interest is the fact that these public sources accounted for 56 percent of all payments to hospitals ([4], pp. 1, 17, 25).
2. *Estimates of the number of people with inadequate medical coverage.*
   a) According to Joseph Califano (former secretary of HEW), the number of poor with no medicaid coverage is about 5.4 million. An additional 3.1 million near-poor persons have no coverage ([10], p. 343).
   b) According to Karen Davis (deputy assistant secretary, HEW), 7 million persons have no coverage, 20 million have inadequate medical coverage, and 41 million have inadequate major medical coverage ([13], p. 35).
3. *Catastrophic expenses for those under 65 (Congressional Budget Office estimates for fiscal 1978)* ([9], p. 2).
   a) Seven million nonaged persons had expenses over $2,500.

b) Two and a half million nonaged persons had expenses over $5,000. This represented 15 percent of the health expenses of the nonaged.

c) Ninety percent of hospital stays (for all age groups) were for less than thirty days.

d) There were 21.4 million families, or 28 percent of total families, that incurred expenses exceeding 15 percent of income. However, 90 percent of these costs were paid by third-party sources. If only out-of-pocket expenses are considered, only 6.9 million families (9 percent) had expenses exceeding 15 percent of income.

4. *Catastrophic expenses for the elderly* ([9], pp. 2–3).
   a) Only 11 percent of nursing-home stays are for less than thirty days; 75 percent are for more than one hundred days.
   b) In fiscal 1978, nursing-home stays longer than sixty days cost almost $18 billion. Much of this is not picked up by third parties.
   c) Thus, the problems of the aged differ from those of the nonaged. For the aged, long-term health care, especially nursing-home care, is the most frequent cause of catastrophic expense. Ninety percent of the people admitted to nursing homes will incur charges exceeding $5,000. In contrast, 70 percent of the nonaged catastrophic expenses are related to short-term general hospital stays ([9], pp. 2–3).
5. *Extent of third-party payments.*
   a) In 1979, 68 percent of all payments for health care services were made by third parties (40 percent by government sources, 27 percent by the private health industry, and 1 percent by other sources). In 1965, third-party sources accounted for only 48 percent of such payments.
   b) According to James Hacking, assistant legislative counsel for the American Association of Retired Persons (AARP), "Third-party payments now make up 92 percent of the income of hospitals. Under third-party payment procedures, the patient, the government, and the private insurance company all fail to raise any kind of restraining hand against rising costs. . . . Although the organization and purpose of hospitals may greatly vary, most were organized to serve communities rather than to exist as carefully run businesses. The consequences of pouring money into hospitals under these circumstances should not surprise anyone" ([10], pp. 379–80).

In summary, several major conclusions can be reached.

1. Government is already spending $90 billion on medical care under a wide variety of programs. Much of this money could be spent more efficiently.
2. There are about 9 million poor or near-poor persons with no coverage.
3. Illnesses costing more than 15 percent of income strike about 10 percent of American families each year.
4. Third-party payments, without real cost-cutting incentives, make up about 90 percent of the payments for acute health care.
5. Nursing-home care, most of which is not covered by medicare, is a major source of catastrophic expense for the elderly.

THE 1979 HIAA PLAN

In 1979, the Health Insurance Association of America presented to the Senate Finance Committee basic principles representing the heart of a catastrophic health insurance program that emphasizes using as much of the already developed private insurance expertise as possible ([10], pp. 549, 555–59).

The major points of this presentation were as follows:

1. Private industry has provided the benefits needed by the average employee and his or her family.
2. The one place where major gaps exist for some employees is in the area of catastrophic protection.
3. The government, through the tax system, can force employers to provide gap-filling coverages. This can be done through a combination of tax incentives and tax disincentives (such as loss of tax deductibility if a plan fails to meet minimum standards).
4. Catastrophic protection would be provided through a single per-person deductible.
5. Employers would be required to expand protection to cover older dependents (up to age 26), people temporarily unemployed (extended coverage), and people temporarily uninsured (such as the spouse of a deceased employee).
6. The additional cost to society of such a program would be $2.4 billion if a $3,000 deductible were used.
7. The government would continue to be responsible for the poor and the elderly.
8. Uninsurable high-risk persons would be taken care of through state insurance pools.

There are several interesting aspects of this proposal.

1. Cost control is not discussed.
2. The insurance industry is, in effect, offering to share health care costs with the government. The government covers the elderly and the poor, the insurance industry covers employed persons in private industry, and others are taken care of in special pools.
3. The tool used to minimize the role of government bureaucracy is taxation.
4. The insurance industry continues to show a willingness to offer catastrophic coverage, which, considering past medical-cost inflation, is a high-risk coverage.

THE ENTHOVEN PLAN

Alain Enthoven, professor of public and private management at Stanford University, has developed a package of proposals that attack both lack of coverage and the cost problem. The proposals go one step further than the HIAA proposal. They attempt to introduce a "pro-competitive" element into health care, which would dampen medical-cost inflation. The basic premise is that the United States can successfully introduce the marketplace

into medicine, and, assuming that there is a marketplace, that cost reduction would occur as a result of both doctors and patients being acutely aware of the cost of treatment. Enthoven's approach is important because many of his ideas are similar to those of recent bills such as the Schweiker bill (S. 1590), the Durenberger bill (S. 1968), and the Ullman bill (H.R. 5740).

As an illustration of Enthoven's principles, a hypothetical hybrid bill is presented below. Actual proposals would not differ significantly from bill to bill.

1. Each year employers above a certain minimum size would offer their employees a choice of at least three distinct plans that qualify as having met minimum standards. Each plan would be offered by a separate carrier. One of the plans would have to be a low-cost option (just meeting minimum standards). In addition, a group prepaid plan or HMO would have to be offered, in areas where such a plan was available.
2. Regardless of the plan chosen, the employer contribution would be that of the "average" plan. Employees choosing an option costing (in total) less than the average option chosen (age-adjusted so as not to discriminate against older employees) could receive a tax-free "bonus" from their employer equal to the employer's "savings." Thus, employees would have the incentive to choose wisely. The low-cost option would, of course, require the insured to pay the deductible and relatively high coinsurance amounts, up the the catastrophic limit.
3. Catastrophic protection would be required after annual expenses exceeded $3,500.
4. The same rules would apply for all competitors; that is, regulations would be created to prevent the "skimming-out" of preferred risks. In addition, basic benefits as defined in the HMO act would constitute minimum uniform standards. Provisions would be standardized, making plans easier to compare.
5. Government, through incentives, would encourage physicians to organize into competing economic units. In particular, prepaid plans, where the need for cost control, service minimization, and preventive care is obvious, would be encouraged.
6. Continuity of coverage would be required for the newborn, divorced, widowed, and unemployed.
7. Employers not in compliance would lose tax credit in their plans.
8. The government would cover the poor and the elderly.

There are several key elements in this plan. First, it assumes that the government has the leverage to create a competitive climate among physicians. As mentioned before, this may be impossible unless there is a slight surplus of physicians. Second, it ignores (again) the nonacute problems of the elderly. Third, it fails to deal with malpractice (although Enthoven does discuss the possibility of an "arbitration" option to be elected by the insured).

In summary, this plan attempts to fill in the gaps and control costs for employed persons by (1) providing minimum benefits, (2) providing catastrophic benefits, (3) forcing the consumer to become cost-conscious by creating incentives to choose plans with more out-of-pocket medical expenses, and (4) encouraging competition among physicians.

PREPAID GROUP PRACTICES

A group prepaid practice can be defined in terms of four essential characteristics:

1. A group of physicians agrees to work together.
2. They agree to provide comprehensive health care.
3. Payment is on a prospective fixed per capita basis.
4. Members of the plan enroll voluntarily.

Enthoven argues that such group practices are a key tool in controlling health costs. In the Shattuck Lecture to the Massachusetts Medical Society [2], reprinted in Senate testimony ([12], p. 255), he articulated the crux of his arguments:

Control of costs: "The method of payment gives the organization a prospective budget. Its physicians and managers must seek to get the most effective medical care out of limited resources. The . . . method eliminates the administrative burden of billing and collecting from patients for each service."

Savings: "The cost savings (10–40 percent, depending on the study) are mainly attributable to much lower hospitalization rates and to greater economy and efficiency of operation. They cannot be explained away by out-of-plan utilization, differences in age and sex composition, previous health rates, or government subsidies."

Lower hospitalization rates: Enthoven quoted as follows from a medicaid study [3] that compared group-practice plans with fee-for-service providers: "The group-practice beneficiaries averaged 340 days in the hospital and 24 surgical admissions per 1,000 persons per year, as compared with 888 days in the hospital and 50 surgical admissions per 1,000 persons per year in the control groups."

Savings also apply to the elderly: Referring to another study [5] that compared the cost to medicare of beneficiaries in six prepaid group-practice plans with the cost of a fee-for-service control group, Enthoven noted that the average cost for the former was 74 percent of the average cost for the latter.

Thus, well-administered group practices, in areas large enough to support them, can reduce medical costs. There are, however, several dangers.

1. Group practices are very expensive to set up. They will not work in all areas, and poor administration can lead to economic disasters or extensive cost cutting at the consumer's expense.

2. Competition to group practices is necessary in order to prevent "institutional" (impersonal) care and "cost before quality" from resulting.
3. Although, to date, group practices have not been looked at critically, there is some "soft" evidence that there are growing pains. Thus, orderly growth might be preferable to massive government subsidies and rapid growth. One source of orderly growth may be insurance companies financing HMO subsidiaries.
4. Other cost-control alternatives should not be overlooked. Karen Davis of HEW discusses three such proposals, namely, providing more information to consumers; encouraging alternate modes of health care delivery, such as nurse practitioners; and increasing review activities, which would make providers at least conscious of costs and possibly accountable for marginal procedures ([13], p. 36).

CATASTROPHIC HEALTH INSURANCE

Current proposals for catastrophic insurance are based on payment by third parties of 100 percent of expenses after a deductible of $3,000–$5,000. Little attention is paid to cost control; in particular, no coinsurance provision is used.

Catastrophic illnesses can be divided into two categories: first, chronic illnesses where treatment is well defined and useful (treatment of many kidney disorders falls into this category); second, serious illnesses where treatment is at best marginal and subjective (certain cancer conditions fall into this category).

For the second category, catastrophic insurance without sufficient coinsurance to make doctors and patients cost-conscious is extremely dangerous, because it would further encourage the purchase of expensive equipment, and the use of that equipment where the benefits would be at best marginal. The patient and the doctor could obtain the psychological benefit of doing everything possible, with no increase in cost. As James Hacking of the AARP states about one such proposal: "S350 will create more catastrophic illnesses than anyone here dreams possible" ([10], p. 378).

More objective information concerning catastrophic insurance can be obtained from a study of Japan's experience under such insurance during the period 1974–76 [1]. The study can be summarized as follows (see also [10], pp. 435, 441, 442):

Background: "The 1973 amendment to the Health Insurance Law made medical care benefits . . . for high-cost illnesses available to nearly 70 percent of the population not previously covered adequately by their health insurance. Workers enrolled in the employer-employee health insurance plans and all persons age 70 and over already had comprehensive health insurance coverage. However, dependents of insured persons and all beneficiaries in the national health insurance plan were required to pay 30 percent of all medical care charges out of pocket, with no stated

maximum liability. When the new benefit was instituted, dependents were still required to pay the 30 percent coinsurance, but a maximum limit of out-of-pocket liability was stipulated by law (30,000 yen within a calendar month)."

Conclusions: "From 1974 to 1976, the first 3 years of the high-cost (catastrophic) illness benefit, an increase of more than 70 percent occurred in the frequency of high-cost cases. This general trend was observed for all of the six major health insurance plans studied. The average expenditure per case increased 5.7 percent from 1974 to 1975 and 14.6 percent from 1975 to 1976, regardless of plan. . . . Although inflation explains a part of these increases, the intensity of services certainly played a part."

Conjecture: "It appears that a shift from low-cost to high-cost illnesses occurred at the cut point; that is, illnesses formerly classified as low cost subsequently incurred expenditures that were high enough to be classified as high cost. . . . The implication is that when a benefit was offered, patients and the medical care system . . . took advantage of the benefit."

While care should be used in interpreting these results, there can be little doubt that when the Japanese removed the 30 percent coinsurance on catastrophic illnesses (i.e., those over 100,000 yen per month), health expenditures did increase significantly. Thus, what limited evidence is available suggests that, as painful as it might be, even in the catastrophic case the patient must continue to pay enough to put a restraint on costly but marginal care. For example, for the extreme case of a $100,000 catastrophic illness, a patient earning $30,000 might be required to pay a total of $5,900, as follows:

	100 percent of the first $500,
plus	40 percent of the next $500,
plus	20 percent of the next $9,000,
plus	10 percent of the next $20,000,
plus	2 percent of charges in excess of $30,000.

Should high medical expenses continue for a second year, these percentages might be cut in half.

In summary, if medical expenses are to be controlled, coinsurance is necessary even for catastrophic illnesses. Without such a control, the logical behavior of both patient and doctor is to "try anything," since there is nothing to lose. This can be a very expensive way to get very little.

MALPRACTICE AND DEFENSIVE MEDICINE

Patients' bills are high because the patients are the ones who ultimately pay malpractice awards. Their bills are high also because of unnecessary treatments and tests. One anonymous public health teacher estimates that

30–35 percent of all clinical tests and X-rays are done for one purpose only—to prevent malpractice suits.

While large malpractice awards are publicized, it appears that the system for granting such awards is not very efficient. Court delays of years are not uncommon, and many people with legitimate claims do not get heard. Moreover, most of the costs of malpractice do not end up as compensation to the victims. Enthoven stated in Senate testimony: "In the process as I understand it, more than 80% of the costs go into legal fees and all of the rest of it, and less than 20% to the compensation of the victims" ([12], p. 243).

Thus, the current malpractice system suffers from a number of weaknesses: it is a very inefficient system of transferring money to victims, it is slow, it results in unnecessary medical treatment, and it results in medical costs being 10–30 percent higher than they need to be (my estimate).

There are two possible replacements for the current system. One is a universal arbitration system: the government would collect a fixed percentage of medical fees, such as 10 percent. These fees would be turned over to state arbitration boards. If medical negligence could be proved, an award would be made based on the severity of the injury. Lawyers would prepare the arguments, but the process would be greatly abbreviated. The arbitration board would have to stay within its budget. Its income, however, would be somewhat supplemented by a filing fee that would prevent "frivolous" cases from entering the docket.

The other possibility is a voluntary arbitration system: consumers could choose whether they wanted a malpractice option or an arbitration option. Those choosing arbitration would receive a substantial reduction in insurance premiums. A system of arbitration, while it would reduce malpractice costs, probably would not have an immediate impact on defensive medicine. However, aside from making doctors aware of the cost of defensive medicine, there may not be much that can be done.

SPECIAL PROBLEMS OF THE ELDERLY

Medicare has not solved the problems of the elderly. While acute catastrophic illnesses are covered, much of the expense facing the elderly arises from a general deterioration in health and not a specific treatable illness. According to James Hacking of the AARP, in 1967 medical expenses for the elderly averaged $532, of which medicare covered 32 percent. By 1977 expenses had risen to $1,738, of which medicare covered 43 percent ([10], p. 379). Thus, noncovered expenses, such as prescriptions and nursing home stays, represent a significant portion of the medical needs of the elderly.

Catastrophic coverage for the elderly cannot be "real," unless coverage

is extended to apply to both the myriad of small expenses (which can add up) and long-term care (both "at home" and in nursing homes).

Long-term care presents special problems. Use is very much subjective and very much dependent on cost. An elderly parent may be put in a nursing home if no cost is involved, but if the cost is $12,000 a year, the parent may be kept at home. Thus, catastrophic coverage for long-term care, if it is not to be a tremendous burden on society, must have several characteristics.

1. There must be limited but genuine cost sharing. To achieve this, penalties for "giving away" assets are necessary. Dignity must be maintained, however—basic assets should remain untouched, deferring any government claim until the death of the surviving spouse.
2. Alternatives should be developed to keep the elderly at home. These include delivered meals, home nursing care, day-care facilities, and homemaker services. Limited government experiments show, however, that it is difficult to design a package that will serve as a substitute for institutional care rather than as an expensive add-on for those who would remain at home in any case ([15], pp. 150–51).
3. Controls should be put on nursing-home facilities to see that minimum quality standards are met.

In summary, catastrophic coverage for the elderly requires extension to cover high usage of routine services such as dentistry and medication. It also requires that long-term care be considered. To prevent overuse of nursing homes, alternatives should be developed and cost sharing should be required. Because of the large expenses involved and the unknowns in this area, a step-by-step process may be preferable to an immediate extension of medicare to all long-term care situations.

CONCLUSIONS

An integrated approach is the key to improving medical care, reducing costs, and eliminating the possibility of families being impoverished by medical expenses.

The following areas have been identified as being part of an integrated national plan.

1. Government guidance to shift the medical emphasis from treatment of disease in acute care facilities to a more balanced approach including prevention and education.
2. Extension of coverage to the poor and those temporarily without coverage.
3. Extension of catastrophic coverage to employees through tax incentives.
4. Broadening of catastrophic coverage for the elderly to include significant outlays for "everyday" care, and long-term health needs such as nursing homes.

5. Increased use of deductibles and coinsurance to reinstitute cost control by the public (including coinsurance on catastrophic coverage).
6. Government encouragement of "product" competition. This would include more choices of plans by employees, government encouragement of HMOs and group prepaid plans, community health centers, and increased home health care.
7. Substitution of an arbitration system for the current malpractice award system.

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DISCUSSION OF PRECEDING PAPER

DANIEL W. PETTENGILL:

The following comments from a veteran with over thirty years in the health insurance business are offered in the hope that they will be useful to the reader of Mr. Elstein's fine paper.

The two major problems facing any health care insurance plan, be it governmental or private, are the following:

1. Despite the amazing progress of the last fifty years, medicine is still more art than science, thus making the risk to be insured a nebulous and ever changing entity.
2. An individual in pain wants to be free of that pain at any cost, and so do all those who love that individual.

The fact that there is no foolproof system for controlling health care costs is not a valid excuse for doing nothing. Actuaries need to work with health professionals and other interested parties to develop and implement techniques that are economical and that do more good than harm.

Deductibles and coinsurance are devices for reducing the portion of the insured health care expenses that the insurer must pay. These two devices deter the utilization of health care only to the extent that the individual or family concerned perceives them as taking an unduly large portion of their income. In many cases, the use of essential as well as nonessential care is deterred. To ease this dilemma somewhat, copayments should be eliminated for those health services that the nation feels should be promoted for all, such as immunization against certain diseases, and should be large, perhaps even 100 percent for services deemed to be of little value. For all other expenses the deductible should be nominal or nonexistent and the coinsurance modest, say 20 percent. Ideally, copayments should be realistically related to family income. Under group health insurance plans, income-related copayments have not been considered practical, because of the administrative work involved and also because the release of income information is a sensitive matter. A number of early group major medical plans did have deductibles graded by the salary of the employee, but few exist today, partly for the above reasons and partly because employers wanted to give their executives a break that would not be obvious to most employees and was permitted by the Internal Revenue Service.

Under a national health insurance plan mandated by the federal government, it might be feasible to ease the inequity of rates of coinsurance that do not vary by income, by having the plan include an annual limit on the amount that a given family could be "out of pocket" in any given year for covered expenses, which limit would be based on the family's gross income. Only those families that had out-of-pocket covered expenses in excess of that limit would need to divulge their income, and then only to the carrier of the plan rather than to all health providers concerned. For the plan to be practical, Congress probably would have to require that the Internal Revenue Service verify the amount of gross income reported for a random sample of families.

Mr. Elstein divides catastrophic illnesses into two categories. I respectfully submit that mental illness is a third category, and that it needs to be handled separately from other illnesses. Even when faced with 50 percent coinsurance, an insecure employee or an unstable child will use hundreds, if not thousands, of dollars worth of psychiatric care year after year, and there always seems to be at least one licensed professional around to provide that care.

My final comment is that long-term nonhospital care for the infirm includes room and board as a large element of its cost, which element bears a very close resemblance to a lifetime disability income benefit. If the infirm individual is part of a family, the economic problems of that family are truly compounded because a separate shelter for the balance of the family must be financed as well. It is my personal opinion that custodial care for the infirm should be handled as a welfare benefit rather than a health insurance benefit—distasteful as such an approach will be to the average American. The key is not to leave the poor and the near poor with the short end of the stick. If that were done, then an equitable welfare approach to the handling of custodial care might be acceptable to most Americans.

JOHN P. COOKSON:

This paper presents a good summary of the health care problem, and an exploration of the basic questions concerning a national health plan. I particularly agree with the discussion of catastrophic insurance and the distinction between "useful" treatments with good prognosis and "marginal" treatments with uncertain value and prognosis.

I believe that in this country the implicit assumption of equal access to medical care for all people has been interpreted to mean equal access to maximum care. However, I am not sure that everyone either understands or wants to bear the burden, either through taxes or premiums, of the maximum level of care in all cases.

I am not saying that we should not be paying for the high cost of care for extremely immature babies, or heart bypass surgery, or artificially maintained life on heart-lung machines. I do not think that actuaries or the insurance industry can answer these questions unilaterally. However, I do believe that as a society we need to examine these questions in light of their cost and effectiveness to determine whether society can afford that level of medical care. And as professionals, actuaries need to have input into this discussion, particularly in trying to quantify these issues.

In my opinion, health insurance currently is helping to finance a significant amount of research and experimental treatment of a high-cost nature. The problem is that the researchers themselves are determining what treatments should be tried, with little control or restraint as long as the insurance funds are there. I believe we need to introduce some planning into this process and select the most effective projects for funding on a limited basis until their merits are proved.

Another concern I have about catastrophic coverage is the annual trend in costs from year to year. At total cost thresholds such as $25,000 per year, the trends (at current levels) on costs above this threshold approach 50 percent per year, in the absence of increasing frequency of new high-cost treatments. With the increased demand that might be created by universal catastrophic coverage with little or no coinsurance, the initial costs are likely to be much higher than anticipated. At a minimum, indexation of the threshold should be considered to keep the annual cost increases manageable.

RICHARD A. COMBS:

Mr. Elstein has presented an interesting summary of the problems in the delivery of health care services in this country. I have several questions and comments regarding the issues raised by the author.

First, the abstract begins: "Medical care in the United States is very expensive. The goals of a national health plan are therefore clear." This would appear to imply that a national plan is needed for every "very expensive" item. Caviar costs more than beans, Rolls Royce charges more than Ford, and a funeral is more expensive than medical care for pneumonia. Do we need national plans for caviar, Rolls Royces, and funerals? If so, could we, as a society, afford them, given the high current level of taxation and the high level of budget deficits? Perhaps we should first solve the funding problems for the social security programs before we start any type of national health plan.

Second, the author refers to an emphasis on acute care. Once a person is ill or injured, acute care certainly is appropriate. It is probably true that

increased preventive measures will decrease the incidence of illness or injury. There are other kinds of preventive measures besides those listed in the section on issues. Adequate exercise, public health measures, and stress management techniques could lessen dependence on acute-care methods.

Third, I was intrigued to discover that the government has been "actively reducing medical school enrollments (to ensure that there is no surplus)." Why are they worried about physician surpluses and not surpluses among teachers and engineers, both professions having had surpluses throughout the 1970s?

Fourth, an alternative view of the proposal to increase competition is presented by Michael Schiffer in *RSA*, VII, No. 2, 684–85.

Fifth, a source is quoted that 75 percent of nursing-home stays are for more than 100 days. Are the nursing homes providing primarily medical care or primarily custodial care?

Sixth, the Enthoven plan requires employers to offer at least three distinct medical plans. It seems to me that there would be a large amount of anti-selection under such a scheme.

Seventh, I was a member of a prepaid group practice plan in the Los Angeles area for some three years. My employer also offered a group major medical plan. The prepaid group plan cost less on a periodic payroll deduction basis as well as at point of service. The care was acceptable to this layman, but was "impersonal," illustrating one of the dangers cited by the author.

Eighth, the author suggests that health care cost inflation would be decreased by having the patient pay $5,900 in the extreme case of a $100,000 catastrophic illness. For most families, the $5,900 would be a catastrophe.

In conclusion, I agree with the author that there are problems in the health care delivery system. There are also problems with the alternatives that have been advanced. I disagree that it would be desirable for the federal government to be heavily involved in the system. I sincerely hope that the private insurance industry will consider the ideas presented by the author in order to resolve some of the problems that exist.

GORDON R. TRAPNELL:

The objective of the Elstein paper is to provide an integrated analysis of national health insurance issues. The complexity of the problem is clearly shown by the collection of recommendations presented. However, it is not essential that a national health policy address all the issues simultaneously. The most needed reforms could be introduced independently, if clear prior-

ities are set, based on a thorough analysis of the sources of cost inflation and the absence of adequate coverage.

The purposes of this discussion are to explain why cost containment should take precedence over filling gaps in coverage, to suggest that a reduction in first-dollar insurance coverage should be the top priority within the cost containment issue, and to clear up a misconception that might have been created by the article with respect to the cost of filling gaps in coverage.

Inflation of medical care costs, in both relative and absolute terms, has been a continuing concern of health actuaries for many years.[1] Further, inflation aggravates other problems by driving up the cost of solutions to the gaps in coverage and other defects of the present system (e.g., lack of adequate preventive care and access by some to only second-class medicine). However, there are few documented examples of anyone not having access to care. Gaps in coverage are primarily a financial problem, not a question of persons going without needed medical care. These facts suggest that cost containment should receive primary attention in any national health policy. The nation may not be able to afford solutions to other problems if inflation continues unabated. It should be noted that both the Carter administration national health plan (through its hospital cost containment proposal) and the Reagan administration pro-competition proposal (under development) assess cost control as the first need to address.

Since there are many causes of medical inflation, an effective policy will need to recognize which causes are most important and most amenable to being solved. Of the five sources of inflation mentioned by Elstein, the proliferation of third-party coverage is fundamental. Thus, implementing policies to deal with it should be given the top priority.

Beyond the increased demand for medical services produced by service benefits (which make medical care nearly a free good to consumers), the growth of third-party payments is a major contributor to the other causes cited. Excessive insurance removes price competition among providers, provides differential incentives for preventive versus acute care, removes barriers to the introduction of complex equipment, and finances defensive medicine on a routine basis.

Underlying the extent of first-dollar coverage are the strong tax preferences given to health benefits paid by an employer. In fact, many health coverages exist almost entirely as a result of the tax preferences. Without the tax subsidy, it would not be economical to give an insurance company $1.25 or more for a $1.00 of benefits for such easily budgetable items as

[1] See the discussion of medical inflation as the most powerful force for national health insurance, session on "Managing Health Care," *RSA*, III, No. 3 (1977), 576.

eyeglasses, routine dental examinations, or service prescription benefits. Further, the tax treatment leads to much greater utilization and higher prices, subsidized at taxpayer expense. Experienced health actuaries are acutely aware of the increases in utilization that occur when price is removed as a factor. A solution that would at least keep the situation from getting worse would be to tax employer contributions for service health benefits, except perhaps for catastrophic coverage. Coverages that depend on subsidies for viability would be reduced, and new policies would be nearly eliminated.[2]

The four other causes of inflation cited are not so easily solved. Federal attempts to expand the growth of HMOs have provided disappointing results. Further, the often-cited efficiencies of HMOs have never been adequately shown to be the primary source of their lower costs. For example, a major part of measured HMO savings is clearly attributable to selection.[3] Although emphasis on preventive care may be a worthwhile policy objective, the hypothesis that a shift in resources from acute to preventive care would significantly reduce the overall cost of health has not been established. Overuse of expensive technology has been the target of a major national regulatory effort, the certificate-of-need programs. These have not produced the results expected. Reform of malpractice would require lawyer-legislators to vote themselves and their colleagues a major reduction in actual and potential income, which they have never done.

If it is determined that the nation has the resources to attempt to fill some of the gaps in the current system, it is essential that policymakers be aware of the high costs involved. The author states that "if the existing hodgepodge of programs were replaced with a single program with clear guidelines, the poor would be far better off, and at very little additional cost to the government." If this could be done, any of the past several administrations would have done it. Unfortunately, such a plan would add billions to the federal budget, according to responsible actuarial estimates. For example, the Carter administration estimated that its recommended national health insurance plan would have spent $9.3 billion in federal outlays[4] to put in a uniform national income floor for eligibility for medicaid, remove categorical restrictions on eligibility for benefits, make medically needy programs universal, and remove benefit package variations among states.[5]

[2] The proposal is similar to the limitation on tax-free contributions to group life insurance that has been in existence since 1964.

[3] Paul Eggers, "Risk Differential between Medicare Beneficiaries Enrolled and Not Enrolled in an HMO," *Health Care Financing Review*, I No. 3 (Winter, 1980), 91–99.

[4] If fully implemented, measured in 1980 dollars.

[5] *National Health Insurance Working Papers*, Vol. II, edited by Dr. Karen Davis (December, 1980). Basic discussions of the actuarial techniques employed in developing cost estimates for

While there are many potential sources of error in estimates of this kind, the general level of cost estimated represents a consensus of responsible actuaries, including those retained by the Carter administration, the Senate Finance Committee, the HIAA, the Congressional Budget Office, and independent experts. Experience with previous new federal programs raises questions as to whether even responsible actuarial estimates will be high enough. Unsupported assertions such as that quoted above, appearing in an official publication of the Society of Actuaries, may give credence to a claim by political advocates that the actuarial cost estimates have been greatly exaggerated, and that a program can be designed that covers all low-income persons without substantially increasing federal outlays. A similar claim was in fact made to persuade Congress to adopt the medicaid program in 1965, and had a major impact on the expansion of federal responsibilities.

In addition to the articles already listed, the interested reader should pursue the extensive presentations by expert actuaries that appear in the Society's publications. Suggested readings include the following.

"A Plan for Cost Containment for Group Medical Expense Coverages," *RSA*, III (1978), 719–30.
"National, State, and Provincial Health Care Insurance," *RSA*, I (1975), 725–44.
"Health Insurance—Legislation and Inflation," *RSA*, I (1975), 361–74.
"Health Insurance—Legislation and Inflation,"*RSA*, I (1975), 127–38.
"Government Health Care Programs," *TSA*, XXVI (1974), D129–D142.
"Health Insurance and Health Care," *TSA*, XXIV (1973), D547–D571.
"Health Insurance in Transition," *TSA*, XXIV (1972), D183–D214.
"Health Insurance in the United States," *TSA*, XXIII (1972), D663–D673.
"Health Services—Public versus Private Financing," *TSA*, XXIII (1971), D245–D262.
"Health Services—Public versus Private Financing," *TSA*, XXIII (1971), D49–D64.

DENNIS A. BARNES:

The causes and effects of rising health care costs are definitely subjects worthy of attention from actuaries. Mr. Elstein presents a clear, well-organized synopsis and solution of the problem. Unfortunately, I see it as the wrong solution.

I see the problems that Mr. Elstein has elaborated as falling into three specific areas: inadequate means to pay, lack of catastrophic coverage, and gaps in coverage. In much of what follows I will be applying principles of the political philosophy known as libertarianism. Since this is not a journal

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national health insurance plans can be found in *A Description of the Health Financing Model: A Tool for Cost Estimation* (U.S. Department of Health and Human Services, 1981) and in Gordon R. Trapnell, *A Comparison of the Costs of Major National Health Insurance Proposals* (U.S. Department of Health, Education, and Welfare, 1976).

in which to expound philosophy, instead of explaining libertarian principles, I will merely refer the curious reader to references [2] and [3] of this discussion.

Let me first cover the area of inadequate means to pay. It would seem logical that the expenses of the poor and of the elderly should be handled together. In fact, we should be considering only expenses of the poor, elderly or not. Neither medicare nor any other government program need pay health care costs for people who can afford to pay, whatever their age. I really do not see why working-class people should pay social security taxes in order to pay J. Paul Getty's medical bills. Of course, there is a readily understandable reason for the nature of the system: when our vote-happy representatives support a bill like medicare they please a large, vocal, heavily voting group—those over age 65. The poor do not comprise such a powerful constituency.

Thus, the question becomes, "How should the medical expenses of the poor be paid?" This brings us to a refinement of that question: "Should health care expenses be treated differently from any other type of expenses?"

As a near-term solution to this first problem, I would suggest a guaranteed annual income, a number of different versions of which have been proposed in the recent past ([1], pp. 190–95). Each person should be allowed to spend any money received in whatever manner he desires. There should be no reason for government to determine paternalistically how one's money should be spent. How much would be spent on medical care and insurance and how much would be spent on cigarettes and alcohol would be up to each individual.

Concerning catastrophic care and temporary gaps in coverage, a number of writers of health insurance are now offering unlimited-maximum catastrophic insurance; many more are offering temporary coverage to insure people who have lost their coverage. In addition, it is unclear to what extent government regulation has stifled the development of products that could address this problem.

This brings me to the final portion of the solution to the problem: the full and immediate deregulation of the insurance industry. State regulation has imposed inequities in the name of equity and burdensome expenses in the name of saving the consumer money. The extent to which government drives up the cost of health insurance premiums, impedes competition by keeping out smaller companies, and hinders product development only exacerbates whatever other problems there may be. I will not pursue this topic further, since deregulation of the insurance industry should be the subject of a separate paper.

One other comment. I personally believe that preventive care is a good idea. However, I believe it should be up to each individual to decide how he wishes to care for his body. In fact, anyone who believes in this area of freedom of choice has another reason for disapproving of government health programs: in its most extreme manifestations, it could lead to such things as making smoking and drinking illegal for the "common good," since these activities are responsible for so many medical problems and therefore cause large outlays of public funds. As silly as I believe smoking and drinking are, I believe everyone should have the choice of whether or not to engage in them.

With all the problems that government has caused and fostered, it seems inappropriate to enlarge the scope of its actions. The crisis in health care is to a large degree a crisis in government. Maybe the political climate is finally right for a push toward a reduction in governmental action as I have outlined.

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2. NOZICK, R. *Anarchy, State and Utopia*. New York: Basic Books, 1974.
3. ROTHBARD, M. N. *For a New Liberty*. New York: Macmillan, 1973.

(AUTHOR'S REVIEW OF DISCUSSION)

ALLEN ELSTEIN:

Since a major purpose of this paper was to provide a forum for discussion of national health issues, I was pleased with the variety and richness of the responses to my article. If there is any single theme that comes out of these responses, it is that for every benefit that is provided there is a cost. Moreover, that cost is difficult to predict and is potentially large. It is thus essential that the insurance industry in general and actuaries in particular take an active role in the process of determining just what public and private benefits will be available in the coming decades. Such a process might be labeled the strategic planning of national health insurance policies.

Mr. Pettengill brings up several key issues. I agree with him that, if out-of-pocket expenses are too high, essential as well as nonessential care may be deterred. This may be particularly true where immediate action is not perceived as critical, such as a series of immunization shots for a poor child. This leads to the natural question as to whether coinsurance percentages that vary by condition can be used effectively to encourage essential care

and at the same time control the use of what might be termed "marginal" care. The answer is not obvious, suggesting that this may be a fertile area for testing beyond that which has been done to date.

The area of providing legitimate benefits for psychological counseling is, as Mr. Pettengill implies, a particularly difficult one. It may well be impossible to differentiate between the needs of a disturbed person and those of a person with relatively minor problems who enjoys going in for a weekly visit. To the extent that mental illness is more subjective than other illnesses, and that the providers of care tend to continue treatment over indefinite periods of time, I agree with Mr. Pettengill that it is useful to classify the more expensive cases of mental illness or psychological problems as a third category of catastrophic illness.

Mr. Cookson focuses on the difference between equal access to medical care and equal access to maximum medical care (regardless of its marginal effectiveness). Of critical importance is the fact that, as long as insurance or government funds are paying the way, there is little incentive for patients, doctors, or researchers to weigh the benefits of maximum care against the costs.

Mr. Cookson's remarks on the cost potential of catastrophic insurance reiterate my concern that the insured must pay enough to be concerned with limiting care. The how much is enough and how much is too much is quite subjective. For example, Mr. Combs feels that $5,900 may be too much for a family that has experienced a $100,000 illness to pay.

Mr. Combs raises a number of interesting points. I will restrict myself to the issue of government involvement in any national health plan. In effect, I believe that we already have a de facto national health plan, with the government involved to the tune of $100 billion. In this de facto plan, surprisingly little of what we would label as strategic planning in the business sense is done. To set direction, we need long-range thinking not only on the part of the government but on the part of the private sector, especially the insurance industry. It should be noted that, at least in some ways, the Enthoven proposal and the proposals for catastrophic health insurance could set the direction for less government involvement in the health arena. A clear distinction should be made between shared strategic planning on national health issues between the government and private industry (this will occur only if private industry makes an active effort to be heard, and has done its homework), which I am advocating, and a national health program in which problems are solved primarily by the government spending significantly more money than now, which I am not advocating. Of particular concern to me is that we address the problems of the elderly now, and not

thirty years from now, when the aging population will make the problems (whether we want to label them medical or custodial) more acute.

Mr. Trapnell gives an extremely useful analysis of the necessity of cost containment. There is little doubt that when third parties pay most of the costs, especially first-dollar costs, the demand for medical services increases to high levels. This is merely a special case of basic microeconomic principles in action. To the extent that the insurance industry continues to sell policies without adequate cost-containment provisions, we may be part of the cost of medical inflation. This is not to say that it would not take a very good sales campaign on the part of an insurance company to convince a union or a corporation that less may be better in the long run.

I am also grateful to Mr. Trapnell for pointing out a misunderstanding that several readers have had. It was not my intention to imply in the introduction that extending coverage to the uncovered poor and near poor would necessarily be cheap, especially if an approach such as that advocated by the Carter administration is used. What I was attempting to do was to acquaint the reader with an argument that has been used by some who favor catastrophic insurance. They argue that the key gap to be dealt with today is the catastrophe. While the problems of the poor are real, their problems could be adequately dealt with if only we would better allocate resources already devoted to them. They point out that large amounts of money are already spent on the poor through a variety of programs. They believe that the problem of meeting the needs of the poor is one of allocating available funds to critical needs more effectively, freeing resources to cover persons and services not now covered. In other words, by reducing marginal expenditures through well-planned uniform standards and by reducing the number of programs that have to be administered, cost savings can be achieved. These savings, perhaps modestly supplemented, could be used to extend critical benefits to poor persons not now covered. The argument is untested, and may or may not work. This suggests that, if such a program is adopted, it may be wise to see just how much cost saving is actually realized before potentially costly program expansions are implemented.

Mr. Barnes's discussion takes an economic and social philosophy, mainly libertarianism, and applies it to the area of health care. Since how much government involvement one sees as desirable is very much dependent on one's underlying philosophical views, I believe that Mr. Barnes's remarks are very valuable. There can be little doubt that the mood of the country has changed to one of wanting less government involvement. This clearly has an impact as to what solutions may be acceptable to the public with respect to health issues. In addition to the work by Milton Friedman referred

to by Mr. Barnes, I would like to refer the interested reader to Milton and Rose Friedman's later book *Free to Choose* (New York: Harcourt Brace Jovanich, 1980), particularly chapter 4, "Cradle to Grave." As a sidelight the reader might find interesting Mr. Friedman's analysis of the American Medical Association, which is given on pages 239–41.