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RATIONING HEALTH CARE

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Recorder: HOWARD G. KURPIT

- Rationing methods, including Oregon legislation
- Economic effects of rationing
- Physician community viewpoint on rationing health care

MR. GREGORY S. BENESH: In this presidential election year, one of the key issues is controlling our health cost. All the candidates agree that the price of health care is too high, and something must be done. However, due to the numerous groups that would be affected by changes, no consensus has yet been reached. One method that has been proposed to solve the cost spiral is health care rationing. Rationing probably would reduce cost increases, but also would have a definite impact on the American lifestyle. We'll discuss various aspects of health care rationing, which hopefully will give us a better understanding of what it is and its implications.

Our first speaker is Janet Carstens. Janet is a consultant in the Minneapolis office of Tillinghast, a Towers-Perrin Company. Ms. Carstens is a consultant for a variety of health insurance payors, including insurance companies, the Blues, and HMOs. Her medical expense product consulting includes traditional health care products as well as managed care. Janet previously worked for Western Life in the group actuarial department where her responsibilities included small group product development and pricing, financial forecasting, and health special risk pricing. Ms. Carstens is an FSA and MAAA and received her BA from the University of Minnesota in 1981. Janet will discuss the Oregon plan for health care rationing.

Our second speaker is Martin Gaynor. Martin is an assistant professor in the Department of Health and Management and the Department of Economics at John Hopkins University. He is a senior research associate of the Health Services Research and Development Center and the Center of Organization and Financing of Care for the Severely Mentally Ill, also at John Hopkins. Martin also is a research associate of the National Bureau of Economic Research. He also has taught at the State University of New York at Binghamton, and Virginia Polytechnic Institution, and has been a visitor at the Institute of Economics of the Hungarian Academy of Sciences in Budapest, Hungary. His research interests are in the economics of organizations, the economics of information, health economics, econometrics, and public economics. His published research has appeared in a number of journals, including the *Journal of Political*

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Economy, the *Rand Journal of Economics*, *Economic Letters*, *Public Choice*, and *Managerial and Decision Economics*. Professor Gaynor received his doctoral degree from Northwestern University and his bachelor's degree from the University of California in San Diego. Dr. Gaynor will discuss various rationing proposals and their effects on the economy.

Our third speaker is John Crosby. John serves as the senior vice president for Health Policy at the American Medical Association. In this capacity, John oversees the health policy and legislative divisions of the AMA as well as Health Access America. Prior to joining the AMA in 1990, John served as senior vice president and general counsel of the National Association of Independent Insurers. He also served as: the national director of Project Hope, Center for Health Information from 1982-83; Congressman Dick Gephardt's administrative assistant in Washington, D.C. from 1977-81; and an associate with the St. Louis law firm of Thompson and Mitchell from 1972-77. John is an honors graduate of Ohio State University's College of Law and received his bachelor's degree in history from Washington University in St. Louis. In 1969, John was named one of the outstanding college athletes in America. John will be talking about the effects of health care rationing on the provider community.

Our recorder is Howard Kurpit, also from Met Life. Howard is an FSA and a member of the Academy of Actuaries. He currently is the actuary for Met Life's traditional small-group health insurance products that are sold through its agency force. Previously, Howard has been an actuary in Met Life's large group department, responsible for the pricing and financial reporting of General Motors.

MS. JANET M. CARSTENS: I think many of us would agree that there are currently several forms of rationing present in our health care system. I'm going to speak about one alternative form, which is the form that has been presented by the State of Oregon. The Oregon system, as originally proposed to the federal government for approval, was rejected. Because the Oregon system represented an explicit form of health care rationing, I believe a brief summary of the system is valuable to this discussion.

The definition of rationing as it applies to Oregon's proposed health care system is: (1) payment for only those medical procedures that the state deems valuable, where value is measured according to the state's perceived benefit to patients, and (2) prioritization of Medicaid health care services based on cost benefit considerations, where the benefit factor is calculated on the needs of the entire population versus the needs of an individual.

One of the main reasons cited for rationing Oregon's health care system is expansion of Medicaid eligibility to include coverage of certain services for all state residents at or below 100% of the federal poverty level. Historically, Oregon, like many other states, had manipulated Medicaid eligibility standards so that current Medicaid coverage was available only to those at or below approximately 50% of the federal poverty level. A second reason cited for rationing Oregon's system is to control rising medical care costs. The increased cost associated with expanding coverage availability would be offset through a ranking of medical services. Payment would only be made for care that ranks above a cutoff point determined by the availability of funds. Costs would

be controlled through emphasizing managed care and preventive services, containing costs associated with excessive utilization, and monitoring of outcomes data.

The beginnings of the Oregon plan really date back to 1987, when Oregon halted Medicaid funding for most major organ transplants. The legislature, concerned about the availability of Medicaid funds, argued that transplants were high-cost procedures that benefited few. The money made available by eliminating transplant coverage was used to fund prenatal care (although this decision was really independent from the decision to discontinue funding the transplants).

Oregon's decision came under national attention when a seven-year-old was denied state funding for a bone marrow transplant and died while his parents were trying to raise alternate funds. Transplant denials were subsequently made to several other individuals. Arguments prompted the state legislature, under the leadership of Senator John Kitzhaber, to draft the basic health services plan. The arguments centered around equity, priorities, cost, and compassion.

Three bills were enacted by the Oregon legislature in 1989 and were designed to assure a basic level of health care coverage to all Oregon residents. Senate Bill 27, which is the most controversial because it incorporates rationing, expands Medicaid coverage to all uninsured individuals with incomes below the federal poverty line. Senate Bill 534 creates a high-risk pool to extend coverage to the medically uninsurable. Senate Bill 935 requires employers to offer the minimum benefit package adopted under Medicaid to all permanent employees and their dependents.

The procedures used to develop the Oregon system proposed under Senate Bill 27 included the establishment of the Oregon Health Services Commission. The commission was appointed to coordinate the development task as an open public process. It consisted of five physicians from various practice areas, four consumer representatives, a public health nurse, and one social services worker. The procedures also included public hearings conducted in various locations throughout the state to allow interested parties to express their views, and town meetings held to ascertain public opinion regarding which services should be financed. Participants at the town meetings completed a questionnaire of their opinions on the relative importance of certain health situations and categories. In addition, there was a random telephone survey of 1,000 state residents to ascertain their beliefs about quality of life and how health care factors may affect it. Respondents to the telephone survey were asked to rank 31 health situations on a scale of 0-100. Last, the procedures included a survey of Oregon's providers to assess the medical effectiveness of various procedures.

The initial Oregon plan included an assignment of a cost benefit rating to 1,600 condition-treatment pairs. Results from the various surveys were incorporated into a formula that included data on expected outcomes of given treatments for numerous health conditions. A computer-generated cost-benefit ratio was then assigned to each medical procedure. The formula was in the form of net benefit value divided by net cost, where benefit value included the duration of time the patient benefits from a particular treatment, public values regarding certain states of health, and the probability that a state of health will result from treatment. Costs included all ancillary costs as well as those for diagnosis, hospitalization, and physician services. The formula reduces the benefits of a medical treatment, its probable result, its duration, and its

value to one figure; the figure is weighed against the cost of the treatment which produces the net benefit. Procedures were then ranked according to their cost-benefit ratio. The initial list of 1,600 condition-treatment pairs was rejected. The Oregon Health Services Commission and many others were dissatisfied with the quality of the results produced by the initial list. Dissatisfaction partially arose from the fact that some items, such as immunizations for children, did not even appear on the list. The commission therefore set about revising the plan.

The revised Oregon plan included a list of 709 procedures; each procedure had a unit cost assigned. The scaling down to 709 procedures from the original 1,600 was accomplished by grouping related treatments into broader categories. Some of the members of the commission reported that in the development of this list, the commission relied more heavily on public values and clinical judgment and less on the formula results. The 709 procedures were categorized into 17 major categories, which ranged from acute to fatal, where treatment prevents death and allows full recovery, to fatal or nonfatal, where treatment causes minimal or no improvement in quality of life. Of these 17 categories, the first nine are considered essential, the next four are considered very important, and the last four are considered valuable to certain individuals. Prioritization of service categories was affected by the information gathered from the telephone surveys and town meetings. Certain condition treatment pairs were eliminated, based on a comparison of available funds to the estimated unit costs of the procedures, and the expected number of Medicaid beneficiaries. This resulted in the last 122 condition treatment pairs being dropped from the list.

The final proposed plan required regular updating of the list. This would be accomplished every two years to account for new technology and health outcomes research. There also was a requirement that the list of priorities be supplemented by a report from an independent actuary on the rates for each of the services. The legislature would then decide how much they were willing and able to spend on health care for the next biennium. If there was a shortfall, or the number of individuals below the poverty level increased, the state would establish a new cutoff point on the list of priorities, in lieu of dropping people from the program or reducing the level of reimbursement to providers. The plan also prohibited the legislature from rearranging items on the list.

Since Medicaid is a joint program between the federal government and the states, federal government approval was required. Oregon therefore requested a waiver of federal Medicaid rules.

Just to review things somewhat, the priority ranking is primarily based on three factors: the cost of each procedure, the number of people who would benefit from the procedure, and the length of time the patient would be healthy following the procedure. The definition of high-ranking categories included procedures that, on average, offer greater improvements in health and quality of life per dollar spent on care. Examples are life-threatening conditions that can be treated, conditions that affect large numbers of people, and conditions that are relatively easily treatable at a low cost with benefits that will last a long time (such as minor cancer treatment, dental care, and preventive care). The definition of low-ranking categories include procedures that, on average, promise little improvement or result in poor outcomes per dollar spent on care. Examples are conditions that are fatal or have no cure, such

as the advanced stages of AIDS, and conditions that are trivial and do not require treatment.

Some of the cited advantages of the Oregon plan have included, first, a decrease in the number of uninsured individuals in Oregon. The program would increase the number of Oregon residents eligible for health care benefits under Medicaid by as many as 120,000 people. Second, the plan represented a fundamental reform in the delivery of health care services in this country. Third, the results of the entire process would be highly visible. Public unwillingness to pay higher taxes for better coverage, and legislative unwillingness to vote higher budgets would have a direct effect on the level of coverage made available. Last, the plan could significantly decrease cost shifting in Oregon, since there would be no reimbursements for specific uncovered services, thus discouraging providers from providing these services.

One of the criticisms of the Oregon plan is that the categories were homogeneous. Most diagnosis categories were ranked homogeneously even though treatments could provide widely varying medical benefits, depending on the specific characteristics of a patient (such as the severity of an illness, the patient's age, the patient's clinical response to treatment, and the presence of concurrent illnesses). Another criticism was that the number of standard coding categories were highly condensed despite a wide range of diseases of different character and severity. Others disliked the fact that the plan only applied to people whose health care is paid for by public funds, and that treatment was not rationed for individuals who could afford to pay. Benefits were reduced only for poor women and children covered by Medicaid; although these individuals represent approximately 77% of the Oregon Medicaid population, they only consume 30% of Medicaid expenditures. Other criticisms included: benefits may be reduced in the future due to economic trends and public funding limits, providers may lose clinical autonomy, and the list of health priorities may become the standard level of coverage for the currently insured population.

Finally, some critics believed that Oregon Medicaid spending is already at a minimum. These critics cite that Oregon has historically spent less than half the national average of state general funds used as state Medicaid matching shares (Oregon ranks near the bottom of all states on Medicaid spending as a percentage of total state spending); Oregon has high administrative costs; and most of Oregon's increased Medicaid costs are due to care for the aged which is exempt under the proposed plan.

Oregon's request for a waiver of federal Medicaid rules was denied. The plan was viewed to be in violation of the Americans with Disabilities Act. The August 10, 1992 issue of *Medicine and Health* reported that the Department of Health and Human Services concluded that Oregon's method was based, in substantial part, on the premise that the value of the life of a person with a disability is less than the value of the life of a person without a disability. The article went on to say that the administration's key complaint centered around the telephone survey the state used to help create its list of prioritized services; it imposed community values on Medicaid that valued a disabled person less than a nondisabled person. An example of this violation was that the list covered liver transplants for a nonalcoholic, but liver transplants for an alcoholic were not covered. This implied potential discrimination against the chemically addicted, who are considered to be disabled.

It also was believed that the plan was based on subjective and arbitrary analysis. The August 14, 1992 issue of *Managed Care Outlook* reported that the coalition of advocacy groups for the disabled cited a report by the Congressional Office of Technology Assessment that found 24% of the condition treatment pairs on the list were moved at least 100 lines up or down the list based on the Oregon Health Services Commission's subjective opinions.

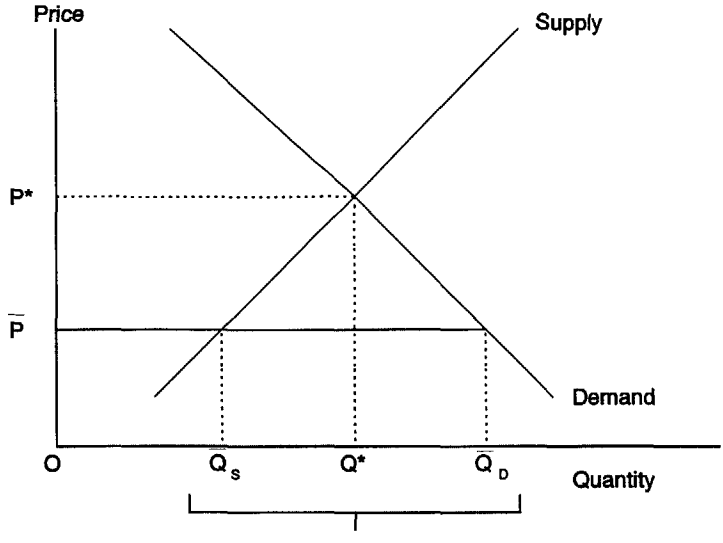
Oregon may try again, however. Governor Barbara Roberts has stated that Oregon would try to address the administration's concerns and resubmit the plan next year. Oregon officials emphasized that the current plan is subject to change, and that mental health and chemical addiction coverage is available beginning in 1993. Attorneys for the state argued that the plan would not violate the American With Disabilities Act. Oregon has asked the federal government for guidance in restructuring their proposal with the Americans with Disabilities Act in mind, and has asked the Bush administration to explain what the state must do to obtain approval.

One of the implications of the rejection of the Oregon plan is that states may be deterred from attempting to implement their own systems to reduce costs and expand coverage to the uninsured. Some of the alternatives that are available to Oregon if the plan is resubmitted and again rejected include: containing reimbursement, negotiating discounts, managed care, and further reducing Medicaid eligibility standards. Each of these alternatives, to some extent, are a form of rationing.

DR. MARTIN GAYNOR: To an economist, rationing is pervasive. Everybody's familiar with the sayings, there's no free lunch; money doesn't grow on trees; and the first and second laws of thermodynamics, which in essence are the same as those two more familiar sayings: resources are scarce. There's not an infinite amount of anything, and that means that rationing occurs all the time in some form or another. We cannot have an infinite amount of everything that we want. Choices and tradeoffs are necessary and a part of this world. Rationing can take a lot of different forms. I think that the rationing that's being discussed currently in health care more often takes the form of what I'd call quotas, but price also rations, waiting time rations, and capacity rations (for example, if this room is full and someone comes to the door, then they may choose to leave rather than stand around, or they may be forced to leave).

Being an economist, let me inflict a graph on you. Chart 1 is a graph of demand and supply. The demand curve shows that at a low price, people will buy more, at a high price, they'll buy less, all other things remaining equal. On the supply side if you can sell whatever you have at a higher price, you'll be happy to sell more of it, and vice versa, again, holding all other relevant things constant. Now, supply equals demand here at some price and some quantity, which means that at this price, the amount that people want to buy is exactly equal to the amount that sellers want to sell. When there is excess demand, there's going to be rationing. A few things can happen. One is that price could be allowed to rise. Another is that price can be kept down, and then some other form of rationing has to be used such as quotas, waiting time or some other form of rationing. That's a basic phenomenon associated with rationing.

CHART 1
Demand and Supply



Usually economists think there are a couple of different ways of rationing. I've mentioned there are more than two. But we usually talk about either rationing by prices or rationing by quantities. It turns out there are some results that, if you're concerned about sort of matching people's needs or wants to the allocation of resources, then you can derive the following results. If incomes are close to equal, but there's a lot of diversity in people's needs, then prices are going to be a better means of rationing those scarce resources. If the opposite is the case, and if people are close in their needs or desires for the good in question, but incomes are very unequal, then some kind of quantity rationing will do much better. This is relevant in health care. The better policy depends on where you're focused. If you're looking at people who are within a very narrow income class, then it may be true that prices are actually a better way of rationing than quotas. That's a point that does not seem to have been considered in the current debate. In health care, typically, price does not serve as an extremely effective rationing device, and that's because of the presence of insurance. Insurance effectively lowers the price of care, not to zero, but to something much, much lower than the true price; that means it's not going to serve as a very effective rationing device. However, one option open to policymakers is to increase cost sharing for consumers and raise the price for them and attempt to use that as a rationing device.

Now, what about health care rationing? The basic issues in rationing are always how much money do we want to spend on health care as a society overall, and which services to buy. Should we put our resources into development of artificial hearts? What about resources devoted to premature infants? What about those resources devoted to people in the last year of life? Issues like this are always paramount. The economic criteria is simply to maximize benefits while minimizing cost.

Now, there may be some very thorny issues in application associated with defining what's a benefit and what's a cost. A benefit to whom, a cost to whom? These benefits and costs are not going to be distributed equally across the population, and these can give rise to very thorny issues in decision making. Just because there's a positive benefit to someone does not automatically mean that utilizing a particular procedure is socially beneficial, at least not by this particular criterion.

Let me say a little something about health care costs. Really, the issue of rationing is the issue of cost and cost control. If there was an unlimited amount of resources to put into health care, we would not need to ration. The issue has to do with containing costs or controlling costs. Health care is roughly about 12% of GNP. More importantly, health care as a proportion of GNP grew a little over 4% per capita from 1980-90. GNP per capita grew only 1.7% over that same time period. A 4% growth rate will lead to a doubling of the level of health expenditures in 16 years. In about 16 years, there will be a doubling at a 4.4% growth rate. So those are significant numbers. I want to argue that cost inflation is the big issue, not the level of cost. You can push the level down, but if the growth rate of spending on health care continues unabated you're back where you started in a few years. So the level is not so much the issue as it is cost inflation.

Now, why care about any of this? One, there's a general feeling that we're at some point where marginal benefits are less than marginal costs, that we're beyond the point of maximizing the benefits net of cost with health care spending in general in this country. Implicit in many of the cries for health care cost containment is 12% is too much of GNP. I'm not going to make a judgment on whether that's true or not. There also are arguments given that the share of GNP devoted to health care gives us the problem of being competitive in the international markets. There's also a feeling that that's a drag on overall economic growth, that productivity in the health care sector is lower than in other sectors, so this puts a drag on the growth rate of GNP as a whole.

What are some of the causes of health care cost inflation? We've had about 500% growth in spending on health care in about the past 40 years. Technological change is probably behind most of this increase. The aging of the population, including expenditures on health care in the last years of life, only explains about 3% of the total increase in health care costs. I'm not talking about the level, but the increase. The growth of insurance coverage only will explain about 10% of that total increase. Growth in income explains about 5% of that total increase. These are the most common factors that are usually thought to be behind health care cost inflation.

I believe technological change is probably behind most of the increase. That would be key in identifying what some of the issues associated with health care rationing are, or I will say health care cost containment. You can either try to control demand or you can try to control supply, or some of both. You can engage in patient cost sharing, which I mentioned earlier. A very common form of insurance contract has patients responsible for 20% of the bill. You could increase that to 30%, 40%, or higher. You could vary that across different kinds of services. You could issue vouchers to individuals who are on public programs for a fixed dollar amount that they can spend on health care. You can engage in rationing. The Oregon plan was presented as an example of a particular form of rationing; in other words, you can

have quotas, or you can make people wait. In the U.K., there may not be quotas for particular procedures, but people are on waiting lists. If you have glaucoma, you may be on a waiting list for as long as one or two years for an operation in the national health service.

I haven't mentioned managed care, but that's another option that's usually discussed as well. You can try to control supply. You can regulate prices. We have the resource-based relative value schedule (RBRVS) for Medicare, prospective payment system for hospitals. Under Medicare, there are state rate-setting programs that are in existence. So you can try and regulate the price that you pay the sellers of these services. You can engage in global budgeting. That's something we don't use in the United States at this point, but that's another possibility. You could also think of managed care as a supply-side control as well.

Now, I think the big issue is, what are we giving up? What's the consequence of cost containment? Well, one possibility is we're just giving up waste. We're giving up things that nobody values. Well, that's not going to be true. My guess is you can talk about eliminating any kind of health care procedure or coverage, and there will be somebody, probably in this room, but certainly somebody who will be made worse off. So, it's very hard to identify pure waste.

There are things that can be identified for which there's too much utilization; any utilization is too much in that the net benefits are not at their maximum for society. However, identifying what those factors are and then arriving at some kind of consensus on that is a very difficult and prickly issue. In principle, economics says if the winners are made better off by an amount that's greater than the losers are made worse off, they could compensate them, and then we should go ahead with the change. The problem is that losers are almost never compensated. These kinds of policies are often not very effective. I feel that if we are serious about containing costs, a lot of what we're going to be giving up is technological advance. Some of that may be technological advances that cost more than they're worth. The other thing is quality of care, measured by any one of a number of different dimensions.

Let me raise issues of equity. Rationing up to this point has been applied to those who are the recipients of publicly financed care. There's obviously an equity issue. One very difficult and thorny question is what standard to achieve. There are at least two ways to approach this. One is to say that the same standard of care should be supplied for the poor as for everyone; everyone in society should have the same quality of care, standard of care, however you want to define it. Another is that there should be two standards of care. If you're poor and you're on public assistance, there's a lower standard that we would call adequate; it is not necessarily the gold-plated version. Again, I feel that these are very difficult issues. But if we are serious about containing costs and rationing health care, these are issues we have to attempt to address. Without addressing these issues, we may end up with policies that are not well thought out, which have consequences that are unintended, and with which we are not happy.

What are the right kinds of questions to ask, in general? The first is to look at benefits versus cost. Are we maximizing the benefits of health care in the society, or of any particular use of health care resources? In other words, are marginal benefits

equal to marginal costs? Second, given that we're interested in containing costs or rationing some kind of procedure or service for which demand is greater than supply, should we use prices or should we use quantities? The answer to that lies in what I presented earlier. It depends, to a great extent, on how diverse we judge the relevant population's wants or needs to be relative to the distribution of income. Third, the question is, what do we want to pay for? Do we want to pay for technology? What kind of technology? Do we want to pay for quality?

MR. JOHN B. CROSBY: My job is to give you a political, a legal, and a bit of a personal perspective on behalf of providers, being that I come from the American Medical Association. Many of us think or believe that some sort of rationing or cost containment is necessary with respect to the health care sector. But, when it comes down to your own family and loved ones, and you have a question about what kind of care they should receive, most of us, I would bet, are going to say we will spend every last dime possible in order to save their lives. I think that poses the societal dilemma that we face with respect to rationing, if that is our central concern. Individuals may well be willing to spend as much as possible on their own health care or their own family's health care. We would feel it is their God-given right, their right as a citizen in the United States, and in most every other country. But society seems to be unwilling to spend all that physicians could provide with respect to health care for individuals. And that is the horn of the dilemma that we are facing, that they're facing in Oregon, and that all of us are facing around the country.

The fact that the Oregon plan was ultimately denied because of a legal wrinkle with respect to the Americans Disabilities Act begs the question a little bit. We have worked with the state of Oregon for almost two years in support of their waiver. The American Medical Association is opposed to rationing, but we think that Oregon deserves the opportunity to try their plan. Our House of Delegates supported their waiver application and said that we should do whatever we possibly could in Washington to achieve that experiment. The people at the Health Care Financing Administration (HCFA), the Department of Health and Human Services (HHS), the Office of Management and Budget (OMB), and the White House were all giving very positive signals to the state of Oregon that their waiver application would be granted. It was only at the last minute, when I think some political considerations came into play, that President Bush perhaps did not want to be labeled the "Rationing President," or the first president that supported rationing, that they backed off and felt that there was a problem with the American Disabilities Act.

Several other waiver applications from around the country have been approved by HHS over the last several months, including a rather momentous one out of California having to do with cuts in welfare benefits to mothers on Aid to Families with Dependent Children (AFDC). That went sailing through, despite the fact that would obviously have a discriminatory impact, and a quality-of-life impact, if you will, on mothers on welfare in the state of California. That waiver went sailing through HHS and was approved by the president, and is now a law in California; however the Oregon waiver was denied.

I think there are some central questions that Oregon poses for us which, as a society, I think we need to address. One, it confronts the basic question of whether there are limits on how much we can spend on health care. We can talk about global budgets;

we can talk about a percentage of the GNP. If there's an actuary in the room that can tell me what the appropriate percentage of GNP is for health care versus defense spending or housing or urban development, I wish you'd stand up and save us all a lot of trouble.

Senator Kitzhaber, who is very eloquent in his creation, support, and defense of the Oregon plan, asked a very basic question. What are we trying to accomplish with our health care system? Are we trying to obtain access to health care for 35 million uninsured, the 120,000 people in Oregon who are under the poverty line but ineligible for Medicaid, such as the seven-year-old boy who was denied his transplant for leukemia? Or are we trying to achieve a healthier population through providing a basic level of care for all people under poverty in Oregon, which would make it the first state that would have all citizens covered. Through a combination of preventive health care and other mechanisms, Oregon would basically broaden the base of adequate health care or minimum levels of health care for all people under poverty, as opposed to those who qualify by either their disease or by the fact that they're under 50% of poverty. I think this poses a very essential question in what constitutes adequate health care for our citizens.

Likewise, I think other illusions that are at the heart of our health care system are part and parcel of the Oregon plan, or any kind of rationing plan. Are all medical interventions of equal value or benefit? Are they all equally effective or not? Obviously, they are not. We are fully aware of that fact. Can we continue to satisfy the public with the feeling that they can spend as much as possible on health care without having any role in paying for it? Can we as a society continue to spend money without any kind of check and balance. Or, alternatively, can we put in some limits, like Oregon is trying to do, without having to make some hard choices?

For example, take the illusion that we don't ration health care and that Oregon is a first step. We all know that there is rationing in health care, whether you don't have adequate health insurance at your place of employment, or any kind of health insurance whatsoever. We have always rationed health care through waiting lines, lack of facilities in the inner city or in rural communities, or just the bureaucratic rationing that's taking place by virtue of claims that are denied, or second or third opinions, or other hassles that various third-party payers might be instituting strictly to keep down costs as opposed to preserving quality or providing access to health care.

Historically, the wealthy have always had more access to care than those who are impoverished or not as well off as you and me. So this is nothing new. *De facto* rationing is taking place already in our society. What Oregon presents to us, and what the Clinton health care plan presents to us through global budgets, is rationing by fact of law, as opposed to simply through circumstances. And, as I said earlier, who is to say what is an adequate level of health care under either of those kinds of systems? What is the right percentage of GNP?

Centralized decision making, as implied or imposed on the health care system, we feel is anathema to all the kinds of choices that Martin described, be they access, quality, or cost containment. The AMA would prefer a system that is based on individual decisions, made millions of times over, but through a more cost-conscious system, whereby the insured, the patient, or the consumer is more aware than we are today,

with respect to the costs of health care, or what the fees that your physician or your hospital might be charging. That is much preferable to us, in terms of a centralized decision system like Oregon. What are we giving up, Martin asked? We're giving up individual choice, be it the patient's choice of physicians, providers, or hospitals; the employee's choice of certain types of health insurance plans; the provider's choice of what kind of practice he or she might want to employ; and of course, you give up a great deal of clinical decision making when you have a centralized or rationed type of system.

We obviously believe that health care is being dispensed, and has to be dispensed, under some sort of economic constraints. There is a limit. I can't tell you what it is, but there is some limit. We would prefer, however, that if you're going to have a rationing or a prioritized system, you first develop some clinical-based criteria by which to judge those procedures and those ailments that should be covered and cared for, as opposed to starting from a dollar figure or with some other economic level, if you will. Obviously, a physician's point of view is that all of this hampers their medical judgment, their clinical autonomy, and the fact that each patient that walks into that treatment room, be it inpatient or outpatient, presents a different set of scientific concerns, a different set of personal concerns and patient characteristics, all of which cannot be judged on the basis of 587 criteria that may or may not be paid for by a particular state. You're putting a physician in the position of denying coverage, denying care for an individual notwithstanding his own scientific or medical point of view on what would be effective and what kind of treatment that individual should receive.

Additional questions obviously deal with the futility of care; what is effective and ineffective care? Without any kind of benefit, what kinds of promises has the physician made to the patient or the family or the surrogate; is the patient competent to decide? All of those questions are begged, and perhaps lost in the equation, if you have centralized decision making, rationing, or global budgets imposed on the health care sector. These are ethical questions for the provider. They're moral questions, particularly when we haven't explored all the other options available to reduce costs before we might impose a rationing system. Obviously they're posing some social questions with respect to the allocation of resources.

Let me close with the thought that I hope will prompt some questions during the next period, and that is: as opposed to rationing, we should be talking about a rational health care system for the United States. The plain fact is that we do not have a national health care policy. We do not have a standard by which access, quality, and cost are judged and paid for by all Americans on an equitable, fair, and affordable basis. Until we have such a policy – and I don't know if Bush, Clinton, or Perot will be able to provide it, but we could talk about that too – states like Oregon have no choice but to make the decisions that they have made. Senator Kitzhaber felt they had no other alternative but to do something about that which they could control under their own system. And, notwithstanding our own feelings about rationing, we supported their waiver for one critical reason: that is, they took things into their own hands and developed a system that they felt was the best for their state. They had 47 town hall meetings. I would challenge any state in the country to match that in terms of trying to get feedback from the public, the providers, the business community, organized labor and all the top organizations and all the people in Oregon, up and

down the line. They all were consulted and had input into that plan. And as late as the end of July, a poll that we helped finance showed that 52% of the people in Oregon supported the waiver application and the health plan and 29% were opposed; obviously a sizable percentage were still opposed to it. Indeed, it was our feeling that if that is what Oregon wants, then they should have the privilege and the right to pursue that, given the fact that we don't have any leadership out of Washington.

MR. KIRAN DESAI: As I understood, most rationing in other countries was for a basic plan. There were people and groups who were outside rationing, so that choice always existed. In England, if there was rationing, you still go outside the system to get your things done. In Canada, if you're on a waiting list, you will come to the United States and get your procedure done. So with rationing, they could come to the United States and do it, Professor Gaynor. Rationing was for a universal kind of coverage, and there were people who could, of their own choice, come outside the group and do it. They do it in England. Is this what's different from what you're envisioning in rationing?

DR. GAYNOR: Not necessarily. There certainly are two-tiered systems. In some sense we do have a two-tiered system here in that we have public plans (Medicaid and Medicare), and we have private plans.

MR. DESAI: The rationing applies, but I thought John said that we have to have a rational plan, and a rational plan can't have rationing on a global basis, and still have other people satisfied outside the rationing.

MR. CROSBY: That's correct, and I think if you looked at any of the 40 major health-care reform proposals now pending in Congress, almost all of them rely on some minimum benefits package as the core level; as you might feel the 587 authorized procedures under Oregon's plan would be considered a minimum benefits package of sort. The question is, do we then tie the tax code to that minimum level of benefits? At the AMA, we think it should be, but preserve for individuals or employers the right to purchase additional coverage and pay for additional care, such as they might desire. In fact, I think that same phenomenon takes place in Canada, Britain, and Germany and in other systems. They go outside the system when it's in their own best interest. The sad fact is that if you're poor or unemployed, or your employer doesn't provide coverage, you don't have those options. That's the rational health care system that we think needs to be introduced in the United States.

MR. DESAI: Just one quick question for Professor Gaynor. There has been much talk about defensive medication, legal fees, and contingency, and so on. In the causes of inflationary factor, where did you account for that and how did you come up with those numbers?

DR. GAYNOR: I didn't specifically talk about that, and that's because the best estimate that's available, which was determined by some people at the AMA, as a matter of fact, is that would account for, at most, 1% of the overall increase. That is in spite of what President Bush is claiming. Defensive medicine and medical malpractice, by the best estimate we have, and I want to indicate that is an estimate, would not explain a very large part of that increase. One might expect the AMA to come up with an estimate that one could have confidence in, at least on the high end.

MR. ROBERT J. MYERS: One of the elements for rationing, for example in the Oregon plan, is to say that people can get Medicaid if they are below 100% of the poverty level, or 50% of the poverty level. This is all very easy to say rather quickly. I wonder, in actual practice, how Oregon would enforce this? How would the state administer it? There is quite a notch situation. If somebody is one dollar above the income or asset level, they get nothing. If they're one dollar below, they get something. Now, of course, if it's based on assets, you can always get rid of a dollar of assets. But sometimes income is impossible to reduce, for example, if it's a Social Security check. How would Oregon handle that?

MR. CROSBY: Bob, it's my understanding that under Oregon's plan their first phase would deal with the below-poverty Medicaid population, but in subsequent years their minimum benefits package would be enforceable on all employers, so that segment of the population would be covered by the same minimum benefits. In the third phase the state would develop a pool, if you will, for the uninsurable or the uninsured that somehow fall in that notch above poverty who would utilize the list of benefits in terms of being paid for out of that pooling system. The state would finance that through a combination of taxes and contributions made by the public.

MS. CARSTENS: The piece that applies to the small employer groups is effective in 1995. I think that their ultimate goal is to have approximately 97% of the total state population have some kind of insurance coverage.

MR. DAVID LANGER: How much would you consider medical care apart from three other considerations: food, clothing, and shelter. Because of the absence, or lack, or deprivation of all those three ultimately has to lead to increased need for medical care. How could we consider just medical care, just on its own merits, without considering the other three?

MS. CARSTENS: I think that's a valid point. You do need to consider all three pieces. What they were proposing in the Oregon system is to look at the pool of funds that had been used for providing medical services in the past, and the pool of funds that would specifically be available in the future just for medical services. But you're right, I think we can't necessarily forget about the other pieces.

MR. LANGER: The absence of those three really raises the cost of medical care, because if you don't have them, you're going to get sicker and sicker.

MR. JOHN A. HARTNEDY: I'd like to ask Martin a question. Basically, is there anything wrong with us spending 12% of GNP on health care. We don't measure, or at least commonly measure, what we spend on automobiles or on food as a percent of GNP. Would it make a big difference if we were responsible for spending our own money for health care? Because right now, consumers are not the purchasers, they just consume. If we were the purchasers and spending our own money on health care, would it, from your point of view, make any difference whether we spent 10-20% of GNP?

DR. GAYNOR: I think you go right to the heart of the matter. I think that economists would unequivocally agree that, in the absence of insurance, much less would be spent on health care. There's another contributing factor, to which John alluded,

and that's the nature of the tax code, and that employer fringe benefits are not taxed. That's an element of tax reform that economists have urged for years and years. It was part of the original 1986 tax reform that did not make it into the law that was passed. I think that part of the general feeling is that 12% might be too much. Now, that is not to say that the amount that would be spent without any health insurance is the right amount, because insurance is beneficial. People like to avoid risk, and in order to avoid risk, you have to accept some expenditure that may be, "in excess." So, I think that's absolutely right. What the right percentage is, again, I don't know.

MR. HARTNEDY: Just one other question, and I'd ask you to look at it as a moralist, if you will. There's a fellow, I think his name was Gates, who wrote an article in *Forbes* a short time ago, on culture. It's the top 10%, that will tend to pull the rest along. You don't culturize from the bottom up; it's from the top down. It seemed to me this also applied to health care and technology. In the countries that have been mentioned, nobody has really said that they have attained equal access to equal quality. People with money go outside the country to get care. I wonder if we need to concede that we won't attain that. Would there be an advantage to that from the point of view of technology? In this country, we are the developers of technology. The ones who can get it are the ones with the money. But at some time, penicillin and a polio vaccine had to be experimental. Somebody had to be a guinea pig.

DR. GAYNOR: There is undoubtedly a tradeoff between that and access under a fixed-budget system. There has to be a tradeoff, because money spent in one place cannot be spent in another. I think that's the kind of thing that we have to wrestle with. I think that there is a great deal of concern about the poor: those who are covered by public programs, those who aren't insured.

The income distribution has widened greatly in the past 12 years. Those policies did not lead to the bottom being pulled up by the top, but rather the bottom falling much further down.

MR. CROSBY: Well, hoping to agree with my colleague, I prefer the analogy of a rising tide carries all ships. And, at least within the provider community, there is a great deal of concern, on the one hand, but also effort on the other to rise up to the level of the basic quality standards among all providers to the extent possible, as well as to provide consumers and the general public with more information regarding the quality of care that they are receiving, be it from hospitals, physicians, or other elements of the system. We are developing, with a consortium of 25 other specialty societies, a list of practice parameters and practice guidelines for some 13,000 different procedures at the present time. Some criticize us for developing cookbook medicine, but given the technological advances, it's very difficult for your rank-and-file physician, much as he or she might try, to keep up with all of the advances. If we can standardize at least some of the procedures, some of the criteria by which they make clinical, diagnostic, and treatment decisions, I think the quality of care will increase; you will get better care, more ethical care and more moralistic care as part and parcel of that.

There is one thing I would add in terms of your actuarial science. I think that within probably 10-15 years, most physicians will have two or three computer screens in

their offices by which they will have available to them not only the patient's entire medical record, but also a whole screen of practice parameters by which to assess options with respect to treatment, both from a pharmaceutical and a diagnostic standpoint. It also will give outcomes effectiveness criteria, by which to determine from a certain treatment what the chances of success are with a 64-year-old African American male who has a history of diabetes. And, unfortunately, Oregon was placed in a situation where it had to prioritize its system prior to having adequate outcomes effectiveness research on which to judge its entire system. That's why it has received some of the criticism it has. But, this is the era that awaits us, whether it's technological, whether it is strictly data collection, I'm not sure. But it's something in which actuaries will play a critical role in the development of, particularly in outcomes effectiveness research.

MS. DOROTHEA D. CARDAMONE: Dr. Gaynor, you attributed most of the increase in cost to technological advance. But as actuaries, I think we know that there's been quite a broadening of coverage and inclusion of social workers as a medical benefit. I think I've seen statistics about quite a large increase in physician incomes, as just one of the points. So I guess I'm asking you, can you refine your statistics a bit, and tell us the source?

DR. GAYNOR: Let me tell you the source first. The source for these numbers, which, as I think I indicated, are somewhat seat-of-the-pants, is a paper by Joseph P. Newhouse in the *Journal of Economic Perspectives*, Summer 1992. According to those estimates, the increase in health insurance coverage could explain about 10% of the rate of growth of health care costs over the last 40 years. So, that does not seem to be the primary culprit. There's no question that health insurance coverage has increased. More people have it, and it's been broadened. But that does not seem to be the primary explainer.

MS. CARDAMONE: I find that we have other statistics on that.

DR. GAYNOR: Physician incomes have been falling, on average, for the past 15 years. So, that cannot explain the rate of growth of health care spending over the past 15 years. It is true that physician incomes are high. In 1990, the average physician was in the top 3% of the income distribution. There's no question that physicians have high earnings. But those earnings have been falling steadily. They can't explain that rate of growth.

MS. CARDAMONE: You must have some in-laws that are doctors.

DR. GAYNOR: No. I'm not married to a doctor, and I don't have any relatives who are physicians. I'm not taking a position on whether their earnings are too high or too low. I'm just saying that can't explain the rate of growth.

MS. CARDAMONE: I didn't say that it explained all of it, but technological advance is a large part, however, not the catch-all. I think there are many other parts.

DR. GAYNOR: I don't disagree with you.

MS. CARDAMONE: My other question, has anyone looked at the state of Hawaii? We've been concentrating on Oregon, but I understand that some things have happened out in Hawaii that might be of interest. Does anyone know what's going on there.

MR. CROSBY: Let me try Hawaii first, and then physician incomes second. Actually, up until the recent hurricane that hit Kauai, Hawaii's health care system was in extremely good shape. They have an employer mandate, whereby all employers have to provide health insurance coverage, down to small businesses, including part-time employees. They have 98% coverage. They are now trying to redefine their community health care clinics so that they can get that last 2% covered. They have a sicker population, on average, than the mainland, so don't think that this is something endemic to Hawaiians; it's not that they are healthier and therefore have lower health care costs. Physicians, on average, make 20% less in Hawaii than they do on the mainland. They have community rating, which we would support and espouse for a new health-care reform system. By and large, it is a model on which I think we should reform much of the rest of the system, if not all of the system, for the entire federal program. It's my understanding that Governor Clinton is looking very closely at the Hawaiian model as a model that he might employ.

MS. CARDAMONE: Do you know how it is financed? Through a payroll tax?

MR. CROSBY: Well, the employer has to provide the coverage. There is no pay option. It's not a play-or-pay type system. If you employ anyone over 20 hours a week, or if you have more than, I believe, five employees, you have to provide health insurance coverage to them.

MS. CARDAMONE: Through the private market?

MR. CROSBY: Yes. One of the good aspects of their system which reduces their administrative costs is the fact that they have four insurers doing business, one of which is Blue Cross/Blue Shield. Two of those insurers have 85% of the business. So there are much less competition and much less administrative costs. They're very happy with their system, and it does offer itself for further study, if any of you are inclined.

Physician income, Martin, I don't know where you get your figures. It has been increasing. The past year, it increased 3.8%, and obviously physicians make a great deal of money. In terms of the total impact of physician income, or physician decisions on health care, it's probably less than 20% of the total $800 billion that we spend on health care. If you eliminated all physician income, in effect, and made them provide care for no reimbursement whatsoever, you would impact, I think, less than 1% of total health care spending in the U.S. So, I'm not sure that is the problem, as such; it's a much more societal question.

It's not paying physicians or reimbursing them for their services that is driving this up, but rather volume and demand by the patient. Some of it is ineffective care. Some of it is defensive medicine. There is a whole list of things that are driving up health care cost in addition to general inflation. For example, we have the most violent

society in the entire world. Violence is driving up health care cost by $55 billion a year.

MR. DAVID V. AXENE: I was going to talk about the numbers for defensive medicine. I was rather surprised to hear a 1% number. I've heard much larger numbers. In the work that I've been doing, we have determined that perhaps as much as 40-50% of the health care cost is for medically unnecessary procedures. I guess until we start talking about rationing we should start looking into how much, perhaps, could be impacted by controlling the fee-for-service reimbursement system. I am somewhat inclined to think that has driven up the inflationary amount as much as anything.

DR. GAYNOR: First, I'm not going to take the medically unnecessary percent. I think you could probably come up with any figure you want, depending on how you look at it. I don't know that particular study. Fee-for-service cannot, in and of itself, drive up health care costs. In part, it depends on what the level of fees are. So, in and of itself, fee-for-service medicine is not necessarily inflationary. There are other factors to consider as well. Managed care – the level of costs for people in managed care plans are lower than for people in fee-for-service plans, absolutely no question about that. But they have increased in an almost parallel fashion. There is no evidence to suggest that managed care is any less inflationary than fee-for-service care.

MR. GEORGE KALB: I'll take the comment that Dave Axene just made about 40-50% of the care is unnecessary from studies that he has seen, and tie that into the question that John Crosby asked, as to what is the appropriate limit or percentage of GNP that health care ought to represent? I'll use those two comments as a backdrop for my question. Let's say the AMA or some other organization were able to develop the criteria for which doctors ought to practice most effectively; the 13,000 or however many diagnostic categories there might be all well known, documented, and agreed to. For example, if I in a given instance, have a diagnostic category number one, and my doctor chooses the most effective pattern laid out, should he, or should anyone have the right to offer me a different approach to taking care of my ailment? Should the doctor have an option? If the most effective, agreed-to pattern of caring for that ailment is well known and documented, should that doctor have an option to choose a different, less effective pattern? Should anyone have that option? Should the government be able to say that certain people should have that option, or not?

MR. CROSBY: Well, I think you should not overemphasize or enlarge upon the practice guidelines, practice parameters movement, as having an end of pure science, whereby every patient can be diagnosed. Patient characteristics change, and no physician and no provider is perfect in every sense of the word. I think that we will get to a point, however, where parameters will be tied, in some broad categories, to payment and reimbursement, such that, if you're outside of that equation you might be second-guessed by the third party payor, for instance, Blue Cross/Blue Shield. Maine has a program whereby it is experimenting with tying professional liability to the use of parameters, such that, if you're an OB/GYN and you follow the parameters for a particular type of patient, you will be protected from medical malpractice cases as a defense in a court of law. That's also a way we're heading with respect to parameters. So, if I understand your question correctly, I would not think that the

end of this is going to be pure science, but perhaps better art, and better quality of care, to the extent that we can get it.

Let me just address those that have asked about professional liability insurance and how defensive medicine might drive up health care costs. Our data indicate that premiums for professional liability amount to about $5 billion for all providers, all physicians, at least. Defensive medicine being practiced is probably another $15 billion. I know President Bush and Vice President Quayle cite a much higher figure. We don't know where they got that data. The fact of the matter is, however, that even if you enacted all of the tort reforms that Quayle and others are espousing, you're not going to eliminate all $20 billion of either your insurance premium or the defensive medicine being practiced. Physicians are still going to do an extra test or two, in the event that something's not working, or they don't have a clear sense of what the patient's ailment is, or what the best procedure is. So, one of the problems you have when you look at the medical malpractice component of health care costs, and why the Congressional Budget Office is unwilling to score it for budgetary purposes, is that we don't know how much of that defensive medicine will come down if we were to enact all of these reforms and the courts would uphold them. There are a lot of "ifs" there. I think it is something that will be an absolute in terms of whether or not the provider community is going to support a reform package. If there aren't some changes with respect to malpractice concerns that they now have, I think you will find a defensive, reactionary approach from the AMA and other organizations to that kind of reform package. I hope I answered your question as much as I understood it.