INDEPENDENCE ISSUE PAPER

Issue Paper #4-93
February 5, 1993

How to Think About Health Care Reform: Disasters of Price-Fixing and Cost-Shifting Can't Be Cured by More of the Same

by Francis M. Miller

INDEPENDENCE INSTITUTE
14142 DENVER WEST PARKWAY, SUITE 185
GOLDEN, COLORADO 80401
(303) 279-6536 FAX (303) 279-4176

February 5, 1993

HOW TO THINK ABOUT HEALTH CARE REFORM
Disasters of Price-Fixing and Cost-Shifting Can't Be Cured by More of the Same

By Francis M. Miller
Independence Senior Fellow
in Health Policy

Strategic Overview Needed

Close observers have been urging reform of America's health care system for at least a decade. But it was not until last year's presidential election that the political community finally responded and through their campaigning, made health care a serious issue in the minds of the public.

The social and economic effects we are now seeing in the health system are the result of 20 years of health care costs growing three times faster than inflation. Making it worse is the adverse impact of cost shifting from DRG reimbursement and managed care contract discounting.

And while medical costs themselves are increasing at 10% to 15% a year, health insurance premiums are increasing by 25% to 40%. It's become virtually impossible for individuals and small groups to purchase health insurance. This has left nearly 37 million people underinsured and at risk in a health care system that, even

At a Glance...

with insurance, tends to dispossess people of their savings when they become seriously ill. This issue paper presents an overview of various dimensions of the health care problem and recommends some short term and long term solutions. Subsequent papers will explore these issues in depth and provide greater data.

Government Takeover: Cure or Folly?

A stubborn attribute of our humanness is the failure to remember big chunks of history and, therefore, a chronic tendency to repeat past mistakes. This is becoming clearly the case with health care.

The recent call for "managed competition" by the Jackson Hole Group is really government regulation in drag. It calls for government sponsored universal access using regional health purchasing organizations.

But when all is said and done, this will give a franchised monopoly to a few giant insurers such as Blue Cross/Blue Shield and Kaiser Permanente, who are either notoriously inefficient or have resisted being held accountable for their quality.

The intent to set global budgets is little more than a continuation and encouragement of the price fixing and cost shifting that has already contributed so greatly to the market failure in health care. What folly to attempt a cure with bigger doses of the very thing that originally made the system sick.

Diagnosing the Root Cause

In attempting to understand the health care problem, most lay observers become fixated on the symptoms rather than the root causes. One example is in noticing that health costs continue rising at compounded rates of 10% to 12% a year with the result that health care now consumes 14% of the U.S. gross domestic product.

However, merely lamenting the danger of health care cost trends or the sheer absolute amount we spend as a citizenry begs the bigger economic questions and the underlying malady. That malady was ill-advised policy making to start with.

Should health care costs continue their never-ending climb beyond their already unsustainable levels our overall economy will, sometime in the 1990's, be pushed over the edge into chaos and ruin. The U.S. economy, should it suffer a setback for any reason, would not be able to absorb the shock of health care becoming 25% or more of gross national product, which it would if other sectors suddenly regressed and health care did not.

It would be a situation not unlike the commodity price collapses of the late 1800's and the 1930's. This time, however, economic disaster would be the result of one particular concern, bodily wellness, becoming a national and personal obsession that sucked resources into itself while competing concerns were left to starve.

Slippery Slope from 1930's

Reframing the health care problem from a historical perspective is also absolutely necessary to understand the underlying root causes of market failure, lest we continue to legislate our failures into stone.

It requires taking a few steps back in history to a time over sixty years ago before the Great Depression. Up to that time, health care was actually a normal competitive industry with hospitals and doctors striving together to make high-quality health services widely available and affordable to the American public.

Unfortunately, the Depression years of the 1930's witnessed two fateful events, which at the time were perceived as positive. One was the formation of Blue Cross and the granting to it of special privileges, including anti-trust. The other wrong turn was the American Medical Association's ethical ruling prohibiting doctors from engaging in competitive practices that would restrict any freedom of choice on the patient's part.

On the surface these actions at the time seemed to promote a greater availability of health financing and access to providers of choice. However, when these along with other actions of government and business are viewed in ensuing decades, it is obvious that this was really the beginning of our "slide down the slippery slope" towards the failed health care market we have today.

A series of similarly innocuous-seeming events have further eroded competition in the health market over the past fifty years and have caused it to sink into abject failure.

The economic symptoms of this failure are now impossible to ignore, leading to the national alarm expressed in Bill Clinton's health task force and in such state proposals as Roy Romer's ColoradoCare plan.

A New Basic Right, with Stealth Funding

The most significant events since World War II were first, the creation of the Great Society entitlement programs in the 1960's which rewrote the social contract making health care more than a privilege. As a result of Medicare and Medicaid, along with a host of additional state initiated programs such as compensation for injured workers and the medically indigent, health care is now widely considered a basic right.

Unfortunately, the social contract was rewritten without ever fully informing the taxpaying public of the eventual economic costs and the social and political burdens.

Next, when health care costs burgeoned in the late 1970's, government responded by using its clout to fix prices for the Medicare and Medicaid programs under DRG's, thus, causing rampant cost shifting towards the private sector. Large employers and insurers responded, in like fashion, by negotiating deep discounts under the guise of managed care.

But given the extreme lack of competition in the health care industry and the structural deficiencies inherent in the franchised monopoly of health providers, the net effect of price fixing and cost shifting has been a not-too-subtle form of hidden and

regressive taxation that sick patients and premium payers must pay in increasing amounts.

When viewed in its entirety, the current health care system is non-competitive and exhibiting the characteristics of a failed market. The amount of inpatient services being provided have continually declined under DRG's, while the amount of costs are increasing. Furthermore, this perverse situation is the direct result of ill-informed government policy designed to increase access for various constituencies -- without having the political courage to seek approval for explicit taxation to pay for it.

The market failure also results from anti-trust policies which not only allowed, but actually encouraged the concentration of market share power in a limited number of health providers and insurers.

These large, dominant, and now cartel-like market players extract their ransom in the form of ever increasing health costs and insurance premiums, with the result, translating into lower take-home pay and reduced purchasing power for workers.

Illusory Political Fix vs. True Market-Based Reform

The current proposals being touted at the state and local levels are typical of politically-driven solutions. That is, they give the soothing impression of appearing to solve the problem in the short run, but they threaten devastating negative consequences for the economy and our society in the long run.

The hard truth is that only by insisting on genuine market-based reforms over a period of years can we achieve a positive, permanent turnaround of current trends.

This will require a strategy for thorough restoration of a devastated health care marketplace and the reintroduction of selected strains of competition -- to foster continuous cost reductions, real gains in productivity and quality, and increased access for the working poor.

The elements of such a strategy are summarized in the following outline:

FIRST, SHORT-TERM STEPS TOWARD A RESTORED MARKET

I. Three Basic Reforms of Medicaid

a) Introduce HMO-like managed care to achieve a levelling off of Medicaid costs and reduce the impact on state and federal deficits,

b) Liberalize eligibility requirements to provide access for the 10-15 million uninsured working poor, and provide 50/50 federal matching funds,

c) Tax excess employee benefits for existing employers and institute a 7% payroll tax on uninsured employers to raise the revenues to pay for the Medicaid program changes.

II. Amend ERISA (federal pension laws) to permit establishment of multiple employer- and consumer-owned health care purchasing cooperatives

a) Allow multiple employers to form their own cooperatives so long as they provide basic benefits,

b) Allow up to 25% of qualified pension plan portfolios to be pledged as reserves for a health plan, including worker compensation and 24 hour medical plans, if a valid reinsurance/stop-loss policy is backing the plan.

III. Legislate basic reform on insurers and providers at the state level

a) Eliminate insurers' ability to "cherry-pick" by requiring community rating and limited restrictions on their underwriting.

b) Eliminate health providers' ability to shift costs by requiring them to give all commercial insurers, as well as self-insured employers and self-pay consumers, an equally-favored pricing status.

THEN, LONG-TERM COMPETITIVE MARKETPLACE REFORMS

IV. Reform Medicare, Medicaid, and other entitlement programs

a) Means test all health care entitlement programs, including redefining poverty levels relative to health care costs,

b) Implement a fixed contribution amount per capita (age, sex, and poverty adjusted) for both federal and state governments. Peg the amount to the average cost of a basic set of HMO-provided benefits. Any amount in excess for a health insurance plan purchased by either the employee or employer would be taxed.

c) Prioritize a set of "value scales" for all medical procedures relative to their proven contribution to improved health status and cost/benefits. Excess medical services purchased would be value-added taxed.

d) Provide an option for consumers to obtain their government and employer contributions as a voucher and spend it as they wish on a basic health insurance plan in the open, competitive market.

V. Fundamentally reform the employer-based system

a) Require all employers to, at a minimum, contribute a defined percentage of their employees' payroll (probably 7%) toward a basic health benefits plan indexed to the cost of the national HMO averages.

b) Surtax excess benefits and discretionary medical procedures and use the monies raised to fund basic entitlement programs and public health education and wellness.

c) Allow for self-insured employer trusts and multiple- employer and consumer cooperatives to participate in regional and national reinsurance pools that finance catastrophic and chronic illness situations.

VI. Set up additional enabling activities by government

a) Create a national reinsurance pool for chronic and catastrophic illness supported by broad based premiums.

b) Develop a national EDI, electronic data exchange network along with standardized billing and data collection.

c) Develop a national public-domain relational data base of comparative cost, utilization, and outcomes information to track the performance of providers and health insurers.

d) Provide technical support and encourage working capital loans to facilitate the creation of health purchasing cooperatives.

INDEPENDENCE INSTITUTE is a Colorado nonprofit corporation. It is governed by a bipartisan board of trustees and holds a 501(c)(3) tax exemption from the IRS. Its public policy research focuses on economic growth, health care, education reform, environment, equal opportunity, and government effectiveness.

FRANCIS M. MILLER heads Millennium Consulting Group in Denver. He has served on the Colorado Health Data Commission since 1985. A former president of the Colorado Business Coalition for Health, he has also held senior management positions with several major accounting firms and corporations.

EDITOR of the Independence Issue Paper series is John K. Andrews, Jr., president of the Institute.

'ACCESS, QUALITY, AFFORDABILITY' GUIDE HEALTH REFORM PROJECT

Health care reforms keyed to consumer choice, competition, and markets are the focus of a policy research project to be conducted by the Independence Institute over the next 18 months. The AQA Project for Colorado Health Policy will advise government and business by means of studies and conferences utilizing a team of experts headed by Fran Miller. "Access to basic health care for everyone, quality of care, and the affordability of those services in a family budget are the criteria from which the AQA Project takes its name," said Institute president John Andrews. *Health Vouchers Could Cure the Medicaid Crisis*, Independence Issue Paper No. 1-93 by CU economist Barry Poulson, and *How to Think about Health Care Reform*, the present paper by Miller, have been published to start the project. Topics of forthcoming AQA studies will include:

What the Colorado Health Data Commission Findings Show about Needed Reforms in Medical Entitlements

How Workers Compensation and the ERISA Pension Law Should Firgure in Colorado's Health Reform Strategy

Waiting for Dr. Clinton: What State Policymakers Can Do to Control Their Destiny as Federal Policy Evolves

Rethinking the Societal Values and Ethical Paradigms behind America's Health Cost Explosion

Pros and Cons of the ColoradoCare Proposal and the Robert Wood Johnson Study

A 1990s Survival Guide for Corporate Purchasers of Health Care