PART II

FROM COMPETITION TO COST-PLUS HEALTH CARE
5. How the Cost-Plus System Evolved

The cost-plus system of health care finance is incompatible with competitive markets in which prices are determined by supply and demand. Cost-plus finance requires a regulated, institutionalized market in which normal competitive pressures are either outlawed or suppressed. This chapter briefly describes how the U.S. market for medical services evolved from a competitive to a regulated market, first for physicians’ services, then for hospital services, and finally for health insurance.

The first building blocks of the cost-plus system were put into place by the political activities of physicians more than 100 years ago. Those activities, coordinated through the American Medical Association (AMA) and county medical societies, are called the actions of organized medicine, to distinguish them from the uncoordinated actions of individual physicians competing against one another in the marketplace. By the 1950s, organized medicine had achieved virtually all of its political goals: the creation of nonprofit institutions designed to control entry into the medical profession and to suppress competition for physicians’ services; the creation of a nonprofit hospital sector, chiefly responsive to physicians; and the creation of a nonprofit health insurance sector that paid most medical bills with little scrutiny and few questions asked. That was Stage I in the evolution of the cost-plus system, and it survived for at least three decades.1

During the 1980s, however, we entered Stage II, the cost-control stage. Physicians now are encountering harassment from third-party institutions and are increasingly torn between their obligations to patients and the demands of third-party payers. The irony

1Similar developments also took place in other countries. For the early history of the politics of medicine in Canada, see Ronald Hamowy, Canadian Medicine: A Study in Restricted Entry (Vancouver: Fraser Institute, 1984). For the British experience, see David Green, Working Class Patients and the Medical Establishment: Self-help in Britain from the Mid-nineteenth Century to 1948 (Hampshire, Eng.: Gower/Maurice Temple Smith, 1985).
is that the problems of today's physicians are attributable in part to the political actions of their counterparts more than a century ago. Today's health care system frustrates many people, who often search for someone or some group to blame. Physicians are all too often their targets. Throughout the past 150 years, though, most physicians have not been involved in politics. To the extent that they have had political preferences, most have favored free enterprise. The vast majority have been far more altruistic than the practitioners of other professions.

The historical facts recounted in this chapter will surprise most physicians as much as they surprise others. Those facts include the ways in which doctors' representatives pursued legislative goals and changed the institutional environment in which medicine is practiced. In doing so, the representatives of physicians had the same motives and many of the same objectives as the representatives of other professions and trades. If there is a difference, it is only that special-interest politics proved more successful in medicine than in other fields. Today's doctors are not responsible for the political activities of doctors in the past. Indeed, physicians today are among the most tragic victims of cost-plus medicine. If they could, the majority would surely undo the harm done through the medical politics of the past.

**Early History of Government Controls**

In medical care, as in many other sectors of the American economy, a genuinely free market emerged not in 1776 but during the middle of the 19th century. Between 1830 and 1850, many of the medical licensing laws left over from the colonial period were repealed. Historian Ronald Hamowy has described the condition

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2For a lengthier historical treatment, see John C. Goodman, *The Regulation of Medical Care: Is the Price Too High?* (Washington: Cato Institute, 1980).


4Although 20 states and the District of Columbia had some form of licensing prior to 1850, these laws were commonly short-lived and poorly enforced. Five states provided no penalty for practicing without a license, and in six more the worst penalty was that unlicensed practitioners could not sue for recovery of fees. Only in New York, South Carolina, Georgia, and Louisiana did unlicensed practitioners face the possibility of imprisonment. See Joseph F. Kett, *The Formation of the American Medical Association: The Role of Institutions, 1780–1860* (New Haven: Yale University Press, 1968), pp. 181–84; and William G. Rothstein, *American Physicians in the Nine-
of the American medical profession at the close of the Civil War as follows:

The profession was, throughout the country, unlicensed and anyone who had the inclination to set himself up as a physician could do so, the exigencies of the market alone determining who would prove successful in the field and who would not. Medical schools abounded, the great bulk of which were privately owned and operated, and the prospective student could gain admission to even the best of them without great difficulty. With free entry into the profession possible and education in medicine cheap and readily available, large numbers of men entered practice.\(^5\)

This experiment in free-market medical care was short-lived, however. The AMA was established in 1847 and quickly became the spokesman for the practitioners of orthodox medicine in the United States. Although the AMA often stressed the importance of raising the quality of care for patients and protecting uninformed consumers from "quacks" and "charlatans," its principal goal—like that of other trade associations—was to advance the financial well-being of its members. It pursued its objective by promoting the establishment of state medical licensing laws and the legal requirement that, to be licensed to practice, a physician must be a graduate of an AMA-approved medical school. Clearly, it sought to raise the incomes of existing practitioners. A report submitted by the committee on educational standards to the first AMA convention in 1847 was unusually candid:

The very large number of physicians in the United States . . . has frequently been the subject of remark. To relieve the diseases of something more than twenty millions of people, we have an army of doctors amounting by a recent computation to forty thousand, which allows one to about every five hundred inhabitants. And if we add to the 40,000 the long list of irregular practitioners who swarm like locusts in every part of the country, the proportion of patients will be still further reduced. No wonder, then, that the profession of medicine has measurably ceased to occupy the

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\(^{5}\)Shamowy, "The Early Development of Medical Licensing Laws," 73.
It is ironic that most unorthodox ("irregular") practitioners at the time probably did more good—or less harm—to their patients than did the orthodox ones. A second irony is that the committee recommended standards so high that few of the convention's delegates could have met them. Indeed, one historian has concluded that "rigid enforcement of the AMA's preliminary standards would have closed down practically every medical school in the country and would have depleted the ranks of formally educated physicians in a few years."

Early Licensing Laws

Virtually every law designed to restrict the practice of medicine was enacted not on the crest of widespread public demand but because of intense pressure from the political representatives of physicians. Moreover, AMA-sponsored legislation invariably contained grandfather clauses that exempted existing practitioners. These laws did nothing to protect the public from quacks and charlatans already active. What they did was protect practitioners from the competitive pressures posed by potential new entrants into the medical profession.

7Rothstein, p. 120.
8According to Hamowy, regular medicine in the 19th century relied heavily on "bloodletting, blistering, and the administration of massive doses of compounds of mercury, antimony, and other mineral poisons as purgatives and emetics, followed by arsenical compounds thought to act as tonics." The two major schools of nonorthodox medicine were electicism and homeopathy. Electicism relied exclusively on botanical remedies, steam baths, and rest. Homeopathy advocated small doses of drugs that, when tested in a healthy person, produced symptoms most closely approximating the symptomology of the disease. Homeopathic doctors were also strong proponents of fresh air, sunshine, bed rest, proper diet, and personal hygiene—therapeutic remedies that the practitioners of regular medicine regarded as being of little or no value. See Hamowy, "The Early Development of Medical Licensing Laws," 73–74.
At the first meeting of the AMA in 1847, the delegates not only endorsed collective fee-setting but unanimously endorsed a code that made adherence to established fee schedules a matter of medical ethics. Chapter II, article 7, section 1, of the organization's original Code of Medical Ethics, read as follows: "Some general rules should be adopted by the faculty, in every town or district, relative to the pecuniary acknowledgments from their patients; and it should be deemed a point of honor to adhere to this rule with as much steadiness as varying circumstances will permit." In other words, the AMA endorsed the ideal of a medical cartel and made participation in it ethically mandatory. Over time, the AMA expanded the range of activities considered "unethical" to include (1) "solicitation of patients, either directly or indirectly," (2) "competition and underbidding," (3) "compensation . . . inadequate to secure good medical service," (4) "interference with reasonable competition in a community," and (5) "impairment of 'free choice' of physicians."10

AMA goals were also promoted by threats of license revocation. The most common causes for revocation, "dishonorable" or "unprofessional" conduct, were mainly euphemisms for what the AMA considered unfair competition. "Incompetence" was grounds for revocation in only 2 of the 42 states that had revocation provisions in their medical practice acts in 1907.11

In 1888, the Journal of the American Medical Association editorialized that "wholesome competition is the life of trade; unrestricted competition may be the death of it." In 1898, the New York state medical fraternity proposed to prevent free vaccination and the administration of free diphtheria antitoxin on the grounds that it was "inimic to the best [financial] welfare of young medical men."13 The AMA's

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10These conditions were contained in a minority report to the report of the Committee on the Costs of Medical Care in 1932, and subsequently were endorsed by the AMA. See Elton Rayack, Professional Power and American Medicine: The Economics of the American Medical Association (Cleveland: World Publishing Co., 1967), p. 152.
12"Competition, Supply and Demand, and Medical Education," Journal of the American Medical Association (September 15, 1888): 382–3.
code of medical ethics condemned the practice of giving free care to affluent patients without compensation as "dishonorable" and "unprofessional" because it tended to injure other physicians financially.\textsuperscript{14}

In addition, organized medicine vigorously sought to eliminate competition from any unlicensed person who would treat the sick for compensation, regardless of the form of treatment and its effect on the patient. In most states, physicians were successful in broadening the definition of medical practice to include drugless and spiritual healers (for example, Christian Scientists, osteopaths, and chiropractors).\textsuperscript{15} At the urging of organized medicine, courts ruled that it was not a defense that patients knowingly accepted the mode of treatment offered, nor that patients may have benefited from the treatment.\textsuperscript{16}

In one case, the Nebraska Supreme Court ruled in 1894 that a Christian Science practitioner had violated the state's medical practice act by accepting compensation in return for treating solely by prayer those who called on him.\textsuperscript{17} A similar decision was reached by the Ohio Supreme Court in 1905. In that case, the court ruled that Christian Science treatment in return for a fee constituted the practice of medicine, even though the cure was to come from God and not from the defendant.\textsuperscript{18}

By 1901, all states and territories except Alaska and Oklahoma had medical examining boards. Of the 51 jurisdictions, 30 required candidates for a license to undergo an examination and to present

\textsuperscript{14}Hamowy, "The Early Development of Medical Licensing Laws," 96.


\textsuperscript{16}Chapter II, article 5, section 9 of the code of medical ethics, adopted at the first AMA convention, read: "A wealthy physician should not give advice \textit{gratis} to the affluent because it is an injury to his professional brethren. The office of physician can never be supported as an exclusively beneficent one; and it is defrauding in some degree, the common funds for its support, when fees are dispensed with, which might justly be claimed." See "Code of Medical Ethics." The injunction apparently does not apply to ministering gratis to another physician—a practice that is quite widespread. See the analysis of the practice in Reuben A. Kessel, "Price Discrimination in Medicine," \textit{Journal of Law and Economics} 1 (October 1958): 20–53.

\textsuperscript{17}State v. Buswell, 40 Nebraska 158, 58 N.W. 728 (1894).

\textsuperscript{18}State v. Marble, 72 Ohio State 21, 73 N.E. 1063 (1905).
a diploma in medicine; seven required either an examination or a diploma; and two made the M.D. degree a prerequisite for the practice of medicine. Although the number of physicians continued to increase, the number per 100,000 people fell from 163 in 1880 to 157 by the turn of the century.\textsuperscript{19}

 Nonetheless, in 1901 the Journal of the American Medical Association continued to complain about overcrowded conditions in the medical profession.\textsuperscript{20} Hamowy explains why: Licensing laws mandating an examination were clearly not sufficiently restrictive to severely limit the numbers of new physicians entering the profession, even when these laws also required a diploma in medicine. The answer was to lie in statutes which both required a diploma and, in addition, empowered the state examining boards to exclude graduates of "substandard" colleges from consideration for licensure.\textsuperscript{21}

**The Flexner Report**

In 1906, the AMA's Council on Medical Education inspected the existing medical schools and found the training acceptable in less than half of them. These findings were never published, however. Arthur Bevan, head of the Council on Medical Education, explained why: "If we could obtain the publication and approval of our work by the Carnegie Foundation for the Advancement of Teaching, it would assist materially in securing the results we are attempting to bring about."\textsuperscript{22}

The AMA's efforts were successful. In 1910, the foundation commissioned Abraham Flexner to perform what amounted to a repeat of the AMA's inspection and grading of medical schools. Flexner had absolutely no qualifications for the task. He was not a physician, scientist, or medical educator. He had an undergraduate degree in the arts and was the owner and operator of a for-profit preparatory school in Louisvile, Kentucky.

Flexner evaluated existing medical schools by conducting a grand inspection tour. Sometimes he evaluated an entire school in one

\textsuperscript{19}Hamowy, "The Early Development of Medical Licensing Laws," 102.
\textsuperscript{20}"Oversupply of Medical Graduates," *Journal of the American Medical Association* 37 (July 27, 1901): 270.
\textsuperscript{21}Hamowy, "The Early Development of Medical Licensing Laws," 103.
\textsuperscript{22}Arthur Bevan, "Cooperation in Medical Education and Medical Service," *Journal of the American Medical Association* 90 (1928): 1178.
afternoon. He measured the schools by comparing each to the medical school at Johns Hopkins. He was accompanied on the tour by the secretary of the AMA's Council on Medical Education, N. P. Colwell, who provided him with the results of the AMA's previous labors. Flexner apparently accepted a good bit of assistance from the AMA and spent many hours at its Chicago headquarters preparing his report.

Control of Medical Schools

The Flexner report had an enormous impact on the future of medical education in the United States. Indeed, as Reuben Kessel has written, "If impact on public policy is the criterion of importance, the Flexner report must be regarded as one of the most important reports ever written." It convinced legislators that only graduates of first class (Class A) medical schools ought to be licensed, and they delegated the classification of institutions—explicitly or implicitly—to the AMA. In time, every state established standards of acceptability for obtaining a license to practice medicine. These standards, set either by statute or by state medical examining boards, provided that the boards consider only the graduates of schools approved by the AMA and/or the American Association of Medical Colleges, whose lists were identical.

Ultimately, the Flexner report led to the large-scale closing of medical schools that failed to meet AMA standards. By exercising its power to certify, the AMA caused an almost continuous reduction in the number of medical schools in the United States over the next four decades. (See Figure 5.1.) As a consequence, the number of medical students dropped dramatically. As Figure 5.2 shows, following the release of the Flexner report the ratio of doctors to population fell steadily for two decades. To see how effective the AMA's policies were, consider that doctors in 1963 had far more to offer patients than at the turn of the century and were in far greater

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23 Abraham Flexner, Medical Education in the United States and Canada, Bulletin no. 4 (Carnegie Foundation for the Advancement of Teaching, 1910).
25 Ibid., 29.
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Figure 5.1
NUMBER OF MEDICAL SCHOOLS IN THE UNITED STATES, 1900 TO 1990*

![Graph showing the number of medical schools in the United States from 1900 to 1990.]


*The numbers given are for academic sessions ending in specified years. Beginning in 1954, the totals include Puerto Rico; beginning in 1960, the totals include osteopathic medical schools.

Demand. But the number of doctors per 100,000 people in 1963—146—was precisely what it had been in the year that Flexner had written his report. 27

The impact of the Flexner report may be unique in U.S. regulatory history. Kessel explains why:

27 See Cotton M. Lindsay and James M. Buchanan, “The Organization and Financing of Medical Care in the United States,” in *Health Services Financing* (London: British Medical Association, 1974), Table 2 (p. 540).
The delegation by the state legislature to the AMA of the power to regulate the medical industry in the public interest is on a par with giving the American Iron and Steel Institute the power to determine the output of steel. This delegation of power by the states to the AMA, which was actively sought and solicited, placed this organization in a position of having to serve two masters who in part have conflicting interests. On the one hand, the AMA was given the task of
providing an adequate supply of properly qualified doctors. On the other, the decision with respect to what is adequate training and an adequate number of doctors affects the pocketbooks of those who do the regulating as well as their closest business and personal associates. It is this power that has been given to the AMA that is the cornerstone of the monopoly power that has been imputed by economists to organized medicine.\textsuperscript{28}

Effects on Medical Practice

The most important consequence of the control of medical education by organized medicine, then, was that physicians acquired the power to reduce the supply of medical services and increase their incomes. But there were other effects. One was a shortage of minority physicians. Of the 375,000 physicians in the United States in 1977, only 1.7 percent were black.\textsuperscript{29} Moreover, 83 percent of the black physicians were trained at two predominantly black medical schools, Howard and Meharry.\textsuperscript{30} Prior to 1910, there had been more black medical schools, and blacks and other minorities had found it relatively easy to enter the profession. Following the Flexner report, most black medical schools were closed, and black would-be physicians confronted rationing schemes at those medical schools that did remain open.\textsuperscript{31} Discrimination against other minorities, such as Jews, and against women, became rampant.\textsuperscript{32}

Because the decision makers on medical school admissions boards could not, or would not, discriminate on the basis of price, they discriminated on other grounds. As Lee Benham has explained, “It

\textsuperscript{28} Kessel, “Price Discrimination in Medicine,” 29.
\textsuperscript{29} Ibid.
should not surprise us that the successful members of the subsequent queue looked remarkably similar to those making the admissions decisions." No doubt many of those decisionmakers reflected the views of Flexner himself. Flexner wrote that “a well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous,” and “the practice of the negro doctor will be limited to his own race.”

Other effects of the Flexner report were that medical education became increasingly lengthy and costly, and its subject matter became increasingly unrelated to the conditions of medical practice. The fact that only nonprofit medical schools could become "approved" probably contributed to the nonmarket-oriented attitude of many medical schools and their willingness to cooperate with the goals of organized medicine.

Several writers have observed that the AMA’s changing positions on the proper standards for medical education correlated far more closely with the financial pressures faced by practicing physicians than with any clearly defined goals of medical training. For example, Philip Kissam has written:

The AMA’s Council on Medical Education has been able to reduce the number of new physicians entering the profession by increasing the standards for accreditation of medical schools, thereby driving some schools out of business, discouraging new schools from opening, and reducing the size of others [yet the] quality standards imposed for physician licensure have never been carefully correlated with definitions of acceptable medical performance. Most significantly, major “improvements” in standards for accredited medical schools generally have been imposed at times when physicians’ incomes were relatively depressed and have been accompanied by open expressions of concern by leaders

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34Flexner, p. 180.

of organized medicine about the "over-crowded" medical profession.36

Economic Effects of the Licensing of Physicians

After surveying the development of licensing laws in various professions, economist Thomas Moore concluded that "licensing raises the cost of entry which, in turn, benefits practitioners already in the occupation at the time of licensing."37 Because that is the principal effect of licensing, Moore concluded that it is also the principal purpose.

Traditionally, a medical license was an unlimited license to perform medical services. A physician, once licensed, could theoretically perform any kind of surgery—including open-heart and brain surgery—without any special training as a surgeon. Further, most state licensing laws granted a lifetime tenure to the licensee. Although most states required periodic license renewal, renewal was generally a clerical procedure requiring little more than the signature of the physician and the payment of a nominal fee. Until recently, few states required physicians to show evidence of having updated their knowledge as a condition for maintaining a license. Not only were physicians not required to keep abreast of the state of medical science in their specialty but, in some states, a physician could continue to practice even if mentally ill. A 1967 survey found that only one state, Arizona, required that a candidate for a medical license be "physically and mentally able safely to engage in the practice of medicine."38 Some statutes did establish mental illness or mental incompetence as grounds for suspension or revocation of a license, if the extent of the illness rendered the physician "unsafe or unreliable as a practitioner." But other states provided


Patient Power

for license revocation or suspension only if the physician entered a mental hospital.\(^{39}\)

In the 15 states that listed malpractice among the specific grounds for licensing discipline, the standard was usually "gross malpractice," "gross neglect," "gross carelessness," or "gross incompetence." The practical effect of these provisions, as one study concluded, was that the "disciplinary criteria are . . . analogous to less stringent criminal standards of gross malpractice, which are usually included in state penal statutes."\(^{40}\) It would appear that Kessel's 1970 observation that "once a doctor wins a license to practice, it is almost never revoked unless he is convicted of law-breaking" was not an exaggeration.\(^{41}\)

Restrictions on Nurses and Other Paramedical Personnel

Although medical practice statutes did little to protect the public from incompetent doctors, they did a great deal to discourage competent nonphysicians, such as nurses, paramedics, and physicians' assistants. Numerous studies in the 1970s established that nonphysicians can safely perform many routine medical acts.\(^{42}\) They include physical examinations, diagnosis and treatment of common illnesses, minor surgery, and decisions to continue or modify prescribed treatment for convalescing or chronically ill patients. Studies also showed that when trained nonphysicians were used innovatively under the direction of physicians, the costs of medical treatment could be substantially reduced.\(^{43}\)

\(^{39}\) Ibid., 286.

\(^{40}\) Ibid., 284.

\(^{41}\) Kessel, "The AMA and the Supply of Physicians," p. 275.


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But standing between the patients and safely administered, lower cost medical treatment were numerous state laws. A 1975 survey found that, in the country as a whole, many—or perhaps most—routine medical procedures could be carried out only by licensed physicians. Moreover, in those states that allowed delegation of medical acts, the nonphysicians usually had licensing laws of their own and lobbied to keep other qualified nonphysicians from legally performing those same acts. 44 Although many states liberalized their medical practice statutes during the 1970s, many of their unjustifiable restrictions exist even today.

Restrictions on Advertising

Professional licensing of physicians was also used to protect physicians from competition with each other. 45 The AMA not only made adherence to a fee schedule an issue of professional ethics, but also pronounced advertising to be unethical and unprofessional. In 1961, the licensing laws of 40 states defined advertising as unprofessional conduct, and thus grounds for license suspension or revocation. 46 However, only advertising that benefited an individual physician was "unprofessional." Advertising that benefited the medical community as a whole was a different matter. Kessel has explained the distinction:

The advertisement of medical services is approved by the medical profession if and only if such advertisements redound to the interest of the medical profession as a whole. Advertisements in this class are, for example, announcements of the availability for sale of Blue Cross-type medical plans. These plans allow their subscribers the choice of any licensed practitioner. . . . On the other hand, advertisements that primarily redound to the interest of a particular group, for example, advertisements by a closed panel medical group, are . . . resorted to only by "unethical" doctors. . . . [A]dvertising in this class constitutes competitive behavior and leads to price cutting. It tends to pit one doctor

44Kissam, "Physician’s Assistant and Nurse Practitioner Laws,” 1–65.
or one group of doctors against the profession as a whole
with respect to shares of the medical care market.\textsuperscript{47}

Organized medicine used its state-created powers to punish deviant advertising behavior on numerous occasions. Here are some examples from the 1970s: In Minnesota, a gynecologist was warned against making radio and newspaper announcements of his one-week drive to encourage women to obtain pap smears by offering discount prices; in Santa Clara, California, the county medical society prohibited clinic doctors who specialized in preventive industrial medicine from seeking new corporate clients; and in St. Louis, the local medical association forced the director of Washington University's sterilization and pregnancy termination clinic to apologize for mailing a brochure describing the center's facilities, even though the brochure was mailed to local physicians.\textsuperscript{48}

The attitude of the AMA toward advertising and price competition was paralleled by that of the associations of related health practitioners. The code of ethics of the American Dental Association, for example, stated:

\begin{quote}
It is unethical for a dentist to give lectures or demonstrations before lay groups on a particular technique (such as hypnosis) that he employs in his office.

It is unethical for specialists to furnish so-called patient education pamphlets to general practitioners for distribution to patients where pamphlets, in effect, stress unduly the superiority of the procedures used by specialists. Publication of such so-called patient education material has the effect of soliciting patients.\textsuperscript{49}
\end{quote}

As another illustration, consider the rules and regulations of the Michigan Optometric Association in 1969. Eligibility for membership in the association was based on a point system and initial membership required 65 points. Constraints on advertising or disseminating information accounted for 70 out of the 100 possible points.

\textsuperscript{47}Kessel, "Price Discrimination in Medicine," 43–4.


\textsuperscript{49}Reprinted in Benham, "Guilds and the Form of Competition in the Health Care Sector," p. 459.
Virtually all of the restrictive practices described above either have been declared illegal by the federal courts or are almost certainly destined to become illegal. Yet the attitudes shaped and molded by the restrictive practices remain pervasive.

Effects on Health Insurance

Until recently, there were only three basic types of medical insurance. Under indemnity medical insurance, doctors and patients determined medical fees jointly at the time the medical services were sold. All or part of the medical bill was then paid by the insurance plan, depending on the specifics of the policy. Examples of medical indemnity insurance were policies sold by Aetna, Travelers, and other “commercial” insurance companies. Nonindemnity medical insurance plans, on the other hand, provided medical care itself, rather than funds to buy those services. Such plans were often called prepaid plans because the patients’ insurance premiums generally covered all of the medical services they subsequently consumed. Examples were Blue Cross and Blue Shield plans. Under the original Blue Cross and Blue Shield plans, there was no deductible and no copayment. Coverage allowed patients to see almost any doctor or receive services in almost any hospital. Physicians and hospitals were compensated directly by the insurers.

The AMA clearly favored Blue Cross “service benefit” insurance and went to great lengths to encourage it. Although both tend to increase the overall demand for physicians’ services, prepaid plans removed visible prices as a factor in patient choices and thus helped eliminate price competition.

The AMA was even more hostile to the third type of insurance: prepaid plans with restricted choice of provider. Under those plans, insurers not only offered a service benefit, but specified which physicians could supply the service and often employed those physicians and/or regulated the way in which they practiced medicine. These plans tended to benefit only the providers associated with the plan, often at the expense of other providers. Examples are health maintenance organizations (HMOs).

PATIENT POWER

The AMA did not merely condemn HMOs and HMO-type health insurance; it denounced them as unethical. According to an AMA House of Delegates resolution adopted in 1932, such plans are "unethical":

1. Where there is solicitation of patients, either directly or indirectly;
2. Where there is competition and underbidding to secure the contract;
3. When the compensation is inadequate to secure good medical service;
4. When there is interference with reasonable competition in a community;
5. When free choice of physicians is prevented;
6. When the contract because of any of its provisions is contrary to sound public policy.51

Five of the six conditions for deeming a prepaid plan unethical were obviously intended to protect the economic position of other physicians. The sixth was open-ended, making it possible to condemn any form of prepaid practice. As Elton Rayack wrote, "Clearly what was involved [in the list of conditions] was a question of medical economics rather than medical ethics, though the two are often synonymous in the jargon of organized medicine."52

Physicians who participated in prepaid health plans sometimes had their licenses and hospital privileges revoked,53 and states were encouraged to pass laws outlawing or restricting the availability of HMOs. A 1972 survey found that 9 states prohibited HMOs altogether, and 20 states either prohibited them or restricted them so severely that they could not operate. Among the restrictions were acts that required medical society approval of the articles of

51 Listed in Rayack, p. 152. These conditions were contained in a minority report to the report of the Committee on the Costs of Medical Care. See Medical Care for the American People. Report of the Committee on the Costs of Medical Care (Chicago: University of Chicago Press, 1932). The minority report was subsequently endorsed by the AMA House of Delegates in 1932. See American Medical Association, Digest of Official Actions, 1846–1958 (Chicago: American Medical Association, 1959), p. 314.
52 Rayack, p. 153.
53 Descriptions of some notorious cases can be found in Kessel, "Price Discrimination in Medicine," 153; Rayack, pp. 180–95; and Goodman, pp. 74–78.

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incorporation, medical society sponsorship or control of the directors or trustees of the plan, or actual medical society control of the plan itself.\textsuperscript{54} These restrictions, however, were overridden by federal law in the 1970s.

\textbf{Effects on the Quality of Medical Care}

The primary goal of laws regulating the right to practice medicine was to raise the incomes of physicians. Did those laws also raise the quality of medical care? That is doubtful. In fact, medical practice laws may have lowered the quality of patient care.\textsuperscript{55} One reason was that organized medicine used its powers to discourage quality comparisons among physicians. The "no criticism" of fellow physicians rule and the "conspiracy of silence" in malpractice and disciplinary records of practicing physicians were examples.

In addition, the AMA-backed education standards substantially reduced the proportion of practicing physicians who were trained in U.S. medical schools. In 1979, for example, about 5,000 students were enrolled in medical schools in the Caribbean.\textsuperscript{56} Although the quality of training in many of those schools was suspect, they successfully prepared students to pass medical licensing exams administered in the United States. It is ironic, in view of the AMA's emphasis on a high quality of medical education, that 46 percent of all newly licensed physicians in 1972 were graduates of foreign medical schools!\textsuperscript{57} Even today, more than 130,000 U.S. doctors (including 20,000 U.S. citizens) are graduates of foreign medical schools. This is equal to one out of every five practicing physicians in the United States.\textsuperscript{58}


\textsuperscript{58}For a brief survey of the role of foreign-trained physicians in the U.S. health care system, see Kenneth H. Bacon, "Foreign Medical Graduates Claim Licensing Bias," \textit{Wall Street Journal}, September 18, 1990.
In 1910, approximately 56 percent of all hospitals in the United States were proprietary, or for-profit, hospitals. By the 1960s, less than 11 percent were proprietary, and they accounted for only 8 percent of admissions and only 4 percent of outpatient visits. (See Figure 5.3.) The decline in the role of proprietary hospitals is puzzling, in that both theoretical and empirical evidence suggests that they are more efficient.

The answer to the puzzle lies in explicit government policies. Some states outlawed proprietary hospitals altogether. In states that...

**Figure 5.3**

**Proprietary Hospitals as a Percent of Total Hospitals**

How the Cost-Plus System Evolved permitted them, they suffered from several government-imposed competitive disadvantages. First, proprietary hospitals paid property taxes and corporate income taxes, whereas nonprofit hospitals did not. Second, nonprofit hospitals received enormous subsidies under the Hill-Burton Hospital Construction Act of 1946, whereas proprietary hospitals did not. Third, only charitable contributions made to nonprofits were (and are) deductible under federal income tax laws. Note that the first and third disadvantages still exist today.

Several states subjected proprietors to regulatory restrictions that did not apply to nonprofit hospitals. In addition, regulatory agencies often discriminated against proprietary hospitals. In fact, under certificate-of-need regulations still in effect in some cities, opening a new hospital, expanding an existing one, or even purchasing major equipment required the permission of a local planning agency. Yet, such agencies were often influenced by powerful nonprofits, which felt threatened by innovative entrepreneurs. In the late 1970s, for example, Hospital Corporation of America (HCA) spent as much as $500,000 on a Dallas certificate-of-need fight and still failed to get approval.

It is not known what role organized medicine played in the demise of proprietary hospitals. What is known is that proprietary hospitals, like proprietary medical schools, were subjects of the AMA’s general hostility toward the “corporate practice of medicine.” Organized medicine had a financial reason to oppose proprietary institutions in both fields. Proprietary institutions are typically dominated by owners interested in maximizing profit. Nonprofits, on the other hand, frequently pursue other goals, many of


61Based on authors’ interviews with HCA officials.

which are consistent with the aims of organized medicine, and such institutions can be more easily dominated by the medical profession. Nonprofit medical schools, for example, tend to prefer longer and more costly physician training, which is consistent with the traditional AMA desire to make entry into the profession more difficult. In the case of the hospital sector, nonprofit institutions are more likely to cooperate with the AMA in restricting price competition among practicing physicians. For example, they frequently restrict their medical staff to members of local medical societies. Expulsion from the medical society for purportedly unethical conduct, then, also would mean loss of hospital privileges and impair the physician's ability to practice and earn income.

Are proprietary hospitals better than nonprofits at lowering costs? Earlier studies found that they were, but more recent studies have found that the nonprofits have lower costs. What the later studies overlook, however, is that hospitals operating under the cost-plus system do not necessarily have incentives to lower their costs.

A better question is, what type of hospital is most efficient? And the answer is not in doubt. During the 1980s, proprietary hospital chains revolutionized the way in which hospitals were run and managed. Prior to that, most nonprofit hospitals were managed by people with little training or experience in modern business management techniques. The hospital chains found they could take over nonprofit institutions suffering annual losses and make substantial profits in a short period of time, while serving the same patient population.

Controls on the Method of Payment: Health Insurance

Much of the blame for escalating health care costs is centered on our system of health insurance. Insurers traditionally have paid whatever bills doctors and hospitals have submitted. This arrangement has encouraged too many tests and too many procedures. It also has encouraged the purchase and use of every new piece of medical technology that has appeared on the market. However,

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63 For a summary of these studies, see J. Rodgers Hollingsworth and Ellen Jane Hollingsworth, Controversy about American Hospitals (Washington: American Enterprise Institute, 1987).
nothing inherent in the market for insurance produces such distor-
tions. Insurers in many other fields use techniques that prevent
abuse and keep down costs. Moreover, competition encourages
those insurers to search for new and effective ways to reduce costs.
That is also the way in which the health insurance market once
worked, when it was free to do so.

In the early part of the 20th century, a large number of prepaid
medical insurance plans developed in Oregon and Washington,
largely as a result of the hazardous working conditions in the lum-
ber, railroad, and mining industries. Many of the plans were propri-
etary, and the insurers looked hard at each claim they received.
Physicians’ fees were scrutinized closely. Physicians were often
warned about unnecessary surgery, and were frequently asked to
justify procedures. They were also often asked to explain or justify
hospital stays that were out of line with the average stays for
particular procedures.

Enter organized medicine. Oregon’s local medical societies cre-
ated their own medical insurance plan. Using state-derived powers
to discipline individual physicians, predatory pricing, and similar
techniques, organized medicine captured the lion’s share of the
market for its own plan. Moreover, once the scheme came to domi-
nate the market, health insurance in Oregon resembled the type
of insurance that later expanded in other states. The physicians’
insurance scheme is today called Blue Shield. ⁶⁴

There are numerous examples in other states of organized medi-
cine’s using its powers to combat the growth of insurance plans
designed to hold down costs and create more price competition.
Physicians who started or cooperated with unauthorized plans
sometimes lost hospital privileges and even their licenses. ⁶⁵ More-
over, the plans viewed most favorably by organized medicine, Blue
Cross and Blue Shield, were often given competitive advantages by
state insurance regulations.

⁶⁴See Lawrence Goldberg and Warren Greenberg, “The Effect of Physician-Con-
trolled Health Insurance: U.S. v. Oregon State Medical Society,” Journal of Health
Politics, Policy and Law 2 (Spring 1977): 48–78; and Lawrence Goldberg and Warren
Greenberg, “The Emergence of Physician-Sponsored Health Insurance: A Historical

⁶⁵For a summary of some of the most notorious cases, see Goodman, chapter 5;
In most states, for example, taxes are assessed on insurance premiums, and the revenue is used to finance the regulatory apparatus. In a majority of states, however, commercial insurers paid taxes on the order of 2 to 3 percent of premiums while the Blues paid lower taxes or no taxes at all.\(^{66}\) Considering the fact that net revenues (premiums minus benefit payments) on group policies are usually less than 5 percent of the total premiums, a 2 to 3 percent premium tax is equal to about 50 to 60 percent of net revenues.

The Blues were also often exempted from other taxes, such as real estate taxes. In some states, commercial insurance policies sold to individuals were required to meet minimum benefit/premium ratios, whereas Blue Cross–Blue Shield policies were not. Other states regulated the rates charged by the Blues, but in terms of overall premium rather than the benefit/premium ratio. In most states, required reserves were also lower or nonexistent for the Blues.\(^{67}\) Moreover, in the early years, physicians and hospitals gave discounts to Blue Cross–Blue Shield plans that were not available to other insurers, and hospitals and physicians were encouraged to place Blue Cross–Blue Shield advertisements (AMA-approved) in their admitting offices and waiting rooms.

As a consequence, Blue Cross and Blue Shield plans soon monopolized the marketplace and began shaping the market for health insurance.\(^{68}\) By 1950, Blue Shield was selling 52 percent of all regular medical insurance and Blue Cross was selling 49 percent of all hospital insurance. For the next three decades, the share of total insurance sold by the two plans never dipped below 40 percent.\(^{69}\)

Two things are important about this development. First, unlike the early health insurance companies, Blue Cross and Blue Shield

\(^{66}\)David Robbins, "Comment," in Greenberg, p. 263.

\(^{67}\)Ibid.

\(^{68}\)It is important to note that, although there is a national Blue Cross organization and members typically have similar views, there are also 67 separate, autonomous plans in the United States, each of which sets its own policies. For most Blue Cross plans, there is a companion Blue Shield plan. Often the two work together and share services and billings. In some cases, the two have merged into a single corporate entity. See Howard J. Bermand and Lewis B. Weeks, The Financial Management of Hospitals, 5th ed. (Washington: Health Administration Press, 1982), pp. 110–21, 145–73.

\(^{69}\)Health Insurance Association of America, Source Book of Health Insurance Data, 1975–76.
never saw themselves as adversaries of the medical community. To the contrary, their plans were largely created and governed by the institutions whose bills they were paying. Not only was there no question of an adversarial relationship, but it was generally thought from the beginning that the Blues were created to represent the medical community, not patients. Two experts in hospital finance have flatly said, "Blue Cross was founded to save hospitals from financial ruin!"  

The second important point about the Blues is that they dominated the market, while any single rival had only a very small market share. That made it difficult for a commercial insurance company to adopt reimbursement procedures that differed fundamentally from those of Blue Cross and Blue Shield. If a commercial company attempted radical deviation, the medical community could threaten a boycott. Even Aetna Life and Casualty, with nearly 12 million policyholders, discovered that it could not fundamentally alter its reimbursement procedures in a way that threatened conventional methods. 

What were the reimbursement procedures adopted by the Blues? In general, they involved very little interference with the clinical judgment of the physicians or with the medical decisions of hospitals. More important, under Blue Cross leadership, hospitals came to be reimbursed in a way that hospitals almost unanimously approved of—cost-plus.

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70 Bermand and Weeks, p. 147.

6. How the Cost-Plus System Works

The cost-plus system of public and private health insurance, effective from the end of World War II until the mid-1980s, virtually assured hospitals that their costs would be covered. Very rarely did hospitals go bankrupt. The system insulated them from the potentially fatal risks that competition naturally creates in other markets.

What is good for hospitals, though, is not necessarily good for patients and policyholders. An insurance system designed to cover hospital costs is inherently adverse to the interests of the insured. The cost-plus system virtually guarantees that health insurance premiums will continue rising, because the people responsible for controlling hospital costs find that they can increase their revenues only by increasing their costs.

In this respect, health insurance contrasts markedly with most other forms of insurance. The automobile insurance industry is not organized to ensure that auto repair shops remain in business. The fire and casualty insurance industry is not organized to ensure that builders and home repair firms stay in business. Insurers are supposed to act on behalf of their clients (the policyholders), not on behalf of those who provide services. However, in the market for health insurance, the situation has been very different.

How Hospitals Get Paid under the Cost-Plus System

Suppose a male patient enters a hospital for a medical procedure. He has a Blue Cross health insurance policy with a $200 deductible and a required copayment of 20 percent. When he is released from the hospital, he receives a bill detailing all of the services that the hospital performed and indicating a charge for each. The amount owed by the man is $200 (the deductible), plus 20 percent of the remaining charges. As our hypothetical patient leaves the hospital, folding his copy of the bill, placing it in his coat pocket, and feeling sadness over the reduction in his bank account, he takes some
consolation from the thought that Blue Cross will pay the remaining 80 percent of the charges. But the man is quite wrong. What Blue Cross pays may be more than 80 percent, or it may be less. More to the point, what Blue Cross pays is only tangentially related to the bill of our hypothetical patient.

The amount paid to the hospital by the patient is based on the hospital’s "charges." The patient might have compared these prices with those of other hospitals. If he chose a lower priced hospital, he might have felt that he was helping to keep health care costs down and, at the same time, to keep insurance premiums down for his employer and fellow workers. But again, he could be quite wrong.

Under cost-plus reimbursement, what Blue Cross pays is not based on the prices that hospitals charge patients, but on hospital costs, which may or may not be reflected in the prices. In choosing a lower priced hospital, our hypothetical patient inadvertently might have chosen a higher cost one, thus contributing to escalating health care costs and higher insurance premiums—and doing precisely the opposite of what he had intended.

Reimbursement Formulas

Table 6.1 lists three formulas traditionally used by Blue Cross to reimburse hospitals. The most common is the per diem method. If, on the average, 30 percent of the patient-days of a particular hospital are accounted for by Blue Cross patients, Blue Cross will pay 30 percent of the hospital's total costs. Cost is determined by various accounting techniques, about which there can be much bickering. Usually, a "plus" factor is thrown in to cover the value of working capital and equity capital. Hence the term "cost-plus."¹

One does not have to study the per diem reimbursement formula for long to realize that the one sure way for a hospital to increase its revenues is to increase its costs. If a hospital adds more beds (even if they go unfilled), buys expensive equipment (even if it goes unused), or cares for more patients or more seriously ill patients, it increases its costs and therefore its revenues from Blue Cross. Conversely, anything a hospital does to decrease its costs also decreases its revenues. Under cost-plus reimbursement, then, Blue

Table 6.1
HOW BLUE CROSS REIMBURSED HOSPITALS UNDER COST-PLUS FINANCE

<table>
<thead>
<tr>
<th>Method</th>
<th>Formula</th>
<th>Amount BC Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Per Diem Method</strong></td>
<td>(Total hospital costs ÷ Total patient days) × Percent of patient days accounted for by BC patients</td>
<td></td>
</tr>
<tr>
<td><strong>Department Method</strong></td>
<td>(BC patient charges ÷ Total patient charges) × Total cost of the department</td>
<td></td>
</tr>
<tr>
<td><strong>Combination Method</strong></td>
<td>(Total cost of routine services ÷ Total patient days) × Percent of patient days accounted for by BC patients + BC patient charges for ancillary services ÷ Total patient charges for ancillary services × Total cost of ancillary services</td>
<td></td>
</tr>
</tbody>
</table>

Patent Power

Cross pays for hospital care in much the same way the Department of Defense pays for some weapons systems, but without the same rationale.²

Two other reimbursement formulas (also depicted in Table 6.1) are the "department" and "combination" methods, which, like the per diem method, essentially reimburse hospitals on the basis of the costs they incur. A 1976 survey showed that of Blue Cross plans using cost-based reimbursement formulas, 61 percent used the per diem method, 25 percent the department method, and 14 percent the combination method.³

Blue Cross plans have been moving away from these formulas over the past two decades. In 1973, 69 percent of Blue Cross plans reimbursed hospitals on the basis of costs and 31 percent reimbursed on the basis of charges (prices). In 1976, 50 percent reimbursed on the basis of costs and 50 percent on charges.⁴ In 1983, 28 percent of Blue Cross contracts were cost-based, 59 percent were charge-based, and the remainder were mixed.⁵

In the cost-plus system, prices do not have the same function they have in the normal market, however. In the cost-plus system (as explained below), prices are chosen to manipulate reimbursement formulas rather than produced by natural market forces. Consequently, it is probably fair to say that all traditional Blue Cross reimbursement methods are ultimately cost-plus.

The cost-plus method of reimbursement was not confined to the private sector. Under the original Medicare and Medicaid programs, the federal government adopted the same payment methods used by Blue Cross.⁶ Thus, the two fastest growing health insurance

²The rationale for the Department of Defense is that new weapons systems are one-of-a-kind items that are being built for the first time. Exact costs are harder to estimate than for off-the-shelf items. In that case, cost-based procurement with competitive bidding may be a reasonable policy.
⁴Ibid., pp. 152–3.
programs in the medical marketplace were firmly entrenched in the cost-plus system.

Hospital Prices

One of the most interesting developments in hospital finance over the last several decades has been the decreasing proportion of hospital bills paid by patients out-of-pocket. In 1950, roughly half of all hospital bills were paid out-of-pocket by patients and half by third parties (employers, insurance companies, or government). In the 1970s, about 90 percent of hospital income came from third-party payers, with about half coming from employers and insurance companies and half from government. Less than 10 percent was paid out-of-pocket by patients. What that means is that only 10 percent of hospital revenue was directly connected with the hospital charges. As Figure 6.1 shows, the other 90 percent was cost-plus reimbursement. Such reimbursement was so pervasive that some health economists concluded that the prices charged by hospitals were little more than numerical artifacts. Writing in the late 1960s, Somers and Somers stated that because hospital "charges now have meaning for only a minority of patients and hospital finances, they have become largely a set of arbitrary statistical factors, instead of a set of prices." 7

Not only did hospital prices fail to allocate resources the way prices do in other markets, but under the original Medicare and Medicaid reimbursement formulas, hospitals had an incentive to manipulate their prices to maximize their reimbursement from government. Under the department method of reimbursement, for example, the amount paid by Medicare is equal to the total charges to Medicare patients divided by total charges to all patients times total cost. One health economist has shown how a hospital can double its income from Medicare under this method of reimbursement by artificially raising its charges for services typically used by Medicare patients and by lowering its charges for other services. 8 Moreover, this practice is not considered illegal or even unethical. Hospitals can buy computer programs that show them how to maximize their revenues under various reimbursement rules.

7Ibid.

8Law, pp. 78–81.
Figure 6.1
HOW HOSPITALS GET THEIR MONEY IN THE COST-PLUS SYSTEM

Perverse Incentives

The cost-plus system is antithetical to the market system, in which prices and competition allocate resources. Frequently, the cost-plus system creates incentives that are the precise opposite of market system incentives. One cannot be certain what the market for hospital services would look like if it were truly competitive. But it is easy to speculate. When a grocery store discovers that it has ordered too many apples, it tries to sell those apples by lowering the price. When a manufacturing company has excess capacity, it
seeks new business and new products and offers attractive prices. Presumably, similar things would happen in a competitive hospital marketplace.

But no matter how many beds go empty, hospitals rarely advertise cut-rate prices on surgery or sales on elective procedures. If prices and competition were allocating resources in the hospital marketplace, a surplus of hospital beds would be great news for consumers. It would mean that prices and therefore health care costs soon would tumble. By contrast, in a cost-plus hospital marketplace, surplus beds and other unused capacity frequently mean just the opposite—that costs will rise. The reason for this anomaly is that what really drives the system is unseen. The prices and competition are apparent, giving the impression of a genuine market at work, but the force that really drives the system is cost-plus.

Hospital Services

Consider the results of a comparison of hospital costs (not prices) prevailing in the 1970s. The study found that the daily cost of maternity care was more than seven times higher at some hospitals than at others, and that the daily cost of medical/surgical care was more than two and one-half times greater. The daily cost of short-term alcoholism treatment was almost five times higher at some hospitals than at others. The reasons for these cost differences varied. According to the authors of the study, 130 out of 138 hospitals invested too much in capacity and equipment. Most had too many admitting physicians. But the most important reason appears to be volume. A great many hospitals were delivering services at such a low volume that they could not take full advantage of economies of scale. As Table 6.2 shows, the differences in costs varied by as much as seven-to-one between high-volume and low-volume hospitals.

How can a hospital stay in business while providing a service that is seven times more costly than that of a rival? In a genuinely competitive market, it couldn’t. But the cost-plus system ensures that reimbursement matches costs. One result is a system in which hospitals have very weak incentives to be efficient—to get rid of

Table 6.2
HOSPITAL COSTS AND HOSPITAL VOLUME, 1975*

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>High Volume</th>
<th>Low Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per patient per day</td>
<td>$20</td>
<td>$32</td>
</tr>
<tr>
<td>Number of visits per day</td>
<td>275</td>
<td>148</td>
</tr>
<tr>
<td>Medical/surgical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per patient per day</td>
<td>$100</td>
<td>$255</td>
</tr>
<tr>
<td>Number of visits per day</td>
<td>824</td>
<td>17</td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per patient per day</td>
<td>$75</td>
<td>$540</td>
</tr>
<tr>
<td>Number of visits per day</td>
<td>55</td>
<td>4</td>
</tr>
<tr>
<td>Short-term alcoholism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per patient per day</td>
<td>$50</td>
<td>$240</td>
</tr>
<tr>
<td>Number of visits per day</td>
<td>247</td>
<td>NA</td>
</tr>
</tbody>
</table>


*Based on data from 138 short-term and general care hospitals in New York State.

High-cost services, take advantage of economies of scale, specialize in procedures in which they are the low-cost producer, etc. Another result is a hospital system in which the nation’s annual health care bill is much higher than it needs to be. Indeed, it is a system that rewards and even encourages waste and inefficiency. As Somers and Somers observed, “In no other realm of economic life today are payments guaranteed for costs that are neither controlled by competition nor regulated by public authority, and in which no incentive for economy can be discerned.”

Risks to Patient Health

What is bad economics also frequently is bad for patient health. Studies have shown that when various types of surgery are performed infrequently, not only are surgery costs higher but the mortality rates are higher as well. For example, the U.S. Department

10Somers and Somers, Medicare and the Hospitals, p. 192.
of Health and Human Services has judged that, for satisfactory results, a hospital should perform at least 200 open-heart surgeries per year. However, in the 1980s, 55 percent of U.S. hospitals that performed open-heart surgeries performed fewer than 200 per year.\(^1\)

This problem was not confined to rural areas, where the incidence of surgery was necessarily small. It also was seen in large cities where consumers had many choices and information was more readily available. American Hospital Association (AHA) data for 1981 showed that annual open-heart surgeries performed in New York City hospitals ranged from a high of 1,337 (at St. Luke’s–Roosevelt Hospital Center) to a low of 75 (at the VA Medical Center in Brooklyn).\(^12\) In 14 Chicago hospitals, the range was from a high of 926 to a low of 6; in 10 Los Angeles hospitals, it was from 1,071 to 35; and in 5 Detroit hospitals, it was from 674 to 2.\(^13\)

Why don’t hospitals with a high volume of surgery and lower mortality rates advertise that fact to attract customers? Because that would be inconsistent with the traditional philosophy of the cost-plus system. Competition and competitive advertising were actively discouraged in the market for physicians’ services. A similar historical development occurred in the hospital sector, where advertising is still largely confined to statements about amenities, quality of food, and convenience of location. Almost never is there any mention of comparative mortality rates or patient safety. Moreover, the AHA has left no doubt about its desire to discourage such advertising. The AHA’s guidelines state:

> Self-aggrandizement of one hospital at the expense of another may be counterproductive, and, if inaccurate, could lead to charges of libel and claims for damages. . . . Quality comparisons, either direct or by implication, between one hospital’s services, facilities, or employees and those of another hospital may be counterproductive, libelous, or difficult to present in a firm and objective manner.\(^14\)


\(^{12}\)Ibid., pp. 101–3.

\(^{13}\)Ibid.

PATIENT POWER

Cost Shifting

In competitive markets, people tend to be charged prices that reflect actual costs. In virtually every regulated market, some consumers end up subsidizing others. For example, in a regulated telephone industry, long-distance calls subsidize local calls. In a regulated airline industry, heavily traveled routes subsidize lightly traveled routes. In this respect, the cost-plus system resembles a regulated market. It is replete with cross-subsidies.

Cross-subsidies are sometimes overt and direct. For example, a 1976 survey found that 30 Blue Cross plans reimbursed hospitals for the bad debts of non-Blue Cross patients. The cost of charity care for non-Blue Cross patients was reimbursed by 27 Blue Cross plans. Cross-subsidies are at other times informal and indirect. For example, it is commonly believed that, within hospitals, the surgery department subsidizes the obstetrics ward; within emergency rooms, patients with minor ailments subsidize patients with serious injuries; and among all patients, paying patients subsidize charity care patients.

What is not generally realized, however, is that cross-subsidies are a natural and inevitable by-product of the cost-plus system of hospital finance. Once it is accepted that the de facto purpose of health insurance is to make sure that hospitals cover their costs and that hospitals are free to determine what costs they will incur, cross-subsidies are unavoidable. Indeed, once those premises are accepted, the only thing left to argue about is how the hospital bill is to be divided among third-party payers.

That is what gives rise to the debate over "cost shifting." In the early years, Medicare and Medicaid officials argued that their payments were forced up so that payments by private health insurance companies could be kept down. Today, the situation is reversed. Private insurance companies complain that the government's reduction of Medicaid and Medicare payments has increased their payments. Likewise, many commercial insurers argue that Blue Cross's efforts to keep its payments down will force their own payments up. Given their premises, that is true. In the cost-plus system, if any third-party payer reduces its payments, the payments of all others will rise to cover the shortfall.

Consider the pronouncements of the Health Insurance Association of America (HIAA), a group of private health insurance companies other than Blue Cross. The HIAA estimated that $5.8 billion in costs were shifted from Medicaid and Medicare patients to private patients in 1982. In response, private insurance companies trimmed benefits and raised premiums by 20 to 40 percent. In other words, when government’s share of hospital costs goes down, the share borne by private insurance companies goes up.

Rethinking the Role of Blue Cross

Although we have discussed the cost-plus system in terms of the dominant role of Blue Cross, it would be a mistake to believe that Blue Cross administrators bear personal responsibility for the system. The national Blue Cross organization is merely a trade group that represents 67 Blue Cross plans, each administered separately by its own governing board. There is every reason to believe that each Blue Cross plan’s administrators respond to economic incentives in much the same way as managers of any other firm do. The incentives in the health insurance marketplace have largely been created by government policies. Recent policy changes have caused the various participants in the cost-plus system to change their behavior in ways that undermine that system and move toward a competitive market. Blue Cross administrators are responding to these new incentives, along with everyone else in the health insurance marketplace.

Hospital Prices in the 1980s

Although the cost-plus system is dissolving and is being replaced by a more competitive market for medical care today, that change is occurring slowly. Meanwhile, the system is far from being a relic. It continues to dominate the medical marketplace—especially in the hospital sector.

Table 6.3 presents recent prices charged by seven Dallas-area hospitals for a complete blood count and a routine urinalysis. They are two of the most common procedures performed in a hospital, and all of the hospitals cited are within easy driving distance of each other. Moreover, since the prices primarily apply to nonelderly

Table 6.3
LINE ITEM PRICES IN DALLAS AREA HOSPITALS, 1988*

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Cost of Complete Blood Count</th>
<th>Cost of Routine Urinalysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>$11.00</td>
<td>$28.00</td>
</tr>
<tr>
<td>Hospital B</td>
<td>20.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Hospital C</td>
<td>21.00</td>
<td>16.25</td>
</tr>
<tr>
<td>Hospital D</td>
<td>21.60</td>
<td>16.00</td>
</tr>
<tr>
<td>Hospital E</td>
<td>27.75</td>
<td>20.00</td>
</tr>
<tr>
<td>Hospital F</td>
<td>28.00</td>
<td>19.50</td>
</tr>
<tr>
<td>Hospital G</td>
<td>33.25</td>
<td>11.75</td>
</tr>
</tbody>
</table>

*Based on actual hospital invoices.

patients, most of whom have employer-provided health insurance, the buyers of the tests are usually private companies. Considering these facts, one would expect that the prices charged by the seven hospitals would be fairly similar. However, as Table 6.3 shows, the charge for a complete blood count at the highest priced hospital is more than three times that at the lowest priced. For urinalysis, the highest price is almost two and one-half times the lowest one. Even more surprising is the fact that the hospital that charges the most for the complete blood count charges the least for urinalysis. The converse is also true. Thus, to minimize health care costs, a patient should purchase the complete blood count at Hospital A and the urinalysis at Hospital G. Moreover, because there is as much or more variation in other prices that Dallas hospitals charge, patients could minimize total health care costs only if they travel among the seven hospitals in much the same way that one might shop for bargains at seven supermarkets.

Unlike supermarket prices, these hospital prices do not represent attempts to attract buyers. That is, Hospital A does not advertise that it has the lowest priced complete blood count in Dallas. To the contrary, a patient in need of a blood test would probably have to go to considerable lengths to find out what the seven hospitals charge for the service. Odds are also high that the patient’s physician would not know the seven prices or whom to contact in the hospital bureaucracies to get the information.
How the Cost-Plus System Works

### Table 6.4
**AVERAGE CHARGE FOR WELL-BABY DELIVERY IN DALLAS AREA HOSPITALS, 1986***

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humana–Medical City</td>
<td>$2,024</td>
</tr>
<tr>
<td>Baylor Medical Center</td>
<td>1,698</td>
</tr>
<tr>
<td>St. Paul Medical Center</td>
<td>1,486</td>
</tr>
<tr>
<td>Irving Hospital</td>
<td>1,449</td>
</tr>
<tr>
<td>Presbyterian Hospital</td>
<td>1,423</td>
</tr>
<tr>
<td>Lewisville Memorial Hospital</td>
<td>1,400</td>
</tr>
<tr>
<td>HCA Medical Center–Plano</td>
<td>1,337</td>
</tr>
<tr>
<td>Memorial Hospital of Garland</td>
<td>1,069</td>
</tr>
</tbody>
</table>

**SOURCE:** Dallas Business Group on Health.

*Based on actual hospital invoices.

Such differences in charges cannot possibly represent differences in actual costs. The tests are performed with standard equipment, purchased in a competitive market. The human skill involved is standard. Although there may be some differences in other costs (for example, a hospital within Dallas may have higher operating costs than one in the suburbs), the costs do not vary by a factor of three to one. The differences in charges are consistent with cost-plus accounting procedures, however. Under cost-plus finance, if a hospital undercharges on one item, it will tend to overcharge on another.

Table 6.4 shows charges for a complete procedure or package of services for eight Dallas-area hospitals. In this case, the procedure is well-baby delivery, a fairly common, well-defined hospital service. As the table shows, the highest priced hospital has an average delivery charge almost twice that of the lowest priced, a surprising difference considering that prospective patients have plenty of time to investigate differences in hospital charges in advance. It is probable, however, that an expectant mother would find it impossible to ascertain the average delivery charge in any Dallas hospital. Indeed, it is not clear that most hospitals would know.\(^{17}\)

\(^{17}\)Note that the total charge for the procedure is the sum of all of the line item prices for each separate service (hospital admission kit, blood test, etc.).
Table 6.5
HOSPITAL PRICES NATIONWIDE, 1986 TO 1988

<table>
<thead>
<tr>
<th>Item or Test</th>
<th>Low Price(^2)</th>
<th>High Price(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrocardiogram</td>
<td>$8.00</td>
<td>$78.35</td>
</tr>
<tr>
<td>Complete blood count</td>
<td>1.00</td>
<td>42.00</td>
</tr>
<tr>
<td>Urinalysis (routine)</td>
<td>3.20</td>
<td>28.00</td>
</tr>
<tr>
<td>Admission kit</td>
<td>2.25</td>
<td>33.00</td>
</tr>
<tr>
<td>Baby diapers</td>
<td>0.30</td>
<td>20.75</td>
</tr>
</tbody>
</table>

SOURCE: Medical Control, Inc.

\(^1\)Based on actual hospital invoices.

\(^2\)Price at the 10th percentile of the distribution.

\(^3\)Price at the 90th percentile of the distribution.

Table 6.5 shows that Dallas is not unique. Line item prices for common items and tests show remarkable variation among the nation’s hospitals. For an electrocardiogram, the variation in price is more than 9 to 1. For the complete blood count, the variation is 42 to 1. For baby diapers, the variation is more than 69 to 1. Similar price differences exist for most other items and tests.

One might suppose that this extreme variance in hospital prices would allow smart buyers to exploit the differences through comparison shopping. For example, consider a large company with employees in many localities around the country. Could the company collect hospital prices and tell its employees where to go for the lowest priced tests, procedures, and services? In the cost-plus system, things are not that simple. Each hospital has as many as 12,000 line item prices. Further, each can use a different accounting and coding system. So prices charged by different hospitals cannot be compared until their accounting is converted to a common system. For the 50 hospitals in the Chicago area alone, there are as many as 600,000 prices to compare. For a company operating nationwide, with employees who have access to approximately 7,000 hospitals, a comparison shopper could possibly be confronted with as many as 84 million different line item prices. Such comparison shopping is a formidable task for any corporate buyer, no matter how sophisticated the computers that assist in making buying decisions.\(^\text{18}\)

\(^\text{18}\)However, some firms such as Medical Control Inc. in Texas, Medstat Inc. in Michigan, and Mediqual Systems in Massachusetts attempt to do it for large, third-party payers.
How the Cost-Plus System Works

What the Cost-Plus System Means for Patients

One of the worst things about being sick in America is having to confront the hospital’s bill. In most cities in the United States, patients cannot find out a hospital’s total charge for a procedure prior to treatment. At the time of discharge, they learn that there is not one price, but hundreds of line item prices. About 90 percent of the items listed on a hospital bill are in principle unreadable. In only a handful of cases can the patient both recognize the service rendered and judge the reasonableness of the charge. Moreover, things are getting worse. To avoid patient outrage, many hospitals are taking recognizable items, such as Tylenol capsules, off their line item statements and hiding the cost in other charges. The end result is that hospital bills are totally incomprehensible.19

As in the case of hotels, the one price that patients can learn about prior to admission is the hospital’s basic room rate. If these rates signaled differences in other prices, patients would at least be able to pick out the lowest priced hospital prior to admission. Unfortunately, other hospital prices are not tied to room rates. In most cities, hospital room charges differ by no more than a factor of two to one. Total hospital bills, on the other hand, can differ as much as ten to one for similar procedures. Moreover, the hospital with the highest room rate does not necessarily charge the highest prices for any or all other services. A 1988 report showed that the Chicago hospital with the highest room rate had some of the lowest charges in the city for laboratory tests, a phenomenon that is consistent with cost-plus accounting.20

Although hospital administrators do not have to give patients advance notice of their total bill, hospitals in Illinois are required to tell the state government. Among the total charges for outpatient services reported by Chicago hospitals to the state of Illinois in 1988, the charge for a mammogram varied by almost 10 to 1, for a CAT scan more than 10 to 1, for a tonsillectomy 27 to 1, and for cataract removal 34 to 1.21 If patients knew about these differences, they


could reduce their medical bills dramatically. Unfortunately, most do not.

Health Insurance as Prepayment for the Consumption of Medical Care

A major argument developed in this book is that health insurance today is often not real insurance; it is instead prepayment for the consumption of medical care. That is especially true of group health insurance plans sold to, or administered by, employers. But in many ways, it is also true of individual and family policies purchased outside of the workplace.

The cost-plus mentality does not view health insurance as a vehicle for protecting the financial assets of people against adverse medical contingencies. Instead, it sees health insurance as a vehicle for paying for medical services. In the cost-plus vision, health insurance (whether public or private) is simply a way of transferring resources from people to providers. Real insurance would interfere with this objective. Thus, real insurance is an anathema to the cost-plus bureaucracy.

One way to appreciate the unusual nature of health insurance is to consider how it differs from other types of insurance including life insurance and fire and casualty insurance. At the risk of oversimplification, we have presented some of these differences in Tables 6.6 and 6.7. Let's consider some of them in more detail.

Prepayment for Consumption Decisions

The essence of conventional insurance is the pooling of risk. Insurable risks are largely risks outside of the policyholder's control. Premiums are set based on the probability that those risky events will occur, and if they do occur, the insurer pays policyholders (or their heirs) a predetermined amount, or an amount established by a predetermined method of assessing damages.

In the market for health insurance, things are very different. Often, benefits are paid even if no risky event has occurred. Thus, insurers often pay for general checkups, diagnostic tests, and exploratory surgery. The insurer agrees to pay for these services even when doctors subsequently discover that there was no illness and, thus, no risky adverse condition. Insurers in these cases are paying for the consumption decisions of policyholders. Even if a risky event does occur, the amount paid is again often determined
<table>
<thead>
<tr>
<th>Category</th>
<th>Life Insurance Purchased by an Individual</th>
<th>Health Insurance Provided by an Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payee</td>
<td>Policyholder</td>
<td>Providers</td>
</tr>
<tr>
<td>Amount paid</td>
<td>Amount fixed in advance</td>
<td>Amount depends on consumption decisions of the employee</td>
</tr>
<tr>
<td>Events that cause a benefit</td>
<td>A risky event</td>
<td>Consumption decisions of the employee; no risky event required</td>
</tr>
<tr>
<td>Insurer’s obligation to pay benefits</td>
<td>Once a risky event has occurred, insurer is fully liable; no further premium payments required</td>
<td>Insurer pays providers only as long as continued premiums are paid; insurer can cancel policy and cease paying benefits even after a risky event has occurred</td>
</tr>
<tr>
<td>Employment conditions</td>
<td>Coverage continues after switch of jobs</td>
<td>Coverage eventually ends after switch of jobs</td>
</tr>
<tr>
<td>Right to future coverage</td>
<td>Guaranteed renewable</td>
<td>No future coverage guaranteed</td>
</tr>
<tr>
<td>Use of premium dollars</td>
<td>Most are kept in reserve for benefits in future years</td>
<td>Most are paid out in benefits the year they are collected</td>
</tr>
<tr>
<td>Premium costs of benefits</td>
<td>Premiums are actuarially fair</td>
<td>Premiums often are not actuarially fair</td>
</tr>
</tbody>
</table>
### Table 6.7

**HOW BENEFITS ARE DETERMINED UNDER HEALTH INSURANCE AND CASUALTY INSURANCE**

<table>
<thead>
<tr>
<th>Category</th>
<th>Casualty Insurance</th>
<th>Health Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of benefit</td>
<td>Replacement cost or value of the lost asset</td>
<td>Determined by the consumption decisions of the policyholder (sometimes managed by the insurer)</td>
</tr>
<tr>
<td>Method of settling claims</td>
<td>Claims adjuster and policyholder agree on extent of damage</td>
<td>No claims adjuster, but may be managed by the insurer</td>
</tr>
<tr>
<td>Insurer’s liability</td>
<td>Insurer is liable for damages from the time of the risky event, even if it takes years to assess damage</td>
<td>Insurer is liable only as long as the policyholder continues to pay premiums; insurer can cancel the policy and cease paying benefits even after the risky event has occurred</td>
</tr>
<tr>
<td>Method of payment</td>
<td>Policyholder receives cash and is not obliged to repair or replace the asset</td>
<td>Policyholder can only receive benefits in the form of medical services</td>
</tr>
</tbody>
</table>
by the consumption decisions of the patient. Suppose, for example, that a patient is diagnosed as having a heart condition. The patient, after consultation with a physician, may opt for less expensive drug therapy, a $25,000 bypass operation, or some intermediate therapy. The amount the insurer pays is totally determined by the treatment chosen. If auto collision insurance worked the same way, a policyholder whose car had been destroyed would be able to choose from a wide array of replacements: from economy car to Cadillac to Rolls Royce. Insurers would pay, depending on which replacement the policyholder preferred. Auto insurance that worked like that would be very expensive.

**Insurer's Obligation to Pay for Damages**

Because conventional insurance payments are tied to the incidence of risky events, once the event has occurred, insurers are completely liable for the damages covered. Health insurance, once again, is different. Under a typical policy, the insurer is liable only as long as the insured continues to be covered and to pay premiums.

Suppose that a couple has a low-weight baby with predictable medical expenses lasting for several years. During that period, the couple's health insurance policy may be segregated in a special way with other policies and the premiums charged may skyrocket (even though the same insurer offers similar coverage to other couples for very low premiums). If the couple drops the policy, the insurer will no longer be obligated to pay. If the policy is acquired through an employer and the employee changes jobs, the insurer is relieved of the obligation to pay after a certain period of time. Moreover, the insurer can cancel the policy, as long as it cancels all similar policies, and cease paying benefits after a period determined by state law.

If life insurance worked the same way, following the death of a spouse, an elderly widow would receive a monthly annuity from the life insurance company. But to receive the annuity, she would have to continue paying monthly premiums, which in time could increase and even exceed the value of her monthly annuity check. Furthermore, the widow would live in fear that her policy would be canceled, leaving her without future income.

**Payments to Providers**

Conventional insurance is based on the idea that the policyholder is the beneficiary. Thus, payments from insurers are ultimately
disposed of according to the policyholder's preferences. Under automobile liability insurance, a person who loses a car in an accident is not required to buy a new car. Under home owners' insurance, a family whose house is destroyed in a fire is not required to build a new house. But, under almost all health insurance policies, the only way a policyholder can realize benefits is to consume medical services. Suppose a terminally ill man is confronted with the choice of expensive, end-of-life medical care or forgoing medical care and opting for a more peaceful end. Health insurers will pay hundreds of thousands of dollars for the medical care, but not one cent to the policyholder if he forgoes the treatment. If life insurance worked the same way, an elderly widow would be required to spend her entire life insurance benefit on her husband's funeral, with nothing left over to meet other financial needs.

Reserves for Future Expenses

Conventional life insurance is based on the idea that more policyholders will file claims in future years than in the current year. For example, consider a group of life insurance policyholders. In the current year, very few of them (perhaps none) will die. But eventually, they all will die. As a result, a large part of a life insurance premium goes into a reserve fund to pay for risky events that will happen in the future.

Health insurance, particularly group health insurance, is different. Most health insurance premium dollars are paid out in the very year they are collected. Rather than creating reserves for future years, health insurance tends to be organized on a pay-as-you-go basis. That helps explain one of the most perplexing problems faced by small business. Suppose that an employee has a premature baby and generates large and continuing medical expenses. Suppose also that there is no possibility of any other employee ever having another baby. The company manager will reason that next year's insurance premium should not rise any more than the industry average. After all, the company paid for this year's risk with this year's premium. Next year, the company will have less risk. So if anything, next year's premium should go down. Under cost-plus health insurance, however, that's not the way premiums are determined. In all probability, the health insurer will try to raise the employer's premium to three or four times its current level. "Who's
going to pay for the expenses of last year’s premature baby?” they will argue. “We can’t ask other companies to pay for it.” If life insurance worked the same way, you would not only be asked to pay a premium that reflected your probability of dying; you would also be asked to help pay the insurer’s expenses for all of the policyholders who died last year—deaths that are totally unrelated to your risk of dying this year.

Critics of the use of the market in health care often make three arguments: (1) there is a great deal of discretion in how doctors and hospitals treat illness and injury, and much of what is done is unnecessary; (2) patients often are too sick and too frightened at the time of treatment to make reasoned decisions; and (3) even if they are rational, patients do not have the knowledge and sophistication to bargain effectively with providers. 22

It is worth considering, therefore, how the market deals with similar problems in automobile collision insurance and homeowners’ insurance. Unquestionably, there is a great deal of discretion in how much people spend on car repair or home repair, and objective studies would undoubtedly find many expenditures unnecessary. Who can doubt that after an auto accident or home fire, the average policyholder would be distraught? And, because people deal with such problems infrequently, few are sophisticated buyers in either the car repair or home repair market, especially in the aftermath of major casualties. These experiences are not identical to medical episodes, but there is great similarity.

In the market for casualty insurance, problems are dealt with in the following way. A claims adjuster (a representative of the insurer) assesses the damage and negotiates a cash settlement with the policyholder. Often the policyholder will be asked to solicit bids from one or more firms that specialize in repair, and the settlement is often based on those bids. Although the policyholder may not be sophisticated in such matters, the claims adjuster is experienced, and it is not uncommon for the adjuster to negotiate directly with a repair firm to ensure that the price is reasonable.

To use the language of the medical marketplace, people with casualty insurance have free choice of providers, they have the

assistance of an experienced person in making buying decisions, and they negotiate a preadmission package price before the service is rendered. Moreover, because payment can be made directly to the policyholder, they can forgo the repairs altogether and use the cash settlement for other purposes.

Table 6.7 shows other important differences between health insurance and casualty insurance. As in the case of life insurance, once a risky event has occurred, the casualty insurer is fully liable for the damages related to that event and cannot cancel the policy and refuse to pay benefits or require that the insurer continue to pay premiums while repair services are being rendered. Moreover, once the risky event has occurred, insurers are liable for damages even if it takes years to determine the extent of those damages, as would be the case in the event of a major hurricane or tornado.

Actuarially Fair Prices and the Politics of Insurance

In an ideal insurance system, people face premium prices that are actuarially fair. Roughly speaking, that means that each person pays a premium that reflects the expected cost and risk that person adds to a large insurance pool. There are advantages to pooling risks across a large number of people in different industries and circumstances, either directly or through reinsurance arrangements. After insurers take full advantage of those opportunities, an actuarially fair premium for an individual reflects the real marginal costs of adding that person to the pool.

Actuarially fair prices are produced naturally in a competitive insurance marketplace. They are comparable to competitive prices for food, clothing, housing, and any other good or service. Moreover, like other competitive prices, they are unavoidable. If one person pays less than an actuarially fair premium, someone else must pay more—either in higher premiums or (in the case of public insurance) in higher taxes. Because some people will have difficulty paying actuarially fair prices, there may be social reasons why we might choose to help them buy insurance—through income tax

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credits, private charity, or other means. But the fact that we subsidize some people’s health insurance is no reason to abolish the price system altogether. However, that is precisely what the cost-plus mentality wants to do.

Prices for Health Insurance

The antipathy of the cost-plus bureaucracy toward actuarially fair insurance prices is not confined to private insurance. They are equally vehement in their opposition to actuarially fair “tax prices” in a system of national health insurance. But the literature on health economics contains few discussions of their reasoning on this issue. In an unusually frank discussion, however, Princeton University health economist Uwe Reinhardt has written as follows: “Europeans tend to view actuarially fair health insurance premiums as manifestly unfair and believe that contributions to health insurance should be based on ability to pay. Most Americans probably abhor actuarially fair health insurance premiums as well. Indeed, the bulk of Americans are covered either by tax-financed government programs or by private group policies that socialize health insurance, at least within the community of a single business firm.”24 Although it is clear that Reinhardt abhors actuarially fair insurance premiums (or tax prices), it is not at all clear that most Americans or Europeans share that view. Because most people on both continents overpay under the current system, it seems likely that a majority would opt for an actuarially fair system if given a clear choice.

Under the current system, lower income (healthier) young workers subsidize the health insurance of higher income (less healthy) older workers in both Europe and the United States. Moreover, on both continents, lower income workers subsidize the health insurance of higher income retirees.25 Despite the pervasiveness of these subsidies, we have never seen a coherent argument explaining why lower income families should subsidize the health insurance of people who are financially better off. Why, then, are these subsidies permitted? Because of politics.

25In Europe, higher income workers do tend to pay higher taxes. But there is no reason to believe that the higher tax payments offset the heavier use of the health care system. In the United States, the per capita aftertax income of the elderly (covered by Medicare) is considerably higher than that of the nonelderly (who pay Medicare taxes). The same is probably also true in many European countries.
Setting Insurance Premiums through the Political System

Recent breakthroughs in understanding the behavior of political systems have shown that when governments have the power to set prices, they almost never choose efficient prices. In insurance terminology, when governments set premiums (or tax prices), they never choose actuarially fair premiums. The reason is that various interest groups exert unequal pressures on the political system and government decisionmaking reflects those pressures.

Government-sponsored insurance schemes at the federal and state level in the United States bear out the theory. Every attempt to establish deposit insurance for banks and savings and loan associations, for example, has failed to charge actuarially fair premiums, and that has led to debacles of which the recent S&L crisis is only one example. Similarly, the failure of the federal government to establish actuarially fair prices through its private pension insurance scheme has undermined the stability of the private pension system.

Case Study: Automobile Liability Insurance

Massachusetts has the highest automobile insurance premiums in the nation. It also has the highest rate of auto insurance claims. One reason is that Massachusetts subsidizes bad driving through artificially low insurance rates. Under Massachusetts law, insurers are forbidden to base their premiums on age, sex, or marital status. Insurers are required to sell policies to almost any driver, and they cannot charge higher premiums for policies transferred to the state’s risk pool. As a result, about 94 percent of young male drivers and 82 percent of young female drivers are in the risk pool. As a proportion of all premiums, policies assigned to the risk pool soared from 23 percent of the market in 1977 to 65 percent in 1989.

27There have been many failed attempts to manage deposit insurance at the state level, dating back to the 19th century. See A. James Meigs and John Goodman, Federal Deposit Insurance: The Case for Radical Reform, NCPA Policy Report no. 155 (Dallas: National Center for Policy Analysis, December 1990).
29Ibid.
Whereas nationally only about 8.3 percent of auto insurance premiums represent risk pool insurance, the Massachusetts risk pool now accounts for one-fifth of all the auto risk pool insurance in the United States. The risk pool invariably loses money, and the deficits are financed by higher premiums charged to other drivers. For all Massachusetts drivers, there is little relationship between driving behavior and insurance premiums.  

Proposals to Treat Health Insurance like Auto Insurance

In almost every state, people are required to buy auto liability insurance as a condition for the right to drive. Many—including some who otherwise advocate free-market solutions to health care problems—have argued that health insurance should be mandatory, in an analogous way. The above discussion should give pause to proponents of such views. If individual health insurance were mandatory, health insurance prices—like auto liability insurance prices—would be determined in the political arena. Moreover, because health insurance is a far more emotional issue than auto liability insurance, the experience of Massachusetts and other states is only a small indication of the political crisis that would be created.

Realistically, governments cannot require the purchase of health insurance and leave insurers, providers, and state legislators free to increase the price without limit. Mandating health insurance is an open invitation to government regulation of the entire health care system.

Why Health Insurance Is Different

During the early years of its development, health insurance had many of the characteristics of other forms of insurance. During the 1950s, for example, premiums charged by commercial insurers


32 The Heritage Foundation plan would require everyone to purchase health insurance under federal law, but under the doctrine of states' rights, it would leave state governments free to impose an unlimited number of mandated health insurance benefits.
reflected real actuarial risks. Policies were often guaranteed renewable, so that once people became sick, they could continue to get insurance coverage. Insurance benefits were usually paid to the patient. Under prepaid schemes, insurers reimbursed hospitals and doctors on the basis of charges, not costs. And the history of health insurance in the logging and mining industries in Washington and Oregon indicates that insurers made real efforts to prevent overuse of medical services and overcharging.

Nevertheless, these characteristics of health insurance slowly vanished as Blue Cross and Blue Shield began to monopolize the health insurance marketplace and as state governments increasingly regulated the market. The philosophy of the Blues was that everyone should pay the same premium, regardless of risk. Thus, the Blues practiced community rating, charging the same premium to everyone in the same community, and explicitly rejected risk rating or experience rating. The group health insurance plans of large employers reflected a similar view, charging employees an artificial premium that was the same for all, regardless of age, location, or job task. Eventually, Blue Cross policies began to have deductibles and copayments. But the Blue Cross philosophy was that people covered by such policies were underinsured. The ideal plan, in the Blue Cross vision, was one that provided first-dollar coverage for all medical expenses, and those were the plans that Blue Cross encouraged employers to buy.

Because of community rating, sick people could buy Blue Cross policies for the same premium price as healthy people. Because of the policy of reimbursing hospitals on the basis of costs, Blue Cross often overpaid for hospital services. How, then, could Blue Cross compete against commercial insurers for healthy customers? The answer was that the Blues were given special regulatory treatment by state governments and, in the early years, special discounts by hospitals and physicians. Physicians also frequently told patients that Blue Cross–Blue Shield plans were "good," while other plans were "bad." Once the Blues dominated the market, all other insurers were forced to reimburse hospitals on the basis of costs and to offer similar plans.

In the cost-plus vision, all payments for health care should come from insurers rather than patients. Even today, hospital administrators often complain about patient deductibles and copayments,
preferring instead to have no financial relationship with patients. And there are still Blue Cross spokesmen who view people as underinsured if their health insurance contains any deductible or copayment.

In the cost-plus vision, everyone should pay the same premium for health insurance, regardless of risk or health status. Insurers should pay health providers based on the costs of needed care—costs wholly determined by physicians' judgments and patients' consumption decisions, with no consideration of monetary costs. Why are actuarially fair insurance premiums incompatible with the cost-plus system? Because they are competitive prices—and in the cost-plus system, no one faces competitive prices for any service.

The cost-plus answer to every financial problem in the medical marketplace is a system of price discrimination in which some buyers are overcharged while others are undercharged. How should we finance the free or below-cost care that physicians provide to low-income patients? The physicians' answer is to overcharge all other patients. How should we finance the hospitals' expenses for people who cannot or will not pay their bills? The hospitals' answer is to overcharge all other buyers. How do we subsidize health insurance premiums, so that sicker and riskier people can afford to pay for them? The insurers' answer is to overcharge everyone else.

The cost-plus vision is not a malevolent one. The goal, after all, is to make medical care and health insurance available to people who might otherwise have none. But the practical consequences are malevolent. Without competitive prices, ordinary people cannot make rational choices between medical care and other goods and services, and between self-insurance and third-party insurance. Without competitive prices, suppliers of medical services cannot be guided to find efficient ways of delivering medical care. Without competitive prices that allow individuals to make rational decisions, there is no alternative to health care rationing administered by large, impersonal bureaucracies.

Perhaps the worst consequence of the cost-plus vision has been the destruction of real insurance and its replacement by a system of prepayment for the consumption of medical care. One way to appreciate what a difference that makes is to consider our discussion about the origins of health insurance (see chapter 5). Health
insurance developed in the riskiest industries—principally mining and logging—where the demand was greatest. But a 1990 report in the *New York Times* found that today’s health insurers are blacklisting the industries with the greatest health risks, and heading the blacklist are mining and logging.\(^\text{33}\)

**The Inevitability of Change**

The cost-plus system may either evolve into a system of national health insurance or be replaced by a system of competitive markets. Even the vested interests who publicly support it privately search for ways to opt out of it. In the next chapter we examine ways in which individual employers, insurers, hospitals, and physicians have attempted to partially opt out of the cost-plus system.

7. Opting Out of the Cost-Plus System

From its inception some 50 years ago, the cost-plus system contained a fatal flaw that ultimately would have to be dealt with. The day of reckoning came less than a decade after the enactment of the Medicare and Medicaid programs. Once the federal government began funneling billions of dollars into the cost-plus system, health care costs exploded. Everyone agreed that something had to be done.

From Regulation to Competition

The initial response was to take a regulatory meat-ax to the system. Laws were passed to effectively keep hospitals from spending money. Certificate-of-need legislation required that hospital management get government permission before it built new hospitals, added new capacity, or purchased expensive equipment. Legislation creating physicians' standards review organizations (PSROs) sought to eliminate "unnecessary" surgery and "unnecessary" lengths of stay.

If the history of government regulation teaches us anything, it is the extreme difficulty of keeping people from doing what is manifestly in their self-interest. That is true even in areas in which the product or service is fairly uncomplicated, such as airline travel or telephone calls. It is much more difficult in a market such as hospital care, in which the service being rendered is not easy to define.

The attempt to keep hospitals from spending money by regulation failed. In the late 1970s and early 1980s, the federal government took a different tack. That consisted of a series of steps designed to partially opt out of the cost-plus system, or to at least limit government's exposure. States were allowed and even encouraged to experiment with alternative methods of Medicaid reimbursement. Medicare abandoned its cost-plus reimbursement formulas and instituted a prospective reimbursement system under which
Figure 7.1
NUMBER OF SURGERIES PERFORMED IN SURGI-CENTERS, 1986 TO 1990

Source: SMG Marketing Group.

Hospitals were paid fixed prices for treating specific conditions. In addition, competition began to make headway.

The medical marketplace today is schizophrenic. On the one hand, it is still dominated by the remnants of cost-plus finance. On the other hand, there is a swirl of competitive, entrepreneurial activity, as health care providers and employers who fund group plans search for alternatives. Such activities threaten the foundations of the cost-plus system, which cannot coexist with a genuine market system. The cost-plus system, which required government help to come into existence, will require more government help to survive. That is why its defenders invariably favor government regulation and abhor competition.

As in other regulated markets, the existence of cross-subsidies in the hospital sector creates opportunities for entrepreneurs. Surgi-centers (for outpatient surgery) came into existence to serve patients that hospitals overcharged for minor surgery (see Figure 7.1). For-profit emergency care clinics began to cater to patients that hospital...

1 Under this system, the diagnosis of a patient is supposed to be categorized by physicians into one of 492 diagnosis-related groups (DRGs). Medicare pays hospitals a fixed price for each DRG. In principle, if the hospital can perform the service for less than Medicare’s price, it makes a profit; if the cost is higher than Medicare’s price, it incurs a loss.
emergency rooms overcharged for minor injuries. Proprietary hospitals expanded to cater to patients who paid their own way and had no desire to subsidize the bad debts or charity care of others. In these ways, entrepreneurship, innovation, and the search for profit tended to eliminate the cross-subsidies.

To the individual consumer in the medical marketplace, such developments are quite welcome because they lead to lower prices. Consumers with minor injuries may see their medical expenses cut in half by choosing an emergency care clinic over a hospital emergency room. A candidate for surgery may be able to achieve similar savings by choosing an outpatient surgical clinic over hospital surgery. In either clinic, the patient is not charged for empty hospital beds, bad debts, charity care, the education of medical students, and dozens of other items unrelated to the person’s own treatment.

But those who are firmly entrenched in the cost-plus system view each of these developments with alarm. Why? Because although such developments may lower prices charged to patients, they are not perceived to lower hospital costs. After all, the cost-plus mentality reasons, all of the hospital’s emergency room expenses still have to be paid. So do the expenses for the bad debts, charity cases, teaching activities, empty hospital beds, etc.

Every time a paying patient with an uncomplicated medical problem is drawn out of the conventional hospital system, it is seen as a loss of revenue—revenue that otherwise would have been used to cover fixed costs. Once lost, the revenue must be made up, and who is left to make it up but the third-party payers who fund the cost-plus system? To the cost-plus mentality, anyone who opts out of the conventional hospital system leaves behind a greater burden to be shared by those who remain. That gives those who remain an even greater financial incentive to join those trying to opt out.

The Changing Market for Health Insurance in the 1980s

Competition and pursuit of self-interest, then, are causing the cost-plus system to unravel. And during the early 1980s, the most important forces for change were the activities of large employers who were paying ever-increasing amounts for the health insurance of their employees.²

Health Maintenance Organizations

One of the best-known attempts to opt out of the cost-plus system involved opting out of fee-for-service medicine altogether and relying on prepaid health care, usually through a health maintenance organization (HMO). During the Nixon administration, the use of HMOs in the private sector was encouraged by federal legislation, which overrode state laws that discouraged or outlawed them and required employers to offer an HMO alternative to conventional health insurance. In 1962, 2 percent of all health insurance was accounted for by HMO premiums. As Figure 7.2 shows, membership in HMOs grew from 6.0 million in 1976 to 28.6 million in 1987, almost a fivefold increase. In some localities, HMOs have more than one-third of the market today.

The term “health maintenance organization” was either coined or popularized by Dr. Paul M. Ellwood, Jr., the man generally credited with being the architect of the Nixon administration’s pro-HMO health care strategy.
Self-Insurance

The truly spectacular change in the 1980s, though, was the move by employers from conventional health insurance to self-insurance. In many instances, companies opted for complete self-insurance. Others self-insured up to a very large amount and paid a "minimum premium" for third-party insurance that became effective only if a high-dollar limit was exceeded. In either case, the companies had the option of operating their own insurance program or contracting with an independent firm or a conventional health insurance company (such as Blue Cross) to administer the program. 4

Consider the "administrative services only" plan run for an employer by Blue Cross. Under the plan, employees are given Blue Cross cards that are presented to hospitals at the time of treatment. But when Blue Cross gets the bills, it sends them to the employer. All Blue Cross does is process claims. All bills are paid by the employer, who assumes all of the financial risk under the plan.

As a variation on this idea, consider the "minimum premium plan," also administered by Blue Cross. Under this plan, the employer agrees to pay all bills up to an amount sufficient to cover employees' normal and expected health care expenses. The money needed to cover these expenses is often deposited in a trust fund, which can earn tax-free interest. If the employer's total health care bills exceed the maximum the employer has agreed to pay, Blue Cross makes up the difference. The insurance premium that the employer pays Blue Cross to assume this top-end risk, the "minimum premium," is much smaller than the premium would be for all the insurance risk.

In 1976, employer self-insurance accounted for only 5 percent of all health insurance. By 1983, 32 percent of all health insurance was accounted for by plans that were either wholly or largely self-insured. 5 Between 1965 and 1983, the Blue Cross–Blue Shield market share dropped from 45 to 35 percent, and the market share of other conventional health insurance companies dropped from 48 to

4 For a description of these techniques and an explanation of some of the benefits, see Employee Benefit Plan Review (June 1980), p. 12 ff.

27 percent. Another way to view this change is to consider the extent to which American business turned to alternative health insurance of all types. In 1976, unconventional insurance (prepaid plans or self-insurance) accounted for only 7 percent of all health insurance; by 1983, it accounted for 38 percent.

The trend toward alternative forms of health insurance was initiated by the nation's largest firms. A survey by the Health Research Institute discovered that, of the 1,500 largest employers, 83 percent were relying on some form of self-insurance by 1984. But the trend was by no means confined to large companies. The growth in self-funding also was evident among medium-sized and even relatively small firms. For example, a 1988 survey found that of firms with 1,000 or more employees, 70 percent were self-insured; of firms with 100 to 999 employees, 29.7 percent were self-insured; and of firms with 100 or fewer employees, 26.7 percent were self-insured. In 1981, 21 percent of employees of medium- and large-sized firms were covered by self-insurance. By 1985, that number had doubled, to 42 percent. Today, 56 percent of employees with health insurance work for an employer who is fully or partially self-insured.

When companies self-insure, they are usually entering a field in which they have no prior experience. Thus it is not surprising that studies show that the act of self-insuring raises health care costs by about 12.3 percent. For self-insurance to be a cost-effective

6Ibid.
7Ibid.
10It is difficult for small firms to self-insure because of the administrative costs and the risk. For large firms, the risk is spread over a larger number of employees and the administrative costs per employee are smaller.
14Jensen and Gabel.
alternative, there must be offsetting advantages that reduce health care costs. Such advantages are twofold. First, employers who self-insure avoid costly state government regulation of health insurance and take advantage of provisions of the federal income tax code that encourage self-insurance. Second, employers who turn to self-insurance put in place important cost-management techniques that traditional insurers were unwilling to implement. Let us consider briefly these two incentives.

Self-Insurance: Escape from Regulation

Health economists Gail Jensen and Jon Gabel have identified five advantages of self-insurance that directly relate to government policies. They are (1) avoiding the state premium taxes, (2) avoiding state-mandated benefits, (3) avoiding capital and financial reserve requirements, (4) avoiding payments to risk pools, and (5) enjoying tax advantages.

Avoiding State Premium Taxes

All 50 states levy taxes on the premiums of commercial insurance companies, and 26 states now levy premium taxes on Blue Cross and Blue Shield. Such taxes are typically 2 to 3 percent of annual premiums. For a company such as General Motors, annual premium taxes could easily exceed $50 million. Companies that self-insure avoid these taxes.

Avoiding State-Mandated Benefits

The market for health insurance has been hit by a tidal wave of state-mandated benefit regulations in recent years (see chapter 11). These are laws requiring insurers to cover specific services and diseases. For insurers, the mandates can be enormously expensive. Take psychiatric care, for example. In 1973, Chrysler Corporation, which offered only limited employee mental health benefits, experienced 30,000 psychiatric visits at a cost of $800,000. In 1978, under a new agreement negotiated with the United Auto Workers, Chrysler greatly liberalized its mental health benefits. Total visits jumped to

\[\text{Jensen and Gabel, p. 329.}\]

\[\text{Ibid.}\]
200,000 at an annual cost of more than $5 million.\textsuperscript{17} Nationwide, outpatient psychiatric benefits add about 11.8 percent to the cost of a family insurance policy.\textsuperscript{18} But 36 states require insurers to cover the services of psychiatrists, whether or not the policyholders want this benefit.\textsuperscript{19} Because companies that self-insure are not subject to these regulations, mandated health insurance benefit laws give companies a powerful incentive to choose self-insurance. According to one study, the mandate for mental health care alone increases the probability that a large firm will self-insure by 93.2 percent.\textsuperscript{20}

Avoiding Capital and Financial Reserve Requirements

Partly to ensure the financial solvency of insurers, state governments require that insurers have large capital reserves. Setting aside large reserves can be costly and raises the cost of insurance. Companies that self-insure are exempt from such requirements.

Avoiding Payments to Risk Pools

Some states have established pools to subsidize health insurance for high-risk individuals. In most cases, the subsidies are financed by taxing all insurers operating within a state. Currently, 15 states have risk pools and many more are considering them. Companies that self-insure are exempt from such taxes, and one study has estimated that the existence of a risk pool increases the probability that a large firm will self-insure by almost 56 percent.\textsuperscript{21}

Enjoying Tax Advantages

Yet another advantage of self-insurance has been created by a change in the federal income tax law. Employers who establish their own health insurance funds can deduct contributions to those funds and earn tax-free interest on the amount accumulated. A 1984


\textsuperscript{21}Ibid.
survey by The Wyatt Company found that 21 percent of surveyed employers self-insured for that reason, up from 9 percent in 1980.\textsuperscript{22}

In the Employee Retirement Income Security Act (ERISA) of 1974, the federal government exempted companies that self-insure from state laws regulating health insurance, such as those listed above. Numerous court decisions have upheld this exemption in the face of attempts by state governments to undermine it. This development has proved to be important. For example, a study of firms that chose to self-insure over the period from 1981 to 1984 concluded that 51 percent would not have opted for self-insurance had it not been for state government regulations that increase the cost of health insurance.\textsuperscript{23}

**Self-Insurance: Escape from Traditional Insurance Methods**

The cost-plus system is at its very worst when health insurance companies do not aggressively monitor the behavior of health care providers. At the risk of unfair characterization, the system can be described in the following way. Under the cost-plus system, hospitals submit bills and insurance companies pay them. At the end of each year, the insurance company compares the employer’s total premiums with the reimbursements that the insurance company actually made. If reimbursements are greater than premiums, the employer’s premiums are raised in the following year. Insurance companies that act in this way are doing little more than processing claims. Thus, one way to look at self-insurance is to view companies as simply formalizing an arrangement that has already existed de facto. Under one form of self-insurance, a conventional insurance company is retained formally to do nothing more than process claims. Under complete self-insurance, the company does its own claims processing. In both versions, however, the role of aggressively monitoring health care expenses and influencing how the funds are spent is left to the employer.

\textsuperscript{22}Jerry Geisel, “Surveys Find Most Employers Self-Funding Health Benefits,” *Business Insurance* (January 28, 1985), p. 10. The funds to which these contributions are made are called voluntary employee beneficiary associations (VEBAs), or 501(c)(9) trusts.

\textsuperscript{23}Ibid.
But the change to self-insurance was important. For even if the change in responsibility was a mere formality, it laid the groundwork for more change. In the early 1980s, companies that controlled their own health insurance plans were in a better position to institute and experiment with other cost-control techniques that traditional insurers refused to implement. By the end of the 1980s, all health insurance companies (including Blue Cross) were actively implementing similar cost-control techniques. To survive in the health insurance market today, management of health care costs is essential.

Case Study: U.S. Administrators, Inc.24

One example of how unconventional health insurance can help employers opt out of the cost-plus system is the case of U.S. Administrators, Inc., an innovator in cost-management techniques used in the 1980s. When a company self-insures, it immediately saves about 2 to 3 percent on its health insurance bill by avoiding the payment of state taxes on insurance premiums. According to Samuel Kaplan, president of U.S. Administrators, though, the potential total savings are 10 to 15 times that amount.

How can these savings be realized? For one thing, Kaplan says, a typical company can save 6 to 12 percent simply by engaging in better auditing and claims review techniques than those used by traditional insurance companies. In addition, companies can save 10 to 15 percent more by employing cost-management techniques. One of the most important of those is comprehensive utilization review—keeping meticulous records to identify doctors and hospitals that overcharge, are too quick to admit patients, or keep patients in the hospital too long.

Kaplan’s company also engages in other cost-containment practices. For example, it maintains a hotline so that patients and physicians can call for prior approval before elective surgery. Physicians describe the diagnosis, state why they recommend surgery, and what they intend to charge. U.S. Administrators keeps records of what other physicians in each geographical area charge and frequently negotiates with the physician over the price.

24This discussion is based on authors’ interviews with Samuel X. Kaplan, president of U.S. Administrators, Inc.
U.S. Administrators also employs another cost-management technique. Say a gall bladder operation normally costs about $3,000, and about $1,000 of that amount is the physician’s fee. U.S. Administrators reasons that the physician has a great deal of control over the other $2,000. So U.S. Administrators might strike the following deal: If the total procedure is under $3,000, the physician gets 125 percent of the agreed fee; if it is over $3,000, the physician gets only 75 percent of the fee. This arrangement gives physicians an incentive to care about all of the costs they can influence.

Kaplan is convinced that such techniques work. And he is willing to bet money on it. U.S. Administrators often puts part of its fee at risk, contingent on how well it performs for its clients. Suppose that an employer has been experiencing average health care costs of $1,000 per employee. U.S. Administrators might strike the following deal: If the company manages to reduce the employer’s cost to $900 per employee, U.S. Administrators gets its contractual fee plus a percentage of the amount saved; if costs go up above $1,000, the employer pays only 75 percent of the contractual fee.

Do these cost-cutting techniques threaten to reduce the quality of health care patients receive? Kaplan is adamant on this point. "Good cost-management leads to better health care," he says. If patients can avoid unnecessary surgery and unnecessary tests, they also avoid the risks associated with those procedures. Many medical procedures are indeed risky and should be avoided unless doing so poses even greater risks to the patient’s health.

**Cost-Management Techniques Developed in the 1980s**

U.S. Administrators, Inc., is not alone. In just a few years in the 1980s, these and other cost-control techniques were implemented, first by large companies and then by smaller ones. Soon, traditional insurers climbed on the cost containment bandwagon. Figure 7.3 shows how radically employer-provided health insurance changed in just five years. In 1984, 96 percent of insured workers were enrolled in a traditional fee-for-service plan. By 1988, the figure had dropped to 28 percent. Today, there are very few traditional insurers. As a representative of a large insurance company explained, "If you’re not involved in cost-management, you can’t be in the market for health insurance."

Various cost-control techniques implemented in the early 1980s by Fortune 500 companies are commonplace today (see Table 7.1).
At the time of their implementation, however, they were considered radical. A brief description of some of the techniques follows.

**Contracting Directly with Health Care Providers**

One way of opting out of the cost-plus system is to negotiate directly with hospitals, doctors, and other health care providers. When employers engage in the negotiations, they are bargaining over price, not merely reimbursement for costs. The use of HMOs is an example of this behavior. Another is the use of a preferred-provider organization (PPO) (see Figure 7.4). Under this arrangement, employers negotiate discounts with doctors and hospitals. Frequently, employees share in the savings if they use designated providers. One survey of U.S. companies found that one-half of all workers who are employed by companies with 1,000 or more employees are covered by an HMO or PPO.²⁵

**Increasing Employees' Deductibles and Copayments**

During the 1960s and 1970s, the trend in employer-sponsored health insurance was toward greater and greater coverage of employees' health care expenses. To employees, a good health

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Percent of Employers Who Use the Strategy</th>
<th>Percent Using the Strategy Who Find It Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precertification of admissions</td>
<td>64%</td>
<td>33%</td>
</tr>
<tr>
<td>Require second opinion</td>
<td>61</td>
<td>14</td>
</tr>
<tr>
<td>Improve employee awareness</td>
<td>49</td>
<td>14</td>
</tr>
<tr>
<td>Coordination of benefits</td>
<td>41</td>
<td>26</td>
</tr>
<tr>
<td>Conduct utilization reviews</td>
<td>39</td>
<td>30</td>
</tr>
<tr>
<td>Individual case management</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td>Increased deductible</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Special pretax spending accounts</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>Employee assistance programs</td>
<td>30</td>
<td>24</td>
</tr>
<tr>
<td>Review of claims checking</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>Special coverage of generic drugs</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Improved data analysis</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>Wellness/fitness programs</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>Preemployment medical exams</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td>Improved monitoring</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>Reduce benefits</td>
<td>22</td>
<td>34</td>
</tr>
<tr>
<td>Require outpatient care</td>
<td>18</td>
<td>24</td>
</tr>
<tr>
<td>Choices/cafeteria-type plans</td>
<td>17</td>
<td>44</td>
</tr>
<tr>
<td>Increase copayment</td>
<td>13</td>
<td>35</td>
</tr>
<tr>
<td>Coverage for special facilities</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>In-house medical service</td>
<td>5</td>
<td>22</td>
</tr>
</tbody>
</table>


*Based on a survey of 1,277 firms.
insurance policy was one that paid for almost everything. Today, that view is vanishing and is certainly not held by most employers. During the 1980s, there was a rapid movement in the opposite direction. A 1985 Business Roundtable survey of large companies found that most had increased the share of costs borne directly by employees by raising deductibles and copayments. Of the companies surveyed, 57 percent had an annual deductible, more than half had raised the deductible since 1982, and 98 percent required a copayment of some type. That trend has continued. Between 1985 and 1988, about 79 percent of all employers increased their deductibles.


A. Foster Higgins & Co., p. 17.
Opting Out of the Cost-Plus System

Offering Flexible Benefits

Closely related to the concept of greater employee cost sharing is the practice of giving the employee a choice between a high-cost health insurance policy (with low deductibles and low copayments) and a low-cost plan (with high deductibles and high copayments). Employees who choose the low-cost plan are allowed to pocket the savings or apply it to some other fringe benefit. The ideal way to structure the option is to allow employees to reap the full financial benefits of choosing the lower cost plan or, conversely, to pay the full cost of choosing the higher cost plan.

Take Pepsico Inc. for example. In 1980, the company offered this option to its employees. However, because it underpriced the high-cost plan, 65 to 75 percent of Pepsico employees chose a plan with no copayment. After Pepsico raised the price of its high-cost plan to reflect actual costs, more than 50 percent of Pepsico employees chose the lower cost plan. 28

A natural extension of this idea is to offer employees a full range of fringe benefit choices, a practice sometimes known as the cafeteria plan. Under this arrangement, employees who save money by choosing lower cost health insurance can divert the savings to some other tax-favored employee benefit (such as a pension plan or day care benefits), and avoid realizing additional taxable income.

According to Harvard Business School professor Regina Herzlinger, Quaker Oats successfully used employee options (including cash dividends to employees) to hold its health care cost increases to only 6 percent per year from 1983 to 1990. 29 When Quaker Oats employees became involved in choosing their own health care plans, they reduced their hospital usage by 46 percent. Overall, the company kept its health care cost increases from 27 percent to 67 percent below the national average.

Encouraging Employees to Make Low-Cost Choices

In the traditional market for hospital care, more than 90 percent of the cost is paid by someone other than the patient. That means


that when patients make wasteful choices, 90 percent of the waste is shifted to someone else, and when they make prudent choices, 90 percent of the savings is realized by someone else. Many companies are changing their health benefit plans to give employees incentives for cost-reducing choices, especially when there are great opportunities to reduce costs. An example of a PPO arrangement with employee incentives is the plan adopted by AT&T, which spends more than $1 billion a year on employee health care. Doctors and hospitals who are part of AT&T's PPO have agreed to limit charges and get company approval prior to expensive procedures. AT&T employees may choose their physicians, but those who choose PPO doctors pay a $150 deductible, a 5 to 10 percent copayment for most charges, and nothing for hospitalization. Those who go outside of the network pay a $200 deductible and a 20 percent copayment for all services.  

Another method of encouraging low-cost consumption is through direct cash payments to employees who are patients. Among Milwaukee HMOs, for example, Samaritan Health Plan offers a $100 gift certificate at a local toy store for mothers who are discharged within 24 hours of giving birth (the average hospital stay in Milwaukee is 48 hours), Compcare offers mothers a choice of two days of home health services by a registered nurse or a $100 U.S. savings bond, and Managed Health Services offers 12 hours of free nanny services and four weeks of diaper service (also valued at about $100). Given that the average daily cost at a Milwaukee hospital is $700, the HMOs make about a $600 profit on the exchange.  

Another technique is an extension of the practice of negotiating over the phone, described above. Health Benefits Research Corporation (HBRC) has a toll-free telephone number for employees of client firms to call prior to surgery. HBRC contacts the physician, determines the fee, and then tells patients what their out-of-pocket costs will be. HBRC negotiates price discounts with physicians and, if a physician refuses to negotiate, refers the patient to a board-certified surgeon who agrees to accept "reasonable and customary"

31Neil Rosenberg, Medical Tribute, November 1, 1990, reported in Medical Benefits 7, no. 23 (December 15, 1990): 2.
reimbursement. The company reports that 63 percent of physicians are willing to negotiate fees and that the savings average 38 percent of the original charges.32

Companies have also created incentives in other ways. For example, the Business Roundtable found that almost all companies surveyed covered outpatient surgery and that more than 40 percent paid a higher percentage of the bill for outpatient than for inpatient surgery. In addition, 98 percent paid for second opinions and 55 percent offered employees a financial incentive to obtain a second opinion.33

*Auditing Claims and Reviewing Utilization*

Most large companies today have a formal procedure for auditing health insurance claims to determine the accuracy of the claim, the eligibility of the claimant, or whether the service is actually covered by the policy. Most large companies also conduct utilization reviews to identify unnecessary procedures or inappropriately long hospital stays. With increasing frequency, companies are employing utilization review techniques before the service is rendered. Many companies require prior approval for surgery. The 1988 Foster Higgins & Co. survey found that almost 75 percent of all large employers (1,000 or more employees) had mandatory utilization review procedures for hospitalization and surgery.34 Moreover, 68 percent of large employers and 37 percent of smaller ones had catastrophic case-management programs to ensure appropriate, cost-effective treatment in the most severe cases.35

*Promoting Wellness*

Yet another cost-control technique is to promote preventive measures. In the Business Roundtable survey, one-third of the companies gave new employees screening physicals, one-fourth offered periodic physicals to all employees, and one-half provided physical fitness programs. In addition, 49 percent offered employee counseling for alcohol and drug abuse, 30 percent did so for family problems, and 29 percent did so for job-related stress.36 Moreover (as

33Ibid., p. 3.
34A. Foster Higgins & Co., p. 5.
35 Ibid., p. 28.
36Business Roundtable Survey, p. 5.
noted in chapter 4), by the end of the decade many employers had become more aggressive. An estimated 6,000 companies refused to hire smokers. Others refused to hire people who drink or engage in risky activities (such as motorcycling). Some companies instituted differential premiums for employees, charging more to those employees who smoked or were overweight.

The Changing Nature of the Medical Marketplace

The medical marketplace cannot be changed by the actions of a single company. But when many engage in the cost-cutting techniques described above, each act is a nibble at the foundations of the cost-plus system. The cumulative effect is to set in motion a process of change.

It is interesting how this change is occurring. A company alters its health benefits policy because to do so is in its self-interest. The self-interested actions of one causes others to change. As companies change their behavior, so do hospitals and insurers. At Blue Cross, for example, administrators have not been sitting idly by, watching their market share disappear. According to a Blue Cross and Blue Shield Association publication released in the mid-1980s, the Blues' plans had 66 HMOs with more than two million members and as many as 40 PPOs. Blue Cross plans across the country are adopting procedures to encourage outpatient surgery, require prior approval of hospital admissions, mandate second opinions before surgery, establish utilization review programs, and encourage reductions in length of stay.37

Most of the changes taking place in the medical marketplace are in the direction of a more competitive market. Why are these changes occurring? One reason is that health care has become more expensive. That gives consumers of medical resources a greater incentive to find ways to economize. A second reason is that the supply of medical resources has outstripped demand—more doctors, more hospitals—largely as a result of government subsidies. That puts greater pressure on the providers of medical services to find new ways of attracting patients. A third reason is that many government impediments to competitive activity have been removed, and there

37Blue Cross and Blue Shield Association, Questions and Answers on the New Health Care (May 1985).
is now more freedom to compete. A fourth reason is the change in Medicare reimbursement rules. By adopting a policy of paying fixed prices for hospital procedures, the federal government has shown itself less willing to pay for the inefficiencies that raise the costs of hospital services.

How Well Are Cost-Management Techniques Working?

The number of hospital admissions steadily declined throughout the 1980s. Perhaps partly as a result of the change in Medicare’s reimbursement policies, there has also been a steady decline in average length of stay for elderly patients (see Figure 7.5). Annual increases in hospital revenues also have been falling (see Figure 7.6).

Now for the bad news. Medical inflation continued to outpace consumer prices in the 1980s. Between 1981 and 1986, hospital expenditures grew by 60 percent. Moreover, after about five years of moderate increases in insurance premiums paid by employers in
the mid-1980s, premium prices began to soar. Over the three-year period from 1985 through 1987, health care costs per employee grew at 6.5 percent per year, or at about twice the rate of inflation (3 percent); over the three-year period from 1988 through 1990, they grew at 17.4 percent, or more than three times the rate of inflation (see Figure 4.4 in chapter 4).

Many of the cost-management techniques that worked well in the early 1980s are not working as well today, and some are not working at all. For example, employers who offered HMOs are now discovering that those who choose the HMO option tend to be healthier. That leaves sicker, more-expensive-to-cover employees in the company’s primary health plan. Employers who negotiated PPO arrangements with hospitals are discovering that the initial savings are slowly vanishing. Discounts on hospital prices accomplish little when everyone has the same discount and nominal prices (which few are paying) continue to rise. Employers who encouraged their employees to choose outpatient surgery are finding that increases in the cost of outpatient care are more than offsetting decreases in inpatient costs.
What went wrong? One explanation is that corporate purchasers of health care underestimated the resilience and determination of the cost-plus bureaucracy. With each change in reimbursement policies, the providers found ways of maximizing revenues under the new set of rules. Take outpatient surgery, for example. When performed at a surgi-center, it can cut the cost of inpatient cataract surgery by 37 percent (see Table 7.2). That provides strong incentives to encourage outpatient treatment. But hospitals have responded by setting up their own outpatient services, and hospital outpatient surgery costs can be 50 percent more. Corporate buyers of health care who encourage outpatient procedures and do not carefully monitor them can end up paying more, not less.

Another way in which providers have responded to new reimbursement procedures is by unbundling their services and charging separate prices for items that were previously lumped in a single package. In principle, virtually every physician-provided service—from an office visit to a heart transplant—is described by a standard five-digit code. The codes are used by Medicare, Medicaid, Blue Cross, and other insurance organizations to determine the amount of payment. However, as Table 7.3 shows, doctors in Chicago and elsewhere have discovered that unbundling can often increase their income even though there has been no change in the amount of services.³⁸ By charging for each separate component of the procedure, physicians were able to bill $5,339, whereas the usual charge

Table 7.3
UNBUNDLING IN CHICAGO

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysterectomy</td>
<td></td>
</tr>
<tr>
<td>Usual, customary charge</td>
<td>$3,304</td>
</tr>
<tr>
<td>Separate charges</td>
<td></td>
</tr>
<tr>
<td>Remove fallopian tubes and ovaries</td>
<td>2,135</td>
</tr>
<tr>
<td>Pelvic examination under anesthesia</td>
<td>340</td>
</tr>
<tr>
<td>Dilation and curettage</td>
<td>848</td>
</tr>
<tr>
<td>Abdominal exploration</td>
<td>2,016</td>
</tr>
<tr>
<td>Total</td>
<td>$5,339</td>
</tr>
<tr>
<td>Gall bladder operation</td>
<td></td>
</tr>
<tr>
<td>Usual, customary charge</td>
<td></td>
</tr>
<tr>
<td>Removal of gallbladder through</td>
<td>$2,576</td>
</tr>
<tr>
<td>illuminated tube or laparoscope</td>
<td></td>
</tr>
<tr>
<td>Separate charges</td>
<td></td>
</tr>
<tr>
<td>Remove gallbladder</td>
<td>2,225</td>
</tr>
<tr>
<td>Look into belly through fiber-optic tube</td>
<td>1,202</td>
</tr>
<tr>
<td>Total</td>
<td>$3,427</td>
</tr>
<tr>
<td>Total knee replacement</td>
<td></td>
</tr>
<tr>
<td>Usual, customary charge</td>
<td>$5,889</td>
</tr>
<tr>
<td>Separate charges</td>
<td></td>
</tr>
<tr>
<td>Replace upper part of knee joint</td>
<td>3,012</td>
</tr>
<tr>
<td>Replace lower part of knee joint</td>
<td>2,844</td>
</tr>
<tr>
<td>Reline kneecap</td>
<td>2,677</td>
</tr>
<tr>
<td>Total</td>
<td>$8,553</td>
</tr>
</tbody>
</table>


for a hysterectomy in Chicago is $3,304. Similarly, through unbundling, a $2,576 gall bladder fee became $3,427 and a $5,889 fee for a knee replacement grew to $8,553.

Another reason that employers have not been more successful is that, even with more cost sharing on the part of employees, the vast bulk of medical expenses is still paid by third parties. Large corporations and large insurance companies have not made the employees and policyholders full participants in the attempt to opt out of cost-plus medicine.
How Employers Are Overlooking the Role of the Consumer

Despite the dramatic changes of the 1980s, most employers still make no real effort to empower their employees as consumers in the medical marketplace. Employees still perceive that they are spending someone else's money rather than their own. Thus, it is still in the self-interest of employees and their physicians to overspend and overuse health care services.

Patients and Doctors

Through innovative utilization review techniques, employers have had some success in negotiating lower physicians' fees and avoiding some unnecessary surgery. But the self-interest of patients and doctors is still antithetical to the employer's. And further intrusions into the doctor-patient relationship will not alter that fact.

The American Medical Association is correct in its complaint that interference in the clinical decisions of physicians threatens to lower the quality of medical care. All too often, physicians must get telephone approval for a procedure from a nurse who bases her judgment on a computerized manual of "acceptable practices." So-called cookbook medical guidelines can harm patients to the extent that such guidelines become barriers to medical care. And once physicians learn what's in the cookbook, they find ways of getting around the system. In one survey, most of the physicians said they would help patients get insurance coverage for a test by representing it as necessary for a diagnosis rather than as part of a general screening. It is simply a matter of time before physicians become equally skilled at obtaining telephone approvals.

Hospital Prices

Although employers have made some progress in informing employees about out-of-pocket costs for surgery, most have done little to help their employees become intelligent shoppers in the hospital marketplace. In most major cities, patients still cannot find out what their total hospital charges will be prior to admission and cannot read the line item bills they receive after discharge.

In the early 1980s, the federal government attempted to get out of the cost-plus system altogether. Under the Medicare program, the federal government began paying fixed prices (determined in advance) for hospital procedures for Medicare patients. As we move along in the 1990s, private-sector, third-party payers increasingly are doing the same thing. It is not uncommon for insurance companies and large employers to cut their own deals with hospitals. That takes the form of a predetermined price per procedure (similar to Medicare) or a predetermined price per patient-day. Such arrangements usually apply only to the employer's share of the bill, however. Employees are left to fend for themselves.

Thus, we have now come full circle. Prior to 1980, private paying patients were the only people who had to struggle with hospital bills they could not understand. In the 1990s, we are again evolving toward a system in which those least capable of coping with hospital line item prices are the only people asked to pay them.

**Shifting Premium Costs to Employees**

One of the most common cost-containment techniques is to ask employees to pay more of the premium in aftertax wages. It is not unusual for employees to pay from 30 to 50 percent of premiums out-of-pocket with aftertax dollars.\(^41\) This procedure does not really lower costs, however. Instead, it is an inefficient way of replacing wages with fringe benefits. Total health care costs (employer plus employee) remain the same.\(^42\) But every dollar paid aftertax is a dollar that loses out on the potential tax subsidy for health insurance. Employees would be better off (would have more take-home pay) if gross wages were lowered and the employer paid the full premium.

Consider a company with annual employee health costs averaging $2,700 per employee. If employees pay one-third of the premium in aftertax wages, they will receive no tax subsidy on $900 of premium payments. That means employers and employees are

\(^41\)Many larger companies can take advantage of provisions in the tax law that allow employees to pay their share of premiums with pretax dollars, however. See the discussion in chapter 9.

\(^42\)To the extent that total health care costs really are lowered, they are lowered only because employees forgo health insurance for themselves or for their dependents. But that leads to a larger number of people without health insurance.
paying an additional $300 to $450 in taxes. If employees pay one-half of the premium in aftertax wages, employers and employees together are paying from $390 to $650 in additional taxes. The fact that such a practice is common indicates that there is even greater waste in the employee benefits laws that regulate employer-provided health care.\textsuperscript{43}

Levels versus Trends

A common mistake made by employee benefits managers is to confuse a one-time shift in costs with a change in the rate of increase in costs. Instituting a procedure to audit claims or negotiate discounts reduces health care costs in the year in which the change is made. But if utilization continues to increase, costs will continue to increase as before. Suppose a company's health insurance costs are increasing at 15 percent per year. In the year in which it adopts cost-containment strategies, its costs drop from the trend line as shown in Figure 7.7. But unless employees have incentives to purchase less health care, costs will continue to climb 15 percent per year from the lower base.

The Leverage Effect of Deductibles

Another mistake made by employee benefits managers is to fail to consider the leverage effect of deductibles that are not increased in line with total health care costs. Table 7.4 provides a simple illustration. In this case, total health care costs rise by 10 percent. But if the employee deductible remains fixed, the employer's cost will rise by 20 percent, or twice the rate of increase in health care spending. On the other hand, if the deductible is also increased by 10 percent, the employer's cost will match the general increase in health care spending.

Casualty of Change: Health Insurance as Prepayment for Consumption of Medical Care

Health insurance in the cost-plus system tends to be prepayment for the consumption of medical care. For large companies it works

\textsuperscript{43}Increasing deductibles and copayments (thus requiring more expenditures with aftertax dollars at the time of consumption of medical care) also eliminates the tax subsidy. In this case, however, there is a more socially useful benefit, in that employees are less wasteful in consuming health care.
like this: Employees (through their employer) pay premiums for the right to receive medical care virtually for free at the point of consumption; if the cost of last year’s consumption exceeds the total premium payment, this year’s premium is increased to make up
for the loss; and premium payments from the employees finance the consumption decisions of those same employees.

In such a system, health insurance companies are not performing any real insurance function. Instead, they are processing claims and doing the accounting. Thus, when large companies self-insure, they are not really entering the insurance business; they are simply taking over the paperwork. Self-insured companies now have entered the cost-containment business in an effort to control the consumption decisions of their employees. To the extent that the companies contract with traditional insurers to manage health care costs, the health insurers are also in the business of cost-management, not insurance.

The employees of a large company form a self-contained pool. The health risks present are kept within the company pool and not combined with health risks elsewhere. Thus, when the company substitutes prepayment for the consumption of medical care for real health insurance, the most visible problem it faces is the problem of rising costs. Not surprisingly, then, the modern corporation faces a vigorous, competitive market for cost-containment services. For all practical purposes, though, it is not part of a market for health insurance.

Things are very different for small companies and individuals. Consider the case of a single individual who wants to buy health insurance as protection against catastrophic medical expenses. Such a person has no interest in prepayment for the consumption of medical care. That would mean that his premiums would always have to match his medical expenses, which would defeat the purpose of having health insurance in the first place.

The original Blue Cross solution to this problem was to monopolize the market and charge everyone the same premium regardless of risk (as discussed in chapter 6). If medical consumption expenses went up, Blue Cross would raise the premiums for everyone. But because Blue Cross could not keep commercial insurers out of the market, the plan was destined to fail. Other insurers sought out the healthier policyholders who were being overcharged by Blue Cross and undercut the price. To the extent that the tactic was successful, Blue Cross was left with riskier policyholders for whom it had to charge even higher premiums.

Plans that offer prepayment for the consumption of medical care cannot compete in a free market with real health insurance. Such
an environment creates profitable opportunities for the latter and large losses for the former. Perhaps for this reason, most of the large commercial health insurers suffered large losses and left the market for individual health insurance during the 1980s. Many also left the market for small group insurance.

The consequences of this exodus were not all good. The more accurate pricing of risk was a benefit for healthier people and for small companies with healthier employees. But for those people and those groups of employees with higher risks, health insurance became increasingly difficult to purchase. Health insurance originally came into being to meet insurance needs in those industries and occupations in which the health risks were greatest. But by the end of the 1980s, we had come full circle. Those insurers who remained in the market sought only the healthiest policyholders, while avoiding and even blacklisting those industries and occupations in which health risks were the highest.

What should be done about this problem? To those steeped in the cost-plus tradition there is only one answer: government must intervene and prevent the accurate pricing of risk. There is “fierce competition for the small group insurance market [based] mainly on risk selection,” Congress has been told by representatives of the Health Insurance Association of America and Blue Cross and Blue Shield. “The major risk in insuring small groups is biased selection, and this risk is so large relative to other risks that it drives the market,” according to Gordon Trapnell, chief economist for the American Association of Actuaries. Competition based on risk selection “should be replaced by competition based on efficiency, service and ability to control costs,” they all agree. Those views are echoed by Jack Meyer, a health economist who formerly headed the Center for Health Policy Research of the “conservative” American Enterprise Institute in Washington, DC. “Providers and insurers are competing on the basis of good health risks in the United States because they are not yet being forced to compete on the basis of good performance,” he says.

Opting Out of the Cost-Plus System

If such comments do not immediately seem strange, imagine their application to life, automobile liability, fire, and casualty insurance. We do not normally criticize insurers in those fields because they are not actively involved in cost management. Cost-containment activities, to the extent they exist, are considered incidental to the real task of insurance, which is the pricing and managing of risk.

The social function of a competitive market for insurance is to move as close as possible to the accurate pricing of risk. Just as in other fields of insurance, there is enormous value in having health insurance risks priced accurately. Only in such an environment can individuals rationally choose between self-insurance and third-party insurance. Only in such an environment can individuals and companies minimize the costs of achieving any particular degree of financial security. In the complex world of modern medicine, cost-management techniques can be quite valuable, at least for expensive medical services. But, as we learned in the 1980s, insurance and cost management are two different services that do not have to be delivered by the same supplier.

The Threat of a Counterrevolution: Price Controls for Health Insurance

As the building blocks of the cost-plus system begin to slowly crumble, those with a vested interest in its continuation are not idle. Increasingly, they are turning to politicians to protect them from the pressures of the emerging competitive market. For example, many major insurers and other special interests are pressuring state governments to impose new regulations on the market for health insurance. Although various proposals differ in detail, the goal is to move toward the original Blue Cross ideal—a single premium for everyone, independent of risk. These regulations would institutionalize health insurance as prepayment for the consumption of medical care and would force insurers into the permanent business of managing health care costs. Under such regulations, it would be impossible for a competitive market for real insurance to emerge.

The Effects of Price Controls

Figures 7.8 and 7.9 illustrate what can happen when government regulations prevent risk from being priced accurately. In this example, 20 people who are known to have expensive-to-treat illnesses
Figure 7.8
PREMIUMS INCREASE AS HEALTHY PEOPLE DROP OUT

Figure 7.9
NUMBER OF INSURED PEOPLE FALLS

High Health Care Consumers
Moderate Health Care Consumers
Low Health Care Consumers
are allowed to enter an insurance pool for the same premium charged to 1,000 people already in the pool.

Because health care costs for each of the 20 newly insured, high-risk individuals are $5,850 greater than the premiums they pay, the premium must be immediately increased by 6 percent for all policyholders. Because of this increase, some of the healthiest people begin to drop their coverage. (One percent are assumed to drop coverage for every 1 percent increase in premiums.)

As healthy people drop their coverage, they reduce income to the pool but have little effect on the pool’s health care costs. As a result, each time a healthy person drops out, premiums must be increased again. In this case, after seven adjustment periods, health insurance premiums have increased by more than 60 percent and more than one-fourth of all policyholders have dropped their coverage. Although this is only a hypothetical example, it illustrates some consequences of the vast majority of “reform” proposals. In almost every case they would exacerbate the nation’s two most pressing health policy problems: rising health insurance costs and a rising number of uninsured.

*Imposing a Regressive, Hidden Tax*

By forcing insurance companies to pay the medical bills of people who are already sick, politicians would be indirectly shifting the cost (through premium increases) to healthy people who buy health insurance. In so doing, they would be imposing a hidden tax on unsuspecting families. It is a tax which is highly regressive. Whereas the income tax system is designed so that higher income families pay higher tax rates, many health insurance reform proposals would impose the highest hidden tax rates on the lowest income families.

For example, if health insurance reform causes the premiums to rise by $1,000 for family coverage, that’s a 10 percent tax on a family with a $10,000 annual income but only a 1 percent tax on a family with $100,000 in annual income. Thus, the tax rate on a family with a $10,000 annual income would be ten times as high as the rate for a $100,000-a-year family.

47These statistics are based on the Bush administration estimate that the least healthy uninsured Americans incur per capita health care costs of $7,100 per year.
Increasing the Number of People without Health Insurance

Contrary to widespread impressions, most of the 33 to 34 million people who are currently uninsured are healthy, not sick. Sixty percent of the uninsured are under 30 years of age and in the healthiest population age groups.\textsuperscript{48} They have below-average incomes and few assets. As a result, they tend to be very sensitive to premium prices.

Moreover, the primary reason why most of the uninsured lack health coverage is that they have judged the price too high relative to the benefits. Very few have been denied coverage. According to one estimate, only 1 percent of Americans under the age of 65 are "uninsurable."\textsuperscript{49} And according to an HIAA survey among employers who do not provide insurance to their employees, 86 percent cite high costs as the reason.\textsuperscript{50} The artificial premium increases that would result from many health insurance reform proposals would substantially increase the number of employers who fail to provide coverage for their employees and the number of individuals who are uninsured by choice.

Case Study: President Bush’s Health Care Plan

As part of his new health care plan, President Bush has made two major proposals—one good and one bad. On the positive side, the president’s proposal would give tax deductions and tax credits to families who purchase their own health insurance.\textsuperscript{51} Since the tax law currently subsidizes employer-provided health insurance, this is a reform that is long overdue on grounds of fairness alone. On the negative side, the president’s health insurance reforms


\textsuperscript{49}Employee Benefit Research Institute (EBRI) \textit{Issue Brief}, no. 110, January 1991.


\textsuperscript{51}"President’s Comprehensive Health Reform Program," February 6, 1992. People with income below the tax filing threshold (approximately the poverty line) would receive tax credits of $1,250 (for an individual) and $3,750 (for a family of three or more). The amount of the credit would decline as income rises, and taxpayers would have the option of taking the credit or a tax deduction. No health insurance credit or deduction would be available to individuals or families with incomes above $50,000 or $80,000, respectively. [p. 2.]
would more than wipe out any advantage the tax incentives create for moderate-income families.

According to the president’s proposal, no employer or insurance company should be able to deny coverage or charge a higher premium to people who have expensive-to-treat illnesses. Thus, a person with AIDS should be able to purchase health insurance for the same price as someone who does not have AIDS. People in hospital cancer wards should be able to buy health insurance for the same price as people who do not have cancer. The Bush proposal would require insurers to subsidize the cost of health insurance for the ill by charging higher premiums to the well. Thus people who do not have AIDS would be forced to pay higher premiums so that people who already have AIDS could pay lower premiums.

Particulars of the Bush Plan

George Bush is not the first person to propose charging the healthy and the sick the same premium for health insurance. Community rating is about to be implemented in Vermont and variations on that idea are under consideration in a dozen states. The only important difference among the proposals is the ease with which sick people can enter a pool and healthy people can leave.

Most proposals give healthy people at least some incentives to buy health insurance. For example, a typical provision is that preexisting conditions are not covered until after a 12-month waiting period. Thus someone who purchases insurance after an illness occurs risks 12 months of medical bills before the insurer starts paying the tab. The Bush proposal, by contrast, has no waiting period. Page 22 of the president’s “white paper” on health policy proposes that hospitals be able to get patients insured the moment they enter the emergency room. Uninsured people would face no financial risk. They could get insurance coverage as they enter a hospital and drop it as they leave.

52 “President’s Comprehensive Health Reform Program,” February 6, 1992. During an initial transition period, premium “bands” would allow some variation in premiums for individuals of the same age and sex. Ultimately, however, through a reinsurance mechanism, “insurers would be able to provide coverage at a near uniform premium for the sick and the healthy” (p. 23).

53 In cases where a hospital emergency room is an individual’s first point of contact with the system, rotating assignment would be used to enroll an uninsured credit-eligible individual to a specific health plan if the individual were unable to make a choice. So, for example, a homeless person entering the hospital and having no
Applying the Concept to Life Insurance

One way to appreciate how radical this reform would be is to imagine applying the same concept to life insurance. Suppose people could buy life insurance for a family member who was terminally ill. Clearly, there would be a huge demand for life insurance among the families of people on death’s doorstep. If people could buy life insurance for the same price regardless of how sick they are, there would be no reason for the healthy to buy it. Life insurance premiums would soar. And since the premium for a $1 million death benefit for someone about to die would be $1 million, real life insurance as we know it would cease to exist. Similarly, if you knew you could buy health insurance after you became sick for the same price charged to the healthy, there would be no reason to purchase it while you were healthy. Only sick people would buy it and premiums would be exorbitant.

Subsidies vs. Price Controls

The worst feature of the Bush plan and other price control solutions is that they would cause enormous harm in order to accomplish a small amount of good. A much better approach would be to tackle the problems of sick people directly and allow healthy people to buy real health insurance. In the example illustrated by Figure 7.8, the attempt to subsidize the medical bills of 20 people led to a 60 percent price increase for 1,000 people and caused 271 people to become uninsured. Those negative consequences could be completely avoided by directly subsidizing the medical bills of the 20 sick people through a government program.

President Bush’s health care plan is not a solution to the problems of private health insurance in the United States. It would cause health insurance premiums to soar, lead to an increasing number of uninsured people, and impose its greatest burdens on moderate-income families. The nation’s health care crisis will not be solved by regulating private health insurance out of existence. To the
Opting Out of the Cost-Plus System

Table 7.5
THE LANGUAGE OF MISGUIDED REFORM

<table>
<thead>
<tr>
<th>Reformers’ Assertions</th>
<th>Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>“In order for insurance to work, people need to be combined into large pools.”</td>
<td>Almost all insured people are already combined into large pools.</td>
</tr>
<tr>
<td>“Some insurers try to take all the good risks, leaving others with the bad ones.”</td>
<td>If insurance is priced accurately, “good” risks are no more profitable than “bad” ones.</td>
</tr>
<tr>
<td>“Medical underwriting (basing premiums on the health condition of potential policyholders) is destabilizing the market.”</td>
<td>There is no evidence that the accurate pricing of risk causes instability. There is a lot of evidence that the failure to price risk accurately causes instability.</td>
</tr>
<tr>
<td>“Competition among insurers should be based on skills at managed care, not on skills at guessing who will become sick.”</td>
<td>Predicting the likelihood of claims and pricing based on those predictions is what the business of insurance is all about. Managing expenses is a different business—one that does not necessarily require insurance companies.</td>
</tr>
</tbody>
</table>

contrary, we need a competitive insurance market in which premiums reflect real risks.

The Health Insurance Reform Debate

The goal of President Bush’s health insurance reform proposal is to force healthy people to pay higher premiums in order to subsidize the medical expenses of less healthy people. Since most people would not voluntarily pay higher premiums, the president’s proposal would create an elaborate price-fixing scheme—designed to prevent insurers from charging healthy people fair prices.

This goal is not clearly stated in the White House health policy position paper, however. Nor is it clearly stated in similar reform proposals. Instead, the advocates of price control talk of “pools,” “medical underwriting,” and the like. But, as Table 7.5 shows, such
industry jargon bears little relationship to real problems and real solutions.

Do We Need Larger Insurance Pools?

An argument often made by price control advocates is that insurance cannot work unless people are placed in large pools. What they often neglect to say is that everyone who has health insurance is already in a large pool. Large insurance companies automatically group policyholders with other policyholders around the country. Most small companies reinsure in a larger, national market.

President Bush’s proposal would not lead to larger pools. In fact, it might lead to smaller ones (e.g., as states are encouraged to create self-contained pools). The Bush reform proposal would regulate the price of entry into the pool and the price of remaining in the pool. The proposal is not really about pools, it’s about prices.

What’s Wrong with Medical Underwriting?

As in the case of life insurance and property and casualty insurance, most health insurers try to base the premiums they charge on the likelihood of future claims. Thus, less-healthy people can expect to pay higher premiums or face exclusions and riders. In this respect, the health insurance market is no different from any other insurance market. To the extent that underwriting is successful, it leads to the more accurate pricing of risk; which leads to lower and more stable prices; which leads to more insured people; which leads to less uncompensated care; which leads to still lower prices, etc.

Many advocates of reform, however, view the accurate pricing of risk as a problem rather than a solution. In their view, the social purpose of health insurance is to pay medical bills rather than to price and manage risk. One frequent argument is that underwriting is destabilizing because some companies try to take all of the “good” risks, leaving other companies with all of the “bad” ones. If risk is priced accurately, however, a good risk is no more profitable than a bad one. Lloyds of London has prospered for more than 100 years insuring risks that other insurers avoided. Moreover, there is nothing in economic theory and no historical evidence to support

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54Exclusions and riders are additions that become part of an insurance policy, excluding or limiting benefits otherwise payable.
the contention that markets in which risk is priced accurately are unstable. To the contrary, both theory and evidence demonstrate that instability is created when risk is not priced accurately.

How Should Health Insurance Be Priced to New Buyers?

If the health insurance marketplace is competitive, there will be a natural tendency to price risk accurately. Different people will pay different premiums depending upon the likelihood that they will incur claims. Policies sold to individuals will be combined with other policies in a larger market. The price charged to a specific buyer will reflect the risk that individual adds to the large pool. Currently, the cost of insuring a 60-year-old male is about four times that for a 25-year-old male. The likely cost of insuring someone living in Los Angeles is about four times that of someone living in Vermont. In competitive markets, premium prices would reflect these expected costs. Buyers would each pay for what they get.

How Should Health Insurance Be Priced to People Already Insured?

Some of the most troublesome problems in the health insurance industry relate to the experience of policyholders who become sick. As we saw in chapter 6, most life insurance contracts are guaranteed renewable. This means that the insurer cannot cancel the policy after a person has a life-threatening illness. Terminally ill people, for example, have the right to continue paying premiums, often at guaranteed rates. In addition, there are usually limits on how much the premiums can rise in future years, and the insurers cannot increase the premium for one policyholder without increasing the premium by the same amount for everyone else who holds that same type of policy.

Not long ago, the health insurance marketplace functioned in a similar manner. Policies that were guaranteed renewable were common. Insurers could not cancel coverage simply because a policyholder became sick, and a premium increase for one had to be matched by increases for all others. There is some evidence that state regulation is responsible for the virtual disappearance of guaranteed renewable policies in the market for individual and family policies.

Real Problems, Real Solutions

There are real problems in the health insurance industry. These problems arise because the traditional insurance philosophy has
been abandoned. To solve the problems, legislation is probably needed. But a workable solution must be one which encourages a competitive market for real insurance—one in which risk is accurately priced.

Solutions must be found for the problems of four separate groups of people: (1) healthy people who choose not to buy health insurance, (2) unhealthy people who are uninsurable, (3) sick people whose policies are canceled or whose premiums are unfairly increased by insurance companies, and (4) employees who experience "job lock."

**Problem: Healthy People Who Are Uninsured**

As noted above, most uninsured Americans are healthy, not sick. They lack health insurance because they have been priced out of the market. Part of the answer is to encourage insurers to charge these people low premiums that reflect their low level of risk. Moreover, the tax law should grant every bit as much encouragement (about a 30 percent subsidy) for individually purchased insurance as it now grants for employer-provided health insurance.

**Problem: People Who Are Uninsurable**

A small but important group of people cannot buy health insurance because they are sick or at high risk. Government can help by creating risk pools or subsidizing the purchase of conventional health insurance with tax dollars, rather than by artificially raising the premiums charged to healthy people. And the amount of subsidy should depend on family income. Low-income families need government help. Ross Perot does not.

**Problem: Unfair Cancellations and Premium Increases**

Sensible reform is needed for people who already have insurance. Insurers should not be able to change the rules of the game after a risky illness has occurred. They should not be able to cancel a policy or unreasonably raise premiums. As noted above, terminally ill people who have life insurance can continue their coverage at pre-agreed premiums. There is no reason why health insurers can’t follow the same practice.

**Problem: Job Lock**

Thirty percent of Americans say they or someone in their household has stayed on a job they wanted to leave because they did not
want to lose employer-provided insurance coverage. Even though economists are almost unanimous in the belief that health insurance costs are fully paid for by workers (as a fringe benefit which substitutes for wages), our outmoded employee benefits system treats the policy as belonging to the employer, not the employee. This might be acceptable if employees worked for the same employer for the whole of their work life. In fact, most do not.

A reasonable solution is to insist that health insurance benefits be personal and portable if they are to receive favorable treatment under the tax law. Thus, employers who want the tax advantages of employer-provided coverage would have to purchase (or provide) a conversion option that would allow employees (or a new employer) to continue coverage after the employee leaves the firm.

The Threat of a Counterrevolution: Outlawing Cost-Control Techniques

Other special interests in the health care industry have also been active. In 1991, for example, there were 195 pieces of legislation introduced at the state level to stop, or cripple, many of the cost-control techniques described here. For example, an Indiana law requires that PPOs must accept any physician willing to join. Thus, Indiana Bell has a PPO that includes every physician in the state. Montana and Oklahoma have adopted similar measures.

In some states, hospital and physicians’ groups are supporting legislation that would require all utilization review to be done by local providers, mandate that utilization review firms remain open 24 hours a day, and require state-specific statistical reporting. Such legislation would raise the cost of utilization review and inhibit its aggressive application. In addition, some states (including Texas) restrict the amount of discount that insurers can give to patients who choose PPO doctors.

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The Threat of a Counterrevolution: Total Government Control

Other proposals would have even more devastating effects on the market for private health insurance. Proposals for pay-or-play plans that have been introduced at the federal and state level, for example, would force employers to provide health insurance to employees or pay a tax that is largely unrelated to the real cost of health insurance. These proposals are designed to force people into a regulated, institutionalized health care system—protected from the pressures of competition (see chapter 12). As in the case of mandated automobile liability insurance in California, New Jersey, and Massachusetts (see chapter 6), these proposals would necessarily politicize all health insurance in the United States. They would constitute an open invitation for government to impose controls on the entire health care system. The ultimate threat, however, is growing support for national health insurance, which also would completely prevent competitive market pressures from solving problems (see chapter 16).

The events of the 1980s created an opportunity for a competitive market for real health insurance to develop in the 1990s. But that will not happen unless public policies encourage its development.
8. Cost-Plus Finance and Low-Deductible Health Insurance

The vehicle by which we spend other people’s money in the medical marketplace is third-party health insurance (provided by an employer, an insurance company, or government). Prior to 1965, increases in health care costs were relatively modest because a large part of the payment was made out-of-pocket by patients. Since then, Medicare and Medicaid have expanded government third-party insurance to more and more services for the elderly and the poor, and private health insurance has expanded for the working population. As Table 8.1 shows, 95 percent of the money Americans now spend in hospitals is someone else’s money at the time they spend it. Four-fifths of all physicians’ payments are now made with other people’s money, as are more than three-quarters of all medical payments for all purposes.

The expansion of third-party insurance coverage since 1965 has had a predictable consequence: Health care spending has soared from 6 percent to 12 percent of our gross national product, and the rate of increase shows no sign of abating.

Numerous economic studies have shown that the amount of medical care that people consume varies with the out-of-pocket price they have to pay, often with no effect on health. For example, a Rand Corporation study found that people who had access to free care spent about 50 percent more than those who had to pay 95 percent of their bills out-of-pocket (up to a maximum of $1,000). People who had free care were about 25 percent more likely to see a physician and 33 percent more likely to enter a hospital.¹ Despite

Table 8.1

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>1965</th>
<th>1990</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>83.2%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Physician</td>
<td>38.4</td>
<td>81.3</td>
</tr>
<tr>
<td>Drugs</td>
<td>6.4</td>
<td>26.4</td>
</tr>
<tr>
<td>Nursing home</td>
<td>35.5</td>
<td>55.2</td>
</tr>
<tr>
<td>All other professional services</td>
<td>NA</td>
<td>72.2</td>
</tr>
<tr>
<td>All personal health care expenditures</td>
<td>48.4</td>
<td>76.7</td>
</tr>
</tbody>
</table>

**Source:** Health Care Financing Administration, Office of the Actuary. Data from the Office of National Cost Estimates.

differences in consumption, there were no apparent differences between the two groups in terms of health outcomes. The Rand study was conducted between 1974 and 1982. A $1,000 deductible over that period would be equivalent to a deductible of between $1,380 and $2,482 today.

**The Self-Insurance Alternative**

People familiar with insurance have long known that it creates perverse incentives for the insured. To take advantage of the benefits under their policies, the beneficiaries do things they would not otherwise do. In recognition of this fact, insurance in most fields is restricted to risks beyond the control of the insured. (For example, automobile casualty insurance does not pay for oil changes, tire rotation, brake adjustment, or other routine maintenance, even though these activities are important for the health of a car and safety of its driver.) Financial advisers almost always recommend

2The one exception was vision care, which is not surprising in that eyeglasses are often viewed as a marginal health care expenditure. High blood pressure was close to statistical significance. Researchers could find no other significant differences in health outcomes. See Joseph Newhouse et al., “Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance,” New England Journal of Medicine 305, no. 25 (December 17, 1981): 1501–7; and Robert Brook et al., “Does Free Care Improve Adults’ Health?” New England Journal of Medicine 309, no. 23 (December 8, 1983): 1426–34.

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Cost-Plus Finance and Low-Deductible Health Insurance

high-deductible policies, because low-dollar claims are the ones in which the most abuse is likely to occur and the premiums needed to cover such claims are often much too high relative to the extra coverage. The same principles apply to health insurance.

The alternative to third-party insurance is self-insurance. Rather than relying on insurers to pay every medical bill, we could put money aside in personal savings for the small expenses involved and use insurance only for rare, high-dollar medical episodes. Such a practice would result in much lower premiums and curtail a great deal of wasteful spending. But instead of exploiting opportunities for self-insurance and taking advantage of its benefits in the health care field, we have moved in the opposite direction, with insurers paying for all manner of routine expenses, including checkups and diagnostic tests, even when there is no illness and no risky event has occurred.

Why Low-Deductible Health Insurance Is Wasteful

Because employees, through their employers, are able to purchase health insurance with pretax dollars but individuals are not permitted to self-insure (personal savings) for small medical expenses with pretax dollars, people often buy low-deductible health insurance and use insurers to pay small medical bills that would be much less expensive if paid out-of-pocket. The following examples show how wasteful this practice can be.

The Cost of a Low-Deductible Policy in Cities with Average Health Care Costs

The cost of catastrophic health insurance is usually quite low. Consider a standard individual health insurance policy for a middle-aged male in a city with average health care costs, such as Indianapolis. (See Table 8.2.) If the policy has a $2,500 deductible, the policyholder is at risk for $2,500. The insurance company, on the other hand, is at risk for $1 million. Given an average premium, this health insurance costs the policyholder about 6/100th of one penny in premiums for each dollar of coverage.

Now contrast this policy with a $1,000-deductible policy that has a 20 percent copayment for the next $5,000 of expenses. In theory,
Table 8.2
COST OF LOWER DEDUCTIBLES FOR A 40-YEAR-OLD MAN IN A
CITY WITH AVERAGE HEALTH CARE COSTS

<table>
<thead>
<tr>
<th>Lowering the Deductible</th>
<th>Additional Annual Premium</th>
<th>Cost of Each $1 of Additional Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>From $2,500 to $1,000</td>
<td>$168.84</td>
<td>14¢</td>
</tr>
<tr>
<td>From $1,000 to $500</td>
<td>255.12</td>
<td>64</td>
</tr>
<tr>
<td>From $500 to $250</td>
<td>153.24</td>
<td>77</td>
</tr>
</tbody>
</table>

SOURCE: Golden Rule Insurance Co.

1Data are for 1991.

2For deductibles of $1,000 or less, the policy has a 20 percent copayment up to a maximum of $1,000.

3Because the policy has a 20 percent copayment, additional coverage is 80 percent of the difference between the two deductibles.

the $1,000 deductible gives the policyholder $1,500 of extra insurance coverage. But because of the 20 percent copayment, the additional coverage actually is only $1,200.3 People who choose the $1,000 deductible will pay about $169 in additional premiums in return for $1,200 of additional insurance coverage. As a result each additional dollar of insurance coverage costs the policyholder 14 cents.4 Table 8.2 also shows the marginal cost (premium increase per additional dollar of coverage) of buying down the deductible even further. As the table shows, lowering the deductible from $1,000 to $500 costs 64 cents in additional premiums for each additional dollar of insurance coverage. Lowering the deductible from $500 to $250 costs 77 cents in additional premiums for each additional dollar of insurance coverage.

3Unless the policyholders have reached the cap on their copayment ($1,000), they must pay 20 percent of medical expenses above the deductible. Thus, if policyholders with a $1,000 deductible have medical expenses of $2,500, they must pay the first $1,000 plus 20 percent of the next $1,500 (or $300). The insurance company, in this instance, will pay $1,200.

4These calculations are based on policies sold by Golden Rule Insurance Co., the largest seller of individual and family policies in the country. Other insurance companies sell similar policies at similar prices. See John C. Goodman and Gerald L. Musgrave, Controlling Health Care Costs with Medical Savings Accounts, NCPA Policy Report no. 168 (Dallas: National Center for Policy Analysis, January 1992).
Cost-Plus Finance and Low-Deductible Health Insurance

Table 8.3
COST OF LOWER DEDUCTIBLES FOR A 40-YEAR-OLD MAN IN A CITY WITH HIGH HEALTH CARE COSTS

<table>
<thead>
<tr>
<th>Lowering the Deductible</th>
<th>Additional Annual Premium</th>
<th>Cost of Each $1 of Additional Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>From $2,500 to $1,000</td>
<td>$389.64</td>
<td>$0.33</td>
</tr>
<tr>
<td>From $1,000 to $500</td>
<td>715.44</td>
<td>1.79</td>
</tr>
<tr>
<td>From $500 to $250</td>
<td>440.28</td>
<td>2.20</td>
</tr>
</tbody>
</table>

SOURCE: Golden Rule Insurance Co.

1Data are for 1991.

2For deductibles of $1,000 or less, the policy has a 20 percent copayment up to a maximum of $1,000.

3Because the policy has a 20 percent copayment, additional coverage is 80 percent of the difference between the two deductibles.

In general, buying a $250 deductible policy rather than a $500 deductible is a good deal only if the policyholder is confident he will have at least $500 in medical expenses. Even in that case, the gain is a small one—a dollar’s worth of medical expenses for each 77 cents in premiums. For the vast majority of people, however, a low-deductible policy is quite wasteful. Considering the administrative expenses, insurers on the average will pay out only 54 cents in claims for each 77 cents in premiums. Policyholders as a group, therefore, will pay far more in premiums than they will receive in benefits.

The Cost of a Low-Deductible Policy in Cities with High Health Care Costs

In general, the higher the health care costs in an area, the more expensive low-deductible health insurance becomes. Table 8.3, for example, shows the costs of a lower deductible for a middle-aged male in a city such as Miami. As the table shows, lowering the deductible from $2,500 to $1,000 is quite expensive, being 33 cents for each additional dollar of coverage. Lowering the deductible from $1,000 to $500 is inherently wasteful, costing $1.79 for each additional dollar of coverage. Lowering the deductible from $500 to $250 costs $2.20 for each additional dollar of coverage, or $1.20 more than any possible benefits the policyholder could derive.
The Cost of a Low-Deductible Policy under Blue Cross Plans in California

Southern California has health care costs that are among the highest in the nation. As a result, Californians who buy lower deductible policies are being especially wasteful. Table 8.4 shows what policyholders would pay to reduce the deductible under Blue Cross plans currently sold for individuals and families in different age groups. Even lowering the deductible from $2,000 to $1,000 is a bad buy in many cases. A deductible of less than $1,000 is always a bad buy.

A California couple with no children will pay from $1 to $2.63 (depending on their age) for each dollar of additional insurance if they choose a $500 rather than a $1,000 deductible. If they further lower the deductible to $250, they will pay from $1.92 to $9.54 for each additional dollar of coverage.

Opportunities for Premium Savings

Because low-deductible health insurance is so wasteful, in most places people would realize substantial premium savings if they increased the deductible. For example, the average employee in the U.S. economy has a deductible of about $250. If it were increased to $1,000, the employee would lose $600 worth of coverage (80% x $750).

Figure 8.1 shows the potential annual savings on individual policies sold in Indianapolis (an average health care cost city), Dallas (an above-average cost city), and Miami (a high-cost city). As the figure shows, in return for giving up $600 of coverage, policyholders would realize immediate savings of 68 percent of that amount in Indianapolis and 90 percent in Dallas through lower premiums. In Miami, policyholders would save $1,156 in reduced premium payments, or $556 more than the coverage they would forgo.

In most places, the savings for families that choose higher deductibles are even greater. In a city with average health care costs, families can save about $1,315 a year by choosing a $1,000 deductible rather than a $250 deductible—savings that are more than twice as much as the value of the coverage forgone. By choosing a $2,500

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Table 8.4
BLUE CROSS PLANS IN SOUTHERN CALIFORNIA: COST OF LOWER DEDUCTIBLES*

<table>
<thead>
<tr>
<th>Status and Age</th>
<th>Lowering Deductible from $2,000 to $1,000</th>
<th>Lowering Deductible from $1,000 to $500</th>
<th>Lowering Deductible from $500 to $250</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single person</td>
<td>Subscriber and spouse</td>
<td>Subscriber and child</td>
</tr>
<tr>
<td></td>
<td>Under 30</td>
<td>Under 30</td>
<td>Under 30</td>
</tr>
<tr>
<td></td>
<td>$0.14</td>
<td>$0.29</td>
<td>$0.15</td>
</tr>
<tr>
<td></td>
<td>$0.72</td>
<td>$1.44</td>
<td>$0.96</td>
</tr>
<tr>
<td></td>
<td>$1.80</td>
<td>$2.28</td>
<td>$1.62</td>
</tr>
<tr>
<td></td>
<td>0.20</td>
<td>0.24</td>
<td>0.23</td>
</tr>
<tr>
<td></td>
<td>1.05</td>
<td>2.52</td>
<td>1.14</td>
</tr>
<tr>
<td></td>
<td>1.02</td>
<td>2.07</td>
<td>1.86</td>
</tr>
<tr>
<td></td>
<td>1.08</td>
<td>2.64</td>
<td>2.55</td>
</tr>
<tr>
<td></td>
<td>2.82</td>
<td>5.64</td>
<td>3.18</td>
</tr>
<tr>
<td></td>
<td>3.84</td>
<td>9.54</td>
<td>5.34</td>
</tr>
</tbody>
</table>

(Continued on next page)
**Table 8.4—Continued**

**BLUE CROSS PLANS IN SOUTHERN CALIFORNIA: COST OF LOWER DEDUCTIBLES**

<table>
<thead>
<tr>
<th>Status and Age</th>
<th>Cost per Dollar of Additional Insurance Coverage for</th>
<th>Lowering Deductible from $2,000 to $1,000</th>
<th>Lowering Deductible from $1,000 to $500</th>
<th>Lowering Deductible from $500 to $250</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30</td>
<td>$0.42</td>
<td>$2.52</td>
<td>$2.22</td>
<td></td>
</tr>
<tr>
<td>30–39</td>
<td>0.56</td>
<td>2.16</td>
<td>3.60</td>
<td></td>
</tr>
<tr>
<td>40–49</td>
<td>0.62</td>
<td>2.82</td>
<td>4.68</td>
<td></td>
</tr>
<tr>
<td>50–59</td>
<td>0.87</td>
<td>3.90</td>
<td>5.04</td>
<td></td>
</tr>
<tr>
<td>60–64</td>
<td>1.16</td>
<td>2.04</td>
<td>10.14</td>
<td></td>
</tr>
<tr>
<td><strong>Subscriber and children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30</td>
<td>$0.27</td>
<td>$1.38</td>
<td>$2.52</td>
<td></td>
</tr>
<tr>
<td>30–39</td>
<td>0.29</td>
<td>0.96</td>
<td>3.90</td>
<td></td>
</tr>
<tr>
<td>40–49</td>
<td>0.30</td>
<td>1.44</td>
<td>4.62</td>
<td></td>
</tr>
<tr>
<td>50–59</td>
<td>0.44</td>
<td>1.44</td>
<td>6.96</td>
<td></td>
</tr>
<tr>
<td>60–64</td>
<td>0.62</td>
<td>1.23</td>
<td>6.18</td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** Blue Cross.

*For Orange, Santa Barbara, and Ventura counties in California in 1991.
Cost-Plus Finance and Low-Deductible Health Insurance

Figure 8.1
ANNUAL PREMIUM SAVINGS FOR A 40-YEAR-OLD MAN IF THE DEDUCTIBLE IS INCREASED FROM $250 TO $1,000*

<table>
<thead>
<tr>
<th>City</th>
<th>Annual Premium Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miami</td>
<td>$1,156</td>
</tr>
<tr>
<td>Dallas</td>
<td>$541</td>
</tr>
<tr>
<td>Indianapolis</td>
<td>$408</td>
</tr>
</tbody>
</table>

SOURCE: Golden Rule Insurance Co.

*Data are for an individual male aged 40 in 1991. Because the policy has a 20 percent copayment, the increase in the deductible eliminates only $600 of health insurance coverage unless the policyholder has medical expenses in excess of $5,000.

deductible rather than a $1,000 deductible, they can save $1,749, or $51 less than the value of the coverage they forgo.6 (See Figure 8.2.) However, under current federal tax law, if such policies are purchased by employers who attempt to pass the savings on to their

6The forgone coverage is 80% x ($2,500 - $250) = $1,800.
Figure 8.2
ANNUAL PREMIUM SAVINGS IF THE DEDUCTIBLE IS INCREASED FOR FAMILIES IN CITIES WITH AVERAGE HEALTH CARE COSTS*

| Increasing the Deductible from $250 to $1,000 | $1,315 |
| Increasing the Deductible from $250 to $2,500 | $1,749 |

SOURCE: Golden Rule Insurance Co.

*Data are for two adults and two children in a city with average health care costs. For deductibles less than $2,500, policyholders face a 20 percent copayment up to $1,000. Unless policyholders have medical expenses of $5,000, they forgo $600 of coverage by moving up from a $250 deductible to a $1,000 deductible and $1,800 of coverage by moving up from a $250 deductible to a $2,500 deductible.

employees in the form of higher wages, up to half the premium savings will go to the government in the form of taxes.

Opportunities for Premium Savings in Large Groups

Considerable savings are possible for individuals and families who choose higher deductible policies, for two reasons. First, when
policyholders spend more of their own money on small medical bills, they are more prudent consumers; they hold down medical costs and, therefore, health insurance premiums. Second, when people have the choice between higher and lower deductibles, healthy people tend to choose high-deductible policies whereas those who are not as healthy tend to choose low deductibles. Thus, people who choose high deductibles are less of an insurance risk.

Suppose, however, that an employer with a large group of employees increases the deductible for every member of the group—the healthy as well as the sick. In that case, any reduction in total medical expenses would be attributable solely to changes in the employees' consumption behavior. But even if there were no behavior changes, health insurance premiums could be cut substantially.

The Experience of Large Groups

Many people, including representatives of major employers and large insurance companies, question whether there are substantial savings in raising the deductible. Yet the claims experiences of large groups show that substantial savings do occur. The reason for the confusion is that apparently contradictory statements can be made about the distribution of claims. For example:

- About 4 percent of the people account for 50 percent of health care spending and 20 percent of the people account for 80 percent of the spending.
- About two-thirds of all health care spending is on medical bills of $5,000 or less.

The first statement, popularized in a widely distributed Blue Cross–Blue Shield publication, implies to many people that most of the money is spent on people who are very sick. By contrast, the second statement implies that most medical bills are small. As Figure 8.3 shows, both statements are correct. The distribution of medical expenses in Figure 8.3 is a reasonable representation of what happens in most large groups. In this case, 50 people spend $60,000, or $1,200 per person on the average. A small percentage of people spend most of the money and at the same time two-thirds of spending is on medical bills below $5,000. If the example were

Figure 8.3

Distribution of Medical Expenses Among 50 People*

*Assumes a $250 deductible and a 20% copayment on the next $5,000 of expenses. Period of coverage is one year.

broadened to include a much larger group, the extremes of the distribution would become more evident. A few people would have medical expenses of several hundred thousand dollars, and many others would have no medical claims. The characteristics of the distribution, however, would be about the same as those shown in Figure 8.3.

When individuals are given a choice, those who choose a $1,000 deductible rather than a $250 deductible can expect a one-third reduction in health insurance premiums. A one-third reduction in
claims costs (and therefore in premiums)\textsuperscript{8} is possible for a large group if the deductible is increased from $250 to about $2,500. Considering that higher deductibles cause people to change their behavior, however, a one-third reduction in premiums for a large group would probably occur at a deductible of between $1,000 and $2,500.

**Winners and Losers with Higher Deductibles**

Except in those instances in which people pay more in premiums than the value of coverage they receive, higher deductibles represent a gamble. On the one hand, a higher deductible results in premium savings. On the other hand, it puts policyholders at greater risk. Thus, some people will gain from a higher deductible and others will lose. A priori, most people won’t know which group they are in.

As Figure 8.3 shows, the vast majority of people would gain from a higher deductible. In any one year, about 70 percent would have very few medical expenses, accounting for only 2.5 percent of all health insurance claims. Those who have large medical bills, on the other hand, would be worse off. Nevertheless (as discussed below), even people who have high medical expenses in any one year would be better off with a high deductible, provided they do not have recurring large medical bills over many years. Take a leukemia patient, for example, who faces large medical expenses indefinitely into the future. With a high annual deductible, the out-of-pocket costs for this patient will simply rise over time.

However, there are ways of structuring health insurance so that even potential leukemia patients are better off with a high deductible. Instead of the annual deductible that is common these days, health insurance could have a “per condition deductible” as was common some years ago. With a per condition deductible, a person diagnosed with cancer would pay the deductible only once, and insurance would pay all of the remaining costs of the cancer treatments, even if those costs were incurred over many years.

\textsuperscript{8} Assumes that administrative costs are proportional to claims, an assumption that is consistent with industry experience.
Allowing People to Self-Insure through Medical Savings Accounts

To help eliminate the perverse incentives in the current system, we should allow individuals to make tax-free deposits each year to individual Medisave accounts. These accounts would serve as self-insurance and as an alternative to the wasteful use of third-party insurers for small medical bills. Funds in the accounts would grow tax free, and withdrawals would be permitted only for legitimate medical expenses. Funds not spent during a person’s working years could be spent on postretirement health care or rolled over into a pension fund.

Medisave accounts would be the private property of the account holder and become part of an individual’s estate at the time of death. If created by an employer, they would be personal and portable for the employee. Medisave contributions should receive at least as much tax encouragement as payments for conventional health insurance. 9

Medisave Accounts with a $1,000 Deductible

Most people have no medical expenses in any given year, and it is not uncommon for people to go for several years without incurring medical costs. Figure 8.4 shows how Medisave balances would grow if not spent in the case of an individual who switches from a $250 deductible to a $1,000 deductible, with $400 in premium savings each year. Consider the benefits of the two alternatives. With a $250 deductible and a 20 percent copayment, the policyholder would pay $400 out of the first $1,000 of medical expenses, and health insurance would pay 80 percent of the remainder. 10 With a $1,000 deductible, the policyholder would be at risk for $600 more each year. With a $1,000 deductible and a Medisave account, however, the policyholder could have at least $400 in additional cash each year—and at worst would pay an additional $200 in medical expenses out of personal funds. On the other hand, if the policyholder makes it through the first 18 months without any medical expenses, the person is clearly better off with a Medisave account.

9 The concept of medical savings accounts was originated by Jesse Hixson, currently a health policy economist with the American Medical Association.

10 The employee’s expenses would be the $250 deductible plus a coinsurance payment of $150 (20% x $750).
even with $1,000 of medical expenses in year two. If the policyholder has no medical expenses for five years, $2,441 will accumulate in the Medisave account, which would be enough to make the Medisave option profitable even with medical expenses of $1,000 for each of the next 48 years.

Medisave Accounts with a $2,500 Family Deductible

As noted above, a family in a city with average health care costs can expect to save about $1,749 in insurance premiums if it chooses

Under a conventional policy, the insured would have to pay $400 out of personal funds. When insurance is combined with Medisave funds, however, the insured would have to pay less than $400 out of other personal funds.
Figure 8.5
GROWTH OF FAMILY MEDISAVE ACCOUNTS WITH $1,750 ANNUAL DEPOSITS*

*End-of-year balance. Assumes 8 percent interest.

a $2,500 rather than a $250 deductible. Figure 8.5 shows how Medisave account balances would grow over time if none of the money were spent. Compare this Medisave option with a conventional health insurance policy. A family with a $250 deductible and a 20 percent copayment (up to $1,000) is at risk for $700 on the first $2,500 of medical expenses in any given year. With the Medisave option, the family will have $1,750 in its account the first year, leaving it at risk for $750 more, or only $50 more than under a conventional policy. Allowing for interest accumulation, this family will be better off with a Medisave account even if it has $2,500 of

12The family’s expenses would be the $250 deductible plus a copayment amount of $450 (20% × [$2,500 − $250]).
medical expenses at the end of each year, every year, indefinitely into the future.

Encouraging Self-Insurance: A Revenue-Neutral Proposal

One way to encourage Medisave accounts without any loss of revenue to the federal government is to permit employers and employees to choose higher deductible policies and place the untaxed premium savings in Medisave accounts. For employees, there would be no change in the amount reserved for health care benefits or in the total tax subsidy for employee benefits. And the change would encourage prudence, eliminate waste, and give employees greater control over their health care dollars.

Currently, many large employers maintain flexible spending accounts (FSAs) for their employees under Section 125 of the Internal Revenue Code. Under this arrangement, employees can reduce their salaries and make contributions to an individual FSA with pretax dollars. The funds are then used to purchase medical expenses at the employee’s discretion. The only difference between an FSA and a Medisave account is that FSA funds are governed by a “use it or lose it” requirement. If employees fail to spend the entire amount in their FSAs in one year, they forfeit the balance. Thus, FSAs create the opposite incentives of Medisave accounts; employees are penalized for not spending FSA funds. A small change in the tax law could change this perverse incentive into a positive incentive: “Use it or keep it.”

Extending Medisave Accounts to Others: A Nonrevenue-Neutral Proposal

Although the federal government grants generous tax subsidies to employer-provided health insurance, a deduction of only 25 percent is given to self-employed people who purchase their own health insurance. No deduction is given for the purchase of health

13Under the current budget rules, any change in policy proposed in Congress must not cause a net loss of federal revenue. The forecasting techniques used to estimate revenue effects are “static” rather than “dynamic,” however. Thus, forecasters tend to ignore any behavioral economic responses that would result from a change in the composition of the total amount of nontaxed employee benefits.

insurance by the unemployed, employees of firms that do not provide health insurance, or employees who must pay for health insurance coverage for their dependents with aftertax dollars.

Most of the 34 million Americans who lack health insurance have no tax encouragement to obtain it. One of the most effective ways to increase the number of people with health insurance would be to grant a tax deduction (or tax credit) to individuals who purchase health insurance with aftertax dollars. Because the choice to purchase health insurance would remain voluntary, this would create far fewer distortions in the labor market than would mandating employer-provided insurance. At the same time we extend tax encouragement for third-party insurance to all Americans, we should also establish tax incentives to self-insure for small medical bills.

Creating Medisave Accounts in Public Programs

Under the current system, the political pressures governing Medicare (for the elderly) and Medicaid (for the poor) are to expand benefits and refuse to pay for them. One consequence is increasing evidence of health care rationing. Medisave accounts could solve problems in both programs. For example, pregnant Medicaid women might have an account to draw on that they could freely spend in the medical marketplace. That would empower patients and expand the number of providers to whom they have access. Similarly, the elderly could choose higher Medicare deductibles and make deposits to their own Medisave accounts.

Medisave Accounts in Singapore

Medisave accounts have been in existence in Singapore since 1984. Unlike the proposals made here, contributions to Singapore’s Medisave accounts are mandatory, being part of the government’s program of insisting that people save to meet needs that might otherwise be unmet or met by the state. (A more extensive discussion of the Singapore system is given in chapter 19.)

See Goodman, Robbins, and Robbins.

For example, individuals might be given a tax deduction for the amount of money that would be necessary to purchase a standard $250 deductible policy. For the purchase of higher deductible policies, taxpayers could be granted the right to deposit the premium savings in Medisave accounts.
Advantages of Medical Savings Accounts

Creating individual and family Medisave accounts would represent a major departure from the current system of paying for health care. These accounts would have immediate advantages, which would become even more important over time. The 12 principal advantages are:

1. **Lowering the Cost of Health Insurance.** Medisave accounts would allow people to substitute less costly self-insurance for more costly third-party insurance for small medical bills. To the degree they are self-insured, people would no longer face premium increases caused by the wasteful consumption decisions of others. And to the extent that third-party insurance is reserved for truly risky, catastrophic events, the cost per dollar of coverage would be much lower than it is today.

2. **Lowering the Administrative Costs of Health Care.** Because we rely on third parties to pay a large part of almost every medical bill, unnecessary and burdensome paperwork is created for doctors, hospital administrators, and insurers. By one estimate, as much as $33 billion a year in administrative costs could be saved by the general use of Medisave accounts.

3. **Lowering the Cost of Health Care.** Medisave accounts would institute the only cost-control program that has ever worked—patients avoiding waste because they have a financial self-interest to do so. When people spent money from their Medisave accounts, they would be spending their own money, not someone else’s—an excellent incentive to buy prudently. By one estimate, the general use of Medisave accounts would reduce total health care spending by almost one-fourth.

4. **Removing Financial Barriers to the Purchase of Health Care.** Under the current system, employers are responding to rising health insurance costs by increasing employee deductibles and copayments. Market prices are encouraging people who buy their own health insurance also to opt for high deductibles and copayments. One downside of this trend is that low-income single mothers and others who live from paycheck to paycheck may forgo medical care because they can’t pay their share of the bill. Medisave accounts ensure that funds are available when the family needs them.
5. **Removing Financial Barriers to the Purchase of Health Insurance during Periods of Unemployment.** Under current law, people who leave an employer who had provided their health insurance are entitled to pay the premiums and extend their coverage for 18 months. Yet, the unemployed are the people least likely to be able to afford those premiums. Medisave accounts solve this problem by providing funds that are separate from those available for ordinary living expenses. Medisave funds may also be used to purchase between-school-and-work policies or between-job policies of the types already marketed.

6. **Restoring the Doctor-Patient Relationship.** Medisave accounts would give individuals direct control over their health care dollars, thereby freeing them from the arbitrary, bureaucratic constraints often imposed by third-party insurers. Physicians would see patients rather than third-party payers as the principal buyers of health care services and would be more likely to act as agents for their patients rather than for an institutional bureaucracy.

7. **Giving Patients More Control over Insured Services.** Every group health insurance plan includes some services and providers and excludes others. But the preferences of the group may not necessarily be those of the individual. In addition, state legislators are increasingly imposing their views on private group policies through mandated health insurance benefit laws. To the extent that individuals are self-insured, they could make such decisions for themselves.

8. **Enjoying the Advantages of a Competitive Medical Marketplace.** Patients who enter hospitals can neither obtain a price in advance nor understand the charges afterward. The evidence suggests that these problems have been created by our system of third-party payment and are not natural phenomena of the marketplace. When patients pay with their own money (as for cosmetic surgery in the United States and most routine surgery at private hospitals in Britain), they usually get a package price in advance and can engage in comparison shopping.

9. **Enjoying the Advantages of Real Health Insurance.** Because health insurance today is largely prepayment for consumption of medical care, people with preexisting health problems
often cannot buy insurance to cover other health risks. Medisave accounts would encourage a market for genuine catastrophic health insurance and would make such insurance available to more people.

10. **Expanding the Benefits of Self-Insurance over Time.** The funds in most Medisave accounts would grow over time, thereby enabling people to choose higher deductible policies and thus rely less on third-party insurers and increase their control over their health care dollars.

11. **Creating Incentives for Better Lifestyle Choices.** Because Medisave accounts would last over an individual’s entire life, they would allow people to engage in lifetime planning and act on the knowledge that health and medical expenses are related to their lifestyle choices. People would bear more of the costs of their bad decisions and reap more of the benefits of their good ones. Those who don’t smoke, eat and drink in moderation, refrain from drug use, and otherwise engage in safe conduct would realize financial rewards for their behavior.

12. **Expanding Health Insurance Options during Retirement.** Medisave accounts would eventually become an important source of funds from which to purchase health insurance or make direct payments for medical expenses not covered by Medicare during retirement. Such funds would help America solve the growing problem of long-term care for the elderly.

**Using Medisave Accounts to Lower the Administrative Costs of Health Insurance**

Health insurance not only creates perverse incentives, but its overuse also leads to high and unnecessary administrative costs. For example, the cost of marketing and administering private health insurance averages between 11 and 12 percent of premiums.\(^{17}\) A study by the American Medical Association has estimated that a physician spends six minutes on each claim and the physician’s staff spends one hour on it, and also that physicians who contract

\(^{17}\)According to estimates by Hay/Huggins Company, the “load factor” for private health insurance ranges from 5.5 percent for groups of 10,000 or more to 40 percent for groups of fewer than five people. See Uwe E. Reinhardt, “Breaking American Health Policy Gridlock,” *Health Affairs* (Summer 1991), exhibit 1, p. 100.
with outside billing services pay about $8 per claim. Medisave accounts offer a way of cutting these costs dramatically while at the same time maintaining—and even improving—the quality of care.

**Lowering Costs with Health Care Debit Cards**

A general system of Medisave accounts would lead naturally to the use of health care debit cards. Patients could pay for physician visits by using their cards, just as people now pay for merchandise at retail stores. Several health care debit card companies already exist, including Pulse Card, headquartered in Kansas City, Kansas, and Security Plus, headquartered in Newport Beach, California.

With an increase in volume and with increased competition, the administrative costs of using health care debit cards would be quite low, relative to the cost of using third-party payers. Currently, the overhead cost for credit card companies is as low as 1.29 percent. Moreover, for most transactions between patients and physicians, that would be the only administrative cost other than paperwork deemed necessary for purely medical reasons. Private and public insurers would not need additional paperwork unless total costs exceeded high patient deductibles.

**Health Care Debit Cards and Medical Records**

Health care debit cards could be combined with another technological innovation to reduce other costs and improve the quality of care. Several companies are experimenting with technology that would put a patient’s entire medical record on a credit card. That would give physicians immediate access to each patient’s complete medical history. Putting medical records on a credit card could be costly. But it might be less costly than the current system under which physicians often treat patients about one-third of the time without access to their records.

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20Currently, there are three competing technologies: magnetic stripe cards, smart cards (with integrated circuits), and optical memory (laser) cards. See C. Peter Waegemann, “Patient Cards—The Promise of the Future?” Medical Practice Management (Spring 1990), pp. 264–68.
21Ibid., p. 264.
The Benefits of the Canadian System without the Costs

Advocates of the Canadian system of national health insurance cite two principal benefits: (1) to receive care, patients entering the health care system need produce only a national health insurance card and (2) the administrative costs of the system are lower because paperwork is reduced and other costs, such as marketing, are eliminated.

Against these advantages, there are severe disadvantages. Because patients are actually spending other people's money when they consume free health care, the potential demand is unlimited and Canadian provincial governments control costs by limiting technology and forcing physicians and hospitals to ration health care. As Canadian waiting lists grow longer, there are increasing reports of unnecessary patient deaths and increasing numbers of Canadians crossing the border for U.S. medical care. In addition, because of the perverse incentives the system creates for providers, physicians often overprovide some services and hospital managers try to avoid the costs of acute care by housing chronic patients who use the hospitals as nursing homes (see discussion in chapter 17).

A system of Medisave accounts plus health care debit cards could produce the benefits of the Canadian system without the adverse side effects. A valid health care debit card would be proof that a patient could pay small medical bills and had third-party insurance to pay large ones. Unlike Canadians, however, U.S. patients using debit cards would have strong incentives to purchase care prudently because they would be spending their own money.

A Ballpark Estimate of the Economic Effects of Medisave Accounts

Various studies have compared administrative costs of health insurance in the United States with those of Canada's national health insurance program. For example, Table 8.5 shows three

22For example, one study claimed that administrative costs in the United States were between 19.3 percent and 24.1 percent of total health care spending and accounted for more than half the difference in cost between the U.S. and Canadian systems. See Steffie Woolhandler and David Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," New England Journal of Medicine 324, no. 18 (May 2, 1991): 1253-58. See also a critique of the study's methodology by the Health Insurance Association of America in Medical Benefits 8, no. 10 (May 30, 1991): 5. In another study, a national health insurance advocacy group, Citizen Fund, claimed that 33.5 cents of every dollar spent by private health insurance was for overhead expenses. See Richard Koenig, 'Insurers' Overhead
estimates of the annual administrative savings that could be realized by adopting the Canadian system, as well as an estimate of the costs of eliminating out-of-pocket charges. The potential savings in administrative costs range from a Lewin/ICF estimate of $34 billion to a General Accounting Office (GAO) estimate of $67 billion.\(^23\) However, the effect of eliminating all deductibles and copayments swamps these savings and leads to a net increase in costs.

We believe the estimates of potential savings from reduced administrative costs are much too high for three reasons. First, government accounting practices always lead to underestimates of the real cost of government provision of goods and services.\(^24\) Second, the estimates completely ignore all indirect costs (for example, the costs of rationing and of physician and hospital responses to perverse incentives) caused by Canada's method of paying for health care. Third, many of the administrative activities in the U.S. health care system are not designed merely to control spending; they also are designed to prevent inappropriate medical care and maintain high quality. The United States is not likely to follow the Canadian practice of giving hospitals global budgets and forcing physicians to ration health care with few questions asked. (These issues are considered more fully in chapter 17.)

Nonetheless, Table 8.5 is interesting. What the GAO calculates as the rock-bottom cost of administering a health care system is probably high when compared with a system of Medisave accounts and health care debit cards. We have used the GAO method to estimate the potential reduction in administrative costs under a

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Table 8.5

ESTIMATES OF THE ECONOMIC EFFECTS OF ADOPTING THE CANADIAN SYSTEM IN THE UNITED STATES

<table>
<thead>
<tr>
<th></th>
<th>Lewin/ICF</th>
<th>Physicians for a National Health Program</th>
<th>General Accounting Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings in administrative costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance overhead</td>
<td>−$22</td>
<td>−$27</td>
<td>−$34</td>
</tr>
<tr>
<td>Physician administrative expenses</td>
<td>−1</td>
<td>−9</td>
<td>−15</td>
</tr>
<tr>
<td>Hospital administrative expenses</td>
<td>−11</td>
<td>−31</td>
<td>−18</td>
</tr>
<tr>
<td>Total decrease in administrative costs</td>
<td>−$34</td>
<td>−$57</td>
<td>−$67</td>
</tr>
<tr>
<td>Expansion of coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For the currently insured (based on Rand estimate)¹</td>
<td>+$54</td>
<td>+$54</td>
<td>+$54</td>
</tr>
<tr>
<td>For the currently uninsured (based on Rand estimate)¹</td>
<td>+19</td>
<td>+19</td>
<td>+19</td>
</tr>
<tr>
<td>Total increase resulting from coverage expansion</td>
<td>+73</td>
<td>+73</td>
<td>+73</td>
</tr>
<tr>
<td>Total net effect</td>
<td>+$39</td>
<td>+$16</td>
<td>+$6</td>
</tr>
</tbody>
</table>


¹Based on GAO estimates for increased hospital spending and GAO estimates increased to reflect the Rand Corporation results for physician spending.
Table 8.6
ECONOMIC EFFECTS OF COMBINING UNIVERSAL HEALTH INSURANCE WITH MEDISAVE ACCOUNTS AND HEALTH CARE DEBIT CARDS

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Change in Costs ($ Billion)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low Estimate</td>
</tr>
<tr>
<td>Savings in administrative costs&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Insurance overhead</td>
<td>$8</td>
</tr>
<tr>
<td>Physician administrative expenses</td>
<td>5</td>
</tr>
<tr>
<td>Hospital administrative expenses</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>-16</td>
</tr>
<tr>
<td>Coverage for the currently uninsured&lt;sup&gt;2&lt;/sup&gt;</td>
<td>12</td>
</tr>
<tr>
<td>Behavioral response&lt;sup&gt;3&lt;/sup&gt;</td>
<td>-90</td>
</tr>
<tr>
<td>Total net effect</td>
<td>-$94</td>
</tr>
</tbody>
</table>

<sup>1</sup>Based on GAO estimates of the potential savings in administrative costs with the following adjustments: For high estimate, one-half of GAO savings attained in reduced insurance overhead, two-thirds of savings attained in reduced physician administrative costs, and one-third of savings attained in reduced hospital administrative costs; for low estimate, one-half of those amounts. See General Accounting Office, Canadian Health Insurance: Lessons for the United States (June 1991), Table 5.1 (p. 63).

<sup>2</sup>Based on GAO and Lewin/ICF estimates. See J. Needleman et al., The Health Care Financing System and the Uninsured (Washington: Lewin/ICF, April 4, 1990), prepared for the Health Care Financing Administration.

<sup>3</sup>Based on Rand Corporation estimates. For high estimate, 23 percent reduction in total health care costs, excluding insurance overhead, research, and public health expenditures; for low estimate, spending is reduced by 45 percent for physicians and 10 percent for hospitals.

system of Medisave accounts and debit cards, and the Rand Corporation's method to estimate the likely reduction in health care spending if people had high-deductible health insurance. Table 8.6 shows the probable effects of a generalized system under which everyone (including Medicaid and Medicare patients) has third-party catastrophic insurance and uses health care debit cards, drawing on individual Medisave accounts to pay small medical bills. As the table shows, a system that combines catastrophic third-party insurance with Medisave accounts should reduce administrative

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Cost-Plus Finance and Low-Deductible Health Insurance

costs by as much as $33 billion. Because the presence of high deductibles would make patients more prudent purchasers of health care, total spending should go down by as much as $147 billion. After extending catastrophic health insurance to the currently uninsured, the net total savings are $168 billion, or almost one-fourth of what the United States now spends on health care.

Twenty Questions and Answers about Medisave Accounts

1. How would Medisave accounts be administered? Medisave accounts would be administered by qualified financial institutions in much the same way as individual retirement accounts (IRAs) are. Individuals could exercise choice over the investment of account balances, with the same restrictions on the types of instruments the accounts could own as now apply to IRAs.

2. How would funds from Medisave accounts be spent? The simplest method would be by debit card. Patients would use their debit cards to satisfy payment at the time medical services were rendered. At the end of each month, the account holders' statements would show recent expenses and account balances. No more paperwork would be needed than with any other credit card.

3. What would prevent fraud and abuse? To receive Medisave funds, a provider of medical services would have to be qualified under IRS rules. Qualifying should be a simple procedure, involving little more than the filing of a one-page form. But if IRS auditors discovered fraudulent behavior, the provider would lose the right to receive Medisave funds and would be subject to criminal penalties.

4. What types of services could be purchased with Medisave funds? Any type of expense considered a medical expense under current IRS rules would qualify. In general, the IRS has been fairly broad in its interpretation of what constitutes a medical expense. An unhealthy step in the wrong direction, however, was the IRS decision to disallow cosmetic surgery. There is no apparent reason why the removal of a disfiguring scar or a change in facial appearance that improves employability and self-esteem is any less important than an orthopedic operation that allows an individual to play a better game of tennis or polo.

5. What tax advantages would be created for Medisave deposits? Medisave deposits would receive the same tax treatment as health insurance premiums. Thus, under employer-provided health insurance plans, Medisave deposits would escape federal income taxes,
FICA taxes, and state and local income taxes. If the opportunity to receive a tax deduction or a tax credit for the purchase of health insurance were extended to individuals, their deposits to Medisave accounts would receive the same tax treatment. Medisave balances would grow tax free and would never be taxed if the funds were used to pay for medical care or purchase long-term care or long-term care insurance.

6. What about low-income families who cannot afford to make Medisave deposits? If low-income families can afford to buy health insurance, they can afford to make Medisave deposits, since the primary purpose of the Medisave option is to enable individuals to divide their normal health insurance costs into two parts: self-insurance and third-party insurance. Currently, no tax subsidy is available for people who purchase health insurance on their own. Health insurance would become more affordable for the currently uninsured if they could deduct some or all of the premiums from their taxable income. It would become even more affordable through a system of refundable tax credits, which would grant greater tax relief to low-income people.

7. How could individuals build up funds in their Medisave accounts? One way would be to choose a higher deductible insurance policy and deposit the premium savings in the Medisave account. For most people, a year or two of such deposits would exceed the amount of their insurance deductible. Young people and people in low-cost areas might be allowed to make even larger deposits. An alternative (which tends to be revenue-neutral for the federal government) would be to permit people to reduce the amount of their annual, tax-deductible contributions to IRAs, 401(k) plans, and other pensions and deposit the difference in a Medisave account.

8. What if medical expenses not covered by health insurance exceeded the balance in an individual’s Medisave account? One solution would be to establish a line of credit so that individuals could effectively borrow to pay medical expenses. Repayment would be made with future Medisave deposits or other personal funds. Another solution would be to adopt Singapore’s practice of permitting family members to share their Medisave funds. This concern would vanish as Medisave balances grew over time.

9. How would members of the same family manage their Medisave accounts? Because family members often are covered under the
same health insurance policy, it seems desirable to permit couples to own joint Medisave accounts and for parents to own family Medisave accounts. In those cases, more than one person could spend from a single account. But even if family members maintained separate accounts, that should not preclude the pooling of family resources to pay medical bills.

10. What about people who are already sick and have large medical obligations at the time the plan is started? Such people might be harmed by a sudden increase in the health insurance deductible unless transitional arrangements were made. Most would benefit from a high deductible in the long run but they might suffer financially at the outset. One solution is for employers to extend credit to employees who are especially disadvantaged, with the loan to be repaid from future Medisave contributions. Another solution is for employers to bear part of the burden of those expenses (in the case of special hardship) during the transition period.

11. What about people who have a catastrophic illness with large annual medical bills likely to last indefinitely into the future? Most of these people would be disadvantaged if they have an annual deductible. A better form of health insurance would be one with a per condition deductible, in which the deductible would be paid only once for an extended illness.

12. Are there circumstances under which individuals could withdraw Medisave funds for nonmedical expenses prior to retirement? A reasonable policy is to apply the same rules that now apply to tax-deferred savings plans (for example, IRAs and 401(k) plans). Thus, nonmedical withdrawals would be fully taxed and would face an additional 10 percent tax penalty.

13. How do we know people would not forgo needed medical care (including preventive care) in order to conserve their Medisave funds? We don’t. The theory behind Medisave accounts is that people should have a store of personal funds with which to purchase medical care. And because the money they spend would be their own, they would have strong incentives to make prudent decisions. Undoubtedly, some of their decisions would be wrong. But many decisions made under the current system also are wrong. Unlike the current system, people would at least have funds on hand with which to pay their share of medical bills. And, since
people would have an incentive to protect future account balances against future medical costs, some would certainly spend more on preventive health care. Because we cannot spend our entire GNP on health, health care has to be rationed in some way. The only alternative to national health insurance, with rationing decisions made by a health care bureaucracy, is self-rationing, with individuals making their own choices between money and medical services.

14. Given the increasing complexity of medical science, how can individuals possibly make wise decisions when spending their Medisave funds? One thing people can do is solicit advice from others who claim to have superior knowledge. For example, most large employers and practically all insurance companies have cost-management programs in which teams of experts make judgments about whether, when, and where medical procedures will be performed. These experienced professionals could play an important role in helping patients make decisions about complicated and expensive procedures. But the professionals’ role will be as advice givers only. We should let the experts advise and the patient decide. Moreover, the fact that individuals would maintain Medisave accounts would not preclude their taking advantage of employer-negotiated price discounts from providers or managed care programs.

15. Given the problems that major employers and insurance companies have in negotiating with hospitals, how can individual patients possibly do better? The reason large institutions have so much difficulty negotiating with hospitals is that the institution is not the patient. And the reason patients spending their own money would wield effective power is the same reason consumers wield power in every market—they can take their money and go elsewhere. Physicians, hospitals, and other health care providers would have considerable incentive to win their business. Moreover, Medisave accounts would not preclude individuals from using employers as bargaining agents.

16. What would happen to Medisave account balances at retirement? People should be able to roll over their Medisave funds into an IRA or some other pension fund. Thus, money not spent on medical care could be used, after taxes, to purchase other goods and services. Alternatively, Medisave balances could be maintained to purchase postretirement health care or long-term care or long-term care insurance.
17. What would prevent wealthy individuals from misusing Medisave accounts to shelter large amounts of tax-deferred income? An individual's total tax-advantaged expense for health insurance plus Medisave deposits could not exceed a reasonable amount. One definition of "reasonable" would be an annual Medisave deposit that would equal the deductible for a standard catastrophic health insurance policy.

18. What about people who join HMOs? They would have the same opportunities as those who join conventional, fee-for-service health insurance plans. Note that because many HMOs are now instituting deductibles, HMO members would have incentives to acquire Medisave accounts. Their HMO premiums plus their deposits to Medisave accounts could not exceed a reasonable amount, however.

19. Under employer-provided plans, would employees have a choice of deductibles? Peritting employees to make individual choices makes sense. Over time, different people would have different accumulations in their Medisave accounts and, quite likely, different preferences about health insurance deductibles. However, under current law, employers have the option of fashioning employee benefit plans, even though it is in their self-interest to create a plan that is most pleasing to employees, given the overall cost. As a practical political matter, it seems wise to continue that feature of the current system.

20. What would happen to flexible spending accounts now available to some employees? Medisave accounts would replace FSAs under employee benefits law. Currently, employees who make deposits to FSAs must use the money or lose it, typically within 12 months. Similar deposits made to Medisave accounts would have no such restrictions.
9. Cost-Plus Medicine and the Tax Law

Principally operating through the tax law, federal policy has shaped and molded employer-provided health insurance plans. In general, federal policy encourages and rewards first-dollar health insurance coverage and other wasteful, inefficient practices. At the same time, federal policy discourages reasonable attempts by employers to eliminate perverse incentives and reduce spiraling health care costs. To make matters worse, federal policy toward employer-provided health insurance is inextricably intertwined with federal policy toward other employee benefits, especially for large corporations. As a result, it is probably not possible to reform the health insurance system without reforming the entire employee benefits system.

Tax deductions for employee benefits totaled about $105 billion in 1990 and are expected to climb to $131 billion in 1992.¹ That is the amount of money not collected in taxes because employee benefits are excluded from taxable wages. On the average, for every dollar the government collects in personal income taxes, about 25 cents goes uncollected because of employee benefits. But for the exclusion for employee benefits, the marginal income tax rate faced by American workers could be 4 percentage points lower.² As a result, the “tax expenditure” for all employee benefits amounts to about $450 per year for every man, woman, and child in the country, or about $1,035 for every American family.

Ostensibly, these large tax subsidies for employee benefits exist because the federal government wants to promote general social goals. Yet, under the current system, those goals are not being met.

¹Estimate based on Special Analyses, Budget of the United States (1990), Table G-2, and “Estimates for Tax Expenditure in the Income Tax,” Budget of the United States for Fiscal Year 1992, Table XI-1.

²For example, people in the 15 percent income tax bracket could otherwise be in the 11 percent tax bracket; people in the 28 percent tax bracket could otherwise be in the 24 percent bracket, etc.
in a reasonable way. The system is inequitable, affecting different families in radically different ways. It creates a false sense of security by misleading workers about the size of their expected retirement benefits. It encourages waste and inefficiency in the medical marketplace, thereby contributing to spiraling health care costs.

Tax subsidies for employee benefits are distributed in a highly arbitrary way. For example, the tax expenditure for employer-provided health insurance alone is about $60 billion a year, or roughly $600 for every American family. But the current system subsidizes lavish health care plans for some workers, whereas others have no opportunity to receive the tax subsidy. Tax-deductible health insurance expenditures range from a high of $3,055 per worker in the automobile industry to as little as $793 for workers in retail trade. Although the auto workers' plans are fully deductible, self-employed individuals are allowed to deduct only 25 percent of their health insurance premiums, and even that deduction has an uncertain future. Unemployed workers and employees of firms that do not provide health insurance receive no tax subsidy for the health insurance they purchase.

In general, the problem of a large population of uninsured people is a creation of the tax law. Most of the 34 million Americans who lack health insurance have no opportunity to purchase it with pretax dollars. At the same time, current law encourages waste and imprudence among those who do have health insurance.

Federal Tax Law and Employee Benefits

Federal tax law has an enormous impact on the employee benefits plans of employers precisely because marginal tax rates are so high. Even a moderate wage earner in the U.S. economy gets to keep less than 70 cents out of each additional dollar earned. The federal income tax rate for this worker is 15 percent and the combined (employer plus employee) Social Security tax rate is 15.3 percent. Thus, federal taxes take 30.3 cents out of each additional dollar of

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Table 9.1
AFTERTAX VALUE OF A DOLLAR OF MONEY WAGES

<table>
<thead>
<tr>
<th>Federal Tax Category¹</th>
<th>Value with No State and Local Income Tax</th>
<th>Value with State and Local Income Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>FICA tax only</td>
<td>85¢</td>
<td>81¢²</td>
</tr>
<tr>
<td>FICA tax plus 15 percent income tax</td>
<td>70</td>
<td>64³</td>
</tr>
<tr>
<td>FICA tax plus 28 percent income tax</td>
<td>57</td>
<td>51³</td>
</tr>
</tbody>
</table>

¹Includes employer’s share of FICA taxes.
²State and local income tax rates equal 4 percent.
³State and local income tax rates equal 6 percent.

wages. If this employee faces a 6 percent state and local income tax, the marginal tax rate is 36.3 percent, leaving the employee with less than two-thirds of a dollar of wages in the form of take-home pay. As Table 9.1 shows, workers in the 28 percent federal income tax bracket face a marginal tax rate of 43.3 percent, leaving them with less than 57 cents in take-home pay out of each additional dollar of earnings. If state and local income taxes apply, the situation is much worse. Indeed, millions of American workers take home just about 50 cents of each additional dollar of earnings.

Such high tax rates give employers and employees strong incentives to replace wages with nontaxable benefits in employees’ compensation packages. Those incentives are irresistible if employees would have purchased the benefits anyway. But even if they would not have, federal tax law makes certain benefits very attractive. For example, Table 9.2 shows the value of health insurance benefits relative to the payment of a dollar of wages. For a worker in the 15 percent tax bracket, federal tax law makes a dollar of wages equivalent to $1.43 in health care benefits. For a worker in the 28 percent bracket, a dollar of wages is equivalent to $1.76 in health care benefits.⁵

⁵The value of the benefit equals 1/(1-t), where t is the marginal federal income tax rate plus the combined employer-employee Social Security payroll tax rate. For a worker in the 15 percent bracket, t = 0.15 + 0.153. For a worker in the 28 percent bracket, t = 0.28 + 0.153.
Table 9.2
RELATIVE VALUE OF A DOLLAR OF EMPLOYER-PROVIDED HEALTH INSURANCE BENEFITS

<table>
<thead>
<tr>
<th>Federal Tax Category</th>
<th>Value with No State and Local Income Tax</th>
<th>Value with State and Local Income Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>FICA tax only</td>
<td>$1.18</td>
<td>$1.24$^2</td>
</tr>
<tr>
<td>FICA tax plus 15</td>
<td>1.43</td>
<td>1.57$^3</td>
</tr>
<tr>
<td>percent income tax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FICA tax plus 28</td>
<td>1.76</td>
<td>1.97$^3</td>
</tr>
<tr>
<td>percent income tax</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$^1$Includes employer’s share of FICA taxes.
$^2$State and local income tax rate equals 4 percent.
$^3$State and local income tax rate equals 6 percent.

If an employer were to pay a worker in the 28 percent federal income tax bracket $1.76 in wages, the worker’s take-home pay would be only $1.00 after taxes. On the other hand, if the $1.76 is spent on nontaxed health care benefits, the worker gets $1.76 of benefits.

Nontaxed employee benefits become even more lucrative if workers face state and local taxes. Consider workers facing a 6 percent state and local income tax rate, for example. For a worker in the 15 percent federal income tax bracket, the combined effect of all taxes is to make a dollar of wages equivalent to $1.57 of employee benefits. For a worker in the 28 percent bracket, the combined effect of all taxes is to make a dollar of wages equivalent to $1.97 of benefits.

Table 9.2 also shows how much waste can be present in the purchase of health insurance and still allow health insurance to be preferable to wages. (See Figure 9.1.) For example, if an employer attempted to give a higher paid employee $1.97 in wages, the employee’s take-home pay would be only $1.00 after taxes. As a result, $1.97 spent on health insurance need only be worth $1.01 to be preferable to $1.97 of gross wages. Thus, 96 cents (or 49 percent of the premium) can represent pure waste and still leave health insurance more attractive than wages.

Given these incentives, it is small wonder that employers and employees respond. For example, on the average, workers in durable goods manufacturing receive employee benefits equal to 19
**Figure 9.1**

**How Much Waste Can Be Present in Health Insurance and Still Leave Health Insurance As Valuable As the Payment Of Wages?**

1. Low-wage employee faces a 15 percent FICA tax and a 4 percent state and local income tax.
2. Average-wage employee faces a 15 percent FICA tax, a 15 percent federal income tax, and a 6 percent state and local income tax.
3. Higher wage employee faces a 15 percent FICA tax, a 28 percent federal income tax, and a 6 percent state and local income tax.
4. Highest wage employee faced a 50 percent federal income tax and an 8 percent state and local income tax in 1980.

percent of earnings. For a manufacturing worker in the 28 percent tax bracket, that means that employee benefits are equal to about 25 percent of take-home pay.
Table 9.3
PERCENT OF EMPLOYEES WITH BENEFITS, 1988

<table>
<thead>
<tr>
<th>Employee Benefit</th>
<th>Medium &amp; Large Firms</th>
<th>Small Firms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health insurance</td>
<td>96.0%</td>
<td>74.7%</td>
</tr>
<tr>
<td>Life insurance</td>
<td>96.0</td>
<td>58.6</td>
</tr>
<tr>
<td>Retirement pension</td>
<td>91.0</td>
<td>43.3</td>
</tr>
<tr>
<td>Educational assistance</td>
<td>76.0</td>
<td>23.0</td>
</tr>
<tr>
<td>Long-term disability insurance</td>
<td>48.0</td>
<td>25.6</td>
</tr>
<tr>
<td>Child care</td>
<td>1.0</td>
<td>4.3</td>
</tr>
</tbody>
</table>

SOURCE: Employee Benefit Research Institute, *Employee Benefit Notes* 10, no. 12 (December 1989), Table 3.

How the Tax Law Discriminates against Small Firms

As Table 9.3 shows, employees of large firms are 29 percent more likely to have employer-provided health insurance and 64 percent more likely to have life insurance than are employees of small firms. Employees of large firms also are more than twice as likely to have a retirement pension and more than three times as likely to receive educational benefits. In general, small firms represent the fastest growing segment of the economy and are providing most of the new jobs. Nonetheless, employees of such firms are receiving the fewest tax subsidies for employee benefits.

Table 9.4 shows the distribution of employee benefits by industry. As the table illustrates, transportation and public utilities employees on the average receive $4,802 per year in nontaxed benefits, while retail employees receive only $1,161. That means that the tax subsidy for transportation and public utilities employees is more than four times greater. Why do small firms (and industries dominated by small firms) provide fewer employee benefits? One reason is that federal tax law governing employee benefits discriminates against small firms.

Interference with Labor Market Contracts

In general, the more competitive a market, the more essential it is that workers receive a compensation package equal to the value of what they produce. The smaller the firm, the more important is this principle. Workers with different skills must receive a different
Table 9.4
EMPLOYEE BENEFITS BY INDUSTRY

<table>
<thead>
<tr>
<th>Industry</th>
<th>Average Annual Earnings</th>
<th>Average Annual Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation and public utilities</td>
<td>$25,678</td>
<td>$4,802</td>
</tr>
<tr>
<td>Mining</td>
<td>29,022</td>
<td>4,527</td>
</tr>
<tr>
<td>Durable goods manufacturing</td>
<td>23,809</td>
<td>4,519</td>
</tr>
<tr>
<td>Construction</td>
<td>26,142</td>
<td>4,078</td>
</tr>
<tr>
<td>Nondurable goods manufacturing</td>
<td>20,307</td>
<td>2,692</td>
</tr>
<tr>
<td>Wholesale trade</td>
<td>20,406</td>
<td>2,408</td>
</tr>
<tr>
<td>Finance, insurance, and real estate</td>
<td>17,630</td>
<td>2,080</td>
</tr>
<tr>
<td>Services(^1)</td>
<td>15,746</td>
<td>1,968</td>
</tr>
<tr>
<td>Retail trade</td>
<td>9,839</td>
<td>1,161</td>
</tr>
</tbody>
</table>


\(^1\) Estimate based on the average employee benefit as a percentage of earnings (12.5 percent) for all other industries.

Total compensation, and the form of the compensation package must be the one most preferred by the worker. The easiest way to achieve this objective is for the employer and each employee to agree on the total amount of compensation and for the employee to choose the specifics (that is, how much in wages, how much in health insurance, etc.). Employee benefits law, however, is designed to prevent benefit packages from being tailored to individual needs. The philosophy implicit in employee benefits law is that all employees should receive the same benefit, and that employees should not be able to choose between taxable wages and nontaxed benefits. This approach to employee benefits is harmful for small firms in competitive markets.

Burdensome Administrative Costs and Unreasonable Compliance Rules

Because complying with the rules and regulations that govern employee benefits is so costly, many employee benefits programs
allowed under the tax code can be administered only by large firms, which can spread the costs over very large numbers of employees. Giving employees choices in a cafeteria of benefits, allowing them to pay their share of health insurance premiums with pretax dollars, and allowing them to pay their deductibles and copayments with pretax dollars through flexible spending accounts are just a few of the opportunities that high administrative costs keep out of reach of small firms.

The Two-Tier System

As a result of the discrimination against small businesses, America is developing a two-tier system with respect to health insurance, retirement pensions, and other benefits. On the one hand, some large companies provide cradle-to-grave benefits for each stage in a worker's life: marriage, pregnancy, child rearing, divorce, retirement, and death. Many large companies now offer day care and elder care for dependents, medical coverage for step-children in remarriages, and job search assistance for a spouse when a two-career couple relocates. On the other hand, about 18.5 million employees lack health insurance and 52 million lack a private pension.

Moreover, those who have the greatest benefits tend to have above-average incomes, and vice versa. As Table 9.4 shows, industries in which employees have the highest incomes are the industries that offer the highest benefits (both in absolute terms and as a percentage of income).

How the Tax Law Distorts Health Insurance Pricing in Large Firms

The original Blue Cross vision was of a system in which everyone is charged the same premium regardless of risk. In such a system, healthy people are overcharged, sicker people are undercharged, and individual health insurance premiums bear no relationship to the underlying cost of providing that insurance. In the 1990s, the

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7Employee Benefit Research Institute, Update: Americans without Health Insurance, EBRI Issue Brief no. 104 (July 1990), Table 5 (p. 12).
8Employee Benefit Research Institute, Pension Coverage and Benefit Entitlement: New Findings from 1988, EBRI Issue Brief no. 94 (September 1989), Table 1 (p. 7).
original Blue Cross vision of health insurance has largely vanished. Only a handful of Blue Cross plans still practice community rating, and even those usually vary their premiums by age. The philosophy still reigns, however, within large corporations.

Most large companies not only provide health insurance, they also adopt an artificial, internal pricing system under which all employees face the same premium, regardless of age, job task, or other indicators of health risk. For example, take the Foster Higgins estimate that employee health costs averaged $3,200 in 1990 and assume that a 60-year-old employee has four times the expected health care costs of a 20-year-old. As Table 9.5 shows, assigning the same premium to both results in a premium that—when compared with expected real costs—is $1,920 too high for the younger worker and $1,920 too low for the older worker.

If the employer pays the full premium, then it makes no real difference how individual premiums are assigned for accounting purposes. But most employers ask employees to pay part of the premium out of their gross wages, and the trend is to increase the employees' share. For example, Table 9.5 also shows what the employee's share of the premium would be if employees are asked to pay half the total premium ($1,600) out of wages. In this case, even though the 20-year-old employee pays only one-half the premium, the charge is still $320 higher than the real cost of the insurance.

A younger employee who must pay the employee's share of the premium with aftertax dollars has an incentive to forgo the coverage and keep the money, or search for a cheaper (more accurately priced) policy elsewhere. Even if employees can pay their share of the premium with pretax dollars, younger employees may still decide to forgo the employer's offer and buy a no-frills policy (for a cheaper price) with aftertax dollars. Thus, artificially charging all employees the same price encourages younger employees to forgo

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10 In 1990, 57 percent of employers required their employees to contribute an average of 22 percent of the costs of their health insurance coverage, and 80 percent required an average contribution of 29 percent for family coverage. See A. Foster Higgins & Co., pp. 11–12.
<table>
<thead>
<tr>
<th>Category</th>
<th>Cost for Employee Age 20</th>
<th>Cost for Employee Age 60</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same Premium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artificial premium</td>
<td>$3,200</td>
<td>$3,200</td>
<td>$6,400</td>
</tr>
<tr>
<td>Real cost</td>
<td>$-1,280</td>
<td>$-5,120</td>
<td>$-6,400</td>
</tr>
<tr>
<td>Difference</td>
<td>$+1,920</td>
<td>$-1,920</td>
<td>0</td>
</tr>
<tr>
<td>Employee Cost Sharing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real cost of total premium</td>
<td>$1,280</td>
<td>$5,120</td>
<td>$6,400</td>
</tr>
<tr>
<td>Employee's share of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>artificial premium (50%)</td>
<td>$-1,600</td>
<td>$-1,600</td>
<td>$-3,200</td>
</tr>
<tr>
<td>Net loss/gain to employee</td>
<td>$-320</td>
<td>$+3,520</td>
<td>$+3,200</td>
</tr>
</tbody>
</table>
coverage under their employers' plans. A similar argument applies to the purchase of employer-provided health insurance for employees' dependents.\textsuperscript{12}

One way to think about the U.S. economy in relation to that of other developed countries is to recognize that corporate employee benefits plans in the United States pursue many of the same ends that are pursued through political systems elsewhere. Whereas European countries charge tax prices unrelated to the real cost of the health insurance that government provides for any particular person, the U.S. corporation also charges a common premium unrelated to expected benefits. Our answer to the European welfare state is the corporate welfare state.

Because corporations are free to act differently, why don't they? One reason may be historical accident and inertia. Unquestionably, employers were encouraged to adopt internal community rating by Blue Cross and other insurers in the early days. Moreover, at the time when many large companies started their health benefits programs, the cost of insurance was so low that it was not cost-effective to spend much time, effort, and money trying to fit differential premiums to differences in employee risks. But now that health insurance costs are so high, why not change?

In a perfectly competitive market, each employee receives wages plus fringe benefits exactly equal to what the employee produces. But in imperfect labor markets, especially those regulated by tax law and employee benefits law, employers may find it in their self-interest to continue the current practice. For one thing, charging every employee the same premium helps create the appearance of equity. For another, employers may benefit when younger, lower paid employees (for whom wages are likely to be more important than fringe benefits) voluntarily forgo coverage. The fewer the number of participants in the company health plan, the lower the total cost. Employers may also gain because of the tax law.

Table 9.6 continues the example of Table 9.5, by comparing two different ways of charging health insurance premiums to employees: (1) premiums based on real actuarial costs and (2) an artificial, same-for-all premium. In both cases, we assume that the aftertax

\textsuperscript{12}This fact may help explain why one of the fast-growing segments of the market for individual and family policies is for dependents of employees.
<table>
<thead>
<tr>
<th>Category</th>
<th>Employee Age 20</th>
<th>Employee Age 60</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Real cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actuarially Fair Pricing</td>
<td>$1,280</td>
<td>$5,120</td>
<td>$6,400</td>
</tr>
<tr>
<td></td>
<td>Employee’s share (50%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>640</td>
<td>2,560</td>
<td>3,200</td>
</tr>
<tr>
<td></td>
<td>Gross wage needed to pay employee’s share after tax</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>918$^{1}$</td>
<td>4,515$^{2}$</td>
<td>5,433</td>
</tr>
<tr>
<td></td>
<td>Taxes on gross wage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>278$^{1}$</td>
<td>1,955$^{2}$</td>
<td>2,233</td>
</tr>
<tr>
<td>Artificial Pricing</td>
<td>$3,200</td>
<td>$3,200</td>
<td>$6,400</td>
</tr>
<tr>
<td></td>
<td>Artificial price</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,600</td>
<td>1,600</td>
<td>3,200</td>
</tr>
<tr>
<td></td>
<td>Gross wage needed to pay employee’s share after tax</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2,296$^{1}$</td>
<td>2,822$^{2}$</td>
<td>5,118</td>
</tr>
<tr>
<td></td>
<td>Taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>696$^{1}$</td>
<td>1,222$^{2}$</td>
<td>1,918</td>
</tr>
</tbody>
</table>

$^{1}$Assumes 15 percent income tax and 15.3 percent FICA tax.
$^{2}$Assumes 28 percent income tax and 15.3 percent FICA tax.
wage plus health insurance coverage is the same for the employees. Given that assumption, employees should be indifferent about the two options. However, less total tax will be paid if the company adopts artificial premiums. In this example, employees are assumed to pay one-half the premium with aftertax dollars. With actuarially fair pricing, employers will pay gross wages of $5,433, out of which $2,233 will be paid in taxes—leaving $3,200 to pay the employees’ share of premiums for the two workers. The older employee is assumed to be in a higher income tax bracket, however (28 percent as opposed to 15 percent). Accordingly, less total tax will be paid if the older employee is charged an artificially low premium (requiring a lower gross wage) and the younger employee an artificially high premium (requiring a higher gross wage). In this case, same-for-all premiums result in a tax savings of $315.

Although $315 may seem like a small sum, for a company with 1,000 employees that figure amounts to $315,000 a year. With 10,000 employees, the figure becomes $3.15 million. Of course, companies will not typically have only young and old workers, so the total savings will be smaller than indicated in these examples. Nonetheless, it seems clear that switching to a system of actuarially fair premiums would increase the tax burden for almost any large company and its employees in cases in which employees must pay their share of premiums with aftertax dollars. That is one way the tax law encourages the current system.

If employees are able to pay their share of premiums with pretax dollars, as an increasing number are, there are no tax advantages from artificial pricing for active employees. But if a company has retirees on the same plan, the tax law encourages artificial pricing in another way. If the 60-year-old in the previous example is retired, the retiree’s share of the premium must be paid with aftertax dollars even though active workers can pay their share of the premium with pretax dollars. In this case, actuarially fair premiums would cost the retiree an additional $960 (50% × $5,120 − $1,600). To pay this additional premium, a retiree in the 28 percent income tax bracket would need $1,333 in additional pretax pension income. Thus, artificial pricing enables the employer to give retirees a $1,333 benefit for a cost of only $960, saving $373 per retiree.

How the Tax Law Contributes to Escalating Health Care Costs

Almost nine out of ten Americans who have health insurance acquire it through an employer, and the type of health insurance
that employers provide responds to the incentives and obeys the regulations of the tax code. The following is a list of just four of the ways in which the tax law encourages waste and discourages prudence in the purchase of health care.

First, the tax law subsidizes overinsurance. In general, federal tax subsidies for employer-provided health insurance are unlimited. The more lavish the benefit, the greater the subsidy. Firms that choose scaled-down, no-frills health insurance are penalized with reduced tax subsidies.

Second, the tax law encourages first-dollar health insurance coverage. Under the current system, any medical bill paid by employer-provided health insurance is subsidized through the tax system. At the same time, no subsidy is available for those who save to pay small medical bills out-of-pocket.\(^\text{13}\)

Third, the tax law severs the relationship between health insurance benefits and employee wages. The easiest way for employers to escape the burden of rising health care costs is to let their employees choose whatever health insurance plan they prefer and to deduct the premium for each employee’s health insurance from that employee’s pretax salary. Health insurance would then become a dollar-for-dollar substitute for wages, and employees would enjoy maximum choice and still get the advantages of a tax subsidy for health insurance. Such an arrangement would also have other advantages. With a direct link between salary and health insurance premiums, employees would be more prudent about their policy choices. Those who want policies with no deductibles and all the bells and whistles, for example, would pay the full premium cost in the form of a salary reduction. Faced with this choice, employees are more likely to choose high-deductible, no-frills catastrophic insurance. In general, however, employee health insurance cannot be individualized in this way, even for large companies. Employee benefits law encourages (and in many cases requires) employers to adopt the same policy for all employees. Often, employees have no idea what the premiums are. In those cases where they are made

\(^{13}\)One exception is the ability to pay medical bills through flexible spending accounts (FSAs). This option is governed by a use-it-or-lose-it policy, however. In addition, medical expenses are tax deductible to the extent that they exceed 7.5 percent of income.
aware (for example, when they are asked to pay part of the premium), each is charged the same premium, regardless of age, sex, place of work, type of work, or any other factor that affects real premium costs. The upshot is that, for the individual employee, there is no relationship between the cost of employer-provided health insurance and personal take-home pay. Small wonder that employees of large companies demand lavish health care benefits. From the perspective of employees, there is no reason not to make such demands.

Fourth, the tax law penalizes cost-control efforts. Under the conventional health plans of most corporations, there is no direct relationship—for the individual employee—between salary and the value of health insurance benefits. Similarly, there is no relationship between salary and wasteful, imprudent health care purchases. In general, employees who act as prudent buyers of health care cannot reap any cash reward for doing so without tax penalty, thereby reflecting a use-it-or-lose-it national health policy. Employees also have no opportunity (under the tax law) to opt out of an employer plan and purchase a less expensive policy on their own.

How the Tax Law Is Contributing to the Rising Number of People Who Lack Health Insurance

One of the great ironies of employee benefits law is that, although it was designed to encourage the purchase of health insurance, some of its most perverse provisions are now causing an increasing number of people to be without health insurance. Because employers cannot individualize health insurance benefits, many are turning to other practices to control their health insurance costs, and those practices are causing an increasing number of people to be without insurance.

For example, an increasing number of smaller firms are responding to rising health insurance premiums by canceling their group policies. Often, employers give employees a bonus or a raise to compensate them for eliminating the health insurance benefit and to encourage them to purchase individual policies (with aftertax dollars) on their own. But, of course, many employees do not.

Many large firms are asking employees to pay (with aftertax dollars) a larger share of the premium. Some employers pay most of the premium for the employee, but ask employees to pay a much
larger share for their dependents. As a result, some employees opt out of the employer's group health insurance plan. More frequently, they drop coverage for their dependents. More than three million people who lack health insurance are dependents of employees who are themselves insured.  

**How the Tax Law Discourages Saving for Postretirement Medical Expenses**

One of the most frightening social problems we face as we move toward the next century is how to pay for retirement pensions and medical care for the elderly. Because both Social Security and Medicare are pay-as-you-go programs, tomorrow's obligations will have to be met almost totally by taxes on tomorrow's workers. The bill will be high (see chapter 13). Clearly, the need is to arrange a system in which the elderly can pay more of their own medical expenses and relieve future workers of an almost impossible burden. But for that to happen, there must be increased saving by today's workers to meet postretirement medical needs.

Although the federal government subsidizes spending on current medical needs to the tune of $60 billion per year, individuals have no opportunity to engage in tax-subsidized savings for postretirement medical needs. Corporations are also greatly constrained in their ability to put aside funds today for the postretirement health care expenses of their employees. As a result, the tax law discourages both individuals and employers from saving and investing today to pay for future health care.

**Principles That Should Guide Public Policy**

Given that our analysis of federal policy toward employee benefits in general and employer-provided health insurance in particular has been highly critical, we conclude this chapter by considering a good public policy toward employee benefits. The need for radical reform is urgent. That reform should be guided by the following seven principles.

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1. The tax subsidy for any employee benefit should be made available to all Americans on equal terms, regardless of the nature of employment. If there are valid social goals (health insurance, retirement pensions, day care, etc.) that merit special encouragement through use of the tax system, no taxpayer should receive more encouragement than any other at the same income level. All Americans should have equal access to tax subsidies, and that access should not be governed by one's employment.

2. All employee benefits should be individualized (a specific amount of money attributed to a specific employee), and each worker's annual employee benefits should be recorded as part of the employee's gross compensation. Few if any employees know the value or cost of the benefits they receive as individuals. That has at least four adverse consequences. First, the current system perpetuates the myth that employee benefits are gifts from employers, rather than something that employees have earned. Second, the system permits older workers (who usually make the decisions about employee benefits packages) to reap subsidies from younger workers in socially undesirable ways. Third, the system perpetuates a retirement pension and retirement health care system under which individuals often have no well-defined property rights in the promised benefit, and thus have no guarantee of receiving it. Fourth, the system encourages waste and inefficiency in health care because there often is no immediate and direct relationship between the individual worker's consumption of health care and take-home pay. These adverse consequences would be eliminated if workers knew the value of the benefits they receive and perceived the benefits to be an alternative to money wages.

3. All individuals should be allowed to make choices among tax-free benefits and should also be allowed to choose between nontaxed benefits and taxable income. Many large corporations now have flexible benefit programs, but small companies are still effectively precluded from operating such programs. Even in large firms, employees generally cannot choose between taxable income

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16In some cases, the value of group benefits is attributed to individual employees, but only after the benefit exceeds a certain amount. For example, for group life insurance coverage in excess of $50,000, the fair market value of the insurance benefit is treated as imputed income and the employee is taxed on that amount. No similar provision exists for group health insurance, however.
and nontaxed benefits. Such restrictions deny workers the opportunity to shape their tax-free benefit package to individual and family needs.

4. **The amount of tax subsidy available to any individual should be limited.** Under the current system, there are very few limits. For example, employers can spend an unlimited amount of money on employee health care plans and employer-provided day care with no tax penalty. The amount that can be spent on conventional pensions is—for all practical purposes—unlimited for most employees. Thus, people in some sectors of the economy have access to a blank check drawn on the U.S. Treasury, but millions of others do not.

5. **Public policy should encourage personal and portable benefits.** Employee benefits are almost always tied to place of employment. In general, employees who switch jobs are removed from the health insurance policy of the previous employer and must face the problem of getting a new insurance policy at the new job. Often, such changes cause great personal hardship for the employee. This situation arises because health insurance policies are viewed as belonging to employers and not to employees—the people the insurance is supposed to benefit. To make matters worse, employees can lose tens of thousands of dollars in pension benefits as a result of a job change, even if they are fully vested. Employees almost always lose any postretirement medical benefits when they switch jobs. A sound employee benefit is one in which the benefit belongs to the employee, not to the employer. In addition, a dynamic, growing economy requires a flexible labor force. Public policy should encourage rather than discourage labor mobility.

6. **Public policy toward health insurance should encourage all reasonable efforts to control rising health care costs.** The current system encourages the purchase of too much of the wrong kind of health insurance, which results in wasteful spending. Almost any health care plan designed to give employees incentives to be prudent buyers in the medical marketplace suffers tax penalties. These features of our tax code are in urgent need of reform.

7. **Public policy should encourage private savings to fund medical expenses during a worker’s retirement years.** Although the current system provides lavish—and, in principle, unlimited—subsidies for employer spending on current health care needs, the
system offers virtually no incentive to save for health care during retirement. Individuals receive no tax subsidy for such savings and employers have very limited options. Such policies are unwise and imprudent.