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Passing the Health Care Buck

Who Pays the Hidden Cost?

Jack A. Meyer

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William R. Johnson
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JACK A. MEYER

1
Overview

Rapidly increasing health care costs are generating a phenomenon known as "cost shift." Shortfalls in Medicare and Medicaid reimbursement of doctors and hospitals have led health care providers to shift unreimbursed costs of serving uninsured patients and government beneficiaries to private sector bill payers.

This study defines the cost shift as a tax, a hidden subsidy of uninsured people and Medicare and Medicaid recipients by private sector payers. The tax is a symptom of the underlying problem of government's unwillingness or financial inability to pay either its fair share of the cost of uncompensated care or the full cost of providing what it has promised. The private sector cannot escape paying this subsidy one way or another unless access to hospital care is reduced, Medicare benefits are cut, or incentives to increase cost consciousness are greatly strengthened. In brief, cost shifting is cost sharing: the employed, insured population shares the costs of care to the poor, unemployed, and elderly.

This study analyzes the merits of the following alternative ways to *finance* the Medicare/Medicaid payment shortfall:

- continuation of cost shifting, either *implicitly* as at present or *explicitly* as an excise tax
- an increase in the payroll tax
- an increase in personal income taxes
- a cap on the current open-ended tax subsidy for the purchase of health insurance

This study concludes that continuing to finance the shortfall through cost shifting is more efficient, but less equitable than the alternatives of explicit taxation. In particular, switching from cost shifting to either income tax or payroll tax financing would add about $700 million to the total tax burden. This is equivalent to about 14 percent of an estimated shortfall of $5 billion. Financing the shortfall through an excise tax on patients with insurance, an explicit form of cost shifting, would also add less to the tax burden than other forms of direct taxation.

An income or payroll tax would be more nearly equitable than the cost shift, because it would put the greatest burden on high-income households. Estimates presented in this study show that the top 60 percent of households by income would bear a somewhat lower proportion of the Medicare/Medicaid subsidy through cost shifting (83 percent) than they would bear with payroll tax financing (89 percent). Further, the most progressive of the alternative methods are the ceiling on the open-ended federal tax subsidy and an increase in the federal income tax. Under federal income tax financing of the Medicare shortfall, for example, the top three income quintiles would pay an estimated 95 percent. The tax subsidy cap, like the excise tax, could also be expected to dampen use of health services. More refined estimates of the distribution of the payment of the cost-shift subsidy by income quintile would probably yield slightly different results, but the relationships among the various alternatives would not change much.

Another alternative to cost shifting—an all-payers system, properly termed mandatory rate setting—is evaluated and found wanting. It does nothing to fix the financing problem and in fact is itself a bizarre form of cost shifting. To generate meaningful savings, a rate-setting program would have to shift costs back to Medicare, which is already on the verge of bankruptcy, or to hospitals. Hospital expenditures are growing not because hospitals can extract monopoly profits—margins average about 3 percent of revenues—but because hospitals are increasingly using sophisticated technology and because the rate of admissions among the elderly is rising. A clampdown on hospital rates thus would force hospitals to choose between major service cutbacks and eventual bankruptcy.

Service cutbacks in response to the preferences of cost-conscious patients, employers, and physicians might improve the value of hospital care received per dollar spent and therefore should not per se be discouraged. By contrast, service cutbacks in response to a central rate-setting authority would fail to improve consumer welfare. A rate-setting agency cannot know where to strike the right balance between cost and quality, nor can it possibly accommodate the wide diversity of patient preferences. Another perverse effect of rate setting is that it obscures from public view the need to balance costs against medical benefits.

Thus the public will react angrily against regulatory actions that appear to deny them something they want. As a result, the rate-setting agency's authority to control hospital costs will be sharply cut back, or people who want better care than the controlled hospitals can afford will abandon them in droves. The ironic, and unfortunate,

result will be a widening gap between levels of care to people in different income classes.

The fundamental difficulty is that as patients we want it all; as taxpayers and premium payers, we do not want to pay for wanting it all. To minimize this inherent conflict, fundamental reforms are required that embody the principles of choice, awareness of limits, and consumer sovereignty. The following changes in government policy would, I believe, promote these principles:

- Place a ceiling on the chief open-ended tax subsidy for health care: the tax-free status of employer contributions to employee health insurance.
- Build a protection against expenses associated with catastrophic illness into Medicare, combined with a greater measure of cost sharing for routine services.
- Adopt a prospective payment for Medicare on a temporary, one-year basis, followed by the conversion of Medicare to a program of premium subsidies to be used for Medicare coverage or any qualified alternative plan (not just health maintenance organizations).
- Continue the process of deregulation in areas such as certificates of need and flexibility for states under Medicaid.
- Use existing antitrust law to encourage fair competition among alternative health care plans and providers.

Even if these reforms were adopted, it might still turn out that what society is willing to pay for is less than what individuals want as patients. This outcome is plausible because health care spending is highly concentrated, and no one wants to deny care to someone who is really sick. If, however, reducing hospital expenditure growth becomes a national priority, high-cost users can no longer be considered off limits. Difficult decisions regarding access to the most advanced health care available will be unavoidable. Under this circumstance, the key issue will be whether rationing authority is dispersed or centralized. The reforms I propose would preserve a pluralistic rationing system.

In the years ahead, health care spending will be driven upward by the growing elderly population and rapid advances in technology. An improved payment mechanism and greater incentives for consumers and providers to be cost conscious would help to isolate and reduce the portion of spending increases where costs exceed benefits. These reforms will attenuate, but not eliminate, the need to trim benefits or raise taxes so that our vital commitments to the elderly and the poor can be met in future years.

2
The Nature of the Cost Shift

In recent years a yawning gap has opened between the actual cost of serving a Medicare or Medicaid patient and the reimbursement a provider can expect from government for this service. The gap has arisen because government does not shoulder a portion of the costs of serving people who are ineligible for government programs yet cannot pay their bills, nor does it pay all the costs for such functions as research and teaching, which benefit all patients. Furthermore, even the direct costs of meeting the hospital needs of Medicare and Medicaid patients are reimbursed by government at rates that fall well short of full economic costs. For example, Medicare will pay hospitals only for a pro rata share of depreciation based on an asset's original cost, which is far below the asset's replacement cost.

The shortfall in Medicare and Medicaid reimbursement has led doctors and hospitals to shift the unreimbursed costs of serving uninsured persons and government beneficiaries to private sector payers. The shift occurs when hospitals charge some patients more for the same service than they charge others. People who pay hospital bills themselves, or are insured either by a commercial insurance company or directly by an employer, pay more for the same service than Medicare and Medicaid beneficiaries. Payments to hospitals by Blue Cross/Blue Shield plans seem to fall somewhere between government reimbursement and payments by commercial insurers. Simply put, through the cost shift, private patients subsidize uninsured persons and public program beneficiaries.

The Medicare/Medicaid payment shortfall is likely to increase in the future. According to a recent Congressional Budget Office (CBO) study, "Medicare will constitute 10.0 percent of the budget by 1988 and the HI [health insurance] trust fund will be exhausted by late 1987. . . . HI deficits are not temporary but grow rapidly. By 1995, annual outlays will exceed payroll tax revenues by about two thirds."[1] Simply put, unless long-term financing reforms are made that reduce demand for hospital services by government program beneficiaries or increase revenues, or both, hospitals will increasingly be forced either to reduce quality of care and access or to shift costs.

It is not only Medicare and Medicaid that pay less than private commercial insurers. Blue Cross also enjoys a differential in many areas. More than half the sixty-nine Blue Cross plans nationally have negotiated hospital discounts, many of which range from 10 to 20 percent. State regulations in New York actually link Blue Cross rates to Medicaid, resulting in an average statewide discount of 30 percent.

Each cost payer is largely immune from the effect of other cost payers' actions to limit costs. Blue Cross is not affected as much by Medicare or Medicaid reimbursement limits as are payers that do not have their own discounts. The size of the differential between the cost and the charge to payers depends also on the proportion of cost-paying patients. Increases in that proportion will increase the differential, as a larger shortfall must be met by relatively fewer charge-paying patients. Thus charge payers complain that they pay a particularly inequitable hidden tax that actually increases as their share of patients declines.

Several arguments can be advanced to justify preferential treatment of certain payers. It may be less costly for hospitals to provide care to patients insured by particular payers, generally because of savings in administrative costs. A study of differential hospital reimbursement by Lewin and Associates found material cost differences among payer classes in business office, accounting, medical records, social services, nursing services, working capital, and collection–bad debt costs.[2] Feldman and Greenberg, however, concluded that there are not substantial differences in cost by payment source. After surveying the literature on the sources of Blue Cross discounts, these authors conclude that "a discount of roughly 0 to 5 percent may be justified by financial savings."[3]

It is also argued that payers who provide comprehensive coverage —sometimes subsidized—reduce hospitals' bad debts and the amount of charity care they must provide. Therefore, the argument goes, these payers should not have to subsidize bad debts and charity care for any patients but their own. This leaves unanswered the question of who should pay for the uninsured.

The case against cost shifting is put bluntly by the commercial insurers. They describe the system of hospital reimbursement as preferential pricing whereby hospitals get what revenues they can from the payers over whom they have the least control, Medicare and Medicaid and many of the Blue Cross/Blue Shield plans, and demand as much as necessary from those over whom they have the most leverage, the commercial charge payers. The commercial insurers argue that this system defeats attempts at systemwide cost containment by giving providers no incentives to be more efficient and to

contain costs. According to this view, the existing system also causes large operating losses for those hospitals with few charge-paying patients and stifles competition within the health care market by putting commercial insurers and public hospitals at a competitive disadvantage.

The response by the commercial health industry is to call for an "all-payers" policy, whereby the states would enforce equitable payment rules for all patients. This is another name for mandatory price controls on hospitals, commonly referred to as state rate setting.

To date, analysis of the cost shift has been dominated by one theme: the cost shift is unfair and should be eliminated by enactment of an all-payers system. This study expands the scope of analysis of the cost-shift issue to encompass several other themes. After sketching the dimensions of the cost-shift problem, I compare the cost shift to the full range of other ways whereby the private sector can cope with the Medicare/Medicaid payment shortfall. Specifically, the cost shift is compared to two other alternatives: more direct forms of taxation and the all-payers system. The study also offers a blueprint for reform of the health care financing system. The recommendations offered are intended to relieve underlying problems driving rapidly rising health care costs, rather than merely to shift the burden of such problems to the private sector.

Notes

1. Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options,* February 1983, p. 101.

2. Lewin and Associates, Inc., "Differential Reimbursement of Hospitals" (Washington, D.C.), September 1981, study prepared for the Health Care Finance Administration.

3. Roger Feldman and Warren Greenberg, "The Relation between the Blue Cross Market Share and the Blue Cross 'Discount' on Hospital Charges; Reply to Alvin Headen," *Journal of Risk and Insurance,* April 1982.

3
Dimensions of the Cost Shift

The existence of a cost shift is acknowledged by nearly everyone familiar with hospital reimbursement, but few attempts have been made to quantify the problem. The best-known attempt was made by the Health Insurance Association of America (HIAA) in October 1981. The results, summarized in table 1, show the total shortfall in government payments. Because there is a one- to two-year time lag in reporting data, projections were made for 1980 and 1981 using the average annual rate of increase in earlier years.

Another way of viewing the cost shift from the public to the private sector is to look at the difference between public and private payments to hospitals per adjusted patient day, as illustrated in table 2. The HIAA calculations show dramatic increases in the per diem differential as well as in the total shortfall since 1975.

It is instructive to consider other attempts to calculate the size of the cost shift from public to private payers. Frank Sloan and Edmund Becker used data from the American Hospital Association's reimbursement survey that were not available to the HIAA, although their methodology was similar. Using the concept of each payer's "fair share" of total payments to hospitals (defined as the proportion of total hospital gross charges or "output" received by patients in that payer category), they compared fair share with actual payments. They found that Medicare and Medicaid paid only about four-fifths of charges while commercially insured patients paid nearly full charges. Their estimate of the total shortfall in Medicare and Medicaid payments was about $1 billion less than the HIAA's estimate of the public-to-private cost shift for that year, but it substantially supports the conclusion that Medicare and Medicaid have limited their own payments at the expense of commercially insured patients.[1]

An earlier analysis of the cost shift was made by Stephen Caulfield of the Government Research Corporation in June 1981. Like HIAA, he lacked the benefit of the later AHA reimbursement survey

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This chapter was written by Sean Sullivan, senior analyst at the American Enterprise Institute.

TABLE 1

TOTAL GOVERNMENT PAYMENT SHORTFALL IN SHORT-TERM HOSPITALS, 1975–1981
(billions of dollars)

Year	*Shortfall*
1975	1.1
1976	1.3
1977	1.8
1978	2.4
1979	3.0
1980	3.9 (est.)
1981	4.8 (est.)

SOURCE: Health Insurance Association of America, *Hospital Cost Shifting: The Hidden Tax*, 1981.

data used by Sloan and Becker. He approached the analysis somewhat differently from HIAA, starting with the premise that charge-paying patients were subsidizing other payers at a rate of 12 to 13 percent (arrived at by subtracting a 2 to 3 percent operating capital requirement from the 15 percent difference between gross charges and gross expenses). Using hospital days by payer as a proxy for cost, Caulfield calculated the private insurance share of total hospital expenditures (excluding federal hospitals) as 45 percent of $72.5 billion—or $32.6 billion. Of that subtotal, he estimated that Blue Cross plans paid for about $8.9 billion on a cost basis (Blue Cross accounted for about 45 percent of private-pay revenues, with 61 percent of its claims

TABLE 2

AVERAGE PAYMENT PER ADJUSTED PATIENT DAY FOR GOVERNMENT AND PRIVATE PATIENTS IN SHORT-TERM HOSPITALS, 1975–1979
(dollars)

Year	*Government*	*Private*	*Difference*
1975	125	137	12
1976	141	160	19
1977	160	185	25
1978	178	211	33
1979	198	239	41

SOURCE: Health Insurance Association of America, *Hospital Cost Shifting: The Hidden Tax*.

volume paid on a cost basis). This left about $23.7 billion of expenditures by charge payers subject to the 12–13 percent differential. For 1979, then, Caulfield found the cost shift to range between $2.84 billion and $3.08 billion, which is nearly the same as the HIAA estimate for that year.

Whether one prefers the later estimate of Sloan and Becker or the earlier ones made by HIAA and Caulfield, the conclusion remains that public payers—Medicare and Medicaid—shift a large chunk of hospital costs onto commercial insurance payers, apparently in the range of $2–3 billion in 1979. Some would also say that the most significant finding by HIAA is the increase in the cost shift—from about $1 billion in 1975 to $3 billion in 1979. If the pattern of growth in the cost shift, as estimated for the period of the late 1970s, has held in recent years, the magnitude of the shift would be in the range of $6–7 billion in 1983.

Note

1. Frank A. Sloan and Edmund R. Becker, "Cross Subsidies and Payment for Hospital Care," *Journal of Health Policy, Politics, and Law*, forthcoming.

4

The Cost Shift Compared with the Income and Payroll Taxes

One way the government can finance part of the cost of Medicare or Medicaid is by not covering all costs attributable to these patients, thereby forcing hospitals to cover these costs in some other way. Cost shifting is compared here with other, more conventional financing methods.

I begin by contrasting cost shifting with reliance on an expanded payroll tax or individual income tax to raise the same amount of money. It is crucial to understand that because the care of Medicare and Medicaid patients uses socially valuable resources, the cost of this care must be borne by the rest of society, whether *explicitly* as when government taxes to finance the full cost, or *implicitly*, as when hospitals shift the uncompensated costs of subsidized patients to other patients. Therefore, an analysis of each alternative mode of finance is an important part of the policy analysis of cost shifting.

The discussion that follows provides rough estimates of the effects of cost shifting as compared with two modes of tax finance. For the purpose of this analysis, suppose that the amount to be financed (the shortfall in Medicare and Medicaid payments) is $5 billion. The use of this figure, which corresponds to an estimate made by the Health Insurance Association of America, is illustrative. The analysis presented here would be the same if a somewhat higher or lower figure were used.

One crucial characteristic of any method of finance is its effect on households with different incomes. The greater the share of the total tax revenue (the $5 billion) paid by high-income households, the more the method of finance tends to equalize the distribution of economic resources across households—that is, the more "progressive" is the means of finance. I first present estimates, therefore, of the distribution of the financing burden across households. In making

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TABLE 3

CHARACTERISTICS OF HOUSEHOLDS IN DIFFERENT INCOME QUINTILES

Income Quintile	*Average Size*	*Percentage Shares of Income*	*Percentage of Income from Transfers*
1 (lowest)	1.6	6	62
2	2.5	12	37
3	3.1	17	19
4	3.3	23	12
5 (highest)	3.4	42	8

SOURCE: Edgar Browning and William Johnson *The Distribution of the Tax Burden* (Washington, D.C.: American Enterprise Institute, 1979); updated to reflect 1981 data.

these estimates, I assume that households do not change their economic behavior in response to higher hospital or insurance costs (in the case of cost shifting) or higher tax rates (in the case of tax financing). In reality, of course, households will change their economic behavior to some extent in response to changing taxes or prices in a way that creates an extra burden (called the "excess burden") of the financing method. The second section below takes up the question of this extra burden and its effect on the total financing burden levied on households of various income levels.

Simple Distributional Effects

To estimate the burden on households of these three financing alternatives, consider the population of U.S. households and unrelated individuals (single persons living alone) in 1981. We can array these households by income (including as income government transfers in cash and in kind) and divide them into quintiles. Table 3 describes some important characteristics of these quintile groups. Quintile 1 is the lowest income group and is made up largely of small households (an average of only 1.6 persons per household). These households rely heavily on government transfers for income, especially social security. The group with the highest income (quintile 5) has larger households and supplies much more labor to the market.

It is natural to assume that relying on the income tax to finance the Medicare/Medicaid shortfall will distribute the burden of any additional tax revenue in the same way as the current tax burden—that is, that if the highest-income quintile pays 60 percent of the

TABLE 4

DISTRIBUTION OF THE BURDEN OF ALTERNATIVE WAYS TO FINANCE THE MEDICARE PAYMENT SHORTFALL, BY INCOME QUINTILE

	Income Tax		*Payroll Tax*		*Cost Shifting*	
Income Quintile	Percent share (1)	($ millions) (2)	Percent share (3)	($ millions) (4)	Percent share (5)	($ millions) (6)
1 (lowest)	0.7	35	2.5	125	5.9	297
2	4.0	200	8.9	445	11.5	573
3	11.4	570	18.2	910	22.6	1,128
4	22.9	1,145	29.4	1,470	26.3	1,315
5 (highest)	61.1	3,055	41.0	2,050	33.7	1,687
Total	100.0	5,000	100.0	5,000	100.0	5,000

NOTE: Detail may not add to totals because of rounding.
SOURCE: See text.

federal individual income tax, it will pay 60 percent of the extra $5 billion needed to finance the shortfall. We assume that the scope but not the structure of the tax is changed to gather $5 billion more revenue. For the income tax, this could be accomplished by an equal percentage surcharge on the original tax payment; for the payroll tax, a simple increase in the tax rate would be one way to raise the equivalent revenue. While a payroll tax rate increase is the option analyzed here, it would also be possible to combine a somewhat smaller rate increase with a further increase in the taxable base. This step would make this option more progressive.

Estimates of the distribution of the individual income tax and payroll tax burdens in 1981 are shown in columns 1 and 3 of table 4.[1] The individual income tax is clearly progressive; that is, high-income households pay a larger share of this tax than they receive in income, so the average tax rises with income. The progressivity is due both to the progressivity of rates on taxable income and to the large amount of untaxed income received by low-income households (chiefly government transfers).

Payroll taxes, such as the social security tax, are commonly thought to be regressive since they tax earnings at a flat rate up to an earnings ceiling; hence, workers who earn more than the ceiling amount will pay a lower fraction of their earnings in payroll taxes. Yet, since low-income households receive a sizable part of their

income in the form of untaxed government transfers (see column 3 in table 3), the effective payroll tax rate is, in fact, greatest on middle-income households, not low-income households. As tables 3 and 4 show, quintiles 3 and 4 pay a larger share of the payroll tax (18.2 percent and 29.4 percent) than they receive in income (17 percent and 23 percent) and hence pay the highest rate of payroll tax.[2] Recent payroll tax changes have raised the ceiling on taxable earnings very high in relation to average earnings. Columns 2 and 4 of table 4 translate the percentage share burdens of both the income and payroll taxes into dollar amounts based on the presumed need to raise $5 billion in revenue.

As for the burden of cost shifting, a natural presumption is that cost shifting raises the hospital bills of all private patients (those using neither Medicare nor Medicaid) by the proportionate amount required to raise $5 billion. In other words, cost shifting acts like a tax on the hospital costs of private patients.[3] This price rise will then be spread to most households (even those not using hospital services) through higher hospitalization insurance premiums.[4] The burden of this cost shifting then falls on non-Medicare and non-Medicaid households in proportion to the sum of their hospital insurance premiums and their out-of-pocket expenses. This number will not necessarily be equal to hospital costs incurred, since insurance premiums for households in any economic class may be different from insured hospital expenses per household in that class.

Fortunately, there are data from the national health care expenditure survey on health insurance premiums per household, including employer-paid premiums and out-of-pocket hospital expenses per person for 1977.[5] These data are broken down by family income level. By using information on family size by income quintile, one can construct expected household payments for health insurance and out-of-pocket hospital expenses per household by income quintile.[6] The distribution of these expenses forms the basis for the distribution of the cost-shifting burden once two further adjustments are made.

First, one must account for the fact that the cost-shift burden on households covered by Medicare or Medicaid is likely to be far less than the burden on other households. Out-of-pocket hospital expenses and insurance premiums for households covered by Medicare and Medicaid are estimated to be 12 percent of the corresponding figures for uncovered households, that is, households whose hospital costs are not paid by Medicare or Medicaid.[7] The average expense for a typical household in any income class will then be a weighted average of the covered and uncovered households, the weights being the proportions of households in the income class that are covered and uncovered,

respectively. The cost-shifting burden for each income quintile will then be proportional to its weighted average relative to the weighted average for each of the other quintiles.

The second adjustment reflects the fact that some hospital bills are unpaid and these bad debts must be covered by a sort of private cost shifting. Using estimates of bad debts as a fraction of hospital revenues, and assuming that bad debts are heavily concentrated in the lowest two income quintiles, we can make a further adjustment by reducing the burden on lower-income households and increasing it on upper-income households.[8]

Columns 5 and 6 of table 4 present the estimates of the cost-shifting burden based on an equal burden among households not receiving Medicare or Medicaid. Comparison with the burden of tax finance reveals that cost shifting places a greater burden than either the payroll tax or the individual income tax on working-class and lower-middle-income households (quintiles 1, 2, and 3). By contrast, the individual income tax burdens the highest-income households the most. The payroll tax, currently the primary source of Medicare funding, falls somewhere between cost shifting and income taxes. Both of the adjustments made to the estimated burden of cost shifting are likely to lead to estimates of a higher burden on upper-income households. Hence, it is probably safe to conclude that while high-income households pay the greatest share of the Medicare payment shortfall under any financing alternative, their share is less under cost shifting than under either the income tax or payroll tax alternatives.

Excess Burden of Financing Alternatives

The calculations presented above assumed no change in consumers' behavior in response to the taxes or higher prices required to cover the Medicare/Medicaid shortfall. In reality, however, households may reduce their hospital use when prices rise through cost shifting or work less when taxes on earned income increase.

This altered behavior means that the total burden of the financing alternative may exceed the revenue collected in taxes or extra hospital charges. This extra or "excess burden" arises from the facts that cost shifting raises hospital prices above their cost and that taxes reduce a worker's after-tax earnings below his value to his employer. The excess burden takes the form of tax revenues lost when people work less in response to higher rates of taxation. The greater the distortion of economic behavior by the tax or the higher price of hospital care, the larger the excess burden.

TABLE 5

TOTAL BURDEN OF FINANCING ALTERNATIVES, INCLUDING EXCESS BURDEN

Income Quintile	*Income Tax ($ millions)*	*Payroll Tax ($ millions)*	*Cost Shifting ($ millions)*
1 (lowest)	27	143	298
2	228	507	574
3	650	1,037	1,131
4	1,305	1,676	1,318
5 (highest)	3,483	2,337	1,691
Total	5,700	5,700	5,012

NOTE: Detail may not add to totals because of rounding.
SOURCE: See text.

The excess burden of higher taxes on earnings depends on both the responsiveness of labor supply to changes in the after-tax reward to work and the current level of taxes on earnings.[9] In particular, the higher the marginal tax rate (the rate at which an extra dollar of income is taxed), the greater the excess burden. When all taxes are accounted for, the current U.S. tax system imposes marginal tax rates of between 40 and 55 percent on the earnings of a typical household.[10] Hence, the excess burden of more taxes on earned income (higher payroll or income taxes) will be significant.

Research on labor supply shows that households reduce their supply of labor about 1.5 percent for every 10 percent reduction in the after-tax wage rate, yielding an elasticity of about 0.15.[11] Our rough estimate is that the excess burden of extra taxes amounts to 14 percent of the tax revenue collected,[12] so that the total burden of raising taxes is about $5.7 billion. This is the total of the $5 billion extra tax revenue plus an excess burden of $0.7 billion ($5 billion × 14 percent). The total burden on each affected household is proportionately higher. This calculation is quite sensitive to the assumed marginal tax rates and elasticities, and could easily be twice or half the amount presented. Columns 1 and 2 in table 5 present the total burden calculations for both income taxes and payroll taxes.

The excess burden of cost shifting can be computed in a similar way by viewing cost shifting as a tax on hospital costs. The excess burden of a tax on hospital costs will be very small, since the excess burden depends crucially on the existing level of taxes on the commodity being taxed and there are no other taxes on hospital costs. Rough calculations yield an excess burden of about $12 million, or

about 0.25 percent of the revenue raised.[13] This number is very small compared with the excess burden of tax finance. It could even be argued that the true excess burden is smaller, since many economists feel that the tax exemption of employer-paid health insurance premiums leads to excess insurance and use of hospitals.[14] Though these computations are very rough, one can conclude with reasonable assurance that the excess burden of cost shifting is far less than the excess burden of tax increases, primarily because labor income is already heavily taxed and hospital costs and health insurance are very lightly taxed.

Unfortunately, one cannot make an unequivocal choice between tax finance and cost shifting to cover the Medicare/Medicaid shortfall. Although there are bound to be many sources of error in the precise calculations presented, it is safe to argue that cost shifting places a greater *share* of the burden on lower and middle-income housholds while direct taxation imposes the greatest *total* burden on all households, taken together. If the assumptions underlying the numbers in table 5 are correct, cost shifting imposes a greater burden on the poorest 60 percent of households than either form of tax finance, even when excess burdens are added in. Given the margin of error in these calculations, however, the computed burdens of payroll taxes and cost shifting on quintiles 2 and 3 might be judged roughly similar. Payroll taxes are, of course, the most likely tax financing alternative, since the Medicare program is currently funded largely through payroll taxes.

Notes

1. These estimates are based on estimates made for 1976 in Edgar Browning and William Johnson, *The Distribution of the Tax Burden* (Washington, D.C.: American Enterprise Institute, 1979), updated to reflect recent changes in the tax laws as well as the bracket creep caused by inflation. I have assumed that the basic structure of income remained constant from 1976 to 1981. Data for the updating come from *Economic Report of the President —1982* and Congressional Budget Office, *Financing Social Security* (1982).

2. Although the payroll tax is nominally divided into an employer's share and an employee's share, most economists agree that the employer's share is in fact "paid" by employees in the form of lower wages. My calculations reflect this common assumption.

3. In theory, it is possible that Medicare cost shifting could in part reduce the incomes of those who produce hospital services, to the extent that the market for those services is not competitive. That is, Medicare underpayment could be viewed as monopsony power countervailing the monopoly power of providers. Such monopoly power as does exist, how-

ever, is probably more prevalent among physicians than among hospital employees or suppliers; so I neglect this line of argument in my analysis.

4. Even if employers pay insurance premiums, it is logical to assume that workers' wages reflect the higher costs, just as with payroll taxes.

5. I am indebted to Gail Wilensky of the National Center for Health Services Research for making these data available. She is not responsible for the use to which they are put.

6. Health insurance premiums per household in 1977 were $522, $826, and $1,050 for households with incomes below $12,000, between $12,000 and $20,000, and above $20,000 respectively. Per capita out-of-pocket expenses were $161, $147, and $153 for these same income groups. The first group corresponds roughly to quintiles 1 and 2, the second group to quintiles 3 and 4, and the third group to quintile 5.

7. Data from the Health Care Financing Administration show that 12 percent of the hospital bills of Medicare recipients is paid by private insurance or out of pocket.

8. Bad debts amount to about 4.2 percent of hospital revenues. One would expect the $5 billion higher hospital bills under cost shifting to induce, therefore, $210 million in bad debts. I assume that $136 million (or 65 percent) of this $210 million is incurred by the bottom income quintile and that 25 percent and 10 percent are incurred by the second and third quintiles respectively. This $210 million shortfall is then made up by an equiproportionate increase in hospital bills.

9. In simplest terms, the excess burden is equal to the tax revenue lost by the government because higher tax rates reduce labor supply and hence the tax base. See Arnold Harberger, "Three Basic Postulates for Applied Welfare Economics," *Journal of Economic Literature*, September 1971.

10. This estimate comes from Browning and Johnson, *The Distribution of the Tax Burden*, updated to reflect recent tax changes. The rate is somewhat higher on low- and high-income households and lower for middle-income households. The high rate on low-income households comes from the implicit tax rate of transfer programs through which benefits fall as earnings rise.

11. Michael Keeley's survey of the labor supply literature finds an average compensated elasticity of 0.37 for nonexperimental studies and 0.16 for the experimental research. See Michael Keeley, *Labor Supply and Public Policy* (New York: Academic Press, Inc., 1981).

12. The derivation of the 14 percent figure is somewhat involved. Assume a marginal tax rate of 0.45, total labor income of $1,800 billion, and labor supply elasticity of 0.15. We seek the tax rate that will raise $5 billion more in revenue, which turns out to be 0.4532. The extra tax rate of 0.0032 applied to the tax base of $1,800 billion would raise $5.7 billion more revenue *if* labor supply did not change. But a tax rise from 0.45 to 0.4532 reduces after-tax wages by 0.58 percent (=0.0032/(1−0.45)),

which, in turn, reduces labor supply by 0.087 percent (=0.15 × 0.58). This is a reduction in labor income of $1.56 billion (= $1,800 billion × 0.00087), which reduces tax revenues (at a tax rate of 0.45) by $700 million. Hence, the net effect of the tax rate hike is to raise $5 billion more revenue (=$5.7 billion − 0.7 billion). The extra or excess burden of the higher tax rate is the revenue lost by the shrinkage of the tax base, or $700 million, which is 14 percent of the revenue raised.

13. I have assumed a price elasticity for hospital services of −0.1, based on a study by Joseph Newhouse, and total hospital costs of about $100 billion. See Joseph P. Newhouse, "The Demand for Medical Care Services: A Retrospective and Prospect," in Jáque Vander Gaag and Mark Perlman, eds., *Health, Economics, and Health Economics* (Leiden, The Netherlands: North Holland Publishing Co., 1981), p. 7.

14. See Martin Feldstein, "The Welfare Loss of Excessive Health Insurance," *Journal of Political Economy*, vol. 81, no. 2, part I, March/April 1973.

5

Other Financing Alternatives: Tax Subsidy Cap and an Excise Tax

A Cap on Tax Exclusion of Employer Premium Contributions

The previous section compared the efficiency and equity of financing a shortfall in Medicare reimbursement to health care providers through cost shifting with two alternative financing mechanisms: increased payroll taxes and increased federal income taxes. This section discusses a third alternative to current policy: limiting the tax subsidy associated with the purchase of health insurance and using the proceeds to increase Medicare payments on behalf of beneficiaries.

It is important to note that added revenue from a tax cap could be used in other ways. Medicaid coverage, for example, could be extended to working poor families or other low-income persons who are not categorically eligible for Medicaid. Short-term cost increases associated with converting Medicaid to a voucher-type program could be defrayed. The revenue, of course, could also be allowed to reduce the government deficit. The discussion here will not analyze all of these alternatives, but instead will focus on the comparative advantage of raising the money through a reduction in the chief health-related tax expenditure relative to other financing mechanisms.

The tax-free status of employer contributions to employee health insurance is estimated to drain $30.7 billion in revenues from government coffers in 1983.[1] An estimated $20.4 billion in federal income taxes is forgone as a result of this exclusion, while payroll taxes are $6.5 billion less and state income taxes $3.8 billion less than they would be if employer contributions were fully taxed.[2] Table 6 shows the potential revenue increases in 1983 associated with varying levels of a ceiling on this tax subsidy, as estimated by Gail Wilensky and Amy Taylor.

This table indicates that a tax subsidy "cap" of $1,800 per year for family policies ($150 per month) and $720 for individual policies would have raised total government revenues by an estimated $5.2 billion in 1983. This figure is roughly equal to the estimated $5 billion in cost shifting used for illustrative purposes in the previous section.

TABLE 6

NUMBER OF SUBSCRIBERS AFFECTED AND TOTAL INCREASED TAX LIABILITY FOR SPECIFIC LIMITATIONS ON TAX-FREE EMPLOYER CONTRIBUTIONS, 1983

Tax Exemption of Insurance Premiums	*Number of Subscribers Affected (thousands)*	*Total Increases ($ millions)* Federal income taxes	FICA[a]	State income taxes	All taxes[a]
None	61,575	20,443	6,465	3,818	30,726
$1,125 for family, $450 for individual policies	44,431	7,998	2,488	1,511	11,996
$1,800 for family, $720 for individual policies	23,497	3,454	1,057	658	5,169
$2,400 for family, $975 for individual policies	10,786	1,564	464	302	2,330

a. Includes employers' share of FICA.

SOURCE: National Center for Health Services Research, National Medical Care Expenditure Survey, unpublished data. This table is reprinted from Gail Wilensky and Amy Taylor, "Tax Expenditures and the Demand for Private Health Insurance," in Jack A. Meyer, ed., *Market Reforms in Health Care: Current Issues, New Directions, Strategic Decisions* (Washington, D.C.: American Enterprise Institute, 1983), p. 175.

Table 7 shows that the incidence of this tax increase would fall mainly on upper-income households, because most lower-income households either pay no taxes or do not receive employer contributions to health insurance exceeding the cap. Table 8 shows the absolute tax burden of this tax subsidy ceiling on households in different income groups. Table 9 compares the distribution of a tax increase for three different levels of the cap.

Although the incidence of a tighter tax cap would fall slightly more on the middle-income groups (that is, their share of the bill would be slightly greater) and slightly less on the upper-income groups, the alternative caps shown here are quite similar in terms of who would pay the bill. Under all three options, only about one-eighth of the tax increase would be borne by those with annual

TABLE 7

DISTRIBUTION OF INCREASED TAX BILL ASSOCIATED WITH TAX SUBSIDY CAP OF $1,800 ON FAMILY COVERAGE, $720 ON INDIVIDUAL COVERAGE, BY FAMILY INCOME
(percent)

Family Income (dollars)	*Percentage of Total Tax Bill*
1– 9,999	1.73
10,000–14,999	3.46
15,000–19,999	6.70
20,000–29,999	18.48
30,000–49,999	47.17
50,000 or more	22.45
Total	100.00

SOURCE: National Medical Care Expenditure Survey, National Center for Health Services Research. These figures calculated by the author are based on data presented in Taylor and Wilensky, "Tax Expenditures."

TABLE 8

DISTRIBUTION OF TAX BILL ASSOCIATED WITH TAX SUBSIDY CAP OF $1,800 ON FAMILY COVERAGE, $720 ON INDIVIDUAL COVERAGE, BY FAMILY INCOME, 1983

Family Income (dollars)	*Number of Subscribers Affected (thousands)*	*Percentage of Subscribers Affected*	*Average Increase in 1983 Total Taxes*[a]	*Increased Total Tax as Proportion of Family Income*[a]
1– 9,999	938	22	$ 86	0.0139
10,000–14,999	1,365	24	118	0.0096
15,000–19,999	2,306	31	135	0.0077
20,000–29,999	5,273	31	163	0.0064
30,000–49,999	9,335	40	235	0.0061
50,000 or more	4,261	38	245	0.0038
Total	23,497	34	198	0.0063

a. Excludes subscribers not affected by any tax change and excludes employers' share of FICA.

SOURCE: National Center for Health Services Research, National Medical Care Expenditure Survey. Figures here are presented in Taylor and Wilensky, "Tax Expenditures," p. 177.

TABLE 9

PERCENTAGE DISTRIBUTION OF TAX BILL INCREASE UNDER THREE ALTERNATIVE CAPS ON THE TAX SUBSIDY, BY FAMILY INCOME, 1983
(percent)

Family Income (dollars)	*$1,125 Family, $450 Individual*	*$1,800 Family, $720 Individual*	*$2,400 Family, $975 Individual*
1– 9,999	1.8	1.7	1.8
10,000–14,999	3.6	3.5	4.1
15,000–19,999	7.3	6.7	6.6
20,000–29,999	20.6	18.5	16.7
30,000–49,999	45.1	47.2	47.4
50,000 or more	21.6	22.4	23.4
Total[a]	100.0%	100.0%	100.0%
Total tax increase[b]	$10.7 billion	$4.7 billion	$2.1 billion

a. Percentages may not add precisely to 100 because of rounding.

b. Excludes subscribers not affected by any tax change and excludes employers' share of FICA.

SOURCE: Calculated by the author from data presented in Taylor and Wilensky, "Tax Expenditures."

incomes below $20,000, and nearly half of the tax increase would be paid by households with incomes between $30,000 and $50,000.

A rough comparison of these distributions to those presented in the previous section suggests that limiting the tax expenditure associated with employer contributions to health insurance would be a more progressive financing mechanism than the current practice of cost shifting.[3] Of course, there are good reasons for limiting this tax subsidy even if the revenue is not used to raise Medicare or Medicaid payments, and the health policy rationale for the tax cap will be spelled out in a later chapter.

An Excise Tax on Hospitals

Another option for meeting the shortfall in Medicare reimbursement of providers involves a kind of surtax on hospitals. It would provide a fund to be redistributed to those hospitals that are most seriously injured financially by government reimbursement policies. This surtax on each hospital bill would be applied only to the bills of patients who had insurance.

The basic idea is to create a fund to which all hospitals would contribute to assist those with a large concentration of public bene-

ficiaries or charity cases not covered by government programs. To the extent that this tax is passed on to hospital bill payers in the form of higher charges (or higher insurance premiums), it is essentially a transfer from purchasers of hospital care who buy from hospitals with a relatively low concentration of "supported" patients to purchasers from hospitals with a higher incidence of such patients.

This option, which I believe is a variation of our current cost-shift policies, does have certain advantages. First, the cost shift would be explicit and visible. Thus, communities would know the amount of the cost-shift subsidy, who received it, and who paid it. Second, an excise tax could cut costs by discouraging utilization and the adoption of expensive new technology, perhaps the two most important factors contributing to the increase in hospital spending relative to gross national product. It is important to note, however, that such advantages are not free—reductions in use or the purchase of new equipment are unlikely to consist wholly of the elimination of pure waste. Stated somewhat differently, while the costs of some purchases of high-technology equipment are very high and the expected benefits for the average use quite low, the benefits are not zero. Some low-risk patients who would forgo certain tests or procedures in a world of tighter cost constraints could turn out to have benefitted from those tests or procedures. In short, cost containment is unlikely to be costless.

A detailed analysis of the incidence of the excise tax option would be quite complicated. A precise estimate of the impact of this approach on the distribution of income would require, at a minimum, knowledge of the different income distributions of categories of insurance subscribers. We would need to know, for example, how the income of Blue Cross subscribers differs from the income of those enrolled in commercial insurance plans.

It is worth noting, however, that since the excise tax is really only a more explicit version of the cost shift, the conclusions about the incidence of the cost shift apply to the excise tax. Although the estimates presented above are necessarily preliminary first approximations, I question whether more refined analysis would yield an answer much different from the one reached earlier: an excise tax would produce less of a drag on economic growth than raising income and payroll taxes or capping the amount of employer-paid health insurance that is tax free to the employee. On the other hand, the tax cap, the income tax, and the payroll tax would be more progressive.

An excise tax on the hospital bills of insured patients might be effective in curtailing use and financing the Medicare/Medicaid payment shortfall, but I believe a cap on employer-paid health in-

surance premiums that are tax free to the employee could accomplish the same result more simply. The combination of no limit on the amount of tax-free health insurance and an excise tax on hospital bills of insured patients would be contradictory. On the one hand, the tax system would be stimulating overinsurance, which is widely understood to inflate the demand for health services. On the other hand, the excise tax would be discouraging hospital use.

Notes

1. See Gail R. Wilensky and Amy Taylor, "Tax Expenditures and the Demand for Private Health Insurance," in Jack A. Meyer, ed., *Market Reforms in Health Care: Current Issues, New Directions, Strategic Decisions* (Washington, D.C.: American Enterprise Institute, 1983).

2. Ibid.

3. The analysis here is complicated by the possibility that people will "substitute away" from health care as its effective price rises. We could view the consumer's choice as occurring among health insurance, other purchased goods, and leisure. An analysis of the cross elasticities among these three choices would be required to assess the net effect. The comparisons here are only approximate because the author does not have quintile distributions for the incidence of a tax-subsidy cap.

6
Responses to the Cost Shift

An All-Payers System

This chapter discusses three types of responses that have been made to the cost shift: proposals for an "all-payers" system (that is, rate control); private sector responses; and state responses that do not involve rate setting. Frustrated because they are paying a disproportionately large share of hospital costs and concerned that their share will become even larger in the future, many commercial insurance companies and some businesses advocate an all-payers system. The basic idea is that state rate-setting authorities would establish allowed rates for each hospital. All payers—Medicare, Medicaid, Blue Cross/Blue Shield, commercial insurers, self-pay patients—would pay a fixed percentage of charges for like services.

If the concept of an all-payers system were taken to mean that all payers paid the same rates, it would pose a serious dilemma. As shown in chapter 3, Medicare and Medicaid pay slightly less than 80 percent of charges. Because hospitals in recent years have been generating operating margins of slightly over 3 percent,[1] a reduction in rates down to or even close to Medicare payment levels would cause a large number of hospitals to go bankrupt. On the other hand, if Medicare payment rates were raised significantly, the Hospital Insurance Trust Fund would go bankrupt even sooner than currently projected.

An all-payers system of this kind could be an effective way of avoiding the dilemma of bankrupt hospitals or a bankrupt Hospital Trust Fund only under two circumstances: first, if hospitals were exercising monopoly pricing power; and second, if controls generate strong incentives on the part of physicians and patients to curtail hospital admissions and use of sophisticated new technology. Neither condition holds.

Monopoly pricing power is not a widespread problem in the hospital sector. Studies by Mark Freeland and Carol Ellen Schendler and by John Virts and George Wilson found that specific health-care

This chapter was written by Sean Sullivan.

inflation—apart from general inflation—was a relatively minor cause of hospital price increases over the past decade. Their work and other similar studies are reviewed in the appendix. These findings suggest to this author that price controls, if applied stringently, would reduce employment and lower the generally available level of technology, trends that could harm the quality of medical care provided.

State rate setting does little to restrain physician and patient demand even though the key problem is excess demand, not hospital costs that are unnecessarily high relative to the volume and nature of services provided. To illustrate, health maintenance organizations (HMOs), which have strong incentives to control demand, have been able to provide medical care at costs ranging from 10 to 40 percent lower than costs in conventional insurance plans.[2] There is some dispute about the extent to which these savings reflect a self-selection bias, since people enrolled in HMOs are relatively younger and healthier than those not enrolled. Some controversy therefore exists about whether such savings would persist if HMO use became more widespread. It seems clear, however, that the savings associated with serving the current population of HMO enrollees have come primarily from fewer inpatient days per enrollee; research has consistently shown that hospital costs per day for HMOs are quite comparable to those for other types of payers.[3]

Advocates of rate setting cite the examples of Maryland and New Jersey, which have adopted the all-payers approach and, until very recently, were the only states to regulate all payers—Medicare and Medicaid as well as Blue Cross, commercial insurers, and self-paying patients. In both states, hospital rate-setting authorities were given jurisdiction over rates paid by all private patients. Through waivers obtained under section 222 of the 1972 Medicare/Medicaid amendments, they gained authority to set rates for Medicare and Medicaid payments comparable to their authority to set rates for private insurers. The secretary of the Department of Health and Human Services can waive the Medicare/Medicaid reimbursement regulations to permit experiments with prospective payment systems.

Through prospective rate setting, hospitals are presumably given incentives to reduce costs to produce an operating surplus. Hospital revenues are determined in advance, forming the basis of payment by all patients. With the waivers, these states can require all payers to reimburse hospitals for the same costs. According to the Maryland Health Services Cost Review Commission, Maryland has achieved both equity among payers and Medicare/Medicaid savings of $86.5 million over three years. These "savings," however, are subject to

question as they are based on a comparison to a generous hypothetical baseline rather than performance of other states over the same period.

In evaluating whether a program has saved money, most scholars use regression analysis rather than comparing actual results to a projection. Regression analysis permits an investigator to isolate the effects of an individual variable, such as a rate-setting program, on a dependent variable, such as hospital costs per capita. When this technique was used to evaluate the effects of Maryland's rate-setting program through 1981, the results show that by any measure—hospital costs per day, per admission, or per capita—there were *no* statistically significant savings. Furthermore, it was found that Medicare spent as much in these states as it did in states that did not set rates.[4]

New Jersey's rate-setting program did show savings of about three percentage points annually, but the effect only occurs after a startup period of at least two years, and over time the effectiveness of rate setting seems to dissipate. More ominously, New Jersey is facing huge unmet hospital capital needs in the 1980s. By 1990, unmet needs for hospital replacement and renovation will total about $3.8 billion, or about 53 percent of the beds in place.[5]

New York, the only state other than New Jersey that showed statistically significant results from rate setting between 1976 and 1981, is the most stringent. The state has reduced the growth of hospital expenditures by more than any other rate-setting state, but in the process has put its hospital system in a serious financial condition. More than 50 percent of its hospitals have been in the red for each of the five years through 1981 (the latest year for which data are available), piling up losses of over $1.1 billion.[6] By 1990 67 percent of New York's hospital plant should have been renovated or replaced, but won't be for lack of capital.[7] New York's experience points up one of the great dangers of rate setting: rather than leaving future recipients of health services more than we had ourselves, we would be looting their inheritance.

Private Sector Initiatives

If the private sector were unable on its own to contain hospital costs, then state intervention might be unavoidable. But there is much that private entities can do and are doing to protect themselves from further cost shifting. Benefits are being redesigned to encourage patients and physicians to be cost conscious. Some businesses are contracting with preferred provider organizations, which offer a lower price in return for a guaranteed level of volume. Health care coali-

tions are collecting, analyzing, and disseminating utilization and payment data, useful in showing which hospitals and physicians are offering the best value for the dollar.[8]

In brief, business for the first time is beginning to behave like a cost-conscious consumer and is encouraging its employees to do the same. These cost-conscious initiatives in the private sector need to be reinforced by improved incentives in public programs so that companies and employees are not swimming against the tide.

State Initiatives Other Than Rate Control

Some states are leading the way in showing what large-volume purchasers of health care can do on their own. Arizona and California have responded to cost pressures with a "prudent-buyer" approach instead of rate setting. Arizona, the only state without a Medicaid program, created a new program, AHCCCS (Arizona Health Care Cost Containment System). The state has received bids from private payers who choose to participate. The competitive bidding system leaves the determination of prices wholly to the market, entirely avoiding any state involvement in rate setting.

California also rejected the idea of controlling all hospital revenues and chose instead a contracting approach for Medi-Cal, the state's Medicaid program. A state "czar" is empowered to negotiate contracts with hospitals to serve Medi-Cal beneficiaries. The California legislature also allowed private insurers to negotiate with providers just as the state is doing, thus opening the entire health care market to the influence of prudent-buyer behavior. The state hopes to save $100–150 million in the first year through the negotiation process. Interestingly, the California Hospital Association supported the scheme as an alternative to mandatory rate setting.

Massachusetts is an intriguing study in contrasts. While the state has launched an all-payers rate-setting venture, it is simultaneously experimenting with more market-oriented cost containment models. These consist of "case management" programs, the largest of which involves a private intermediary, the Commonwealth Health Care Corporation (CHCC). CHCC will receive a prepayment from the state, which it will then distribute on a fixed capitation basis to several primary-care networks organized to serve Medicaid recipients. Primary-care physicians will "manage" the care of enrollees and will be at risk to the extent that they must live within the prepaid capitation limit. This program introduces the kind of incentives to be cost conscious that are generally associated with HMOs. Similar primary-care network models with case management are being

tried in other locations ranging from Kentucky and Tennessee to Santa Barbara County, California.

Notes

1. ICF, Inc., "Background Data on Changes in Hospital Expenditures and Revenues, 1971–1981," Washington, D.C., January 1983, p. 6.

2. Harold Luft, "How Do Health Maintenance Organizations Achieve Their Savings?" *New England Journal of Medicine*, vol. 298 (June 15, 1978), pp. 1336–43.

3. Ibid.

4. Michael A. Morrisey, Frank A. Sloan, and Samuel A. Mitchell, "State Rate Setting: Evidence on Some Unresolved Issues," *Health Affairs*, vol. 2, no. 2, Summer 1983.

5. Harold M. Ting and John D. Valiante, "Future Capital Needs of Community Hospitals," *Health Affairs*, vol. 1, no. 3 (Summer 1982), p. 20.

6. Hospital Association of New York State, *Fiscal Pressures Survey, 1981*, Albany, New York, November 1982.

7. Ting and Valiante, "Future Capital Needs."

8. For a more complete review of private sector initiatives in health care cost containment, see Patricia W. Samors and Sean Sullivan, "Containing Health Care Costs," in Jack A. Meyer, ed., *Meeting Human Needs: Toward a New Public Philosophy* (Washington, D.C.: American Enterprise Institute, 1982), pp. 364–82.

7
Learning from Past Mistakes

Effective health care cost containment takes a lot of work. Why not let government do it by supporting mandatory state rate-setting programs?

Perhaps the most important reason is the issue of control. If a rate-setting agency makes the decisions as to where cuts should be made, individual private sector organizations with different needs and different preferences do not make those decisions. Unless the state wishes to finance a very large, expensive bureaucracy, the state rate-setting agency will have to exert its impact by enforcing uniform rules. Uniform rules cannot possibly accommodate the specific circumstances and preferences of a wide variety of individual employers. Thus, if the private sector cedes to a rate-setting agency its authority to bargain with hospitals, it loses the ability to shape hospital care to its own taste. Further, an all-payers system would stifle the very dynamics of the market for health insurance that need to be stimulated in order to achieve meaningful cost control. Specifically, under rate setting there is no innovation and no price competition, nor are there incentives for physicians and patients to restrain use.

All-Payers—A Bizarre Form of Cost Shifting

Rate setting fundamentally is another form of cost shifting. The difference is that it shifts costs back to Medicare, which is already in deep financial trouble, or onto hospitals, which have to have positive operating margins to survive—an impossibility if costs are shifted back to hospitals enough to create genuine savings.

Rate setting does nothing to fix the underlying problem of how to make sure that the money is available to assure that our older citizens receive good-quality health care. In fact, regulation makes the problem worse because its effects are illusory:

1. *Regulation can appear to be "working" when, in fact, costs are only covered up, shifted, and delayed.* Someone, however, will eventually pay. In the meantime, the focus on regulatory solutions and

their *apparent* success obscures the need and desire to seek true answers that are long lasting. And therein lies the tragedy of historical and current government regulation in health care.

2. *Controls on providers will ultimately make it more difficult to attract needed resources to the health care industry.* Controls on hospital charges will lead to deteriorating hospital services and bankruptcies; overly rigid controls on insurers will lead to reduced insurance company offerings of health insurance; controls on drug manufacturers will lead to a decline in the development of new drugs. A shortfall of skilled supply in health care a decade or two from now is no less real a threat than a shortfall in modernized manufacturing capacity. In fact, given the demographic trends pointing to relatively more elderly people and a corresponding increase in the need for health services, facilities and manpower, the threat is more real in health care.

3. *Simply ruling that charges or reimbursement cannot exceed a given level does not prevent costs from exceeding that level.* Controls or limits on *rates, charges,* or *prices* do not make the underlying costs evaporate, but rather tend to make them change form. The true cost of care can be disguised by rate controls, but eventually providers learn how to "game" the system and shift the costs not covered by one program to other people or another program.

4. *Health care does not have to be viewed as being different from other industries.* The government has regulated other "special" industries such as petroleum, natural gas, airlines, and trucking. Slowly but surely, these regulations are being rolled back or repealed. We are now trying to improve, not replace, the marketplace in many of these industries.

New Roadblocks to Reform

Although promising reforms discussed in the next section have recently been endorsed by the Reagan administration, I am concerned that the government will remain the prisoner of past policies, particularly by becoming ensnared in the implementation of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, H.R. 4961) and the Social Security Act of 1983. The health care provisions of this legislation suggest that Congress has not yet confronted the real problems with our health care finance system.

The fundamental forces that have driven up the costs of health care are (1) open-ended federal tax subsidies for the purchase of ever more comprehensive insurance, which inflates the demand for health care services; (2) a widespread lack of choice in the purchase of

health insurance; (3) retrospective cost-based reimbursement of doctors and hospitals by both government and private insurers, which in effect rewards (and thus entrenches) inefficiency; and (4) ironically, government regulation itself, which tends to confirm the status quo, protecting those who provide too much health care too expensively and impeding innovative efforts to lower costs. In my view, only two of the many provisions relating to health care in these new laws even begin to address these basic problems—prospective payments and Medicare payments to HMOs. These two steps in the right direction need to be extended or modified significantly if they are to hold real promise of improving the efficiency of the system.

Prospective Payment. Prospectively set rates or spending amounts may reverse some of the inherently cost-generating incentives associated with retrospective reimbursement, but are subject to other problems. Many prospective systems retain few elements of "prospectivity" once they are implemented and end up being tied to the same allowable-cost system that has characterized federal reimbursement policy for years. Moreover, prospective payments to providers may put some pressure on each provider to cut costs but may not encourage true economies as much as they lead to service cutbacks.

I am concerned that the federal government, after dragging its feet for years on developing a new reimbursement mechanism, is rushing headlong into a very complex approach to reimbursement involving prepayment on a case-by-case basis. Under this plan, currently under development for use in fiscal year 1984, some 467 categories of illness, called "diagnostically related groups" (DRGs), will be used as a basis of adjusting a fixed prepayment by Medicare to hospitals for the mixture of illnesses treated by that hospital.

Although this approach sounds promising and fair, it is easier to *describe* a process of separating patients on the basis of diagnosis than to *implement* such a system. It seems likely that individual diagnostically related groups will contain patients with widely differing needs; for example, the severity of the condition may differ substantially. Such differences would be associated with widely varying price tags. Research conducted by Dr. Susan Horn at Johns Hopkins University tends to confirm the wide variation in severity within DRG cells. This will lead either to serious reimbursement inequities or to a process of continuous refinements and appeals from hospitals that feel that the system has not adequately controlled for their particular case mix.

Furthermore, despite its complexity and detail, a DRG system is still incomplete as a cost-control mechanism. As long as hospital

admissions are not affected, a key loophole remains to be closed. This is particularly problematic in view of the evidence suggesting that rates of hospital admission are very important in explaining the cost advantage that prepaid plans have over traditional health plans.

Hospital admission rates as well as the number and type of services performed are controlled by physicians, responding according to their training, their perception of patient expectations, and local practices. The proposed DRG prospective payment system eliminates the perverse incentives of cost-based reimbursement, but it remains a highly indirect, tenuous way of getting at the main causes of hospital spending growth in excess of general inflation. In effect, it puts on hospital administrators the burden of controlling physician decisions.

Medicare Payments to HMOs. TEFRA modifies current law by authorizing prospective reimbursement under risk-sharing contracts with competitive medical plans at 95 percent of the adjusted average per capita cost (AAPCC). The new provision, in effect, would share savings associated with lower HMO costs between the federal government and Medicare enrollees who select an HMO.

Greater use of HMOs by the elderly may not do much to encourage overall health care cost containment: although HMOs have a cost edge at present, they may well have that edge because their members are younger and healthier than the average. A system of medical vouchers for Medicare patients might do much more, by allowing a variety of new health plans—including case management systems or preferred provider organizations—to compete with HMOs and the traditional Medicare plan for taxpayers' dollars. (Congress considered but dropped a proposal of this sort in 1981–1982.)

A Better Approach to Medicare Financing

Exclusive or even primary reliance on prospective payment, as the plan is now envisioned, would lead to little progress in the effort to contain the cost of Medicare without cutting benefits. In my view the complex, yet incomplete, system of prospective payment could take its place next to certificate-of-need, professional standards review organizations, and rate setting as well-intentioned but ineffective strategies unless coupled with cost sharing, vouchers, and structural tax reforms. The administration and Congress should place the array of complicated formulas and target rates for "allowable" increases specified under TEFRA on the back burner and move more promising new proposals to the front burner.

Both prospective reimbursement and the new HMO reimbursement policy need to be broadened and converted into a voucher system for Medicare. With this approach, beneficiaries would be given a voucher for the purchase of any qualified private health plan in their area. If the premium of the plan selected was lower than the voucher amount, the beneficiary would receive the difference in cash from Medicare, while those choosing plans with higher premiums would pay the extra amount themselves. The value of the voucher could vary according to factors such as age, sex, and local medical costs.

The voucher approach would breathe life into the concept of prospective payment by including incentives to reduce admissions to hospitals and by broadening the range of alternatives to traditional fee-for-service medicine beyond HMOs. If we are going to test the concept of prospective payment, we cannot leave any major loopholes. And if we are going to couple this concept with the use of multiple choice, that choice cannot be constrained to include only the reigning champion, fee for service, and the best-known challenger, HMOs. As primary-care networks (PCNs), preferred provider organizations (PPOs), independent practice associations (IPAs), and other hybrids with some of the features of both fee for service and HMOs continue to develop, we must not effectively shut them out of the Medicare market.

To the extent that competition among HMOs, PCNs, PPOs, Blue Cross, Blue Shield, and commercial insurers for the taxpayers' dollars yields lower costs for a given package of services, a voucher plan promises a way to meet the health needs of our growing elderly population in an environment of increasingly scarce federal dollars. It is important to note, however, that a voucher approach would not yield immediate savings. In fact, there could be a small increase in outlays initially as the more cost-effective plans are reimbursed at a community-wide average level that exceeds their costs.

It would also be important to accompany a voucher program with a plan under which the government, drawing upon private sector expertise, screened plans seeking to serve the elderly and provided information about alternatives to beneficiaries. In a sense, the government would play a role similar to the roles played by many private employers and unions in screening plans for employees.

We must be wary of regulatory fixes promising short-term savings. These false panaceas can drive into hiding more lasting cures that do not promise overnight relief.

There are legitimate concerns about the side effects of vouchers. As Paul Ginsburg has noted, under a voluntary voucher (under which

beneficiaries choose between Medicare and private sector alternatives), private plans would have difficulty in competing with Medicare. This is because the private plans have selling costs that Medicare does not have, and typically pay providers at higher rates than does Medicare. In addition, voluntary vouchers could lead to increased federal outlays through a process of adverse and preferred risk selection, in which the Medicare program is left with relatively high users while low users opt out, generating more costs to the system than if they had stayed in the program.[1]

Professor Alain Enthoven has argued that the basic problem of adverse selection could be solved by requiring plans to quote premiums for the standard Medicare benefit package, competing on the basis of their cost-saving potential and not their benefits. Combining this feature with requirements such as open enrollment and minimum benefit packages would, in Enthoven's view, provide the necessary consumer protection and substantially reduce adverse selection.

A mandatory voucher, under which Medicare makes a fixed payment to any qualified plan but does not retain its own specific benefit package as an option, should also alleviate the main problems noted in connection with a voluntary voucher. The most serious concern with a mandatory voucher is that the government would no longer assure reimbursement for a specific set of services, and there would be no guarantee that the voucher amount would keep pace with overall increases in health care costs. But, to the extent that the opening of this market to newer plans would yield economies, any given budget would go further in meeting the health care needs of the elderly.

While a voucher approach is not without its drawbacks, these limitations must be compared with the inherent defects of the system of retrospective cost-based reimbursement that has characterized Medicare policy since the program's inception. We may need some time to work out the problems with a voucher approach. As an interlude between cost-based reimbursement and a mandatory voucher, both a prospective payment system and voluntary vouchers could play a useful transitional role.

Note

1. Paul B. Ginsburg, "Market-Oriented Options in Medicare and Medicaid," in Jack A. Meyer, ed., *Market Reforms in Health Care: Current Issues, New Directions, Strategic Decisions* (Washington, D.C.: American Enterprise Institute, 1983).

8
A Blueprint for Reform

As the magnitude of the cost-shifting phenomenon grows, those insurers who cannot extract a significant "discount" from the total cost of treating their patients are likely to seek a new overlay of controls that block providers from passing the buck to them. The more cost shifting is unrestrained by such new controls, the more nongovernmental bill payers will impose this hidden tax on their clients—largely consisting of the nation's employers who purchase group insurance policies for their workers. Sharply higher premiums will raise business costs and will ultimately lead to lower real incomes for workers. Alternatively, the more cost shifting is restrained by new controls that limit fee or rate increases for "all payers," the greater the squeeze on provider margins and the greater the threat to the vitality and innovative impulse of the industry.

Thus, in the absence of systemwide reforms leading to *actual lower costs* (as opposed to an artificial supression of charges), we have two choices: (1) side effects of cost shifting that mainly take the form of a lower level of real income in our economy than would otherwise be achieved or (2) side effects that mainly involve a process in which squeezed providers first eat their seed corn by chewing up capital budgets and reserves and then cut services or reduce their quality. As the saying goes, "You can pay me now or you can pay me later."

The real problem facing health care reformers is that as individuals we want it all; as members of society, we do not want to pay for wanting it all. Cost shifting is not the core problem itself; rather, it is a symptom of the inherent contradiction between the citizen as patient and the citizen as taxpayer. Government is caught in the middle. There is no strong constituency for raising taxes; government program beneficiaries don't want to be denied; and the private sector is tired of absorbing the shortfall. This is clearly an untenable situation.

In my view, health care reforms with the following features will help to reconcile these contradictions in a fair and sensible fashion:

- Set up a system of sharing costs that encourages people to economize on the use of routine health services, while offering greater protection from the costs of serious illness.
- Provide federal aid to low-income people that increases or decreases with increasing or decreasing need.
- Aid those unable to purchase adequate health insurance by providing fixed-dollar subsidies instead of open-ended subsidies.
- Allow both employees and government beneficiaries to choose among alternative health care plans.

These features are based on the principles of choice, limits, and power to the patient. Instead of the "less is beautiful" mentality of the controls strategy, these principles would make consumers more aware of and accountable for the financial consequences of their decisions. The incentives-based approach puts the consumer into the health picture again, not so much at the point of *use* of the system (when cost considerations understandably seem almost immaterial to the consumer) but at the point of choosing a health care plan.

A Market Approach

A market-oriented incentives approach holds more promise than a controls approach for decelerating health care cost increases while preserving the quality of and access to care so highly valued by consumers. This strategy seeks to induce prudent buying of health care services, both direct and through insurance, as well as vigorous review of claims by the employers, insurers, and governments that pay them. Instead of trying to fix the prices that providers of health services may charge on the costs they incur, this approach simply aims to make it in the providers' own best interests to hold down both costs and prices. If, for example, consumers are given a range of health care plans to choose from and allowed to reap the savings when they choose an efficient plan, something like a market discipline can be restored to the industry.

Market reforms present consumers with choices and trade-offs in which the "cost" of less can be weighed against the cost of more. Plans featuring comprehensive coverage can be compared with plans with a little more exposure to out-of-pocket expenses, and plans covering the most elaborate style of care would be assessed against those fully covering a more standard style of care. The key difference is that the consumer would no longer be indifferent about such choices, as there would be financial consequences associated with the choices. Consumers may still choose the high-style, no-restrictions

type of plan, but under this approach they would have to ante up for it. Comparison shopping among no-frills plans, many-frills plans, and varieties in between is the aim of this strategy. But, under the consumer choice system of signals and incentives, if you want a little extra, you have to pay a little extra.

It is important to stress that market-oriented proposals do not offer health care cost containment as a "free good." In fact, no proposal could honestly offer such an outcome. To a large extent, we will have to *give up something* in return for cost control: the convenience of high-style care; the freedom to patronize any health care provider, no matter how far that provider's costs are out of line; the freedom to have our own personal physician on every visit; and so on. The important aspect of an incentives-based strategy, in my view, is that it promises to make this "cost of cost containment" smaller than a controls strategy. At least in theory, the strategy I favor would provide a more effective mechanism for isolating the wasteful component of spending increases so that such waste can be reduced, while preserving the desirable or necessary components of spending increases. These are associated with such factors as advances in technology and new health care needs associated with an aging population. Achieving this promise will not be simple, as there are many obstacles and challenges confronting a market-based health care strategy.[1]

The market-oriented strategy is consistent with a desire to assist those who lack adequate resources to purchase basic health insurance. Indeed, any comprehensive reform package must include proposals addressed to the needs of the millions of people who fall between the cracks of public programs and private insurance. We need a plan to help the victims of adverse selection and arbitrary eligibility restrictions in government programs so that people are not penalized for being in a medically needy situation, for being out of work temporarily, or for being members of an intact low-income family with a working male. We do not want the sick, the unemployed, and the working poor subsidizing the well, the employed, and the affluent in our society. It is my hope that some of the savings generated by the reforms proposed here could ultimately be used to provide assistance, scaled to income, to those lacking any health care coverage.

Proposed market-oriented reforms, taken together, stress the twin concepts of *choice* and *limits*. These are the key ingredients to effective cost containment that have been missing in our public policy. A recent study conducted by the National Center for Health Services Research found that 82 percent of Americans receiving health insur-

ance coverage through employment-related group plans have no choice of plan. Where choice of plan exists in the workplace, it is often a biased choice, as many employers pay a fixed *share* of the premium for any plan. Typically, employees choosing more expensive plans pay only about one-third of the extra cost.[2] A fixed *dollar* contribution in any given period could be expected to increase selection of less expensive plans.

It is important to stress that differences in premiums do not simply reflect differences in covered services. To some extent, they reflect the more vigilant review of claims and practice patterns of providers by some insurers. Some, but not all, private insurers practice the "everybody wins on most items, everybody loses on others" approach that has characterized Medicare and Medicaid reimbursement policies. Thus consumers will be able to make some choices among plans that do not differ significantly in benefits but do differ in *claims control*. Of course, it is worth reiterating that this does not mean consumers electing the lower-cost plans escape a trade-off. It does mean that what they give up may not be covered services but the right to select, at no extra cost, a health plan that imposes no limits on their selection of providers.

To the extent that the competition among plans engendered by improved incentives leads to genuine savings, we will achieve a "positive-sum game" instead of the zero-sum game so characteristic of rigid formulas and regulations.

Implementing the features enumerated above can be done through the following changes in government policy:

Taxes

- Place a ceiling on the chief open-ended tax subsidy for health care—the tax-free status of employer contributions to employee health insurance.

Medicare and Medicaid

- Adopt mandatory prospective payment for Medicare on a temporary, one-year basis, followed by the conversion of Medicare to a program of premium subsidies to be used for Medicare coverage or any qualified alternative plan.
- Build protection against expenses associated with catastrophic illness into Medicare, combined with a greater measure of cost sharing for routine services.
- Convert Medicaid to a system of sliding-scale premium subsidies in which the very poor would be fully subsidized.

Other

- Continue the process of deregulation in areas such as certificate-of-need (CON) and flexibility for states under Medicaid.
- Use existing antitrust law to encourage fair competition among alternative health care plans and providers.

The Importance of Changing Tax Policy

Subjecting a portion of premiums above a ceiling to taxation (and this could be coupled with tax rebates equivalent to the extent to which premiums fall below the ceiling) would put *consumer* pressure on insurers. These insurers (instead of the federal government!) would, in turn, put pressure on providers because insurers would have to compete for the consumer's dollar more than they do at present. Insurers that reward elaborate medicine will have to think twice about charging $40 or $50 more per month than those that do not if employees (or public beneficiaries) are feeling the financial pinch.

I do not believe in *mandating* choice; I prefer to encourage it through the introduction of a *limit* on the exclusion from employee taxable income of employer contributions to health insurance. Such a limit would encourage choice because some employees would want an alternative to a very comprehensive insurance plan that would now bring with it a small increase in taxes. Some employees would prefer a plan with some coverage exclusions and no tax bite to one with fewer exclusions and a tax bite. In fact, despite the small amount of choice and the prevalence of upwardly biased choice, a surprising share of those with a choice of plans—almost half—choose the least expensive option offered.[3]

One criticism of placing a ceiling on the tax subsidy involves the concern that it will entail considerable administrative complexity and end up substituting one kind of government regulation for another. Similar concerns have been voiced about a voucher approach to Medicare reimbursement, as some believe that the plan qualification process will cause the federal government to regulate the insurance market as heavily as it has tried to regulate health care providers.

In my view, these concerns are valid, but are not controlling factors. In designing incentives-based policies, we should be careful to avoid loading them up with too many "regulatory extras." At the same time, it is necessary to build certain minimal protections into these new approaches to guard against abuses. The challenge is to formulate new policies in such a way as to protect consumers without adding an elaborate new regulatory overlay to the health care sector.

To strike this balance between administrative simplicity and considerations of consumer protection or fairness, I would favor a uniform national ceiling on the tax subsidy rather than regional variation. I would also avoid requirements on employers to offer a multiple choice of plans, and postpone the use of tax rebates for later use only if the tax subsidy ceiling, per se, failed to provide sufficient stimulus for choice and cost savings. I would limit the requirements on health plans needed for qualification to a few items, such as open enrollment and some limitations on plan switching. These requirements may be a sufficient way to guard against adverse risk selection without mandating community rating of premiums or requiring a detailed government review of every provision of every health plan.

It is also possible for the government to protect the public interest by contracting with or delegating authority to private sector review authorities. For example, both the tax-subsidy cap and the voucher approach will require a certain degree of consumer information to achieve success, but this could be accomplished through a plan in which the government arranges for more information to be disseminated by private organizations. A similar course can be followed regarding the screening or qualification of plans. In other words, consumer protection does not have to translate into a bureaucratic tangle.

A Cautionary Note

Even if the reforms suggested here were adopted, we might still find that the health care that people want—demand—as individuals exceeds what they are willing to pay for. This is a plausible expectation since health care spending is highly concentrated among high-cost users. For example, 8.7 percent of Medicare Part A enrollees account for 80.2 percent of Part A reimbursements,[4] and 28 percent of total Medicare program expenditures were accounted for by people in their last year of life.[5] No one wants to deny a really sick person any conceivable treatment that might do some good.

If this high-cost group is off limits, savings potential is severely limited. If, on the other hand, reducing hospital expenditure growth becomes a national priority, ways must be found to reduce the use of resources devoted to high-cost illness. Under this circumstance, the core question becomes, Who will do the rationing? The proposed reforms and reliance on the private sector would disperse rationing authority and accountability to patients, employers, physicians, etc. An all-payers system—rate setting—will concentrate rationing au-

thority while fooling the public into thinking rationing can somehow be avoided. Rate setting thus not only fails to solve the cost-shifting problem, but also is a sure-fire recipe for political strife. If patients themselves do not feel accountable for the financial consequences of their choices, they will not limit their demands and will react angrily against an agency that is perceived as arbitrarily denying possibly life-saving treatment.

Notes

1. Paul B. Ginsburg, "Market-Oriented Options in Medicare and Medicaid," in Jack A. Meyer, ed., *Market Reforms in Health Care: Current Issues, New Directions, Strategic Decisions* (Washington, D.C.: American Enterprise Institute, 1983).

2. Gail Wilensky and Pamela Farley, "Options, Incentives, and Employment-Related Health Insurance Coverage," in *Advances in Health Economics and Health Services Research*, vol. 4 (Greenwich, Conn.: JAI Press, forthcoming).

3. Ginsburg, "Market-Oriented Options," pp. 112–16.

4. Marion Gornick, James Beebe, and Ronald Prihoda, "Options for Change: Impact of a Catastrophic Cap in the Medicare Program," Working Paper, Office of Research, Demonstrations and Statistics, Health Care Financing Administration, U.S. Department of Health and Human Services, August 1982, p. 16.

5. James Lubitz and Ronald Prihoda, "Use and Costs of Medicare Services in the Last Years of Life," draft, Office of Research, Demonstrations and Statistics, Health Care Financing Administration, U.S. Department of Health and Human Services, June 29, 1982, p. 6.

9
Avoiding Fancy Fixes

It is important to select a blueprint for overall guidance that is structured around the principles offered here and that rejects the burdensome regulatory model implicit in comprehensive national health insurance plans. A bill introduced by Congressman Richard Gephardt (H.R. 850) incorporates most of these promising principles, and Gephardt himself has described his bill as a guiding work plan for reform, subject to modification or to enactment on a piecemeal, step-by-step basis. Similar legislation has been introduced in the Senate by Senators David Durenberger (S. 433) and Orrin Hatch (S. 139). But we should be careful in analyzing these bills not to make the ambitious or the perfect the enemy of the good. It is not necessary to endorse every feature of a reform plan in order to agree that it is preferable to business as usual.

The federal government needs a new health *policy*, but it does not need an elaborate national *plan*. Such a policy involves sending consistent rather than conflicting messages and stressing the concepts of *choices* and *limits* in government tax and reimbursement policy. It couples these reforms with further deregulation of the health care system. Many of the other, more complex and more controversial features embodied in the broader market-reform blueprint—such as tax-free rebates for the selection of lower-cost health plans and mandatory choice in the private sector of at least three health plans—could be held in abeyance for possible later use, if needed. We may discover that these measures, which could impose substantial costs on either the government or private employers, are not required to build the necessary momentum for continued reforms. Other, more regulatory features of the Gephardt blueprint, such as the proposed "health courts" and a "health benefits assurance corporation," should be sidestepped completely.

Health care reform advocates should learn from the experience of regulatory reform in the airline and trucking industries. Despite the sharp debate over comprehensive legislative proposals for deregulation, the market-oriented reform movement sputtered for several

years as the political force of those with a well-focused vested interest in the status quo outweighed the general, diffuse interest of the consumer. The impetus for reform in airlines and trucking came not from any grand design, but from the step-by-step relaxation of regulation initiated by the leadership of the Civil Aeronautics Board and the Interstate Commerce Commission. After administrative change was well underway, Congress caught up with the process and ratified it through legislative reform.

Our natural tendency is to think of legislative change leading reform, with agency administrators and bureaucrats following to cement and implement the changes directed by legislators. This vision often places the cart before the horse.

Because health care reform will involve potentially huge wealth transfers and a departure from the concept of a uniform standard of care (with trade-offs between cost and risk), an incremental approach may succeed where a comprehensive approach would fail. The step-by-step approach is less disruptive to the key players in the system; yet, if the proper steps are taken, this approach is not the prisoner of the status quo. The gradualist approach to health care reform also allows for a process of trial and error and midcourse corrections, as we grope for ways to use market incentives while simultaneously ensuring that the cost of care remains within the reach of those with low incomes or high health risks.

Although I favor a lean rather than a fancy approach to health care reform, I would stress the need for a theme and coherence. The pieces of a piecemeal strategy must fit together. We need to take carefully thought out, small steps in the right direction instead of agonizing over the difficulty of taking the big plunge and then settling for small steps in the wrong direction.

10
Facing Difficult Choices

In deciding whether the merits of the reforms proposed in this volume outweigh their limitations, it is important to understand that the status quo, as we have known it in recent years, is an unlikely alternative. If market-oriented reforms languish, a combination of tightened federal controls on the private health care sector and benefit reductions in federal health programs is the likely consequence. Competing national objectives will force us to make continuous alterations in the social contract.

I am not suggesting that our social contract with health care program beneficiaries should be untouchable. The mandatory vouchers I propose for Medicare, for example, represent a change in the nature of the entitlement. I argue that sensible program reforms involving defensible conversions of open-ended entitlements into limited but still generous subsidies can obviate, to some extent, the need for sharp cuts in benefits. Given the inexorable government budget squeeze, we have a choice between a business-as-usual approach to the structure of the programs, coupled with steady reductions in their generosity, or a set of reforms that modify that structure. There is no guarantee the reforms will succeed in bridging the entire gap between health care needs and available resources. But we can at least mitigate the need to renege on our past commitments if we address the reforms to the fundamental causes of the problem instead of to its symptoms.

Medicare and Medicaid costs are doubling every four years, and tax expenditures related to health care are rising steadily. Against this backdrop, measures such as means-testing eligibility for Medicare, virtually unthinkable until recently, will move to the front burner of public policy debate if fundamental structural reforms move to the back burner. In Medicaid, we can expect "nominal" copayments to become less nominal, eligibility to tighten further, and covered services to continue shrinking if other ways are not found to trim the sharp increase in total program cost. There is already evidence of such changes in recent legislation.

The reforms I favor would not exempt our vital social agreements from modification, but they would feature incremental rather than immediate changes. They would *trim benefit increases for those who could best afford to bear the burden* while spurning cost sharing in which the poorest or sickest members of society subsidize those in a better financial position or in better health.

We must avoid vilifying the advocates of reasonable, fair program reforms. To leave anachronistic or unwieldy program structures intact may be less humane than to propose changes, despite the tendency to depict the defenders of the status quo as the only humanitarians.

The only way to avoid the difficult choices I pose here between benefit cuts and long-term structural reforms in a variety of social programs lies in an imprudent return to the combination of higher inflation, higher taxes, and governmental deficits that enabled us, temporarily, to avoid such choices in the past. Ultimately, our nation must decide whether we are willing to pay for unlimited commitments delivered through inefficient program designs in the form of higher prices, taxes, and borrowing costs. All of these prices of avoiding change would put a drag on economic growth and future increases in living standards.

Appendix

Sources of Hospital Expenditure Growth

Several efforts have been made to determine the relative importance of the factors driving hospital spending. Martin Feldstein and Amy Taylor did a study in 1976 for the U.S. Council on Wage and Price Stability. They concluded that the sharp increase in cost per patient day primarily reflected the changing character of hospital care, chiefly the growing number of employees and the increasing volume of equipment and supplies, rather than an extraordinary rise in input prices. Their analysis showed that for the period 1955–1975, about 75 percent of the increase in average cost per patient day after adjustment for general inflation was due to the increase in inputs per patient day, while only about 25 percent was due to input price increases in excess of the general increase in consumer prices.[1]

Mark Freeland and Carol Ellen Schendler, in an article for the Winter 1981 issue of *Health Care Financing Review*, published by the Health Care Financing Administration (HCFA), present a five-factor analysis of the growth in hospital expenditures for the years 1969–1979.[2] They assign the following responsibilities for the increase in spending for inpatient care at community hospitals:

GNP deflator (general inflation)	49.2%
Hospital input price in excess of deflator	10.2
Intensity of services per admission	21.9
Admissions per capita	12.3
Population	6.4

Their analysis does not "match up" neatly with that of Feldstein and Taylor, but it is still possible to make rough comparisons. If intensity of services per admission and admissions per capita are taken together as the rough equivalent of Feldstein and Taylor's increase in inputs per patient day, they account for about 34 percent of the total increase versus about 10 percent for hospital price-specific inflation. This is not too different from Feldstein and Taylor's

TABLE A–1

SOURCES OF CHANGE IN HOSPITAL EXPENDITURE, 1965–1981
(dollars in billions)

	1965–1981		*1965–1972*		*1972–1981*	
	$ billions	percent	$ billions	percent	$ billions	percent
Change in prices	67.3	64.6	10.1	48.1	57.2	68.8
Change in utilization	28.2	27.1	9.2	43.8	19.0	22.9
Change in population	8.6	8.3	1.7	8.1	6.9	8.3
Total	104.1	100.0	21.0	100.0	83.1	100.0

SOURCE: John R. Virts and George W. Wilson, "Inflation and the Behavior of Sectoral Prices," *Business Economics*, May 1983, vol. 18, no. 3.

finding that inputs per patient day account for three times as much of the total increase as hospital-specific input price increases.

Samuel Mitchell of the Federation of American Hospitals offers another assessment in the Summer 1982 issue of *Health Affairs*.[3] Using data from HCFA and from the U.S. Department of Labor, Bureau of Labor Statistics, he presents the following four-factor analysis for the 1970–1980 period:

General inflation	60.7%
Medical care-specific inflation	1.4
Greater volume and sophistication of services	31.6
Population	6.3

Mitchell assigns much greater significance than Freeland and Schendler to general inflation, and almost none to hospital-specific inflation. His finding on the importance of greater volume and intensity of services, however, is close to theirs—31.6 percent versus 34.2 percent.

John Virts and George Wilson of Eli Lilly and Company present yet another analysis in their article on inflation and the behavior of sectoral prices.[4] Virts and Wilson use a three-factor model to analyze the increase in expenditures for twelve health care sectors, including hospitals. The factors are prices in the health care sector, real per capita utilization of sectoral output, and population. They use expenditure data from HCFA and population data from the Bureau of Labor Statistics. Table A–1 shows their findings on the relative importance of the three factors. Their analysis shows price increases accounting for nearly two-thirds of the total increase in hospital spending for the period 1965–1981. Increases in real per capita utilization, interest-

ingly, account for about 27 percent of the total increase, a little less than the estimates of Mitchell and of Freeland and Schendler, but in the same neighborhood. The table also shows that the relative importance of the factors changed markedly during the period studied. Utilization changes were almost as significant as price changes during the first half of the period from 1965 to 1972. After that, however, price changes became dominant.

Virts and Wilson go on to break inflation down into general or "imposed" inflation and specific health care inflation, as the other analysts did. They find that of the $57.2 billion in increased hospital expenditures attributable to price changes during the period 1972–1981, only $7.8 billion—or less than 10 percent of the total increase in hospital spending—was due to specific health care inflation. This finding suggests that the potential efficacy of hospital price controls appears very limited, since the causes of "imposed" inflation lie outside health care markets.

Notes

1. Martin Feldstein and Amy Taylor, *The Rapid Rise of Hospital Costs* (Washington, D.C.: Council on Wage and Price Stability, January 1977), p. 20.

2. Mark S. Freeland and Carol Ellen Schendler, "National Health Expenditures: Short-Term Outlook and Long-Term Projections," in *Health Care Financing Review*, Winter 1981, p. 103 (published by Health Care Financing Administration, U.S. Department of Health and Human Services).

3. Samuel A. Mitchell, "Issues, Evidence, and the Policymaker's Dilemma," *Health Affairs*, Summer 1982, p. 85.

4. John R. Virts and George W. Wilson, "Inflation and the Behavior of Sectoral Prices," *Business Economics*, vol. 18, no. 3 (May 1983), pp. 45–54.

A Note on the Book

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Passing the Health Care Buck
Who Pays the Hidden Cost?

JACK A. MEYER
with
William R. Johnson and Sean Sullivan

Most analyses of the financing of health care assistance to low-income households and the elderly focus on the magnitude of the potential deficit in public payments to health care providers. Most proposals to change the system only suggest ways of passing the buck from one bill payer to another. This volume widens the scope of analysis by assessing alternative ways of reconciling our open-ended public commitments with our limited fiscal resources. It shows that current policies only shift health care costs from the public to the private sector, and it contrasts the economic efficiency and fairness of more direct forms of taxation with this "hidden tax."

This study advances the debate in health care cost containment from attempts to relieve the symptoms of underfunding to ways of correcting the problem at its source. It offers an incentives-based, market-oriented approach in both public programs and private insurance. This approach, according to the authors, is preferable to the regulatory model that has characterized most government policies in recent years.

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