Can the states solve the health care crisis?

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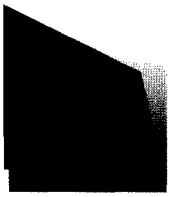

The United States spends a larger share of gross domestic product (GDP) on health care than any major industrialized nation.[1] While U.S. health expenditures as a share of GDP are estimated to have topped 13 percent in 1991, Germany and Japan spend 8.2 and 6.8 percent, respectively. Even socialist Sweden, known for high expenditure levels on public health, spent only 9 percent. To make matters worse, this gap has been widening. In 1980, total health care costs as a share of GDP was 9.3 percent for the U.S. compared to 7.1 percent, on average, for the 24 OECD nations. By 1990, U.S. expenditures had risen to 12.4 percent of GDP while the share for the OECD group had increased to only 7.6 percent.[2]

Increased health care costs affect all sectors of the U.S. economy. According to a Washington State study, health costs consume 25 percent of the average private firm's profits and translates into a 3 to 5 percent surcharge on the price of U.S. products when sold abroad.[3] Health costs currently account for 15 percent of the federal budget (up from 10 percent in 1980) and, if unchecked, are expected to consume 28 percent by 2002, according to the Congressional Budget Office. Federal spending for the Medicaid program alone is on a pace to eclipse 50 percent of all federal benefits targeted for the poor by 1993.[4] In the case of state and local governments, rising health care costs (particularly those associated with Medicaid payments) are frequently seen as the primary culprit in budget deficits. Given that state and local governments cannot run explicit budget deficits like the federal government, these rising costs are forcing reductions in other budget areas. Most observers agree that the U.S. cannot continue funding such robust growth in health expenditures.

At the same time that costs are high and growing, there is a substantial support for broadening health care coverage to all citizens. In particular, those citizens and workers who are above but close to the poverty level often lack adequate health care benefits. Several options have emerged in an attempt to meet the twin goals of cost containment and universal access. These range from trying to inject more market incentives into health care provision and consumption to adopting government based national health care insurance. Impatient for federal action and weary of the failure of private markets, many states are trying to craft their own health plans.

This article discusses why health costs have been rising at such a rapid rate in the U.S., and examines state initiatives aimed at addressing this issue.

How fast are medical costs rising?

In 1970, personal consumption expenditures for medical care totaled $55 billion. By 1988 the figure had grown to $443 billion, a nominal increase of 705 percent.[5] Table 1 shows the rate of increase by type of medical

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TABLE 1

Personal consumption expenditures for medical care by type of services
(billions of dollars)

	1970	1988	Percent change
Total	55.0	443.0	705.5
Hospital	19.7	182.3	825.4
Physician	14.0	105.0	650.0
Drugs, appliances	10.0	44.7	347.0
Dentists	4.9	27.0	451.0
Net cost of health insurance	2.1	29.3	1,295.2
All other medical	4.3	54.3	1,162.8

SOURCE: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, various issues.

service. As is shown, the rate of expenditure growth shows considerable variation depending on the service in question.

Furthermore, as the comparison with the Consumer Price Index (CPI) in Figure 1 shows, prices for medical care commodities and services have grown much faster than the CPI for all items in recent years. Growth rates in the two major components of medical prices exceeded the general inflation rate. Other statistics illustrate similar gains in expenditures. Figure 2 illustrates national health expenditures as a share of GNP and personal consumption for medical care as a share of disposable income from 1970 to 1988. Regardless of how it is measured, the trend is clearly for health care expenditures to consume a growing share of the economy.

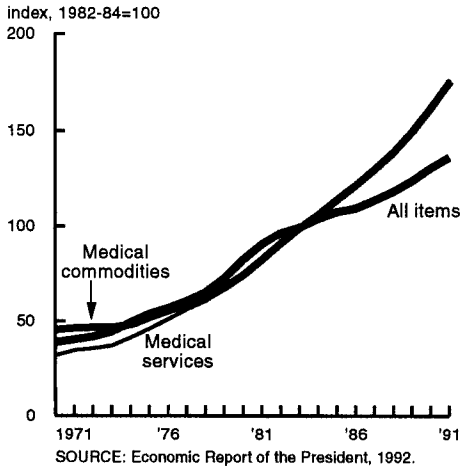
Even more troubling is the possibility that higher expenditure levels on health care are not translating into significantly better health care. Measures of U.S. public health remain poor when compared to other developed nations. For example, the U.S. ranks eighth in the world in life expectancy, 11th in maternal mortality, 18th in child mortality, and 22nd in infant mortality.[6]

Why are health care costs growing so quickly?

The market for health care is unique in that asymmetric information between buyer and provider and restricted competition among suppliers and third party payments are the rule, not the exception. Incentives embodied in America's system of health care are complex and rarely emphasize cost containment. The Health Care Financing Administration (HCFA) identifies three factors as affecting the growth of personal health care expenditures:[7] increases in the prices charged for services; increases in the population receiving medical treatment; and increases in the intensity with which medical services are used. In 1988, the HCFA estimated that price increases accounted for 67 percent

FIGURE 1

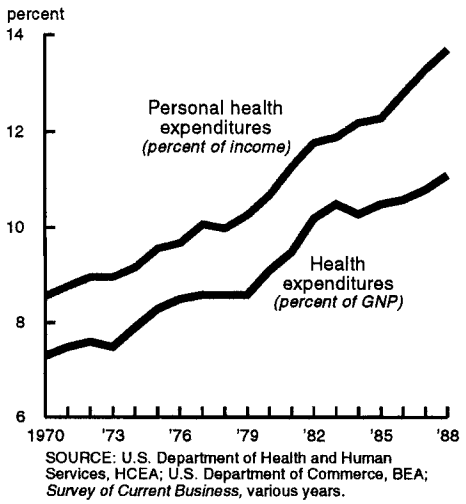
CPI: All items vs. medical commodities and services



SOURCE: Economic Report of the President, 1992.

FIGURE 2

Health expenditures compared to GNP and disposable income



SOURCE: U.S. Department of Health and Human Services, HCEA; U.S. Department of Commerce, BEA; *Survey of Current Business*, various years.

TABLE 2

Factors affecting growth of personal health care expenditures
(percent contribution)

	1981	1982	1983	1984	1985	1986	1987	1988
Prices	67	69	67	73	61	52	52	67
Population	7	9	10	12	11	11	9	10
Intensity	26	22	23	15	28	37	39	23

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration.

of growth in personal health care expenditures, followed by increases in intensity of service utilization (23 percent) and population changes (10 percent). However, future demographic changes, namely the aging of baby boomers, will have a profound effect on medical spending, given that people 65 years or older spend four times as much on health care as younger people. The pattern for these three factors is shown in Table 2. In order to understand why prices for medical commodities and services have risen so quickly, we must look at the factors affecting supply of and demand for health care.[8]

Demand factors

One of the primary factors in the spiraling costs of health care is the low price elasticity of demand for medical services. According to some estimates, the price elasticity of demand for medical services may be as low as 0.2.[9] This means that the consumption of medicine tends to be relatively unaffected by price increases so that total expenditures increase over time as prices rise.

Health insurance often distorts the costs of consuming medical care. An individual covered by an insurance plan often bears no additional cost for consuming additional units of medical care once they have exceeded the deductible on their policy. Consequently, at a given threshold, medical care consumption becomes costless (other than for the individual's time) and presumably the absence of immediate cost encourages greater consumption, even though the costs are ultimately passed along to consumers in the form of higher premiums and/or taxes. As a result, consumers are relatively insensitive to price increases in medical services since the penalty of higher cost medical consumption only shows up in higher insurance premiums, which are shared by all policyholders, muting the magnitude of the cost increase to any individual.

Further evidence of the potentially distorting effect of insurance can be seen in the percentage increases in the cost of medical services. Services traditionally covered by insurance, such as hospital stays, have risen much faster than health services like eye exams which tend not to be included in coverage. From 1970 to 1988, hospital service expenditures increased by more than 800 percent while less frequently or not fully covered items such as drugs and eyeglasses showed a gain of less than 350 percent. This evidence suggests that some of the observed price increases in specific health care procedures are related to the distorting effects which insurance coverage has had on the demand for medical services.

Other factors influencing demand and therefore the price of medical services include demographic and lifestyle factors and the environment. Clearly, as life expectancy grows and the population ages, demand for medical services increases. The elderly consume a significant portion of health care as is illustrated by the fact that a large percentage of health care expenditures are spent on the very elderly, particularly during their last years of life. For example, the U.S. spends 1 percent of GNP on health care for elderly people in the last year of their lives (Fuchs [1984]). Lifestyle changes also play a role. Society's increasing incidence of alcohol and drug abuse and other abusive behaviors reduce the stock of health while increasing health care expenditures. The quality of the environment also plays a role. Problems with air and water quality provide environmental hazards which potentially lead to a greater demand for medical care.

Supply factors

Productivity gains in the provision of medical services have been slow for a variety of reasons. First, insurance and public health reimbursement programs have traditionally paid medical providers on a cost of service plus a small profit basis. Since providers are always assured of covering their costs there is little incentive to improve productivity and lower

costs. Similarly, the use of "best practice" techniques, in which expensive procedures with sometimes marginal benefits to the consumer of the service are used, also encourages potentially wasteful uses of resources.

There is a limited supply of physicians because, despite a large applicant pool, the number of medical school seats is limited. This limited supply of doctors helps to keep the costs of their services high. Furthermore, increased specialization among doctors has actually increased the variety of potential services and has helped create a demand for those services. The relative abundance of medical specialists has encouraged patients to seek specialists for routine medical procedures which could be treated by general practice physicians who presumably charge lower fees. Part of the Canadian system of health care cost control is to restrict the number and availability of medical specialists.

Asymmetric information is another important factor affecting the cost of health care. The health care market is one of the few areas where most consumers are generally uninformed about purchasing decisions. Because medical information is specialized, the consumer often has no knowledge as to whether the treatment prescribed for a given illness is necessary. Without a third party opinion, there is little reason for restraint in prescribing medical treatment. Furthermore, many consumers purchase medical care infrequently and consequently do not know whether the price for a particular procedure is in fact a good price. Since price advertising is not common in the medical profession it is very difficult for consumers to develop even a casual understanding of the costs of the system.

The emphasis on medical technology also contributes to high costs. The U.S. is a leader in the development and use of high technology medical treatments. Much of this may be due in part to the historical tendency for insurance coverage to pay for any treatment without regard to cost. Furthermore, in comparison to the Canadian system, technology is used much more broadly. In Canada, high technology devices such as CAT scanners tend to be available only at specific hospitals, while in the U.S., they are available almost everywhere.

Health care costs in the Seventh District

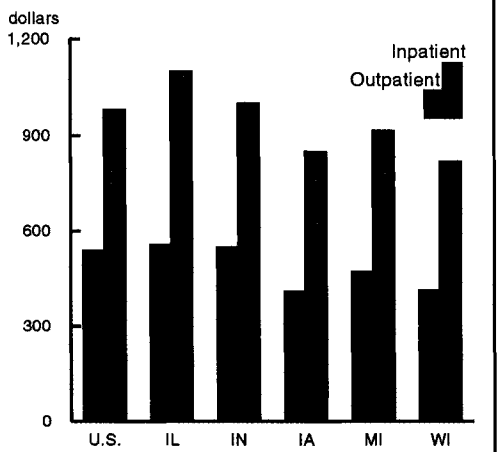
Costs and demand for medical care are not uniform across the U.S. This lack of uniformity has led some analysts to favor state based solutions to health care cost and availability concerns, fearing that a federal solution will fail to recognize local variations in these problems. This section examines the supply and demand factors as well as the cost for health care in the states comprising the Seventh District (Illinois, Indiana, Iowa, Michigan, and Wisconsin) relative to the rest of the nation.

One indicator of the District's cost of health care can be found in average surgery and hospital charges. For inpatient surgery, the District's average 1989 cost per surgery was $936 versus a U.S. average of $980. However the average surgery charge within the District ranged from $1,099 in Illinois to a low of $817 in Wisconsin (see Figure 3). The Figure also shows a similar pattern for outpatient surgeries. Similarly, the average daily cost per admission for hospitals was below the national average of $586 in Indiana ($571), Iowa ($431), and Wisconsin ($483). The costs were above the U.S. average in Illinois ($632) and Michigan ($643).[10]

District states were found to lag the nation in utilization containment for health care services. For example, the national average for surgical procedures is 74 per 1,000 of population. All of the District states, except Iowa with 61 per

FIGURE 3

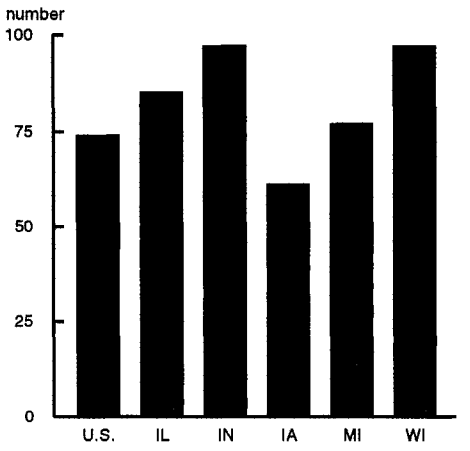
Average charge per surgical procedure (1989)



SOURCE: Mutual of Omaha Insurance Company, *Current Trends in Health Care Costs and Utilization.*

FIGURE 4

Number of inpatient surgeries per 1,000 population (1989)



SOURCE: Mutual of Omaha Insurance Company, *Current Trends in Health Care Costs and Utilization.*

1,000, had surgical rates which were significantly higher (see Figure 4). Similarly, District statistics for the average length of stay for a hospital visit are slightly above the U.S. average. The national average hospital stay is 7.2 days. District states range from 6.6 days for Indiana and 7.4 for Michigan, Wisconsin, and Illinois, to 8.2 for Iowa.[11] This higher utilization may reflect the fact that health insurance coverage in District states is generally broader than the U.S. as a whole. For the U.S., 17.4 percent of the nonelderly population have no health insurance, while the percentage without coverage in the District is much lower. Wisconsin leads the way with only 9.8 percent of the population without health insurance, followed by Michigan (11.9), Iowa (12.7), Illinois (14.5), and Indiana (16.9).[12] Broader coverage may encourage more active use of medical services.

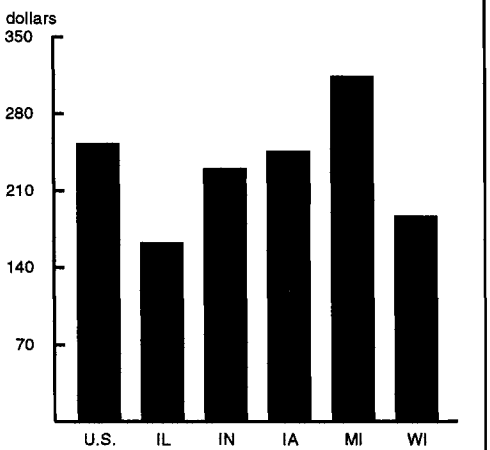
In the area of public expenditures for health and hospitals, District annual per capita public expenditures were below the U.S. average. As Figure 5 shows, only Michigan's public spending on health and hospitals is above the U.S. average. Even in the difficult area of Medicaid payments per capita, three of the five District states spent less than the national average. The U.S. average for Medicaid payments was $185 as compared to $151 in Illinois, $167 in Indiana, and $149 in Iowa. Only Michigan and Wisconsin were above at $198 and $209 respectively.[13]

Other factors which can influence the supply of and demand for medical services include the availability of health services (the health care infrastructure) and health characteristics of District citizens. With respect to health care availability, the District is better than average in access to hospital facilities. While the U.S. average is 4.1 hospital beds per 1,000 of population, District state averages are 4.5 for Illinois, 4.2 for Indiana, 5.2 for Iowa, 4.0 for Michigan, and 4.5 for Wisconsin.[14] In the number of physicians relative to the population as a whole the District fares somewhat worse. The national average for physicians per 100,000 population is 225. All of the District states are below this figure with Iowa showing the largest relative deficit at 154 physicians per 100,000 population (see Figure 6). However, it should be noted that a relatively large supply of physicians does not appear to reduce medical costs. States such as New York and California have among the highest prices and expenditure levels for medical services despite having more doctors per 100,000 population. The concentration of higher priced medical specialists coupled with a demand for their services may explain why the presence of more physicians has not created price competition which would act to hold down medical costs in these two states.

In terms of health characteristics of District citizens two statistics are helpful. Demographically the District has approximately the same

FIGURE 5

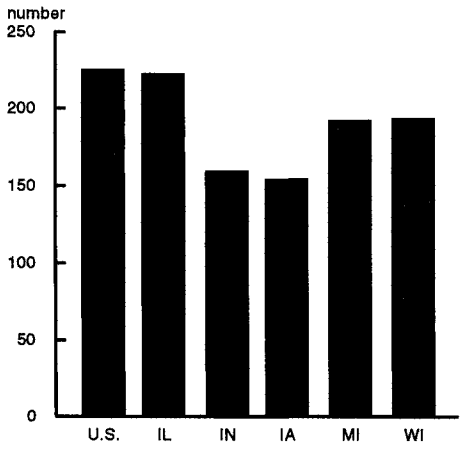
State and local per capita spending on health and hospitals (1988)



SOURCE: State Policy Research Inc., *States in Profile,* Table I-20.

FIGURE 6

Number of physicians per 100,000 population (1986)



SOURCE: State Policy Research Inc., *States in Profile*, Table I-14.

percentage of citizens that are 65 or older as the rest of the nation (roughly 12.5 percent). This is important since the elderly consume a significantly larger share of health care expenditures than the rest of the population. Since the District's share of this segment of the population is roughly similar to the nation, health care costs attributed to the elderly should rise at the same rate as the national average. Table 3 shows the mortality rates from the four leading causes of death. As expected, the District averages are roughly comparable to all regions except the West, where death rates from heart disease, cancer, and stroke are all significantly lower.

One area where District states may be able to make headway in controlling health care costs is managed care. District figures on participation in HMOs (health maintenance organizations) and PPOs (preferred provider organizations) indicate that District states, like much of the U.S., could increase participation in these organizations to control health care costs. Evidence suggests that these types of health organizations have a greater incentive for internal cost control which reduces total medical costs since fees for procedures are often fixed. Nationally, 13.2 percent of the population is enrolled in HMOs. In the District, Wisconsin leads the way with nearly 22 percent of its population in HMOs, followed by Michigan (15.3 percent), Illinois (13 percent), Indiana (7.8 percent), and Iowa (7.2 percent).[15]

Explaining the variation in regional medical costs

Some of the factors which explain the variation in regional health care costs are obvious. Areas with a higher cost of living and higher labor costs tend to have higher medical costs. Similarly, metropolitan areas with technologically advanced hospitals, concentrations of medical specialists, and the ability to perform advanced medical work also tend to have higher medical costs.

However other forces are at work. One recent study examining regional cost differences in Medicaid was conducted by Jane Sneddon Little of the Federal Reserve Bank of Boston.[16] While Little's findings concern variations in state Medicaid costs, they provide some interesting insights into potential explanations for variations in general health costs. In her paper, the rate of reimbursement provided by Medicaid for nursing home care is found to be the most significant factor in explaining regional Medicaid price variations. States with high nursing home reimbursement rates tended to have high Medicaid costs and vice versa. However, while states with lower reimbursement rates had lower Medicaid

TABLE 3

Death rates—four leading causes
(1987 per 100,000 residents)

State	Heart	Cancer	Stroke	Accident
IL	336.8	200.1	59.6	33.1
IN	322.9	199.9	69.0	38.7
IA	366.8	208.3	77.0	37.2
MI	331.2	191.8	59.5	34.2
WI	326.9	196.5	70.6	34.4
Regional averages				
Northeast	343.6	218.2	60.1	33.2
Seventh District	336.9	199.3	67.1	35.5
North Central*	328.6	195.9	68.5	38.8
South	319.3	201.3	66.4	45.5
West	218.5	153.5	46.5	48.2

*Minus Seventh District states.
SOURCE: National Center for Health Statistics, Monthly Vital Statistics Report, September 26, 1989.

costs, these savings did not appear to spill over into personal health care costs for nonMedicaid recipients. Practices such as cost shifting from Medicaid to other payors (such as private insurers willing to pay higher charges for medical services) appear to be common, making personal health care expenditures vary less from state to state. The tendency to cost shift makes it very difficult to know what medical services are being provided in state to state comparisons. Each state's medical dollar may be buying different levels of service and this may explain some of the regional variation in medical costs.

Cost shifting also occurs in the health care system as a whole when negotiated discounts are used to control private health care costs. What happens is that either an individual company or group of companies negotiate specific discounts with a particular provider. For example, a different fee structure for services at a particular hospital might be the focus of such a discount. While these discounts provide lower costs to the recipients of the discounts, they may lead the health care provider to charge even higher fees to companies and individuals not included in the negotiated discount plan. Furthermore, the discount can also lead to reduced access to health care for individuals covered by the discount because the provider has an incentive to serve full paying patients first, rather than those with the discount. Negotiated discounts can limit health care costs for a segment of the population but they may not reduce the cost of health care for society at large unless the discount is available to everyone.

Proposals for reforming the health care system

Factors such as regional variations in the utilization, cost, and availability of health care have spurred a wide range of state health care reform measures in the U.S. Virtually all of these proposals are designed to address two issues: cost containment and access to health care. The interest in cost containment is obvious given the escalation in health care prices. Government, business, and individual consumers all agree that health care costs cannot continue to rise at current rates. There are an estimated 37 million Americans without health insurance[17] who have less access to medical care and often are forced to receive medical care in emergency situations, increasing the cost of treatment. This treatment is often uncompensated, which induces cost shifting to privately insured patients. Consequently, cost containment and access to health care are the twin goals of most proposals.

Most reform proposals are a variation on three general frameworks: market based reforms, "play or pay" proposals, or national health insurance. All three types of proposals include the private provision of at least some medical services and do not favor the adoption of an all inclusive public health care system, such as the system in the United Kingdom, where medical services are provided through publicly supported facilities staffed with public employees.

Market based reforms

Most of the so called market based reform proposals assume that a lack of market discipline explains much of the recent rise in medical costs. Since insurance often makes the consumption of medical care relatively costless to consumers, they have no real incentive to seek lower prices or reduce their consumption of medical care. If consumers were forced to bear a greater cost for consuming medical care, according to this view, they would consume it more wisely and would have a greater incentive to limit their use of medical care by adopting healthier lifestyles. Similarly, if health care providers found that higher prices for medical services reduced patient demand, it is assumed that they would have a greater incentive to provide more cost efficient care. For example, the Heritage Foundation has proposed making health care a taxable benefit.[18] The argument is that because health insurance is tax exempt, individuals purchase more health insurance (in terms of taking on broader coverage) than they would if they actually had to bear the full cost of the purchase, if only from a tax perspective. If the full cost of employer sponsored plans was taxable, people might be more willing to opt for lower cost managed care and HMO options or accept coverage which more closely reflects their lifestyle.

Generally speaking, these proposals are also geared toward maintaining a system of private insurance as the most efficient method for providing health coverage for everyone. In order to extend private health insurance to the poor, market based proposals usually contain voucher and tax credit options. For example, the Bush Administration's market based reform proposal provides for a $3,750 voucher for a family of four to purchase health insurance.

Opponents point out that the cost of health insurance for a family of four will probably exceed the voucher payment. Supporters of these proposals believe that managed care programs now being pursued by insurers show great promise for controlling health care costs. Since insurers have a profit motive, they are best positioned to monitor the appropriateness of medical expenditures and procedures.[19] Critics of market based proposals worry that medical rationing will result. While making consumers bear more of the cost of consuming medical care would probably reduce demand for medical services, it may also lead to underconsumption of appropriate medical care. To avoid copayments or higher insurance premiums, individuals may try to avoid consuming medical care even when beneficial. For example, they might avoid diagnostic screenings where early detection of disease might prevent more expensive treatment later.

"Play or pay" proposals

These proposals try to expand health care coverage by requiring that employers provide a minimal health insurance package for their employees (play) or pay a payroll tax for a new health care program designed to cover the uninsured with publicly provided health plans. These proposals usually have guidelines that would initially apply play or pay standards to businesses of a certain minimum size (10 employees) and then only to employees working more than 17.5 hours per week. Furthermore, to reduce potential opposition, most play or pay options include some provision for cost containment, usually through a form of public rate setting for medical services.

Play or pay is partially designed to address the plight of workers in industries where health insurance coverage tends to be slight. For example it is estimated that almost 50 percent of retail and nearly 75 percent of hotel and restaurant workers are not covered by health insurance. However, critics of play or pay point out that the additional costs of pay or play may encourage businesses to lay off marginal workers or at least limit their demand for new workers. The target group of employees might find themselves not only uninsured but unemployed. Also, it is unclear how employers who currently provide health care would react to the play or pay option. Given that the payroll tax may be cheaper than paying for health insurance premiums, it may be that some employers would actually choose to repeal coverage and pay the tax, thereby straining the financial solvency of the system.[20]

National health insurance

National health insurance proposals are usually based on the Canadian health insurance system in which the government becomes the primary payer for all medical services. The provision of medical services remains a private industry but the government pays for virtually all medical treatment for all Canadian citizens. To pay for the system, Canada levies taxes in lieu of private health insurance premiums. While secondary insurance plans are available to cover certain special costs (such as private hospital rooms, dental services, and eyeglasses), almost all other costs from check-ups to surgery are covered by national health insurance. The government also becomes responsible for setting rates for medical procedures and is therefore able to use its single-payer clout to try to control medical costs. The system also reduces costs by cutting the administrative expense associated with dealing with large numbers of private insurers. (The U.S. has an estimated 1,500 private insurance companies).

The Canadian system is also designed to reflect differing regional preferences for medical care. The central government pays a minimum of 40 percent of each provinces' health tab but the remainder is allocated by each province. In designing a health care program, each province must address five national objectives. These are: 1) the plan must cover all citizens; 2) all medical and basic hospital services must be included; 3) no user fees or other special billing fees can be used to limit access; 4) the plan must be transferable with no change in coverage if a plan recipient changes jobs; and 5) it must be publicly administered.[21]

The biggest objection to national health insurance plans concerns de facto access to health care. The government sets the reimbursement rates for specified procedures only and establishes the capital spending for hospitals. As a result, highly sophisticated equipment tends to be found in only a handful of university hospitals. For example, while the U.S. has nearly 2,000 hospitals with magnetic resonance imaging machines (MRIs), Canada

has only 15.[22] Thus, Canadian hospitals often have to schedule procedures to reflect the availability of equipment. This in turn causes long waits for routine but necessary surgery. The U.S. General Accounting Office (GAO) estimates that in Canada, six month waits for CAT scans and one year waits for orthopedic work such as hip replacements are common. In contrast, privately insured Americans are largely accustomed to a system of medical care on demand. The benefit of the Canadian system is evident in lower fees and average per capita health costs. However, there is some dispute whether the lower per capita health costs are the product of the health insurance system or simply reflect the fact that proportionately fewer Canadians are either poor or old than is the case in the U.S. These are the most expensive patients to treat.[23]

U.S. state based plans

States have grown impatient waiting for the federal government to devise a national health care plan. Pressured by constituents and the growing contribution of health care costs to state budget problems, more than two dozen states have passed some form of health care reform. Some of these programs are sweeping in scope while others intend to address more limited areas such as reducing the cost of publicly provided health programs or increasing health care coverage. The following examples illustrate the variety of the proposals being developed at the state level.

Iowa

Iowa has shown increasing interest in play or pay reforms to address health care cost and availability issues. Massachusetts passed a similar measure in 1988 but the implementation of the plan has been delayed until 1995 by a state budget crisis and a severe economic downturn.[24] The Iowa proposal has been designed by a consortium of hospitals, businesses, labor unions, and insurers. As such it has broader based support than most reform efforts. The plan would require all Iowa residents to have health insurance and would extend coverage in two ways. Employers would either have to provide health insurance for their employees or pay a 5 percent payroll tax. The payroll tax would be used to provide health insurance subsidies on a sliding scale for those uninsured that have incomes up to 250 percent of the federal poverty level.

Under the Iowa proposal, cost containment is achieved in a variety of ways. First, emphasis would be placed on using managed care methods designed to limit the choice of medical providers for consumers. In addition, while insurance would still be provided by private insurance companies, reimbursement rates from insurers to medical providers would be standardized. Furthermore, growth in the cost of health insurance would be limited by establishing a ceiling on the percentage of health insurance premiums that could be claimed as profit and overhead by the insurer, presumably encouraging insurers to reduce overhead in order to increase profits.

Opposition to Iowa's play or pay scheme has been voiced by several parties. The first source of friction is small business. For those small businesses which traditionally have not provided health insurance to their workers, the play or pay program immediately increases costs. These Iowa businesses usually claim they will be less competitive if they face an additional cost of doing business which small businesses in neighboring states will not face. For large companies with comprehensive medical plans, there is the fear that these businesses will drop medical coverage (estimated to cost 13 percent of payroll costs) in favor of the lower priced 5 percent payroll tax. Such an incentive would lower health care expense for firms with medical plans but it would also have the unintended effect of expanding the share of the population needing to receive insurance through the state's health insurance pool which would be created through the new payroll tax. In response to this, some have suggested placing up to a 10 percent payroll tax on larger companies in an effort to discourage such defections.[25] However, these fears may be unfounded or at least limited in any case. Employees would certainly object to any unilateral withdrawal of health benefits, and multistate companies would be hard pressed to offer medical benefits which differed so drastically from one location to another.

Oregon

Oregon has come up with an innovative but controversial proposal for insuring health care coverage for nearly all state residents while containing costs. The future of the plan is in limbo since the state did not receive the waiver from the U.S. Department of Health and

Human Services (HHS) which was needed to implement the plan, but it is expected that the state will resubmit the proposal once the HHS objections can be addressed. One aspect of the plan which is drawing particular attention involves guaranteeing health care for all state residents below the poverty level through a system of public rationing of medical care. The potential use of rationing to control expenses has been evolving in the state since 1989. Under previous law, Oregon has set out plans to insure coverage for all citizens through either private insurance or Medicaid. To make this affordable, the state proposed limiting the range of services provided. The idea was to establish a minimum health plan of specific covered services which would be extended through Medicaid to all citizens below the federal poverty level. (Previously, Medicaid in Oregon only covered citizens with incomes lower than 50 percent of the poverty level.) As a second step, by 1995, most employers will have to provide a health benefits package which provides the same level of coverage as the state's Medicaid package provides.

The Oregon proposal attempts to contain costs by limiting the types of treatments available to patients. Oregon has circumscribed the allowable range of health care services by creating a ranking of possible medical treatments. The Oregon Health Services Commission compressed 10,000 diagnoses and treatments into 709 "condition-treatment" pairs. For example, one such pair would be: condition—appendicitis; treatment—appendectomy. Next, the commission developed 17 social importance categories for the 709 condition-treatment pairs. These categories ranged from those deemed "essential" to those deemed "valuable to certain individuals." An example of an essential treatment would be a procedure which prevents death and leads to full recovery of the patient. An example of a treatment which would be valuable to certain individuals would be a treatment which provides minimal improvement in the patient's quality of life or is geared to helping recovery from a self-limiting condition, for example, plastic surgery for minor scarring. This procedure created a rank ordering for the condition-treatment pairs based on the impact of the treatment on the patient's quality of life and the clinical effectiveness of the treatment. Once the list was established it was submitted to the legislature and it was the legislature's task to determine how much of the list would receive state funding. The legislature decided to appropriate enough funds to cover services numbered 1 through 587 on the list. Services below 587 would not be covered in the Medicaid package. Health care providers would be legally entitled to deny treatment to patients seeking treatments not covered by the plan. The tradeoff in the Oregon system is clear. Health care is extended to a broader audience but at the cost of limiting the available services.

Critics of the rationing system have questioned the ethics of such an approach. Is it ethically correct to ever withhold treatment even if the benefits of the treatment are marginal? One of the objections raised by the U.S Department of Health and Human Services in rejecting the state's request for a waiver to implement the program was the possibility that treatment for people with disabilities could be denied under the Oregon ranking system. Since the treatment might be necessary but may have little effect in improving the condition of a disabled individual, it was likely that the Oregon plan would not cover these medical procedures. This was seen as potentially discriminatory. By ranking potential treatments on both a societal and individual benefit basis, government is in fact determining the value of a treatment for an individual. Proponents of the plan counter that rationing of medical care already exists when individuals are denied health care coverage. This plan insures that everyone has at least a minimal level of medical care guaranteed. More broadly, the nature of public budgeting is always to ration dollars between competing goals. Health care competes with national defense for funding. Given this, why should rationing amongst health care benefits be any different?

A less philosophical argument questions whether the cost containment goals of this approach will, in fact, work. Given that a diagnosis is more of an art than a science, some question whether health care providers can circumvent limits on coverage and tailor some diagnoses to fall under covered treatment classes. Also because the effect of treatment and the severity of the same illness varies from patient to patient, ranking systems may be inherently arbitrary and doomed to fail. A treatment which might provide a complete return to health for one patient may be ineffective for another. As such the rankings may be arbitrary and ineffective.[26]

Vermont

Vermont has recently passed a law requiring that universal health care coverage be made available to all residents by October 1994. This legislation has prompted the state to consider two primary options for providing universal care. The first would be to adopt a Canadian style, single-payer health insurance program in which the state would set medical prices and be responsible for paying all medical bills. Alternatively, the state is also considering a multiple-payer plan in which the state would set all health care prices, but private insurance companies would still be used to provide health insurance coverage.

As envisioned, the Canadian style program would provide comprehensive care to all residents without any deductibles or copayments by patients. The system would be financed from revenues from the state's income, sales, and payroll taxes. Proponents of the system believe that costs will be contained not only through price setting, but also through a reduction in administrative cost by eliminating multiple payers. As of yet it is not certain whether the single-payer will be a public or private agency.

The multiple-payer approach is based loosely on the experience of West Germany's health plan which was considered successful at containing health care costs in the 1980s. (A multiple-payer approach has since been adopted throughout unified Germany.) The system consists of a number of nonprofit organizations (called sickness funds in Germany) which collect insurance premiums from employers and employees. The premiums are then paid to regional doctor's associations which uses the money to provide health care. The state sets prices and provides insurance to the unemployed. It is assumed that in Vermont, existing insurance companies would serve the role of collecting premiums.

While it is unclear which approach will be adopted, Vermont has already passed several health care reforms. The state has established a three member Health Care Authority with oversight authority including the power to negotiate insurance rates for state residents. Other reforms include: establishing a standard set of benefits; insuring that benefits are portable from one job to another; subsidizing primary care coverage for all pregnant women and teenagers with family incomes up to 225 percent of the federal poverty level; and centralized budgeting with nonbinding expenditure targets for hospitals, clinics, and physicians.[27]

Virginia

A more limited approach aimed just at cost containment is being tried by Virginia. The state has chosen to revive its certificate of need program. This program, which was started in 1974 by the federal government, was designed to create state oversight for hospital expansions. The belief was that through aggressive growth plans, hospitals were creating an oversupply of hospital beds and services and in doing so were driving costs up through duplication of services. Unrestricted capital construction and high technology acquisition encouraged utilization of expensive hospital facilities for procedures which could be performed in doctors' offices. The certificate of need program required hospitals to prove to a state board that they had a need for expansion or new equipment.

The program was largely discontinued by states when federal funding was eliminated in 1986. However, Virginia has returned to the certification of need concept in an effort to control costs. Part of the state's interest in returning to this form of regulation stems from the fact that from 1989 to 1991 hospitals spent $130 million on expansion and new technology in Virginia. The state estimates that 50 percent of this would have been denied if the certification of need program had been in effect. Furthermore, the certification program uncovers one of the problems with incentives in the health care market. Unregulated competition in health care encourages hospitals to provide the best technology for patients rather than the best price per unit of care.

Critics of the certification program point out that its success has been mixed. One study by the University of Alabama at Birmingham found that the program may have encouraged hospital expansion as hospitals accelerated growth plans in anticipation of tougher regulation which would reduce future expansion. Others have criticized the program for reducing access to health care by limiting the facilities of hospitals.[28]

Kentucky

Another more limited reform approach aimed at controlling Medicaid costs is being tried in a number of states, but most notably in Kentucky. These programs are generally designed to introduce managed care reforms into

the Medicaid system. In Kentucky's case, the thrust of the reform is to use family physicians as the primary care giver for Medicaid cases. In the past, Medicaid patients often had no family doctor. When treatment was needed the recipient would go to the hospital or seek out a specialist for their specific ailment. This method of treatment was expensive and resulted in uncoordinated care for patients. By using a family doctor, additional treatment can be coordinated and costs reduced by using specialists and hospitals only when they are necessary. Kentucky estimates that this program will save the state $120 million this year while covering 288,500 participants.

Critics of the program believe that the set reimbursement schedules for family physicians treating Medicaid patients will encourage doctors to reduce the quality of their services. Also, critics point out that such an approach may not work well in states with little experience with managed care programs, particularly those with few HMOs. For example, Wisconsin estimates that it saves $10 million per year with its managed care system for 122,000 AFDC recipients; however, it has been unable to expand the program because of the lack of HMOs to function as service providers.[29]

Conclusion

Due to the lack of national consensus on a health care policy, states are again proving to be the laboratories of public policy. Through the state's varied approaches, a better understanding of the most promising programs for expanding coverage and moderating costs may emerge. Clearly, any solutions will have to address those aspects of the health care market that have gone awry. The practice of providing the best possible care without regard to cost will likely give way to a more cost effective approach to health care provision. It is also likely that individual consumers of health care services will have to bear a greater share of the cost of consuming health care. Greater incentives for maintaining personal health are likely to be adopted, as well as the use of disincentives for destructive and self-inflicted health problems related to behaviors such as smoking and drinking, which currently bear no insurance penalty.

Most of all, solutions will have to address both the cost and access to health care. Based on the diversity of the proposals under consideration, the state experiments in health care are on the right track and may well point to an effective health care policy for the nation as a whole.

FOOTNOTES

[1]See Health Insurance Association of America, (1990), p. 55.

[2]See Koretz (1992), p. 22.

[3]See Gardner (1992), p. 28.

[4]Wessel, *The Wall Street Journal*, May 11, 1992, p. 1.

[5]HIAA, p. 61.

[6]See Harden (1992), p. 61.

[7]Ibid, p. 48.

[8]For more on supply and demand factors affecting medical costs, see Fuchs (1972).

[9]Ibid.

[10]American Hospital Association (1989).

[11]HIAA, p. 64.

[12]State Policy Research, Inc. (1990), Table I-24.

[13]Ibid, Table I-19.

[14]Ibid, Table I-15.

[15]HIAA, p. 31.

[16]Little (1992), pp. 43-66.

[17]Rowley (1992), p. 15.

[18]Graham (1992), p. 23.

[19]Ibid, pp. 22-26.

[20]Ibid, pp. 22-26.

[21]Ibid, pp. 14-16, 18, 22.

[22]Lays (1992), p. 62.

[23]*New York Times Company* (1992), p. A-14.

[24]Biemesderfer (1992), p. 58.

[25]Worthington (1992b), pp. 1-2.

[26]Wiener (1992), pp. 26-30.

[27]Worthington (1992a), pp. 15-16.

[28]Wagar (1992), pp. 20-22.

[29]Knapp (1982), pp. 16-19.

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