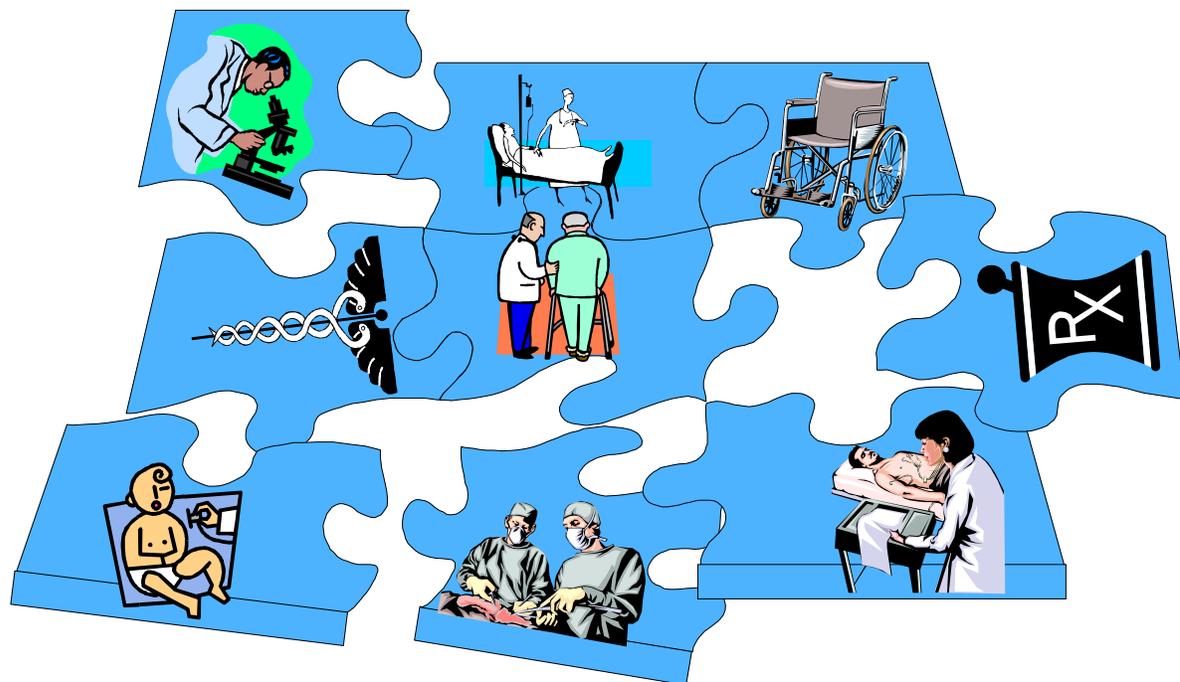


BLUEPRINT FOR FAIR SHARE HEALTH CARE: INCREMENTAL STEPS TOWARD UNIVERSAL COVERAGE



CONSUMERS UNION

MAY 24, 1999

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SUMMARY:
BLUEPRINT FOR *FAIR SHARE HEALTH CARE*
MAY 24, 1999

Introduction

Today consumers are at greater risk of being uninsured or underinsured than they were in 1994, when efforts to enact health care reform died. While the *easy* part of achieving health care reform is developing policy models that lead to universal coverage, the more difficult ingredients are Presidential and Congressional leadership, campaign finance reform, and a powerful consumer-based grassroots movement.

What the Public Wants

One of the reasons health reform has not been enacted is that there is no public opinion consensus on how to reform the health care system. The needed public consensus for reform never emerged because of the public's diversity of viewpoint, and the basic satisfaction level of the vast majority of Americans who are insured. Some of the areas where there is a near consensus of public opinion: people tend to want *choice* of doctor and health plan; *quality* health care; *prompt* health care; a *voluntary* system. In general, the public tends to oppose an expanded *government* interference in what should be private health care decision-making; rapid *change* in the health care system; policies that *increase taxes or health insurance premiums*; or *rationing* of health care.

Health Care Market Failure

Many types of market failure present challenges for finding solutions to the health care problems. Some of the dimensions of market failure (and the limitations of market-based solutions) include: (1) third-party insurance payment makes consumers less sensitive to health care costs; (2) Americans are too compassionate to let gravely ill people be denied needed treatment because they can't afford it; (3) for many medical decisions, doctors, not consumers, are the decision makers; (4) information is imperfect; (5) employers, not employees, often choose health plans; (6) the cost of providing "the product" varies from one consumer to another; (7) powerful special interests (who profit from the current health care system) are a dominant force in shaping policy through their advocacy before Congress and state legislators/regulators.

Failed Incrementalism

The health reform measures enacted since 1994 have not moved the nation closer to universal coverage. Instead, with each small step forward, the country has moved two steps backward. The result: there are now about 43 million Americans with no health insurance; 31 million Americans are underinsured, facing financial catastrophe if they get sick even though they have health insurance; health care costs as a percent of gross domestic product are projected to continue to increase, from 14 percent today, to 17 percent in 2007. The Health Insurance Portability and Accountability Act has not met the high expectations, demonstrating that the real issue defying easy solution is affordability of coverage. The Children's Health Insurance Program, while a step in the right direction, will leave millions of children uninsured. The burden of paying for health care continues to fall disproportionately on the poor and the sick.

While in one sense these failures were totally predictable in a system that requires a major overhaul, not just incremental reform, that isn't the whole story. Piecemeal reform need not move us backwards, even if it doesn't necessarily yield the ideal solution. And regardless of what is ideal, we know the political process does not seem to allow for a comprehensive approach at this time. So should we do nothing and wait for the system to collapse? At Consumers Union, we don't think so. We believe that the most responsible path for those who care about universal health care is to develop a long term blueprint which pieces together the key elements of what must be done – and what must be prevented – to facilitate achievement of our ultimate goal.

Models for Reform

Consumers Union's goal for health care reform is: *Every person must have access to quality health care at an affordable price, with the right to choose providers and the right to have complaints resolved fairly.*

There are many possible paths that could lead to this goal. We could use the public sector as a single payer of all health insurance for all people. Or we could mandate employer-provided coverage (with various levels of employer funding). We could provide incentives for states to individually take the lead on the path toward affordable coverage for all. Another approach would be to allow individuals to buy into the Federal Employee Health Benefits Program. Another path would be an individual mandate (combined with an overhaul of the individual health insurance market and targeted subsidies to make premiums affordable).¹

¹ This would represent a dramatic change from our current employment-based system. There are various ways of structuring such a system. One way would be to use the income tax system as the enforcer. In any individual-based system, careful design to achieve the equivalent of community rating (in our employment based system) is key. In addition, we would need income-based subsidies to assure affordability.

Principles to Guide the Path to Affordable Health Care

The following principles should guide efforts to piece together enough health care reform to meet our ultimate goal of quality, affordable health care:

1. Broad pooling of risks (keeping the sick and the healthy in one broad risk pool.)
2. Progressive financing (with contributions based on ability to pay).
3. Targeted subsidies based on income (making coverage affordable to all, including all children, the working poor, early retirees).
4. *Meaningful* and understandable consumer choice (replacing frivolous variation in benefits with standard benefit packages).
5. Comprehensive benefits (including prescription drugs, caps on out-of-pocket costs, and no limits on lifetime benefits).
6. Healthy competition in the marketplace (prohibiting companies from profiting by excluding the sick from coverage).
7. Fair marketplace rules (leveling the playing field so that companies that meet consumers' needs are rewarded).²
8. High quality care (with protections for patients that assure full accountability for treatment decisions and create incentives for good outcomes).
9. Targeted programs for vulnerable populations (meeting the needs of the poor, the elderly, the disabled, and the very young).
10. Strengthened safety net (with consumer-friendly reforms of Medicare and expanded access and continuity of coverage for Medicaid).

Implications for Public Policy

Changes that would move us forward include programs for early retirees and children, targeted subsidies for the unemployed and working families, a tax credit for families spending the most (as a percent of income) on health care, and expanded Medicare benefits. Changes that would be a step backward (continuing the path of failed incrementalism) include expanded Medical Savings Accounts, changing Medicare benefits from “defined benefit” to “defined contribution³,” eliminating state benefit mandates (without creating a comprehensive standard benefit in their place), and exempting more insurers from state consumer protections.

² In other words, companies that meet the needs of high-risk populations would not be penalized. One mechanism is risk adjustment that provides higher payments (i.e., transfers between health plans) to companies serving higher risks.

³ A “defined benefits” means a fixed benefit package, while a “defined contribution” refers to fixed payments, e.g., through a voucher. The latter holds the potential to provide better budget control, while placing beneficiaries at risk of erosion of their benefits.

Conclusion – A Call for *FAIR SHARE HEALTH CARE*

We need to move from our patchwork system characterized by gaps, toward a *tapestry* concept that weaves together into a coherent whole the various functional parts of the system, acknowledging that we are all in this together, and interdependent. Consumers Union needs to educate the public about the unfair burden the current health care system places on the poor and the sick. We need to help the nation define health care finance fairness – and work toward limits on families’ exposure to out-of-pocket health care expenditures and premiums. We need to adopt as our motto, “Fair Share Health Care,” with each American paying a fair share – and every American enjoying quality coverage.

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Introduction

The quest for a health care system that provides quality, affordable health care to all of America's citizens continues to be unfulfilled. Since 1937, efforts of Members of Congress and Presidents, Republicans and Democrats alike, to enact assorted national health bills have met the same fate: *failure*. The 1994 demise of President Clinton's attempt to enact the Health Security Act was followed by marketplace changes and piecemeal legislative efforts that leave American consumers at *greater* risk of being uninsured or underinsured. It is clear after decades of failure that the *easy* part of health reform is developing the policy models that lead to universal coverage. The more elusive, yet necessary, ingredients of success include effective Presidential and Congressional leadership, campaign finance reform, and a powerful pro-reform consumer-based grassroots movement. The sad reality may be that increased consumer hardship – rising out-of-pocket costs, reduced coverage, and increased risk of losing coverage – may be what it takes to light the ignition for a successful campaign to enact real reform.

What the Public Wants

One of the reasons that health care reform has never been enacted by Congress is the difficulty in determining what the public truly wants from health reform. So much depends on individuals' situations – which vary widely. Are they insured or uninsured? Are they employed with an employer-based plan or not? Are they healthy or sick? There is not a consensus of views among the public. There were a variety of messages of public “wants” from the 1993 - 1994 health reform debate. Some of the lessons of that debate are:

- People want ***choice***: choice of doctor, choice of health plan. By having choice, members of the public feel empowered to be in control of their health care situation.
- People want ***quality***: Americans value the high quality of care -- “the best health care in the world” that those able to receive care in our health care system enjoy.

- People want *prompt* health care: they do not want to be forced to face “queues” for care that mean delay of treatment, whatever their health care needs might be.
- People like *voluntary* programs, and this presents challenges to reform since the key to bringing average costs down is the largest possible risk pool.

The medical savings account (MSA) demonstration seems to have yielded another indicator of what consumers want. There seems to be a consensus that fewer consumers than expected have enrolled in the MSA demonstration program. While some people blame excessive government regulation, others say that the lack of enthusiasm stems from the public’s desire to have first-dollar, comprehensive coverage.

The 1993 - 1994 debate also taught us what the American public does *not* want in their health care system. In general:

- People do not want *government* involvement in decisions about their health care. They prefer decisions to be made by doctors, not bureaucrats.
- People do not want rapid *change* in the system. If they are satisfied with the health care plan that they have (and it is important to remember that over 80 percent of nonelderly Americans have coverage), then they feel threatened by “reform.”
- People do not want to pay *higher taxes or premiums*.
- People tend to oppose *rationing* of care – whether by the government, profit-oriented health plans, or unaffordably high prices.

Because of the absence of consensus, coupled with the fact that an overwhelming majority of Americans have coverage, public opinion is susceptible to being influenced by advertising that tries to sway opinion. Hence, the public was open to the loud message from “Harry and Louise” that made people feel threatened by change, building on the concern that they would lose their choice of doctor if the Clinton health plan were enacted. Ironically, in its place they now have the very system Harry and Louise cautioned against.

Health Care Market Failure

Consumers Union continues to support working for a health care system that meets *all* consumers’ needs, despite the lack of a public consensus. Whatever one’s perspective on how to best expand health care coverage, there is agreement about the existence of

market failure in the health care system. While Consumers Union has been devoted for over 60 years to providing information to consumers to help make a variety of consumer product and service markets work better, there are many sources of market failure in the health care system that make market-based solutions incapable of meeting all of our goals for the health care system. Some of the dimensions of market failure in the health care system are:

1. *Third-party (insurance) payment makes consumers less sensitive to the cost of health care.*

Since consumers don't have to pay directly the full cost of doctors' visits and hospitalization (once they've met their deductible), they may "demand" more services than they would if they faced the full cost.

2. *Americans are too compassionate to let gravely ill people be denied treatment because they can't afford it*

In most markets, there is acceptance that people with more disposable income can buy more expensive products, whether it is the market for cars, houses, or toasters. Yet when it comes to health care, there has been a fair deal of support for making sure that everyone's basic health care needs be met – whether through private insurance, Medicare, Medicaid, or so-called "charity care" provided by hospitals and doctors. This support is strong where there is a human face – a real person with a health care crisis – but not strong enough to forge a groundswell that insists on reform. Americans do not accept letting emergency rooms turn away bleeding patients, denying needed treatment to the poorest children, or denying acute health care to the elderly. Letting the marketplace price these people out of care is not acceptable to the public. (For sure, the level of support for health care for all varies, as does the degree of care that people support. Certain populations – the elderly, the poorest of the poor, and children – have been targeted for assistance).

3. *For many medical decisions, doctors, not consumers, are the decision-makers.*

Recently, there has been more focus on involving consumers in treatment decisions. But unlike other markets, it is doctors, not consumers, who have the expertise needed to shape decisions. Since it is consumers, not doctors, who pay the bill (either directly or indirectly), this disparity in decision-maker and payer introduces market-failure since doctors are not facing the price of the service that they recommend.

4. *Information is imperfect.*

Full and understandable information in the marketplace is a key to effective market performance. Yet the health care marketplace is characterized by inadequate information. Consumers do not know their doctors' medical malpractice records; they can not adequately compare the quality of care offered by competing health plans; they do not have a good basis for choosing between different hospitals and health care providers; they do not have the expertise, or resources, or time, in many cases, to make a fully informed decision about competing treatment alternatives.

5. *Employers, not employees, often choose health plans for employees.*

Fewer than half of employees are able to choose from more than one health plan for their coverage. Without a large degree of choice, many consumers are not in a position to “discipline” the marketplace by “voting with their feet” -- switching from one health plan to another.

6. *The cost of providing the “product” varies from one consumer to another.*

With most consumer goods and services, the cost of providing the good or service to one individual (at a given place and time) is the same as the cost of providing it to another. This is not the case with health insurance, since there is a high degree of variation in health costs – based on age, sex, and basic health condition. Insurers understand this variation well, and have a strong incentive to avoid people with higher expected costs (or charge a high price). And there is an interdependence among consumers – in any given risk pool, higher expenditures by one member can lead to higher premiums for the others. Similarly, if healthy consumers choose to enroll in high-deductible health plans, this “selection” can ultimately result in higher premiums for less-healthy consumers who wish to continue to have comprehensive, traditional policies. Unless the government steps in to adjust the premiums people face, consumers pay varying prices for what may appear to them to be identical policies.

7. *Power of special interests*

The voice of special interests – doctors, insurance companies and managed care health plans, pharmaceutical companies, trial lawyers, employers – tends to be very loud and strong before Congress, and too often drowns out the voice of people most in need, in particular the uninsured and underinsured. In a sense, this results in market failure because government policy shapes the health care marketplace, and too often it the special interests, not the consumer interests, that have the most influence on these public policies.

Failed Incrementalism

After Congress failed to enact comprehensive health care reform in 1994, Consumers Union (like others) was forced to respond to incremental health care initiatives. As a result, we developed a short-term, modest consumer agenda for health care reform⁴ which included the following goals:

- Preserve Medicare benefits – in real terms.
- Preserve Medicaid as a safety net for the poor.
- Build consumer protections into managed care plans.
- Improve the private health insurance market (for example by making policies affordable to people who have pre-existing conditions).
- Contain health care costs.
- Improve the ability of consumers to make sound choices in the health care marketplace.
- Make it easier, not harder, for states to enact health reform and protect consumers.
- Improve the private health insurance marketplace for seniors.
- Expand health care coverage of children.
- Enact campaign finance reform.

Indeed, Congress did pursue an incremental strategy on health care, enacting the Health Insurance Portability and Accountability Act in 1996 (i.e., the Kassebaum-Kennedy Act), supposedly making health insurance “portable” when you changed jobs, and the Children’s Health Insurance Program of 1997, which aimed to expand health insurance coverage to children.

And where are we today on our goal of affordable health care coverage? The reality of recent Congressional incrementalism has been “one step forward, two steps back.”

⁴ Rhoda H. Karpatkin and Gail E. Shearer, “A Short-Term Consumer Agenda for Health Care Reform,” *American Journal of Public Health*, October 1995, Vol. 85, No. 10, pp. 1352-1355.

- The number of uninsured Americans has increased to about 43 million, approximately one sixth of the population.
- The number of underinsured Americans has increased to about 31 million. These are consumers who have insurance yet are at risk of facing health care costs exceeding 10 percent of their income.
- While health cost increases in recent years have been modest when compared with increases over the past two decades, health care spending continues to consume a growing share of the gross domestic product, with the percent projected to increase from 13.6 percent today to 16.6 percent by 2007.⁵
- Some analysts estimate relatively low increases in health care inflation (3.3 percent in 1998)⁶, while other indicators show premiums continuing to increase faster than inflation. For example, average federal employee health benefits program premiums will increase 10.2 percent in 1999.⁷
- The reality of the private insurance market, in which insurance premiums are largely unregulated, has served to undermine the goals of The Kassenbaum-Kennedy Act by raising premiums for those who were meant to be helped.
- While the 1997 Children's Health Insurance Program provided \$24 billion of funding over a 10 year program to increase coverage of children, welfare reform has led to *decreases* in Medicaid coverage for children. It is estimated that 4.7 million children are eligible for Medicaid yet not enrolled.⁸ Even with the Children's Program and increased Medicaid outreach, millions of children will remain uninsured.
- Over half of families headed by a person 65 or older pay more than 10 percent of their income on out-of-pocket costs and premiums.
- The burden of paying for health care falls disproportionately on the poor and the sick. Families with income below poverty spend more than 16 percent of their income on premiums and out-of-pocket costs. People in the top 10 percent of health care spending face out-of-pocket costs four times as high as the average.

⁵ Sheila Smith, National Health Statistics Group, Health Care Finance Administration, article to be published in September/October 1998 issue of *Health Affairs*.

⁶ Paul Ginsburg, Center for Studying Health System Change, and Jon Gabel, KPMG Peat Marwick, upcoming article in September/October 1998 *Health Affairs*.

⁷ Office of Personnel Management, reported in *Washington Post*, Stephen Barr, September 13, 1998.

⁸ AHCPR

- Though over 75 percent of Americans are enrolled in some form of managed care, they have no assurance that they will get needed medical care.

While in one sense these failures were totally predictable in a system that requires a major overhaul, not just incremental reform, that isn't the whole story. Piecemeal reform need not move us backwards, even if it doesn't yield the ideal solution. And regardless of what is ideal, we know the political process does not seem to allow for a comprehensive approach at this time. So should we do nothing and wait for the system to collapse? At Consumers Union, we don't think so. We believe that the most responsible path to affordable health care is to develop a long term blueprint which pieces together the key elements of what must be done – and what must be prevented – to facilitate achievement of our ultimate goal.

Models for Reform

Developing the policy models that will achieve affordable health care for all is the easy part. The principles that guided us during the 1993 to 1994 reform effort were:

- **Universal access to quality health care** for all U.S. residents regardless of age, income, employment status or health status;
- **Cost containment** with a national health-care budget and control over wasteful paperwork and procedures;
- **Fair-share financing** with savings from cost containment as a central funding source and additional funding obtained on a fair and equitable basis;
- **Public accountability** with consumers represented on all boards overseeing health care;
- **Freedom of choice** so that consumers can choose their doctors and where they will seek health care.

In 1997, Consumers Union's health care team developed the following vision statement to help guide our advocacy efforts:

Every consumer must have access to quality health care at an affordable price, with the right to choose providers and the right to have complaints resolved fairly.

There are many possible paths that could lead to this goal. One relatively efficient model for meeting these principles and this updated vision statement is a single-payer system, such as expansion of Medicare. Another is an employer mandate model, such as the Health Care for Working Families Act introduced in the 105th Congress by Senator Kennedy. Senator Wellstone's Health Americans Act, also introduced in 1998, would let states take the lead in creating the reform model, while working toward a universal system that would limit the financial exposure faced by American families. Expanding the Federal Employees Health Benefits Program (FEHBP) to all Americans is another approach that was popular during the 1993-1994 debate. An individual mandate – combined with a major overhaul of the individual health insurance market and targeted subsidies to make premiums affordable – is yet another option that could achieve these principles. Some of these models would require considerable fine-tuning to assure that all gaps are closed. But the important point is that there are many different paths to achieving quality health care at an affordable price.

Elements of the Path to Affordable Health Care

It is clear that there are more than enough models for health care reform. At the same time, there are countless proposals that may be called health care reform but that do not necessarily move us in the direction of quality, affordable care. Without effective leadership, campaign finance reform, and strong consumer-based grass-roots momentum for meaningful health care reform, there will undoubtedly be a plethora of health care proposals. Advocates of affordable coverage for all need to have a framework for evaluating these proposals, so that we can form alliances to promote piecemeal changes that truly do move closer to universality and to block initiatives that undermine the fundamental conditions necessary for evolving our health care system toward universality. Below is our attempt to begin to build such a framework.

1. Broad pooling of risks

This controversial issue is at the core of philosophical divisions on health care. It pits supporters of unabated individual freedom and responsibility against those who believe we should join forces as a community to meet everybody's needs. Members of the former group would prefer high deductibles, medical savings accounts, increased privatization, and (at the extreme) self-insurance. Members of the latter group, such as supporters of the Medicare program, would favor cross-subsidization of the sick by the healthy, community rating, and comprehensive benefits packages.

Consumers Union strongly favors broad pooling of risks. We have serious reservations about policy proposals that split the healthy from the sick, driving up premiums for sick people whose options are limited. We have concerns about proposals that allow private insurers to subtly market policies to relatively healthy people, leaving

the high risks for the tax-payer financed safety safety net – if they are poor enough, old enough, or sick enough.⁹

At the core of the need for broad risk-pooling is the fact that there is substantial variation in each individual's need for health care at any particular point in time. In any one year, most people are healthy. While average per capita health expenditures were nearly \$3,000 in 1996, all but the top 20 percent of health care spenders spent less than this. The top 10 percent of spenders accounted for over 70 percent of health care costs in 1996.¹⁰ This variation in risk exists across different income levels, age levels, and insurance status.

It is possible to devise ways of rewarding a healthy life-style without fragmenting the risk pool. If good health is not a sufficient reward, public policy should take steps to reward those who lead a healthy life style – especially those who avoid cigarettes. Possible steps include discounts on premiums. But our nation's health care system must be driven by compassion for those who have health care needs due to illness, disease, accident-related injuries, genetic diseases, and congenital birth defects, often through no fault of their own. The only way to make high quality health care affordable to *all*, even the sick, is by keeping the healthy and sick in one broad risk pool.

2. *Progressive financing*

Were we creating a health care finance system from scratch today, it would be very unlikely that our nation's health policy experts would create a finance system like the one that presently exists. Few people realize that one of the biggest federal health care programs is a public policy that, by design, offers bigger benefits for higher tax brackets. Key features of today's health care system:

- ◆ Our employer-based health care system is financed primarily by premiums, which are not income-adjusted, and therefore extremely regressive. While average employer paid premiums were about \$2,400 per employee in 1996, and average family premiums were about \$750, in reality employees pay the bill (when their employer pays premiums directly) through reduced wages. Low wage employees simply can not afford the coverage that they need; it should not come as a surprise that they are the least likely to have coverage.¹¹
- ◆ During 1998, the country excluded \$248 billion from income taxation because of employer-paid health insurance premiums.¹² This exclusion alone cost the federal government \$66 billion in 1998. Total tax expenditures by the federal

⁹ Or covered through subsidies from premium-payers, hidden from public view.

¹⁰ Table 7, *Hidden from View – The Growing Burden of Health Care Costs*, Consumers Union, January 1998.

¹¹ Table 5, *Hidden from View – The Growing Burden of Health Care Costs*, Consumers Union, January 1998.

¹² Table 13-2, 1998 Green Book Committee on Ways and Means, U.S. House of Representatives.

and state government¹³ equaled \$125 billion in 1998.¹⁴ This is an alarmingly high figure when compared with the cost of providing safety net coverage for the poor through Medicaid – total federal and state costs are estimated at \$185 billion in 1998. Medicare, the safety net for seniors and the disabled, is expected to cost \$221 billion in 1998.¹⁵ These exclusions benefit those in higher tax brackets far more than those in lower tax brackets. If your wage is low and your employer provides no coverage, your tax benefit is zero and you are likely to be uninsured. If your income is \$100,000 and your employer pays a \$10,000 premium for your health coverage, your tax benefit is about \$3,900 (considering federal taxes only). An estimated 69 percent of federal health benefits tax expenditures benefit the 36 percent of the population with the highest incomes (over \$50,000 per year).¹⁶ It is unlikely that *any* Congress would enact today a policy that so blatantly benefits the rich and leaves the working poor at high risk of being uninsured.

For fairness sake, we need to build more *progressivity* into our health finance system. We need to search for opportunities to replace tax policy that benefits those in high tax brackets with fair tax policy that provides comparable benefits to all, including the working poor and middle income families. We need to search for opportunities to replace regressive policies with progressive and even proportional taxes, where payments to the system increase as ability to pay (i.e., income) increases. Where possible we need to transform tax deductions into tax credits, which would substantially target relief to low and moderate income families.

3. *Targeted Subsidies*

In order to both make health care coverage affordable and build toward universal coverage (hence fostering a broad risk pool), we will need to provide targeted subsidies to make health insurance affordable to people with low and moderate family incomes. The need for subsidy is clear; a family of four with income twice the poverty level would have to pay 20 percent of its income for health insurance, if purchased in the open market (outside of employment).¹⁷ The easy challenge is identifying worthy groups to subsidize. Some good candidates include unemployed people (who risk losing any protections offered by the Kassenbaum-Kennedy Act if they have a lengthy interruption in health

¹³ Including this exclusion, as well as the exclusion for reimbursement accounts, the medical expense deduction, the exclusion of health benefits from Social Security and Medicare HI taxes, and state income tax expenditures.

¹⁴ John Sheils and Paul Hogan, "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs*, March/April 1999, p. 178.

¹⁵ "1998 Green Book," Committee on Ways and Means, U.S. House of Representatives, 1998, p. 104.

¹⁶ Sheils and Hogan, *op. cit.* p. 181.

¹⁷ Jon Gabel, Kelly Hunt, and Jean Kim, KPMG Peat Marwick, LLP, *The Financial Burden of Self-Paid Health Insurance on the Poor and Near-Poor*, The Commonwealth Fund, November 1997.

http://www.cmwf.org/health_care/gabel251.html. (Note: 41 percent of a four-person family's income if income is at the poverty level. A single person would have to spend 16 percent of her/his income if at 200 percent of poverty, and 32 percent if at poverty level.)

coverage), the working poor (who are least likely to benefit from employer-provided health insurance), and children (many of whom will remain uninsured even after Children's Program is fully implemented). The harder challenge is raising the tens (and even hundreds) of billions of dollars needed each year to fund these subsidies.

4. *Meaningful Consumer Choice*

Consumer groups have supported freedom of choice of provider as a core value for many years. If consumers have the power to choose their doctor, and “vote with their feet,” or at least the option of a health plan with choice, then they will have the power to exert considerable control over their personal health care destiny. Over the past decade, the growth of managed care has meant erosion of this freedom, though recent consumer demand for choice has resulted in expanded choices with managed care plans. Yet today, many consumers have neither the ability to choose between alternative health plans, nor the ability to select their own doctor. Many have no choice but a restrictive health maintenance organization. People in rural areas face limited choices.

In 1997, Congress enacted Medicare+Choice – an ironic name for a new policy that adds confusion to a health care system that has offered seniors and the disabled far more choice than any other health insurance system. Medicare beneficiaries are not celebrating new options such as medical savings accounts (where deductibles can be as high as \$6,000) or private fee-for-service options (in which they are no longer protected against unrestricted doctors' bills). In fact, insurers must understand seniors' interests; insurer interest in selling Medicare MSA's or private fee-for-service plans has been minimal.

Consumers need *meaningful* choice in the marketplace. They need an array of reasonable options. Frivolous variation in benefits (for example, through tiny variations in the definitions of key terms) undermines competition in the marketplace and merely confuses consumers, making apples-to-apples comparisons impossible. *Standardization* of benefits is one way to promote meaningful choice. In 1990, Congress enacted reform that led to 10 standard benefits packages in the Medicare supplement insurance market, eliminating confusion and making it more difficult for insurance agents to confuse and mislead consumers.

Furthermore, policy makers should not introduce choice without being concerned about the implications of consumer choice on the system. In other words, if new options will attract relatively healthy people or relatively sick people, then Congress should make sure that some mechanism is developed to assure that everyone continues to pay his or her fair share. (Economists call this risk adjustment – and continue to bemoan the fact that risk adjustment efforts are at an early stage of development).

The bottom line on choice – whenever seniors, employees, Medicaid beneficiaries, individuals, or the disabled are choosing a health plan, the choices that they face should meet the “*kitchen table test*.” Can the choices be lined up on the kitchen table allowing consumers to compare apples-to-apples, making an informed decision about coverage that will truly meet their needs?

5. *Comprehensive Benefits*

One of the hidden tragedies of today’s health care system is that many people who have health insurance coverage lack true security because of gaps in coverage. Many policies (including Medicare) lack coverage for prescription drugs. Many have limits on lifetime benefits that are unrealistic and inadequate in the event of a catastrophic illness such as paralysis. Many lack limits on out-of-pocket costs. Recently “created” insurance policy options – medical savings accounts – have high deductibles (e.g., \$4500 for a family). The bottom line: 31 million Americans are *underinsured* and risk financial devastation in the event of a catastrophic illness.

As the ongoing (and never ending) debate of how to pay for health care continues, it is important that policymakers keep in mind the fact that policies riddled with loopholes do *not* translate into lower health care costs. They merely transfer costs from those who pay premiums to those in our society who are the sickest, and face burdensome out-of-pocket costs. Standard benefit packages could eliminate loopholes, improve market performance, and reduce the ranks of the underinsured.

6. *Promote “Healthy” Competition*

It is essential that policymakers recognize that “health care” is not a product like toasters or cars. Rules of competition that work well in a market for toasters or cars do not work well in a market where bottom-line profitability depends on who is purchasing the product (in this case, an insurance policy). Because health risks vary substantially, insurance companies can build their profits substantially by excluding from coverage even a small amount (e.g., 10 percent) of applicants. A competitive environment where insurance companies compete by avoiding the sickest applicants, leads to denial of coverage (and high premiums) for people with pre-existing conditions and risk pools that divide the healthy from the sick. Policymakers must set fair rules that prohibit *unhealthy* competition and that encourage *healthy* competition. Unhealthy competition is fueled when insurance companies are allowed to deny coverage to high risks, and charge premiums without restriction. Tools that help promote healthy competition include standardization of benefits (to facilitate informed choice), greater freedom of choice of health plan by consumers, and risk adjustment (so that companies that sell only to the healthy must help pay for the bills for the sick as well).

7. *Establish Fair Marketplace Rules*

In today's health care marketplace, a company that is committed to striving to meet the needs of healthy and sick consumers is punished on its bottom line, since it must compete head to head with companies that do not. Marketplace reality puts pressure on companies to sink to the level of competitors. The Medigap marketplace offers a good example. Many years ago, most companies selling Medigap policies offered "community rated" policies which have premiums that do not vary with age of the policyholder. Gradually, companies shifted to a premium structure (called attained age) in which the premium *automatically* increases with age, making premiums very high for older enrollees, but relatively low for 65 year olds buying their first policy. Companies offering the consumer-friendly community rated policies have been pressured into switching to attained-age policies so that they can compete in this marketplace. Fair rules are an essential ingredient to an improved health care marketplace.

8. *Provide Quality Care*

One way to boost profitability is for health plans to cut the quality of care, for example by cutting nursing care in hospitals or by denying costly treatments. We need to preserve incentives for medical professionals and health plans to provide quality care. In order to maintain an adequate level of quality, Congress should enact patient protection legislation that assures full accountability for treatment decisions and creates incentives for good outcomes.

9. *Target Vulnerable Populations*

Congress must move beyond failed incrementalism to a new vision of incremental reform that advances steadily toward universal coverage. We need to halt the erosion of coverage. We need to go back to children (the group least able to protect themselves) and work harder to get eligible children enrolled in Medicaid. We need to finish the job that the Children's Health Insurance Program of 1997 started, and make sure that 100 percent of children are protected by comprehensive health coverage. We need to address the needs of early-retirees, ideally by creating a program that covers all of them, with the help of targeted subsidies.

10. *Strengthen the Safety Net*

We are facing disturbing erosions in our safety net for the poor and for seniors. With over half of people over the age of 65 paying more than 10 percent of their income out-of-their own pocket for health care, the burden seniors endure paying for health care is too high. With welfare reform meaning *less* Medicaid coverage, Medicaid is meeting less of the needs of our country's poorest. It is now estimated that nearly 5 million children who are eligible for Medicaid are not enrolled. We should take steps to fix Medicare and Medicaid so that these programs do a better job of meeting the needs of the

most vulnerable members of our society –those with the lowest incomes, seniors, and people with disabilities.

Implications for Public Policy

Will the next wave of “health reform” be yet another example of failed incrementalism, or will it move the nation closer to the goal of high quality, affordable health care? Based on the elements outlined above, we have an action plan designed to promote policies that represent steps forward and block policies that take us further down the path of failed incrementalism. The former list could be considered to be a first cut of a blueprint for moving toward “*fair share health care.*”

Steps Forward

1. Modify the current Medicare program to assure that all people aged 55 to 64 (“early retirees”) will have quality, affordable health coverage.
2. Extend high quality, affordable health coverage to *all* children, for example by gradually phasing into coverage *all* children born in a given year (e.g., 2000) and then allowing them to remain covered as they grow older.
3. Create a program that subsidizes health coverage for the unemployed, to assure that they do not have a gap in coverage.
4. Create subsidies (either directly or through carefully designed tax credits)¹⁸ for working families to make quality coverage affordable for them (e.g., limiting their premium contribution to 5 percent of income) or to soften the financial burden of illness (e.g., by reducing their taxes in years when health care expenditures exceed 5 to 10 percent of their income).
5. Provide incentives (such as a higher match rate for Medicaid or increased funding for the Children’s Health Insurance Program) for states to enact a program that provides quality, affordable health care to all of its residents or to enact insurance market reforms that move toward community rating and subsidized coverage.
6. Reform the Medicare benefits package, adding prescription drug coverage and a cap on out-of-pocket costs.

¹⁸ See “Tax Credits and the Uninsured,” Consumers Union, March 18, 1999 (available at www.consunion.org) for an analysis of steps needed to assure tax credits would be a positive incremental step.

7. Simplify Medicaid's enrollment process and allow enrollees to remain with Medicaid for a full year, regardless of income, working toward enrollment of all who are eligible for Medicaid benefits and expanding eligibility.
8. Prohibit insurance companies/health plans from having lifetime limits (e.g. \$1 million) and close other loopholes that leave millions of insured consumers *underinsured* (at risk of not having their insurance needs met by their policy).
9. Extend the Children's Health Insurance Program to include parents of all children eligible for coverage, or create subsidies that cover all adults with income under 200% of poverty.
10. Develop and phase-in standard benefit packages for health maintenance organizations, to facilitate comparisons between plans and enact strong consumer protections to improve the quality of care and hold HMO's accountable for treatment decisions.

Steps Backwards

1. ***Don't*** expand eligibility to medical savings accounts to all Americans (regardless of employer size), eliminating the limits in the demonstration project.
2. ***Don't*** convert Medicare from a "defined benefit" program to a "defined contribution" program or poorly-designed "premium support" system.¹⁹
3. ***Don't*** create HealthMarts, a proposal for voluntary purchasing cooperatives that would keep premiums low by exempting plans from state benefit mandates.
4. ***Don't*** enact MEWA (Multiple employer welfare association) legislation that would exempt plans offered by small employers from state consumer protection regulation, further eroding accountability of health plans for their treatment decisions.
5. ***Don't*** abandon the employer-based system in favor of individual policies, without building in protections to keep insurance affordable to high risks.
6. ***Don't*** increase the age of eligibility to Medicare to 67.
7. ***Don't*** cut the budget for Medicaid or Medicare.

¹⁹ See letter of February 2, 1999 (and attachments) to Senator John B. Breaux from Gail Shearer and Adrienne Hahn (Consumers Union) critiquing the Breaux/Thomas premium support proposal under consideration by the Bipartisan Commission on the Future of Medicare. Available at www.consunion.org.

8. *Don't* limit liability for negligence in the provision of health care by imposing caps on damages that deny fair compensation.
9. *Don't* expand tax breaks for long-term care insurance without adequately building in consumer protections such as protection against inflation and premium increases.
10. *Don't* make it easier for insurers to market “niche” products such as cancer insurance and intensive care insurance that waste consumer health care dollars and fail to provide comprehensive care.

Conclusion – A Call for “Fair Share Health Care”

In sum, we need to move our nation away from a patchwork system that is filled with gaps and that places the burden of paying for health care disproportionately on the poor and the sick. We need to change our vision into a concept of a *tapestry* – recognizing our *interdependence*. When it comes to health care, we should recognize that “we are all in this together.”

Consumers Union needs to educate the public about the unfair burden the current health care system places on the poor and the sick. We need to help the nation define health care finance fairness – and work toward limits on families’ exposure to out-of-pocket health care expenditures and premiums

We want to move the nation toward a vision of “*fair share health care.*” Our system should be fair, with costs paid more progressively based on ability to pay. The marketplace should be fair, with Congress setting the rules and regulators intervening when competition alone does not suffice. We should all pay our *fair share* – even those of us lucky enough to be healthy. We need to make sure that high quality care is preserved and strengthened.