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TAKING AMERICA'S HEALTH CARE SYSTEM OFF THE SICK LIST

INTRODUCTION

Astounding advances in medical technology and procedures in recent decades are making it possible for Americans to receive the most sophisticated medical care in world history. But the system for financing this care is so flawed that it puts these advances beyond the reach of many. Congress currently is considering ways of addressing some of the biggest gaps in the system. These gaps include inadequate coverage for catastrophic acute and long-term illnesses, particularly among the elderly, and underinsurance among workers and the self-employed. Lawmakers are discovering, however, that simply expanding existing programs will not necessarily close the health care system's coverage gaps. It will vastly increase the system's cost to consumer and taxpayer. The challenge to policymakers is to find a way to meet rising demands with limited resources.

Congress can meet this challenge and construct an adequate, compassionate national health care policy that addresses the needs of all Americans--without having to choose between impoverishing the country or rationing medicine. This requires comprehensive reexamination and restructuring of policies and programs. Lawmakers must face the fact that the problems with the current system are the result of major defects in America's health care financing structure. These have spawned such endemic problems as a third party payment system that encourages soaring costs; a regulated insurance system that is insufficiently flexible to meet new needs; and a tax treatment of medical expenses that is often contrary to the objective of providing all Americans with access to quality health care.

In the past, Congress has aggravated the national health care system's problems by applying band-aids. This treatment no longer will work. It is time for Congress to explore new ways of structuring health care. Among its top priorities, Congress should:

1) **review the regulation** of health insurance to foster more economical and better targeted plans;

2) **overhaul the tax treatment** of health insurance and medical costs to reverse the current trend toward expensive but inadequate coverage; and

3) **examine the potential** for converting federally financed programs to a system of vouchers.

Most important, Congress should learn from its own successes and, as it did with tax policy and is doing with welfare, begin a far-ranging inquiry into the flaws of America's health care system and a discussion of major proposals to reform it. The precise cure for what ails the health care system is not yet known. It will be discovered only by a national debate and a readiness to experiment.

THE ENDEMIC PROBLEMS OF AMERICA'S HEALTH CARE SYSTEM

Medical science has made tremendous advances in the past half century, and the United States has been in the vanguard of these developments. Today the quality of American medical care is second to none. But this achievement has exacted a heavy price on the nation's health care financing structure.

Rising costs. Health care costs are increasing dramatically. Between 1980 and 1985, total national health expenditures, public and private, grew at an average of almost $35 billion a year. By 1985, the most recent year for which accurate figures are available, Americans spent $425 billion on their health, either directly or through insurance and taxes. Between 1965 and 1985, total national expenditures on health care, as a percentage of gross national product (GNP), almost doubled, from 5.9 percent to 10.7 percent.[1] And since 1981, the cost of medical care has increased at an average of over twice the annual inflation rate for all goods and services.[2] Spending on federal health programs has increased at a particularly alarming pace. Between 1975 and 1985, total federal spending on Medicare and Medicaid more than quadrupled, growing from $25 billion to $103 billion per year. Spending on these two programs as a percentage of total federal spending increased from 7.5 percent to 10.9 percent.[3]

Rising demands. At the same time that they are concerned by these spiraling costs, Americans want more health services. Americans now expect, almost as a right, treatments and procedures that were considered medical miracles less than a

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1. Health Care Financing Administration, *Health Care Financing Review*, Volume 8, Number 1, Fall 1986, p. 13.

2. U.S. Department of Labor, *Monthly Labor Review*, March 1987, p. 83, table 32.

3. All figures are for fiscal years. Source for Medicaid figures: Health Care Financing Administration, *Medicare and Medicaid Data Book, 1984*, June 1986, table 2.6, and unpublished HCFA data for Medicaid program in years 1983-1985. Source for Medicare and general budget figures: Office of Management and Budget, *Historical Tables: Budget of the United States Government Fiscal Year 1988*, table 3.3.

generation ago. Moreover, there is a broad public consensus that adequate health care should be available to all citizens in a modern, affluent society. In the past, quality health care was often viewed more as a luxury than as a necessity. This change in social philosophy places enormous additional demands on the system.

Gaps in Coverage. Despite rapid rising expenditures for health services, many Americans lack basic protection against health care costs and thus do not have full access to services. Too many of the nation's elderly for instance, cannot afford the cost of a lingering illness or a long spell of nursing home care. Growing numbers of young, working Americans and their families have insufficient or even no insurance coverage for medical problems. Perhaps as many as 35 million Americans under 65 have no health insurance of any type. Of this number, about half are working adults, and the other half are either nonworking adults or children.[4] This lack of coverage for dependents is particularly disturbing, since medical problems not identified and treated at an early stage usually become much more serious and expensive later. One major factor contributing to this problem is that many small businesses cannot afford the high cost of employee group health plans. Of the nation's total private sector, nonagricultural, civilian workforce, 52 percent are either self-employed or work in companies of fewer than 100 employees. This same group contains 76 percent of all workers lacking any health insurance.[5]

Each of these problems has generated public pressure on Congress to devise solutions. The tendency of lawmakers has been to turn to new spending programs, such as the creation of Medicare and Medicaid in 1965, or to put increased burdens on employers through mandated benefits, which is a popular proposal today. But in an age of trillion dollar budgets with $200 billion deficits, the answer cannot be still more federal spending. Nor can it be hiking the labor costs of small firms, for this threatens to destroy the jobs of those now without insurance. To find genuine solutions to America's health care problems, Congress must take a closer look at what caused the problems in the first place.

The problems of rising health care costs and inadequate coverage derive largely from a combination of two factors:

1) **An interest group approach** to health care on the part of Congress, which often has resulted in counterproductive public policies, and

2) **An outdated and inflexible** health care financing structure, which has failed to adapt to changes in medical technology and the structure of American society.

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4. Employee Benefit Research Institute, *A Profile of the Nonelderly Population Without Health Insurance*, Issue Brief Number 66, May 1987. Tabulations are based on the Census Bureau's March 1986 Current Population Survey.

5. *Ibid.*

INTEREST GROUP APPROACH

Two decades of congressional action on health policy has been driven by the demands of specific groups of Americans seeking particular benefits. The result has been a system in which the government heavily subsidizes health care for sensitive or strong constituencies, such as middle-class elderly and unionized workers, while such poorly organized though potentially potent groups as the young or the self-employed have had far less help from Uncle Sam.

This piecemeal, interest group approach may have been politically necessary at one time, but has turned out to be economically unsound. It has led to a patchwork system with both huge gaps and wasteful or redundant spending. Moreover, the approach has had serious side effects on other programs. An unintended result of Medicaid services for the poor, for instance, has been the encouragement of welfare dependency. This is because Medicaid benefits are tied to eligibility for other welfare programs. So some adults on welfare will refuse a low paying job, because that may mean the loss of health coverage.

Corporate Deduction. Similarly, interest group politics has led to very uneven tax support for health coverage. Corporations, for instance, won the right to exclude from their taxable income--without limit--the cost of providing health benefits to their workers. This policy has strong union support, since it also allows workers to receive compensation earmarked for health in untaxed dollars. Workers thus have a strong tendency to use these tax-free health dollars for routine, immediate needs, such as dental plans or low hospital deductibles. They have little incentive to protect themselves and their families against less likely catastrophic health costs. Thus many companies have tax relief, with large revenue losses to the federal Treasury, for plans that cover minor costs, yet provide poor coverage for rarer but financially much more devastating eventualities.

Ironically, although the tax code is perhaps the most powerful vehicle available to Congress to set health policy because it affects all but the poorest Americans, political pressures continue to produce bad policy. Example: the 1986 tax reforms further discouraged Americans from paying out of their own pockets for routine or inexpensive treatments by limiting the medical deduction only to expenses above 7.5 percent of adjusted gross income and by increasing the standard deduction (which discourages itemizing--the only way medical costs can be deducted by individual taxpayers). This means that the medical deduction is now largely irrelevant to most individuals and families. Even worse, it eliminates tax relief for those most in need of relief from health care costs. Of the total population without any health insurance, roughly one-third have incomes between 100 and 200 percent of the poverty level, and another one-quarter earn 200 to 400 percent of the poverty standard.[6] Few of these Americans will be able to itemize their tax deductions, and as a result could spend thousands of dollars on medical care without being able to deduct a penny.

The only positive change in the 1986 tax law was to allow self-employed individuals to deduct 25 percent of their health insurance premiums before itemizing.

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6. *Ibid.*

Previously, this group of Americans, who tend to have inadequate insurance, could not deduct their premiums, while large businesses could deduct the full cost of their employee health benefits.

OUTDATED FINANCING STRUCTURE

The other major factor responsible for America's current health care problems is an increasingly outmoded health care financing structure. The present structure is essentially a product of the 1930s and 1940s and reflects the economic and social conditions of that period, as well as the state of medical science. In the intervening years, both society and medical technology have changed dramatically but the basic health care financing structure has remained relatively static.

The Problem of Third Party Payments

The chief characteristic of America's health care financing structure is a "third party payment" system, whereby most consumers pay directly for only a small portion of their medical bills. The third party payer is either an insurance company, an employer, or a government agency.

In the vast majority of cases where an insurance company pays the bills, the premiums to finance that coverage are payed for by an employer. In recent years there has been a trend toward "self-insurance," under which an employer directly pays the hospitals and doctors and eliminates the insurance company as a middleman. The federal and state governments act as third party payers for a range of individuals through various health care programs for the poor, the elderly, military personnel, veterans, Indians, and government employees. Third party payments had their origin in the government imposed wage controls during World War II, which encouraged employers to provide workers with non-cash benefits. The exclusion of these benefits from taxation and the requirement that they be subject to collective bargaining accelerated their spread after the war.

Dominant System. During the post-war years, this third party payment system, both public and private, has come to dominate American health care. In 1950, third party payments accounted for 16 percent of the nation's total personal health care expenditures. By 1965, that figure had risen to 48 percent and by 1985 it stood at 72 percent.[7]

The basic purpose of insurance in general is to protect policyholders against unforeseen and unaffordable losses by spreading risks among them. But insurance companies normally raise premiums for those in high risk categories and for those who file numerous claims for low cost items. This practice limits the cost of insurance to the average customer. It also discourages the insured from engaging in risky behavior. Thus reckless drivers with a series of costly accidents, for instance, soon find their premiums skyrocketing.

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7. Health Care Administration, *op. cit.*, p. 16; and Bureau of the Census, *Historical Statistics of the U.S.*, Series B-236-247.

It has long been a principle of health insurance, however, that within a group of insured, no single policyholder should face steadily rising premium costs. This is because individuals often have little or no control over illnesses that lead to claims--unlike an automobile driver, who can drive more carefully or give up driving altogether. In the case of health insurance, heavy costs run up by one individual normally are spread as higher premiums across the whole group.

This system helps those with medical insurance who need many or expensive medical services. Such individuals would face enormous premiums under normal insurance policies. Though this seems reasonable and makes sense, it has produced unintended financial side effects. Among them:

1) The third party system fuels a rapid escalation in health care costs.

Because the system insulates both patients and health care providers from the real costs of their decisions, it not only discourages patients from questioning possibly unnecessary procedures but also it encourages providers to authorize marginal but expensive procedures. The reason: providers know that patients will pay little or none of the costs and may later fault the hospital or physician if the procedures are not carried out. This encourages excessive use of health services, boosting medical costs. Providers also are encouraged to charge more for even simple or routine items if they know that patients will just pass the costs on to employers or the government. The most striking evidence of how the third party payment system creates both new demands and inflated costs is found in cases where governments mandate coverage for specific services. Example: Based on the argument that chiropractors are a low cost alternative to medical doctors, the state of Hawaii mandated in 1980 that employers cover chiropractic services in their health insurance policies. The result was that by 1984 the per case cost for chiropractors was three times the cost for general practitioners, and Hawaii had four times the number of chiropractors as in 1978.[8]

Market Distortion. In an attempt to counter rising costs in such government-provided medical programs as Medicare, Washington has imposed direct cost controls on the medical industry. Thus in 1983, Congress instituted a system of fixed price reimbursement for particular Medicare procedures. But as with all forms of price control, this system has distorted the medical market. For instance, complaints of hospitals "dumping" Medicare patients--sending them home before they are well because the cost of continued treatment exceeds the fixed price--are on the rise.

The inflationary aspects of the third party payment system have been exacerbated by excessive reliance on cost-plus reimbursement. This means that the insurer pays the hospital a percentage of the hospital's costs, plus an additional percentage of the hospital's working and equity capital. While different reimbursement formulas can be used, the basic effect is to create a perverse incentive for hospitals to increase costs. Increased costs mean increased income for a hospital, while reduced costs mean lower income. The more a hospital expands

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8. American Legislative Exchange Council, "Mandated Health Benefits: Time to Evaluate," May 1986.

its facilities, equipment, or services, the more revenue it receives, regardless of the demand for these items.[9]

Pre-Paid Plans. In recent years, rising health care expenditures have led the government and private companies increasingly to question costs and limit payments, generating a move away from this system. Some employers have directly assumed the responsibility for reviewing claims or have offered their workers cash bonuses for spotting overcharges in hospital and doctor bills. Corporations have also turned to using Health Maintenance Organizations (HMOs) and other pre-paid plans which pay doctors fixed amounts in advance for treating their employees whenever they need medical care.

But the cost-plus reimbursement system's basic structure remains in place. Even current trends such as increased government regulation, more companies turning to self-insurance, and the expanded use of HMOs, largely represent an effort to micromanage medical costs--not a free market medical system driven by consumer demand.

2) The third party system has skewed health insurance toward providing coverage for more predictable, lower-cost medical care and away from coverage for less predictable but more costly care.

Since private third party health insurance provided by employers is tax-deductible to the businesses and is not included in the worker's taxable income, employees have come increasingly to see health plans as a vehicle for sheltering routine health expenses from tax, rather than as real insurance against large, but unlikely, medical costs. Thus between 1970 and 1984 the number of Americans with dental benefits jumped from 12 million to 107 million.[10] Other examples of "front-end" coverage would include: policies that pay for the first thirty days in a hospital, but little or nothing beyond that; policies with little or no deductible; or policies which pay up to a set amount for specified services. These kinds of plans provide tax-free dollars for inexpensive, routine items, but can leave policyholders vulnerable to catastrophic losses. This is exactly opposite of the protection provided under all other forms of insurance.

Worker's Concern. The incentives in the third party system also lead to a bias toward the treatment of acute medical conditions, rather than potentially more expensive chronic illnesses. An acute condition generally means a specific medical problem which can be permanently cured with a specific course of treatment. Most plans reflect the typical worker's greater concern with more immediate risks. Thus there is little demand for longer term care, nor does Medicare provide protection against such costs, even though long-term care for a patient with a chronic or degenerative condition can be many times the cost of even the most expensive surgery.

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9. For a detailed analysis of cost-plus reimbursement see, John Goodman and Gerald Musgrave, "The Changing Market for Health Insurance: Opting Out of the Cost Plus System," National Center for Policy Analysis, *Policy Report* Number 118, September 1985.

10. Health Insurance Association of America, "Source Book of Health Insurance Data," 1986 Update, table 1.8.

Currently, most Americans would be forced to spend themselves into poverty and rely on Medicaid to pick up the remaining costs if they needed a long spell in a nursing home. Private insurance and Medicare combined now account for only 2.7 percent of all nursing home payments, and most of this is for short-term recuperative care following the treatment of an acute condition.[11]

3) The third party system discourages health insurance coverage in the segments of the economy where most jobs are being created.

Between 1982 and 1985, during a period of rapid economic growth, the number of workers without health insurance increased by 22.5 percent.[12] These workers tend to be self-employed or to work in small businesses and in entry-level jobs in the service sector where most jobs were created.

For a small business, the costs of group health insurance plans, which are basically designed for larger companies, can be prohibitive. In the case of low-wage employees, because health insurance is more alternative compensation than insurance, providing these benefits would increase their compensation beyond the value of their productivity. At the same time, because low-wage employees have less disposable income or because they are secondary wage earners, many prefer to be paid in cash. For the self-employed person the only reason for not taking his income directly in cash is if alternative methods reduce his taxes. Given the way the tax code is structured, the self-employed can usually find more lucrative tax breaks than health insurance.

4) Technological and social change compound the problems of America's health care financing structure.

A system of employer-provided health benefits for workers and their dependents may have made sense in the 1940s and 1950s when America's workforce was concentrated in manufacturing industries, heavily unionized, largely urban-based, and characterized by single earner, two-parent families. The coverage bias in favor of acute care and front-end expenses, also reflected the state of medical science at that time.

In 1940, the term "modern medicine" meant the growing use of Penicillin and recently discovered sulfa drugs to treat a wide range of bacterial infections. Hospitalization was synonymous with serious illness and insurance which covered the first thirty days of hospital care was de facto catastrophic coverage. There was little doctors could do for most patients with chronic or degenerative conditions and, with the exception of serious mental illness, such patients were usually cared for at home by relatives. Preventive medicine also was in its infancy.

Since the end of World War II, however, American society and medical technology have changed dramatically, putting enormous strains on the health care system.

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11. Health Care Financing Administration, *op. cit.*

12. Employee Benefit Research Institute, *op. cit.*

Job growth in recent decades has been greatest in the white collar, professional, and service areas. In spite of a major expansion by unions into the public and service sectors, their share of the nation's workforce is less than half of what it was at its height in 1953. The growth of non-unionized employment, smaller companies, and frequent job changes has provoked the coverage gaps now a feature of the system.

Just as significant have been such social trends as declining family sizes, increased numbers of single parent families and, as a result of large numbers of women entering the workplace, the rise of two-earner families. Two-earner couples can be faced with double coverage for some types of medical care, for instance, but no coverage for other kinds. As more workers change jobs more frequently, they must increasingly take into account the differences in health benefits between their current and prospective employers.

Medical Breakthroughs. As much as American society may have changed in the post-war years, medical science has changed even more. The term "modern medicine" now evokes images of computers, lasers, miniature electronic devices, portable X-ray machines, organ transplants, artificial hearts, CAT scanners, radiation therapy, ultra-sound treatments, and a host of other technologies and procedures unimaginable forty years ago.

These advances have decreased the risks involved in many medical treatments and made procedures that were once difficult or complex, simple and routine. They have also provided cures for previously untreatable conditions or prolonged the lives and reduced the suffering of patients whose conditions are still incurable. These medical breakthroughs mean that ordinary Americans can be treated for once incurable diseases and injuries. But often only at enormous cost. America's health care financing structure has fundamentally failed to adapt to all these changes.

At the same time, medical care at both ends of the spectrum continues to move away from hospitals. At the acute end, conditions that once required hospitalization can now be treated in doctors' offices, surgical centers, or with prescription drugs. At the other end, patients with chronic or degenerative conditions can now receive more intensive care for longer periods of time at home or in a nursing home. Moreover, the ability to prolong life, together with the aging population, is increasing dramatically the demand for nursing home care.

As America's health care financing structure continues to be pulled apart at the seams by these social and technological changes, it is becoming clear that a fundamental, sweeping reform of U.S. health policy is needed.

NEEDED: A CONSUMER-BASED STRATEGY

The chief virtue of the free market is that it translates consumer demand into powerful incentives for providers to offer adequate supplies of goods and services at reasonable prices and to increase their efficiency through constant innovations in design, production, and distribution. But the history of the U.S. health care system has ignored this virtue. It has attempted to regulate demand by manipulating costs and supply. The predictable effects have been economic distortion and inefficiency.

The challenge is to free America's health care system from the escalating costs of overregulation, which increasingly denies access to large segments of the population and threatens the quality of health care for all Americans.

If Congress is to achieve effective and lasting health care reform, it must reorient the system to serve the people needing that care--the individual patient or consumer. Only the power of consumer demand ultimately can ensure quality care at a reasonable price, because only the individual consumer can decide what best suits his or her particular needs.

Critics of a strategy based on freely functioning markets, however, contend that health care differs fundamentally from other services, making market selections impossible.[13] In particular, critics allege three unique features of health care. They are:

Allegation #1: Consumers of health care have insufficient expertise to make wise choices.

Medical care is said to be a service too technical for most consumers to understand and thus be able to make sensible choices. Only a trained expert is capable of judging accurately whether the cost of a given medical service is reasonable and the procedure necessary. To prevent suppliers of health services exploiting this consumer ignorance, it is argued, government either must set prices in advance or carefully audit the costs after services are provided.

Allegation #2: Consumers often do not have enough time to choose carefully.

The urgent nature of many medical needs often makes choice impossible. A pedestrian knocked down by a truck or a businessman experiencing a heart attack at an airport does not have time to consult the price lists of rival hospitals.

Allegation #3: Consumers cannot avoid health care costs.

A person cannot plan or budget for medical costs the way he can for other items, like buying a new car or a stereo. Nor can he normally plan to purchase health care incrementally, like buying an extra car later.

At first glance, these allegations seem valid. Yet they are not unique to medical care, and do not imply that there are such fundamental differences between health care and other services that an effective market must be ruled out.

Consumer's Strategy. To an extent, all specialized services are subject to arguments of "uniqueness." Yet the fact that many consumers lack even the most basic understanding of many professions does not prevent them from contracting for the services of, say, builders, tax accountants, lawyers, or auto mechanics. Consumers have ways of compensating for their lack of specialized knowledge.

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13. For a good examination of the arguments for and against the anti-competitive nature of the health care market, see Rita Ricardo-Campbell, *The Economics and Politics of Health* (Chapel Hill, North Carolina: The University of North Carolina Press, 1982), particularly chapters 4 and 5.

Normally the consumer determines the general type of service he needs or wants. For example, does he want an architect to design a house or an office building; does he need a mechanic to fix a transmission or tune an engine? Next he selects a specific provider based on such considerations as cost and reputation. Finally, because the consumer is paying for the service, he has an incentive to question the provider's fees and reasons for recommending specific courses of action. He also has an incentive to seek professional advice in making technical choices, such as a broker when buying stocks, or a building engineer when buying a house. Clearly, the stakes can be higher with medical services, but the process is not fundamentally different.

A consumer starts by determining the kind of doctor he needs. For example, does he need a general practitioner, an allergist, or an ophthamologist? Next, he will often ask friends, relatives or other doctors for specific recommendations. If he will be going to the doctor regularly, say a pediatrician for his children, he might take great care to find one whose judgment he can really trust. If one doctor says he needs an operation, his insurance company may want him to get a second opinion. In short, the only element that is likely to be missing is cost comparison.

Small Percentage Emergencies. While it is true that in a medical emergency there is no time for a consumer to engage in comparison shopping, this, too, is not sufficient reason to treat medical care as a service not susceptible to the normal functioning of a market. Emergencies are routinely accommodated by insurance. Just as auto emergencies are a small element in most American's repair bills, medical emergencies comprise a relatively small percentage of a consumer's potential demand for health services. At most, only 15 percent of all medical care is of an emergency nature.[14] And even for the most critical non-emergency conditions it usually is possible to delay treatment at least long enough for a second opinion on the best type of treatment. In fact, insurance companies and employers increasingly have looked to such second opinions as a way to improve treatment and control health care costs.

While the need for medical care can be both unpredictable and expensive, such occurences are precisely the ones that any properly constructed insurance policy is designed to accommodate. Furthermore, many health expenses, such as regular checkups, dental care, and minor ailments like strep throat, are usually affordable, if not exactly predictable.

Many of the health decisions a consumer makes, moreover, will determine the quantity and cost of the treatment he needs. A person who neglects proper preventive care, does not seek treatment when he first develops a problem, or disregards his doctor's instructions, can wind up needing more expensive and costly treatment later.

HOW TO REBUILD AMERICA'S HEALTH CARE SYSTEM

The first step in reforming the U.S. health care system thus is to recognize that markets can operate effectively and that it is possible to develop policies which

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14. *Ibid.*, p. 93.

increase the consumer's power within a more competitive health care industry, while ensuring that cost is not a barrier to adequate levels of health care. To create such a system, congressional action is needed in three areas: the basic structure of health insurance; health-related tax policies; and government health care programs.

1) Reforming the Health Insurance Structure.

Most Americans think of insurance as being tied to the specific value of some item, such as a fire insurance policy equal to the value of a house. This need not be so. In the case of life insurance, for instance, the size of the liability is totally arbitrary because it is impossible to put "prices" on human lives. If health insurance were structured similarly to life insurance, where the policy would pay any claim of a general type within a specified dollar range, it would enable policyholders to be protected against costs without the policy being tied to specific treatments, providers, or services. For example, a basic acute care policy might cover treatments whose total costs are between $500 and $5,000, such as appendectomies, pacemaker insertions, or hip replacements.

Essentially, insurance policies would be divided according to a set of cost levels (basic, major, and catastrophic), and the following four general types of medical care:

Acute care. This is any single course of treatment undertaken to cure a specific condition permanently. Examples: a gall bladder operation or a tonsillectomy.

Long-term care. This is constant or regular periodic treatment needed to stabilize or mitigate the effects of a chronic or degenerative condition that cannot be permanently cured. Examples: constant treatment for a victim of multiple sclerosis or Alzheimer's disease.

Preventive care. This is treatment or a procedure to identify conditions requiring acute or long-term treatment, or to decrease the probability of those conditions occurring. Examples: regular checkups or cholesterol tests.

Discretionary care. This involves the treatment of any condition which would not cause significant disability or discomfort if left untreated. Examples: cosmetic surgery or a slight hearing impairment.

The advantage of a private insurance structure based on specified dollar ranges for general types of treatments, is that it would be a simple way to give consumers the protection they really need--protection against the costs of a total package of medical care, not protection against specific procedures or the services of particular providers.

To encourage insurance companies to provide such a structure of health insurance would necessitate repealing a multitude of state laws requiring insurers to include specific benefits in their policies. In their place could be substituted much simpler regulations setting the general parameters and coverage levels for policies. Insurers could also be exempted from covering incidental items such as private hospital rooms.

Encouraging Coinsurance. Another reform might be to encourage or even require the wider use of coinsurance, where the policyholder pays a fixed percentage of all costs associated with a given treatment. The advantage of coinsurance is that the consumer has an incentive to question costs at every step of the treatment. To ensure adequate protection against high medical costs, coinsurance percentages could be tapered, with higher percentages for low cost treatments and lower percentages for high cost treatments.

Special attention should focus on ways to encourage insurers to make catastrophic acute and long-term care insurance more affordable. It may be possible, for example, to reduce the costs of this coverage by taxing insurance company reserve funds for these policies at lower rates. Every dollar taken in taxes from reserve funds is a dollar that cannot be used to expand the reserves by earning interest, or to pay claims.

The effect of these reforms would be to simplify health insurance and make it more like other forms of insurance, to the benefit of both policyholders and insurers. Policyholders would no longer have to worry whether their insurance covered specific medical services. Insurers would be freed from a multitude of detailed regulations and the need to second guess providers. At the same time, insurers would retain enough flexibility for competition and innovation. Similarly, providers would feel the pressure of increased competition due to heightened consumer choices spurred by cost consideration.

2) Reforming Health-Related Tax Policies.

An effective consumer approach to health care requires an incentive structure which encourages consumers to question the need and cost of all the health care they purchase and pay as much of those costs as possible, yet does not prevent them from obtaining needed care because of cost. The most effective and equitable way to do this is to use the personal tax code to shield Americans from heavy costs while also encouraging them to make economical choices.

Separate Deductions. The first step toward this would be to encourage consumers to replace third party providers by transferring most health-related tax breaks from the corporate to the individual income tax code. Currently, the individual can take a deduction for medical expenses only if they exceed 7.5 percent of adjusted gross income. Instead of this there should be three separate deductions for expenditures on health insurance premiums, coinsurance payments, and unreimbursed medical expenses. Taxpayers should be allowed to deduct a large percentage of their unreimbursed medical expenses, a lesser percentage of their coinsurance payments, and a small percentage of their health insurance premiums. In addition, taxpayers should be allowed to take these deductions "above-the-line," that is, without itemizing other deductions and in addition to the standard deduction.

Allowing the largest tax deduction for out-of-pocket uninsured medical expenses would give consumers an incentive to pay directly for more of their own medical care, particularly that which is inexpensive or routine, such as preventive check ups, dental care, or minor emergency treatments.

Because most incentives to purchase insurance are inherent in its nature, providing a small tax break for insurance premiums would increase those incentives only slightly, but would discourage over-insurance. Providing a third tax break for coinsurance payments would target special assistance to those individiduals who need it most--ones who incur substantial, unforeseen medical expenses.

Another possible reform would be to allow taxpayers to include, in calculating their deductible medical expenses, any payments made for medical care or insurance on behalf of a relative included as a dependent on the taxpayer's health insurance, regardless of whether that relative qualifies as a dependent for other tax purposes. Under current law, for a taxpayer to deduct any expenditures on behalf of a dependent, the taxpayer must demonstrate that he provided at least 50 percent of the dependent's total support for the year.

Second Line of Defense. This would encourage families to assume more of the health care costs for medically or financially needy relatives, particularly the elderly, the disabled, the unemployed and low-wage earners. This would help, for example, the 35 percent of all workers without any health insurance who are between the ages of 18 and 24.[15] The change would also assist taxpayers in providing for some of the medical needs of elderly parents. The effect would be to make families the second line of defense against medical costs--behind insurance but ahead of the government.

The current tax write-off for businesses providing employee health benefits would be changed to a two-level tax deduction. Corporations would be permitted to deduct fully their expenditures for on-site employee preventive health services and "wellness" plans and for contributions to employee disability income insurance policies. But only a partial deduction should be allowed for employer contributions to employee catastrophic and major care policies, reflecting the change in the individual code giving them relief. All deductions for employer contributions to employee minor, preventive, and discretionary care policies would be disallowed.

Target Benefits. These steps would encourage corporations to target their health benefits to where they can do the most good, with firms encouraged to make sure their employees stay healthy rather than providing tax-free dollars for questionable coverage.

Shifting the tax deductions for health care from the corporate to the individual tax code would have other benefits as well. By stimulating greater use of alternatives to company health insurance plans, it would allow for the increasing mobility in the nation's workforce, since workers would not automatically lose their health benefits if they quit their jobs or were laid off. It would also give individuals and families greater ability to tailor their health coverage to suit their own particular situation.

3) Reforming Government Health Care Programs

America has decided, through actions of Congress, to pay directly for the medical care of certain groups, most notably the poor, the elderly, and veterans.

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15. Employee Benefit Research Institute, *op. cit.*

These obligations are fulfilled in different ways. Health care for veterans, for example, is provided in hospitals owned and operated by the government, while the government reimburses private hospitals and doctors who care for the elderly. Health programs for the poor are a mixture of the two. Without debating the validity of these social obligations, it should be recognized that government also has an obligation to taxpayers to use their money wisely, for these and other programs. Congress must insure that these programs genuinely benefit the recipients and also give taxpayers the most value for the dollar.

Voucher Alternatives. A more efficient way for government to provide health benefits to these groups would be through a system of health care vouchers. Such a program could be structured in one of two ways. One would be for the government to provide a voucher equal to a fixed dollar amount to each beneficiary, who could then apply it to the purchase of the health insurance plan of his choice. The alternative would be to allow beneficiaries to choose from among several different approved plans the one which best suits their needs, with the government directly paying the cost of the premiums. Federal employees currently receive health insurance coverage in this way, and rival private sector plans compete vigorously for their business.

Each of these approaches, if applied to federally supported programs, would allow market forces to take the place of complex bureaucracies in allocating medical services, and take advantage of the enhanced risk spreading spreading features of a restructured insurance system. Indeed, health care vouchers hold the potential to both reduce the overall costs of these programs and improve the quality of care available to beneficiaries.

CONCLUSION

It is time for Congress to wake up to the reality that a major overhaul of America's health care financing structure is long overdue. Lawmakers must realize that simply tinkering with the system by adding new programs, changing the regulations governing others, or forcing private firms to provide new benefits will only add to the system's problems. These approaches will not solve the problems of a system whose basic financing structure is fundamentally unsound. Congress must, instead, reform the basic structure of health insurance, health-related tax policies, and government health care programs.

Time for Reexamination. A great debate has taken place over the nation's tax code under the Reagan Administration, building on ideas vigorously discussed during the 1970s. That debate led to a fundamental overhaul of the tax code. A debate also has been underway in recent years over the future of welfare. It is time for policymakers and Congress to begin a similar examination of America's chronically deficient health care system.

Policymakers who may be wary of sweeping reforms need to consider the price of not reforming U.S. health care is growing daily. It is a price paid not only in dollars but in decreased access and declining quality for a growing share of the population.

As public attention focuses more and more on America's health care problems the distinction between rhetoric and reform will become sharper. The question for Congress is: which will be its real health care agenda?

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