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LECTURE

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It is a pleasure to be in Switzerland again. I have been here a number of times and during the course of my visits I have come to learn at least a little bit about not only your health care system, but your economy as well. What I would like to do is to talk briefly about the US health care system in transition. And I use those words carefully, because what we are doing now mostly in the United States, is going through a period of change. I want to describe some of the economic drivers and the political drivers of that change and share with you how I think they are likely to come out. I do not know whether this will be true for Switzerland, although there are some aspects with a use of private insurance and strong senders of health related industries and particularly device in pharmaceutical areas, where we share some interest. But I think it is something which you should want to know about so that you can watch what happens as we go through some of this change and think about whether or not it is a direction you might find of interest and relevance as well. As I have said, we are in the middle of what can only be regarded as tumultuous change. It is a change that is

being driven by the private sector, where employers, who for the most part sponsor insurance for the under 65 population, are being very aggressive as purchasers, seeking better value for their money, and if they cannot tell the better value, then seeking lower prices and if they are not getting them in their traditional sources of hospitals and physicians, then going elsewhere. The public sector, especially Medicare and Medicaid, are reluctantly being pressed to follow, because the spending in those public areas is growing two and a half times faster right now than spending in the private sector. Now, this was not always so. In fact, in the 1980's Medicare grew slower than spending in the private sector of health care. But two things have changed and together they have produced this very different result. One thing is that regulations, which were introduced by Medicare in the early and late 1980's, have been around long enough, so that physicians and hospitals have figured out how to get around the regulations. Now, countries differ in their attitudes toward regulations. In the United States, we take paying taxes quite seriously, and while there are tax cheats, of course, most people in the United States regard paying even their income taxes as something that they have to do and we have high compliance rates. But our attitude toward regulation is very different. Regulations are regarded as something to be thwarted and something to be circumvented, as long as you do not go a foul of law. But anything else is fair. And, in fact, in some cases appears to even be regarded as sport. When I headed Medicare, we were introducing a change in the way physicians were paid. And before the regulations were even formally introduced, I could pick up newspapers, newsletters, that were being sent around to the physicians, advertising seminars, like this, where physicians would be told how to build a system so as to maximize the reimbursement. The regulations were not even issued and we already had a cottage industry developing about how to get around these regulations. I say that, because our attitude toward regulations is not to take them as serious social obligations, but rather as something to be circumvented, as long as you do not get caught, being against the law. And that what happened between the 1980's and the 1990's is that the regulatory structure that was in place for the public sector was in place long enough, so that it could be gamed, it could be circumvented. And at the same time a private sector, that had been quite passive, realised, that their profits were being affected, that their employees were not getting the wage increases that they could have if they had been better at controlling health care spending. And those two things came together and so in the 1990's, first, we saw Medicare growing 50% higher in real terms per person and in the last year, we have information for 1993 to 1994, Medicare growing at almost two and a half times the growth in spending in the private sector. Now let me give you a little bit of a perspective in what has been going on in the private sector and then I want to touch for a few minutes on what is going on in the public sector. As many of you know, the Uni-

ted States has just completed a very difficult two-year debate on health care reform. Health care reform was probably the second or third most important issue during the 1992 election. It received a lot of attention. It became a very important part of the domestic priorities of the Clinton Administration. I think, however, what happened, is that there was a misunderstanding in Washington about what was driving the politics of the issue, although not necessarily the economics. The politics, as I understand it from the 1992 period, was that health care reform became an issue, because we had a very worried middle class. And the reason we had a worried middle class is that we were just coming out of a very different kind of a recession, a white collar recession. Normally in the United States, we have what we call blue collar recessions. Workers in heavy industry, like steel and automotive areas, or marginal workers, who have jobs some of the time and not all year, tend to lose jobs in recessions. But in this recession in early 1990, many of the people who found themselves out of work were programmers or were other skilled personnel. Some of it happened because of the down sizing in the defence industry and so people who were related to defence spending found themselves out of work. The reason this is important is that, what concerned these people was not the numbers of people we have without insurance coverage or even the high rates in spending the United States has been so known for, but rather that, if they lost their job, they would also lose their health insurance, since most health insurance is job-related. And if they or someone in their family had had a medical problem, they might not be able to get insurance again, when they got a new job. It was that stability of insurance for the middle class, worried about losing their jobs, that most drove the public concern about health care reform. And yet what had been proposed by the Administration was a very large incomprehensive change, proposing not just to focus on some very targeted areas of concern, but to go after many areas that people have in the past thought, needed some sort of change and to take them all together. But as it turned out very quickly, the American public began registering a lot of concern about the amount of change that was being proposed and whether or not the financing was adequate, because even though we are a country that loves something for nothing and that likes to hear promises about how we can have it all, many Americans began to be uneasy, that more was being promised than could possibly have been delivered. Insurance that was like the best of health care coverage for all of the employed and the unemployed and other uninsured and new benefits for the elderly and new early retiring health benefits and that only some young workers and smokers would have to pay more and that the result of this intensified public concern was, that at the end of this two year period in fact, no health care reform, as you know, was passed in the United States. To my mind, although this is probably properly the domain of a political scientist and not an economist, I think the Health Security Act was a very important part of

having seen a majority republican Congress elected. And the reason is, that the American public took this one piece of legislation that represented such a showpiece, such an important part of what was being proposed, and, in rejecting it turned to the other political party. Now things swing back and forth in our country as in your country and you have to be careful in interpreting last year's results as this year's direction. But what we now see, is a reliance first and foremost on changes that are going on in the private sector and a push because of the financing for the public sector to follow suit. And let me share with you some of these things that are going on in the private sector. Many different models are being tried. Sometimes, it is an employer offering what is called a "health maintenance organization", an arrangement, where a certain amount is paid for a person per month to cover all of their health care. And the individual has to go to the place and the physicians and the hospital that are part of the plan. The way these groups can offer health care at lower spending rates is by keeping tighter control on access to technology and access to specialists and sometimes by pressing people to wait longer for appointments. Some of these organizations do it a little and some of them do it a lot. But these very traditional types of HMOs or Managed Care are not the only things that are going on in the United States. In fact, they are not where most of the growth is occurring. The much more interesting things that are going on are other types of arrangements. Let me give you some examples. Sometimes, employers will purchase the availability to go to a network of physicians and hospitals and they will do so at discounted fee schedules and with some promise of reviewing how medicine is practised. But in the second case, as part of the network, individuals can leave and go see other doctors of their choosing, but may have to pay 20% of the charge or some other amount, or go to a hospital that is not part of the network, but again pay some of the amount. So a very important component to the settling of a strike by a company called Nynex, they are the New York telephone company, and the tension there was between union members, who were used to having a fully paid health care plan and management, who could not afford to keep paying for wherever and whenever individuals wanted to seek health care. And the compromise that occurred several years ago was to offer a place where all of your health care would be covered, but if you wanted to leave, you could, but you would have to pay a higher price. So it was one compromise, that many other employers since then have followed. But there are some much more creative ideas, that are also being tried, and let me give you some more examples. Forbes Magazine is using something called "Medical Savings Accounts". And the idea there is to allow individuals to have an allowance for health care spending that is under their control, that if they spend wisely, they can have money left over to be used for other things. If they do not, if they want to use their health care, spend money for health care, that is fine, that is what it is there for. They will have less available for

other things. But there is a problem because of US tax laws in really having this effective. And the problem is that, at the end of the year, if you have this money set aside and subject to favorable tax laws, if there is any left over, you have to either use it or you lose it, it goes away. And so while you have people with an incentive to be careful during the year, because they cannot roll it over until next year with the same favorable tax consequences, you do not have as much pressure to be careful about how you spend as many people feel you might, if you were not pressed to do that. Now to make that change is actually a very small change in law. I wrote some language for House Republicans a couple of years ago that would allow people who had employer sponsored insurance the choice of either having whatever insurance their company was offering or having an *ex varia* equivalent, that means, when you adjust for the age and sex of the individual, what would be a fair amount relative to their not being part of the insurance plan, but to be able to take that money, have a catastrophic insurance plan to make sure if they got very sick, that they would not be a burden to society. And any remaining dollars would be set aside for their use and control on a separate account. But unlike the current account at the end of the year anything that was left could be rolled over into their account for the next year to be used. Depending on how you set it up, you could have it cost the Treasury nothing. But it would allow people who wanted to more actively control their own spending a much greater say in how their shelter, their tax shelter, health care dollars, could be used. There are other ideas that employers are trying. International Paper is going back to an idea that was very popular in the 1940's and 1950's, it is an indemnity insurance plan, where they will go out and spend a certain amount of money for a particular type of case. Anything that goes beyond that, the individual can go to whoever they want, but they have to pay the differential, again a very old concept that is being brought back into some favour. What is happening now, is so much change, that it is really hard to know exactly where we are. And it is even harder to know how long it will go on in the future. But you have two very powerful forces coming together, and these probably, having the two of them, is unique to the United States. One is a set of very aggressive purchasers, large corporations, small corporations and small employers, who come together as a group and form a buying group to act like a large corporation, are having very powerful purchasing effects. But in the United States there is something that most of the other countries do not have, that is the reason you are seeing such dramatic change so quickly. And that is, aggressive purchasers are meeting out with an overcapacity of market. In the United States, almost everywhere, there are places where this is not true, but almost everywhere, there is an abundance, many might say an excess, of almost everything involved in health care: physicians, especially speciality physicians, high-tech centres, hospitals, hospital beds, device manufacturers. And what this means

is, that when you have aggressive purchasing come in contact with an oversupplied market, they can force dramatic changes. Now what is happening in the United States is something that I never thought I would report about in my professional lifetime. It is not just a slowing of health care spending, we are seeing a slowing of health care spending, there is a debate about whether it is a little above the Consumer Price Index, our inflation rate, or at that or a little below, our measures are not keeping up fast enough to tell us. It is at least as low as it has been over our forty year trend. But what is more astounding is, that in some parts of the United States there are absolute declines in spending being reported, in the areas of the country where Dr. Tice is from, although a little south of him, mostly in California, where there are large mature managed care groups and lots and lots of physicians and hospitals and nurses and laboratories centres and those forces are coming together and causing dramatic change. Premiums in the area around San Francisco were reported to decline 5 - 15% in the latest year we have information. That is an astounding occurrence in the United States. Now, I do not think that we will see absolute declines all over the country. I do not think we will see them in California for very long. But it reminds us what an energized private sector can do in terms of demanding change. As big a change as President Clinton had proposed as part of the Health Security Act, and there were many aspects of change being involved, the dramatic level of change that is occurring in the private sector is much greater than any government would ever achieve. Political forces do not allow the kinds of dramatic changes that energized private sectors can perform. What we will have to see is how long it will continue. As long as there is excess capacity in the system, and there is plenty as of 1995, the potential for dramatic change is there. And I believe, much to the pain of all those who are involved in providing health care services in the United States, that we are at the beginning of this change cycle and nowhere are we near the end of it. Now the interesting thing is, that the public sector is just starting to follow suit, being dragged reluctantly into these efforts at change. And there is a very simple reason. If you take Medicare, which is our program for the elderly, and Medicaid, which is the federal state program for some, but not all poor people, if you take those two pieces out of the budget and you take interest on the debt, which is a reflection of our deficit spending out of the budget, the rest of the budget is expected to grow at 3.8% per year for the next five years. But Medicaid is expected to grow between 9 and 11% per year and Medicare is expected to grow at 10.5%. And the part that is directly financed by the Federal Budget, the part that pays for physicians and clinical laboratories and out-patient procedures in the hospital, that part is expected to grow at 12.5% per year. So the reason you cannot avoid what is going on in the public sector anymore, is it dominates the budget because of the 10 and 12% growth in health care versus the 3.8% growth everywhere else. In addition,

part of Medicare is funded by a Trust Fund, and that Trust Fund is due to run out of money in seven years. Now, you could find a way to add a little and put that date out, but the fundamental problem is still there: health care in a public sector growing much faster than anything else in the budget and much faster than the private sector. Now, on the part to the poor, the Federal Government hopes to basically give the problem to the States. Take a certain amount of money and tell the States they should figure out what to do. We will see whether or not this actually happens. Some States have said, if you let us do it our way, if you give us enough flexibility, we will set off for 5% growth instead of 9 or 10% growth. But I did a lot of negotiations with governors when I was running Medicaid and what they say and what they actually agree to when it comes time for a vote are not always the same thing. These are very difficult issues, and we will see whether it actually happens. It is further along than I would have guessed, the discussions are continuing, and it may be that the Federal Government will have to give more money to the States, maybe 7% not 5%, but right now, it looks like that exchange of responsibilities with just some outcome and performance measures attached may happen. But the problem for Medicare is much more difficult, because the political power of the elderly is much, much, much greater than the political power of the poor. And what happens to this program, is as yet unclear. But what is clear, is that we cannot continue where we are. There is not the money, there is not the willingness to increase taxes, and that is before we get to the ageing of our population, which starts in seriousness in 2010. That is when the first of the post World War II Baby Boomers starts to retire, our bulge in our population will hit retirement between 2010 and 2030. It is not a big surprise that we have a problem in Medicare. There are no incentives to care about what is being spent. The elderly are sheltered by Medicare and 90% have either a private insurance to supplement Medicare or Medicaid, the program for the poor. So that from the users of health care there is very little reason to care about what is being done, as long as there is any benefit to be had, no matter what is costs. And for the people providing services, for the most part, as more as provided, more payment is received. Now that is not an unusual way for any kind of a market to respond. But when you have pressures from both, the people providing services and from the people using services and a legal environment that encourages any bad outcome to be taken to the court system, there is very little to hold back from spending. And that is basically what is happening. Now there is a lot of talk about making some very substantial changes, opening up options, giving seniors more choice, rewarding those who choose well by allowing them to have cash rebates, if they can come under the price of a basic package or setting the price of the basic package at what it could be purchased for but might not necessarily be purchased for at a lower price version. Some are suggesting moving all of the way to a vouchered system, al-