Boston University

OpenBU http://open.bu.edu

BU Publications BUMC Perspectives on Health Policy

1974-11

Federal Role in Health Policy: November 1974 no. 3

https://hdl.handle.net/2144/22272
"Downloaded from OpenBU. Boston University's institutional repository."

Boston University
Medical Center

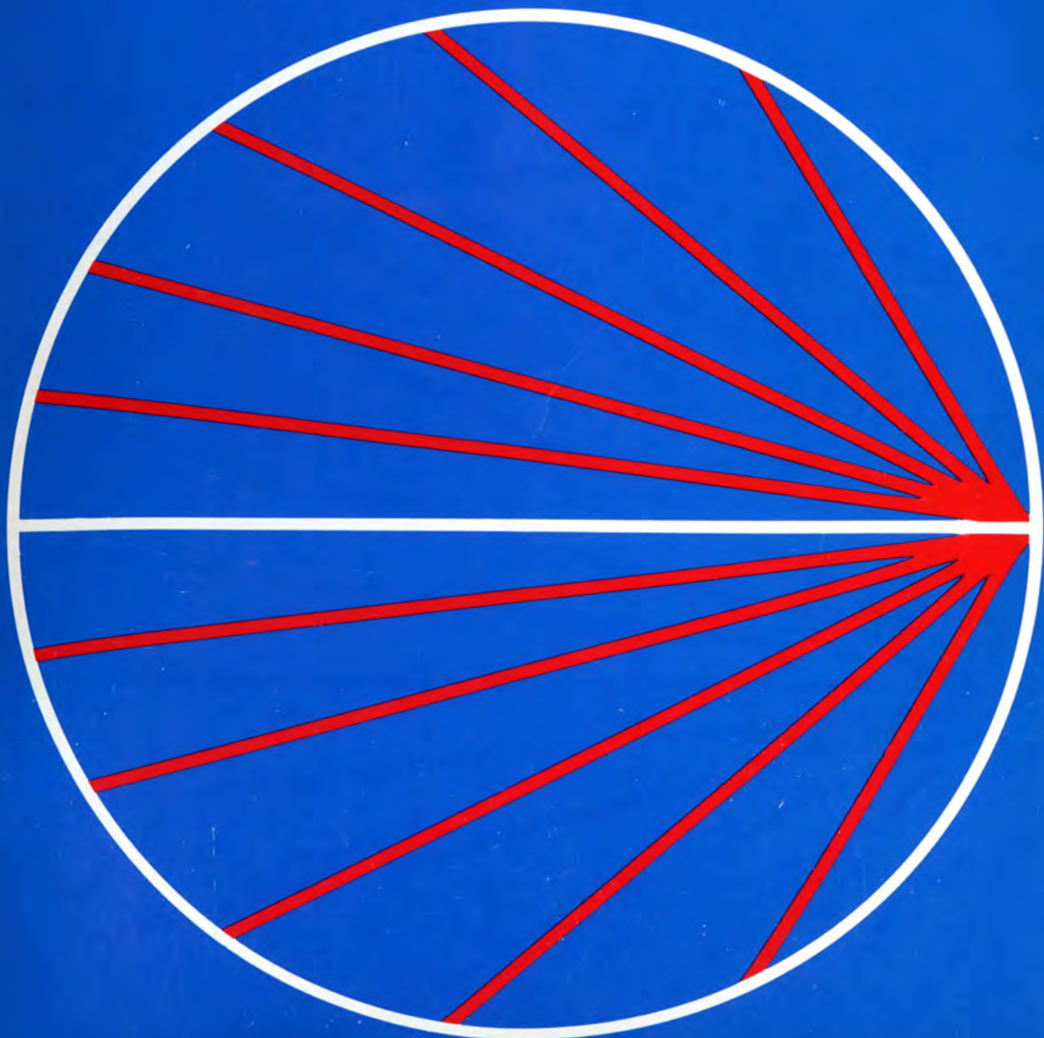
Perspectives
on Health Policy

No. 3
November,
1974

The Federal Role in Health Policy

S. Philip Caper
James J. Mongan
D. Patrick O'Donoghue

Daniel S. Bernstein
moderator/editor



Boston University
Medical Center

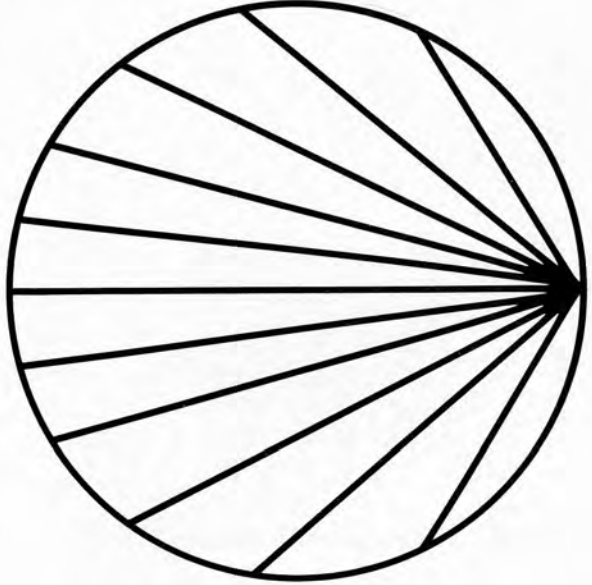
Perspectives
on Health Policy

No. 3
November,
1974

The Federal Role in Health Policy

S. Philip Caper
James J. Mongan
D. Patrick O'Donoghue

Daniel S. Bernstein
moderator/editor



The symposium reported in this volume was presented May 11, 1974, in the Chester Scott Keefer Auditorium of University Hospital, a member of Boston University Medical Center.

Library of Congress Catalog Number: 74-31427

Copyright © by the participants and Boston University Medical Center. Permission to quote or excerpt is hereby given, with appropriate citation of the participant and Boston University Medical Center.

Published November, 1974.

Produced for the Department of Postgraduate Medicine,
Boston University School of Medicine,
by the Office of Informational Services,
Boston University Medical Center
720 Harrison Avenue
Boston, MA 02118

Donald R. Giller, coordinating editor
Jerome Schuerger, designer

Contents

About the Participants/**v**

Abbreviations in This Volume/**vi**

THE PRESENTATIONS/**1**
Daniel S. Bernstein, moderator

The Federal Role
in Health Financing/**2**
James J. Mongan

Federal Health Legislation:
A Perspective/**6**
S. Philip Caper

Approaches to Health-Care Regulations/**10**
D. Patrick O'Donoghue

THE PANEL/**16**

About the Participants

Daniel S. Bernstein, M.D., is associate dean for postgraduate education and hospital affiliations at Boston University School of Medicine. He was previously assistant director of the Tri-State Regional Medical Program. He has been involved in the development of Professional Standards Review Organizations within Massachusetts and in the training of PSRO management nationally.

S. Philip Caper, M.D., is a professional staff member of the Subcommittee on Health of the Committee on Labor and Public Welfare, United States Senate. He has participated in legislative activities concerned with national health insurance, health-manpower needs and Health Maintenance Organizations.

James J. Mongan, M.D., is a professional staff member of the United States Senate Finance Committee. His past work has related to Medicare, Medicaid and Health Maintenance Organization legislation. He has also played a major role in the shaping of Professional Standards Review Organizations.

D. Patrick O'Donoghue, M.D., M.P.H., is president of Spectrum Research, Inc. and Policy Center, Inc., both located in Washington, D.C. and Denver. He is an adjunct associate professor of medicine at Boston University School of Medicine. He has studied and written broadly in the fields of health financing and delivery; health-care quality assurance; and regulatory theory and practice.

Abbreviations in This Volume

CAB: Civil Aeronautics Board
CHIP: Comprehensive Health Insurance Plan
FMC: Foundation for medical care
HMO: Health Maintenance Organization
PSRO: Professional Standards Review Organization

The Presentations

Daniel S. Bernstein
Moderator

The Federal Role in Health Financing

James J. Mongan

Daniel S. Bernstein: I would like to welcome all of you who have come to participate in a very interesting program concerning the federal role in health care, a topic especially relevant to all of the events occurring in Washington and across the country today in the health-care system.

Our panel consists of Dr. James Mongan, a staff member of the U.S. Senate Finance Committee; Dr. Philip Caper, a staff member of the U.S. Senate Committee on Labor and Public Welfare; and Dr. Patrick O'Donoghue, president of Spectrum Research, Inc., and Policy Center, Inc. of Denver, Colorado.

Our speakers have special interests and expertise in various matters concerning health insurance. I am not sure just how much of the populace is interested in health insurance, but the Congress of the United States is indeed interested in it. With the evolution of Professional Standards Review Organizations and their implementation currently, the health system clearly is changing in this country, and dramatically so.

Perhaps I can start off the discussion by asking Dr. James Mongan, who has been listening to testimony to the U.S. Senate Finance Committee about PSROs in the past week, to give us his reflections concerning the issue of federal health insurance in the Congress.

James J. Mongan: Dr. Bernstein asked me to talk about the federal financing of health care, which is certainly a broad enough topic and leaves me free to essentially just touch on items in an outline. I thought I would go back historically a little, and then mention future legislation briefly.

As you all know, the federal role in financing increased vastly with the passage of the Medicaid and Medicare programs in 1965. These programs

now account for expenditures of some $25 billion a year. The first major amendments to these programs came in 1972 with the passage of a bill called "HR 1," signed into law as Public Law 92-603. Congress had started work on those first Medicare amendments back in 1969; it took three years to get that legislation through because it got tied up in the welfare-reform battle. But the package of Medicare amendments contained a number of significant items. I guess the most significant would be the extension of the original Medicare program, which had covered only those over 65, to also cover a number of disability recipients. For the first time the over-65 age barrier for Medicare was broken, and that covered about a million additional people under the program, at a cost of about a billion additional dollars.

Along with this one extension of coverage, HR 1 contained primarily a series of controls. The original Medicare program was basically a benefits package with very few controls included in it. The costs of Medicare were rising rather rapidly and there was also some very disturbing testimony with respect to the quality of some of the services the government was purchasing under that program. Therefore, the bill, aside from containing the extension of coverage to some of the disabled, also contained a series of controls. I will just mention very briefly a few of these:

1. There were some limitations put on hospital per-diem costs reimbursable under Medicare.
2. There were limitations on the extent to which physicians' prevailing fees could increase from year to year.
3. There were limitations on capital expenditures and whether those would be recognized for Medicare reimbursement.
4. There was a quality- and utilization-control mechanism included in the bill, known as the PSRO amendment, to set up review organizations, composed of physicians, throughout the country. These organizations would review whether the services reimbursed under the program were necessary and met proper quality standards.

Let me just touch for a moment during this outline on future health-insurance legislation. In October, 1972, when the first series of Medicare amendments was passed, the Congress turned toward the question of expanding the federal health-insurance programs. There are about 10 or 11 national health-insurance proposals currently before the Congress, and, it appears at this point, they have been narrowed down to three major alter-

native approaches. Let me briefly describe those three approaches and their similarities and differences.

The three approaches are the Long-Ribicoff bill, which is sponsored by the chairman of the Finance Committee. This bill has eight cosponsors on the Finance Committee, and it represents, to a certain extent, the Finance Committee view. The Administration proposal is called CHIP (Comprehensive Health Insurance Plan), and the third is the Kennedy-Mills bill.

The Long-Ribicoff bill is a three-part proposal: The first part is a catastrophic health-insurance bill; the second part is a federalized Medicaid program that would cover the basic expenses of low-income people to fill in under the catastrophic deductibles; and the third part of the bill is a voluntary certification program for private health-insurance policies. Basically, the catastrophic portion has two rather high deductibles at $2,000 and 60 days of hospitalization. Title II of the bill—the Medicaid portion—would fill in those first 60 days and $2,000 for low-income people. The theory of the bill is that people would obtain private health insurance against the first 60 days and first $2,000 if they were not low-income people. Title 3 of the bill speaks to the private health-insurance industry and would set standards for the insurance they would offer that would say, for example, a certified policy would have to provide at least 60 days of care and pay for at least the first $2,000 worth of bills. Title 3 would speak to the insurance-company retention rate that would be acceptable in those policies, and it would address exclusions such as coverage of the newborn and that sort of thing. Certification of health-insurance policies would be voluntary, however. If an insurer did not offer a voluntary policy, it could not be a carrier or intermediary under the Medicare program. This provision is thought to be enough clout to get the major third-party insurers to participate in the program, at which point it is felt that the others would follow suit for competitive reasons.

The Administration bill (CHIP) — the second major approach currently before the Congress—has broad eligibility covering most of the people in the country. It speaks to both basic and catastrophic costs. There are deductibles and copayments that would rise to a limit of $1,500 under CHIP. CHIP would be not only administered by private insurance companies but underwritten by them as well. The basic approach of the Administration bill is to mandate employer-employee private health-insurance coverage rather than run the program through the government. The mandated employer-employee coverage would be regulated by the state governments under the Administration bill, and the bill would be financed, of course, by these mandated premium payments along with

some general revenues for the low-income portion of the program.

The third bill—the Kennedy-Mills bill—was only recently introduced, and it would also have very broad eligibility, covering most all in the country, and, again, a broad benefits structure with deductibles and copayments, but rising only to a limit of $1,000 under this bill. The Kennedy-Mills bill would be administered by the Social Security Administration, and the coverage would be run through Social Security, rather than through the private insurers. The latter would act as carriers and intermediaries, as they do under Medicare. The bill would be financed through a payroll tax rather than through the mandated employer-employee premiums.

Let me discuss briefly the similarities between those bills, and the differences. All three of these approaches have two striking similarities: They all speak to catastrophic costs, and they all speak to providing basic coverage to low-income people. The difference comes in the area of what to do with respect to basic coverage for the average working person; the three bills take three strikingly different and rather graded approaches in that area.

The Long-Ribicoff bill would basically not move into the area of basic coverage other than to set up this voluntary certification program. The government's role would be limited to certifying private insurance policies so that the consumer would be assured as to whether this policy was adequate or not, given the rest of the federal program.

The Administration bill would go a step further, you might say, since employer-employee coverage would be mandated. In other words, the government would mandate that employers provide health-insurance protection to their employees.

The Kennedy-Mills bill would essentially provide both the basic and the catastrophic coverage to all persons through the federal-government mechanism, roughly parallel to Medicare and Medicaid, using the insurers as carriers and intermediaries.

That's a rather fast journey through those bills. I may not have done them complete justice; if not, I will try to do so during the question period.

Federal Health Legislation: A Perspective

S. Philip Caper

Bernstein: Dr. Caper has been more closely aligned with the Kennedy-Mills bill, while Dr. Mongan is most familiar with the Long-Ribicoff bill emanating from the Finance Committee. It seems to me that all of these bills are compromises and a step "down and away" from the original Kennedy health-insurance bill. Perhaps Dr. Caper would like to mention some of the reasons why Senator Kennnedy has aligned himself with Representative Mills in the generation of the Kennedy-Mills bill.

S. Philip Caper: Senator Kennedy would like to see S-3, the original Health Security Act, passed, but it does not look as though this is going to happen. He certainly has compromised; he's not happy about some of the areas in which he's compromised, but he's willing to give it a try. He thinks that compromise is worthwhile at this time in order to get a bill passed, and that is very important. The greatest areas of compromise in the bill are with respect to the role of the private insurance industry and co-insurance and deductibles. These compromises were made purely to get the price tag of the bill down to that of the Administration's bill.

The cost of the Kennedy-Mills bill in the federal budget is about $40 billion. I always try to point out that the cost issue is a "red herring" because the on-the-budget price tag is not the real cost of providing health care to our society. All private and public expenditures together represent the real cost. The total cost of all of the proposals, if you look at private and public expenditures together, is the same. The real issues concern how much the financing mechanism will be in the private sector, how much in the public sector, and what the impact will be on the delivery system and on inflation in the health-care industry. The Kennedy-Mills bill came

about purely because, in Senator Kennedy's judgment, it was necessary to amend S-3 and compromise in order to get a health-insurance bill to move through Congress.

Bernstein: Could you perhaps expand a little bit more on the Kennedy-Mills bill in contrast to the Long-Ribicoff bill?

Caper: Before I do that, let me take a few minutes to try to put all of the federal health legislation into some perspective and to try to organize my own thinking in terms of what all the federal activity means — what forces are responsible for generating it, what the federal government is trying to accomplish, and why the federal government is involved in the first place.

I think all current federal legislative activity is due to an ethical orientation of our society. That ethic concerns the availability of health services to everyone in the population. I think the decision is about 90 per cent made that health-care services are to be made available on a reasonably equitable basis to everyone in the country. I think there is very little basic disagreement (although there is still some) with that premise. All federal legislative activities can be explained in terms of that basic ethic.

The first and most visible mechanism to assure an entitlement to health-care services is the financing of health services. That explains the flurry of activity in recent years in the national health-insurance area. The concept of health care as a universal right raises some very difficult issues, primarily with respect to the ability of the system to provide it. To make that promise a reality and to translate ecomomic capability for the purchase of health services into accessibility to the system, to generate adequate resources, and to make them available is a monumental problem. I think the keystone to activity at the federal level in the health field is the health-insurance legislation. It is by far the most important legislation being considered at this time.

The corollaries of the basic axiom of "health care as a right" create problems relating, first, to the generation of resources, an area in which the federal government has been interested and active for a number of years — support to medical schools, National Institutes of Health, community mental-health centers, and a long list of federal programs — most of which are under the jurisdiction of the subcommittee I serve. The committee that Dr. Mongan serves has responsibility for the financing legislation. It has basic responsiblity for the laws governing the tax structure of the country. You can't really talk about a national health-insurance program without talking in terms of modification of the tax laws. That is how the Ways and Means and the Finance Committees got into the health-

care field in the first place. Health insurance is basically a type of income-redistribution program. Assuring that people who are not now able to purchase health insurance become able to purchase it really does mean, to some extent, a redistribution of purchasing power.

A second important issue raised by the idea of universal entitlement to health services is that of the adequacy of the present structure of the health-care system within a community. There is a fair amount of federal activity concerning the question of whether the existing health-care system, which is basically a fee-for-service system composed of very small units of productivity (individual practitioners and small group practices), will be capable of delivering health services as a "right." The Health Maintenance Organization legislation and the thrust toward organizing health services and restructuring the financial incentives from the point of view of the providers of health services are very important examples of recent federal activity in this area.

A third example of federal legislation, which is very important but not universally recognized as yet, is the present set of proposals in both houses of Congress to extend and to strengthen the mechanism for health planning throughout the country: that is, to construct a decision-making mechanism so that the health needs of a community can be assessed and so that plans can be adopted to bring about the satisfaction of those needs. I think that this legislation, which I am certain will be passed by Congress within the next several months, is going to play a very important role in the American health system in the future. The fact that the Kennedy-Mills bill ties eligibility for participation in the program to conformance with decisions made by the health-planning agency in the area confirms its importance.

A fourth area — and in some ways the one that will have the most profound impact on the practice of medicine — is the area of quality assurance. The federal government has had a very limited role in the assurance of quality in the health industry up to the present. Regulatory agencies like the Food and Drug Administration are about the only examples of federal involvement in the assurance of quality in the health-care industry. The Professional Standards Review Organization (PSRO) legislation, which is extremely important, is almost certain to be tied in to any expanded federal health-insurance program. PSROs are, as you know, undergoing development and are the subject of great debates within the medical community. I think that the PSRO law is the most important currently-active federal area for the practice of medicine because the PSRO law calls for the establishment of formal and visible standards on a local level. Even though the standards may vary from one locality to

another, this is going to force an examination of the efficacy of many clinical procedures that have been taken for granted for many years or which have been believed in almost as an act of faith by practitioners of medicine. The Harvard School of Public Health's Center for the Evaluation of Clinical Procedures, which among other issues is studying the efficacy of the coronary-artery by-pass procedure, is one very good example of an approach to such issues. If an enacted national health-insurance program entitles everyone who needs a coronary artery by-pass procedure to have one — at a cost of about $15,000 — the total national cost could become astronomical. The question, which I think is a very serious question, is, "What is the real impact of that procedure on extending the patient's lifespan or its impact on the patient's quality of life?"

At some point, the inflation and the increasingly greater percentage of our gross national product being put into health services is going to have to stop. Spending for health services can't go on forever the way it has been, and accepting fiscal restraint implies making decisions that will involve tradeoffs. For instance, are we better off as a society putting money into nutrition or into artificial hearts? These, I think, are the kinds of issues that implicitly or explicitly are going to have to be addressed. That's why I think that the process of beginning to actually look at the efficacy of clinical procedures, beginning to compare what goes on in teaching hospitals and community hospitals, and beginning to ask questions like, "Which method, from the standpoint of society as a whole, is really the best choice?" is so extraordinarily important. That, to me, is a very exciting and very challenging prospect for medicine.

I am certain that when the dust settles, the medical profession will begin to look at these questions as doctors begin to appreciate the importance of validating the efficacy of clinical procedures in the context of a universal system of financing health services.

Approaches to Health-Care Regulation

D. Patrick O'Donoghue

Bernstein: Dr. Caper initiated a subject close to Dr. O'Donoghue's interests in terms of tradeoffs in the health system (or nonsystem), which everyone has categorized at least as a system of disparate elements. Perhaps Dr. O'Donoghue would like to comment on the impact of health-insurance schemes within the practice of medicine, especially since he was instrumental in generating the Health Maintenance Organization (HMO) bill, and health insurance and HMOs go almost hand-in-hand. Seed money, resources and tradeoffs are Dr. O'Donoghue's basic interests.

D. Patrick O'Donoghue: I thought that my general topic should be health-care regulation, which Drs. Caper and Mongan have touched upon in part. I was looking for the best way to start an introduction and, what I came up with is that, as I have been attending a number of conferences and discussions concerning health-care regulations, six points stood out to me, which would help to put this discussion in perspective. They do touch in part upon the tradeoff point, and, in some ways, they also touch upon the health-care insurance area.

The first and most obvious issue is that *health-care regulation, necessarily implied by the discussion of the various insurance bills, is not an "either-or" choice.* It is frequently discussed in those terms; That is to say, "We are either going to have regulation, or we are not." That is probably not the right issue. The question probably is, "What kinds of regulation are we likely to have?" In particular, one always has to look at the objectives of the regulation and who is going to be regulated, because that makes a difference. Trying to regulate 3,000 people is more difficult in some ways than regulating 50, and less difficult in others. The question

then becomes, "How is the regulation going to be carried out; what kind of incentive pattern might we build into the regulation to make it perform better than other kinds of regulations have performed in the past?" That is the first point.

The second point I wanted to make — and this relates very closely to the health-insurance area — is that certainly *the kind of regulation that you are considering is tied to the financing and organizational structure of whatever system is involved.* If it is the health-care system, there are a number of examples that stand out, and I'll run through just a few.

If you are talking about health-care *prices,* certainly the way in which you reimburse or pay providers makes a big difference in the kind of regulation you think about. If you're on a cost-plus-reimbursement system for hospitals, and a fee-for-service for physicians and other individual practitioners, then you have a heavily insured system such as has been discussed here. Then you immediately begin to think about various kinds of cost and price regulations designed to keep the lid on inflation. If, on the other hand, you have providers and HMOs, or you have hospitals on prospective reimbursement systems, then this kind of unit-price regulation seems less necessary.

If you look at the *quantity* area, you come up with a little of the same conclusion. If you have a fee-for-service system that is heavily insured, then you're quite concerned about what's going to happen to not only the prices of health care but the quantities of health care provided, such as coronary-artery procedures. In that case, you begin to think about erecting various kinds of utilization review and similar kinds of regulatory mechanisms, as the Congress has in fact done in the PSRO program. Again, if you are talking about an HMO or a foundation for medical care (FMC), this kind of external regulation may be less necessary, although it almost certainly is necessary as an internal mechanism. It is particularly true of FMCs, of course, where the control lines are usually less well established than they are in a regular, group-practice HMO. In fact, as most of you know, the PSRO program really grew out of some of the FMCs, especially in the western part of the United States.

Again, if you look at the *number of facilities,* you come up with somewhat the same idea, and this of course is what is being attacked in the health-planning bills. That is to say, if you have a cost-plus-reimbursement process for hospitals and a heavily insured system, a regular incentive in that system is to build additional facilities since they can be easily reimbursed and included in the per-diem charges, especially when the charges are not agreed upon in advance. In that situation, you think about

finding some way to regulate the amounts of capital expenditures. This has led to the passage of certificate-of-need laws in almost half of the states, as well as in Section 221 of PL 92-603, under which hospitals will not be reimbursed for capital expenditures not approved by a planning agency under Medicare-Medicaid and the other titles of the Social Security Act.

In another example, if an HMO exists and you have a situation of changed structural organization, you begin to worry about *financial underservice;* in other words, there is an incentive in that type of organization to provide too few services. This point has been considered in this area and illustrates the general thesis that you cannot talk about regulation independent of the financing and structure of the system.

The third point I wanted to make is that we sometimes get the feeling that there are two groups in the room in these types of discussions. It is almost like the image of two trains passing in the night. I think that one group of discussors and considerers of regulation is primarily concerned about *efficiency.* In other words, they're concerned whether the system is going to be maximally efficient. The other group is primarily concerned about *equity;* that is, will the system provide services to as many people as possible? Certainly, Dr. Caper has reiterated the motto of the equity point of view — "Health care is a right." To pick an example outside of health care, consider the Civil Aeronautics Board (CAB) and their routing policies for individual airlines. They, in the past at least, have allocated some of these routes in rather interesting ways. When an airline was assigned the route between Boston and Washington, it was also designated to serve Boston and Springfield, or Boston and the western part of the state, as the case may be. The economists have repeatedly attacked this method of allocating routes with the basic charge that it is inefficient. In other words, the economists said that it would be more efficient to have some air carriers concentrating on long routes and some on short routes. I think that argument essentially begged the question, which is, as the CAB saw it and as the "equity" group would see it, that the real objective was to get service to small towns and cities of the United States. Given that it would have been too obvious, politically, to directly subsidize airlines, this kind of regulation represented a way of improving the equity of the delivery of services while reducing cost efficiency. My guess is that the more honest of the equity groups would admit that there was an efficiency loss.

The fourth point, referring again to the "trains passing in the night" image, is that *some of the regulatory discussions do in fact reflect different models of government.* One model is the public-interest model; that is to

say, regulators will maximize the public interest as they see it. The other model might be termed the "enlightened self-interest" model, which is that regulators, as well as other individuals, probably operate to maximize their own enlightened self-interest. That does not mean their narrow self-interest, but their self-interest broadly conceived. Of course, the public interest and the regulators' self-interest may run together at times.

The models differ when, for example, the state passes a certificate-of-need law, and the public-interest group assumes that the people who are administering that law will act in the public interest as disinterested parties, regulating hospitals fairly harshly and stringently, at arms length, in an effort to lower the concentration of hospital beds in some areas and to raise them in others. The enlightened self-interest model of regulation assumes instead that the regulators will primarily consider their primary constituencies — the hospitals — which are most concerned about their activities, in order to develop the closest ties with the hospital group so that the law may be administered in a way that protects and does not unduly damage the interest of the hospitals being regulated. The net effect of the law in this instance may be some reduction in the concentration of the ratio of hospital beds to population in the area; and that will primarily be achieved not by the more equitable distribution — as the public-interest model would predict, but by keeping out new entries into the hospital area and by decreasing innovation.

The fifth point that I want to make concerns the question of *consumer knowledge in regard to health care.* In other words, there is one group — the economists — who assume that we have underrated the consumer's knowledge — that he, in fact, does know or could know more than we give him credit for. The other view, primarily espoused by the physicians and other health providers, is that health care is a very complex area, that it is difficult enough for physicians as well as other health-care specialists to understand, and that the consumer should not rely on his own knowledge regarding decisions about what kinds of health care he should receive. Those are the two polar positions. There are intermediate views concerning the knowledgeability of consumers about health care. But, in any case, let's look briefly at the implications for regulation.

Take personnel licensure. If you assume that consumers are not very knowledgeable about health care, then personnel licensure is seen as a necessary regulatory mechanism to insure that when a person receives service from his physician, nurse or dentist, that health provider will have met certain minimal levels of quality. Thus, the argument would be that

even if licensure hasn't worked very well and even if it isn't very good, it is certainly better than nothing. Consider what would occur if we didn't have it. All sorts of charlatans would appear in the marketplace, and the consumer would have great difficulty determining the difference between the well-trained physician and the complete charlatan.

The other view of personnel licensure assumes that consumers are fairly knowledgeable about health care, that personnel licensure is pretty unnecessary because people certainly would be able to tell whether or not a physician is reasonably well-trained. This view would have us believe that personnel licensure has acted primarily as a restrictive mechanism in that it has reduced the number of physicians as well as other personnel, or at least that it has been a contributing factor in that relative reduction. It has enabled the professions to keep a tight control over their own practices and, thus, it has restricted the kinds of innovations that have been introduced into the health area.

The sixth and last point is related to the *state of knowledge about health-care regulation.* Policy Center, Inc. at present has a study funded by the National Science Foundation to examine closely what we do know about health-care regulation across the board. For that purpose, we divided the study into seven types of regulatory mechanisms, and our task is to determine what is known based upon the existing evidence. The state of knowledge about regulation in the health-care area, at least from what we have determined, is highly sketchy. It is variable between the different regulatory areas. I think there is more known about utilization review and medical audit and that kind of regulation-monitoring than about other types of regulation. There seems to be less known at the other extreme concerning items such as institutional-quality regulation and regulation of private insurers, both of which have been in force for a long period. In response to that point and in partial defense of my profession, health-care research, a lot of these regulatory mechanisms are new. Therefore, it is proper, currently, to begin to evaluate these newer modes of regulation if we evaluate them in a comprehensive and quantitative way. On the other hand, personnel licensure, regulation of institutional quality, and certificate-of-need legislation have been in existence for some time, which allows us to develop more knowledge about health-care regulation. Certainly, the overall problem is that most of the current discussions and arguments about health-care regulation are really made from a very limited knowledge base.

These are the six points that I wanted to make when I began. As I see it, the purpose of the six points is to try to inject some perspective into our

discussions and considerations about health-care regulation. I think they have at least helped me understand some of the different themes that we see in some of these considerations.

The Panel

Question: I speak from the perspective of one who has been a regulator at a local level for many years. I have found that the current regulations, forerunners of those to come, have served as a disincentive for improved quality of care and have resulted in a "grab-bag" approach to determine who can get the most out of the bag. I recognize that, relative to the federal establishment, one must look first at the total system and the financing of it, because that is where you can create a system. I wonder if there is any thought concerning how you can get back to the individual patient. The PSRO mechanism talks about the doctor and the quality of care from the standpoint of the doctor; I can tell you, however, from my perspective of licensing nursing homes for many years, that the quality of care at the present time in most nursing homes and in most hospitals is so deplorable as to be beyond belief. I see an aggravation of this problem with the various proposals that have been made — whether it is the Kennedy-Mills bill, the Long-Ribicoff bill, or any of the others. None of them seems to take note of the fact that one is talking about a health system. I find that as the system has more money pumped into it, this infusion steadily pushes this concern for quality of care aside in order to get the most efficiency out of the system. The humanitarian motivation has been steadily eroded. Is there any area where anyone is taking any interest in this — not in terms of the models you are talking about, but in terms of some model that will provide an incentive for the individual nurse's aide, or L.P.N., or R.N., or even the physician to concern herself or himself with the individual patient's welfare and not be so overly concerned about who the hell is going to pay for it?

Mongan: I'll try to answer that. I guess I could be a little more helpful if you could get a little more specific. You indicate that some of the current regulatory approaches are exacerbating the problem that bothers you. If you could get more specific and tell us what the current regulations are that cause the problem, maybe you could help answer the question yourself in terms of what you would propose.

Question: I'll give you an example. I had a woman die at Cincinnati General Hospital some months ago following osteomyelitis. She had been hemiparetic for some time. She was a woman in her seventies who had been hospitalized for no more than two or three days before she died, having come directly from the nursing home. She then returned to that nursing home from another hospital, still with the osteomyelitis, and she had been removed from the hospital to the nursing home because the physicians could no longer justify keeping her there under her current insurance coverage. The hospital and the physicians had to move her out. Since she had come to the hospital from the nursing home, she was sent back to the nursing home with essentially the same problem because they were afraid of severe criticism if she continued to remain in the hospital. She went back to the nursing home, where they couldn't possibly take care of her. I doubt if there are three nursing homes in the entire city that really give quality care of the type that would be necessary to maintain that kind of a patient. Yet, under present rules and regulations, she had to be removed from the hospital unless she was prepared to really do battle with third-party payers. So, she went back to the nursing home. We have all sorts of political ramifications, but the fact of the matter is that it was not the fault of any one individual, because this was investigated. It was the fault of a system that tends to ignore the needs of individual patients because it has become so large and overwhelming that no one administratively has the stamina anymore to pay attention to the individual.

Mongan: I guess, now, with that more specific definition of how the regulations hurt, it is fair to say that, generically, the problem you are talking about is that we had a series of often-overlapping — and sometimes conflicting — utilization-review requirements and regulations. These regulations cause, in some instances at least, some hospital administrators and nursing-home administrators to become skittish about whether or not they want to keep somebody or take somebody in the first place because the claim may be denied. The answer to that, obviously, is not to abolish utilization-review requirements, because I think everybody has agreed that you have to have some kind of review and audit as to whether the care is

necessary. What I think you are putting your finger on is that whatever mechanism is developed has to be sensitive to individual differences of the sort you described and can't consist of a series of various regulations that don't relate to that specific patient.

I don't want to represent myself as a proponent or opponent of various pieces of legislation. I can, however, tell you that I think the Congress, in passing the PSRO law, was trying to get away from the situation that existed in current utilization review, where you had insurance companies such as Blue Cross arbitrarily limiting what they would and wouldn't pay rather than having those claims subjected to the professional judgment of the physicians in the area. Congress has attempted to develop a more flexible system that would take into account individual patient differences that, apparently, were not taken into account in your particular case. Your point, I think, is that regulation must be flexible enough to account for the needs of each particular patient; I don't think you are arguing for not having any utilization review at all and keeping every elderly patient in the hospital *ad infinitum*. It must be flexible and sensitive regulation.

I might just use that question to make one other point. Since you introduced the long-term care issue, I think it is true that every one of the major national health-insurance proposals is probably more deficient in the long-term care area than in any other area. Frankly, Congress has, in the past avoided — and it looks like it is continuing to avoid — the long-term care area. There are a variety of reasons for that — the state's concern about what the ultimate expense will be, a concern about what will happen to individual and family responsibility if the federal government assumes too large a role. But the net result is that none of the bills is very satisfactory in the long-term care area, and I'm a little less sanguine about solving that problem than I am about solving the specific problem you mentioned. I think as the years go by the federal government will become further involved in this area, but right now most of the bills are still only talking about covering hospitalization plus 100 days of extended care; and, as you know, that is really not long-term care.

Bernstein: What would be the population affected by these three types of bills? In other words, what is the population base?

Mongan: Well, getting back to Dr. Caper's point about the cost being the same, I think the population base is the same under each of these bills. The real issue is what is done with that population base and how benefits are delivered to each group in that population. All of these bills speak to everybody in the country, but they speak in a different fashion.

Bernstein: There has been a great deal written about the fact that the bills never address themselves to the "working poor." The working poor are still suffering from discrimination. The rich get richer under the bills; and the poor are always well taken care of if they can show that they are really poor.

Mongan: Well, that involves us in defining just who are "the poor." It's not hard to define the "working poor," but it becomes a little more difficult to define what income level you are talking about. Actually, I think that these three bills and almost all the others have taken one big step. There is one disastrous flaw in the current Medicaid program — basically, it covers just welfare-type families. In other words, unless you are aged, blind, disabled or receive Aid for Dependent Children, you can't get benefits. You may have the same income as welfare families, but if you are working you are not eligible for Medicaid. Now, all of these bills deal with that — the Long-Ribicoff, the Kennedy-Mills, and the Administration proposals — and most of the others are not limiting benefits to categorical groups anymore. For their low-income benefits, they are saying that any low-income person, whether he is working or not working, will receive benefits from the federal government. Then you get into a discussion of what "low income" should be. The limits in the Long-Ribicoff bill, which are the same ones used in the Kennedy bill in terms of how much deductible or copayment a person would have to pay, were $2,400 for a single person, $3,600 for a couple, $4,800 for a family of four and $400 additional for each member, with a spindown above that. In the Long-Ribicoff bill, those people who would be covered under that level and above that level would be expected to purchase private insurance. In the Kennedy bill they're all covered, both above and below it; but below that level, as I understand it, they wouldn't have the copayment and deductible obligation. All of the bills have taken the step of stopping discrimination between working and nonworking families. Whether the legislation will stop the discrimination between poor and nonpoor depends on your own definition: If you think that that's an adequate definition of low income, then the proposed bills have dealt with the problem completely. If you don't, then you would probably want to see the income limit raised.

Question: How do these bills interface with the Medicare program?

Caper: The Kennedy-Mills bill would retain a Medicare trust fund. It would expand Medicare benefits to some extent, particularly with respect

to drug and long-term-care coverage. It would basically retain the Medicare program much as it is now except that participation in the program on the part of providers — hospitals, doctors and so on — would be dependent upon conformance with health-planning decisions and with other quality standards that are built into the legislation, primarily having to do with certification. Only board-certified surgeons, for example, would be reimbursed for performing surgery unless none was available in a given area. The Kennedy-Mills bill would essentially retain the Medicare program as a financing mechanism, much as it is now, by the establishment of a trust fund, use of insurance intermediaries, and so on.

Mongan: I would like to add to that. I think a fair summary of the three bills is that the Kennedy-Mills bill would improve somewhat the present Medicare program, particularly in the drug area and, in some instances, in the long-term-care area. The Long-Ribicoff bill also proposes a few improvements in the Medicare program in that some preventive-health services would be covered that are not now covered. The addition of the catastrophic program means essentially that the upper limits on the Medicare benefits would be removed with respect to hospital days and home-health visits. And finally, though the drug benefit is not in the Long-Ribicoff bill, it has been passed by the Senate Finance Committee and is currently in conference. I think that down the road you are going to see an improvement of the Medicare program in the drug area. Those two bills take that approach. The Administration bill (and I'll try to be fair to them) takes a little different approach. They do modify the current Medicare program, and there is great debate in Washington as to whether they are improving it or making the coverage worse, with people on both sides arguing it different ways. The Administration bill changes the deductible and co-insurance provisions so that people pay a little more in the front end. The claim is that they give longer benefits down the road, while, actually, the benefits are the same. Other people argue that contention with specific instances of how the elderly would be disadvantaged under the Administration bill. Suffice it to say, Congress is not going to pass a bill that cuts back on existing Medicare benefits — that much is clear. I think that under any of these bills the benefits will be expanded somewhat, most probably in the drug area, removing upper limits.

Question: I'd like to address this question to Dr. Caper. The panel has been discussing the structure of health-care systems. As a physician who has practiced internal medicine for 15 years and psychiatry for about 10

years, I have noted a gradual deterioration in the quality of doctor-patient relationships. Would your proposal — the Kennedy-Mills bill — give rise to a type of health care that further deteriorates this relationship?

Caper: The first observation I would like to make is that the deterioration you note has taken place under a system that is overwhelmingly fee-for-service and overwhelmingly single- or small-group-practitioner oriented. The question, I suppose, is, "Will the stimulation of larger group practices produced by a change in the payment mechanism to a prepayment device lead to a proliferation of HMOs, and thereby exacerbate, alleviate or have no effect on that trend?" I don't know the answer to that question, but I do know that many of the group practices and HMOs I've seen — the Harvard Community Health Plan, the Group Health Cooperative of Puget Sound, some of the foundations for medical care — certainly don't lead to production-line medicine. I think that the relationship between doctor and patient is obviously and clearly an interpersonal relationship dependent more upon the interest of the doctor and the patient in establishing that relationship than on whether a doctor is practicing in an HMO or not. There is nothing incompatible between the HMO concept and the idea of a patient relating to an individual physician. He can have his own physician in the HMO setting. Even now in fee-for-service group practices, doctors cover for one another, and a patient may see any one of a number of physicians. I do not think that restructuring the way medical care is delivered at a local level will necessarily have an impact in this regard. I don't think that the quality of the doctor-patient relationship is really dependent upon those kinds of considerations.

The other comment I want to make is that nobody I know has ever advocated (Senate Kennedy hasn't: I think he's been widely misquoted, intentionally to some extent) remaking the health-care system into an all-HMO system. Senator Kennedy has never advocated that approach, but he has advocated the introduction of some diversity and some pluralism and some competition into a health-care-delivery system that is really, to use the AMA's term, a "monolithic system." In excess of 95 per cent of health services are delivered on a fee-for-service basis. Senator Kennedy would like to see 10 per cent or 20 per cent of health care delivered on an HMO or prepaid basis at the outset, with careful evaluation of the process. Obviously, the HMO concept is not going to work out if physicians are opposed to it, if they won't participate in it, or if the patients don't like it. But physicians should be given the opportunity to try to develop HMOs

and group practices, which has never really been possible on any widespread basis in this country yet. Senator Kennedy views HMO and group practice as being a fairly noncoercive way of introducing some new forces into the system to rationalize the delivery of services and guarantee people the access to services when they need them. This process will tend to alter the incentives so that there will be many internal incentives generated to control costs. There are none now. I hope that answers your question.

Question: What are the provisions for coverage of psychiatric diseases under these proposed bills?

Caper: The Kennedy-Mills bill would provide the equivalent of half the cost of 30 visits to a private psychiatrist's office or the equivalent of the full cost of 30 such visits to an institutional provider, the cost of 30 full days of inpatient care, plus 60 partial days in a nonresidential psychiatric setting.

Mongan: May I expand on that? Basically, that type of psychiatric coverage is similar to the Administration's benefit package. The Long-Ribicoff bill takes Medicare's benefit package for Title I, the catastrophic portion. In the low-income group, they have a broader package that takes a little different approach; one would have unlimited benefits if it is in an organized mental-health setting. When care is delivered in an individual psychiatrist's office, coverage would allow up to five visits, with more visits after a formal review of the necessity of the plan of treatment. I think, again, as in the long-term-care area, this gets into another generic area. Long-term-care and psychiatric insurance benefits are areas that Congress has consistently limited, in contrast to other health-care coverage. This type of restriction provokes the psychiatric people and various groups representing psychiatrists to make the claim that there is discrimination against mental illness, which has some justification in fact. On the other hand, Congress is concerned about controlling the utilization of mental-health services. I don't think the debate has been settled yet. I think you're going to have broadened psychiatric benefits. Any one of the proposed bills will have broader benefits than under the current Medicare structure, but I don't expect open-ended psychiatric benefits at this point.

Frankly, I must say the available data are not as convincing as one would hope. The American Psychiatric Association did a large study on utilization of psychiatric services and, in general, the point they make is

that where private policies cover psychiatric services, the costs don't go through the roof and that, indeed, people do not indiscriminately enter into psychoanalysis. These points could be used as an argument for broader psychiatric coverage. On the other hand, there are arguments, not as well-documented, which say that psychiatric coverage reduces utilization of other health services. But this study showed that it is those who were referred to the psychiatrist but didn't go who accounted for the reduction in the utilization of medical services, and not those who took the psychiatric treatment. This is a very interesting point. Additionally, the study showed that upper-middle-class people in urban centers used the psychiatric benefit more often than other classes did, which raises some questions of tax equity: i.e., should everybody in the country be taxed for a benefit all won't use? I think the psychiatric benefits are going to be broader than existing Medicare benefits, but I don't think Congress will pass an unlimited benefit package in the psychiatric area.

Question: Are you saying that in the Kennedy-Mills bill there are more provisions for psychiatric care than we have now?

Caper: Psychiatric-care benefits vary tremendously, depending upon the type of policy you have. If you are talking about a universal program, essentially you are talking about the Kennedy-Mills plan, which does provide, on a general basis, much broader psychiatric coverage than is now available. Many people have no mental-health benefits. The Kennedy-Mills bill does not provide open-ended psychiatric benefits for the reasons that Dr. Mongan articulated a minute ago.

Question: What do you mean by "open-ended" care?

Caper: Unlimited benefits.

Question: I don't quite understand the Kennedy-Mills bill in this regard.

Caper: The Kennedy-Mills bill does provide limited psychiatric benefits, and the limits are as I described previously. The coverage is broad, but the American Psychiatric Association doesn't think they are broad enough; so it depends on to whom you are talking.

Question: In that the need for mental-health care is on the increase, why aren't mental-health benefits treated the same way all other benefits are?

Caper: I'm not necessarily defending any of the bills, but there are reasons why the limits on mental-health and psychiatric benefits have been singled out. It's important to understand why that's the case. There are people who do not want any mental-health benefits included in a plan.

Question: I would be interested in having each of the panelists express himself on the private health-insurance industry and its future role. Each of the proposed bills is different, and, of course, the original Kennedy-Griffiths bill was very different because, at least overtly, it would have eliminated in a very short period of time the private health-insurance companies. If one looks at some of the studies comparing their retention rates, it would appear that the costs are less for the private insurance companies than for either Social Security or Blue Cross/Blue Shield. If the Social Security agency were given the sole underwriting and carrier business, does the panel really have that much faith in the bureaucratic system? Is it wise to attempt to push for a plan that will disenfranchise the so-called "private sector" of insurance, rather than build a plan utilizing private insurance companies with the appropriate government regulations and accountability? Should we remove the private companies so rapidly while increasing the bureaucratic process so much at this time?

Mongan: I'll let Dr. Caper talk from the point of view of the Kennedy-Mills bill. Let me talk from the views of the Long-Ribicoff bill and the Administration's position because I think you do have three different approaches here. I think the Kennedy-Mills bill calls for a straight administrative role for the private health-insurance industry, but I'll let Dr. Caper discuss that in further detail. The Administration has essentially made the judgment under its bill that private health-insurance companies should carry the burden of the job, and it is essentially turning over this national health-insurance issue to private health insurers regulated by the states. Frankly, and I'm speaking editorially, which is not the committee view, I doubt that the Administration is going to succeed with that view in Congress at this point; there are a lot of congressmen who don't agree. A mandated premium is, after all, very close to a tax; if you're telling an employer that he has to purchase private health insurance, that is not much different from taxing him. I don't think Congress is going to exercise that kind of taxing authority without putting more stringent control over the health-insurance industry than is written into the Administration bill. As the bill is structured currently, I don't think it will pass; that's my own view.

Senators Long and Ribicoff are attempting to say, I think, that their minds are open at the moment. They made a great point of this when they testified before the Senate Ways and Means Committee. The Administration has seemed to have made a decision that it thinks private insurers can do a better job than Social Security, and the Administration wants to turn the management over to private insurance companies. Senators Long and Ribicoff are saying, "Frankly, we don't think we know at this point." They do think they know that private health-insurance companies have not been able to provide adequate coverage for the low-income area, not necessarily through any fault of their own; people currently don't have the money to buy the policy. Both senators also think that insurance coverage has not been adequate for catastrophic illnesses and that is an overriding reason for having a federal role there. With respect to basic coverage for the average working person, the senators think the case has not yet been proven one way or the other, which is the derivation of the Title III portion of their bill. What they want to do over a three-year period after the passage of the bill is to attempt to upgrade and stimulate broader availability of private health insurance. The HEW Secretary is going to have to report on how broadly available and how adequate that insurance is in three years, and if the private insurers have done the job, the federal government need go no further. If they haven't done the job, then clearly I think you will have a move for further expansion at that point.

What do some of the statistics show, and why are Senators Long and Ribicoff open-minded about this sort of thing? They quoted the Ways and Means statement that said four out of five of those above and below the income levels currently have private health insurance. One can interpret that either way — as a record of success or a record of failure. The senators don't read it as a record of failure, but as a job reasonably well done but that has to be better. They recognize that that insurance isn't perfect. I attended a meeting in Atlanta at which it was said, "That's terribly misleading. Private insurers cover only 26 per cent of the cost of health services: They're not doing very well." That statement in turn was terribly misleading because that figure concerns the total health bill; the government picks up 35 per cent of the total cost, and private insurance is really more in the range of 55 per cent of the cost. One doesn't want it to get up to 100 per cent because there are health items such as over-the-counter drugs, visual aids, and other elements which are very difficult to insure. I think Senators Long and Ribicoff are saying that basically they think the issue of private versus public insurance is an open question. I think that

the data are not very good concerning the issue of whether Aetna or Blue Cross or Social Security has the lowest overhead or retention rate. As any of you who are concerned with health insurance know, it is very difficult to compare retention rates because, in many cases, the companies who are doing the best job have the highest administrative costs in that they are working for utilization control, admission certification, and so on. The studies are hardly perfect, and I don't think that all of the evidence is in. I do think that there are some private insurers who are not doing an adequate job, and *that* consideration should be addressed. Senators Long and Ribicoff are planning to speak on that issue. Whether the better private insurers have failed or not is an open question at this point in time. The Administration thinks the issue is a closed question and that Congressional health legislation should utilize the private insurers almost exclusively.

Caper: I would like to discuss, for the most part, the Kennedy-Griffiths bill, because I think it is easier to understand the reason for the elimination of the role of the private insurance industry in the details of that bill. The Kennedy-Griffiths bill is only in the very broadest sense a health-insurance bill; it is a bill that addresses many of the problems in the health-care system. The basic assumption underlying Kennedy-Griffiths is that payment for health-care services should be a legal entitlement; the only qualification for eligibility should be residence in the United States. It would cover everyone in the U.S. and would provide a standard set of benefits. When you have done that, you have divorced the issue of payment for benefits from eligibility for them. That is, you haven't made payment a condition for participation in the program from the standpoint of the consumer of health services. At that point, it is no longer an insurance-type program. Contributions to the fund would be determined on a basis other than the need for services; in the Kennedy-Griffiths bill it would be determined by employment and the income-tax system. In that situation, eligibility for services is completely disassociated from whether or not you have contributed to the fund. Once that has been accomplished, it becomes very difficult to justify a continued role for the private-insurance industry. The control, of course, is a different issue, but eligibility for services would not be dependent upon contributions to the fund; it would be independent of economic status.

Question: In the instance of an enacted Kennedy-Griffiths bill, would there then be a need for an actuary service?

Caper: Yes and no. You end up needing one because there will be questions concerning the cost of certain health services. You would need it in terms of determining appropriate cost, but you wouldn't need an actuary in terms of determining what a person ought to contribute to the system to receive these services, because his contribution is independent of whether or not he receives services. So, it's quite a different concept from the Administration proposal, for example, which is basically still a health-insurance proposal where the cost of policies could vary. Experience rating would still be allowed in the Administration proposal, and that is one of Senator Kennedy's major objections to it. Some employers would have to pay more than others if their employees happen to have a higher rate of utilization of health services. It would lead, inevitably, to pressures on employers to try to hire people who are not likely to have characteristics that would raise the company's share of insurance premiums. Also, the Administration bill is not compulsory, which means that the employer would be free to say to potential employees, "You can have the job, but turn down the health-insurance benefits!" In this instance, obviously, the employer would not have to contribute to health-care premiums. Once one accepts the basic assumptions underlying the Kennedy-Griffiths proposal, it becomes difficult to justify the continued existence of the private insurance companies other than in a purely administrative role; they would act as claims payers, and that's all. The private insurers would be reimbursed from a federal trust fund.

Question: Do you think a much larger Social Security agency would be better check-writers and managers of the administrative machinery than the better private insurance companies?

Caper: In the Kennedy-Mills bill, it is proposed to retain the private insurance companies as intermediaries, but that is the only role that they would fulfill once you have made the basic assumption that you are going to divorce the means of generating the trust fund — or the "pot" of money — to pay for services, from the actual requirement for services. Once that assumption is made, it becomes very hard to understand why you would need the private insurance companies at all. There are very powerful political reasons for retaining them, because, obviously, to do away with an industry that size is difficult.

Question: Have there been any studies of the relative efficiency of having Social Security or the private insurers pay?

O'Donoghue: There haven't been many studies. There is one study from the Social Security Administration, however, which essentially found that there was not much difference who paid. There are several considerations for which one has to account when looking at administrative costs. One is the average size of the pay-out. If one is considering administrative costs over the total cost of the pay-out, the size of the individual pay-out makes a great deal of difference. Of course, the size of the insured group makes a lot of difference, too. If there are many little groups, the administrative costs will tend to be higher.

Question: How will inflation affect health insurance and how will the government handle the excessive costs of the service industry? Be they government, medicine, law or whatever agency, the bigger they become, the more uneconomic they are.

O'Donoghue: In the health-care area, I'm not sure we have good evidence as to what is optimal size or scale; this is particularly true of physician groups. I don't think we can say that small units are necessarily more efficient than large ones in the health-care area, and we don't have much evidence that the obverse is true, either.

Are there reasons to suspect that health care will or won't participate in the general inflation? If health-care costs go up at about the same rate that general costs do, not much will happen. In the past, health-care costs have risen at a rate considerably higher than the general rate, and I think most of us suspect that there are reasons for that occurrence that are independent of the causes of the general inflation. Because of these special reasons, current regulatory and financing actions have been directed toward the cost of health-care problems. I think there is no question that further expansion of insurance coverage will be accompanied by increasing regulation of the cost factors. Before Medicare/Medicaid legislation, health care was purchased privately, with coverage limited to what an individual could afford to purchase. The elderly were particularly affected unfavorably and, initially, health-insurance legislation was directed at this group; as a result, this group will be generally unaffected by inflation in health costs.

Caper: I touched on inflation earlier in my talk. I think that the rate of increase in health-care costs during the last eight or nine years is much higher than previously; the costs have been rising at a rate much more rapid than that of the economy as a whole. I don't know what the impact

of general inflation is going to be on health care, but I do feel very strongly that, at some point, there is going to be a limit imposed on increasing expenditures for health care. When health-care expenditures approach nine or 10 per cent of the Gross National Product, the government will begin to allocate resources and level off further expenditures for health care. The issue is a major one with respect to the role of private-versus-public sectors in the financing of health-care services. A very important question will be, "To what extent can public policy, once formulated, be implemented through the financing mechanism?" I think the payment mechanism is the most potent and influential lever available by which Congress can affect public policy. I'm convinced there is nothing that will work as effectively as that. If the Administration bill, which would retain and certainly increase the importance of the private sector in insuring health services, is implemented, and if, for example, there are essentially 100 major insurance companies in the country that are writing the health-insurance policies, how can that lid be put on? There will have to be at least some regulation of premiums, and, more likely, there will be very strict regulation of premiums. The question then arises, "Aren't you better off just doing it in the public sector in the first place and essentially turning health insurance into a regulated public industry?"

This question is tied in with the issue of standards in the health-care field. Who determines when sufficient health-care services have been delivered? How do you determine the ceiling for the number of health-care services offered? How much more money are we as a country willing to put into health-care services? What proof are we going to demand that increasing our expenditures is having the desired effect — that is, to improve health? When are these questions going to be asked? As the percentage of our total Gross National Product for health-care services rises, when are we going to reach the point where we simply say, "That's all." When that happens, how are future allocations going to be determined? On what basis will those decisions be made? Who is going to decide these issues?

Question: Do you think that we ought to eliminate the private sector of health insurance and have a good public sector? Some people fear that, because it may be socialism, but others say, "What is wrong with that if it is good for the country?"

Caper: I think there is something qualitatively different about health care, which is that the marketplace has never worked and, I think, never can work very well in the health-care field, because those who pay for the services are not really making the purchasing decisions. The person who is

providing the services is making the decisions, and the growth of health insurance, both public and private, has, I think, greatly attenuated the impact of cost at the time the service is delivered on the "purchasing" decision of the patient. If a physician feels that the patient needs an operation and is to go into the hospital, you won't find much argument.

Question: If what you say is true, how do you get builders to build low-cost housing?

Caper: In that instance, the buyer can say, "I can't afford a $40,000 home; I want a $20,000 home." If the doctor tells you that you need hemodialysis and it is going to cost you $20,000 a year, then you, as a patient, have no alternative but to say, "All right. I have to have it." I think there is a qualitative difference. In the area of food, obviously people can decide whether they are going to buy steak, soy beans or fish protein — as they wish and as they can afford. A case can be made that all three proteins are adequate, while one is a luxury and two aren't. In health care, the people are not faced with that decision, because the purchaser of health care has very little to say about the quality or quantity of services received. The consumer of health care is heavily dependent upon the provider, who doesn't have a direct financial stake in determining the services, particularly with respect to insurance or third-party payers.

Bernstein: Would you like to comment on this point, Dr. Mongan?

Mongan: I'm not very good with the broad philosophical questions. I don't know anything about the area of housing or the food industry. I know a little about the health-care industry. But I dislike getting into these issues of whether it should be all publicly or all privately organized, because politically it just doesn't work that way; it is not worth my spending much time on it. Realistically, the data do not seem to show that great a difference, so I would have to beg the question.

Bernstein: Dr. O'Donoghue, would you like to comment on the question of the difference between the health-care industry and other service industries, such as food and housing?

O'Donoghue: I think the health-care industry is quite different from the food industry. Housing, I think, is somewhat different as well. I think the consumer is probably less knowledgeable about health care than either of

those two, which does affect one's view of the health industry. On the other hand, there are certainly other types of industries that are not that different from health — education, for example. I think the student does have greater knowledge of the educational system than does the health-care consumer of the health system, but certainly you have the situation in education where the primary decider in education tends to be the provider, again. Those two may be somewhat similar.

Question: Let's take the situation where the patient comes to you and says, "My friends and I were reading this article that came out about national health-insurance programs. Tell me basically what the differences are in cost to me, and what do you see as the best choice for routine care. I see you 10 to 15 times a year for my kids. My newborn care wasn't covered under Blue Cross/Blue Shield or Major Medical insurance; my routine physicals weren't covered under Major Medical; my medications weren't covered under Major Medical; and shots for my kids weren't covered. What program is the best? What is it going to cost me, and what am I going to get for it in terms of taxes and premiums, etc.?"

Caper: I think the differences between the various proposals in question should be viewed broadly: Which one provides the most equitable system of paying for health-care costs? I suppose that even there, equity depends on where you are. The person who makes $40,000 a year will be paying more for health insurance under the Kennedy-Griffiths bill because, even then, he is picking up the costs in his property tax for providing care at a municipal hospital.

Question: I want to know the difference between the three bills in dollars, and what I am going to get for each. Here I am, making $10,000, and my family hasn't spent anything near $1,600 for medical bills this past year. We have spent several hundred dollars for dental bills, medicine, eyeglasses, etc. Now, let's get back to the nitty gritty.

Caper: Isn't your question really, "What is going to be the distribution of health-care costs?"

Bernstein: Perhaps he wants to know what his Social Security tax rise is going to be with the institution of any one of these three bills. Is one more than the other?

Question: Take one of the bills, address it, and discuss whether we are paying for things that are not covered now under Blue Cross/Blue Shield, such as the costs of drugs, shots, physical examinations, asthma attacks and getting glasses. That's one group of problems. Another group is catastrophic insurance. What is it going to cost the average man who pays for one of these bills and who has a family of four? That shouldn't be too hard to answer!

Mongan: I'm awfully sorry you feel that your question isn't hard to answer, because it really is hard! I'll go over the reasons for the difficulties and then I'll try honestly to answer it in terms of the three bills discussed. It is hard to answer because it depends, first of all, on whether you are sick during a given year, and I can't predict that. It is hard to answer because it depends on what decisions under many of the bills you make with respect to what cost you want to insure yourself against privately. It's hard to answer because it depends on your income. The fourth thing that makes it hard to answer is that there are expenses that are not covered under any of these bills and I'll try to give you an idea by going through the three of them.

Under the Long-Ribicoff bill, for example, at a $10,000 income level an individual would be above the low-income level program. What that person's going to get from the federal government is catastrophic protection that will be initiated after $2,000 of costs or 60 days of hospitalization. We are going to pay for that catastrophic provision by a payroll tax of 0.3 per cent on the employer and the employee. Whether you want to count both the employer and employee contribution as a payment is something economists debate. Under the theory of the Long-Ribicoff bill, one would purchase private health insurance against the first $2,000 and the first 60 days — and the cost of that is going to vary somewhat. The average package for an average family is about $500 a year now. The package one would purchase may (the bill would set standards for that package) have to cover the 60 days and that $2,000, but it can have deductibles up to 10 per cent of that amount. Therefore, depending upon the package one purchases, one could be out-of-pocket for those basic expenses, which includes the $500 premium. There is some co-insurance after the deductible ceiling is met and one could insure against that. One variable under the Long-Ribicoff bill is that it doesn't mandate what the employer or employee pays; therefore one may be out all of that premium alone, or in most cases in this country through various union bargaining arrangements, the employer will pick up a substantial portion of the cost.

Under the Administration bill, one would have private health-insurance premiums. The employer would pick up 75 per cent of the premium after a few years, and the individual would pick up 25 per cent. If ill, one would also pay deductibles and co-insurance up to $1,500 a year. Assume that the premium is, perhaps, $125. Start with that payment and one could go on up to $1,625, depending on how much sickness occurred. Conceivably one would pay more if long-term-care were needed. Thus, all I can give you for a range of the cost for the Administration bill is $125 to $1,625 — or higher.

Under the Kennedy-Mills bill, it will depend somewhat on the personal income of the individual, because the bill will be financed by a payroll tax — three per cent on the employer and one per cent on the employee. Whether, again, one would consider that as a four per cent tax or a one per cent tax on the individual; whether the employer would give that to the employee in lieu of wages or would give the employee a wage increase also, I can't answer. I can't speak for every employer. But the bill will be financed by that three per cent on the employer and one per cent on the employee up to a $20,000 wage base, so that would mean $200 from the employee, with another $600 from the employer. There would be no private health-insurance premium. Individual co-insurance liability would rise up to $1,000; therefore, the range would be $200 up to $1,200. Again, there might be additional expenses for long-term care that are not covered in this bill.

I'm saying that all of these bills seem to range (and some of them mandate it and some of them don't) from $200 up to the $1,200 to $1,500 range, with the individual making a number of the decisions as to how much of those costs one would want to insure against.

Question: What is the future of federal capitation to medical and nursing schools? How can most of these schools survive when they have overextended themselves in training professionals at a time when federal funds are being reduced? Should medical schools really be active in the public-policy area?

Caper: That is very much an open question. As we all are aware, the present Administration would like to cut back on capitation support, cut back on scholarship support, and so on. Senator Kennedy doesn't agree with the Administration. I can talk about what Senator Kennedy's committee has done historically. The Institute of Medicine recently completed a study on the cost of education in the health professions. Obviously, the

basic reason for performing the study was the policy position adopted by the Kennedy committee in 1971 that the federal government should shoulder a substantial proportion (it was about one-third at that time) of the cost of educating students in the health professions. The problem, in 1971, was that no one knew what medical education cost, and the committee didn't know how much money to allocate. That was the genesis of the study. I think what you're seeing now is the result of a much larger conflict that is going on: a real clash in philosophy between the Administration and Congress. Congress is dominated by Democrats and will continue to be so even more next year. The Administration, to sum up its domestic policy, espouses less federal-government involvement with respect to almost everything, especially in relation to educating doctors. Some of the aberrant behavior that one visualizes in Washington, I think, is the result of savage political infighting between these two camps. The Administration does everything it can to frustrate the intent of Congress when it is in disagreement. And this Administration has gone far beyond any previous Administration in doing that. It will hold up funds until the very last minute and then shovel them all out; and they say, "Look, we've spent $60 million on this program and we didn't get anything for it. That proves our point." One could say the reason for the failure of many programs was because of administration from Washington in such a way that it was impossible for people to respond to it. I can't predict what's going to happen, and I certainly can't defend the behavior of the government; I think it has been abysmal, especially in terms of those who are the recipients of poorly administered programs. These individuals are bewildered, and justifiably question the stability of government programs. I think there is little that we can rely on from the present Administration. Until some of these basic policy issues are resolved with respect to the appropriate role of the federal government in medicine, in educating doctors, and in financing services, I think we will continue to have schizophrenic behavior on the part of government. I wish it were otherwise and I wish I could say something that would be more comforting than that, but I cannot.

Bernstein: While I hesitate to end the conference on this pessimistic note, I think we must. I want to thank the participants and the audience for a provocative and thoughtful discussion on some of the health issues confronting the nation today.

UNIVERSITY HOSPITAL
18 55
EDUCATION · HEALTH · RESEARCH