Consumer Choice Health Plan: The Debate about the Tax Exemption of Nonprofit Hospitals

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The 1978
Michael M. Davis Lecture

CENTER FOR HEALTH
AMINISTRATION STUDIES
GRADUATE SCHOOL OF BUSINESS
UNIVERSITY OF CHICAGO

THE SPEAKER

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THE OCCASION

Dr. Enthoven delivered this lecture at the University of Chicago on June 1, 1978

Consumer-Choice Health Plan:

A Rational Economic Design for National Health Insurance

The phrase "national health insurance" does not have a precise agreed upon meaning. To some, it means a government monopoly on health insurance, as in Canada. To others it has a broader meaning: a national system of health care financing that assures, one way or another, that everybody is protected at least from large medical bills. In a sense, we already have a national health insurance system, with separate programs for the aged, the poor, the employed middle class, veterans, military dependents, and other groups. And few will publicly defend the gaps in coverage that leave the working poor, the unemployed, and a few others unprotected. The rhetoric about universal, mandatory, comprehensive national health insurance speaks to an issue that has already been settled in our society, at least in principle. The important issue in health care financing policy today is not *whether* we should have national health insurance. The important issues are in the details of its design, especially how the design will affect the quality, accessibility, distribution, and cost of health care services. Achievement of the broad social purposes of national health insurance does not necessarily require a government monopoly of health care financing or what Charles Schultze calls "the command and control techniques of government bureaucracy." They might be served equally well or better through competition in the private (and local public) sector.

The overriding problem in our health care economy today is cost. National spending on health care increased from about $39 billion in 1965, or about $200 per capita, to more than $160 billion in 1977, or about $740 per capita. Net of general inflation, per capita spending on

health care nearly doubled in 12 years. Government's share of this increased from 25 per cent in 1965 to 42 per cent in 1976. Medicare outlays alone are projected to double in four years, from about $17.8 billion in 1976 to $34.9 billion in 1980. These costs are becoming a serious burden on the public and private sectors.

There are good reasons for much of the increase in spending. The growth in public and private insurance coverage brought access to many who previously did not have it, especially the aged and the poor. Advances in technology increased the power of medicine to prolong life and enhance its quality. The population aged. The health care system took on new assignments. The pay of health care workers was brought up to the level of other industries. Rising incomes and expectations increased consumer demand for health care services. Our present concern with the growth in spending should not mislead us into thinking it is all bad.

But, especially in recent years, the increase has far exceeded what could be justified on these grounds. Hospital charges and physician fees rose faster than the Consumer Price Index. Health workers' pay overshot equality with other industries. There is great inefficiency, such as duplication of costly underused facilities. Wide variations in the per capita consumption of various costly health services among similar populations, without any apparent difference in medical need or health outcome, suggest that there is much spending that yields no significant benefit in terms of health. People might be just as healthy with half as much hospitalization.

While the nation is spending more, some people are enjoying the benefits less. Gaps in coverage leave some unprotected from heavy financial burdens, others protected only after medical costs have made them poor. Public funds (including tax subsidies) do more for the well-protected well-to-do than for the working poor who need help more. Also there is uneven geographic distribution, leaving many rural

and inner-city residents poorly served while there are too many doctors in some well-to-do areas.

The main cause of the unjustified and unnecessary increase in costs is the complex of perverse incentives inherent in the system of fee-for-service for doctors, cost-reimbursement for hospitals, and third-party intermediaries to protect consumers that dominates our health care financing today. Fee-for-service rewards the doctor for providing more and more costly services whether or not more is necessary or beneficial to the patient. Cost-reimbursement rewards the hospital with more revenue for generating more costs. Indeed, a hospital administrator who seriously pursued cost cutting, e.g. by instituting tighter controls on surgery and laboratory use and avoiding buying costly diagnostic equipment by referring patients to other hospitals, would be punished by a loss in revenue (Medicare and Medicaid would cut him dollar for dollar), and a loss in physician staff and, therefore, patients. Third-party reimbursement leaves the consumer with, at most, a weak financial incentive to question the need for or value of services or to seek out a less costly provider or style of care.

These incentives are reinforced by the demands and expectations of anxious patients, the prestige associated with costly technological care, the malpractice-induced need for "defensive medicine," and the government-inspired proliferation of health manpower—especially physicians. In 1973, we had about 1.73 doctors per 1000 population; by 1990, we will have 2.4. And more doctors mean more doctoring, higher fees and more cost.

Thus, the present financing system rewards cost-increasing behavior and provides no incentive for economy. At the same time, it is inequitable. Medicare and Medicaid are among the worst offenders.

Medicare pays more on behalf of people who choose more costly systems of care. For example, in 1970, Medicare paid $202 per capita on

behalf of beneficiaries cared for by cost-effective Group Health Cooperative of Puget Sound, but paid $356, or 76 per cent more, on behalf of similar beneficiaries in the same area who chose to get their care from the fee-for-service sector. Medicare pays more to doctors who charge more and more to hospitals that cost more. At the same time, Medicare pays more on behalf of the well-off than the worse off, white than black, well-served than underserved.

Medicaid, which also relies almost entirely on third-party, fee-for-service and cost-reimbursement, is particularly vulnerable to fraud and abuse. Its beneficiaries are particularly unlikely to be able to judge the need for or value of services provided to them, and are not motivated to weigh the value against the cost because they are not spending their own money.

Tax-subsidized private insurance, with no limit on tax-free employer contributions, subsidizes employee decisions to select more costly health care systems, and encourages employee pressure for generous employer-paid benefits. This tax system also provides more subsidy for better paid and covered than for poorly paid and covered people.

These incentives also help to defeat regulation and local efforts at cost containment. Why should a health systems agency or a board of county supervisors defy local pressures and force the closing of an unneeded hospital, with loss of jobs, when most of the extra costs of keeping it open are paid from outside their area?

Physicians receive only about 20 per cent of total national health care spending, but they control or influence a great deal more. They are the primary decision-makers in our health care system. But the uncontrolled fee-for-service third-party intermediary system imposes on them very little responsibility for the economic consequences of their health care decisions. They can hospitalize, order tests, demand the

purchase of costly equipment with absolutely no penalty for being wasteful. Their education and professional attitudes combine with the financial incentives and other factors, to minimize concern over cost and to foster cost-increasing behavior. If the decision-makers are not concerned with cost-effectiveness, the system will not be cost-effective.

By contrast, an economically rational system of health care financing would have built-in incentives for cost-effectiveness. It would reward physicians (and others) for finding ways to deliver better care at less cost. In such a system, physicians would accept responsibility for providing health care services to defined populations, largely for a prospective per capita payment, or some other form of payment that rewards economy in the use of resources.

The system of fee-for-service, cost-reimbursement, and third-party intermediaries is protected from fair competition from other systems of health care organization and financing by a complex of laws and restrictive practices. As a result, in most places, there is little or no competition among providers of care to produce services more efficiently or to offer a less costly style of care.

Most employed people get their health insurance through their employer or labor-management health and welfare fund. Employer contributions to health insurance are tax-free compensation. Moreover, the employee group is usually used as a base for spreading risk and administrative costs. Most employees are offered a single third-party reimbursement plan, or, in some cases, a very limited choice. Employers have seen health benefits as a way of attracting qualified employees to their company, or as a way of discouraging unionization. Union leaders have seen health benefits as a prize to be won at the bargaining table. Both emphasize benefits specific to the employer or union, and not the use of this medical purchasing power to create a market of competing provider groups in the community. And the tax

subsidy implicit in the exclusion of employer contributions from taxable income is, of course, greater for people with higher premiums. Thus, the tax laws subsidize more costly systems of care.

Medicare beneficiaries are also stuck with the fee-for-service cost-reimbursement third-party intermediary system. They can get their care, for example, from prepaid group practice health maintenance organizations that provide care at a substantially lower cost. And some of them do. But they do not get to realize the savings for themselves in the form of reduced premiums or co-payments or improved benefits. The Medicare law has a provision for buying services from health maintenance organizations on other than a fee-for-service cost-reimbursement basis, but it has not been put into practice to any appreciable extent.

There are alternatives to the fee-for-service third-party intermediary system. The most important one in operation in our country is the health maintenance organization (HMO). An HMO agrees to provide its enrollees with comprehensive health care services for a fixed prospective per capita payment. This means that its physicians and managers do not automatically get more money for doing more services, whether or not they are necessary or beneficial to the patient. Rather they must seek to provide the most effective medical care they can out of limited resources. Competition puts pressure on them to keep the costs down and the quality of service up.

The HMO is not merely a device for financing the same bundle of services offered by fee-for-service medicine; and it is not merely an incentive scheme for lowering cost. Medical care is not a standard product. It has many dimensions including perceived quality, technological versus personal style of care, accessibility and convenience, use of various types of services, etc. Different physicians and consumers see more or less value in various forms of preventive care and in high technology. An HMO can exert

substantial influence over these variables, and, within the limits set by competition, medical standards, etc., can design its program to appeal to one or another segment of the market.

In 1973, Congress passed .he Health Maintenance Organization Act, one of whose provisions requires every employer to offer employees the opportunity to enroll in a group practice and an individual practice HMO, if available. This was an important step in the direction of creating competition among provider groups. That such a law was necessary is evidence that the private market as previously constituted was not effective in creating such competition. But the HMO Act falls far short of creating the kind of competition that exists in the markets for most goods and services. For one thing, the law's definition of an HMO is far too restrictive. It leaves out other approaches to creating organized systems with built-in incentives for economy. And "mandatory dual choice" leaves the market segmented. Some employers can sign up with one HMO, others sign up with another, so each HMO competes with a fee-for-service third-party plan, but they do not compete with each other. If we want competition to have a significant impact on the cost of the nation's health services, then I believe we need to create a system of fair market competition among all alternative health plans.

In recent years, the main line of government policy has been to attack the problems created by inappropriate incentives with various forms of regulation, e.g. planning controls on hospital capacity, controls on hospital prices and spending, controls on hospital utilization, and controls on physician fees. The weight of evidence, based on experience in other industries, as well as in health care, supports the view that *such regulation is likely to raise costs and retard beneficial innovation.*

A great deal of regulation of health services is inevitable. And in some fields, regulation is used to maintain competition, e.g. the Securities and Exchange Commission and the Federal

Trade Commission. The issue, then, is not regulation in general; it is the specific types of regulation and their likely consequences. The point is that direct controls on prices, in opposition to the basic financial incentives, are not likely to make things better.

In the long run, price regulation amounts to cost-reimbursement and gives the same incentives. Regulation tends to protect regulated firms whenever competition or technological change threatens established positions within the industry. The main reason some hospitals favor state rate regulation is that it functions as a cartel to protect them from buyers who want to cut costs; they know that the approved rates are based on their costs.

Medical care has many characteristics that make it particularly unsuitable for successful economic regulation. Basic to the problem is the subtle, elusive, and indeed almost indefinable nature of the product. In the health care sector to date, the only economic regulation that has been thoroughly tested is regulation of hospital capacity. And it is clear that certificate-of-need regulation has not helped control the problem of overbedding.

Physician fee controls have been advocated, and were tried in the Nixon Administration. In judging their likely value as a cost control device, one should be aware that the "doctor visit" is highly compressible. And the need for doctor visits is impossible to test objectively, except in extreme cases. So a doctor whose income is threatened by price controls can "make it up on volume." He can suggest that the worried patient come back and see him next week instead of next month. And he can add to the content and cost of each visit.

Overall controls on hospital spending face similar prospects: circumvention, "unbundling," and exceptions. In 1977, the Carter Administration proposed the Hospital Cost Containment Act, an annual percentage limit on the increase in hospital revenues. The bill was emasculated by a "wage pass-through" even before it was proposed, despite the fact that

hospital workers now earn more than their counterparts doing similar jobs in other sectors. But even if such controls were ultimately successful at controlling total hospital spending at the stated growth rate, there would be no force in the system to motivate efficiency or equity in the production or allocation of services. At best, the controls would freeze the hospital industry in its present wasteful pattern. Worse yet, such across-the-board limits reward the fat and punish the lean. With such perverse incentives built in, these controls are more likely to raise than lower costs.

The performance of the private sector in health services is shaped by numerous regulations and public programs and by the tax laws. Some people use the poor performance of the private sector to argue for more government controls or even for a complete government takeover. I believe it would make more sense to go back and correct the laws and programs that are causing the problems in the first place. If government cannot accomplish that, it is hard to see why we should expect more regulation to make things better.

If regulation of prices and capacity won't reduce costs and improve the efficiency of resource allocation, what will? Rational economic incentives and fair market competition are the answer. We know that appropriate incentives can do a lot to help control costs. Health maintenance organizations and other similar organized health care systems with built-in incentives to use resources wisely are delivering good quality comprehensive care for a cost considerably below that offered in the fee-for-service sector. A recent review of the many comparison studies over the past 25 years concluded, "The evidence indicates that the total costs (premium and out-of-pocket) for HMO enrollees are 10-40 per cent lower than for comparable people with health insurance." The point is not that *all* HMOs cost a lot less; in any industry there will be more and less efficient producers. The point is that a substantial number of HMOs have shown that the savings

can be large. Moreover, HMOs have achieved large savings even in the absence of real competition from similar organizations.

Some may then ask, "If HMOs are superior, why haven't they grown faster?" The main answer is the strong and pervasive anti-HMO bias in the policies of the Federal government and the consequent lack of incentives for consumers and providers to join HMOs under existing financial arrangements. The tax laws, the Medicare law, the planning laws, and the HMO Act all have important anti-HMO biases. Most people do not have a choice between an HMO and a third-party, fee-for-service health plan, or if they do, the tax laws, Medicare, and employer financing arrangments do not let them keep the savings. HMOs have done very well in competitive multiple-choice situations.

To achieve good quality comprehensive care for all, at a cost we can afford, we must change the fundamental structure of the health care financing and delivery systems. Instead of today's fragmented system dominated by cost-increasing incentives, we need a health care economy made up predominantly, though not exclusively, of competing organized systems in which groups of physicians would accept responsibility for the cost of providing comprehensive health care services to defined populations.

Today we cannot see very clearly what such an economy would look like. We should seek to find our way there by a *fair market test* among competing alternatives in which systems that do a better job for a lower cost survive and grow. Many types of systems might succeed in such a competition, including not only prepaid group practices (PGP) and individual practice associations (IPA), the two "official" types of HMO, but also health maintenance plans, health care alliances as proposed by Ellwood and McClure, and variable cost insurance as proposed by Newhouse and Taylor.[1] The essential ideas are (1) that beneficiaries have a choice from among competing systems, and they can agree to get their care from a limited set of providers (or on referral under their control); (2) the premium for their health insurance reflects the cost-generating behavior of these providers; and (3) consumers who choose more cost-effective health plans get to keep the savings generated by that choice (in the form of lower premiums or better benefits). In a competitive situation, the providers will be under pressure to control costs; those who don't will lose patients. Thus, the delivery system would be transformed voluntarily in response to consumers who are seeking out and choosing what is in their own best interest.

[1]These systems are discussed in greater detail in my Shattuck Lecture "Cutting Cost Without Cutting the Quality of Care," *The New England Journal of Medicine*, 298:1229–1238, 1978.

To bring such a competitive market into existence, and to make it work effectively to achieve efficiency and equity in health resource allocation, we need positive action by government. Such action is needed to assure that all people have a choice among competing alternatives and that they have good information on which to base their choices. Action is also needed to assure that most providers are subject to competition. Furthermore, we must correct the inequities and cost-increasing incentives in the tax laws and Medicare. We should take money now used to subsidize people's choice of more costly systems of care, and use it to raise the floor under the least well covered. We should give people an incentive to seek out systems that provide care economically by letting them keep the savings. While Government should assure that people have enough money to join a good plan, people at the margin should have to use their own (net after-tax) money to pay the difference between the government's subsidy and their health plan premium, in order to motivate them to seek value for it.

The critical issues in the design of national health insurance are in the incentives it provides, and consequently, its impact on the structure of the delivery system. In examining a national health insurance proposal, we should ask whether it gives providers and consumers

incentives to seek out and join systems that use health care resources wisely. The traditional purpose of national health insurance, to assure universal coverage, can be accomplished in a variety of ways. No one NHI scheme can claim to be the only way to do that.

What are the national health insurance alternatives? While each comes in many variations, four basic concepts are getting serious consideration in Washington today. The approach that relies most on direct control by the Federal Government is the *Health Security Act*, introduced by Senator Kennedy and Congressman Corman. Health Security is designed to get away from third-party reimbursement and to shift health care financing to a per capita and prospective budgeting basis within a publicly determined total. It would assign the entire financing and management of NHI to the Federal Government. There would be a firm lid on total health care spending based on the earmarked tax revenues. The budget would be alocated to each HEW region on a per capita basis. Within these totals, the Health Security Board would then contract for covered services with participating providers. In brief, Health Security would create a system that is centrally and politically controlled, in which every participating provider gets all his money from the Federal Government. Spending for personal health care services would be set in the political process on the basis of national priorities rather than in the marketplace based on individual priorities.

Health Security seeks to reorganize health services into HMOs. And it seeks to equalize per capita spending among regions and between HMOs and the fee-for-service sector.

Many of Health Security's weaknesses are the weaknesses of any government monopoly. Experience in government and study of its actual performance have led me to these conclusions about its behavior:

1. Government responds to well-focused producer interests; competitive markets respond to broad consumer interests. People specialize in production, diversify in consumption. They are therefore much more likely to pressure their representatives in government on their producer interests than on consumer interests.

2. As Charles Schultze recently put it, "The rule of 'do no direct harm' is a powerful force in shaping the nature of social intervention. We put few obstacles in the way of a market-generated shift of industry to the South. . . , but we find it extraordinarily difficult to close a military base or a post office." Moreover, the political system is extremely risk averse. These factors make it very difficult to innovate in a government-regulated environment.

3. When every dollar in the system is a Federal dollar, what every dollar is spent on becomes a Federal case. Last year's Congressional deadlock on Medicaid funding for abortion illustrates the point.

4. Equality of treatment by government tends to mean uniformity. The uniform product is often a bargained compromise that pleases no one.

5. The Government generally does a poor job providing services to individuals. The bumper sticker that says "If you like the Post Office, you'll love National Health Insurance" strikes a responsive chord.

6. Government performs poorly as a cost-effective purchaser, whether it's the Rayburn Building, the C-5A, or Medicaid. Government buyers are surrounded by complex procedural rules; they don't have the authority and responsibility to use their own best judgment that is normal for their private sector counterparts. The government seems addicted to cost-reimbursement despite its notorious record for generating cost overruns. Cost-reimbursement protects providers.

Applying these insights to health care has led me to the conclusion that Health Security cannot achieve its goals. The government cannot restructure the system by direct controls. People would resist such changes involuntarily imposed. Experience with other regulated in-

dustries, and with NHI in other countries, suggests government would freeze the system in its existing patterns. The "do no direct harm" rule has prevented the government for years from closing unneeded Public Health Service hospitals and military bases. Government attempts to close hospitals in obviously overbedded areas drown in a deluge of lawsuits and pressure from employee groups. The Health Security Act seems almost designed to freeze existing allocations and to protect existing jobs.

The government does not have the management capability to run a program like Health Security, and it is difficult to see how it could acquire it. Health Security would add well over $100 billion to Federal outlays in FY 1978 costs—which effectively rules it out from a fiscal point of view.

In recent months, variations on the Health Security theme have been under discussion.

One variation on the theme would be to create a "quasi-public corporation," something like Amtrack or the Post Office, to perform the functions of the Health Security Board. Apparently, the idea is to escape the widespread disillusionment with the performance of government agencies by creating one that is only quasi-governmental.

Another variation on the theme involves "off-budget financing," a notion that is attracting a great deal of interest in Washington these days. If increases in the Federal budget are unpopular, and tax increases are unacceptable, then why not pass a law that employers must make "premium contributions." The idea is reminiscent of the Society Security retirement contributions that are now generally known as payroll taxes. This might at first appear to have great political potential: we could follow mandated health security premium contributions with national security premium contributions and reduce Federal spending and taxes a great deal. My own inclination would be to credit the voters with a great deal more sophistication than the enthusiasts of "off-budget financing" give them credit for.

Ironically, by insisting on paying for 100 per cent of covered benefits, Health Security would deny cost-effective health maintenance organizations their most powerful selling point, i.e. lower premiums with consumers allowed to keep the full savings. In a system in which comprehensive care is a "right" for everybody, regardless of ability or willingness to pay, and the government sets the per capita amount that will be spent, there is not much incentive for individual economizing choices.

A second basic NHI concept was first proposed by the Nixon Administration in 1974. Called the Comprehensive Health Insurance Plan, or "CHIP," it would have established a three-part national program including (1) an employee health benefits program requiring employers to offer employees a private health insurance plan meeting certain standards, (2) a State-operated assisted health care program providing coverage for low-income families and for families and employment groups who are high medical risks for health insurance, and (3) a Federal health care program for the aged, in effect, expanded Medicare.

The employee plan would require employers to offer full-time employees a health benefits plan including hospital, medical and preventive services and protection against catastrophic illness. Coverage would be implemented through private health insurance, and financed through employer and employee premium contributions. The assisted plan was designed to make health insurance available to all persons not otherwise insured. There would be income-related deductibles, co-insurance, and maximum family liability. Premiums would be income-related, and tied to the state average for the employee plan.

CHIP has some apparent strengths. Its cost to the Federal budget would be low (about $8 billion in FY 1978 costs) and it keeps management and underwriting in the private sector.

HEW has recently come up with a variation on this theme, called "Publicly Guaranteed Health Plan" (PGHP) under which everybody

coverage for the poor and insurance against catastrophic expense for the non-poor.

The Long-Ribicoff proposal would federalize the acute care part of Medicaid, providing essentially full insurance coverage for low income families—for example, up to $5,400 income for a family of four. (Above that income, a family could become eligible if its medical expenses were large enough to cause it to "spend down" to an income net of medical expense of $5,400.) For non-poor families, Long-Ribicoff would provide insurance against catastrophic medical expense. Long-Ribicoff would add about $12 billion to the Federal budget.

But the proposal has some important weaknesses. It has a big work disincentive for a low-income family at the cutoff income. There wouldn't be much point for such a family to work to raise its income above $5,400 if it expected substantial medical bills. This could and should be revised to reflect the lessons and decisions that went into the Administration's welfare reform proposal. That is, the loss of benefits as earned income rises should be gradual, so as to preserve work incentives.

Assuring that everyone has protection against catastrophic medical expense is a good idea. But the way it is done in this bill provides no restraint on cost once the catastrophic limit is reached. Because the proposal uses the third-party reimbursement principle, it rewards providers for cost-increasing behavior. I fear it would pull resources out of primary care that is often useful and into very costly catastrophic care that often does not do much good. Perhaps the main problem with this approach is that it does nothing to correct the fundamental economic inventives that are causing the system to perform poorly. Like CHIP, it leaves to direct economic regulation the all-important problem of cost-control.

The fourth alternative is consumer choice health plan (CCHP).[2] Consumer choice health

[2]For more detail, see Enthoven, Alain C.: "Consumer-Choice Health Plan," *The New England Journal of Medicine*, 298:650–658, 709–720, 1978.

plan is based on the belief that, when it comes to choosing a health plan, the American consumer is the best judge of what is in his own best interest. He should be given a choice from among competing alternatives, and the information needed to help him choose wisely. Because health care services benefit individuals, and people have a variety of tastes about systems and styles of care, consumer preferences, and not majority vote, should be the basic force guiding the allocation of health resources.

CCHP draws its inspiration from the successful Federal Employees Health Benefits Program (FEHBP) and from the successful, if limited, experience with competing organized systems. In 1971, Odin Anderson and Joel May of the University of Chicago wrote:

> In a country with the heterogeneity of the United States, a single delivery and payment system would hardly be appropriate. It is then mandatory that significant experiences with a variety of delivery and financing methods be examined as to their possible roles in a universal health insurance program. The Federal Employees Health Benefits Program is such a national program and has been in operation for Federal Civil Service employees since 1960. . . . This Program could serve as a viable model for the implementation of universal health insurance in this country, accommodating the aspirations of the providers of services and the recipients of services within politically tolerable cost limits.[3]

The FEHBP now covers about 10.5 million federal employees, retirees and dependents. About 80 different health benefits plans participate, including Blue Cross-Blue Shield, Aetna Life and Casualty, and many HMO's. It works with remarkable simplicity. The Government as

[3]*The Federal Employees Health Benefits Program, 1961–1968; A Model for National Health Insurance?* Center for Health Administration Studies, University of Chicago, A9 Perspectives, 1971.

employer contributes 60 per cent of the average of the premiums of six of the largest plans toward whichever plan the employee chooses. The employee pays the rest. If he prefers a more costly plan, he is free to choose it, but he pays the difference himself. If he chooses a less costly plan, he gets to keep the savings. The quality and cost of the plans are "policed" by the beneficiaries and the competition.

CCHP generalizes these ideas to the whole population. It can be thought of in two-parts: a financing system and a pro-competitive regulatory system.

Financing:

1. *Tax credit.* The present exclusion of employer premium contributions and deductibility of employee contributions to health insurance and deductibility of medical expenses from taxable income (now costing about $10.1 billion) would be replaced by a refundable tax credit based on actuarial category (e.g., family of our, parents under age 65), usable only as a premium contribution in a qualified health plan. That is, the present open-ended tax subsidy of roughly 30 per cent of health insurance costs up to any level would be replaced by a 100 percent subsidy up to a predetermined level with no subsidy above that. People who choose health benefits plans with premiums above the subsidy level would pay the difference out of their own net-after-tax incomes.

2. *Vouchers for Medicaid.* Medicaid would be replaced by a system of vouchers for premium payments to qualified health benefits plans. Their value would vary gradually with income and reach 100 per cent of the actuarial cost of basic benefits in the case of the very poor. The means-testing and administration of the vouchers would be integrated with the Carter Administration's proposed reformed welfare system (or whatever system is enacted). A key principle is the preservation of work incentives.

3. *Freedom of Choice in Medicare.* The Medicare law would be changed to permit each beneficiary to have his adjusted average per capita cost paid to the qualified health plan of his choice as a fixed prospective periodic payment. (Conventional Medicare would be retained for present beneficiaries who choose it.) A voucher would supplement Medicare for the poor.

Thus, government assistance to individuals for personal health care would be in the form of fixed prospective periodic premium subsidies based on need. A "controllable" outlay would replace today's open-ended commitment through third-party reimbursement.

Pro-Competitive Regulatory Framework:

To be eligible to receive the tax credits and vouchers, a qualified health benefits plan would have to compete under these rules:

1. *Open Enrollment.* All plans would participate in an annual government-managed open-enrollment process in which any eligible person could enroll in any plan in his area. This would create competition and assure everybody access to all qualified plans in his area. The process would resemble the one used by the FEHBP.

2. *Community Rating by Actuarial Category,* i.e. a qualified plan must charge the same premium to all persons in the same actuarial category enrolled for the same benefits in the same area. Community rating, in effect, sets a common market price for all customers in each risk class. It precludes prohibitive rates for poor risks and helps to spread health care costs over large groups. Allowing variation of premium by actuarial category allows health plans to charge higher premiums to higher-risk groups; the members of these groups are then compensated by larger tax credits or vouchers. (Each plan can set its own community rates.)

3. *Premium Rating by Market Area* would "internalize" the costs of health services by NHI market area and give local regulators incentives to control costs. (Today, because the cost of operating unneeded health facilities is paid mostly from outside their area, while the

jobs are inside their area, local regulators have little incentive to close them.)

4. *A Limit on Each Family's Out-of-Pocket Costs.* Qualified plans may use cost-sharing but must publish a limit on individual (or family) out-of-pocket outlays above which the plan pays all costs for covered benefits, to provide full protection against catastrophic medical costs and to prevent "medical bankruptcies." Qualified plans would be permitted to require that their members obtain all their covered benefits from participating providers, with whom they have made agreements on fees and utilization controls, or on referral by them. The pressure of economic competition would gradually force health plans to make such agreements. But if a plan did not have an agreement with a participating provider in a needed specialty, it would nevertheless have to pay the cost and limit the beneficiary's outlay to the agreed limits.

5. *Low Option.* Qualified plans would be required to offer one option limited to the basic benefits defined in the NHI law. This would prevent plans from limiting membership to the well-to-do by only offering plans with costly supplemental benefits. They could also offer options with additional benefits if they wanted to.

In CCHP, as in any system of NHI, there would be requirements for grievance procedures, safeguards for civil rights and against fraud and conflict of interest and quality standards for participating providers.

Note that these criteria for qualified health plans are "performance standards" not "design standards." They say what a health plan must do to be qualified, not how it must organize to do it. In particular, a health plan would not have to be an HMO to qualify. This is to leave maximum freedom for innovation in organizational design, consistent with the broad social purposes of the program.

An essential part of CCHP, and a major departure from present practice, would be a program to provide consumers with meaningful

useful information on the features and merits of alternative health plans. Each plan would be required to publish total per capita costs, including premiums and out-of-pocket costs. (A credit card system would enable health plans to capture out-of-pocket cost information.) The administrative agency would have the authority to review and approve (for accuracy and balance) promotional materials, including presentations to be included in the booklet available to all eligible persons at "open season." The administrative agency would also have authority to review and approve contract language so that all options offered would either conform to standard contracts or be able to be described by a standard contract and a manageable number of additions and exclusions. This supervision would force plans to publish their terms in a format that is understandable to consumers and that facilitates direct comparison among plans. There are limits to what government agencies can accomplish in developing evaluative information. I would hope that employers and unions would take an active role in developing consumer reports to aid their employees.

The costs would depend on the level of the tax credit as a percent of actuarial cost. In FY 1978, a poor family of four with no earned income would get a voucher worth $1,350. If a non-poor family got 30 percent of that, or $405, the total net cost to the Federal budget, after subtracting the costs of the replaced Medicaid and the health-related tax expenditures would be about $4 billion. If a non-poor family of four got 60 percent of the $1,350, or $810, the total net cost to the Federal budget would be about $23 billion. And the government could start with the lower amount and gradually phase in greater subsidies as revenues permit.

CCHP is not an immediate radical replacement of the present financing system with a whole new one. Rather, it is a set of "mid-course corrections" in the present financing system, whose cumulative impact would alter the delivery system radically, but gradually and

voluntarily. I fully expect that if it were enacted, further corrections would subsequently be needed, based on experience.

Some of CCHP's critics ask me, "How can you propose a return to the free market when the market in health care services obviously works so badly?" First, I am not proposing a return to some mythical "free market;" that could not exist in health services in our society. Nor am I proposing to rely on today's market system which performs badly, in large part because of the public policies and programs that shape it. Rather, I am proposing a new competitive market system carefully designed to reconcile society's interest in assuring every American access to comprehensive health services of good quality, willingly provided, at a cost in balance with other goals, with a freedom of choice that respects each person's preferences.

Is such a plan politically feasible? It has no interest group support so far. While it may not be a "first choice" for any group, it might well be an acceptable "second best" for many. This was the experience of the FEHBP back in 1959. A fair market test among competing alternatives is something most Americans should be able to agree on.

What are the implications of CCHP for hospital administrators? I have found their reactions particularly interesting and supportive.

The conversion to a health services economy of competing organized systems would surely mean a substantial reduction in hospital inpatient days. That is the main way HMO's and similar organizations reduce cost. It would also mean that hospitals would have to compete to supply services to cost conscious expert buyers, that is health plans. I feared that this prospect would lead hospital administrators to oppose CCHP. But the hospital administrators with whom I have discussed the proposal have had a different reaction. They recognized that hospitals would still be needed, and that some of the reduction in inpatient services would be offset by an increase in outpatient services. And the

changes would come gradually, with time to adapt. But business for the hospital was not their main concern.

They recognized that the present system of health care financing is putting the hospital administrator in an almost impossible position. Society is paying him to do things that raise cost, and then trying to regulate him to stop the cost increases. The result is a great deal of frustrating, unproductive effort trying to understand and then work around the regulations, or going to Washington to try to get the regulations changed. Coping with the regulations becomes the key to success or failure. And these are people who wanted to be managers, not lawyers! Moreover, hospitals are now being characterized as "obese" as political leaders seek to build support for cost controls. Hospital administrators generally chose their line of work because they thought they would be rendering a humanitarian public service. Naturally they don't like to be pilloried as incompetents or public enemies.

In the world brought about by CCHP, hospitals would be competing for contracts with health plans, which themselves would be competing for members. It would be in the interest of the health plans to work out contracts that reward hospitals for providing better care at less cost. I would expect such contracts to have a substantial component of prospective per capita payment and risk-sharing arrangements that reward cost reduction. Cost-reimbursement contracts wouldn't survive for long. Thus, hospital administrators would find themselves in a position resembling most managers in the private sector. They would have a prospective budget within which to manage. They would be able to see improved efficiency translated into increased net revenue, which would be available for capital formation or better pay, or into an improved competitive position. In effect, the system would reward them for doing what society wants them to do, that is providing better care at less cost.