COST PRESSURES AND HEALTH POLICY REFORM

by James R. Jones

Prologue:
When Democrat James Jones emerged as chairman of the House Budget Committee in 1980, he solidified a growing reputation as a forceful policymaker, an eminence that helps him in Tulsa, the center of a solidly Republican district he has represented since 1972. As a White House staff assistant to President Johnson before he was thirty, Jones has come to know the corridors of power, though he is neither a conventional Democrat nor a legislator who always follows in lockstep the directions of his party’s House leadership. Philosophically, Jones believes that the mechanisms of free-market competition produce economic growth more readily than government spending. Jones is inclined to believe that we need more, not less, defense spending, although he stood up for social spending as Budget Committee chairman in a more aggressive fashion than some of his colleagues anticipated. Jones, a senior member of the House Ways and Means Committee who often finds himself at odds with the panel’s chairman, takes an active role in trade issues. On the key Ways and Means panel, Jones often joins with other younger members, Democrats and Republicans, to press alternatives to traditional Democratic economic positions. Jones’s new emphasis in health legislation is a bill that would seek to control consumer health expenses in two ways: first, it would seek to insure all Americans against catastrophic medical expenses and, secondly, it would strive to reduce the rate of inflation for health care expenses by discouraging overinsurance and overutilization of health care. Jones’s interest in health issues is something of an anomaly. He is not a member of the Ways and Means Subcommittee on Health, nor does he have anything to gain politically from his involvement, given the steps of retrenchment the government is taking to resolve its budget problems. Perhaps his activity can best be characterized as a demonstration of leadership at a time when many policymakers are running for cover.
The rising cost of health care is a saga well known within health policy circles, but the consequences of this phenomenon for the entire society have been given less attention. I believe that this perspective deserves more attention and careful thought because it involves every American family. And it affects our taxes because the federal government is the primary payer for health care in our nation today.

You may believe that I am crying wolf. I know that many people have heard this line before from policymakers, yet the wolf has never appeared. In all candor, I must say that the wolf is at the door. The stagnant economy has brought the need for change closer and closer, and it will occur, if not today, then tomorrow.

The evidence for this is strong. Think about the current health care situation. Federal, state, and local governments purchase 42.8 percent of the care provided by the nation’s second largest industry—the health industry. The nation’s economy is bearing an ever-increasing burden from rising health care costs. In 1970, Americans spent $75 billion on health care, with the money coming from both public and private sources. This represented 7.6 percent of the Gross National Product (GNP), and a per capita expenditure of $358.

In 1981, that bill rose to $287 billion, an amount equal to 9.8 percent of the GNP, and a per capita expenditure of $1,225. Health spending in 1981 was 15.1 percent higher than in 1980, compared to an increase of 11.4 percent in the GNP. Studies indicate that by 1990, we will be spending $750 billion on health care. That is more than the entire current federal budget. It will be around 11.5 percent of the GNP, and on a per capita basis, it will represent an expenditure of $3,057 for every man, woman, and child in the United States.

The situation with Medicare and Medicaid is even more dire. The cost of Medicare has been rising at a rate of $5 billion annually for the last several years, and will total $48 billion this year. True, retired workers have paid into Medicare, Medicaid, and other tax supported programs. They deserve the care they paid for. But what they paid in is pennies compared to the dollars that must be paid out when their claims are filed.

At today’s ravenous inflation rate, the payroll tax dollar of today will be worth only a few cents by the end of the 1980s. If the benefits promised to and expected by older Americans are to be paid, many new tax dollars must be deducted from employee wages. And it appears that one day soon, we will have too few workers to finance the care retired people need. The statistics are frightening. In 1935, there were eleven workers for every person over sixty-five. In 1979, there were only three working adults for every person over sixty-five. There will be only two workers for every retired American by 1990, according to management consultant Peter Drucker.
With health care costs rising more rapidly than the GNP, government must take action to moderate this spiral. The question has become how to put on the brakes and still maintain a quality medical service? In candor, I must say that the eventual goal of most proposals to limit costs is to put pressure on providers to make the difficult decisions to determine how this can be done. Unfortunately, it takes some financial “pinch” for private sector interest to be peaked on this issue. The federal government, while lacking a constituency for reform, is already hard pressed to pay current health care bills, let alone what’s projected in the near future. The potential insolvency of the Health Insurance Trust Fund only adds to the extensive budgetary pressures that already exist.

One idea that has received a good deal of attention as a possible way of bringing down costs is the so-called “competitive” approach to the health care system. The competitive idea gained much momentum during the debate on the Carter hospital cost containment legislation. In fact, the first two bills I introduced in the 96th Congress were in direct response to the regulatory push promoted in that legislation, and my belief that we needed to explore all possibilities before resorting to such extreme action. I sponsored three bills in the 96th Congress, all reflecting support for the competitive model, but with an emphasis on extending to citizens protection against the economic consequences of catastrophic illness. Two of these bills were based on a proposal advocated by economist Martin Feldstein, which favors consumer cost sharing as a means to make patients more cost conscious.

The third measure also extended catastrophic protection to people without such coverage and sought to emphasize cost consciousness, but from a somewhat different point. This bill, the Consumer Health Expense Control Act, adjusted more appropriately for the variances in the needs for catastrophic insurance between low, middle, and upper income individuals. The measure also embodied a number of elements of the competitive model as popularized by Alain Enthoven. I have been attracted by the concept of allowing the marketplace to set prices for health care, but since introducing these bills, I have had a chance to look at some of the problems that would be encountered in implementing such a system.

There certainly are problems with the competitive approach. Organized labor opposes a ceiling on the limit an employer can contribute toward an employee’s health plan and still have that amount excluded from the employee’s taxable income. Labor views this change as a new tax on their hard-won fringe benefits. Insurers fear that requiring multiple choices among health plans will result in what they call adverse selection– the sick would take the high option plans and the well would take the low-cost plans. The risks would not be equally distributed. Organized consumer groups, particularly the elderly, are concerned about what these proposals might do to their out-of-pocket payments. Employ-
ers worry about the complication of being forced to offer multiple programs from multiple insurers, as well as the effects this could have on labor agreements. Doctors and hospitals have mixed feelings about these proposals, as we do on Capitol Hill,

Clearly, the competitive approach is not perfect. Just as clearly, however, we cannot afford to do nothing. I have stepped back and reassessed what the federal government can and should do in the private sector with regard to health care costs. Most recently, I have been working on a new approach which demonstrates some shift in my thinking.

The Catastrophic Health Expense and Cost Constraint Act (CHECC) will be introduced in the near future because of my concern with two important health issues: (1) the lack of coverage for catastrophic medical expenses for all individuals in this country, and (2) the effect of continued high health care costs on all Americans, whether they are covered by private insurance, Medicare, Medicaid, or have no insurance. We should provide the proper incentives for cost constraints through our tax expenditures, and what and how Medicare and Medicaid reimburse for health care.

The first part of the bill addresses the major gap in health insurance—coverage for catastrophic medical expenses. This goal would primarily be accomplished through the private sector by way of incentives—not mandatory requirements—to improve private insurance protection. My proposal would not require employers to make fixed contributions, allow for rebates, or any of the many other stipulations that were in the original Enthoven concept of competition. It is not that I do not think these concepts are a good idea or should not be implemented in the private sector. I simply question the need to further complicate the tax code and spell out these requirements for employers and employees. While my proposal includes some changes in the tax code, all tax changes are specifically designed to make available a government catastrophic plan as a last resort for those in the gaps, and at the same time encourage more complete catastrophic coverage in the private sector. In addition to the private sector coverage, a fall-back government program would care for those who incurred catastrophic expenses and were uncovered by a private plan. In the end, either through the public or private catastrophic insurance plan, every individual would be covered for their catastrophic medical expenses.

The final section of the proposal is designed to address my pervasive concern with health care costs in general, and my specific concerns with health care costs of Medicare and Medicaid in the long run. Primarily, this provision would allow for a Medicare waiver to be sought from the Secretary of Health and Human Services so long as there was a petition
to use a prospective payment system in place of the cost-based reimbursement system. The petitioners could decide how inclusive they would like their prospective system to be, that is, which payers will be covered. Realistically, this is the only way that a prospective system can be put in place, since each locality has a unique set of circumstances regarding what costs need to be constrained.

I recognize that the shift to any new system, including prospective payment, will not be simple or easy. However, the retrospective system is not working and we must try something else. The merits of a prospective system are (1) the federal government and other health insurers can have predictable outlays, and (2) there is an incentive for the provider to use the most cost-effective approach to treating the patient, since any savings from the predetermined amount is a profit to the provider. Furthermore, when the provider exceeds the amount allowed for under a prospective plan, the provider is at risk for the additional amount.

A move towards a prospective payment system has widespread support, including elderly groups, insurers, and hospitals. However, there is a good deal of disagreement on what type of proposal would actually work best. That is why I think it would be very difficult to develop a solution that would be applicable nationwide. We can have national standards and criteria without having identical programs throughout the country.

When I offer this legislation, it is in the spirit of striving to find a solution to the problem, and posing one possible way to go. I have a sense of urgency about dealing with this situation, which is in part prompted by the Social Security Trustee’s Report, and I know that the longer we wait to act, fewer options will be available to us. The budgetary pressures will soon force us to take some action, and I would rather that be positive action than merely reaction to a bad situation.

The following are excerpts of an interview with Representative Jones conducted in his office by John K. Iglehart, editor of Health Affairs.

Q: In your view, does the federal role in health care extend mostly to Medicare and Medicaid, as this administration supports, or do you feel government has a system-wide responsibility as President Carter seemed to suggest in his policies? For instance, Carter’s hospital cost containment bill tried to control not only the public costs but privately generated costs as well.
A: We have to deal with health costs for more than just that 40 percent which is paid by government. If you just try to contain costs that the government bears, it will be most likely shifted to the private payer. I opposed President Carter’s mandatory regulations on cost containment because I felt it was going in the wrong direction of regulatory policy and that health institutions would probably spend as much time and resources
finding ways to get around the regulations when, in fact, they ought to be finding ways to deliver health care more efficiently. You have to deal with the health system on an overall basis, public and private. We had better deal with it fairly quickly or there’s going to be a real outcry and demand among the public to change the basic health delivery system in this country. We cannot continue to have the kind of increase in overall health care costs as a percentage of GNP that we’ve seen between 1970 and 1980.

Q: Obviously, today’s environment precludes the possibility of enactment of a national health insurance plan. In your view, will the time ever be right again for serious consideration of NHI legislation?

A: We’re going to have to have some sort of national health insurance program as part of an overall health policy but I would set that around the concept of a catastrophic health insurance policy as a minimum of coverage for everybody.

Q: I take it, based on the bills you sponsored in the last Congress, that you believe that cost-sharing requirements are really appropriate economic incentives to impose on consumers to make them more conscious of costs.

A: I can tell you that in my own instance, without knowing the cost of health care, I want it all. It’s sort of like the Pentagon buying weapons systems. They want it all. Or like my kids going to Toys-R-Us—they want it all as long as they’re not paying the bill. When I have to foot part of the bill, I’m a little more conscious of the service I get and I get pickier on whether or not the bill is added correctly and things like that. I think you have to get the consumer into the marketplace of health care if you are ever going to get the kind of public pressure to keep those costs moderated. The greatest pressure comes about when the consumers collectively urge providers to be cost conscious.

Q: You are inclined to support the marketplace model of health care rather than dependence on government regulation. Do you regard health care as any different than airlines or trucks in terms of its appropriateness for deregulation?

A: I don’t think the health care system will ever be deregulated, or should be. Regulations aren’t inherently good or bad. Good regulations are appropriate in areas of legitimate federal interests and I support them. What I have problems with is when the government exceeds its bounds and becomes overly involved in inappropriate areas. Inadvertently, we complicate the system when we do that, and compound the problem. Still, particularly when tax dollars are involved, there always exists a tension between documenting how those dollars are being spent through some kind of reporting system and how to assure that accountability without too much paperwork and intrusion into a system.

Q: The Reagan administration favors dismantling the federal health planning program. Do you support its position?

A: I disagree with the administration’s plan to totally dismantle the health
planning program. I recognize that there have been problems with this program and that it has not been as successful as we would have wanted. However, it seems to me that we ought to try to correct those problems rather than totally eliminate the program. The Congressional Budget Office (CBO) released a study in March that outlined several options regarding the planning program. The CBO paper notes that some individual health planning activities may have been successful. We should identify the successes, and strive to determine how the federal government can influence their replication.

Q: You criticized Health and Human Services Secretary Schweiker this year for the level of the department’s request for immunization programs. What was your specific complaint in this regard?
A: I argued during this past winter’s debate on the budget that the funding requested by the president for immunizations was inadequate. The administration sought $28.9 million, an increase of only $600,000 over the 1982 funding level. This slight increase is inadequate to maintain the immunization level for newborns. The cost of vaccines has increased by more than 40 percent over the last two years. Apparently the secretary has come to agree with me that immunization funding is not adequate. Schweiker, according to The Washington Post, sought additional funding for immunizations of $6 million for 1982 and $5.5 million for 1983 in a letter to Office of Management and Budget Director David Stockman.

Q: Where does biomedical research funding stand as a priority in the view of the House Budget Committee?
A: Biomedical research is an area where everyone in the nation, indeed the world, benefits. It is also an area where the federal government is the primary source of funding. This clearly is a federal responsibility and must be given a high priority. At the same time, I believe that we must continuously evaluate all public programs to determine how they can be improved. The National Institutes of Health are no exception to this principle.

Q: You represent a district, Tulsa, Oklahoma, where the world’s largest insurance company currently is striving to develop a health maintenance organization that would compete against fee-for-service doctors there. Do you support Prudential’s efforts there as a reflection of the competition model that you espouse? Have you spoken out publicly in this regard as an influential leader of the area?
A: I am very supportive of private sector initiatives to contain health care costs, and Prudential has been a leader in this area. Because they are a large company, they can afford to research this model, and do not see it, yet, as a money-making venture. They do not receive federal subsidies for their ventures, although they do seek to be federally qualified as a health maintenance organization. I understand that this is the same pattern they will follow in Tulsa, and commend them in this regard. I hope
this will be a successful method of lowering costs.

Q: As chairman of the House Budget Committee, you obviously have a large role in that process. Are you satisfied with the process today? Are you seeking changes in it or at least thinking about changes in it?

A: We’re recommending some changes before the next Congress. But they are changes at the margin. The disappointment in the budget process has been its implementation by this administration and by Congress. There’s nothing wrong with the process. What’s wrong is there’s not a willingness to be realistic or courageous in implementing the process. When the administration has a political showdown with Congress and rests its case on totally unrealistic economic assumptions, it results in them winning the political showdown and the budget not living up to its promises. A one percent error in the rate of unemployment, for example, equates to a $25-35 billion error in the budget. Every administration fudges, but this administration had totally unrealistic economic assumption in its budget. That’s one part of it. The other part of it is courage. If you are willing to close the deficits by cutting spending and raising taxes, you must be consistent with your votes. It’s one thing to vote for a budget. It’s something else to actually implement it. And that takes courage—not process.

Q: President Carter warned, in his last budget before he left office, that, in his view, the entitlement programs were getting out of hand, and certainly the Reagan administration believes that. Do you share that view?

A: Yes, I do. I think the entitlement programs are getting out of hand. Essentially most entitlement programs should not be entitlements. Rather the programs should be judged on their merits in relation to the other demands for federal resources. But my biggest concern is not so much the entitlement programs themselves as the automatic escalators for those entitlement programs. This whole issue of indexing government programs has gotten out of hand. And until we get some appropriate limitations on automatic indexing, we are never going to get federal spending under control. Right now nearly half of the federal budget—entitlement and nonentitlement programs—increases automatically on a formula based on the Consumer Price Index (CPI). The way the CPI is configured, it overstates inflation, and the automatic increases of those programs on the basis of that index overcompensates for inflation.

Q: Are you generally supportive of the devolution of powers that is reflected in President Reagan’s New Federalism?

A: I think that there does need to be a new approach towards federalism, a redefinition, if you will, of the responsibilities of the several levels of government and the methods to pay for those responsibilities. I do not agree with the approach this administration has taken in separating different kinds of social welfare programs and making, for example, one level of government responsible for health and another level responsible
for food and basic AFDC (Aid to Families with Dependent Children) payments. Basically, I favor taxes being raised and spent at the same level of government—if the local government makes the spending decisions, they should raise the revenues.

Q: Generally speaking, where would you fix the responsibility for health and income maintenance programs if you were assigned that task?
A: I am inclined to think that both health and income support for the vulnerable are national responsibilities. On the other hand, probably a large share of the infrastructure, such as highways, bridges and public transportation, is a local responsibility. The interstate highway system, of course, requires federal participation.

Q: Do you support the idea of a balanced budget through a constitutional amendment?
A: No. I view the congressional debate on a balanced budget constitutional amendment as the economic Watergate of the 1980s. It is a massive cover-up by both the administration and Congress for a lack of courage and economic judgment. Before jumping headlong into placing an economic formula in the Constitution, something our founding fathers debated but avoided, Americans should demand that Congress study the amendment and its likely results rather than merely voting on election year slogans. There can be only two results if the amendment is adopted. The most likely is that it will mirror the constitutional amendment that sought to prohibit the use of alcohol. The prohibition amendment was a sham. Congress probably will do what many state legislatures do to comply with similar state constitutional strictures. It will develop several budgets—capital budget, operating budget, trust fund budget, and off-budget expenditures. If future governments are as adept as this one at painting false images through the media and avoiding the tough economic decisions, then surely they will find a way technically to comply. But the net result would still be large federal borrowing which will raise inflationary risks and keep upward pressure on interest rates.