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In summer 1990, *Health Affairs* published the remarkable findings of a ten-nation survey of the public’s view of their health care system.\(^1\) In that survey, the United States ranked lowest in the percentage of respondents who agreed with the statement: “On the whole, our health system works pretty well, and only minor changes are necessary to make it work better.” About 60 percent of the American respondents concurred with the statement: “There are some good things in our health care system, but fundamental changes are needed to make it work better.” Close to 30 percent went so far as to agree that “our health care system has so much wrong with it that we need to completely rebuild it.” Only the Italian health system came even close to earning so dismal a rating.

If Americans seek fundamental reform or complete rebuilding of their health system, there is no dearth of proposals to accomplish these goals. Most proposals seek to achieve two objectives at once. First, they seek to extend health insurance coverage to the thirty-four to thirty-seven million or so Americans who now lack that coverage. Second, they seek to offer those who pay for health care—patients, business, and government—instruments to control both the cost of benefits and total expenditures.

In a recent publication by the Pharmaceutical Manufacturers Association (PMA), there is a giant matrix spanning several pages, which lists the numerous proposals and positions taken by the many stakeholders in the health sector.\(^2\) Not included in the matrix is any inkling of what the Bush administration might eventually propose, what might eventually emerge from the ongoing deliberations of the Advisory Council on Social Security, or what might eventually be proposed by the hard-working National Coalition on Health Care, an outgrowth of the erstwhile National Leadership Commission on Health Care.\(^3\)

Entered into each cell of the PMA matrix is a symbol signifying whether the stakeholder or proponent represented by the corresponding

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column of the matrix either supports or opposes the particular design feature shown in the corresponding row of the matrix, or whether no attitude has been explicitly registered so far. Although many of the cells remain yet to be filled with “favor” or “oppose,” those that are completed follow a predictable pattern.

Totally unsurprising, for example, is the Health Insurance Association of America’s (HIAA’s) opposition to the oft-proposed taxation of employer-paid health insurance benefits. We should not expect that industry to give up easily the public tax subsidy it has enjoyed for so long. Such subsidies expand one’s market. Just as unsurprising is the opposition to the idea by the National Association of Manufacturers and the U.S. Chamber of Commerce. These organizations, too, appreciate that the current tax treatment of fringe benefits strengthens their members’ hands in the labor market, for it enables them to do for employees what employees cannot do for themselves: buy things with pretax dollars. Remarkably, what the AFL-CIO thinks on the matter is not shown in the matrix. If an economist had to place a bet on the matter, however, he or she would bet that labor would be loath to give up that public tax subsidy to private spending as well.

Similarly, the opposition of the American Medical Association (AMA) and the American Society of Internal Medicine (ASIM) to negotiate and/or control prices in health care is not unexpected. Although, in principle, all American providers of health care support the idea that health care should be cost-effective and that those who pay for health care must have some sense of budgetary control at the onset of their fiscal year, we must not forget that every health dollar debited by some payer to an expense account is credited by some provider of health care to a revenue account. Each side of the ledger tends to color rather differently one’s perception of proper cost control. For example, as part of the budget compact passed in late 1990, Congress confidently determined that U.S. physicians can treat the nation’s aged adequately in 1991 if total Medicare outlays on physician services in fiscal year 1991 were raised by 7.3 percent above such outlays in fiscal year 1990. By contrast, the AMA has determined just as confidently that the job can be done properly only if these expenditures were raised by no less than 13.7 percent, and possibly by as much as 14.9 percent.4

If one were to summarize broadly the positions taken by major stakeholders in the issues of access and costs, the following would be a reasonable synopsis.

Government, business, and the American taxpayer would dearly love to see health insurance and access to needed health care extended to every American, but they believe that there is so much waste and overpayment within the present
health system that added millions of people could easily be brought into the fold in a budget-neutral way.

The providers of health care would dearly love to see health insurance and access to needed health care extended to every American, but they argue that America spends only the barest minimum needed to finance the care being delivered now, and that added numbers of Americans can be properly cared for only if society is willing to spend an extra $30 to $60 billion or so on top of the $700 billion this nation already spends on health care.

The private health insurance industry would dearly love to see health insurance and access to needed care extended to every American, as long as policies aimed at that goal do not eat into the industry's market.

Each position, taken by itself, makes perfect sense from the stakeholder's own narrow perspective. Alas, jointly they spell gridlock for American health policy. No single interest group now seems strong enough to shepherd a coherent health care reform package into legislation, because every such group seems powerful enough to sabotage whatever someone else proposes. One must wonder whether even President Bush, master builder of the Mideast Coalition, would be capable of forging a directed American health care coalition under our Byzantine system of governance.

This raises a fundamental question: In the probable absence of any coherent, politically viable strategy for health care reform, whither the American health sector in the 1990s? Will it simply lumber on with the status quo? Or will it look drastically different by the end of the decade?

Health Care In The 1990s

The following seems a plausible scenario: A generally sluggish economy, the public's unwillingness to suffer tax increases, coupled with its clamoring for ever more government services and assistance—including sundry bailouts—will beget government deficits of unprecedented size. It may be possible to finance these deficits with a combination of home-grown and foreign savings, as long as the demand for financing by the private sector of the U.S. economy remains sluggish and as long as Eastern Europe and mainland China remain too risky for Western capital. Eventually, however, the world's suppliers of funds are apt to tire of holding ever larger mountains of American paper and will seek greener pastures for their funds. They will accept additional American IOUs only at commensurately), higher real interest rates.

Long before that upward pressure on real interest rates actually will be felt, the U.S. government is likely to begin a series of increasingly strident
assaults upon domestic spending. The Medicare budget remains an inviting target for such assaults. Apparently unbeknownst to the providers of health care, who have bemoaned that program’s “brutal budget cuts” throughout the 1980s, the Medicare budget actually tripled during that period, from $34 billion in 1980 to over $100 billion in 1990. One must wonder whether Congress will let it triple again during the 1990s. There is apt to be much more concerted pressure to curb the annual growth in that program’s outlay.

In seeking these curbs, the Medicare program can rely upon a powerful arsenal that the market devotees in the Reagan administration, wittingly or unwittingly—and, surely, quite ironically—took right out of the pages of Soviet economic textbooks: a system of administered prices set by the central government. For better or for worse, this system of centrally administered prices has endowed the federal government with the lever of a clever hydraulic tax system.

It is now generally agreed that Medicaid pays the typical American hospital less than fully allocated costs for services rendered to Medicaid patients. During the past few years, Medicare, too, appears to have paid the typical hospital something short of fully allocated costs. For the most part, uninsured patients who are treated by hospitals pay them less even than truly incremental costs, let alone fully allocated costs. Jointly, these three groups of patients therefore leave the hospital with substantial uncovered fixed costs. The shortfall is made up by charging privately insured patients commensurately more than fully allocated costs. Large private payers with some market clout may be able to escape a part of this so-called cost shift by way of discounts garnered through preferred provider organizations (PPOs) or contracts with health maintenance organizations (HMOS). Private payers who lack that market power, however, bear the full brunt of the shift. They pay full charges. Big business has, so far, played along with this system with amazing passivity.

As noted, small business firms now appear to be the main target of the cost shift. But they are victims of yet another major cost driver, namely, the extraordinarily high loading factor for administrative costs typically incorporated into the premiums for group health insurance policies sold to small business firms. Exhibit 1 illustrates this phenomenon. Clearly, through their health insurance premiums, many small American firms now support almost as much paper pushing as they do health care proper.

During the past two decades or so, the annual growth in total national health spending has exceeded the annual growth in nonhealth gross national product (GNP) by close to three percentage points. That trend is likely to persist through much of the 1990s, particularly if nonhealth GNP remains in recession for some time. If federal and state governments
Exhibit 1
Administrative Expense Breakdown For Conventionally Insured Plans, As A Percentage Of Incurred Claims

<table>
<thead>
<tr>
<th>Number of employees</th>
<th>Claims administration</th>
<th>General administration</th>
<th>Interest</th>
<th>Risk and profit</th>
<th>Commissions</th>
<th>Premium taxes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 4</td>
<td>9.3%</td>
<td>12.5%</td>
<td>–1.5%</td>
<td>8.5%</td>
<td>8.4%</td>
<td>2.8%</td>
<td>40.0%</td>
</tr>
<tr>
<td>5 to 9</td>
<td>8.6%</td>
<td>11.2%</td>
<td>–1.5%</td>
<td>8.0%</td>
<td>6.0%</td>
<td>2.7%</td>
<td>35.0</td>
</tr>
<tr>
<td>10 to 19</td>
<td>7.2%</td>
<td>9.2%</td>
<td>–1.5%</td>
<td>7.5%</td>
<td>5.0%</td>
<td>2.6%</td>
<td>30.0</td>
</tr>
<tr>
<td>20 to 49</td>
<td>6.3%</td>
<td>7.6%</td>
<td>–1.5%</td>
<td>6.8%</td>
<td>3.3%</td>
<td>2.5%</td>
<td>25.0</td>
</tr>
<tr>
<td>50 to 99</td>
<td>4.3%</td>
<td>4.8%</td>
<td>–1.5%</td>
<td>6.0%</td>
<td>2.0%</td>
<td>2.4%</td>
<td>18.0</td>
</tr>
<tr>
<td>100 to 499</td>
<td>4.1%</td>
<td>4.0%</td>
<td>–1.5%</td>
<td>5.5%</td>
<td>1.6%</td>
<td>2.3%</td>
<td>16.0</td>
</tr>
<tr>
<td>500 to 2,499</td>
<td>3.9%</td>
<td>3.2%</td>
<td>–1.5%</td>
<td>3.5%</td>
<td>0.7%</td>
<td>2.2%</td>
<td>12.0</td>
</tr>
<tr>
<td>2,500 to 9,999</td>
<td>3.8%</td>
<td>1.4%</td>
<td>–1.5%</td>
<td>1.8%</td>
<td>0.3%</td>
<td>2.2%</td>
<td>8.0</td>
</tr>
<tr>
<td>10,000 or more</td>
<td>3.0%</td>
<td>0.7%</td>
<td>–1.5%</td>
<td>1.1%</td>
<td>0.1%</td>
<td>2.1%</td>
<td>5.5</td>
</tr>
</tbody>
</table>


continue to operate the hydraulic tax system as they have in recent years, if big business finally bestirs itself and resists the cost shift from government (leaving it to be absorbed mainly by small business), and if small American business continues to be the victim of the heavy loading factors shown in Exhibit 1, then we can expect more and more small firms simply to drop health insurance as a fringe benefit or not to put it on their books at all. Thus, there is likely to be growth in the number of uninsured low-income and middle-class working Americans—a group not as easily overlooked by politicians as are members of the so-called underclass.

Government Options

Government has three major options to respond to this development. First, it can simply look the other way, assuming that the problem will be taken care of by America’s fabled thousand points of light. In practice, of course, these points of light will be the emergency rooms of the nation’s hospitals. When 20 to 30 percent of the residents in a hospital’s market area go without health insurance—as is already the case in many parts of the nation—the thousand-points-of-light approach will mean severe fiscal pressure upon the hospitals and doctors who feel morally obligated to treat critically ill uninsured patients. These providers, naturally, will do their part in the aforementioned hydraulic tax system. They will pass on the cost of their charity care to those private payers least able to resist higher charges, small business firms prominent among them. As a result, those small firms; that still offer their employees health insurance coverage are likely to see their premiums shoot up ever more rapidly. The erosion of insurance coverage among small business firms is likely to accelerate.
This first option is a short-run remedy likely to set off a vicious cycle that feeds upon itself.

Government's second option would be to face the problem squarely and cover anyone not privately insured by a public fail-safe insurance system. That option, of course, would require politicians openly to utter the dreaded t-word (taxes), for the approach would saddle the government with added outlays anywhere up from $60 billion or so. Furthermore, if the government sought to control the cost of such a program by activating ever more vigorously its lever of the hydraulic health tax system—simply by lowering fees to doctors and hospitals unilaterally—the second option also would likely drive up the health insurance premiums of small business firms, thereby triggering part of the same vicious cycle described under the first option above. The second option, then, is not an attractive remedy either.

This leaves us with government's third option, namely, mandated employer-provided health insurance. With one stroke of the legislative pen, that option would sweep roughly two-thirds of the currently uninsured into mainstream American health insurance and, thus, health care. The remainder of the uninsured presumably could be absorbed into an expanded Medicaid program or, more probably, left as a more manageable problem for the thousand points of light in the nation's emergency rooms.

To be sure, a mandate upon employers to provide their employees with health insurance is a tax, pure and simple. If the mandate is to provide an insurance policy, it becomes a head tax on employment, that is, a tax whose magnitude is not linked to the wages of the employee. If the mandate is a so-called pay-or-play-plan, under which employers must either offer their employees health insurance or pay x percent of payroll into a government health insurance trust fund, the mandate becomes a form of payroll tax. From the politician's perspective, however, this form of taxation is relatively attractive, because it can be artfully referred to in words that spare one's lips from having to trace out even the semblance of the dreaded letter t. Furthermore, if business is mandated to provide insurance outright, government can redirect added funds toward health care within the private sector without having these funds flow through its own budget.

The third option strikes me as the option most likely to be adopted first by various state governments and eventually by the federal government. Quite aside from its appeal among politicians, it now appears also to have the widest support among the providers of health care whose powerful hands have always guided the pen of those who write health policy. The option has already found explicit endorsement by the AMA. It is likely to be supported also by the American Hospital Association, should that
organization ever be able to reach an internal consensus on a preferred health care reform strategy. Although President Bush had tarred the idea as outright socialism during his election campaign, it should be possible to relabel the package more felicitously for eventual approval all around. After all, the idea is really former President Richard Nixon’s, who was wise enough to label it “Community Health Insurance Partnership” (CHIP). Besides, what the president may not sign, many governors will.

Repercussions In The System

One would expect large business firms, which currently underwrite so much of the cost of the uninsured through the hydraulic tax system, tacitly to endorse an employer mandate as well, although no self-respecting American chief executive officer is likely to campaign openly for the idea as long as it remains stigmatized as “socialism.” Organizations representing small businesses, on the other hand, would be likely to offer genuine opposition. Indeed, it is improbable that the small-business sector would ever accept a mandate to provide employees health insurance so long as its insurance premiums remain experience rated over even small, single firms; so long as 30 to 40 percent of these premiums go up in administrative smoke; and so long as small business firms remain the ultimate, most heavily taxed repository of health care costs in our health tax system. It can be doubted that small business firms will forever be willing to pay their neighborhood hospitals much more for standard medical procedures than do large business firms with greater market muscle. That form of pricing will be labeled “unfair,” market be damned.

If mandated employer-provided health insurance passes into legislation at all, it is likely to be accompanied, at the behest of small business and possibly even the U.S. Chamber of Commerce, by severe regulation of the private health insurance industry. In the end, the policies sold by that industry are likely to be subject to (1) mandatory open enrollment; (2) mandatory community-rated premiums; and (3) a mandated all-payer reimbursement system, under which every payer within a given region will pay the same provider the same fee for the same service.

Such fees, of course, would have to be negotiated, at both the national and regional levels, between associations of payers and the corresponding associations of providers. Bodies to perform that task would have to be established by legislation and endowed with the power to negotiate binding schedules of fees or capitation payments. Both government and the providers of health care would be wise to begin exploring the nature of this novel, semiprivate, semipublic institutional framework. Fortunately, Western Europe—particularly the Statutory Health Insurance
System of Germany—offers a rich set of working models. Europe more so than Canada will provide insights for U.S. health policy during the 1990s.

The development I forecast is not likely to be the product of a bold, visionary, preemptive strategy and of sweeping legislation at any one time. Instead, it is likely to emerge gradually, as the product of a tortuous lurching by the health sector along the only logical path left open, absent a more coherent strategy. Very elegant the approach is not. One may aptly describe it as “health policy keister-backwards,” as our health sector is inexorably backed into this particular comer, not by anyone in particular, but simply by the march of events and government’s piecemeal reactions to them. It is a plausible default option for a health policy that has for so long now been stuck in gridlock.

NOTES

3. The Department of Health and Human Services (HHS) is said to be working on a proposed reform package, although little about that effort has leaked to the outside, possibly because there is little to leak.
5. Diagnosis-related groups (DRGs) are nothing other than an accounting-cost relative value scale for hospitals. They become a fee schedule only when a monetary value is assigned to the basic DRG unit. That value could have been set through competitive bidding, or by negotiation. Instead, the Reagan administration chose to let it be set more or less unilaterally by Congress. Furthermore, throughout most of the Reagan and Bush administrations, there have been government-imposed controls on physician fees under Medicare. All told, these resemble more the pricing policies of centrally planned economies than the “procompetitive” strategy heralded by the Reagan administration.
6. Actually, the term cost shift is not a felicitous one in this context. The phenomenon is nothing other than straightforward price discrimination of the sort routinely practiced by the hotel and airline industries. It is found where the fixed unit costs of a good or service are high relative to incremental costs and where customers cannot resell the good or service among themselves.
8. For a proposal along this line, see U.E. Reinhardt, “Health Insurance for the Nation’s Poor,” Health Affairs (Spring 1987): 101–112.
9. My favorite is “The All-American, Private-Public Sector, Judeo-Christian Health-Care Partnership Act.”
10. See President Nixon’s Health Message to the U.S. Congress, 18 February 1971.
11. The allocation of fixed costs among the customers of firms with high fixed costs and low incremental costs is rarely “fair.”
12. Relative value scales would probably be set nationally. The monetary points of the base units would be set regionally.