Letters

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A U.S. Senator On Government Regulation

To the Editor:

As several papers in the November/December 1997 issue of Health Affairs point out, Americans are losing confidence in the quality of care they receive from our health care system. Although the traditional fee-for-service system was guilty of overutilization and runaway costs, Americans did feel that they would get the necessary services, treatment, and information to recover from a serious illness or manage a chronic health problem. Americans are now worried that managed care only manages costs and, in effect, ration care.

Elected representatives at the state and federal levels cannot ignore or dismiss these concerns. Nor should they rush to legislate or regulate. Micromanaging health plans on popular issues, and legislating accordingly, will not solve the fundamental problems of consumer confidence and the quality of our health care system.

Health care quality is often defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” Gerard Anderson states in his paper (“In Search of Value: An International Comparison of Cost, Access, and Outcomes”) that the United States still spends more per capita on health than any other industrialized country and continues to rank in the bottom quartile with respect to outcomes indicators such as life expectancy and infant mortality. And as Bruce Bradley points out in his paper (“Putting Patients First Helps Business”), “improved quality should drive down costs, benefit patients, and improve providers’ professional satisfaction” (p. 121).

What should be the role of the federal government in assuring affordable, accessible, high-quality care for all Americans? The states have developed comprehensive approaches that provide regulation for those components of the health care system under their jurisdiction. The challenge for the federal government is to define regulatory solutions for those sectors under direct federal control in ways that are consistent with our combination of employer-sponsored, publicly provided, and privately purchased coverage, and that advance a consumer-choice health care market. These regulatory solutions, in my opinion, would not determine medical necessity, establish hospital lengths-of-stay, or impede private-sector initiatives. Furthermore, any regulation would not set into statute standards that would preclude efforts for continued quality improvement or that would fail to recognize the evolutionary nature of medical practice.

Information is a powerful tool. Full disclosure by health plans can empower consumers and lead them to align their purchasing decisions with personal preferences. Lynn Etheredge suggests that the government can help this effort by requiring health plans to publicly report a common set of performance measures (“Promarket Regulation: An SEC-FASB Model”). Alain Enthoven and Sara Singer suggest that development of these performance measures and “an information infrastructure for medical outcomes and provider credentialing” is an additional role for government (“Markets and Collective Action in Regulating Managed Care,” p. 30). I believe that the federal government has an obligation to facilitate the development of medical outcomes and performance measures, to ensure that these measures receive wide distribution, and to provide assistance for those who wish to use them.

The practice of medicine is based on trust,
and as Steve Zatkin (“A Health Plan’s View of Government Regulation”) points out, “government has a basic responsibility to ensure that health plans and providers are qualified and operate in the public interest” (p. 33). I believe that this particular responsibility requires the federal government to act as an informed purchaser of health care, to ensure that the care provided to beneficiaries of federally funded programs is appropriate and that providers are held accountable.

I also believe that the federal government is obligated to regulate that segment of the market for which it has sole regulatory responsibility. The McCarran-Ferguson Act of 1945 granted states the authority to regulate the business of insurance. However, the Employee Retirement Income Security Act (ERISA) of 1974 preempted state law with regard to the regulation of employee benefit plans. About 125 million workers now receive their health coverage through employer-sponsored or self-insured health plans. While ERISA provides detailed standards for employer-provided pensions, it provides only minimal standards for health plans. I believe that it is time to amend ERISA and provide those who are covered under federally regulated, employer-sponsored plans with a uniform grievance and appeals mechanism; the assurance that emergency services, for symptoms that a prudent layperson would consider requiring such services, would be fully reimbursed by a health plan; and the knowledge that providers can inform their patients of all treatment options and serve as their patients’ advocates. These are the same provisions that we included for Medicare beneficiaries in the Balanced Budget Act of 1997.

Managed care regulation will be a necessary subject of debate for Congress during the current legislative session. The decisions we make at the end of that debate will need to take into account the cost, accessibility, and quality of our health care system. To ignore any one of these fundamental issues would not be in the public’s best interest. We must acknowledge Americans’ concerns and legislate carefully and thoughtfully to enhance the market by providing our citizens with information about their health plans, logical and necessary consumer protections, and an investment in health outcomes and performance measures.

I commend the editors of Health Affairs for a most timely edition.

Senator Jim Jeffords (R-VT)
Washington, D.C.

NOTE

Medicare: Still Looking For Solutions

To the Editor:

It is hardly surprising that our paper, “Re-thinking Medicare Reform” (Health Affairs, January/February 1998), prompted largely critical responses. After all, we ourselves had criticized those who regard vouchers as the necessary solution to Medicare’s problems—including Stuart Butler as well as Henry Aaron and Robert Reischauer. We welcome this opportunity to respond to their comments.

We first note that our critics did not take up the challenge of responding to our two main arguments. We asserted and documented that there is no reason to suppose that Medicare requires fundamental restructuring into a voucher system because of either demographic pressures or the absence of workable options for controlling its costs. It is true that our critique of these two assumptions does not, by itself, constitute a sufficient positive case for a Medicare global budget, our own policy preference. But readers should be reminded that our paper was largely a critique, an effort to widen the discussion of reform options, not a full elaboration of our particular reform suggestion. So, in this respect, the critics missed (or at least avoided) the central claims of our piece.

On the other hand, both of our sets of critics identified two issues on which there is more common ground than our paper suggested. We agree, for example, that in theory
there are forms of vouchers that would not suffer from the liabilities we identified. It is, however, easier to argue for an idealized voucher system than to put one into actual practice. But we concede that Butler as well as Aaron and Reischauer are aware of the distributitional problems we raised.

Second, Butler suggested that there is no necessary connection between the argument for vouchers and the arguments for “managed care.” Here, too, we agree. One can imagine voucher systems without managed care and managed care arrangements of various forms without vouchers. In this case, we were criticizing the case made by Aaron and Reischauer for introducing vouchers as an instrument to link Medicare to the managed care arrangements the majority of Americans face.

What remains in dispute are a number of other topics, only three of which we have the space to deal with here. We take up, in order, Butler’s critique of the “price controls” he rightly regards us as proposing and the two new arguments for Medicare vouchers introduced by Aaron and Reischauer.

Butler suggests that we have asked the right questions about Medicare reform, but he doubts our answers. Despite obvious ideological differences between us, our dispute with his claims here is largely on logical and empirical grounds. For instance, we find it unacceptable to use evidence of personal experience—Butler’s “thirty years living under Britain’s National Health Service”—as decisive grounds for any policy claim. Butler may or may not be right about the NHS, but he has to present more convincing evidence than self-reporting. Second, even if he were right about waiting times and other associated troubles in Britain, their relevance for the U.S. Medicare program is questionable. We used evidence from Organization for Economic Cooperation and Development (OECD) studies and generalized from a number of national experiences with cost controls. What has been the case for many different countries offers plausible (not determinate) grounds for believing that cost controls are possible for another industrial democracy like the United States. While the comparative evidence supported this claim of possibility, it could not supply the political will and strategic judgments that are the other crucial elements of policy choice. Were Butler to use comparative evidence of trouble from a single case, it would have to be of a system that is more similar to the U.S. system of medical organization and government administration (such as in Canada or Australia) than Britain’s system is.

Butler exhibits an overly general use of an economic model that is problematic for medical care. As Kenneth Arrow pointed out decades ago, the characteristics of demand and supply for medical care make appeals to the virtues of purely competitive market models highly misleading. 2

We agree with Arrow and think that Butler’s rather casual invocation of analogues to competition in other industries does not constitute a plausible counterargument. Moreover, his claim that price controls “encourage gaming and the politicization of health care” is misleading in a crucial respect: No system of health care finance in the industrial democracies is without extensive gaming and politicization. The introduction of a voucher system would not eliminate political pressures on Medicare; rather, it would merely shift their primary source from doctors and hospitals to insurance companies. Contrasting ideal models with real options is as common as it is unhelpful.

However, for all of our differences with Butler, we appreciate the generosity with which he characterized our contribution to the debate over Medicare’s future and his care in presenting our views.

Aaron and Reischauer have added two new claims to their case for transforming Medicare through the use of vouchers. The first of these is that Medicare must move toward managed care because “public support may begin to erode” if the program remains “substantially different” from the private-sector norm. This is a puzzling claim, coming as it does in the midst of what seems to most analysts to be a public backlash against managed care. There is simply no evidence that the public is (or is about to begin) clamoring for Medicare
vouchers. It thus is a considerable feat for Aaron and Reischauer to turn substantial public discontent with managed care into a public mandate for a Medicare voucher system.

Moreover, Medicare has always been “substantially different” from private health insurance, since the elderly (and later the disabled and renal-failure patients) have a right to health insurance that is not extended to the working-age population. Yet far from creating public resentment, Medicare has consistently ranked in surveys as one of the nation’s most popular government programs.

Finally, the choice of health plans that Aaron and Reischauer envision for Medicare under their managed competition scheme presents another anomaly for their own argument: The range of choices would be far wider than that now enjoyed in the employed population, since most workers either have no choice or can choose from only two plans. So, according to their own logic, wouldn’t their plan create public resentment against Medicare for guaranteeing a substantially broader choice of health plans than exists in the private sector?

The second additional justification for Medicare vouchers is that the program’s benefits package is “inadequate.” Here we are in complete agreement, and we have emphasized this needed area of reform elsewhere. We applaud Aaron and Reischauer’s attention to the topic, one too often ignored in the Medicare debate. Unfortunately, they offer no explanation of how a voucher system would expand Medicare coverage other than a vague appeal to the ostensible virtues of managed competition. Such expansion ultimately depends upon the abilities of managed care plans to produce the savings necessary to finance benefits beyond the basic Medicare package. This is a highly uncertain prospect, as earlier commentary on the limits of managed competition has emphasized.

During the past year many health maintenance organizations (HMOs) experienced significant financial losses and had particular difficulty controlling prescription drug costs, one of the “extra” benefits often mentioned as needed for Medicare. There are also signs that a number of managed care plans seriously underestimated the costs of servicing the Medicare population. In fact, there are now reports that large national Medicare HMOs are trimming benefits. It should be remembered that plans’ ability to provide additional benefits to Medicare enrollees was due in no small part to favorable risk selection and consequent overpayment by the federal government. The reduction of these excess payments to managed care plans, as required by the Balanced Budget Act of 1997, increases the likelihood that more plans will trim additional benefits that were in effect the result of public subsidies, not plan efficiency.

Moreover, as Aaron and Reischauer themselves note, much of the growth of Medicare managed care is expected to come in the form of preferred provider organizations, point-of-service plans, and provider-sponsored organizations. These are precisely the plans that have the least proven track records in cost control. Aaron and Reischauer thus fail to show where they would find the funds for expanding Medicare benefits in their voucher scheme other than using market rhetoric as a Trojan horse to attempt to win payroll-tax increases for Medicare.

Finally, Aaron and Reischauer argue that our suggestion of a budget cap for Medicare does not “face reality.” Yet, their vision of how Medicare vouchers would operate is idealized in a number of crucial respects. They assert that plans “will compete to provide high-quality care at an affordable price” and will curb “services of marginal efficacy.” These are advertising slogans for managed competition, not an analysis of the dynamics of private health insurance markets based on risk selec-
tion. Private-sector experience provides little assurance that competing health plans will offer access to high-quality care, especially to chronically ill enrollees. The same incentives that may reduce marginally effective services, after all, also reward both the withholding of beneficial care and the exclusion of high-risk patients.

We have no disagreement with Aaron and Reischauer that a “carefully regulated marketplace,” combined with the universalism of social insurance, requires extensive government regulation, control, and monitoring (and sanctions as well). Given the potential dangers inherent in unraveling the Medicare risk pool, as well as the exaggerated claims for cost control and benefit expansion made on behalf of such a system, we question if such a transformation is worth the risk. Aaron and Reischauer’s proposed regulatory limits on managed competition are certainly preferable to many others, but the extensively regulated Medicare voucher system they envision would impose considerable administrative complexity (and costs) on the program. In addition, they continue to base their system on individual-level risk adjustment, simply asserting that “vouchers could be adjusted for differences in participants’ risks,” while ignoring the well-known difficulties the Netherlands and Israel—among other nations—have had with risk adjustment in less individualized forms. Without adequate risk adjustment, Medicare vouchers would invite considerable risk selection, undermining goals of efficiency.

This is merely one example of Aaron and Reischauer’s inclination to compare idealized models of policy with admittedly flawed but operationally realistic options. It is odd to see highly regulated managed competition, deemed impossible as the Clinton reform, re-discovered as ideal for Medicare. We doubt that Aaron and Reischauer are realistic about the probabilities that a defined contribution form of Medicare would not segment beneficiaries according to income and health status. We similarly are skeptical that turning Medicare over to the American insurance industry would reduce fraud and abuse satisfactorily.

Aaron and Reischauer are surely correct that health care analysts should not ignore marketplace realities in their prescriptions. “Like it or not,” they say, “these trends and developments are here to stay.” We think more modesty about trends is called for than this statement suggests. We know too well the failures of futurology to let that work as an argument.

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NOTES
3. We are indebted to Joe White for making this point to us.

Evils Of Cost Shifting

To the Editor:

Victor Fuchs is an undisputed leader in economic thought relative to health care financing and delivery (“Physicians as Agents of Social Control: The Thoughts of Victor Fuchs,” Health Affairs, January/February 1998). This letter offers different views on three issues: (1) cost shifting, (2) universal health benefit coverage, and (3) the value of non-profit hospitals and Blue Cross and Blue Shield plans.

Unlike Fuchs, I believe that “cost shifting
to cover the expense of caring for the poor and uninsured” is no less active today than it was in the past. It is mediated through charges from providers of health care to payers as a cost of doing business. Its destructive effect is increasing and threatens the viability of health care financing in this country.

Cost shifting is not equally spread to all payers: Medicare, Medicaid, and network-based products such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), particularly those used by more sophisticated Employee Retirement Income Security Act (ERISA)–qualified plans, accept lesser amounts of cost shifting by availing themselves of discounted charges for health services.1 Employer-sponsored groups of fewer than a hundred and those persons covered by individual policies bear more of the cost-shifting burden and are the least able to deal with it, lacking economic power or the power of informed purchasers in many instances.

These vulnerable payers are progressively dropping their coverage because it is unaffordable, thereby swelling the ranks of the uninsured. Left alone, this process will bankrupt the health care financing system, in the not-too-distant future.

Universal coverage would significantly reduce the destructive effects of cost shifting. I believe its time has come. Fuchs has made the case in previous writings.2 He has noted that it meets Adam Smith’s 1776 definition of a “necessary.”3 In the same paper he outlined points valuable to a universal health benefit scheme, particularly that of a well-insulated deliberative body to determine necessary basic benefits.4 He accurately commented that universal coverage requires two things: subsidization of those unable to pay, and compulsion of those unwilling to pay.5 Cost shifting may be the triggering event pushing America to universal health benefit coverage. Mandating basic coverage for every individual, payroll deductions by the employer where applicable, and means-tested vouchers for others would provide funding.

The value of nonprofit hospitals and Blue Cross and Blue Shield plans is greater than ever in our American free-enterprise economy, though perhaps for other reasons than those noted by Fuchs. They counterbalance the economic incentive of the for-profits while maintaining the nonprofit focus on the needs of the consumer. This tension between for-profits and nonprofits in health care financing and delivery serves the American people very well.

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4. Ibid.

A New Commission To Guide The Managed Care Revolution
To the Editor:

Recent discussions in the pages of this journal and elsewhere have highlighted a growing trend in U.S. medical care delivery: the “clash of cultures” inherent in a growing commercial enterprise, especially the managed care sector. These discussions have prompted the following historical reflections, critique of managed care, and proposal for a new entity to guide us in adopting managed care more rationally and fairly.

After the crash of 1929 the Great Depression dragged on through the first two terms of Franklin D. Roosevelt’s presidency, before finally being lifted by defense spending after Pearl Harbor. In response to the Depression, FDR’s New Deal effort put in place legislation and agencies that became fundamental to our
society and commerce, including the Securities and Exchange Commission (SEC).

The SEC was created in response to dangerous securities-trading practices, such as unlimited “margin” (credit) purchases, that threatened the very existence of many brokerage houses. The commission set national standards for corporate behavior, which have resulted in a more stable market and less personal and corporate ruin during its periodic downturns. President Roosevelt stated that one of the functions of government in a free society is to “prevent commerce from devouring itself.”

Now, sixty years later, we have become the first Western nation to give over our health care to private corporations. Commerce has taken over much of American medicine and now threatens to devour itself. More than half of U.S. patients are now covered by managed care, sometimes referred to as “health care reform.” This is not reform; it is “health care conquest.” As a result, a rich commerce is in deep turmoil, casting a profoundly negative public image.

The misdeeds and malfeasances of managed care are so numerous as to defy categorization. They have stimulated the legislatures of many states to pass piecemeal legislation regulating some of the more rampant excesses. Lawsuits against medical corporations have become increasingly successful, despite the protection of the Employee Retirement Income Security Act (ERISA). Among the current trends are indictment of executives, bankruptcy for the worst corporate behaviors, disenrollment, a decline in investors, and even a widespread search for “old-fashioned docs,” who are not salary-bonded to corporate cupidity.

Although I am critical of managed care as it has evolved, I cannot claim immunity, since I worked with Robert Ebert to establish the Harvard Community Health Plan three decades ago. My goal is not to wipe out managed care plans altogether. These plans can provide a needed service to communities. Yet even in the nonprofit sector there is abundant evidence that managed care can be a dangerous form of medical practice because it mingles the insurance function with the delivery function. This intrinsic conflict of interest is at the basis of managed care’s most serious ills: excluding high-risk coverage or denying treatment to increase revenue.

What managed care needs is another FDR. We also need a new SEC to steer managed care on a straight course, avoid its worst tendencies, encourage professional behavior, and foster government participation in the care of high-risk and low-income cohorts. John McArthur and I have proposed the establishment of the National Council on Medical Care (NCMC) as a new agency to set standards for corporate behavior throughout the U.S. managed care industry.1

Others have proposed a similar remedy. In November, the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry released a “Patients’ Bill of Rights” embodying some of the same standards. Rep. Charlie Norwood (R-GA) has sponsored the Patient Access to Responsible Care Act, now in Congress, which would enact an inclusive set of guidelines and standards. There is a persistent rumor that a new coalition of nonprofit managed care plans, under the leadership of Kaiser Permanente, is progressing in the same direction.2

As we develop such an approach, we emphasize that corporate standards for corporate behavior should not be confounded with detailed clinical and ethical guidelines. Corporate standards deal, for example, with the responsibility of corpo-
rations to act in the public interest, to exert budgetary thrift in the expenditure of the premiums they have accepted from their subscribers, and to avoid exclusionary coverage. Such standards would avoid treatment denial and encourage corporate responsibility for the health of communities. Lacking an FDR, we must take the initiative ourselves to set up an SEC-like entity for managed care. The proposed NCMC would act in such a capacity.

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A Combination Approach To Children’s Health Insurance

To the Editor:

As described in Sara Rosenbaum and colleagues’ thoughtful review of the state child health insurance program (“The Children’s Hour: The State Children’s Health Insurance Program,” Health Affairs, January/February 1998), the new federal law offers states many options for extending coverage to uninsured low-income children. Although the choice of whether to extend coverage through Medicaid or a separate state program is often (rightly) identified as the critical threshold issue, the attention focused on the pros and cons of the Medicaid expansion debate has sometimes meant that the option to expand Medicaid and also create a separate state program to cover children whose family incomes are above the Medicaid income limits has been getting too little attention in state capitols. For most states the “combination” approach has significant programmatic and fiscal advantages, particularly compared with an approach that puts all of the new child health funds into a separate state program.

A combination approach can reduce the program coordination issues that arise in a dual-program system. It sounds simple enough to set up a new health program for children who are ineligible for Medicaid, but, in fact, a dual-program system inevitably raises important implementation issues that likely will have a large impact on whether the new child health initiative lives up to its potential. For example, will there be procedures to ensure that children whose parents apply for the “wrong” program do not fall through the cracks of a dual-program system and remain uninsured? What systems will be developed so that children whose family income fluctuates or whose family circumstances change in ways that affect family income—such as through marriage or divorce—are not dropped from coverage when they become ineligible for one program but eligible for the other? Will children be transferred to the appropriate program in a manner that ensures seamless coverage and continuity of care?

Cross-program coordination issues do not go away if a state adopts a combination approach, but this approach can avoid some of the problems that arise in a dual-program system, particularly if it ensures that all children in a family are eligible for the same program. Under a combination approach, a state can use its new child health funds to raise Medicaid eligibility standards somewhat and apply the same income eligibility standards to all children, regardless of age. For example, a state could cover all children through age eighteen with family income under 150 percent of the poverty level through Medicaid while covering higher-income children under a separate state program.

Most states now have age-based eligibility Medicaid standards, meaning that one child may be covered while siblings remain uninsured. As of January 1998 some thirty-one states apply a higher income standard for children under age six than for older children, and several states have two or even three different Medicaid income eligibility standards applying to children of different ages. Some states have proposed to use a portion of their child health funds to raise and even out their Medici-
aid eligibility standards for children; other states have paid little attention to this issue. States that retain age-based eligibility distinctions are missing an important opportunity to limit the coordination problems that result from a dual-program system. Unless a state eliminates age-based eligibility distinctions, the state not only must design and implement systems to ensure that all families are enrolled in the appropriate program, it also must ensure that each child in each family is enrolled and remains enrolled in the appropriate program. By raising the Medicaid eligibility standards and eliminating aged-based distinctions, changes in program eligibility—and potential coverage gaps—that result from family income fluctuations, changes in family circumstances, or a child’s birthday can be limited considerably.

The combination approach also offers fiscal advantages over the separate-program option. Medicaid provides open-ended federal funding for all children the state chooses to cover under a Medicaid child health expansion. This protects states from being caught short by capped (and declining) federal child health funding and forced to either create waiting lists or bear all of the costs of covering additional eligible children. The combination approach allows states to take advantage of this aspect of the Medicaid financing structure with respect to a larger portion of its low-income children.

The issues relating to age-based eligibility standards and cross-program coordination underscore the need for states that already have or that plan to create a separate child health program to consider how their new child health initiative will fit together with Medicaid. This, in turn, presents an opportunity for states to revisit their Medicaid rules and procedures so that what emerges from this new initiative is an integrated, streamlined child health coverage system that addresses the needs of all children.

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Correction

To the editor:

In our recent DataWatch, “State Spending for Medicare and Medicaid Home Care Programs” (Health Affairs, January/February 1998), we presented 1995 data on Medicare spending from the Health Care Financing Administration (HCFA). However, as we were preparing the paper (but unknown to us at the time), HCFA revised the figures downward. Thus, several numbers that we reported in the paper as final 1995 Medicare spending numbers were, in fact, preliminary spending numbers.

These revisions affect the numbers reported in the last column of the first row of Exhibit 1 and the first two columns of Exhibit 2. The revisions also result in several states’ shifting categories in Exhibit 4. The scatterplot presented in Exhibit 3 remains substantially unchanged; the correlation coefficient did not change at all. The revisions to the HCFA data do not change our conclusions or the policy implications discussed in the paper.

Interested readers may obtain copies of the corrected exhibits from the authors at the Urban Institute, 2100 M Street, NW, Washington, DC 20037 (tel.: 202-833-7200). We regret the error and any confusion that it may have caused.

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Correction

In John Eisenberg’s paper, “Health Services Research in a Market-Oriented Health Care System” (Health Affairs, January/February 1998) on page 99, the source for Exhibit 1 should read, “Author’s modification of a framework developed by Clifton Gaus, Lisa A. Simpson, and Linda Demlo.”