

The Health Care Mess: How We Got Into It and How We'll Get Out of It

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In the Beginning

My introduction to the world of health-care reform

In the summer of 1986, John Musick, my boss at Minnesota COACT (Citizen Organizations Acting Together), asked me if I would like to direct a citizen campaign for universal health insurance. At that time, I knew almost nothing about health policy. I couldn't have told you how much the U.S. spent on health care, how many uninsured Americans there were, or what a carotid endarterectomy was. All I was sure of was that the health-care system was complex, the U.S. did not guarantee health insurance to all its citizens, and the opposition to universal coverage by the U.S. health insurance industry and the American Medical Association (AMA) was the main reason why. As I would learn later, the insurance industry and the AMA had thwarted four previous attempts to establish an American universal health insurance program – once just before World War I, again during the Depression, a third time after Harry Truman was elected president in 1948, and again in the early 1970s when Richard Nixon was supporting a universal health insurance plan.

But ignorant as I was about health policy in 1986, my gut reaction to John's question was excitement. It excited me to think about building an army of people to take on the insurance industry and the AMA. The affordability of health insurance and medical care was a health and economic issue that affected all Americans – deeply and personally. It would be three more years before the media began talking about the “health-care crisis,” but the staff and members of COACT were already well aware that a crisis was upon us. So too, it turned out, were citizen groups around the country.

COACT's leaders and staff were aware of the problem because we had been organizing low- and middle-income Minnesotans on a variety of economic issues since COACT's formation in Duluth in 1975. By 1980, which is when I went to work for COACT as a community organizer in the southern Minnesota town of Mankato, the problem of unaffordable health insurance was becoming more visible, especially in rural Minnesota where COACT's offices were concentrated. Rural Minnesota had been especially hard hit by the 1980-81 recession. Many farmers, small business owners, and rural citizens were telling us they were coping with hard economic times by, among other things, scaling back the level of insurance coverage they had (for example, they were buying insurance with \$500 deductibles for each member of the family), or, worse, dropping insurance all together.

I had no doubt, then, that a campaign to make health insurance available to all Americans would excite COACT's membership and staff and help us attract even more members. But my excitement at John's question was tempered by what I perceived to be two big obstacles to a successful people's campaign to establish universal insurance in this country. I discussed both obstacles with John briefly.

The first obstacle was the power of our opponents. I did not know at the time that the U.S. health-care system absorbs one-seventh of every dollar Americans earn, but I knew the players in that industry, including the insurers, the doctors, the hospitals, and the drug industry, made beaucoup bucks and had a lot of political power and would use it against any proposal they saw as a threat to their welfare. I assumed that it would take an unusually strong movement – something at least as strong as the civil rights and anti-war movements of the sixties – to beat these guys. Even

though COACT represented 20,000 Minnesotans and had an annual budget of about \$700,000, we were minnows compared to the whales that dominated the health-care industry.

The second problem I perceived was the complexity of the U.S. health-care system and the difficulty COACT's leaders and staff would have in explaining the problem and the solution to the ordinary citizens we would have to mobilize. Within a few years, I would not feel this way. Within a few years I would realize that most people can understand health policy – even enjoy it – if it's introduced to them in bite-sized pieces, free of jargon or, if jargon is unavoidable, with jargon explained.

Despite my concern about the complexity of health policy and the power of our opponents, I told John I would be happy to direct a campaign for universal coverage if the COACT board decided we should undertake it. John agreed that the opposition would be intense and that we would have to work in coalition with other organizations.

Things moved very quickly after that conversation. COACT's board endorsed the health-care campaign that fall, and, in November 1986, officers of Minnesota COACT and the Minnesota Senior Federation, another citizen group representing tens of thousands of citizens, sent a letter to several dozen Minnesota organizations, including religious organizations, farm groups, and unions, inviting them to a meeting to discuss creating a coalition to fight for legislation at the state and federal level to extend health insurance coverage to all citizens. In April 1987, the coalition, subsequently known as the Health Care Campaign of Minnesota (HCCM), was formally created. Within two years, it had grown to 30 groups.

My knowledge of the health-care system grew rapidly throughout the remainder of the 1980s and the first half of the 1990s. My understanding deepened in stages that corresponded to the positions that COACT and HCCM were taking. During the last three years of the 1980s, when we were attempting to create new public programs that would make it easier for the uninsured to buy insurance, I learned about the impact the high cost of health insurance was having on people's pocket books and the effect that not having insurance was having on people's health. Between 1990 and 1992, when COACT and HCCM were lobbying state and federal legislators to sponsor legislation creating a "single-payer" health insurance system, I concentrated my studies on why the U.S. health-care system is so expensive compared to other countries and what could be done to reduce those costs. After 1993, I focused on the consequences of America's ludicrous experiment with "health maintenance organizations" (HMOs). Nineteen-ninety-three was the year politicians, led by Bill and Hillary Clinton, endorsed HMOs as the solution to the health-care crisis. Thanks to that endorsement and to the power of the HMO industry, health reform proposals that did not propose a prominent role for HMOs were kept off the American political agenda for the rest of the nineties.

By the late 1990s, it was becoming apparent to the entire world that HMOs were doomed to fail. They were damaging quality of care, they hadn't made a dent in inflation, and they were exerting a corrupting influence on democracy. The HMO industry corrupted democracy not merely by funneling huge sums of money to politicians, but by funding a relentless propaganda campaign designed to bamboozle the public and policy-makers into thinking the problems we hear about HMOs are either non-existent or are caused by somebody else. HMO spin doctors would have us believe that most HMO horror stories are not real or are overblown by crazy reporters and disgruntled doctors, and that the real cause of inflation and inferior quality in the U.S. is greedy doctors who promote unnecessary treatments to their patients.

But the days of the HMO industry are numbered. That truth was announced first in 1996 by a chorus of citizen outrage that was dubbed "the HMO backlash" by the media. This was followed a few years later by another chorus of outrage, this one from the throats of employers astonished by the return of double-digit inflation in health insurance premiums. HMOs have given us the worst of

both worlds – deteriorating quality of medical care, and no savings to show for it. The HMO industry is on the ropes, economically and politically.

The obvious failure of the HMO industry to function as advertised has created an opportunity for a real debate about health-care reform, a debate in which all sectors of society get to be heard, not just the HMO industry and its allies in Congress and state legislatures. I compare the slow death of the HMO industry to the death of the dinosaurs 70 million years ago. As long as those big, predatory monsters ruled the earth, the growth of mammals and other species remained stunted. But once the dinosaurs died off, the opportunities for weaker, smaller species suddenly multiplied. Similarly, the slow demise of the HMO industry creates new opportunities for advocates of an efficient, democratically controlled, national health insurance system.

But if little people with fresh ideas (the mammals in my dinosaur metaphor) are to flourish in the new environment, they must understand the U.S. health-care system – where it came from, why it is so costly, why HMOs failed, and which solutions will work and which won't. A truly democratic debate about health-care reform also requires that reporters and news producers understand health policy so that they will be much less susceptible to reporting health industry propaganda as fact, something the media did far too often prior to the HMO backlash of 1996. I wrote this book for the average busy person and the average busy reporter. This book takes you by the hand and walks you through the health-care jungle, explaining players and jargon as we go. It's the book I wish I'd had when I jumped into the health-care reform debate in 1986.

Mapping our journey

This book is based on the health policy trainings I have been doing over the last 15 years. If you're new to the health policy debate, you might think that a one- or two-hour training on health-care policy might be confusing or, at best, boring. I never felt that way teaching it, and, judging from the comments and body language of my audiences, my listeners have never felt that way. I draft my lectures the way script writers draft scenes for movies: I develop one scene or frame at a time, I don't try to cram too much into any one scene, and I make an effort to ensure that the audience understands the relationship between the current scene and previous scenes.

The book is divided into eleven chapters. Chapter 2 presents a short history of the U.S. health-care system. I learned early in my career that people are more likely to understand my comments about the health policy debate if they have been exposed to the jargon that permeates health policy, and that the easiest way to make people comfortable with the jargon is to tell the story of how the health-care system came to be. This story itself is fascinating, and it doesn't take long to tell. But once you've heard it, you know not only all the important jargon, but you know the logic – the good logic and the crazy logic – that motivated the movers and shakers (the insurers, the doctors, the hospitals, the drug companies, the employers, and the politicians) who created the system we live with today.

Once you've heard the history of the U.S. system, you're ready for Chapter 3 – a review of the data showing that the current system is failing badly. I start with data demonstrating that the U.S. system is the most expensive in the world, even though it has the "advantage" of leaving millions of Americans with no health insurance. Because we have a few people in our midst who labor under the illusion that it's no big deal to be uninsured, I spend some time in Chapter 3 going over the data that demonstrates that being uninsured is a threat to your health. Of course, being *insured* is no bowl of cherries either. For millions of employers and individuals, health insurance premiums are a huge financial burden.

Chapters 4 and 5 examine explanations offered by defenders of the U.S. system for why our system is so expensive. When you read about some guy saying somewhere that the U.S. system is

expensive because Americans are “over-insured” or sue too often, what’s the answer to those arguments? Chapters 4 and 5 evaluate these and other excuses for our incredibly expensive system.

When you’re done with Chapters 4 and 5, you’re left with only one possible explanation for why the U.S. system is so expensive, namely, it’s *wasteful*. Chapters 6 and 7 present the evidence supporting the assertion that this explanation is accurate. In Chapter 8, I present the evidence that the public agrees with my argument that the system, not patient behavior, is the primary cause of the health-care crisis. Chapters 9 and 10 present the evidence that market solutions are incapable of eliminating the waste in the system.

In Chapter 11, and to some extent in Chapters 6 and 7, I examine the evidence that a “single-payer” system is the best solution to the U.S. health-care crisis. A single-payer system is one in which one payer reimburses “providers” – doctors, hospitals, and other individuals and organizations that deliver health care to patients. I explain that Medicare, our national program for the elderly and disabled, is a rough approximation of a single-payer system. Unlike the nation’s nonelderly, who are insured by more than a thousand insurance companies, Medicare is the sole payer for doctors and hospitals who treat the elderly. Hence, calling Medicare “single-payer” for the elderly and disabled is roughly accurate. If we plugged some of the coverage holes in Medicare (prescription drugs being a big one), kicked the insurance industry out of Medicare, and then reduced the Medicare eligibility age from 65 to zero, we’d have a Medicare-for-all (single-payer) system in effect.

Americans will endorse a universal Medicare plan

The fight for a Medicare-for-all plan, and the fight against non-solutions like HMOs, is rewarding for several reasons. First, health care is so personal, and its quality and availability can mean the difference between life and death. Second, hundreds of billions of dollars are at stake. Third, and perhaps most importantly, polls and focus groups and my own personal experience tell me that a sizable majority of the public agrees with my diagnosis (our system is very wasteful) and my prescription (we need a Medicare-for-all program). Knowing that so many people share my perceptions turns what would be a very interesting fight into a very enjoyable fight as well. I do not labor under the illusion that majority opinion is always right. But in the health policy wars, the public is right and the “experts” – the people who dominate the current debate, including insurance company executives, politicians, big business executives, academicians who take money from the drug and insurance industry, and columnists – are wrong. The experts have lots of theory, money, and access to the media on their side, but the public has facts and commonsense on its side.

In Chapter 8, I present the evidence supporting my argument that the public’s opinion is consistent with the facts and conflicts with the opinion of experts. But I can’t wait till Chapter 8 to give you a taste of how supportive the public is of a Medicare-for-all system. Knowing that substantial majorities agree with me, that the underdogs have got it right and the top dogs have got it wrong, motivates me to learn health policy inside and out, and I suspect it will do the same for any open-minded reader. So I’m going to tell you a true story that supports my argument that a large majority of Americans will endorse a single-payer system if they are exposed to a fair debate about what’s causing the health-care crisis and what should be done about it.

The story is about a debate between a single-payer advocate, an HMO advocate, and an advocate of “medical savings accounts.” (Medical savings accounts emerged as the most prominent Republican solution to the health-care crisis when Republicans took over Congress in 1995). The debate occurred in front a group of citizens selected to represent all Minnesotans. I was the single-payer advocate. Single-payer won – not by a teeny bit, but by a landslide.

The story begins late in September 1996 when I got a call from a woman named Laurie Sether. She asked if I would be willing to be one of three speakers on health-care reform at a "citizens forum" being convened by the Minneapolis *Star Tribune* and KTCA-TV, the Twin Cities' public television station, on the evening of October 1. Laurie wanted me to present the case for a single-payer health-care system. She said she was still looking for a speaker to advocate "managed competition" (the phrase used to describe proposals built around the HMO industry's mythology), and another to present the case for medical savings accounts (MSAs, a type of health insurance which relies on huge deductibles to get people to reduce their use of medical services).

I didn't ask, but I guessed why Laurie had decided to nail down a single-payer advocate first. People who can speak intelligently about reforming the U.S. health-care system from a consumer's point of view are rare. Conversely, people who can speak in favor of HMOs and MSAs are a dime a dozen. The HMO industry pays lots of people lots of money to peddle HMO propaganda, and the non-HMO wing of the insurance industry pays lots of people to peddle MSAs. But no industry sugar daddy pays consumers or anyone else to advocate for a single-payer system.

Laurie said each speaker would have five minutes to make an opening statement, and then we would take questions for the next three-and-a-half hours from a group of randomly selected Minnesotans. This format concerned me. I saw it as guaranteeing frustration for speakers and audience members alike. Health policy, I said, can be intimidating if basic information isn't presented first. I said I would have preferred to have the *Star Tribune* and KTCA host three different meetings, or failing that, allow each speaker to talk for half an hour. But Laurie said the format was fixed, and the best she could do would be to extend the opening statements to ten minutes. I agreed to participate.

On the morning of October 1, I learned that the managed competition advocate would be Michael Scandrett, director of what was then called the Minnesota Council of HMOs, and that the proponent of MSAs would be Liz Quam, a woman who had, until recently, been on the staff of the Minnesota Department of Health. Mike Scandrett was an attorney who knew the arguments for managed competition well. Before becoming the director for the Council of HMOs, he had worked as a writer of legislation for the Minnesota Senate. In that capacity, he had written all the major managed competition bills that the Minnesota legislature enacted in the early 1990s. The HMO industry showed its gratitude by hiring him in 1995 to run the Council of HMOs.

At 5:30 on the evening of October 1, the three speakers and the 14 Minnesotans selected to participate assembled around four long tables arranged in a square in a room on the second floor of the *Star Tribune* building in downtown Minneapolis. KTCA-TV put two people – a cameraman and a woman holding a fat microphone at the end of an impossibly long boom – inside this box. A woman from the League of Women Voters moderated.

I was the first speaker. I used my ten-minute opening statement to remind people that the other two speakers were promoting proposals supported by the insurance industry – the HMO wing of the industry in the case of managed competition, and the non-HMO wing in the case of MSAs. "Single-payer, on the other hand, isn't getting a dime from the insurance industry," I said. "All the single-payer proposal has is broad public support."

After the other two speakers had made their opening remarks, the citizen panelists started asking questions of the speakers. The first question was a hostile question for Mike from a woman from southern Minnesota who ran a small business. And away we went. Questions from the panelists came one after the other; each of the speakers offered short comments on most of the questions. In the middle of this Tower of Babel, KTCA's cameraman and boom-mike woman rushed around inside the corral of tables to record the comments of each speaker.

Three-and-a-half hours later, the moderator brought the questions to a close and posed a series of questions to the 14 citizens. First she asked them to vote on the three proposals. The vote

was eight for single-payer, three for managed competition, one for a hybrid of single-payer and managed competition, zero for MSAs, and two abstentions. The next question the moderator posed was, "Would you be willing to pay more in taxes to cover the uninsured under a single-payer system?" I objected to that question. "A single-payer system will cut total health-care spending at least enough to pay for the uninsured," I argued. "The fair way to pose the question is, 'Assuming your other health-care costs were reduced by \$1,000, would you support a tax increase of \$1,000 to guarantee universal access under a single-payer?'" The moderator, bless her heart, agreed to this phrasing of the question and put it to the citizen panel. Eleven said yes and three abstained. At that point, Laurie Sether stood up and pushed for a vote on a rephrased version of the question: She wanted people to consider whether their employers would pass on the savings to them in the form of higher wages if a single-payer relieved employers of the burden of paying for insurance. I was annoyed at this obvious effort by a non-participant to influence the outcome of the debate, but I said nothing. The moderator let that question be put to a vote. But the vote remained the same. I was pleased to see these citizens turn down an appeal to their selfishness. Finally, the moderator asked the citizens if they thought Congress had failed to give single-payer a fair hearing. Eleven said yes, three said no.¹

I couldn't have been happier with the outcome of this forum. The lopsided votes in favor of single-payer was strong evidence that single-payer will win any reasonably fair debate, even a relatively short debate that skitters from topic to topic as this one had. The outcome of this debate, and other evidence that majorities of Americans like the single-payer proposal once they understand it, is the single most important reason why I believe America will, sooner or later, solve the health-care crisis by enacting a Medicare-for-all system.

2

How We Got Into This Mess: A History of the U.S. Health Insurance System

Origins of the U.S. health insurance system

So how did the U.S. come to be the only industrialized country in the world without a national health insurance system? How did employers get hornswoiggled into paying for health insurance? Where did HMOs come from and why did anyone think they were a good idea? Is it true, as conservatives argue, that Medicare “is going bankrupt” and can only be “saved” if we turn the nation’s elderly over to HMOs? Why is health care in the U.S. so expensive? These and other questions about our system are easier to answer once you understand the history of the U.S. system.

The U.S. health insurance industry is only about 70 years old. Prior to the 1930s, health insurance was virtually nonexistent in the US.¹ Health insurance companies had not yet been formed, and government health insurance programs (such as Medicare) did not yet exist. You could buy life insurance, burial insurance, insurance against being disabled, and “sickness” insurance, which would pay you a certain portion of your wages (not your medical bills) if you got sick. But very few people could buy health insurance.

The main reason the insurance industry wasn’t selling health insurance prior to the 1930s was that the costs of illness were so variable compared to the costs of other types of misfortune the industry insured against. If I sell you a policy guaranteeing you two-thirds of your current wages for up to six months if you get sick, I have a pretty good idea of how much money I should charge you in order to have the revenues to meet your claims and make a profit. Similarly, if I sell you disability, life, and burial insurance, my costs are relatively predictable. But the true cost of insuring you for medical bills is tougher to predict because the types of illness which afflict humanity are so numerous and varied.

In Europe, however, health insurance was available to large segments of society in the 50 years preceding the Depression. During this period, beginning with the German government in 1883, European governments established prototypes of the national health insurance programs that exist today in every industrialized nation except the U.S. These programs are not what we think of today when we hear the phrase “national health insurance.” They were limited to working people, and they often emphasized sickness insurance over health insurance.

When the Depression hit the industrialized world in 1929, large numbers of U.S. patients were unable to pay for medical care, and, as a result, physician and hospital income plummeted. In California, for example, physician income fell by 45 percent between 1929 and 1933.² Hospitals and doctors responded by forming the nation’s first successful health insurance companies. Baylor University Hospital in Dallas, Texas established the first health insurance company in 1929. The

¹ The only people who had anything resembling health insurance prior to the 1930s were the few Americans who obtained medical coverage from a variety of “mutual aid associations,” sometimes called “lodges” and “fraternal orders,” and a handful of workers in a few industries with high injury rates operating in remote areas, notably, railroads, lumber, and mining, who were guaranteed medical care by their employers through plans that resembled HMOs. Lodges and fraternal orders were more common among immigrant communities, and were virtually nonexistent in rural America. The railroads and other companies that provided medical care directly to their workers typically did so by contracting with doctors to treat all company employees who might need medical attention. (See further discussion of the early HMOs in Chapter 9.)

hospital agreed to provide 1,400 teachers in the Dallas school system with up to 21 days of hospital coverage in exchange for the princely sum of \$6 per year per teacher, due in monthly installments of 50 cents. The coverage took effect on December 20, 1929, just two months after the stock market crash of 1929. The first teacher to have her bills paid under this new form of insurance was Alma Dickson. She slipped on an icy sidewalk a few days after her coverage took effect, broke an ankle, and spent the Christmas holidays at Baylor University Hospital.³

Encouraged by Baylor University Hospital's success, hospitals throughout the country began setting up their own insurance companies. An insurance company formed by eight hospitals in St. Paul, Minnesota in 1933 used a blue cross in its advertisements. The company eventually assumed the name Blue Cross. Like Baylor's insurance company, the St. Paul Blue Cross company marketed itself to large employers. Employees of the St. Paul Union Stockyards Company were the first to sign up at 75 cents a month. The Blue Cross name and the familiar Blue Cross insignia were quickly adopted by similar hospital-sponsored insurance companies all over the country. By 1949, more than six million Americans were enrolled in 39 Blue Cross plans.⁴ Doctors, seeing that hospitals were succeeding in the insurance business, soon established their own insurance companies under the name Blue *Shield*. The first Blue Shield was established by the California Medical Association in 1939.⁵

Until just recently, all Blue Cross and Blue Shield companies were nonprofit, which means, among other things, that they couldn't pay exorbitant salaries and they couldn't issue stock (and, therefore, they didn't have to respond to stockholder demands for high profits). The reason for this is that the states, not the federal government, have historically regulated the insurance industry, and when the hospitals first approached state legislatures asking for permission to set up and run insurance companies, the legislatures gave them permission but only on the condition that the insurance companies be nonprofit, just as the great majority of hospitals were. Legislators didn't want for-profit insurers milking the nonprofit hospitals and, conversely, they didn't want nonprofit hospitals getting around the prohibition against excessive profits by siphoning off huge profits from for-profit insurance companies.

When established life insurance companies like Metropolitan and Prudential (most of which were for-profit) saw that the Blue Cross and Blue Shield companies were surviving, they began to offer health insurance. The first health insurance policies offered by private insurers other than Blue Cross and Blue Shield appeared in 1934. By the end of the 1940s, the number of for-profit insurers competing with the Blues was in the hundreds.⁶ To compete with the Blues, for-profits used a method of premium-setting known as "experience rating," which means the insurer offers low rates for healthy groups and individuals and high rates for less healthy people. This practice, which became widespread by the early 1950s, posed a serious threat to the Blues. If they didn't abandon their practice of charging the same price to every customer, a practice known as "community rating," and take up experience rating, they would be left with sicker and sicker enrollees, and they would eventually have to price themselves out of the market.² By the late 1950s, most Blues had switched to experience rating, and by the 1980s, community rating was rare.

The number of people who could afford to buy health insurance rose rapidly in the late 1930s and early 1940s as government expenditures on the armed forces pushed the economy out of the Depression. The fortunes of the young health insurance industry were further boosted by the

² Despite their gradual abandonment of experience rating, Blue Cross and Blue Shield companies lost market share during the 1950s to the for-profits. Between 1948 and 1958, Blue Cross plans' share of the market fell slightly from 51 to 50 percent, and Blue Shield plans' share fell from 49 to 44 percent (Robert Cunningham III and Robert M. Cunningham, Jr., *The Blues: A History of the Blue Cross and Blue Shield System*, Northern Illinois University Press, DeKalb, IL, 1997, 97).

federal government's decision to impose wage and price controls during World War II, but to exempt health insurance.³ The extremely tight labor market created by World War II put great pressure on employers to offer high wages and benefits to retain employees. The loophole in the wage-and-price controls created for health insurance caused many firms which had not previously offered health insurance to begin doing so. After the war, unions began to bargain aggressively for health insurance. By 1954, over 60 percent of Americans had hospital insurance, 50 percent had surgical insurance, and 25 percent had some form of insurance for non-surgical medical services (mainly physician services in hospitals).⁷

Most of these insured Americans got their insurance through their employer, primarily because employer-sponsored health insurance was, and is, less expensive than insurance purchased by individuals. Employer-sponsored insurance is less expensive because it costs the insurance companies less to sell insurance to groups than to individuals. The administrative cost to insurers of selling a single policy to one employer with 200 employees, for example, is much less than the cost of selling 200 separate policies to 200 individuals.

Broadly speaking, two classes of people were left out of America's emerging employer-based health insurance system: the retired and the unemployed. In 1965, Congress enacted Medicare for the elderly and Medicaid for the very poor.⁴ Medicare, which was operated at the federal level by what was then called the Department of Health, Education and Welfare,⁵ began to enroll seniors on July 1, 1966. By 1970, 97 percent of elderly Americans were enrolled in Medicare; that proportion remains the same today.⁸ Although Medicaid is partially financed by the federal government, it is

Table 2-1: Government programs cut the number of uninsured: The uninsured in the U.S., selected years, 1953-1999

| Year | Number | Percent |
|-------|-------------------------------|---------|
| 1953: | 71 million | 44 |
| 1958: | 64 million | 37 |
| 1963: | 63 million | 33 |
| 1965: | Medicare and Medicaid enacted | |
| 1970: | 49 million | 24 |
| 1976: | 23 million | 11 |
| 1980: | 30 million | 13 |
| 1985: | 37 million | 15 |
| 1990: | 34.7 million | 13.9 |
| 1995: | 40.6 million | 15.4 |
| 1996: | 41.7 million | 15.6 |

³ Wage and price controls were imposed in 1942; the exemption for employee fringe benefits, including health insurance, was created in 1943. The exemption was not unlimited; employers could raise employee fringe benefits only up to 5 percent of total payroll. Note that *offering* health insurance is not the same as *paying* for it. During the 1940s, the large majority of employees paid for all of the cost of their employer-sponsored health insurance (Robert Cunningham, "Joint custody: Bipartisan interest expands scope of tax-credit proposals," *Health Affairs* 2002; (Web Exclusives):W290-W298, footnote 29, W298.) Nevertheless, working for an employer who offered health insurance was a draw for workers because insurance was so much less costly when purchased as part of a group than as an individual.

⁴ In 1972, Medicare was extended to the disabled of any age and those with end stage renal (kidney) disease of any age. For the sake of brevity, I will often refer to Medicare enrollees as "seniors" or "the elderly." Readers should not forget that that is shorthand for "the elderly *and* nonelderly disabled *and* kidney-disease patients."

⁵ The Department of Health, Education, and Welfare is now called the Department of Health and Human Services.

| | | |
|-------|--------------|------|
| 1997: | 43.4 million | 16.1 |
| 1998: | 44.3 million | 16.3 |
| 1999: | 42.6 million | 15.5 |
| 2000: | 38.7 million | 14.0 |
| 2001: | 41.2 million | 14.6 |

Sources: Estimates for 1976 and earlier are based on studies by various researchers. The estimates for the years after 1976 are based upon annual surveys by the U.S. Census Bureau, usually reported each September. The Census Bureau began conducting annual surveys on the number of uninsured in 1979. The source for all post-1976 years other than 2001 is <http://www.census.gov/hhes/hlthins/historic/hihist1.html>, accessed July 24, 2002. The Census Bureau's survey questions changed in 1988 and again in 1999, lowering the number of uninsured both times. The source for the 2001 figure is Robert Pear, "After the decline, the number of uninsured rose in 2001," *New York Times*, September 30, 2002, A21.

Table 2-2: Minorities are the hardest hit: Uninsured rates by race, 2000

| | |
|------------------|-----|
| Hispanics | 32% |
| Blacks | 19% |
| Asians | 18% |
| National average | 14% |
| Whites | 10% |

Source: Robert Pear, "Number of uninsured drops for second year," *New York Times*, September 28, 2001, A19.

administered by the states, and for that reason enrollment in Medicaid occurred more slowly.

Medicare and Medicaid had a huge impact on the uninsured rate. The rate fell from about 33 percent in 1963 to 11 percent in 1976 (see Table 2-1). The 1976 figure was probably the lowest uninsured rate America ever recorded. The percentage of Americans without health insurance climbed every year after that until 1999. The rate dropped in 1999 and 2000, then rose again in 2001. Table 2-2 indicates that minorities had uninsured rates above the 14.0-percent national average rate for 2000, while the uninsured rate among whites was slightly below the national average.

The origins of HMOs and the modern U.S. health-care system

Health-care inflation in the U.S. worsened in the late 1960s, largely because Medicare and Medicaid permitted many more Americans to buy health care. Inflation was to be expected. Any time additional buyers flood a market in great numbers, prices will rise unless government sets limits on those prices. Medicare and Medicaid permitted millions of the nation's elderly and poor to buy medical services that had previously been out of their reach. With all these new patients seeking health care, with no immediate increase in the supply of doctors and hospitals, and with no price controls, total expenditures on health care were bound to rise.

In 1929, the year when Baylor University Hospital was forming the first Blue Cross company, Americans were spending 4 cents of every dollar earned on health care. We were still

spending about 4 cents per dollar earned in 1948 when Harry Truman campaigned on a promise to promote national health insurance if he were elected president. By 1970 that number had risen to 7 cents.⁹ Today we spend an estimated 15 cents of every dollar of income on health care, and are projected to spend 17 percent by 2011 (see Table 2-3).

Although the 7 cents we were spending on health care in 1970 looks low today, it seemed high in 1970. In January 1970, both *Fortune* and *Business Week* ran cover stories on “the health-care crisis,” and Senator Ted Kennedy introduced a national health insurance bill that would be called a single-payer bill today. President Richard Nixon was looking for a way to control health-care inflation that did not rely on the price controls that all other industrialized nations used. A Minnesota physician named Paul Ellwood came up with a proposal that appealed to Nixon, a proposal Ellwood called “the health maintenance strategy.” On February 5, 1970, Ellwood met with Nixon’s advisors at the DuPont Plaza Hotel in Washington, DC to discuss this strategy. He argued that the solution to America’s health-care inflation was a new type of health insurance company that he called the “health maintenance organization.”⁶

You can think of an HMO as an insurance company and a doctor’s office under one roof. Traditionally, insurance companies and doctors’ offices were separate entities. In other words, doctors didn’t work for insurance companies, either as contractors or as salaried employees; doctors were independent agents. They or their patients submitted bills to insurance companies for each service the doctor provided, and the insurance

Table 2-3: From billions to trillions: Total spending on health care in the U.S., selected years, 1960 to 2000

| | Total health expenditures | |
|------------------|---------------------------|-----------------|
| | Billions of dollars | Percent of GDP* |
| 1960 | 27 | 5.1 |
| 1970 | 73 | 7.0 |
| 1980 | 246 | 8.0 |
| 1990 | 696 | 12.0 |
| 1991 | 762 | 12.7 |
| 1992 | 827 | 13.1 |
| 1993 | 888 | 13.4 |
| 1994 | 937 | 13.3 |
| 1995 | 990 | 13.5 |
| 1996 | 1,040 | 13.3 |
| 1997 | 1,091 | 13.1 |
| 1998 | 1,150 | 13.1 |
| 1999 | 1,216 | 13.1 |
| 2000 | 1,300 | 13.2 |
| 2001 (projected) | 1,424 | 14.0 |
| 2002 (projected) | 1,546 | 14.7 |
| 2011 (projected) | 2,816 | 17.0 |

* GDP stands for gross domestic product. It is a measure of total income earned by all Americans.

⁶ According to Ellwood, he invented the phrase “health maintenance organization” in May 1970 (“An interview with Paul Ellwood, Jr., MD,” *Managed Care*, November 1997, <http://www.managedcaremag.com/archives/9711/9711.qnaellwood.shtml> accessed October 6, 2002).

Sources: For years through 2,000, Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace 2002*, Exhibit 1.1, http://www.kff.org/content/2002/3161/marketplace2002_finalc.pdf, accessed September 28, 2002; for years after 2000, Stephen Heffler et al., "Health spending projections for 2001-2011: The latest outlook," *Health Affairs* 2002;21(2):207-218, Exhibit 1.

company paid the doctor's fee, no questions asked. This arrangement is commonly called "fee-for-service" medicine, because doctors are paid a fee for each service they render to patients.

There was a kernel of truth to Ellwood's argument. If doctors are paid a fee for every service they provide, and if doctors know that no one will challenge their decisions to order services, some doctors will order too many services. But in concentrating so intently on the *volume* of medical services sold, Ellwood gave little attention to another very obvious cause of medical inflation – *price*. You don't have to have a PhD in economics to know that total spending on anything, be it health care or pineapple juice, depends on two numbers – the *volume* of the good or service sold, and the *price* at which the good or service is sold. All other industrialized countries have treated the *price* of medical care as the primary problem. For three decades, the U.S. has treated *volume* of medical services as the primary problem. It's not an exaggeration to say we can thank Paul Ellwood for that. Because of his influence on Nixon, Ellwood played a very important role in the HMO revolution.

Ellwood told Nixon's staff that his proposal would control health-care inflation by giving doctors financial incentives to deny medical services to their patients.⁷ In other words, Ellwood proposed to turn the fee-for-service incentive upside down. The incentive could be turned upside down, said Ellwood, by letting HMOs pay doctors a set fee per person per year. This method of payment is called "capitation" ("capita" is Latin for "head"). Under the capitation payment method, the doctor cannot make more money by ordering more tests and unnecessary services. In fact, it's the other way around. Under capitation, the doctor makes more money the fewer services the doctor orders. That's because the doctor is being paid a fee per patient per year that doesn't change to reflect the number of services the doctor orders. If the doctor's patients wind up costing, on average, a lot less than the capitation fee, the doctor pockets the difference.

Ellwood argued that capitation would cause HMOs to be unusually good at keeping people healthy. If patients were healthy, they would not need medical services and, therefore, would not be draining HMOs of their profits. Ellwood's belief that the profit motive would drive HMOs to keep their patients healthy led him to think that the name "health maintenance organization" was an appropriate label for this newfangled type of insurance company.

In addition to capitation, the other distinguishing feature of the early HMOs was their limited choice of doctors. (Today, only the latter feature – a limited choice of doctor – distinguishes HMOs from other types of health insurance companies. Capitation is now used by non-HMO insurers as well.) If you are insured by a traditional insurance company, you can see any doctor you choose. But if you are insured by an HMO, you must choose from among the doctors available in the HMO's "network." Why do HMOs insist on limiting your choice of doctor? HMOs argue that limiting the doctors you can see permits the HMO to select only the best doctors. But there is no scientific evidence to support the claim that doctors who work for HMOs are better than doctors who do not. A more compelling explanation is that limiting your choice of doctor gives the HMO more influence over its doctors. An HMO that provides a clinic with 50 percent of its patients is more likely to get cooperation from that clinic than it will from a clinic that gets just 5 percent of its

⁷ For a summary of Ellwood's pro-HMO arguments to Nixon, see Paul M. Ellwood et al., "Health maintenance strategy," *Medical Care* 1971;9:291-298.

patients from the HMO.¹⁰ A clinic that is heavily dependent upon HMO patients is more likely to deny services and impose heavier workloads on its doctors.

HMOs did not rely solely on capitation and heavier workloads to ensure that their doctors cut costs. HMOs also pioneered a cost-control technique known as “utilization review.” Utilization review means someone other than the doctor and the patient decides whether a medical service is necessary. Utilization review can occur before, during, or after a medical service is provided. Prior authorization of surgery is an example of utilization review that occurs prior to a service being provided. A review of a doctor’s decision to keep a patient in the hospital after the patient has been hospitalized is an example of concurrent utilization review. A decision by an insurer to deny payment for an emergency room visit after the patient has gone to the emergency room is an example of utilization review following provision of a service.

We can think of drug “formularies” as a form of utilization review or, more precisely, of prior utilization review. Formularies are lists of drugs HMOs will pay for. Some HMOs, for example, will pay for the antidepressant Zoloft but not Prozac. HMOs claim they make these drug decisions on both quality and cost grounds, but cost appears to be the main criterion. If an HMO can tell the manufacturer of Zoloft that it will buy a large volume, the manufacturer will offer the HMO a big discount. An HMO that forces its doctors to prescribe only Zoloft and never Prozac is more likely to meet its minimum volume requirement and get the discount. And, to repeat, an HMO is in a better position to force its doctors to prescribe Zoloft if it insures a high proportion of the doctor’s patients. Which, to repeat, is why HMOs limit your choice of doctor.

An obvious question should occur to anyone at this point: Why won’t capitation, utilization review and above-average workloads cause HMOs to damage health instead of maintain it? Ellwood had an answer for this question. He said somebody (he didn’t say who) would be responsible for publishing “performance reports” on HMOs. These performance reports, he said, would scare HMOs into making sure that their doctors did not offer inferior medical care in response to the pressure of financial incentives, utilization reviewers, and high workloads. For a variety of reasons, primarily expense, this idea of “performance reports” was doomed from the beginning. Documents which actually tell consumers which HMO is better than another have yet to appear.

Despite the glaring flaws in Ellwood’s HMO proposal, his logic persuaded Nixon. The following statement to Congress in 1972 by Elliot Richardson, Nixon’s Secretary for the Department of Health, Education, and Welfare, indicates the Nixon administration had bought Ellwood’s logic lock, stock and barrel: “HMOs have a strong financial interest in preventing illness, or failing that, in treating it in its early stages, promoting a full recovery, and preventing any recurrences; they are motivated to function efficiently because they must stay within predetermined budgets.”¹¹ In 1973, at Nixon’s request, Congress passed the Health Maintenance Organization Act of 1973. This law subsidized the formation of the planet’s first HMO industry. As Table 2-4 indicates, the number of Americans enrolled in HMOs grew slowly during the 1970s, then soared in the 1980s. HMO enrollment peaked at 30.1 percent of the American population in 1999, then fell back to 30.0 percent in 2000. However, the vast majority of the remainder of the

Table 2-4: Enrollment in HMOs grew rapidly after 1985: Enrollment in HMOs, selected years, 1976 to 1997

| | 1976 | 1980 | 1985 | 1990 | 1995 | 1997 | 1999 |
|--|------|------|------|------|------|------|------|
| Number (millions of people) | 6.0 | 9.1 | 21.0 | 33.0 | 50.9 | 66.8 | 83 |
| As a percent of US population ³ | 4 | 7 | 13 | 19 | 25 | 30 | |

Sources: Centers for Disease Control, <http://www.cdc.gov/nchswww/fastats/pdf/hu98t135.pdf> for 1976 data, and <http://www.cdc.gov/nchs/products/pubs/pubd/hus/tables/2001/01hus147.pdf>, for all subsequent years, accessed October 2, 2002.

nonelderly insured were insured by companies that used at least some of the cost-cutting tactics of HMOs.

Why would people enroll in HMOs if HMOs restricted their choice of doctor, encouraged doctors to deny services, and worked their doctors harder? Answer: people saved money, either for themselves or their employers. For the last ten to 15 years, HMO premiums have tended to be 5 to 10 percent lower than the premiums of traditional insurance companies. Why? Because HMOs enrolled healthier people, they provided fewer services, they shifted costs onto the taxpayer, and they extracted discounts from hospitals and drug companies that traditional insurers could not get (see Chapter 9).

The vast majority of those who enrolled in HMOs were people who used to have insurance from a traditional insurance company. As traditional insurers like Prudential and Blue Cross Blue Shield watched their customers leave for HMOs, they began to adopt utilization review so that they could cut services as HMOs had. Some traditional insurers even set up their own HMOs. In Minnesota, for example, Blue Cross Blue Shield created an HMO called Blue Plus. Traditional insurers also began to experiment with bonuses. Bonuses would go to doctors who kept health-care use under certain levels.

By the late 1980s, the cost-control techniques pioneered by HMOs – financial incentives for doctors (capitation and bonuses), utilization review, and heavier workloads – had come to be known collectively as “managed care.”⁸ As traditional insurers began to adopt managed care tactics, health policy experts began referring to health insurance companies that used any form of managed care, including HMOs, as “managed care insurers” or “managed care plans” (MCPs). (For reasons I never understood, the word “plan” replaced the words “policy” and “company” some time in the late 1980s or early 1990s.) Experts reserved the phrase HMO for MCPs that restricted the patient’s

⁸ Jacob Hacker and Ted Marmor report that the phrase “managed care” does not appear in either of two widely read histories of the U.S. health care system published in the early 1980s – Paul Starr’s lengthy 1982 history of the U.S. health-care system, *The Social Transformation of American Medicine*, and Lawrence Brown’s 1983 book, *Politics and Health Care Organizations*. According to Hacker and Marmor, the phrase “managed care” first appeared in the *New York Times* in 1985, but it was not used frequently until the early 1990s. The *Times* mentioned the phrase 27 times in 1990, 287 in 1994, and 587 times in 1998 (“The misleading language of managed care,” *Journal of Health Policy, Politics, and Law* 1999;24:1033-1043).

choice of doctor. In the professional health policy literature, an HMO is defined as an MCP that tells its enrollees which doctors it can see and which they can't see; patients are not free to pay a little more and see any doctor they want. Non-HMO MCPs, on the other hand, either give their enrollees complete freedom to pick their doctors, or, at worst, they give their enrollees financial incentives to stay within a particular network of doctors. However, even in those MCPs which use financial incentives to keep patients within a limited panel of doctors, enrollees are free to see any doctor they want if they're willing to make a higher co-payment or accept a lower reimbursement rate. Reporters and the public generally don't make any distinction between HMOs and other types of MCPs. For the media and the public, any insurance company that uses managed care is an HMO. In this book, I will maintain the experts' distinction between HMOs and non-HMO MCPs.

In the early 1990s, enrollment in all types of MCPs soared. In January 1993, Ellwood announced the victory of the MCP juggernaut. "Indemnity insurance is essentially dead," he said, "and it was HMOs that did it."⁹ Today, roughly 95 percent of Americans who have insurance are insured by an MCP. Very few have traditional insurance.¹⁰ Among Americans over 64 insured by Medicare (which is 97 percent of all elderly), 12 percent were enrolled in MCPs as of 2002.

In addition to financial incentives, utilization review, and higher workloads, HMOs and other types of MCPs have relied heavily on extracting discounts from doctors, hospitals, and drug companies. However, many, perhaps most, observers who use the phrase "managed care" do not include discounting in their definition of "managed care." If there were a category known as "managed *cost*," perhaps discounting would fall into it.

The ascent of managed competition

Despite the rapid spread of MCPs in the 1980s, health insurance premiums rose at double-digit rates annually in the late 1980s and early 1990s. And as inflation rose, so did the number of uninsured. These developments called the entire HMO project into question, and had placed national health insurance and price controls back on the national agenda. In Minnesota, the Health Care Campaign of Minnesota was organized in April 1987 and I was hired as its first half-time organizer. In January 1989, David Himmelstein and Steffie Woolhandler, doctors at Harvard Medical School, published a call for a single-payer system in the *New England Journal of Medicine*.¹³ In December 1989, COACT and HCCM were among the first citizen groups in the country to endorse the single-payer proposal. By 1991, single-payer legislation had been introduced in several states and the U.S. House of Representatives. By 1994, according to *USA Today*, single-payer bills had been introduced in "more than a dozen" states.¹⁴

The burgeoning single-payer movement worried HMO advocates. As Michael Scandrett, then the director of Minnesota's HMO industry trade group, observed, single-payer "was the demon in the closet"¹⁵ – the bogeyman legislators and managed care advocates feared they would have to deal with if they didn't find a market-based solution to health-care inflation. Managed care advocates thought they found a solution in a theory called "managed competition." Economists and

⁹ "Indemnity insurance" is often used to describe the old-fashioned health insurance company that MCPs have virtually eliminated. These insurers would reimburse patients after patients had paid their medical bills. The formal term for reimbursing people who have incurred a cost or suffered a loss for which they are insured is to "indemnify" them.

¹⁰ Citing data from the Health Insurance Association of America (the trade group for non-HMO MCPs), Jacob Hacker and Ted Marmor report, "Only 2 percent of private health plans in 1997 conformed to the traditional model of fee-for-service indemnity insurance. Another 16 percent used fee-for-service payment but employed some form of utilization review. Thus between 80 and 98 percent of today's private health insurers appear to fall into the general category of managed care" ("The misleading language of managed care," *Journal of Health Politics, Policy and Law* 1999;24:1033-1043, 1036-1037).

MCP proponents Alain Enthoven, who invented the phrase “managed competition,”¹⁶ and Richard Kronick presented the theory in a two-part article published in the *New England Journal of Medicine* in 1989. The theory was a more elaborate version of Ellwood's “health maintenance strategy.” Like Ellwood, Enthoven and Kronick endorsed managed care and MCP “performance reports,” or “report cards” as MCP advocates began to call them in the early 1990s. But they said more than this was needed. They argued that the reason the rapid spread of MCPs hadn't reduced inflation was that competition between MCPs was not vigorous enough. Competition could be invigorated, they said, if it were “managed.” Specifically, they recommended that Congress eliminate tax subsidies for the purchase of health insurance in order to make consumers more “cost conscious,” and they recommended the formation of large purchasing coalitions so that consumers would have more negotiating clout with insurers.

As Jacob Hacker noted in his fascinating book about the demise of the Clinton plan, “By 1990 Enthoven and Paul Ellwood were worried. Both men were committed to a private-sector approach to health-care reform, and both feared that the government was on the verge of assuming broad regulatory authority over the medical system.”¹⁷ Something had to be done. As he had in 1970, Ellwood leaped forward to offer assistance to the managed-care industry and others who opposed a single-payer system. With the help of Enthoven and another four dozen conservative experts, corporate executives, health professionals, and politicians, Ellwood developed a more detailed managed competition proposal that formed the template for dozens of market-based bills introduced in Congress and state legislatures in 1993 and 1994.

Ellwood's project began in earnest in February 1990 when he hosted a four-day meeting at his home in Jackson Hole, Wyoming (where he had moved in the early 1970s). His guests discussed what Ellwood called “the crisis in the health-care delivery system.” The guests included executives of Aetna, Cigna, Travelers, Metropolitan Life, and Prudential (five large insurance companies that had begun to morph into MCPs); Bernard Tresnowski, the head of the Blue Cross and Blue Shield Association (which represented all the state-level Blues plans, many of which had also transformed themselves into MCPs); Senator Dave Durenberger (R-MN); and Enthoven.^{18,11} According to Hacker, who based his account of these and other Ellwood-hosted meetings on interviews with participants in these meetings, “All of [the participants] agreed with Enthoven and Ellwood's grim assessment of the situation, and all recognized that their interests were on the line. By the end of the four-day conference, the group had tentatively agreed to work with Enthoven and Ellwood to come up with a serious reform proposal.”¹⁹

Over the next 18 months, Ellwood, Enthoven, and a health policy consultant named Lynn Etheredge who had been asked to join the group by Blue Cross's Tresnowski, wrote several drafts of a managed competition proposal. After getting endorsement from the members of the group, which by 1990 was calling itself the Jackson Hole Group, the three men gave the paper the grandiose title, “The Jackson Hole initiatives for a Twenty-First Century American health-care system,” and submitted it to an economics journal. It was published in 1992.²⁰

Critics and supporters alike saw managed competition as an attempt to save the health insurance industry. Ellwood et al. warned that a government-financed and regulated system (read: single-payer) would result if readers did not endorse managed competition. “At stake is whether the Twenty-First Century American health system will be built around competitive markets,” they said.²¹

¹¹ In appendix B of his book, *The Road to Nowhere*, Jacob Hacker lists 51 participants in meetings of what came to be called the Jackson Hole Group held between 1990 and 1992 (*The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security*, Princeton University Press, Princeton, NJ, 1997). The *New York Times* said the total number of participants over the same time period was “about 100” (Robin Toner, “Hillary Clinton's potent brain trust,” February 28, 1993, A1). Thirty-two people were listed as “Jackson Hole participants” at the end of the Jackson Hole Group's 1992 paper in *Health Economics*.

“Managed competition is a last-ditch effort to preserve a role for the insurance industry in health care,” said Dr. Steffie Woolhandler, a leader of the U.S. single-payer movement.²²

The publication of the Jackson Hole Group’s paper in the first issue of an obscure journal of economics did not make headlines. What catapulted managed competition into the headlines was the endorsement of the theory by presidential candidate Bill Clinton in the fall of 1992. The Clinton-Gore campaign used the phrase “managed competition” in a press release issued on October 8, 1992, the *New York Times* endorsed the concept on October 10, 1992, and Clinton uttered the phrase in the first presidential debate with George Bush and Ross Perot on October 12, 1992.

For roughly the next two years, managed competition was praised effusively by the small handful of Americans – mainly politicians, corporate executives, professors, and pundits – who dominated the health-care reform debate. The *New York Times*’ editorial page led the cheerleading. “The debate over health-care reform is over,” said the *Times* in an editorial published on October 10, 1992. “Managed competition has won. That outcome is . . . wondrous. . . .”²³ In 1993, state legislatures all over the country debated managed competition, and in the spring of 1993 the Minnesota and Washington legislatures enacted legislation based on the theory. In September 1993, President Clinton introduced his Health Security Act, a bill his advisors called “managed competition with a budget.” It included all the components of managed competition plus an “employer mandate” (a phrase which means employers would be required to pay for insurance for their employees), but it also required the health-care system to operate within a budget, which, in practice, meant premiums would be subjected to price controls.

Just as managed competition was gathering steam among politicians, enrollment in MCPs, the centerpiece of all managed competition proposals, shot up, primarily because small employers began to push their employees into MCPs as large employers had in the 1980s. Best of all, from the point of view of managed-care advocates, premium inflation began to drop rapidly in 1992 and didn’t stop dropping until 1996 (it fell from 10.9 percent in 1992 to 0.5 percent in 1996).²⁴ Managed-care advocates crowed that this reduction in premium inflation, coming concurrently with the unusually rapid increase in enrollment in MCPs in the early 1990s, was proof that MCPs were finally working as advertised and that managed competition would save the nation from its health-care crisis. Politicians, health policy experts, and reporters universally agreed. Managed competition advocates that I knew in Minnesota were in seventh heaven during 1993 and 1994.

The fall of managed competition and managed care

But the establishment’s infatuation with managed competition changed to ambivalence during the mid-1990s. For the elite, managed competition first began to lose its luster with the death of Bill Clinton’s plan in the fall of 1994. The bill, which had been greeted with so much enthusiasm by health policy experts, large employers, and politicians in 1993, was on life support by the spring of 1994, and pronounced dead by Senate Majority Leader George Mitchell (D-ME) on September 26, 1994. In 1995, the legislatures of Washington and Minnesota repealed substantial chunks of the managed competition bills they had enacted just two years earlier. During 1995, managed competition rapidly disappeared from the media’s radar.

To make matters worse, *public* opinion about MCPs deteriorated rapidly beginning approximately in 1995. Public opinion of managed care had never been good – polls taken in the late 1980s and early 1990s indicated a majority of the public opposed managed-care cost-control tactics (see Chapter 8). But after 1995, public opinion became increasingly hostile. By 1996, consumers and doctors were in open revolt against the new MCP-dominated system. The revolt, dubbed the “HMO backlash” by the media, was manifested not just in polling data, but in a blizzard

of “HMO horror stories” in the media, legislation introduced in state legislatures and Congress to protect patients from MCPs, lawsuits by doctors and patients against MCPs, and an endless stream of popular invective against “HMOs” in the media, late-night comedy routines, cartoons, movies, novels, and everyday conversation.

The great MCP juggernaut might have survived these stormy seas if it had been able to keep premium inflation low. After all, it was the HMO advocates’ promise of cost reduction, not their promises “of health maintenance,” that sold the HMO project to the business community, Congress, and Nixon in the first place. Between 1992 and 1996, health-care inflation cooled, and advocates claimed that managed care, if not managed competition, deserved all the credit. Enthoven, for example, announced in 1997 that “there is no explanation [for the drop in inflation] except competitive markets and managed care.”²⁵ The *New York Times*’ editors, who had so eagerly promoted managed competition in 1992 and 1993, also attributed the inflation lull to managed care companies. “The rise of managed care has brought . . . a surprisingly swift deceleration of health-care inflation,” said the editors in October 1997.²⁶ By early 1998, *U.S. News and World Report* was still under the illusion that MCPs saved money. “The mounting complaints about HMOs have tended to obscure the genuine gains that have occurred in the managed-care era . . .,” wrote reporter Susan Brink. “Thanks to managed care, most Americans have more money in their pockets [and] more companies can afford to provide health benefits to employees.”²⁷

But by 1997, it was clear to more perceptive observers that “competitive markets and managed care” were losing the war against inflation. “Health care costs edging up and a bigger surge is feared,” announced a *New York Times* headline in January 1997.²⁸ “Price surge on the way,” said a headline in *Modern Healthcare* in June 1997.²⁹ By 1999, even the unperceptive could read the writing on the wall: Premium inflation had returned and relief was nowhere in sight. “[I]f the system of managed care no longer manages costs, what sort of future does it have?” asked the *Wall Street Journal* in 1999. By 2000, premium inflation had returned to double-digit levels. Because underlying inflation remained very low, real premium inflation levels approximated the real premium inflation levels of the late 1980s and early 1990s that preceded the 1992-96 inflation lull. By 2000, a substantial portion of the experts – the politicians, large employer representatives, academicians, and pundits – who had so enthusiastically promoted managed competition eight years earlier were discussing what sort of system would replace the MCP-dominated system.

Although the insular health policy community (the professors and think-tank experts who write for journals like *Health Affairs* and *Health Services Research*) continued to assert that tinkering with the MCP industry would fix it (the most common tinkering suggested was the ever-popular and ever-elusive MCP report card), and although Republicans persisted in promoting managed competition as the solution to the alleged “crisis” in the Medicare program, Democrats and most employers and pundits had, by 2000, ceased promoting managed competition. “I’m not as sure as everybody else is about managed care any longer,” said Donna Shalala, Clinton’s Secretary of Health and Human Services at the end of Clinton’s term. “And I started out as their biggest fan.”³⁰ “The protagonists of managed care now are in full retreat,” wrote managed care advocate James Robinson in an article entitled, “The end of managed care,” in the *Journal of the American Medical Association* in 2001.³¹ In an interview with the *Los Angeles Times* in 2001, George Lundberg, the former editor of the *Journal of the American Medical Association* who as recently as 1996 had co-authored an article with Paul Ellwood defending managed care, offered this caustic assessment of managed care:

Managed care is basically over. People hate it, and it's no longer controlling costs. Health-care inflation is now back in the double digits. So if it's not saving money, then why should we have it? But like an unembalmed corpse decomposing, dismantling managed care is going to be very messy and very smelly, and take awhile.³²

As 2001 came to a close, Art Caplan, the director of the Center for Bioethics at the University of Pennsylvania and, in the early 1990s, an advisor to Hillary Clinton, observed, "Events of the past year demonstrate beyond a doubt that managed care has failed – and failed dismally. The greatest single ethical crisis facing American health care as we move into the new year is what to do about it."³³

The most astonishing condemnation of the new system came from Paul Ellwood himself. On May 2, 1999, the *Boston Globe* published an article describing some scathing remarks Ellwood made at a conference at Harvard University the previous day. Ellwood hammered the quality of medical care provided in America – he called it a “national disgrace” – and repudiated his long-held belief that competition between HMOs and other MCPs would maintain or improve quality. The *Globe* paraphrased Ellwood saying that would “never” happen. “We thought in proposing the HMO idea that they would respond to both price and quality demands,” Ellwood was quoted as saying. They didn’t, he said; they responded only to price and let quality deteriorate. “Ultimately, this thing is going to require government intervention,” said Ellwood. “The question is what form government intervention will take.” Ellwood told the audience his change of heart stemmed from personal experience. He said he had fallen off a horse recently and crushed a vertebra in his neck (an injury that can paralyze and kill). The article continued:

The fact that Ellwood is not paralyzed today, he said, is no thanks to the care he received. He recounted a series of near-miss medical adventures that could well have left him paralyzed. Encountering a young neurosurgical resident, Ellwood was immediately commanded to stand up – a potentially disastrous maneuver. “But I did it,” he said. “I was sedated – and he was a doctor. When you’re a patient you’re vulnerable and the power slips away from you.” That night, the protective collar he was wearing came off, “and the nurses didn’t know how to put it back on.” The next day, the surgeon said he didn’t need a special surgically installed brace to immobilize his head and refused to install it when Ellwood insisted.

Ellwood reached this conclusion: “Patients can get just atrocious care and can do very little about it.”³⁴ When I read these words, I shook my head and wondered, “Why do some guys literally have to fall on their heads before they understand how the world works?”

In 1996, Ellwood told a similar story to Lisa Belkin, a reporter with the *New York Times Magazine*. He said he required surgery “some time ago” (the article did not indicate what type of surgery), and he was surprised to learn that his surgeon intended to perform the procedure on an outpatient basis, that is, without hospitalizing him overnight after the surgery. He said that his doctor sent him home while he was still under the effects of anesthesia and, of course, suffering the pain homo sapiens feel when they have been cut with a sharp knife. On the way home in a car driven by a friend, Ellwood began to experience nausea, dizziness and vomiting, all of which are common side effects of surgery and which, in days of yore, were considered common enough to hospitalize patients who had undergone surgery. “I had to decide whether to go back to the hospital

¹² The *Globe* reported that Ellwood said he had been treated by “fee-for-service doctors working in an institution that was part of a national for-profit hospital chain,” but that Ellwood also said “care is no better in prepaid health plans, or HMOs, and that the idea that such plans would compete on quality has not worked as he thought it would.” To imply, as the *Globe* and Ellwood did, that a fee-for-service sector, free of MCP influence, existed in the U.S. in 1999 was misleading. By then, true fee-for-service medicine was virtually nonexistent in the U.S. The accurate description of Ellwood’s doctors and nurses is, almost certainly, that they were working in a hospital which, like hospitals all over the country, had gutted its RN staffs and put pressure on their doctors to deny care in order to look good to MCPs they sought contracts with.

to die or to go on home to die,” Ellwood joked, “so I decided to come on home to die.” When he returned to see his surgeon for a checkup, he told the surgeon what had happened to him. “The guy got this little smile on his face,” Ellwood said. “Then he leaned in real close and looked me right in the eye [and said, pausing for emphasis between every word], ‘Ellwood . . . it’s . . . your . . . own . . . damn . . . fault.’”³⁵

How the system is financed

While the managed care revolution was transforming the U.S. health-care system, another significant but less visible change was occurring: The government was paying for a larger and larger portion of the U.S. health-care bill. As Table 2-5 indicates, taxes financed 60 percent of total health-care spending in the U.S. in 1999, up from 31 percent in 1965, the year Congress enacted the Medicare and Medicaid programs. Not surprisingly, the table indicates the most important reason for this change was the enactment of the Medicare and Medicaid programs.

The fact that taxes pay for 60 percent of our health-care bill surprises most people. Our health-care system is usually described as an “employer-based system,” and statistics indicate that a majority of Americans have been insured through employer-sponsored health insurance for about the last four decades. As of 1999, 63 percent of

Table 2-5: Our taxes pay for 60 percent of health-care spending: Percent of national health-care spending paid for by taxes, 1965 and 1999

| | <u>1965</u> | <u>1999</u> |
|---------------------------------|-------------|-------------|
| Medicare | 0% | 18% |
| Medicaid | 0% | 15% |
| Other health programs | 25% | 12% |
| Public employee health benefits | 1% | 5% |
| Tax subsidies | 4% | 9% |
| Total tax-financed * | 31% | 60% |

* Total percent figures do not equal the sum of the columns due to rounding.

Source: Steffie Woolhandler and David U. Himmelstein, “Paying for national health insurance – and not getting it,” *Health Affairs* 2002;21(4):88-98, Exhibit 2.

Americans got their health insurance through an employer.³⁶ So how can taxes account for 60 percent of total health-care spending? There are several answers.

First, government programs insure sicker people than the American employers do. Medicare, the largest government health insurance program in the country, is an obvious example. Medicare insures the most expensive sectors of the population, namely, the elderly and the disabled. Ninety-seven percent of all Americans aged 65 and over are insured through Medicare. Unlike the private sector, Medicare cannot pick and choose who it will insure.

Second, one-fifth of all workers are employed in the public sector and, therefore, have their insurance paid for by taxes.³⁷ If, for some reason, you wanted to treat public employees as part of the pool of Americans who receive “employer-sponsored” insurance, the proportion of the total U.S. health-care bill paid for by taxes would drop from 60 percent to 55 percent.

Finally, employers who offer insurance, and employees who accept it, get tax breaks.¹³

The remaining 40 percent of health-care spending is paid for by employers and individuals. If you add up what individuals pay in the form of out-of-pocket expenditures (money spent on medical services not covered by health insurance) and in premiums (including not only the premiums individuals pay when they buy individual insurance, but the 20 to 30 percent of employer-sponsored premiums that employees pay), individual pay roughly half of the 40 percent that taxes don't pay for, and employers pay for the other half.

History review and a peek at the future

So there you have it. As of 2001, 15 percent of us had no insurance, and the great majority of the other 85 percent had insurance through an HMO or other type of MCP. Our jerry-built health insurance system is only 70 years old, which is fewer years than the average American life span today, but during those seven decades the system has undergone rapid, at times even tumultuous, change. To recapitulate, here are the major phases our system went through.

Blue Cross (hospital) and Blue Shield (physician) companies sprang up during the 1930s. For-profit insurance companies, seeing the Blue Crosses and Blue Shields succeed, started selling health insurance in the late 1930s.

Employers started offering health insurance as a fringe benefit during the 1940s, which accelerated the spread of health insurance. By the 1950s two-thirds of Americans had basic hospital and physician coverage.

But the poor and elderly were not served by the new insurance industry, so Congress enacted Medicare and Medicaid in 1965. While Medicare and Medicaid made huge reductions in the percentage of Americans with no health insurance, they added, temporarily, to the medical inflation rate.

In response to the increase in health-care inflation, Nixon and Congress subsidized the world's first HMO industry, and HMOs began taking market share from the traditional insurers, slowly in the 1970s and rapidly in the 1980s.

The spread of HMOs caused both the nonprofit (Blue Cross and Blue Shield) and for-profit sectors of the traditional insurance industry to adopt HMO cost-control tactics and change into managed care plans. Between 1985 and 1995, MCPs took over the insurance industry. Between 1989 and 1992, managed competition rose from nowhere to become the nation's de facto health policy.

But the death of Clinton's managed competition bill in 1994, the rise of the consumer backlash against managed care in 1996, and the return of premium inflation in the late 1990s spelled the end for managed competition, and dealt a body blow to the MCP industry.

At the dawn of the new millennium, the American health-care system was unstable. Even experts who had vigorously defended MCPs against the backlash were acknowledging that the tension between patients, doctors and employers on the one hand and MCPs on the other could not go unresolved forever – that change in the system was inevitable. But there is nothing resembling a consensus on how substantial that change will be nor on what will take the place of MCPs if the MCP industry disappears or is transformed. There is a consensus among experts, and substantial agreement among even health-care professionals, that we can't go back to the old system of

¹³ Employer-sponsored insurance is exempt from income and payroll taxes; employees whose employers offer them "flexible spending accounts" (accounts that employees use to pay for medical expenditures not covered by their insurance) don't pay taxes on the money they put into those accounts; and individuals, employed or not, can deduct medical costs in excess of 7.5 percent of their adjusted gross income.

traditional insurance that MCPs replaced because that system, like today's MCP system, was too expensive.

I believe expenditure controls on doctors, hospitals, and drug companies are inevitable, and that odds are high that America will adopt a national health insurance program based on the single-payer, Medicare-for-all model, especially if meaningful campaign finance reform is enacted. I predict, however, that, before we implement price controls and a single-payer system the U.S. will go through a phase in which we experiment with tax credits and medical savings accounts (or other types of insurance policies with big deductibles). I predict the entire process will take somewhere in the range of one to three decades. I think three decades is the outer limit because of the large number of baby boomers who will be needing health care by then. The elderly cost a lot more to take care of than the nonelderly. If this nation hasn't figured out how to provide health care efficiently before the boomers turn gray, the pressure for price controls and a Medicare-for-all system will be at an all-time high, and the credibility of those who said managed care, large deductibles, or tax credits could solve the problem will be at an all-time low.

3

Evidence That the U.S. Health-care System Is Failing

Evaluating health-care systems

If you were asked to come up with a list of criteria with which to evaluate a nation's health-care system, what would they be? When I first started studying the U.S. system 15 years ago, I had three simple criteria: cost (are costs excessive?), access (does everyone have access to necessary health services?), and quality (are the services we're getting high quality?). In the course of fighting the takeover of our health-care system by MCPs during the 1990s, I adopted two more criteria: privacy (are patient medical records available to third parties without patient consent?), and democracy (have insurance companies, hospital chains, and pharmaceutical manufacturers become so powerful that a thorough debate about health-care reform is impossible?).

By any of these measures, the U.S. health-care system is a mess. Costs are extremely high, the number of uninsured is high and growing, quality is declining, medical privacy is a thing of the past, and democracy has been corrupted thanks to the huge companies that have taken over our health-care system and the money they have rained on Congress, state legislatures, state and federal regulators, and colleges and universities. In this chapter I will focus on the first two criteria – cost and access. I'll deal with the quality issue at more length in Chapters 5 and 9. I'll discuss the destruction of privacy and the corruption of democracy briefly in Chapter 11.

The U.S. health-care system costs a bundle

The first thing most people think of when you ask them whether they think health care is affordable is the high cost of health insurance premiums. Table 3-1 shows the results of a survey of employers in 40 states in which employers were asked how much they paid in 1996 for family coverage (coverage for an employee plus dependents, typically two or three dependents) and single coverage (coverage just for the employee). The average for the country was just under \$5,000 for family coverage and just under \$2,000 for single coverage. These figures include both the employer's and the employee's contributions to the premiums (employers paid 71 percent of family premiums and 83 percent of single premiums in 1996). By 2002, total family premiums (that is, the total of the employer's and the employee's share) had hit \$8,000 a year and single coverage had reached \$3,000 a year.³⁸ Don't forget, premiums for people who buy insurance on their own (that is, separate from a group of employees) are usually much higher than the premiums employers pay. When we discuss the futility of tax credits in Chapter 10, we will encounter some outrageous premiums for people buying individual policies.

But money that employers and individuals pay to insurance companies in the form of premiums is not the only way Americans pay for health care. As we saw in the last chapter, we also pay two other ways: We pay taxes to support government insurance

Table 3-1: Health insurance is expensive: Premiums paid for employer-sponsored health insurance in selected states,* and 40-state average, 1996, \$s

| State | CO | FL | MA | MN | NY | OK | OR | SC | WA | 40-state avg |
|--------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------------|
| Family | 4,740 | 4,988 | 6,016 | 5,026 | 5,360 | 4,607 | 4,462 | 4,041 | 4,468 | 4,953 |
| Single | 1,912 | 1,910 | 2,316 | 1,953 | 2,183 | 1,737 | 1,992 | 1,568 | 1,905 | 1,997 |

* Of the 40 states included in this survey, I selected these nine states because they varied by region and by how dominated they were by MCPs. Massachusetts, the state with the highest family premiums and second-highest single premiums among the 40 surveyed, is heavily penetrated by MCPs. On the other hand, South Carolina, the state with the lowest family premiums, had a low MCP-market-penetration rate. Minnesota, a state where the health-care system is as controlled by MCPs as any in the country, and the state where the phrase “health maintenance organization” was invented, had premiums near the national average.

Source: James E. Branscome et al., “Private employer-sponsored health insurance: New estimates by state,” *Health Affairs* 2000;19(1):139-147.

programs (such as Medicare and Medicaid), and we pay “out of pocket,” that is, we pay out of our own wallets, purses, and bank accounts for medical care that is not covered by insurance. A medical expenditure can be uncovered and, therefore, require an out-of-pocket payment (a) because we don’t have insurance, (b) because we have insurance but it doesn’t cover what we need (for example, we need a prescription drug but our insurance doesn’t cover drugs), or (c) because we have insurance that covers what we need but we have to pay a “co-payment” (for example, the first \$15 of a prescription refill) or a “deductible” (for example, the first \$500 of our medical expenses per year).

When we add up these three types of expenditures – premiums, taxes, and out-of-pocket payments – over the course of a year, we find that the U.S. currently spends about \$1.5 trillion annually on health care (see Tables 2-3 and 3-2). As Table 3-2 indicates, just over half of this sum goes to hospitals (32 percent) and doctors (22 percent). Expenditures on nursing homes and prescription drugs constitute the third and fourth largest types of expenditures.

Most people have little occasion to think in terms of trillions of dollars. So, to make this more manageable, let’s break this gargantuan national health-care bill down into costs per American. In 1998, the U.S. spent \$4,270 per person on health care. How high is that? As Table 3-3 indicates, that’s extremely high by world standards. You see that Switzerland, the nation with the world’s second-most expensive health-care system, spent just \$2,740 in 1998, a third less than the U.S. did. Luxembourg, the nation with the third-most expensive system, spent only \$2,440, which is 54 percent of the U.S. figure. Fourth-place Germany spent 56 percent of the U.S. amount, fifth-place Canada spent 53 percent, and sixth-place Iceland spent 51 percent. The other 17 countries listed spent less than half what the U.S. spent.¹⁴

Another way to measure health spending is as a percent of Gross Domestic

¹⁴ The 23 countries listed in Table 3-3 are all members of the Organization for Economic Cooperation and Development headquartered in Paris. The OECD, which collects and publishes economic and demographic data on member nations, currently consists of 23 industrialized nations and six developing nations with close ties to the West.

Table 3-2: Hospitals and doctors account for half all health expenditures: National health expenditures, 1970 and 2000, billions of dollars

| Category of expenditure | 1970 | 2000 |
|--|------------|-----------------------|
| Personal health care | | |
| Hospital care | 27.6 (38%) | 412.1 (32%) |
| Physician services | 14.0 (19%) | 286.4 (22%) |
| Prescription drugs | 5.5 (8%) | 121.8 (9%) |
| Nursing home care ^(a) | | 4.2 (6%) 92.2 (7%) |
| Dental services | 4.7 | 60.0 |
| Other professional services | | 0.7 39.0 |
| Other personal health care | | 1.3 36.7 |
| Home health care | 0.2 | 32.4 |
| Nondurable medical equipment | 3.3 | 31.2 |
| Durable medical equipment | 1.6 | 18.5 |
| Subtotal | 63.2 | 1,130.4 |
| Insurance overhead (gov. and private) ^(b) | 2.8 | 80.9 |
| Public health activities (gov.) | 1.4 | 44.2 |
| Research ^(c) | 2.0 | 25.3 |
| Construction | 3.8 | 18.6 |
| Total | \$73.1 | \$1,299.5 |

(a) Nursing homes only. Additional long-term care services provided in hospital-based facilities are counted as hospital care.

(b) These numbers are for insurance overhead (or administrative costs) only. They do not include the overhead costs of hospitals, doctors and other providers.

(c) Research expenditures on drugs are excluded from “research” and instead are included in the “prescription drug” category.

Source: Katharine Levit et al., “Inflation spurs health spending in 2000,” *Health Affairs* 2002;21(1):172-181.

Product. GDP is a measure of the total income of a nation. (We have already encountered this measure. Recall that in Chapter 2 I said the U.S. spent 4 percent of its total income on health care in 1929, about 4 percent in 1948 when Harry Truman campaigned for national health insurance, 7 percent in 1970, and 14 percent today.) Table 3-3 indicates that 14 percent is extremely high. Only two other nations listed in the table spent more than 10 percent of their incomes on health care.

Table 3-3: U.S. costs are the highest in the world: Spending on health care by 23 industrialized nations, 1998

| Country | Percent of GDP spent on health | Per capita spending (in U.S. dollars) |
|----------------|-----------------------------------|--|
| United States | 14.0 | 4,270 |
| Switzerland | 10.2 | 2,740 |
| Luxembourg | 7.0 | 2,440 |
| Germany | 10.6 | 2,400 |
| Canada | 9.3 | 2,250 |
| Iceland | 8.3 | 2,190 |
| France | 9.6 | 2,120 |
| Denmark | 8.0 | 2,100 |
| Norway | 7.5 | 2,090 |
| Australia | 8.7 | 2,040 |
| Netherlands | 8.6 | 2,030 |
| Austria | 8.3 | 2,000 |
| Belgium | 7.6 | 1,850 |
| Sweden | 8.6 | 1,820 |
| Japan | 7.4 | 1,780 |
| Italy | 7.6 | 1,660 |
| Finland | 7.4 | 1,600 |
| United Kingdom | 6.9 | 1,450 |
| New Zealand | 8.0 | 1,440 |
| Ireland | 6.1 | 1,390 |
| Greece | 8.7 | 1,270 |
| Spain | 7.5 | 1,240 |
| Czech Republic | 7.2 | 950 |

Source: Organization for Economic Cooperation and Development (OECD), reported in Gerard F. Anderson et al., "Health spending and outcomes: Trends in OECD countries, 1960-1998" *Health Affairs* 2000;19(3):150-157, Exhibit 1.

Access: Tens of millions are uninsured and underinsured

The extraordinarily high cost of the U.S. system looks even worse when you consider that the U.S. is the only nation in the industrialized world other than South Africa that permits large numbers of its citizens to go without health insurance. If the roles were reversed, you might understand how the U.S. could spend twice what the rest of the First World spends on health care per person. But the roles are not reversed. It's the U.S. that insures only 85 percent of its citizens; it's the rest of the industrialized world that insures 100 percent of its citizens.

In the course of my public speaking and lobbying, I have heard opponents of universal coverage claim that there is no need for a universal health insurance plan because the uninsured got medical care whenever they need it. Those who make this claim never offer any proof of it. If they offer any justification at all, they cite the fact that most doctors and all hospitals offer some "charity care" to poor patients. The unspoken assumption is that "charity care" is available to anyone who needs it, and charity care is the equivalent of "good care." I want to take a minute to address these assumptions because, if they're true, then what I just said about the U.S. looking even more

expensive if you take the uninsured into account isn't true. Is it true that uninsured people get adequate medical care when they need it?

The research indicates unequivocally that uninsured people get fewer medical services than insured people, and when they do get care, it is often delayed or in some other way inferior. "Not having health insurance does make a difference," wrote Dr. Steven A. Schroeder in the pages of the *New England Journal of Medicine*. "Those who have it are likely to receive more and better health care. Those who do not have it are more likely to delay obtaining necessary, even lifesaving care."³⁹ Here is just one example. Researchers at Harvard reported that breast cancer in uninsured women is more advanced at the time it is first diagnosed than it is in insured women, and that uninsured women are more likely to die within the 7.5 years after diagnosis than insured women. The first finding implies that uninsured women are less likely to see a doctor or get a mammogram (a fact confirmed by other studies). The second finding was based on a comparison of insured and uninsured women with similar stages of cancer at diagnosis (that is, early versus late stage), so the conclusion that uninsured women are more likely to die implies the uninsured women got treatment inferior to that of insured women after their diagnosis.⁴⁰

Data from one of the latest and best studies on this issue are shown in Table 3-4. This table indicates that uninsured people with chronic illnesses see doctors less often than do insured people with chronic diseases. The huge differences in visit rates for people with heart disease are especially disturbing. Table 3-5 confirms Table 3-4's findings on doctor visits, and also indicates that the uninsured are more likely to delay getting care and are slightly more likely to use emergency room services. Emergency room services are the only category of medical services that the uninsured use more of. This is probably due to the fact that most citizens know hospitals have to treat seriously ill patients if they show up in the ER, with or without insurance. It is no doubt also due to the fact that delay in seeking care raises the risk that a nonurgent health problem will become an emergency. Table 3-6 presents data from another study indicating the

Table 3-4: The uninsured see doctors less often: Doctor visits per person per year by the insured and uninsured, chronically ill, nonelderly, 1996

| | Insured | Uninsured |
|-------------------------------|---------|-----------|
| People with heart disease | 9.0 | 2.9 |
| People with hypertension | 10.0 | 7.4 |
| People with arthritis | 10.7 | 7.9 |
| People with chronic back pain | 10.2 | 8.3 |

Source: Families U.S.A, *Getting Less Care: The Uninsured with Chronic Health Conditions*, 2001, Washington DC.

Table 3-5: The uninsured see doctors less often, go to ER's a little more often, and delay care more often: Differences in access to health care between Minnesota's insured and uninsured, 1995

| | Group* | Individual* | Uninsured |
|---|--------|---------------------|-----------|
| Percent delayed getting care in last 12 months | 11.5 | 11.8 | 38.5 |
| | | Percent with doctor | |
| visit in last 3 months | 54.2 | 42.7 | 28.8 |
| Percent with emergency room visit in past 12 months | 14.8 | 10.3 | 15.9 |

* “Group” means insured as part of a group, typically at the place of employment. “Individual” means insured through a policy purchased by an individual.

Source: Kathleen Thiede Call et al., *Minnesota Health Care Insurance and Access Survey, 1995*, Institute for Health Services Research, University of Minnesota, Minneapolis, MN, Aug/USSt 1996.

Table 3-6: The uninsured delay seeking care more often: Percentage of insured and uninsured hospitalized patients who delayed* obtaining care.

| | | | |
|-----------------------|------|----------|------|
| Uninsured poor | 33.3 | | |
| All uninsured | | 23.9 | |
| | | Medicaid | 22.7 |
| HMO | 18.2 | | |
| Traditional insurance | 15.7 | | |

* Delay was defined by the patients. They were asked, “[D]o you feel that you delayed seeing a doctor or other medical person longer than you should have?” Patients who delayed getting medical attention were in the hospital about 9 percent longer than patients who said they did not delay.

Source: Joel S. Weissman et al., “Delayed access to health care: Risk factors, reasons, and consequences,” *Annals of Internal Medicine* 1991;114:325-331.

uninsured are more likely to delay getting care; 24 percent of the uninsured said they delayed getting care compared to 16 percent of the insured.

So research has demonstrated that the uninsured get fewer services, but does that difference damage the health of uninsured people? Studies of this question are a lot fewer than studies that simply asked whether uninsured people get fewer services, but they all point in the expected direction: Lack of insurance is a health risk.⁴¹ A recent example of such a study examined differences in health status among insured and uninsured adults aged 51 to 61. The study found that the uninsured adults were 1.6 times more likely to suffer a “major decline” in health between 1992 and 1996 than the insured were.⁴² After reviewing the literature on this question, the Institute of Medicine stated bluntly: “Adults without health insurance coverage die sooner and experience greater declines in health status over time than do adults with continuous coverage.”⁴³

The people who say America’s uninsured get all the medical care they need are dead wrong. The uninsured do get medical care, but it’s a lot less, perhaps a third less in terms of expenditures,

than the insured get,¹⁵ and it is often delayed. And the consequence of this inferior care is inferior health.

But you don't have to be completely uninsured to forgo necessary health care for financial reasons. A large body of research indicates that even copayments and deductibles will cause many people to delay or forgo needed services, including services needed for serious symptoms.⁴⁴ And, of course, pre-existing condition exclusions and the failure of an insurance policy to cover a certain type of health-care service are even more inhibiting than deductibles or copayments. Drugs, mental health services, and long-term care are the most prominent examples of services left out of insurance policies. The effect of the drug coverage gap on patient behavior is significant. Medicare beneficiaries with prescription drug coverage bought 24.35 prescriptions in 1998 compared with 16.65 purchased by beneficiaries without drug coverage.⁴⁵ Those without drug coverage are an example of the "underinsured."

I have never seen a study that attempted to measure the total number of underinsured in the U.S. The few studies I have seen measured the number of *nonelderly* underinsured. The most widely cited of these studies concluded that 29 million nonelderly insured Americans were underinsured in 1994. The authors defined "underinsured" to mean having insurance that exposed the insured person to "out-of-pocket expenditures in excess of 10 percent of family income in the event of a catastrophic illness."⁴⁶ They noted that the percent of underinsured among the nonelderly had increased substantially since 1977 because the value of typical catastrophic coverage had not kept up with the cost of health care.

If we define long-term care as a form of health care to which all Americans should have access, the number of underinsured is far greater than 29 million. Long-term care is not covered by a typical health insurance policy. Long-term care coverage is sold in separate policies, and only 5 percent of Americans have such policies. Medicare, contrary to many people's impression, covers very little nursing home care. Medicare will pay for up to 100 days in a nursing home per year, but only if you've been hospitalized first. And in today's managed care world, you have to be at death's door to get admitted to a hospital. The nation's so-called safety net for nursing home costs (which are in the range of \$40,000 to \$80,000 per year) is not Medicare, but rather Medicaid, which, by definition, is not insurance. Medicaid is not insurance because you have to impoverish yourself to become eligible. If we include long-term care in our definition of health insurance, we may say 95 percent of us are underinsured.

The figures in Table 3-7 suggest that a substantial portion of the elderly are among the underinsured even though 97 percent of them are covered by Medicare. The table indicates that the elderly were paying 19 percent of their total incomes for health care (not counting long-term care) in 1965, the year before Medicare began, and that this percentage fell to 11 percent in 1968. But at the turn of the century it was at 19 percent, and is expected to rise rapidly over the first quarter of the 21st century. I'm sure a

Table 3-7: Out-of-pocket health costs for the elderly, selected years

¹⁵ In a report to Congress which, among other things, estimated the cost of insuring the uninsured, the U.S. General Accounting Office stated that per capita health expenditures on the uninsured were about 60 percent of the expenditures on the insured (*Canadian Health Insurance: Estimating Costs and Savings for the United States*, Washington, DC, April 1992, 13).

| | 1965 | 1968 | 1977 | 1980 | 1984 | 1988 | 1998 | 2010 | 2025 |
|--|------|------|------|------|------|------|------|-------|-------|
| Percent of income paid for health care | 19 | 11 | 12.3 | 12.7 | 13.7 | 18.1 | 18.6 | 24.7* | 28.6* |

* Estimate.

Sources: Marilyn Moon, "Health policy 2001: Medicare," *New England Journal of Medicine* 2001; 344:928-931 (for years 1965 and 1968); U.S. Senate Special Committee on Aging, cited in David U. Himmelstein and Steffie Woolhandler, *The National Health Program Book*, 1994, 35 (for years 1977 through 1988); Marilyn Moon, *Growth in Medicare Spending: What Will Beneficiaries Pay?* Washington, DC, Urban Institute, 1999, Chart ES-1, vii (for years 1998 through 2025).

substantial portion of our elderly and disabled are in poverty because of the out-of-pocket expenses they bear, even though they have health insurance through Medicare.

Why our system is so expensive

The high cost of the U.S. health-care system is the cause of the health-care crisis. It is the cause of the growing number of uninsured and underinsured. It is the reason why out-of-pocket expenses are rising for the elderly. It is the reason why President Nixon, Congress and large employers pushed the country into our experiment with managed care, an experiment that has failed so badly it has created an "HMO backlash." It is a significant cause of our inability to find the political will to set up a national health insurance system to guarantee coverage to all Americans.

To prescribe a solution to any problem, one must first have an accurate diagnosis. In this case, we have to have an accurate diagnosis of the causes of the high cost of American health care. I devote the next four chapters to such a diagnosis. In the next two chapters I review common explanations for America's high costs that are either misleading or flat wrong. In Chapters 6 and 7 I lay out the evidence supporting my argument that waste in the health-care system is the real cause of the high cost of our system.

Let me begin my diagnosis by taking note of the simple fact total expenditures on anything, be it health care, pianos or Tiddly Winks, is a product of two numbers – volume and price. In the case of health care, the \$1.5 trillion dollars the U.S. spends annually is a product of the *volume* of medical goods and services sold times the *price* at which those goods and services are sold. Thus, the most basic question we can ask at the outset of our investigation is, Is *volume* of services the primary problem, or is *price* the main problem? Or, to put it another way, Is the problem primarily that too many medical services are being ordered (either because ignorant consumers demand them or greedy doctors promote them to ignorant consumers), or is the problem primarily that the price at which medical goods and services are sold are unnecessarily high?

Note what's at stake here. If *volume* is the problem, that's a strong argument either for "managing" health care with some or all of the managed care tools we talked about in Chapter 2 – financial incentives, utilization review, and rising workloads on health-care professionals – or imposing large deductibles on patients. If, however, *price* is the primary problem, that's a strong argument for not attempting to ratchet down volume (that is, leaving doctors and patients alone), and instead, concentrating on price reductions, that is, subjecting doctors, drug companies and

insurers to price ceilings, and hospitals to either price ceilings on their charges or, preferably, budgets.¹⁶

If you're a consumer, your self-interest should lead you to prefer the price-is-the-problem diagnosis. If *volume* turns out to be the primary problem, then you must be prepared to accept (a) limits on your freedom to choose the medical services you and your doctor think you need and/or (b) huge deductibles. However, if *price* turns out to be the primary problem, it's the supply-side – the clinics, hospitals, and drug companies – that must suffer limitations on their freedoms, in this case, their freedom to charge whatever they want. Conversely, if you're a doctor, hospital manager, drug company executive, or insurance company executive, your self-interest, narrowly defined, should lead you to prefer the volume-is-the-problem diagnosis.

Given the greater firepower of the doctors, hospitals, drug companies and insurers, it is no surprise that conventional wisdom in this country is that volume is the main problem. It was this conventional wisdom that led to the disastrous managed care experiment. The volume-is-the-problem claim is the most fundamental premise underlying managed care theology. It is also the fundamental premise underlying the right wing's endorsement of MSAs and employers' recent interest in insurance policies with large deductibles. The only difference between managed care theology and large-deductible theology is that managed care advocates believe volume is excessive because doctors are greedy, while large-deductible advocates believe volume is excessive because consumers are "overinsured."

The greater firepower of the doctors, hospitals, drug companies and insurers also explains why price is not talked about as the main problem and why price controls are not even on the table for discussion. As we will see in Chapter 8, the average American opposes managed care and, depending on the poll you read, either supports price controls or perceives prices to be excessive. But despite the public's position *against* managed care and *for* a solution that addresses excessive prices, the power of the doctors, hospitals, drug companies, insurance companies, and large employers guaranteed that American policy would be to blame consumers (and to some degree doctors) for driving up volume, and to avoid a discussion of price controls.

The disproportionate influence the supply-side has over the health-care reform debate can be seen in a listing of the most common explanations for high U.S. health-care costs. In the course of speaking to thousands of people about what's wrong with the U.S. system, and in the course of reading constantly about health policy for 15 years, I've heard every explanation imaginable for the high cost of our system compared to the cost of other nation's systems. In Table 3-8, I've listed the six categories into which these explanations fall. They are: Americans get too many medical services; we are getting older; we have more slovenly lifestyles; we sue for malpractice too often; we're more violent; and quality of care is better in the U.S.

I call these explanations "excuses" because they are misleading or just plain bogus. It is misleading, for example, for the experts who dominate the health-care debate, and the reporters who pass on their opinions as fact, to blame America's high costs on the aging of the population. Yes, it's unquestionably true that health-care costs rise as the proportion of a nation's population over 65 rises. But it is grossly misleading to suggest that America's health-care costs are twice those of other countries because Americans are older than other nations. The malpractice excuse (number 4 on the

¹⁶ Hospitals in the U.S. are currently paid for each service they render. One way to control expenditures on hospitals is to set limits on what hospitals could charge for each service. Another way would be to set budgets for hospitals for an entire year rather than set limits on the price of each service. In a multiple-payer system, setting limits on hospital charges is the only form of hospital expenditure control possible. Under such a system, all payers (insurers, government programs, and out-of-pocket payers) would be told by a government agency what the charge limit is on each hospital service. Only under a single-payer system, that is, one in which all hospital revenues flow from the same payer, is hospital budgeting feasible.

list in Table 3-8) is an example of an excuse that is just flat out false. The cost of frivolous malpractice suits is just too small to play anything resembling an important role in driving up U.S. health-care costs. I'll examine all six excuses in more detail in the next two chapters.

What is interesting about the list in Table 3-8 is that five of the excuses – the excessive services, age, lifestyle, malpractice, and violence excuses – blame consumers, while the sixth – superior quality – praises the health-care industry. With the exception of excuse number 2(a) (the HMO industry's favorite excuse, the one which blames doctors for the alleged overuse of the system), none of these six excuses places any blame on the supply side – on the insurers, the drug manufacturers, hospitals, and clinics. In Chapters 6 and 7, we'll discuss a seventh explanation for which there is abundant evidence and with which most Americans agree: The U.S. system is expensive because the supply-side is wasteful and sets prices excessively high.

Table 3-8: Six excuses for the high cost of America's health-care system

- (1) Americans get too many medical services
 - (a) because doctors order too many services
 - (b) because patients demand too many servicesAmericans are older
- Americans have worse lifestyles
- (4) Americans sue for malpractice too often
- Americans are more violent
- U.S. quality is superior

4

Excuses for the High Cost of American Health Care: The Overuse Excuse

Overview

In this chapter, I review the first of the six excuses for America's high costs listed Table 3-8. This explanation – that Americans get too many medical services – has been the most common explanation for America's high health-care costs for the last 30 years.

Prior to the takeover of the health-care system by managed care plans (MCPs), the alleged overuse of the system was blamed primarily on the old fee-for-service method of paying doctors. HMO advocates, you recall, argued that Americans were grossly overusing the system because fee-for-service payment gave doctors the incentive to order too many services. Managed-care advocates were still selling this notion years after managed care had clearly failed. In an interview with the *Washington Post* published in February 2001, William Donaldson, the CEO of Aetna at the time, explained the giant MCP's mission as "trying to bring some discipline to . . . doctors . . . who send out for 25 tests or who do things that are unnecessary." Donaldson, whose claim to fame is that he co-founded the Wall Street investment firm of Donaldson, Lufkin and Jenrette, served as undersecretary of state under Henry Kissinger, was the chairman of the New York Stock Exchange, and, in 2002, was appointed by President Bush to the chairmanship of the Securities Exchange Commission, went on to explain how it is that America's doctors have become so profligate. They got that way at medical school, he said. "The medical profession has been taught in school that everything is okay," Donaldson opined. "I mean: 'Send out for 1,000 tests. Do it.' You know, with no attention to price control. No attention to the efficient and effective practice of medicine."⁴⁷

But, by the late 1990s, HMO and managed-care advocates were in retreat and advocates of large-deductible policies – medical savings accounts (MSAs) and "defined contribution" plans – were getting lots of attention in the media. Now it was much less fashionable to say doctors and the fee-for-service method caused unnecessary services. Now it was fashionable to blame "overinsured" patients.¹⁷ This excerpt from a 2002 story in the *Washington Post* is typical of the new version of the overuse excuse:

But if there is one overarching cause of soaring health-care expenditures, it is Americans' insatiable appetite for each and every medical test and treatment available, the experts agree. "The truth is Americans want everything and they don't want to pay for anything," said Governor Howard Dean (D-VT), who is running for president on a health-care platform. "We need to admit to ourselves that health care is expensive because we all want the best for our families."⁴⁸

Notice how effortlessly the villains got switched. In the worldview of HMO advocates, the problem was that *doctors* had the wrong incentives, not patients. In the worldview of large-deductible advocates, the problem is that *patients* have the wrong incentives – they demand too many medical services because their insurance pays for "everything." This confusion as to who is causing the alleged overuse of the system is your first clue that neither camp has much data to support its position.

¹⁷ This has been less true of medical and health policy journals. These journals continue to devote much attention to inappropriate ordering of services by doctors.

Overuse of the system in fact occurs. But so does *underuse*, and underuse may well be more prevalent than overuse. The existence of underuse is my main objection to the constant prattle about overuse, be it from the managed-care advocates or large-deductible advocates. If politicians and the media permit managed-care and large-deductible advocates to bray about overuse and ignore underuse, we run the risk that policy makers and employers will adopt mechanisms that worsen the underuse problem in an effort to fix the overuse problem. Exposing Americans, especially low-income Americans, to deductibles of \$2,000 to \$4,000 is an example of the trouble we could cause ourselves if we diagnose overuse and ignore underuse. A huge deductible may well cause some patients to stop overusing the system, but it will also cause other patients to forgo necessary medical services. In short, because underuse probably offsets overuse, and because solutions that address only overuse could well aggravate the underuse problem, we should not discuss overuse by itself – we should not treat it as a problem separate from underuse.

I begin my discussion of the overuse excuse with a review of the evidence that overuse occurs – that some patients do get unnecessary services. Then I'll review the evidence that underuse also occurs. I'll follow this with the evidence that overuse cannot explain the huge difference between the costs of the U.S. and other countries. Then I'll review the evidence that doctors, not patients, are primarily responsible for the overuse that does occur.

The evidence that some medical services are overused

America's grand experiment with managed care required that a critical mass of politicians and business leaders accept two propositions: (1) that American doctors frequently order unnecessary medical goods and services, and (2) that MCPs were capable of distinguishing necessary from unnecessary care and would only cut back on the unnecessary care. A substantial body of evidence indicates proposition 1 is true; but there is no evidence that proposition 2 is true.

As we saw in Chapter 2, Paul Ellwood and other early proponents of HMOs did not argue that the primary cause of health-care inflation was the excessive *price* at which medical services were sold. They argued, rather, that the primary problem was an excessive *volume* of services, and that the fee-for-service system was to blame. The fee-for-service system, they said, gave doctors an incentive to provide services even if the services weren't necessary, and to ignore preventive services because doctors make more money under a fee-for-service system when patients get sick. As it turned out, HMOs saved money both ways – by cutting volume *and* price (they cut prices by extracting discounts from hospitals, clinics, and drug companies).¹⁸ But in the early 1970s when HMO advocates were lobbying Congress for legislation that would eventually be enacted as the HMO Act of 1973, the principal argument they offered was that HMOs would save money by reducing unnecessary services.

In the early 1970s, the overuse argument had little scientific evidence to support it. But over the last three decades, studies have been published which strongly suggest that America is paying for a substantial number of unnecessary medical services. These studies fall into two categories: "small area" studies (studies which demonstrate that the rate at which certain types of services are provided vary greatly within small geographic areas); and "appropriateness" studies (those in which doctors are asked to examine the files of patients who received certain treatments and to indicate whether they think the patient was an appropriate candidate for that treatment).

¹⁸ As we will see in Chapter 9, the money HMOs saved by squashing the prices of their suppliers was offset to some degree by cost shifting – the practice whereby a clinic or hospital or drug company raises rates for uninsured people and other weak buyers in order to make up for large discounts given to HMOs and other powerful buyers.

The “small area” studies were the first to be published. The first of these appeared in 1973, the year the HMO Act was enacted, in *Science*. The study, authored by John Wennberg, MD of Dartmouth Medical School and one of his colleagues, demonstrated that the rate at which doctors performed surgery varied greatly among New England communities separated by no more than a few miles. Tonsillectomy rates in Vermont communities, for example, ranged from 3 to 15 per 1,000 residents.⁴⁹ In subsequent studies, Wennberg reported that the probability that a woman in Maine would have a hysterectomy by the time she was 70 ranged from a low of 20 percent to a high of 70 percent,⁵⁰ and that the rate of back surgery varied tenfold among Maine communities.⁵¹ Interestingly, Wennberg and his colleagues also found that small-area variations were as large in Norway and Britain as they were in New England.⁵² These and other small-area studies indicated that variation was greatest for surgeries such as tonsillectomy, hysterectomy, prostatectomy, and coronary artery bypass where the indications for surgery were less precisely defined. For procedures such as appendectomy and gall bladder surgery, where the indications are more clearly defined, variation tends to be a lot less.

Mark Chassin, Robert Brook and other scholars at the Rand Corporation (a think tank in Santa Monica) demonstrated that variations in rates are just as large among states as they are among communities in close proximity to one another. In 1986, they published an analysis of the rate at which 123 procedures were used in states (and in the case of some large states, *regions* of those states) across the country. “We found large and significant differences in the use of services provided by all medical and surgical specialties,” they stated. “Of 123 procedures studied, 67 showed at least threefold differences between sites with the highest and lowest rates of use.”⁵³ Interestingly, they noted that states that had high use rates of one medical service had low rates of other services.

There are also a few studies documenting that the rates of some types of surgery vary greatly by country. For example, a 1987 study reported that America and Canada have very high cesarean-section rates compared to 17 other industrialized countries. In 1981, the U.S. rate was 18 per 100 deliveries and Canada’s was 16, far above the average of 9 for the other 17 countries.⁵⁴

In 1989, Wennberg organized the Center for the Evaluative Clinical Sciences at Dartmouth Medical School. In 1996 this institution published *The Dartmouth Atlas of Health Care*. According to the 2000 edition of the atlas, heart patients in Elyria, Ohio get angioplasty seven times more often than heart patients in York, Pa., 360 miles away, and men in Baton Rouge, Louisiana undergo prostate surgery at a rate more than eight times higher than those in Tuscaloosa, Alabama.⁵⁵

As provocative as the small-area studies are, they do not demonstrate that surgeons in the high-rate areas are doing unnecessary surgeries, or that the surgeons in the low-rate areas are denying necessary care to their patients. Chassin and his Rand colleagues made this point explicitly in their national study of 123 procedures:

[T]he available data do not allow us to explain the wide variations we have observed. . . . [W]e cannot establish the “correct” use rates from these data. For any given procedure, geographic differences may reflect substantial inappropriate overuse in the high-use areas with very little inappropriate use in the low-use areas. On the other hand, the variations may have occurred because physicians in the low-use areas were not providing enough services to those who needed them, whereas those in the high-use areas were meeting legitimate medical needs in an appropriate manner.⁵⁶

The authors speculated that differences in the “incidence of disease” might explain these variations.

However, the inconclusiveness of small-area studies did not prevent Wennberg (who later became an advocate of managed competition¹⁹) and other managed-care advocates from implying or stating that variation in rates of medical services is in fact proof that surgeons in high-rate areas are performing unnecessary surgery. This testimony by Wennberg before the Senate Appropriations Committee in 1985 is an example:

[I]f the low-cost patterns of care were the norm, we would not be faced with the pending bankruptcy of the Medicare Trust Fund, nor would we now be concerned with the specter that medical care must be rationed. For many medical and surgical conditions, the variations suggest opportunities to reduce expenditures under the Medicare and Medicaid programs without reducing the benefits of medical care.⁵⁷

Citing Wennberg, the Pepper Commission (a federal commission on health care) stated in its 1990 report, “The most important factor [causing variations] seems to be differences in the practice styles of physicians.”⁵⁸ AARP, a group which supported managed competition in the early 1990s, had this to say about Wennberg’s work in a 1992 issue of its newsletter subtitled, “Unnecessary operations raise costs”:

“What’s the reason for these differences in rates of surgery?” asks Howard A. Fishbein, MD, an epidemiologist at the Center for Medical Effectiveness Research at the Agency for Health Care Policy and Research [a federal agency established in 1989 that Wennberg lobbied to create]. “Most of the variation can probably be explained by differences in the practice styles of physicians. . . .” When surgeons with a fervent belief in the value of surgery are carefully educated, though, Fishbein says they tend to slow down their use of surgery.⁵⁹

The implication of this excerpt is that medical scientists have determined (a) that the lower rates of surgery are the correct ones, (b) that the doctors who perform higher rates of surgery do so because they bring more fervor than science to their jobs, and (c) these excessively enthusiastic doctors can be induced to do less surgery when they are “educated” by their better informed colleagues. All of these implications were unproven and grossly misleading in 1992, and they remain unproven and grossly misleading today.

Dr. Fishbein’s assertion that “most of the variation” can be attributed to differences in physician “practice styles” was not merely unsupported by science; it actually contradicted at least one very good scientific study published in 1987 by Chassin and his Rand colleagues. That study was designed to answer the question, Do high-use areas also have high rates of inappropriate use? The results appeared in the first of three “appropriateness” studies Rand scholars published in 1987 and 1988. This study had a three-part design. First, the authors calculated utilization rates for 153 procedures in eight states. They found that rates of use of the 153 procedures varied greatly among the states. Then they asked a panel of nine doctors to judge whether patients who received three of these 153 procedures were appropriate candidates for these procedures. Then they compared the rate of inappropriate use of these three procedures with the overall utilization rates in the eight states

¹⁹ Wennberg became a member of the Jackson Hole Group, the exclusive club of health policy experts, insurance company executives, big business executives, and politicians who met at the home of Paul Ellwood in Jackson Hole, Wyoming to promote managed care and managed competition. However, Wennberg apparently reversed position some time between 1993 (the year the *New York Times* described him as a member of the Jackson Hole Group) and 1996. In the latter year, he authored an article for *Health Affairs* in which he stated he did not approve of “strategies that micromanage the doctor-patient relationship. . . .” (John E. Wennberg, “On the appropriateness of small-area analysis for cost containment,” *Health Affairs* 1996;15(4):164-167, 165).

to see if they could find a correlation between inappropriate use of these three procedures and above-average utilization rates.

The three procedures they selected for analysis of appropriateness were coronary angiography (a test done to look for blockages in coronary arteries), upper gastrointestinal tract endoscopy, and carotid endarterectomy (a procedure that cleans plaque out of arteries that run up the sides of the neck). They asked a panel of nine doctors – one panel for each of the three procedures – to agree on a set of criteria with which to judge the appropriateness of the procedure, and then to review the medical records of patients who had undergone that procedure and to indicate whether they thought the surgery was appropriate, inappropriate, or of uncertain value. These physician panels concluded that 17 percent of the angiographies, 17 percent of upper gastrointestinal tract endoscopies, and 32 percent of carotid edarterectomies were inappropriate.⁶⁰

However, when Chassin et al. looked for a correlation between high rates of inappropriate use of these three procedures and high overall rates of use of the 153 procedures, they found none. “[I]n no case can differences in appropriateness explain the large differences in overall rates,” they concluded. “Thus, we did not find evidence to support the hypothesis that areas with high use of medical and surgical procedures show these high rates primarily or to any meaningful extent because physicians in these areas perform procedures more often for inappropriate indications than their counterparts in areas of lower use.”⁶¹ Other experts agree with this conclusion. “The practice variations literature has not led to the expected conclusion that variations result from overuse,” wrote one expert in a 1998 book on the subject.⁶²

A handful of appropriateness studies have been published since 1987, the year the first of the Rand appropriateness studies appeared. These studies indicate that a few services are overused and a few are underused. However, given how few studies have actually been done, and given the limitations on these studies, it is impossible to say what portion of the thousands of treatments available in the U.S. are overused and how extensive the overuse of these treatments is.

To give you some idea of how limited the appropriateness literature is, consider Table 4-1. You see there short descriptions of the results of 16 studies of overuse discussed in a 1998 literature review in the *Milbank Quarterly*.²⁰ The 16 studies examined a total of 13 treatments for acute and chronic conditions.²¹ Five of these studies examined treatments of acute conditions (all but one were respiratory conditions), and eleven dealt with chronic conditions. The authors observed that it is difficult to “provide a numerical summary” of the studies’ findings. However, they calculated a “simple average” (which means they didn’t weight the studies according to the prevalence of the disease examined) and reported that “30 percent [of acute-care patients] received contraindicated . . . care” and “20 percent of [patients with chronic conditions] received contraindicated care.”⁶³ (By my calculation, the simple average for chronic patients is 12 percent, not 20, but in view of how crude this methodology is, we needn’t tarry long on this difference.)

It is not wise to extrapolate from the studies described in Table 4-1 to the entire U.S. health-care system. First, the 13 treatments examined in the 16 studies described in the table constitute a very tiny portion of all treatments offered in this country. According to the U.S. General Accounting Office, there are 7,200 treatments listed in *Current Procedural Terminology*, the thick book of codes published by the American Medical Association that doctors use to determine which code they should use on claim forms.⁶⁴ The second reason why it is unwise to extrapolate from the

²⁰ A literature review is based on a search of the scientific literature to find all the good studies done on a given subject. The authors of the *Milbank Quarterly* article actually reviewed 48 articles. Only 16 of these studies identified the percentage of patients who received unnecessary acute or chronic care. The others either dealt with preventive care, or underuse of acute and chronic care.

²¹ Table 4-1 lists 18 conditions studied. However, two of the studies examined more than one condition, which is why the total number of studies – published papers – comes to 16.

simple averages of overuse shown in Table 4-1 is that the guidelines used to determine appropriateness are controversial. Consider, for example, the issues raised by the study (referred to in Table 4-1) that claimed to find a 23-percent overuse of ear tubes for otitis media (infection of the inner ear suffered by three out of four kids under age six). The study, done by Rand researcher Robert Brook and three others,⁶⁵ drew withering criticism from physicians, which is some indication that the guideline used in the study to determine what constitutes appropriate use of ear tubes is not universally supported. As one expert put it, “In view of the low degree of agreement on the optimal management of glue ear [another phrase for otitis media], it is not surprising that the conclusions of this appropriateness study were challenged. . . .”⁶⁶

The decision about when to treat otitis media with ear tubes is complex because it is impossible to predict with certainty all the benefits and adverse reactions that will

Table 4-1: Some medical services are overused: Studies reporting the provision of unnecessary services, 1987 to 1997

Acute conditions

| Type of treatment | Year of study | Study findings |
|----------------------------|---------------|--|
| Antibiotics | 1996 | 60% of patients with colds given antibiotics 16% of patients with upper respiratory infections given antibiotics Antibiotics given to more than 70% of patients with pharyngitis, 50% with rhinitis, and 30% with upper respiratory infections |
| Hospitalization | 1995 | 9% of hospital admissions for pneumonia, and 4% of admissions for bronchitis/asthma inappropriate |
| Ear tubes for otitis media | 1994 | 23 percent inappropriate |

Chronic conditions

| | | |
|------------------------------|------|---|
| Depression | 1993 | 7% of hospital admissions inappropriate |
| Hysterectomy | 1993 | 16% inappropriate |
| Angiography | 1993 | 4% inappropriate 17% inappropriate |
| Coronary artery bypass graft | 1988 | 14% inappropriate 2% inappropriate 2% inappropriate |

| | | |
|---|------|-------------------|
| Angioplasty | 1993 | 4% inappropriate |
| Calcium channel blockers for heart attack patients | 1993 | 21% inappropriate |
| Pacemakers for heart attack patients | 1988 | 20% inappropriate |
| Carotid endarterectomy | 1987 | 32% inappropriate |
| Upper gastro endoscopy | 1987 | 17% inappropriate |
| Cataract extraction | 1996 | 2% inappropriate |

Source: Mark A. Schuster et al., "How good is the quality of health care in the United States?" *Milbank Quarterly* 1998;76:517-563.

result from the insertion of ear tubes. The issue is not whether the tubes will permit the inner ear to drain and thereby relieve pressure and pain in the short run; that happens quite predictably. The issue is whether this short-term benefit is augmented further by longer-term improvements in the child's IQ and his ability to hear and speak, and whether these benefits outweigh the possible side-effects, which include adverse reactions to general anesthesia, recurrent infection around the tube, permanent perforation of the ear drum, and hearing loss due to recurrent infections. The research on whether prolonged ear infections do long-term damage to IQ is inconclusive. One study concluded that children who have otitis media for more than 130 days by the time they are seven are more likely to have a slightly lower IQ than kids who suffered less than 30 days of otitis media. Other studies have not confirmed this association.⁶⁷

With all these pros and cons to consider, totaling up all the pros, totaling up all the cons, subtracting one from the other, and thereby deriving an unambiguous guideline applicable to all patients is very difficult to do. But that's precisely what "appropriateness" researchers have to do. The ear tube study defined "appropriate tube placements" to mean "those for which the expected health benefits exceed the expected negative health consequences by a sufficiently wide margin that the procedure is worth doing" (financial costs were not a factor).⁶⁸ Moreover, the guideline used in the study was developed by a private-sector, for-profit, utilization review firm called Value Health Sciences (VHS) that did utilization review for MCPs. According to a report in *Medical Economics*, "The VHS company brochure claimed that [it] saved clients \$67.5 million from treatment denials in 1995. . . ."⁶⁹ Two of the four authors of the ear tube study worked for and held stock in VHS. Is it any wonder that the study's conclusion that 23 percent of tube placements are inappropriate drew a lot of criticism?

A report accompanying another guideline on ear tubes, this one developed by the federal Agency for Health Care Policy and Research, conceded what is obvious to many – that the process of determining when ear tubes are appropriate is somewhat subjective. "Of note," said the report, "is that the final recommendations are at least partially subjective; judgments about the quality of the science could not be fully objective."⁷⁰ I would add that subjectivity arises not only in judging the quality of "the science" of a study (that is, the strength of its methodology), but in the process of assigning weights to the benefits and harms caused by a treatment.

Just as the small-area studies were misused, so too were the appropriateness studies. Beginning in the late 1980s, big business executives, politicians, and scholars sympathetic to managed care developed the habit of indicting the entire U.S. health-care system based on the handful of controversial appropriateness studies available. “Somewhere along the line, an assertion of uncertain origin – that perhaps 25 percent of all care delivered in this country was most likely unnecessary – gained currency in federal health policy circles,” wrote Julie Kosterlitz for the *National Journal* in 1991.⁷¹ The Rand studies, and remarks about these studies by Rand scholars, were no doubt the origin of this claim. Based on the small number of appropriateness studies available in 1989, Rand’s Robert Brook wrote in the *Journal of the American Medical Association* that year, “If one could extrapolate from the available literature, then perhaps one fourth of hospital days, one fourth of procedures, and two fifths of medications could be done without.”⁷² Brook’s extrapolation was broadcast widely by the media. *Financial World*, for example, reprinted Brook’s estimate that a fourth of all services are unnecessary in a breathless article entitled, “How doctors have ruined health care.”⁷³ Brook was quoted in AARP’s newsletter saying, “Our best guess is that one-quarter of the things we do to people – not only surgery but all medical procedures – we could get rid of without having any impact on health.”⁷⁴ As the following statement by *Consumer Reports* indicates, the magazine decided the percentage of the health-care dollar wasted on unnecessary services was 20 percent, not 25 percent: “For a wide range of clinical procedures, on average, roughly 20 percent of the money we now spend could be saved with no loss in quality of care.”⁷⁵

The claim by Brook and others that overuse of the medical services was rampant was repeated by other health policy experts. President Clinton also endorsed the 25-percent figure. In his September 22, 1993 speech to the nation introducing his managed competition bill to Congress, Clinton claimed his bill would cut total health-care spending by \$200 billion, or about a fourth of total spending that year.²² Big business groups all over the country asserted that unnecessary care was costing the nation dearly and that managed care, armed with appropriateness studies, could solve the problem. “If utilization management and reimbursement were based on quality standards of scientific literature, we would see the costs level out considerably,” intoned John M. Burns, MD, vice president of health management for Honeywell, Inc.⁷⁶ The increasingly MCP-dominated health insurance industry was, of course, quite eager to promote the notion that “science” had determined once and for all that most medical services were overused.

Although I am critical of the way small-area and appropriateness studies have been misused, I am convinced overuse of medical services occurs. However, I’m unconvinced that one-fourth of all medical services are superfluous. That claim cannot be documented today and, in my opinion, never will be documented.

The evidence that underuse occurs

Underuse of medical services has drawn a lot less attention from experts than overuse has. “Most health services research to date has been directed at identifying and reducing excessive utilization,” wrote two Rand Corporation scholars in 1997. “Little attention has been given to underuse of care.”⁷⁷

²² In his September 22 speech, Clinton didn’t explain how he thought \$200 billion would be saved. But the arguments he and others in his administration made for his bill made it clear they thought the savings would come from reduced services. Seven months later, the Congressional Budget Office announced Clinton’s plan would save only \$37 billion over six years (which amounts to less than a 1 percent cut in total spending per year, far below Clinton’s 25-percent figure) (Tom Hamburger, “CBO puts high price on managed competition,” *Minneapolis Star Tribune*, May 5, 1994, 7A).

There are, broadly speaking, two types of underuse. The first is underuse caused by the failure of patients to get necessary medical services even though they visited a doctor or other health-care professional. Studies that seek to identify this type of underuse face the same difficulties that studies of overuse face. The second type of underuse is due to the inability or unwillingness of patients to seek medical care in the first place. This type of underuse is even more difficult to identify because, as Mark Chassin put it, “Studying this problem requires searching for events that should have happened but didn’t. Identifying patient populations who should have received a particular health service is a difficult and expensive task.”⁷⁸

Studies of underuse of both types were reviewed by Schuster et al. in the *Milbank Quarterly* literature review of overuse that I cited in Table 4-1. Because the results of these studies are much harder to reduce to a few summary statements in a table, I do not present the results in table form as I did for the overuse studies in Table 4-1. Here are some examples of their findings:

Between 10 and 48 percent of pneumonia patients received appropriate care (for example, blood pressure readings and oxygen therapy);

Between 6 and 33 percent of hip fracture patients failed to receive appropriate components of care (for example, serum potassium test and electrocardiogram);

44 percent of pregnant women failed to get all necessary tests during their first or second visit to a physician;

45 percent of diabetics did not receive a blood cholesterol screening during the previous year;

45 percent of people with high blood pressure did not have it under control;

33 percent of women over age 69 with breast cancer failed to receive appropriate treatment;

30 percent of heart attack patients who should have received thrombolytics did not;

14 percent of deaths in a hospital from stroke, pneumonia, or heart attack could have been prevented with appropriate care.⁷⁹

After surveying the studies of underuse, Schuster et al. calculated simple averages of the results and concluded that “about 50 percent” of patients failed to receive necessary *preventive* care, 30 percent of *acute care* patients failed to get necessary care, and 40 percent of *chronically ill* patients failed to receive necessary care. If we compare these figures with the overuse figures (no patients received unnecessary preventive services, 30 percent of acutely ill patients received unnecessary services, and 20 percent of chronically ill patients received unnecessary services), underuse is a slightly more prevalent problem than overuse.⁸⁰

Schuster et al. did not include two Rand studies that were published just a few months before their literature review was published. One of these, a study by Laouri et al., followed up on 352 patients who tested positive on a stress test for an angiogram.²³ They found 44 percent underuse, that is, that 44 percent of the patients who should have had an angiogram still hadn’t gotten one within a year after their stress test.⁸¹ Laouri et al. then followed up on the patients who had angiograms that indicated they should have either bypass surgery or angioplasty.²⁴ They found that 25 percent of patients who should have had bypass surgery or angioplasty (the two procedures

²³ In stress tests patients walk on a treadmill with sensors glued at various places on their torsos to measure heart function. If the test suggests the patient’s heart is not functioning normally, an angiogram may be ordered. An angiogram is a moving picture of the heart. The angiogram reveals narrowed (or “occluded”) arteries.

²⁴ Angioplasty is a procedure in which a tube with a balloon on the end of it is inserted into an artery in the leg or arm and threaded into the blocked coronary artery. When the balloon reaches the area where the artery has become dangerously narrow, the balloon is opened up to flatten the artery walls and expand the diameter of the artery.

are known collectively as “revascularization procedures”) got neither. The authors concluded, “Underuse of coronary revascularization procedures . . . occurs to a significant degree even among insured patients attending private hospitals.”⁸²

Similar findings were reported by Leape et al. in a study of New York cardiac patients. They found a revascularization underuse rate of 26 percent.⁸³

Look back at the overuse rates for bypass surgery and angioplasty in Table 4-1. You see overuse rates for bypass surgery ranging from 2 to 14 percent (three studies on the overuse of this procedure appear in Table 4-1), and a 4-percent overuse rate for angiography. The underuse rates reported in the three studies I just reviewed – 25 and 26 percent for revascularization and 44 percent for angiograms – dwarf the rates of overuse shown in Table 4-1.

Studies documenting the rapidly declining quality of care in our nation’s nursing homes and emergency rooms constitute further evidence of underuse. The problem is clearest in the nursing home sector. Reports issued by the Department of Health and Human Services in 2000 and in 2002 documented enormous gaps between the work force levels needed in the nation’s nursing homes and the actual work force levels.⁸⁴ According to the 2002 report, “In 2000, over 91 percent of nursing homes had nurse aide staffing levels that fell below the thresholds identified as minimally necessary to provide the needed care.” Problems created by staff shortages include preventable problems such as severe bedsores, malnutrition, dehydration, abnormal weight loss, severe infections, and congestive heart failure. The 2002 report estimated that adequate staffing of nursing homes would require an 8 percent increase in total spending (or \$7.6 billion annually).

The crisis in America’s emergency rooms has been building for at least two decades. Over the last decade, a mountain of anecdotal evidence and small body of scientific evidence has accumulated indicating that the supply of emergency care services is woefully insufficient to meet the demand, in both urban and rural areas.⁸⁵ According to a survey released by the American College of Emergency Physicians and the American Hospital Association in 2002, six of ten hospitals report that their ERs are so near capacity that they cannot easily handle more patients.⁸⁶ Whereas a shortage of nurses is the primary cause of underuse of nursing home services, underuse of emergency services is caused by several factors, including a shortage of nurses.

The great majority of the underuse studies I have just reviewed – most of those reviewed by Schuster et al., and all of the studies of underuse by cardiac patients, nursing home patients, and patients needing emergency care – examined underuse of the first type, that is, underuse by patients who have had contact with the health care system. If we add underuse of the second type – underuse caused by patient failure to see a doctor at all – the total amount of underuse is probably much more extensive than overuse. However, good data on the extent of the second type of underuse are even more scarce than good data on underuse of the first type, and data on overuse. As Chassin observed, this is because estimating the extent of underuse by patients who never enter the medical system is very difficult to do. It requires expensive techniques.

The most common technique is to poll people, ask them about their health problems, perhaps carry out medical examinations of them, and then see whether they sought medical care for their health problems. According to one poll, 13 percent of insured adult Americans either did not get medical care they needed in 2001 or they delayed getting it.⁸⁷ In 2001, the *New England Journal of Medicine* published an article based on a national survey of adults to determine the prevalence of hypertension (high blood pressure) and whether people with hypertension were getting treatment. The article found an enormous amount of hypertension (42 million adults during the 1992 to 1994 period of the survey), and a high rate of underuse among these hypertensives: 31 percent were unaware they had high blood pressure, and another 17 percent were aware of their hypertension but

were not being treated for it. These two numbers yield a total underuse rate of 48 percent.²⁵⁸⁸ The article did not describe the reasons for such gross underuse. It noted that the underusers saw a physician at least three times in the previous year, and that health insurance status (having health insurance or not having it) was not correlated with underuse. Rampant underuse of hypertension treatment is a serious problem; uncontrolled high blood pressure can lead to stroke and heart disease.

The second type of underuse is also rampant among people with tooth decay, diabetes, and mental health problems. One-third of Americans don't see a dentist even once a year, according to a 2002 report.⁸⁹ Five million of the nation's 16 million diabetics don't know they have diabetes.⁹⁰ In 1999 the U.S. Surgeon General released a report that concluded that "22 percent of the population has a diagnosable mental disorder" and that "nearly two-thirds of all people with diagnosable mental disorders do not seek treatment." The *New York Times* reported, "The report is significant because it meticulously analyzes huge amounts of data and puts the imprimatur of the government on the finding, just as the surgeon general's report on smoking and health did in 1964."⁹¹ The Surgeon General attributed the failure to seek treatment to lack of health insurance, gaps in health insurance, and to the stigma associated with mental illness.

Evidence indicates there is an enormous amount of underuse of the second type of long-term services. Families USA reported that 66 percent of the elderly who received long-term care services at home in 1993 received only unpaid services, and another 24 percent received both paid and unpaid services. Of the unpaid caregivers, 32 percent defined their own health as "fair or poor"; yet these caregivers provided a total of 39 hours of care a week. It is sometimes difficult to distinguish the care one would expect family members to give one another from care that ought to be provided by health-care professionals.⁹² Nevertheless, these statistics suggest that a substantial portion of unpaid home care is a source of emotional and physical distress to the caregivers and should, therefore, be provided by the health-care system. But it isn't.

The evidence we reviewed in Chapter 3 about the effects of being uninsured and underinsured is also evidence of underuse (probably of both types). Recall that a substantial body of research indicates the uninsured and underinsured are far more likely not to see a doctor and more likely not to get necessary services, and a small body of literature indicates that the uninsured and underinsured suffer diminished health because they got fewer services. The studies are solid evidence that underuse is extensive. These studies of the uninsured and underinsured, coupled with studies of overuse and underuse among the insured that I just reviewed, strongly suggest that underuse occurs at a greater rate than overuse.

Comparisons of American utilization rates with those of other countries

Comparisons of American medical use rates with those of use rates in other countries reinforces the conclusion that underuse is a serious problem in the U.S. and that overuse cannot explain the high cost of U.S. medical care. If excessive use of services (whether caused by doctors or patients) were a particularly severe problem for the U.S., one would expect to find that citizens of other countries utilize medical care less often than Americans do. With the exception of several

²⁵ Another 29 percent were being treated for hypertension, but their blood pressure was still high (above 140/90). Because antihypertensive medication is generally effective, we may speculate that this 29 percent did not have their blood pressure under control because they were not buying their prescribed medications. If this speculation is correct, that would mean a total of 77 percent of Americans with high blood pressure were underusing the health care system. Only 23 percent of Americans with high blood pressure were being treated for it and had their blood pressure within normal limits.

surgical procedures such as bypass surgery and hysterectomies, the evidence indicates Americans get fewer, not more, medical services.

Table 4-2 indicates that Americans are more likely than Canadians and Germans to experience denial of medical services or to have to postpone necessary medical care for financial reasons. One-and-a-half to twice as many Americans said they were not able to get, or had to postpone, needed medical care. Take note of the enormous differences in out-of-pocket expenses. Americans paid an average of \$993 out of their own pockets in 1995, three times what the average Canadian or German paid that year. I will come back to these figures when we discuss the large-deductible version of the excessive services argument – that Americans are “overinsured.”

Tables 4-3 and 4-4 also contradict the argument that “excessive” use of services explains high U.S. health-care costs. Table 4-3 indicates Americans are less likely to be admitted to a hospital (“admitted” means you stay overnight) than are citizens of other nations, and, when Americans do get admitted, their length of stay is shorter than it is for

Table 4-2: Americans are “underinsured” compared to Canadians and Germans: Out-of-pocket expenditures, and percent of Americans, Canadians, and Germans unable to get needed care, 1995

| | United States (n = 1,214) | Canada (n = 1,472) | Germany (n = 1,210) |
|--|------------------------------|-----------------------|------------------------|
| Out-of-pocket expenditures last year | \$993 | \$302 | \$328 |
| Not able to get needed medical care | 12% | 8%* | 6%* |
| Postponed needed medical care | 30% | 16%* | 13%* |
| Serious problem having enough money to pay doctor or hospital bills | 20% | 6%* | 3%* |
| Discouraged from medical treatment | 19% | 12%* | 6%* |
| Per capita expenditures, 1998 | \$4,270 | \$2,250 | \$2,400 |

* Statistically significant at .05 level.

Sources: All data except per capita expenditures are from Karen Donelan et al., “All payer, single payer, managed care, no payer: Patients’ perspectives in three nations,” *Health Affairs* 1996;15(2):254-265; per capita expenditures from Gerard F. Anderson et al., “Health spending and outcomes: Trends in OECD countries, 1960-1998” *Health Affairs* 2000;19(3):150-157, Exhibit 1.

Table 4-3: Americans use fewer hospital services: Hospital use rates in six nations, 1995

| Country | per 1,000 population | Hospital beds | |
|---------------|----------------------|--|--------------------------------|
| | | Average length of stay (days) ^(a) | Percent of population admitted |
| Germany | 9.7 | 14.2 | 20.7 |
| France | 8.9 | 11.2 | 22.7 |
| Italy | 6.4 | 10.5 | 16.0 ^(b) |
| Canada | 5.1 | 12.2 | 12.5 ^(c) |
| United King. | 4.7 | 9.9 | 20.8 |
| United States | 4.1 | 8.0 | 12.4 |

(a) Includes community hospitals, federal hospitals, and psychiatric hospitals.

(b) 1994 data

(c) 1993 data.

Source: Gerard Anderson, "In search of value: An international comparison of cost, access, and outcomes," *Health Affairs* 1997;16(6):163-171.

Table 4-4: Americans see their doctors less often: Physician visits per capita in eight nations, 1988, 1995, and 1996

| | 1988 ^(a) | 1995 ^(b) | 1996 | |
|----------------|---------------------|---------------------|------|------|
| United Kingdom | 5.3 | 5.8 | 5.9 | |
| United States | 5.3 | 6.0 | 6.0 | |
| France | 7.1 | 6.3 | 6.5 | |
| Canada | 6.6 | 6.8 | 6.5 | |
| Italy | 11.0 | -- | -- | |
| Australia | -- | 10.6 | -- | |
| Germany | 11.5 | 6.4 | 6.5 | |
| Japan | | 12.5 | 16.3 | 16.0 |

(a) Data for Germany are for 1987.

(b) Data are for 1995 or most recent available year.

Sources: All data from OECD. Data for 1998 are reported in David U. Himmelstein and Steffie Woolhandler, *The National Health Program Book*, Common Courage Press, 1994, 101; 1995 data

are reported in Steffie Woolhandler and David U. Himmelstein, *For Our Patients, Not for Profits: A Call to Action*, The Center for National Health Program Studies, 1998; 1996 data are reported in *The 1998 Commonwealth Fund International Health Policy Survey*, Commonwealth Fund (October 1998).

Table 4-5: Doctors in Japan order more services for cancer patients than Japanese-American doctors do: Percent of Japanese and Japanese-American doctors who would recommend life-sustaining treatment for terminally ill patients with gastric cancer

| | Japanese doctors | Japanese-American doctors |
|--|------------------|---------------------------|
| Blood transfusions for gastrointestinal bleeding | 74% | 42% |
| Total parenteral nutrition for malnutrition | 67% | 33% |
| Vasopressors for life-threatening hypotension | 61% | 34% |

Source: A. Asai et al., "Attitudes of Japanese and Japanese-American physicians towards life-sustaining treatment," *Lancet* 1995;346:356-59.

hospitalized patients in other countries. Specifically, we see that only 12 percent of the U.S. population was admitted to a hospital in 1995 (versus 23 percent in France, the country with the highest rate), and that the average stay for hospitalized Americans was 8 days (versus a high of 14 days in Germany). Similarly, Table 4-4 indicates Americans see their doctors less often than do citizens of other countries. In 1996, Americans made 6.0 visits to doctors, slightly below the 6.5 visits made by the French, Canadians, and Germans, and way below the 16 visits made by the Japanese.

Speaking of the Japanese, Table 4-5 presents the findings of an article published in *Lancet*, the widely-read British medical journal. This study found that Japanese doctors (doctors who practice in Japan) are nearly *twice* as likely to order three different types of treatment for terminally ill gastric cancer patients than are Japanese-American doctors (doctors of Japanese descent practicing in America). Specifically, Japanese doctors were much more likely to order: blood transfusions for patients losing blood through their intestines; parenteral nutrition (getting food into the body by injection into muscles or veins) for patients whose cancer is causing them to be malnourished; and drugs called "vassopressors" that raise blood pressure (by causing blood vessels to constrict) in patients who, because of blood loss, have low blood pressure. The study did not seek to identify the causes of these differences. The spread of HMOs in the U.S. during the 1980s and 1990s, which increased pressure on doctors not to order services, no doubt played an important role. Japan, like Canada and Germany, puts much more emphasis on controlling the *price* of health-care services than it does on the *volume* of services.

There is some evidence that America's shorter hospital stays are actually *adding* to total health-care spending because patients ejected from the hospital too early wind up needing additional services when their conditions worsen. A study published in the *Journal of Thoracic and Cardiovascular Surgery*, for example, found that this is the case for patients who undergo bypass surgery. The

average length-of-stay in a hospital for bypass patients fell from nine days to 5.4 days between 1990 and 1998, but during that time readmissions to hospitals and use of extended care facilities rose. In 1990, almost all bypass patients went home after leaving the hospital and only 0.5 percent had to be readmitted. But by 1998, 43 percent left the hospital and stayed for more than ten days at an extended care facility and only 57 percent went home, while 5 percent had to be readmitted.⁹³

There is some evidence that Americans get more of a few types of treatments, particularly surgery, than do citizens of other countries. Research indicates Americans get more coronary artery bypass grafts, prostatectomies, and hysterectomies than people in other countries. On the other hand, a few studies indicate Americans get an average amount of other types of expensive services. Table 4-6 shows that the American consumption of bone marrow transplants for leukemia occurs at a rate midway between France's (the high rate) and Germany's (the low rate). Bone marrow transplantation is a very expensive procedure (it cost \$140,000 in the U.S. in 1994).

Table 4-6: Americans use an average number of bone marrow transplants: Annual rate of allogeneic bone marrow transplants per capita in ten nations, 1989 through 1991

| | <u>Transplantations per 100,000 population per year</u> |
|----------------|---|
| France | 1.34 |
| Sweden | 0.90 |
| Canada | 0.89 |
| Australia | 0.88 |
| United Kingdom | 0.82 |
| United States | 0.81 |
| Denmark | 0.78 |
| Netherlands | 0.78 |
| New Zealand | 0.74 |
| Germany | 0.56 |

Source: George Silberman et al., "Availability and appropriateness of allogeneic bone marrow transplantations for chronic myeloid leukemia in ten countries," *New England Journal of Medicine* 1994;331:1063-1067.

To sum up, the preponderance of the somewhat limit evidence indicates (a) underuse of the U.S. health-care system is more extensive than overuse, and (b) the average American gets no more services than do citizens in other countries, and, in the case of hospital and physician services (the core of every nation's health system), that the

typical American gets fewer services. The excessive-use-of-services excuse, it turns out, cannot explain why the U.S. system is twice as expensive as the systems of the rest of the industrialized world.

A closer look at the “overinsured” version of the excessive-services excuse

In Chapter 2, I reviewed the origins of the “doctors are to blame” version of the excessive volume excuse. We saw that Paul Ellwood managed to persuade Richard Nixon that volume of services was the main problem, and that this problem was in turn due to doctors ordering too many services because, under the fee-for-service system, they stood to get rich by doing so. In this section, I examine more closely the latest version of the excessive-services excuse – the one that says “overinsured” *patients* are the primary cause of overuse. Now that managed care is failing, this excuse is getting lots of mileage, especially from the new insurance companies, like the Golden Rule Insurance Company, that are selling policies with huge deductibles, and from employers who seek to rationalize shifting more costs to their employees.

The overinsured excuse, fully articulated, goes like this: “America’s health-care costs are high because most insurance policies cover too much of the cost of health care. Because patients know their insurance will pay a large portion of their medical bills, they have an incentive to demand services they don’t need. If patients had to pay a larger portion of their medical bills, they would ask for fewer services, and health-care inflation would be reduced.” The sound-bite versions that proponents offer to the media are typically shorter and more evasive. “The central issue in health-care reform . . . is how best to respond economically to insatiable public demand,” claims pollster Daniel Yankelovich.⁹⁴ “[C]onsumers are prudent about using services,” says John Tyler, an agent for Golden Rule, explaining how policies with huge deductibles “control health-care costs.”⁹⁵ “[P]atients . . . control costs by not going to the doctor until they need to,” argues Robert Tenery, Jr., MD, president of the Texas Medical Association. . . .⁹⁶ “Imagine if we sold auto-purchase insurance and said, go and buy whatever car you want and we’ll pay 80 percent of it,” writes James C. Robinson, an economist who has frequently defended managed care.⁹⁷ “More than anything,” argues a doctor in a letter to the *New England Journal of Medicine*, “the widespread existence of insurance has permitted and, in fact, encouraged the prices that shock us all: the \$25 bedpan, the first-visit fee . . . of \$100 or more, the \$600 CAT scan”⁹⁸ According to this doctor, patients with head injuries, for example, would solicit bids from three or four hospitals on their CAT scan charges before deciding which hospital to go to.

The argument for higher out-of-pocket costs rests on two premises that are infrequently articulated and never documented by those who preach the wonders of high out-of-pocket costs. The first premise is that Americans are getting gobs of services they don’t need. The second premise is that this gross overuse is due to patient demand fueled by low deductibles. Dr. Tenery’s statement (that patients will “control costs by not going to the doctor until they need to”) is typical of the arguments in favor of more cost-sharing. Dr. Tenery is obviously assuming (a) that all or most patients are currently “going to the doctor” when they don’t need to, and (b) they’re doing so because they incur little or no out-of-pocket costs. But he offers no documentation for these assumptions.

As we have just seen, there is truth in the first premise – some overuse of the health-care system does occur. But we have also seen why a one-eyed fixation on overuse to the exclusion of underuse is dangerous: It leads you to think that underuse isn’t a serious problem, and that no damage will be done to patients if the public is pushed to buy policies with large deductibles. There is a kernel of truth to the second premise – some patients do demand services that are inappropriate, and doctors sometimes cave in to their patients. Overuse of antibiotics may be the most frequently mentioned example of inappropriate patient demand leading to inappropriate ordering of services by doctors. But the evidence supporting the claim that overuse, to the extent it exists, is primarily a

patient-induced problem is almost entirely anecdotal. That handful of anecdotal evidence is, moreover, contradicted by common experience and a few studies which indicate that most medical services are ordered by doctors, not patients.⁹⁹

For many people, the most effective argument against the overinsured excuse is the fact that out-of-pocket costs are much higher in the U.S. where per capita health costs are the highest in the world. If the overinsured excuse were correct, one would think it would be the other way around; you would think U.S. costs would be among the lowest. But they aren't. In Table 4-2 we saw that American out-of-pocket expenditures were triple those of Canadians and Germans in 1994 – \$993 in the U.S. versus \$302 in Canada and \$328 in Germany. Yet, Canadian and German costs are about half the level of U.S. costs. Worse still, Table 4-2 indicates Americans are much more likely to suffer rationing than Canadians and Germans are. In short, large out-of-pocket payments give us the worst of both worlds – they have little effect on cost, but they sure damage quality of health care.

Closing thoughts on the excessive volume excuse

Advocates of managed competition and large deductibles have a common interest in persuading the public that excessive volume, not excessive price, is the problem. They differ, however, in who they think is to blame for excessive volume. Managed competition advocates blame doctors primarily, while large-deductible advocates blame patients. But the fundamental premise both camps share – that volume is excessive – is wrong. In this chapter, we have reviewed evidence indicating that if underuse is subtracted from overuse there is no probably no net overuse of medical services, and there may even be a net underuse. Rather than preach on about excessive use of services, both camps should acknowledge that America suffers from overuse of some services and underuse of others. This they will be reluctant to do, however, because it makes their solutions look silly. How can you argue that the fee-for-service system is the great engine of inflation, and that managed care tools are needed to combat fee-for-service incentives, if in fact underuse is as bad or worse than overuse? How can you argue that patients should be exposed to deductibles of \$2,000 and up when millions of Americans, many of them insured with small deductibles, are already underusing the system?

Applying massive doses of managed care or large deductibles to a society that both overuses and underuses medical care is a bad idea. Managed care and large deductibles may reduce unnecessary care, but they will also reduce *necessary* care. The solution to overuse is more research on what works, and more education of doctors and patients about that research. The solution to underuse is more education of patients and doctors, little or no out-of-pocket costs for low-income people, and universal health insurance. For the true believers in managed care and large deductibles, these solutions don't glitter like the city on the hill they dream of. Research and education are, by comparison to these grand schemes, rather prosaic. They do not require a PhD in economics to comprehend. But they do have one important advantage: They will work much more effectively.

5

Other Excuses for the High Cost of American Health Care

Introduction

In the last chapter, we saw that excessive use of the health-care system cannot explain the high cost of the U.S. system. In this chapter I discuss the remaining five excuses for the high cost of American health care listed in Table 3-8. They are:

Americans are older;
Americans have worse lifestyles;
Americans sue for malpractice too often;
Americans are more violent; and
U.S. quality is superior.

When the experts who dominate the U.S. health-care debate offer the first excuse (the overuse excuse) and the fifth and sixth excuses, they often compare the U.S. to other countries. Invokers of the overuse and quality excuses, for example, will often allege that other countries deny necessary medical services to their citizens whereas the U.S. allegedly does not. But when experts peddle the second, third and fourth excuses, they rarely compare the U.S. explicitly to other countries. I can't recall actually hearing someone say, for example, "The U.S. system is twice as expensive as Germany's because the Germans are much older than the Americans." Nor have I actually heard someone say, "America could cut its costs to Germany's level if Americans would cut their average weight to German levels and would sue their doctors only as often as Germans do." When apologists for the American way offer these age, lifestyle, and malpractice-suit excuses, they usually don't compare the costs of these alleged defects in American patients with analogous defects in the peoples of other countries. They tend, rather, to offer these three excuses to explain why health-care inflation is rising in the U.S., to explain, for example, why inflation got hotter after 1996. Thus, we tend to hear the age and lifestyle excuses frequently during periods of high health-care inflation (in recent times, these periods have been 1987 to 1991, and the years since 1997) and less often during periods of relatively low inflation (e.g., the inflation lull of 1992 to 1996). Similarly, we tend to hear the malpractice excuse more often when malpractice insurance premiums are rising.

For two reasons, however, I will discuss all six excuses, including the age, lifestyle, and malpractice excuses, as if proponents always used these excuses in the context of explaining the difference between American and other-country health costs. The frequency with which these age, lifestyle, and malpractice excuses are made create the impression that Americans are older, less disciplined, and more litigious than citizens of other nations. Second, the debate about why U.S. health-care costs rise or fall over a short period of time should, at this point in our history, be seen as a distraction from the far more fundamental question, Why is the U.S. per capita cost double that of the rest of the industrialized world? To ensure that we stay focused on this latter question, I will frequently phrase all six excuses for America's high costs as if the proponents of these excuses usually compared America to other countries. For example, I'll usually refer to the age excuse as "Americans are older" (meaning "older than the peoples of other countries") rather than "Americans are aging."

Excuse number 2: Americans are older

To listen to apologists for the U.S. health insurance industry, you would think the bouts of health-care inflation we suffered between 1987 and 1992 and since 1996 were caused by outbreaks of aging among Americans. Here is an example from a 1992 edition of *Mayo Today*, the newsletter for Mayo Clinic doctors: “The relation of an aging population to the rising cost of care is obvious,” said the newsletter. “Spending on health care is directly related to age. As individuals grow older, they generally become sicker and need more care. This is one of the biggest factors contributing to increases in health-care expenditures.”¹⁰⁰ Here’s another typical example from a 2001 article in the *New York Times* reporting that health insurance companies were raising their premiums by 15 percent, the highest rate since 1991: “[T]he average age of the American population is increasing, and that means more medical bills.”¹⁰¹

The following statement seems dreadfully obvious and not necessary to say, but here goes: The aging of the population cannot explain changes in the health-care inflation rate over short periods of time. If the Mayo Clinic and the *New York Times* had set out to explain why U.S. health-care costs were very high in 2000 compared with some time decades earlier, say 1940, then a discussion of the change in average age that occurred over those 60 years would be entirely appropriate. But it is ludicrous to suggest that an outbreak of aging played a role in the sudden increase in premium inflation that occurred across the U.S. between 1996 and 2000. The average age of America’s population changes at a glacial pace compared to the speed with which health-care inflation changes. But that is the implication of the explanations like those offered in the Mayo Clinic newsletter and the *New York Times*. By their odd logic, average age must have stopped growing between 1992 and 1996 when American enjoyed a health-care inflation lull. Of course, that didn’t happen either. There was no cessation of aging in 1992, and no outbreak of aging in 1996.

The age excuse not only fails to explain the ups and downs of medical inflation, it also fails to explain differences between the health-care costs of the U.S. and other nations. If high American health-care costs were due to America’s average age, one would expect to find that Americans are older than citizens of other industrialized nations. But as Table 5-1 indicates, the opposite is true: The U.S. has a lower median age than most other countries, and a lower proportion of its populace is elderly.

The source for Table 5-1 is the Organization for Economic Development and Cooperation (OECD). Using 1994 OECD data, Yale professor Ted Marmor ranked 20 OECD member-nations according to the percent of their populations that were over 65 and the percentage of their Gross Domestic Product spent on health care. He found no correlation between the two numbers. The U.S. was in first place in spending by a mile but ranked 15th in age (that is, only four out of 20 countries were younger than we were).¹⁰²

Table 5-1: America is not older than other countries: Median age and percent over 65 in seven nations, 1996

| Country | Median age | Percent over 65 |
|---------|------------|-----------------|
| Japan | 40.0 | 14.7 |
| Italy | 39.0 | 16.4 |
| Germany | 38.0 | 15.3 |

| | | |
|--------|------|------|
| France | 37.0 | 15.4 |
| UK | 37.0 | 15.8 |
| US | 35.0 | 12.2 |
| Canada | 35.0 | 12.1 |

Source: Gerard Anderson, "In search of value: An international comparison of cost, access, and outcomes," *Health Affairs* 1997;16(6):163-171.

Excuse number 3: Americans have worse lifestyles

Americans unquestionably do things, or fail to do things, which result in worse health and, often, higher health-care costs. Obesity, drug abuse, smoking, failure to practice safe sex, and failure to wear seat belts are examples of behaviors that damage health and, thereby, add to health-care costs. Politicians and experts often state or imply that this fact warrants the conclusion that dumb lifestyle choices are the primary cause of America's high health expenditures. Minnesota's Governor Jesse Ventura is an example. Speaking at a Minneapolis hospital about his "big plan" for health-care reform, Ventura said, "We can control costs if people are taking responsibility for their own health. This is not about them being triathletes or marathon runners, but they could just go for a walk after dinner."¹⁰³

It is true that America could reduce its health costs substantially if enough Americans began to exercise, quit smoking, kick drug habits, and changed their diets. For both health and financial reasons, public policies designed to promote healthier living should be part of any health-care system. But single-minded attention to these truths obscures a more fundamental problem with the lifestyle excuse: It can't account for the huge difference between America's per capita health-care expenditures and those of the rest of the developed world.

What little literature I've seen comparing American lifestyles to those of people in other OECD countries shows little difference in behaviors – certainly not enough to account for a two-fold difference in health costs. People all over the world drink, smoke, and suffer from sexually transmitted diseases. The obesity epidemic we hear so much about in the U.S. is not limited to the U.S.; obesity is spreading rapidly in other countries, including Third World countries.¹⁰⁴

Table 5-2 presents the most detailed study I've ever seen on this question. It describes the smoking and drinking habits of people in 23 industrialized nations plus Turkey. Like several other studies discussed already, this one was done by the OECD. You can see that the percent of Americans who smoke is below the OECD average, although those Americans who do smoke consume more tobacco than smokers in other countries. Americans consume an average amount of alcohol. If American smoking and drinking habits are influencing U.S. health-care costs by driving up numbers of doctor visits and days in the hospital, it is not obvious from the data on hospital use and doctor

Table 5-2: American smoking and drinking habits are not very different from those of citizens of other nations: Smoking and drinking rates in OECD* nations, 1991

| | Percent of women who smoke ^(a) | Percent of men who smoke ^(a) | Tobacco consumption ^(b) | Alcohol consumption ^(c) |
|-----------|---|---|------------------------------------|------------------------------------|
| Australia | 26.6 ^(e) | 29.9 ^(e) | 1,964 | 9.9 |
| Austria | 21.3 ^(h) | 40.0 ^(h) | 2,350 | 12.6 |
| Belgium | 23.5 ^(f) | 42.4 ^(f) | 2,467 | 11.8 |

| | | | | | |
|----------------|---------------------|---------------------|----------------------|---------------------|------|
| Canada | 26.0 | 26.0 | 1,720 | 10.6 | |
| Denmark | 40.6 | 47.3 | 2,401 | 11.6 | |
| Finland | 21.0 | 35.0 | 1,372 | 9.2 | |
| France | | 19.2 | 37.8 | 2,269 | 15.7 |
| Germany | 22.2 ^(e) | 38.0 ^(e) | 2,843 ⁽ⁱ⁾ | 14.2 | |
| Greece | 26.0 | 61.0 | 3,307 ^(f) | 2.3 ^(e) | |
| Iceland | 29.6 | 31.4 | 2,447 | 5.1 ^(d) | |
| Ireland | 27.0 | 30.0 | 2,237 ^(f) | 9.1 | |
| Italy | 17.3 | 40.8 ^(h) | 2,643 ^(h) | 10.7 | |
| Japan | 14.2 | 61.2 | 2,519 ^(g) | 6.3 ^(g) | |
| Luxembourg | - | - | - | 14.7 ^(d) | |
| Netherlands | 31.0 ^(d) | 39.0 ^(d) | 2,931 ^(f) | 9.9 ^(d) | |
| New Zealand | 25.2 | 27.0 | 1,783 | 10.3 | |
| Norway | 33.0 | 36.0 | 1,570 ^(e) | 4.8 | |
| Portugal | 5.1 ^(g) | 33.6 ^(g) | 2,916 ^(k) | 9.8 ^(d) | |
| Spain | 21.4 ^(e) | 51.5 ^(e) | - | 13.6 ^(d) | |
| Sweden | 25.0 | 26.0 | 1,860 | 6.3 | |
| Switzerland | 29.0 ^(d) | 39.0 ^(d) | 3,100 ^(j) | 12.9 | |
| Turkey | - | 62.8 ^(e) | - | 0.5 ^(e) | |
| United Kingdom | 29.0 ^(d) | 31.0 ^(d) | 1,990 ^(k) | 8.9 | |
| United States | 23.5 | 28.1 | 3,010 ^(l) | 9.6 ^(g) | |
| OECD average | 24.4 | 38.9 | 2,367 | 9.6 | |

* OECD stands for the Organization for Economic Cooperation and Development.

(a) Percent of population 15 or older. (d) 1990 (g) 1987 (j) 1982
 (b) Grams per person age 15 or older (e) 1989 (h) 1986 (k) 1985
 (c) Litres per person age 15 or older (f) 1988 (i) 1979 (l) 1984

Source: George J. Schieber et al., "Health system performance in OECD countries, 1980-1992," *Health Affairs* 1994;13(4):101-112.

visits shown in Tables 4-3 and 4-4. These data do not support the claim that American health-care costs are high because Americans drink and smoke more.

A 1999 survey of tenth-grade students in Europe and the U.S. reported that European students were more likely to smoke cigarettes and drink alcohol but less likely to use illicit drugs such as marijuana and Ecstasy. Thirty-seven percent of European students, but only 26 percent of U.S. students, had smoked at least one cigarette in the previous 30 days, and 61 percent of European tenth-graders, but only 40 percent of U.S. students, had drunk alcohol in the last 30 days. On the other hand, one in four American students used illicit drugs compared to, at most, one in ten in European countries.¹⁰⁵ In view of the substantial amount of research implicating tobacco and alcohol in human disease, it is difficult to conclude from this study that drug-consumption habits of American teens are adding more to U.S. health-care costs than the habits of European teens are adding to European costs. It may well be that the smoking and drinking habits of European teens are putting a larger drain on European health systems.

Excuse number 4: Americans sue too often

Malpractice lawsuits have been filed in noticeable numbers in America since the 1930s. But the myth that malpractice suits are excessive and play a major role in health-care inflation did not

begin to take hold until the 1970s when the first of two “malpractice crises” occurred. In the early 1970s, again in the mid-1980s, and in several states in the early 2000s, the premiums doctors and hospitals paid for malpractice liability insurance soared. Interestingly, the premium inflation of the 1980s was accompanied by inflation in premiums for other types of liability insurance, including insurance for day care centers, schools, and truckers. It is interesting, obviously, because it suggests that something besides the behavior of patients and the size of malpractice awards from juries caused the inflation in malpractice premiums in the 1980s.

The American Medical Association, which today represents a third of the nation’s physicians, responded to each of these bursts of premium inflation with a national campaign to convince politicians and the public that malpractice premiums were rising because Americans sued doctors too often.²⁶ The AMA, with help from the insurance industry and the Chamber of Commerce, has been amazingly successful. All 50 states have passed legislation enacting some version of what the AMA considers to be malpractice reform, and in the early 1990s the AMA persuaded the Republican leadership in Congress and the White House to support even more “reform” at the federal level. During the 1992 presidential debate, former President George Bush asserted that “the malpractice . . . trial lawyers’ lawsuits . . . are running the costs of medical care up \$25 to \$50 billion.”¹⁰⁶

Table 5-3 indicates most Americans eventually bought the AMA line. You see that “malpractice lawsuits” was the most frequently cited factor in a poll conducted in 1993. Fifty-nine percent of Americans said “malpractice lawsuits” contributed “a great

Table 5-3: The public thinks malpractice suits cause health-care inflation

| Factor | Percent saying the factor contributes a great deal |
|--|--|
| Malpractice lawsuits | 59 |
| Waste and abuse | 58 |
| Fraudulent claims | 50 |
| Doctors practicing defensive medicine to avoid suits | 44 |
| AIDS | 44 |
| New expensive drugs | 43 |
| New technology | 39 |
| Urban problems, like crime and drugs | 34 |
| An aging population | 29 |
| Expectations of the public for the best possible treatment for any condition | 25 |

Source: Robert J. Blendon et al., “Bridging the gap between expert and public views on health care reform,” *Journal of the American Medical Association*, 1993;269(19):2573-8.

deal . . . to high health-care costs,” and 44 percent said the same about “defensive

²⁶ For example, *American Medical News*, a newspaper published every two weeks by the AMA, reported, “The AMA and the National Medical Association, the nation’s largest African-American physicians’ group, . . . held a joint news conference to repeat the argument that the current liability system raises health care costs” (Diane M. Gianelli and Brian McCormick, “Pushing tort reform before the Senate,” May 8, 1995, 1).

medicine” (the ordering of unnecessary medical goods and services by doctors to minimize the likelihood of malpractice lawsuits by patients and their families). Other polls confirmed this finding. The *Wall Street Journal* reported that 60 percent of Americans think malpractice litigation is “one of the biggest causes of spiraling U.S. health-care costs,”¹⁰⁷ and the Robert Wood Johnson Foundation (a prolific funder of health policy research) reported that 64 percent of Americans think malpractice suits are “to blame” for health-care inflation.¹⁰⁸ (Make sure to glance at the last two items in Table 5-3; they indicate the public doesn’t buy the overuse and age excuses.)

But the AMA and the American public could not be more wrong. First, only a small fraction of patients harmed by malpractice sue. Second, malpractice suits cannot possibly be “one of the biggest causes” of health-care inflation because malpractice costs amount to 2 or 3 percent of total health-care spending. Third, the real cause of the “malpractice crisis” is – are you ready for this? – malpractice. If you look back at Table 5-3, you will notice that the scholars who conducted this poll didn’t give their respondents an opportunity to comment on “malpractice by doctors.” That tells you something about how completely bamboozled the American public has been by the AMA propaganda. Even experts at Harvard think there’s no point in including a question about malpractice itself in a survey about causes of health-care inflation.

Let me walk you through the evidence supporting the statements I just made, beginning with the statement that malpractice costs are no more than 2 or 3 percent of health expenditures. Table 5-4 presents an estimate of the cost of our malpractice system as of 1994, broken into its two components: premiums paid for malpractice insurance by doctors and hospitals, and the cost of defensive medicine. Total premiums paid to liability insurance companies is relatively easy to determine; the total came to \$9 billion

Table 5-4: Malpractice costs amount to 2.5 percent of total health-care costs: Costs of malpractice insurance and defensive medicine, 1994, \$

| | |
|--|-------------|
| Malpractice premiums for all US doctors and hospitals | 9 billion |
| Defensive medicine | 12 billion |
| Total | 21 billion |
| US health-care expenditures | 949 billion |
| \$21 billion = 2% of \$949 billion | |
| Savings from AMA-recommended malpractice reform in 1994: | |
| In dollars | 4.3 billion |
| As percent of total health-care spending | 0.5* |

* Total health-care spending in 1994 was \$949 billion. \$4.3 billion is 0.5 percent of \$949 billion.

Sources: The estimates of the cost of malpractice premiums, defensive medicine, and savings from malpractice reform are those of the National Medical Liability Reform Coalition, which included the American Medical Association, the American Hospital Association, the National Association of Manufacturers, and MMI Companies (a hospital liability insurer). The coalition contracted with a consulting firm known as Lewin/VHI to prepare its estimates. The Lewin/VHI estimate of \$4.3 billion in savings is reported in Brian McCormick, “Study: Defensive medicine costs nearly \$10 billion,” *American Medical News*, February 15, 1993, 4. The 1994 Lewin/VHI estimates of premiums and defensive medicine costs are cited in Spencer Rich, “Malpractice curbs won’t work, Nader says,” *Washington Post*, Health, June 15, 1993, 5. The 1994 spending total is from

Katharine R. Levit et al., "Health care spending in 1994: Slowest in decades," *Health Affairs* 1996;15(2):130-144.

in 1994. The cost of "defensive medicine" is much tougher to estimate. The table lists an estimate of \$12 billion, a figure endorsed by the AMA and other proponents of the malpractice excuse. When you add \$9 billion in premiums to \$12 billion for defensive medicine, you get \$21 billion, which turns out to be just 2 percent of total health spending in 1994.²⁷

No one, not even the AMA, is proposing to abolish the court system and deny all victims of malpractice the right to sue. That means the savings from malpractice "reform" will be an even tinier portion of total health-care spending than 2 percent. According to the AMA, the "reform" measures it supported during the first half of the 1990s would have saved a grand total of \$4 billion in 1994, which amounts to just 0.5 percent of the \$949 billion the U.S. spent on health-care that year.

Given the great hue and cry about malpractice costs over the last three decades, you might think American scholars would have published numerous studies on how many Americans are hurt by malpractice and what percent of these sue. You would be flat wrong. Very few studies on this question exist.²⁸

Two of the best studies focused on hospitals, which is where 80 percent of malpractice occurs (that's because more risky forms of treatment occur in hospitals). One study, based on 21,000 patient records from 23 California hospitals, concluded that only 4 percent of malpractice victims were compensated for their injuries.¹⁰⁹ The second study, based on 30,000 records of patients treated in 51 New York hospitals, reported that just 2 percent of malpractice victims sued. (The study didn't indicate what percent of these received compensation but, obviously, not all of this 2 percent won jury awards.) Interestingly, this study was conducted by scholars at the schools of medicine, public health, law, and government at Harvard University. The study was published as a series of articles in the *New England Journal of Medicine*.¹¹⁰ The authors concluded, "Thus, . . . there is no basis for the charge that the amount of malpractice litigation is excessive. On the contrary, there seems to be a major 'deficit' of litigation."¹¹¹ I repeat: People with MD after their names were part of this study.

The implication of the California and Harvard studies is that enormous obstacles stand between malpractice victims and the courts. Three stories of people I knew personally, presented in Appendix B, illustrate some of these obstacles.²⁹

²⁷ Other proponents of the malpractice excuse say total malpractice costs were even lower than \$21 billion in 1994. When former Representative Rod Grams (R-MN) introduced a malpractice "reform" bill in 1994 at the request of the AMA, he announced, "Defensive medicine and frivolous lawsuits cost Americans over \$15 billion each year. How can the president and Democratic leadership ignore this part of the health-care debate?" (Tom Hamburger, "Grams offers legislation seeking major reform on medical malpractice," *Minneapolis Star Tribune*, July 21, 1994, 15A).

²⁸ The authors of one of these studies took note of the contrast between the attention paid to malpractice premiums and the attention paid to the number of people hurt by malpractice. "Curiously, . . . the problem of medical injury has received comparatively little attention. . . ." they wrote (Lucian L. Leape, et al., "The nature of adverse events in hospitalized patients: Results of the Harvard Medical Practice Study II," *New England Journal of Medicine*, 1991;324:377-338, 377).

²⁹ Note the similarity between the overuse excuse and the malpractice excuse. What each has in common is an important kernel of truth – some patients do get services they don't need, and some patients sue for malpractice when they shouldn't. But the two excuses conveniently ignore serious problems – the overuse excuse ignores underuse, and the malpractice excuse ignores the enormous number of malpractice victims who never sue. In our discussion of the malpractice excuse, we concluded that malpractice reform could actually add to the nation's health-care expenditures if "reform" means making sure all malpractice victims are compensated. The same may well be true of the overuse argument. If we could eliminate all overuse and underuse, the net effect might well be an increase in America's health-care expenditures.

Excuse number 5: Americans are more violent

This is an excuse I rarely hear anywhere, and I never see it in the professional journals – the health policy and medical journals. Even the experts, who tend to engage in consumer-blaming, don't buy this one. We can dismiss the violence excuse for the same reason we can dismiss the malpractice excuse – the total cost is just too tiny to have much influence on total health-care spending.

The few people who claim that violence is a driving force behind U.S. health-care inflation, and those who have studied the problem, focus on gun violence. The reasons are obvious: Violence with fists or weapons other than guns causes much less damage to human beings; and gun violence is more common in the U.S.¹¹² I have seen two studies that examined the cost of medical care given to victims of gun shots, and both concluded that the total cost came to 0.2 percent of total health-care spending (see Table 5-5). The two studies cited in the table appear to be the most thorough ever done on the subject of gun-violence costs. Both studies included in their definition of gunshot costs the costs of ambulance services, hospitalization, physicians, drugs, physical therapy, and home health

Table 5-5: Gun violence accounts for a tiny portion of total U.S. health-care costs: Cost of injuries caused by guns, U.S., 1990 and 1994

| | Cost of treating gunshot injuries (\$, billions) | Total U.S. health care expenditures (\$, billions) | Gunshot costs as percent of total expenditures |
|------|--|--|--|
| 1990 | 1.4 | 699.4 | 0.2 |
| 1994 | 2.3 | 947.7 | 0.2 |

Sources: The estimate of cost of gun injuries for 1990 is from Wendy Max and Dorothy P. Rice, "Shooting in the dark: Estimating the cost of firearm injuries," *Health Affairs* 1993;12(4):171-185; the estimate of cost of gun injuries for 1994 is from Philip J. Cook et al., "The medical costs of gunshot injuries in the United States," *Journal of the American Medical Association*, 1999;282:447-454; total spending figures are from Katharine R. Levit et al., "Health spending in 1998: Signals of change," *Health Affairs* 2000;19(1):124-132, Exhibit 1.

care. The earlier study, done by Max and Rice, also included the cost of home modification, vocational rehabilitation, health insurance, and "other" expenses. Max and Rice did not distinguish gun injuries caused intentionally from those inflicted unintentionally or which were self-inflicted. Cook et al., the authors of the second study, did make this distinction; they found that 74 percent of gunshot injuries were caused by assaults. So if we restrict the definition of medical costs caused by "violence" to gunshot wounds *inflicted intentionally by others* (which is what U.S. apologists have in mind when they offer "violence" as an excuse for high U.S. health-care costs), the total cost for 1994 was even less than two-tenths of a percent of total spending.

I have never seen a study comparing the cost of gunshot wounds in the U.S. to the cost in other countries. But in view of how small the costs of gunshot wound are compared to total costs, we may predict with certainty that such a study would throw no light on the question of why U.S. health costs are so much higher than those of other countries.

Excuse number 6: Quality of care in the U.S. is superior

“The United States now has the best health-care system in the world.” Thus spake Senator Phil Gramm, the recently retired Republican senator from Texas, back in the early 1990s when one could still hear occasional discussions about the health systems of other countries.¹¹³ But Senator Gramm is wrong. It *is* accurate to say the U.S. has some of the world’s finest health-care professionals and medical centers. But that’s not equivalent to Senator Gramm’s claim that our “system” is the best.

Comparing the quality of the U.S. health-care system to the quality of other systems is difficult because health-care systems are complex. We’re talking about huge systems in which hundreds of thousands of health-care professionals deliver thousands of different types of treatments to millions of patients. In the U.S., we have 690,000 doctors,¹¹⁴ two million registered nurses,¹¹⁵ tens of thousands of other professional healers such as pharmacists, acupuncturists and chiropractors, 6,000 hospitals,¹¹⁶ 17,000 nursing homes,¹¹⁷ and tens of thousands of home health agencies, pharmacies, chemical dependency treatment agencies, and manufacturers of drugs, pacemakers, wheel chairs, and many other goods that American patients need. For physicians alone (never mind chiropractors, acupuncturists and other types of healers), the number of services they bill for is in excess of 7,000. That’s the number of codes listed in *Current Procedural Terminology*, the thick book published by the American Medical Association that tells physicians what code to enter on insurance claim forms to describe the type of treatment given.

In part because of the lack of interest within the U.S. health policy community in other nation’s health systems, and in part because health systems are so complex, studies comparing one nation’s system to another’s are scarce. The few studies that exist (at least in the English language) tend to compare only the U.S. and Canada. And much of that research was done in the 1980s and early 1990s when there was still a glimmer of hope that a single-payer system would get an honest debate in Congress. Research on other systems, especially research on public opinion about those systems, became scarcer after 1993 when the White House and numerous federal and state politicians endorsed managed competition as the solution to the health-care crisis.

The complexity of health-care systems means that any comparison of systems must rely on a variety of measures. The types of measures used fall into three categories: polling data, “vital statistics” (such as infant mortality rates and average lifespans), and studies that compare the quality of particular treatments, such as heart surgery. Each category has its strengths and weaknesses. The advantage of polls and vital statistics is that they are global measures – they tell you something about the entire system, not just one part of it, say, emergency services or treatment of back pain. Conversely, the advantage of studies that focus on the quality of care given to particular types of patients is that they can tell you something about small pieces of the system. I examine each of these three types of evidence next.

The quality excuse: Evidence from surveys

We begin with the surveys. There aren’t many of them. The most comprehensive survey was done in 1990 by Robert Blendon and his colleagues at Harvard and two other institutions. They asked a thousand citizens in each of ten countries whether they thought their “health-care system” needs “only minor changes,” needs “fundamental changes,” or must be “completely rebuilt.” The ten countries, ranked in order of score, are listed in Table 5-6. The U.S. ranked tenth out of ten (ours was the least popular of all ten systems studied), while Canada ranked number one. Only 10 percent of Americans were willing to say their system needed just minor change, while 60 percent

wanted fundamental change, and 29 percent wanted the revolution. Meanwhile, 56 percent of Canadians said their system needed only minor change.

The column on the right side of Table 5-6 presents per capita expenditures on health for each nation in 1987. You see an interesting pattern. You see a general correlation between spending on health care and the popularity of the health system. In other words, as spending declined, the popularity of the system declined. You will note, however, one flaming exception to this trend – America. We vastly outspent the other nine nations, and yet there we sat, at the bottom of the heap in terms of citizen

Table 5-6: Americans are unhappier with our system than citizens in nine other countries are with theirs: The public’s view of their health system in ten nations, 1990; per capita health expenditures, 1987

| | Minor changes needed ^(a) | Fundamental changes needed ^(b) | Completely rebuild system ^(c) | Per capita health exps (\$) |
|-------------|-------------------------------------|---|--|-----------------------------|
| Canada | 56% | 38% | 5% | 1,483 |
| Netherlands | 47% | 46% | 5% | 1,041 |
| W. Germany | 41% | 41% | 13% | 1,093 |
| France | 41% | 42% | 10% | 1,105 |
| Australia | 34% | 43% | 17% | 939 |
| Sweden | 32% | 58% | 6% | 1,233 |
| Japan | 29% | 47% | 6% | 915 |
| UK | 27% | 52% | 17% | 758 |
| Italy | 12% | 46% | 40% | 841 |
| US | 10% | 60% | 29% | 2,051 |

(a) The survey question was worded as follows: “On the whole, the health-care system works pretty well, and only minor changes are necessary to make it work better.”

(b) The question was, “There are some good things in our health-care system, but fundamental changes are needed to make it work better.”

(c) The question was, “Our health-care system has so much wrong with it that we need to completely rebuild it.”

Source: Robert J. Blendon et al., “Satisfaction with health systems in ten nations,” *Health Affairs* 1990;9(2):185-192.

Table 5-7: Americans are more dissatisfied than are citizens of Canada and the United Kingdom: The public’s view of their health-care system in three nations, 1990 and 1998, and per capita spending, 1996

| | Rebuild completely | | Minor changes needed | | 1996 | Per capita spending % change since ‘90 |
|----------------|--------------------|------|----------------------|------|-------|---|
| | 1990 | 1998 | 1990 | 1998 | | |
| United States | 29% | 33% | 10% | 17% | 3,708 | 38% |
| Canada | 5% | 23% | 56% | 20% | 2,002 | 18% |
| United Kingdom | 17% | 14% | 27% | 25% | 1,304 | 36% |

Sources: Polling data are from *1998 Commonwealth Fund International Health Policy Survey*, Commonwealth Fund (October 1998); cost data are from Organization for Economic Cooperation and Development, reported in Gerard F. Anderson, "In search of value: An international comparison of cost, access, and outcomes," *Health Affairs* 1997;16(6):163-171.

satisfaction.

This survey has not been repeated. The best updated version of this study was done in five English-speaking countries in 1998. The results from the 1998 survey for the three countries that were also in the 1990 survey appear in Table 5-7, along with the 1990 scores for these countries. Among these three countries, the U.S. system still remains the least popular, but the gap between the U.S. and Canada is smaller than it was in 1990. The table indicates that dissatisfaction rates remained roughly the same in the U.S. and the United Kingdom over the 1990-98 period, and increased in Canada.

As the right-most column in Table 5-7 indicates, the rising dissatisfaction in Canada occurred during a period of much slower growth in health expenditures in Canada compared with the U.S. and the U.K. The slowdown in Canadian spending was so substantial that Canada fell from the world's second-most expensive health-care system in 1987 to the fifth most expensive by 1996. Reports published since 1999 indicate that this downward trend in the growth rate of Canada's health spending is over.

Another way to assess the quality of a country's health-care system is to ask its doctors what they think. The same team of researchers who did the ten-nation survey described in Table 5-6 asked doctors in the U.S., Canada, and Germany the same questions they asked in the ten-nation survey – does their system need minor or fundamental change or does it need to be completely rebuilt. The researchers reported that "both West German and Canadian physicians were more satisfied with their systems than were U.S. physicians."¹⁸ The differences were large, especially between the German and U.S. doctors (see Table 5-8). Nearly half the German doctors were willing to say their system works well while less than a quarter of U.S. doctors were willing to say that.

Table 5-8: German and Canadian doctors like their systems better than American doctors like ours: Percent of U.S., Canadian and German doctors who say their systems work “pretty well and only minor changes are needed,” 1991

| | |
|---------|----|
| Germany | 48 |
| Canada | 33 |
| US | 23 |

Source: Robert J. Blendon et al., “Physicians’ perspectives on caring for patients in the United States, Canada, and West Germany,” *New England Journal of Medicine* 1993;328:1011-1016.

However, none of these international surveys – the ten-nation survey, the survey of five English-speaking nations, and the survey of doctors in three countries – can be treated as measures of quality only. That’s because the questions the pollsters used were not limited to quality. The pollsters asked people to comment on their “health-care system,” which means people were asked to think about both the quality of their system *and* its cost. It’s possible that the greater dissatisfaction expressed by Americans reflects more anger about the high cost of health care here rather than about quality of care. But we can say this: At minimum, these surveys lend not one iota of support to those who claim our health-care system is expensive because quality is superior.

The same pollsters who did the survey shown in Table 5-7 also asked their respondents to rate the quality of care they got at their last visit to their doctor and hospital. Obviously, these questions focused just on quality. Australians, Canadians, and New Zealanders were more willing to rate their last doctor visit as “excellent” than were citizens of the U.K. and the U.S. (see Table 5-9). Because this poll was conducted in 1998, well after the HMO backlash started in the U.S., Americans may have been complaining not so much about their doctor as about the interference in the doctor-patient relationship by managed care plans. Table 5-9 indicates the percent of citizens who rated their last hospital visit as excellent was roughly the same in all five countries. Table 5-9 provides no evidence for the claim that America’s health-care system is twice as expensive because it’s twice as good. In fact, our slightly inferior showing on the physician question suggests the quality of medical care in the U.S. is somewhat inferior to that of other countries.

Table 5-9: Americans less satisfied with physicians: Proportion of citizens of five nations who rated their physician and hospital care as excellent, 1998

| | Aus | Can | NZ | UK | US |
|---|---------|---------|---------|---------|---------|
| “Care received at most recent doctor visit” | 36% | 37% | 34% | 19% | 29% |
| “Overall hospital experience” | 27% | 28% | 24% | 28% | 26% |
| Per capita spending 1997 | \$1,805 | \$2,095 | \$1,352 | \$1,347 | \$4,090 |

Source: 1998 Commonwealth Fund International Health Policy Survey, Commonwealth Fund (October 1998).

The quality excuse: vital statistics

Now let’s shift from surveys to the second category of data comparing national health systems – vital statistics. Table 5-10 compares longevity and infant mortality in the 29 nations that were members of the Organization for Economic Development in 1995. The U.S. ranked 23rd in infant mortality (which is the percent of babies born alive who die in their first year), 20th in life expectancy for males, and 19th in life expectancy for females. The U.S. infant mortality rate of 8.0 per 1,000 was worse even than those for Spain and Portugal, countries which are much poorer than we are.

The quality excuse: studies of particular types of treatment

Now we move from the survey and vital statistics data – the data that give us a bird’s-eye view – to studies of the quality of particular types of health care. Unlike surveys and vital statistics, these studies tend to focus on just two countries at a time, and most of these compared the U.S. and Canada. I will discuss the U.S.-Canadian studies in a little more detail in Chapter 11 (see Table 11-4). Here I describe two studies, one which examined the primary care sectors of the health-care systems of ten countries, and

Table 5-10: The U.S. ranks low in infant mortality and longevity: Infant mortality and life expectancy, 29 OECD countries, 1995

| Country | Infant mortality per 1,000 live births | Life expectancy at birth, males (years) | Life expectancy at birth, females (years) |
|----------------|--|---|---|
| Australia | 5.7 | 75.0 | 80.9 |
| Austria | 5.4 | 73.5 | 80.1 |
| Belgium | 7.0 | 73.3 | 80.0 |
| Canada | 6.0 | 75.3 | 81.3 |
| Czech Republic | 7.7 | 70.0 | 76.9 |
| Denmark | 5.5 | 72.5 | 77.8 |
| Finland | 4.0 (best) | 72.8 | 80.2 |
| France | 5.0 | 73.9 | 81.9 |
| Germany | 5.3 | 73.0 | 79.5 |
| Greece | 8.1 | 75.1 | 80.3 |
| Hungary | 11.0 | 65.3 (worst) | 74.5 |

| | | | |
|----------------|-------------------------|--------------------------|--------------------------|
| Iceland | 6.1 | 76.5 (best) | 80.6 |
| Ireland | 6.3 | 72.9 | 78.5 |
| Italy | 6.2 | 74.4 | 80.8 |
| Japan | 4.3 | 76.4 | 82.8 (best) |
| Korea | 9.0 | 70.0 | 76.0 |
| Luxembourg | 5.0 | 72.5 | 79.5 |
| Mexico | 16.5 | 69.5 | 76.0 |
| Netherlands | 5.5 | 74.6 | 80.4 |
| New Zealand | 7.0 | 73.8 | 79.2 |
| Norway | 4.0 (best) | 74.8 | 80.8 |
| Poland | 13.6 | 67.6 | 76.4 |
| Portugal | 7.4 | 71.5 | 78.6 |
| Spain | 5.5 | 73.2 | 81.2 |
| Sweden | 4.1 | 76.2 | 81.5 |
| Switzerland | 5.0 | 75.3 | 81.7 |
| Turkey | 45.0 (worst) | 65.4(*) | 70.0(*) (worst) |
| United Kingdom | 6.0 | 74.3 | 79.7 |
| United States | 8.0 (23 rd) | 72.5 (20 th) | 79.2 (19 th) |

* 1994 data

Source: Gerard Anderson, "In search of value: An international comparison of cost, access, and outcomes," *Health Affairs* 1997;16(6):163-171.

another which examined the quality of ten types of surgery in the U.S. and Canada. Primary care is defined as the care people get when they first contact their medical system, that is, before they are referred to more specialized health-care professionals. Family doctors, internists, pediatricians, and obstetrician-gynecologists are usually described as primary care doctors. A 1991 study of the quality of primary care in ten countries concluded that primary care in the U.S. was inferior to that of most of the other countries studied.¹¹⁹ Here is how the Minneapolis Star Tribune summarized the study:

A study of the primary health care offered to citizens of ten industrialized nations has found the United States at the bottom. Dr. Barbara Starfield of the Johns Hopkins School of Hygiene and Public Health compared Australia, Belgium, Canada, Denmark, Finland, West Germany, the Netherlands, Sweden, United Kingdom, and the United States on three levels. . . . The United States ranked near the bottom in all three categories. The Netherlands, Canada and Sweden fared well across the board.¹²⁰

In a 1998 article, Dr. Starfield repeated her conclusion that the U.S. system is inferior to those of other countries, primarily because of its relatively poor primary care.¹²¹

The study described in Table 5-11 below is one of the best of the three dozen studies comparing the U.S. and Canada. It was done by researchers affiliated with Dartmouth, the University of Manitoba, and the Manitoba Center for Health Policy and Evaluation. It compared three-year mortality rates of Canadians (Manitobans) and Americans (New Englanders) over 65 who underwent one of ten types of surgery. The study found that Canadian mortality rates were lower for eight of the ten procedures, higher for open prostatectomy, and almost identical for hip fracture repair.

The authors noted that the Canadian surgeons may have outperformed the American surgeons even on open prostatectomy and hip fracture repair. They stated that

the New England men who underwent open prostatectomy may have been healthier than the Canadian men, which would have given the American patients a survival edge that had nothing to do with the quality of American surgery. The authors also noted that differences in “geographic distribution of patients and hospitals” in the two regions may have biased the hip surgery results against Manitoba. Because New England is compact and densely populated while Manitoba is more rural, the average New Englander who breaks a hip is much closer to a hospital than the average Manitoban. The authors reported that Manitobans were in fact more likely to experience a delay in surgery than New Englanders were. So, we can summarize this study by saying, for procedures where the playing field was level, Canada’s doctors outperformed America’s doctors in eight out of eight contests.

The quality excuse: recapitulation

The evidence we’ve just reviewed – surveys, vital statistics, and studies comparing the quality of certain types of care in the U.S. and other countries – indicates that quality of care in the U.S. is not better than, and may actually be somewhat inferior to, that of other countries. By no stretch of the imagination does this evidence support the claim made by apologists for the current system that quality of care in the U.S. is so

Table 5-11: Canadians are more likely to survive surgery than Americans: Manitoban versus New England mortality rates for ten types of surgery among elderly patients, 1980s*

| <u>Procedure</u> | Manitoba | Three-year mortality rate (percent) New England | |
|--|--------------|--|-------|
| Total hip replacement | | 8.35 | 10.56 |
| Simple cholecystectomy | 10.37 | | 16.53 |
| Open prostatectomy | | 15.64 | 12.23 |
| Carotid endarterectomy | 15.02 | | 21.73 |
| Transurethral prostatectomy | 20.45 | 22.15 | |
| Cholecystectomy with exploration of common bile duct | | 19.65 | 23.19 |
| Coronary artery bypass surgery | 12.43 | | 15.99 |
| Heart valve replacement | 19.81 | 24.94 | |
| Repair of hip fracture | | 42.13 | 41.83 |
| Concurrent valve replacement/bypass surgery | | 27.72 | 29.43 |

* The Manitoba results were for surgery done between 1980 and 1986; the New England results were for surgery done in 1984 and 1985.

Source: Leslie L. Roos et al., “Health and surgical outcomes in Canada and the US,” *Health Affairs* 1992;11(2):56-72.

superior to that of other countries that it warrants paying twice as much for it. As the *Philadelphia Inquirer* put it succinctly at the beginning of a series of articles about the U.S., Canadian and German health-care systems, "Americans pay more than people in other advanced countries, but aren't healthier. Canada and Germany get good care for less."¹²²

The quality excuse: The U.S. does more research

A relatively rare variation on the quality excuse is that America does more research than other countries. This claim is not supported by the evidence. Whether research effort is measured in terms of results (medical articles published; see Table 5-12) or expenditures (see Table 5-13), the U.S. effort appears to be about average. An unpublished paper presented to the Federation of European Cancer Societies in 2001 confirms this conclusion. The study, conducted by Dr. Francesco Grossi of the National Institute for Research on Cancer in Genoa, Italy, examined the number and "impact" of papers on cancer treatment published in the US and other industrialized nations. Dr. Grossi found that U.S. scientists placed fifth in "impact," behind Canada (in first place), Holland, Britain and Australia. Seven other countries "closely followed" the U.S., according to the newspaper article about this study.¹²³

Table 5-12: America publishes an average number of medical articles: Medical articles published per million population, 1990

| | |
|---------|-----|
| Israel | 819 |
| Sweden | 781 |
| UK | 594 |
| US | 526 |
| Canada | 520 |
| Germany | 354 |
| Japan | 250 |

Source: David U. Himmelstein and Steffie Woolhandler, *The National Health Program Book*, Common Courage Press, Monroe, ME, 1994, 109.

Table 5-13: America spends an average amount on research: Total health research and development expenditures per capita, 1994

| Country | Dollars per capita |
|-------------|--------------------|
| Switzerland | 164 |
| UK | 78 |
| Denmark | 71 |
| France | 63 |
| US | 59 |
| Japan | 35 |
| Canada | 22 |

Source: OECD, presented in Steffie Woolhandler and David U. Himmelstein, *For Our Patients, Not for Profits: A Call to Action*, The Center for National Health Program Studies, 1998, 114.

6

Waste In the System: Administrative Waste and Excess Capacity

A mental map of the waste

If you accept my arguments that the six excuses reviewed in Chapters 4 and 5 cannot explain the high cost of American health care, then your mind should be wide open to accepting the argument I make in this chapter and the next: The cause of America's high cost is wastefulness in the health-care industry. Or, to frame it in the volume-versus-price terms I was using back in Chapter 3, your mind should be open to the argument that excessive prices, driven by wasteful practices, is the main problem, not excessive use of health care.

When I speak of the health-care industry, I mean the health-care *delivery* sector and the health *insurance* sector. When I say the industry is wasteful, I mean two things. First, I mean that the industry spends a lot more money than is necessary to produce the medical goods and services we buy. Second, I mean that some players within the industry set their prices higher than is necessary, even taking into account their wasteful practices, which permits them to make enormous profits. Let me offer two examples to illustrate both types of waste.

The hospital industry is wasteful primarily in the first sense – its prices are high because it spends a lot of money on things it doesn't need to serve patients, such as advertising, empty beds, idle diagnostic machinery, clerks whose sole function is to deal with numerous insurance companies seeking to avoid paying bills, and enormous salaries for top management. But the hospital industry is not wasteful in the second sense I mentioned, that is, it doesn't set its prices so high above its costs that it makes huge profits. Profits in the hospital sector as a whole have never been unusually high (median hospital profits have hovered around 4 to 6 percent over the last decade), and for some rural hospitals, profit is so low they are in danger of going bankrupt.³⁰

Thus, when we read a study indicating that U.S. hospitals charge much more for a good or service than independent suppliers do, or Canadian hospitals do, we should not conclude that American hospitals are making enormous profits. We should conclude, rather, that they are inefficient. For example, one study reported that American hospitals charged 20 times more than Canadian hospitals for syringes, needles, and swabs and three times more for blood cell counts.¹²⁴ In view of the relatively reasonable profits of most U.S. hospitals, it is unlikely that these high prices were due to excessive profit-taking by U.S. hospitals. For the average U.S. hospital, it is far more likely that inefficient hospital practices explain high charges.

The drug industry, however, is an example of a sector within the health-care industry that is wasteful in both senses – it spends enormous sums of money on activities it shouldn't spend money on, and it sets its prices at such sky-high levels that it enjoys obscene profits. Examples of wasteful expenditures include the huge sums the drug companies spend on lobbying, advertising, cajoling doctors to prescribe their drugs, and researching “me too” drugs. The evidence that the drug industry often corrupts the research it funds is accumulating so fast that it

³⁰ Because the great majority of hospitals in the U.S. are nonprofit, it is more accurate to speak of the hospital industry's “margins” rather than its “profits.” “Surplus” is what accountants call the excess of revenue over costs of nonprofits, and “profit” is used to describe the excess of revenue over costs of for-profits. “Margins” refers to both profits and surpluses. I use “profit” in the text because it's a term most readers are familiar with.

may soon be fair to state that a large portion of the drug industry's expenditures on research are worse than a waste of money; they are expenditures that actually increase risks to patients. The evidence that the drug industry is guilty of price-gouging is the huge profits they make despite their wasteful expenditures. The drug industry makes profits three to four times those of the average Fortune 500 company, year in and year out. I will amplify these arguments in Chapter 7.

The waste in our health-care system can be divided into four categories: Administrative waste, excess capacity, excessively high fees and prices, and fraud. Unnecessary services constitutes a fifth category of waste, but, for reasons I discussed in Chapter 4, I don't list this category in Table 6-1. After you've read the descriptions of the four categories of waste listed in Table 6-1, I believe you'll agree that any type of waste in the health-care industry you can think of can be assigned to one of these categories, or to the category of unnecessary services.

Table 6-1: Waste in the American system can be divided into administrative waste, excess capacity, excessively high fees and prices, and fraud

Administrative waste*
 Insurance company overhead
 Provider (doctor and hospital) overhead
Excess capacity
High fees and prices
 High fees
 High drug prices
Fraud

* Ideally, other types of administrative waste should be listed here, not just excessive insurance company and provider overhead. The drug industry is unquestionably another source of excessive administrative costs. But the few studies that estimated administrative waste did not attempt to estimate excessive administrative expenditures by the drug industry. (Getting reliable data on drug industry administrative costs is probably impossible for anyone without subpoena power). Nor did they measure the variety of administrative costs employers and consumers incur in shopping for insurance and doing battle with insurance companies that refuse to reimburse doctors or authorize services.

“Administrative waste” refers to *excessive* administrative expenditures. Every human enterprise, be it a business or a high school choir, has to spend some money on administration. The issue is not whether we should be able to reduce administrative spending to zero, but whether the amount of money the U.S. health-care industry spends on administrative functions (clerical services, advertising, and other services that do not constitute medical care) is excessive. The answer is clearly yes.

“Excess capacity,” the second category of waste, refers to too many buildings and too much equipment. This is primarily a problem within the hospital industry. “High fees and prices” needs no further explanation. Fraud is estimated to siphon off as much as ten percent of the 1.5 trillion dollars the U.S. spends each year on health care.

I will discuss administrative waste and excess capacity in this chapter, and excessive fees and prices and fraud in Chapter 7. I discussed unnecessary services in Chapter 4 and will not discuss it further. I have kept the discussion of unnecessary services separate from the discussion of the other types of waste because the problem of unnecessary services has been exaggerated by proponents of managed competition and high-deductible policies, and because the solution to unnecessary services (research and education) remains the same regardless of whether we implement a single-payer system.

Waste category number one: Administrative waste

In 1993, the year that Bill and Hillary Clinton led the nation's policy makers and pundits in mass genuflection to the theory of "managed competition," the *Washington Monthly* published a fascinating article entitled, "Dead on arrival: Why Washington's power elite won't consider single payer health reform."¹²⁵ The authors – Tom Hamburger, then the Washington bureau chief for the Minneapolis *Star Tribune*, and Ted Marmor, a health policy expert at Yale – blamed the self-reinforcing behavior of Washington's "three established tribes – the politicians, the press, and the experts." Hamburger and Marmor reported that politicians refused to discuss the single-payer proposal because they were "terrified" of the health insurance industry; reporters generally failed to inform their readers of the details of single-payer and other health policy proposals because they were "too focused on politics, not on substance"; and experts didn't write articles and speak about single-payer because foundations generally refused to fund research on single-payer and because experts were fearful of "being dismissed as cranks or out-of-touch with *realpolitik*."

To this analysis I would add one other factor: The health insurance industry pours money into the nation's colleges, universities, and think tanks to fund professors and projects to the industry's liking. For example, the American Association of Health Plans, the trade group for HMOs, gave money to two professors at the University of California San Francisco to write an article which claimed that scientific research demonstrates that HMO care is not inferior to the care offered by doctors outside HMOs.¹²⁶ (I wrote a rebuttal to this article for the *American Journal of Public Health*¹²⁷). Blue Cross Blue Shield of Minnesota has funded a position at the University of Minnesota called the "Blue Cross Professor of Health Insurance," now occupied by Roger Feldman, an economist who claims managed care saves money and who advocates market solutions to the health-care crisis.¹²⁸ Stephen Shortell is the Blue Cross of California Distinguished Professor of Health Policy and Management at UC Berkeley.¹²⁹ Glenn Melnick is the Blue Cross of California Professor of Health Care at the University of Southern California.¹³⁰ Aetna, the nation's largest private-sector insurer, "gave a grant to the University of Pennsylvania for reworking the medical school curriculum to cover managed care issues," reported *American Medical News*.^{131 31}

We have already seen that health policy researchers paid much more attention to overuse than underuse of medical services. But nothing illustrates the bias of the nation's health policy experts better than their disinterest in the administrative costs of the U.S. system. With the exception of a few scholars associated with Physicians for a National Health Program (PNHP), a group representing 9,000 physicians who support a single-payer system, the health policy experts in this country have published no research on the total cost of administering the U.S. system. Most of what little research has been published on this subject appeared between 1991 and 1993, largely in response to two papers published in 1991, one by Steffie Woolhandler and David Himmelstein, leaders of PNHP who teach at Harvard Medical School, and the other by the U.S. General

³¹ The practice of buying influence at universities is not peculiar to the health insurance industry. American students may now sit at the feet of learned professors who occupy the Yahoo! chair of information systems technology (Stanford), the Coca Cola distinguished professor of marketing (University of Arizona), the Taco Bell distinguished professor of hotel and restaurant administration (Washington State University) (Paul Starr, "Your name here," *The American Prospect*, September-October 1998, 96), the Kmart professor of marketing (University of West Virginia), and the Freeport McMoRan (a mining company accused of despoiling the environment) chair in environmental studies (Tulane) (Eyal Press and Jennifer Washburn, "The kept university," *Atlantic Monthly*, March 2001, http://srd.yahoo.com/goo/%22The+kept+university%22/4/T=1010929679/F=dbd95fd3bfc0858f38faf12a4fb7da7c/*http://www.newamerica.net/articles/article.cfm?pubID=134&T2=Article, accessed January 13, 2002).

Accounting Office, a research arm of Congress.³² The Woolhandler-Himmelstein paper, published on May 2, 1991 in the *New England Journal of Medicine*, measured total administrative spending in the U.S. The GAO report, which had been requested by Representative John Conyers (D-MI), a single-payer supporter and, at the time, chairman of the House Committee on Government Operations, addressed a slightly different question: How much money would the U.S. save in administrative expenses if it adopted Ontario's single-payer system (Ontario is Canada's largest province)?

The widespread apathy among experts toward administrative spending stands in stark contrast to the enormous size of administrative costs. In their 1991 paper, Woolhandler and Himmelstein estimated that administering our system absorbed 22 percent of our health-care dollar in 1983, and 24 percent in 1987. In a subsequent paper, they estimated the total cost had risen to 25 percent in 1993. To put it another way, only three-fourths of our health-care dollar actually goes to doctors, nurses, pharmacists, home care workers etc. to take care of patients.

Of course, it's not possible for any group or business to devote all of its revenue to its "mission" or "program" and zero money to overhead. The issue, then, is not whether all administrative expenditures our health system incurs now are wasted. The issue is whether some portion of it is unnecessary. The small body of research available on this subject indicates that about half of the 25 percent of our health-care dollar spent on administration is necessary and the other half is wasted.

The wasted half is due to three features of our health insurance system: (1) The system is dominated by managed care plans; (2) the system consists of hundreds of health insurance companies and dozens of government insurance programs rather than one insurer (one payer of doctors and hospitals), which is the case under a single-payer system; and (3) the health-care industry is not constrained by true competition nor by regulation, and industry players, free from accountability to consumers and government, waste money in the two ways I've already mentioned – by spending on things they shouldn't, and by setting prices way above cost. I'll discuss the impact of managed care and multiple payers in this chapter. I'll talk about the absence of competition in the industry in Chapter 9 where I discuss the defects of managed competition.

Waste generated by managed care

You get some sense of the impact of managed care on administrative costs in Table 6-2. This table reports the results of a study that examined job growth in the entire U.S. health-care

³² The Woolhandler-Himmelstein paper and the GAO report provoked a conference on the subject of administrative costs; the conference, funded by the Robert Wood Johnson Foundation and conducted by the Alpha Center (an arm of the Robert Wood Johnson Foundation), was held in February 1992. Not surprisingly, this conference produced a number of papers sympathetic to the MCP industry, including: Anne K. Gauthier et al., "Administrative costs in the U.S. health care system: The problem or the solution," *Inquiry* 1992;29:308-320; and Kenneth E. Thorpe, "Inside the black box of administrative costs," *Health Affairs* 1992;11(2):41-55. The paper by Gauthier et al. asserted, for example, "New administrative structures are needed for the more difficult management tasks facing our society, such as . . . controlling costs, managing care, improving patient outcomes, producing useful data, and changing provider behavior" (317). The unabashed and undocumented claim that (a) all these things need doing and (b) must be done by health insurance companies should have embarrassed these authors.

Health Affairs published several articles on the issues raised by Woolhandler-Himmelstein and the GAO in its spring and summer 1992 editions, and *Health Care Financing Review* published an article on administrative costs of several nations. These and a half dozen other papers constitute the entire body of peer-reviewed literature on the cost of administering the U.S. system.

The media's interest in administrative costs has been as lukewarm as the experts'. In the early 1990s, newspapers published several articles about the rising overhead costs generated by managed care. (See, for example, Mariann Caprino, "Sick of paper," *Minneapolis Star Tribune*, January 15, 1993, 1; and Thomas M. Burton, "Firms that promise lower medical bills may increase them," *Wall Street Journal*, July 28, 1992, A1). With the exception of a few articles generated by government investigations of MCPs, the media has ignored the subject of administrative costs.

industry (both the insurance and provider sectors) between 1968 and 1993. You can see that growth in administrative jobs greatly exceeded growth in medical jobs. Between 1968 and 1993, the number of *medical* personnel working in the U.S. grew 159 percent, way below the 288 percent by which *administrative* personnel grew. This is not surprising. As we saw in Chapter 2, enrollment in managed care insurance grew rapidly during this period, especially after 1980.

Keep this table in mind, and the next time you hear about a study that claims to show that MCPs save money, ask whether the study measured all MCP costs (medical costs plus administrative costs) or just medical costs. It is common for managed-care advocates and experts to cite studies showing that MCPs reduce medical services as evidence that MCPs reduce *total* health-care costs. There is no question that MCPs cut medical services. But they also *raise* administrative costs. The increase in administrative costs probably offsets the savings realized through reduced services to patients, for a net effect on health-care inflation of zero.

Table 6-3 illustrates the same trend we saw in Table 6-2. Whereas Table 6-2 looks at the entire health-care industry, Table 6-3 looks at just the HMO industry. This table reports what happened to the administrative expenses of Minnesota's HMOs compared to their health-care expenses (that is, their expenditures on patients) between 1980 and 1991, a period during which HMO enrollment in Minnesota more than doubled. You see that HMO administrative expenses rose 403 percent compared to a mere 255 percent increase in their health-care expenditures. Given that their enrollment more than doubled, the rapid increase in administrative expenditures is astonishing. In most

Table 6-2: Administrative personnel have grown much faster than medical staff: Full-time-equivalent medical personnel (thousands) in the U.S., 1968 and 1993

| | 1968 | 1993 | Percent change |
|------------------------------|-------|--------|----------------|
| All medical personnel | 3,976 | 10,308 | 159 |
| All administrative personnel | 719 | 2,792 | 288 |
| Physicians | 430 | 761 | 77 |
| Registered nurses | 544 | 1,434 | 164 |
| Licensed practical nurses | 250 | 537 | 115 |

Source: David U. Himmelstein and Steffie Woolhandler, "Who administers? Who cares? Medical administrative and clinical employment in the United States and Canada," *American Journal of Public Health* 1996;86:172-178.

Table 6-3: HMO administrative costs shot up as HMOs spread: Minnesota HMO expenditures, 1980 and 1991 (per HMO member per month)

| Expense category | 1980 | 1991 | Percent change ^(a) |
|----------------------|-----------------------|------------------------|-------------------------------|
| Health care | \$30.11 | \$106.73 | 255% |
| Administrative | \$3.14 ^(b) | \$15.78 ^(b) | 403% |
| Total | \$33.44 | \$122.43 | 266% |
| Total HMO enrollment | 451,105 | 1,193,800 | |

(a) Percent changes calculated by the author. The figures for this column reported in the original source were wrong.

(b) These figures understate the HMOs' administrative costs. If you divide the \$15.78 of overhead in 1991 by \$122.43, you get 13 percent. Other data indicate the percentage is higher, possibly two to three times as high (see discussion in Chapter 11). The Minnesota Department of Health, the source for these data, requires HMOs to file annual reports on their expenditures. The Department permits HMOs to allocate some administrative services to the medical services category.

Source: Bert McKasy, Minnesota Commissioner of Commerce, and Marlene E. Marschall, Commissioner of Health, *Study of Health Care Management Companies*, St. Paul, MN, March 1993.

industries, a doubling of production would reduce overhead (another term for administrative costs) per unit produced. The fact that overhead per patient insured rose so dramatically during the 1980s in Minnesota was probably due to competition among HMOs to tighten their grip on doctors and cut the volume of medical services, which in turn required the HMOs to hire a lot more people to police the doctors. As was the case around the country, the huge increase in enrollment in Minnesota HMOs during the 1980s came at the expense of traditional insurers like Blue Cross. The Blues and other traditional insurers responded by adopting managed care tactics, which means their administrative costs also soared.

Whereas Table 6-2 shows that administrative costs mushroomed throughout the *entire health-care industry* as managed care spread, and whereas Table 6-3 shows administrative costs skyrocketing in the *HMO industry*, Table 6-4 shows administrative costs ballooned in the *hospital industry* during the period that managed care spread. You see that total hospital employment rose by 11 percent during the 1981-1993 period, but administrative personnel rose by 47 percent and, perversely enough, nurses were cut by 7 percent.

Given the limitations in the research, it is hard to say how much of the increase in administrative costs associated with managed care was generated within the insurance sector and how much appeared in the doctor-hospital-health-care-delivery sector. It is clear that managed care forced many clinics and hospitals to beef up their administrative staff to do more record-keeping for, and to argue with, MCPs. But it's not so clear that the displacement of the old-fashioned indemnity insurers by MCPs caused an increase in insurance industry overhead. It certainly is possible. On the one hand, MCPs had to hire a lot of people to police doctors that the indemnity insurers did not need. But, on the other hand, MCPs that used capitation and utilization review usually did not demand a bill for every service rendered as traditional insurers did; that means they needed fewer claims processors than traditional insurers did.

Table 6-4: Hospital administrative expenditure shot up as managed care spread: Percentage change in full-time-equivalent hospital personnel* per 1,000 adjusted patient days, adjusted for changes in patient health, 1981-1993

| | |
|--------------------|-------|
| Total | 11.3% |
| Nursing | -7.3% |
| Technicians | 16.2% |
| Nonprofessional | 19.5% |
| Administration | 46.5% |
| Other professional | 50.0% |

* “Nursing” personnel included registered nurses, licensed practical nurses, and aides; “technicians” included clinical technical personnel, such as pharmacy technicians; “nonprofessional” included nonclinical support personnel; “administration” included nonclinical administrative staff; and “other professional” included clinical professional staff such as dietitians, physical therapists, and social workers.

Source: Linda H. Aiken et al., “Downsizing the hospital nursing workforce,” *Health Affairs* 1996;15(4): 88-92.

Administrative waste generated by multiple payers in the insurance sector

Now let’s turn to the question of how America’s multiple-payer system contributes to excessive administrative costs. “Multiple-payer” means that America’s doctors, hospitals and other health-care professionals are paid by many different insurance companies and government insurance programs. It is difficult to find solid data on the number of health insurers operating in America today. That’s probably due to the fact that the fifty states regulate the insurance industry, which means there is no single government agency in America with a list of all health insurance companies currently licensed to do business in the country. Estimates of the total number of private-sector insurers operating in the U.S. run from 1,500 to 2,000.³³

In Minnesota in the late 1990s, approximately 250 health insurance companies were licensed to serve the state’s nearly 5 million residents. Like many other states, Minnesotans are also served by dozens of federally funded agencies, such as Medicare, Medicaid (which operates as fifty different programs, one for each state), the Veterans Health Administration and other programs for military personnel, plus dozens of state-funded programs that expand coverage beyond the poor people covered by Medicaid.

³³ Here is how two articles from the health policy literature put it:

Last year [1994], health-care providers submitted more than 4.8 billion claims to over 2,000 different commercial health insurance firms, health maintenance organizations, preferred provider organizations, Medicaid, and Medicare processors. [“Processors” refers to the private-sector insurance companies that process claims for Medicare.] (Stephen C. Gleason, “Health system deregulation: Some aspects of health care system reform need not be held hostage,” *Journal of the American Medical Association* 1995; 274:1483-1486, 1484.)

The current [1992] insurance market consists of approximately 1,500 third-party payers offering an infinite variety of payment, incentive, and benefit. . . . (Anne K. Gauthier et al., “Administrative costs in the U.S. health care system: The problem or the solution?” *Inquiry* 1992;29:308-320, 309.)

The multiple-payer system (with or without dominance by managed care companies) creates high administrative costs for both the insurance and the provider sectors. It creates high administrative costs for the insurance sector because private-sector insurers spend money on things public insurers spend little or nothing on, namely, marketing, underwriting (a strange word that means the insurer spends money to discover a patient's health history and adjust premiums accordingly), second-guessing doctors, lobbying, high salaries and lavish perks for executives, and, in the case of for-profit insurers, dividends for stockholders. The multiple-payer system generates high costs for providers because it forces providers to deal with dozens, hundreds, or thousands of different insurers, all operating with different rules and forms. Below I offer evidence that administrative costs for both insurers and providers are higher in multiple-payer systems. But before we turn to that evidence, let me first describe in a little more detail how existing single-payer systems work.

Canada's system is administered at the provincial and territorial level (Canada has ten provinces and three territories). The Canadian federal government provides the majority of the funding and sets minimum standards each provincial and territorial program must meet. The provincial health ministry is the single-payer, which means it's the sole source of funding for providers. Moreover, the health ministry has the authority to set limits on physician fees and to negotiate budgets with hospitals. Even though Canada's national health insurance program provides spotty coverage for prescription drugs (the poor and the elderly are usually the only populations covered), Canada imposes price controls on drugs at the national level, and the provinces cut their drug costs even further by buying drugs in large volumes from drug manufacturers, which gives them the clout to negotiate prices even below the national price ceilings. As you can see, the phrase "single payer" is really shorthand for two features: One payer reimburses doctors and hospitals, and that one payer has the authority to set limits on what doctors, hospitals, and drug companies can charge. The one-payer feature, and the fact that this one payer doesn't attempt to supervise doctors as America's insurers do, accounts for Canada's 1-percent insurer overhead.

Traditional Medicare (the non-HMO portion of Medicare which enrolls 85 percent of all Medicare beneficiaries) resembles a true single-payer but is by no means an ideal single-payer. Medicare resembles a single-payer primarily because it is the sole payer of clinics and hospitals which treat Medicare beneficiaries for services insured by Medicare. Moreover, traditional Medicare pays these providers directly, that is, it does not funnel payments through insurance companies so that the insurance company can scrape 15 to 35 percent off the top before passing the rest on to providers. Finally, Medicare sets limits on the fees doctors can charge. But (and here's where Medicare departs from a true single-payer), Medicare does not negotiate budgets for American hospitals. Instead, Medicare pays hospitals for each patient treated, and sets limits on what it will pay. Note I have said nothing about whether Medicare controls prices for drugs. Why? Because Medicare doesn't cover drugs (with the exception of a few drugs administered in a hospital, such as intravenous antibiotics).

With this explanation of Canada's system and of traditional Medicare, you're equipped to make sense of Table 6-5 which compares the overheads of the Canadian system and the U.S. Medicare program (the entire program, not just traditional Medicare) with those of private U.S. insurers. As you can see, the overhead costs of the Canadian system (1 percent of total revenues) and of Medicare (2 to 3 percent) are small compared to the 15-to-35-percent overhead of U.S. insurance companies. If these differences shock you, I urge you to consult the source materials I cite in Table 6-5. Better yet, use your commonsense. Ask yourself, what administrative activities do private-sector insurers engage in that Canada's national insurance program and traditional Medicare either do not engage in at all or pay very little for? Answer: marketing, underwriting (doing research

on applicants to see how sick they are and setting premiums accordingly), policing doctors (in the case of MCPs but not traditional insurers), lobbying, paying spectacular salaries to management, and paying dividends to stockholders (in the case of for-profit insurers but not nonprofits).

***Modern Healthcare*, a trade journal for the health-care industry, reported my favorite example of private-sector administrative waste. In the early 1990s, the U.S.**

Table 6-5: Single-payers have lower overhead: Administrative costs for Canada's system, Medicare, and private health insurance companies as a percent of total revenue

Canada: 1%

Medicare: 2-3%*

Average, all private-sector health insurance companies: 15-35%

* I list a range of 2-3 percent for Medicare because the number varies from year to year.

Sources: For Canada, Steffie Woolhandler and David U. Himmelstein, "The deteriorating administrative efficiency of the U.S. health care system," *New England Journal of Medicine* 1991;324:1253-1258; for Medicare, annual reports of Medicare's trustees; for health-insurance-company figures, see Appendix A.

Senate investigated Blue Cross Blue Shield plans in the District of Columbia and several eastern states. The Senate report found numerous unexplained trips to exotic places by executives of the District of Columbia Blue Cross Blue Shield. *Modern Healthcare* offered this tidbit: "Also on the travel bill: a trip by the plan's president Joseph Gamble, that took him to London, Paris and finally Zimbabwe at a cost of nearly \$8,000. The reason for the trip? Mr. Gamble had to give a speech in Zimbabwe on fraud in the insurance industry."¹³²

An audit of the books of Allina, a mammoth Minnesota nonprofit HMO, by Attorney General Mike Hatch, turned up numerous examples of clearly wasteful administrative expenditures. Allina, which does business only in Minnesota, Wisconsin and the Dakotas, paid for more than 1,000 trips to California and Florida, more than 30 trips to Hawaii, as well as trips to Aruba, London, France, Italy, Amsterdam, Athens, Mexico and Puerto Rico between 1998 and 2000. One of the California trips was taken by eight Allina executives to the beautiful city of Monterey to take a seminar on how Allina could find its "moral center." One dinner for these ethically challenged executives was served in a restaurant overlooking the 18th hole of the Pebble Beach Golf Course. Cost: \$1,500.¹³³

Lobbying legislators and the public is another administrative expense private-sector insurers incur that Canada's system and traditional Medicare do not incur. The single best known example of such lobbying is the series of "Harry and Louise" ads prepared for the Health Insurance Association of America. These ads attacked Bill Clinton's 1993 Health Security Act. Other examples of lobbying by the insurance industry include expensive media campaigns against Proposition 186, the 1994 single-payer ballot initiative in California, and Measure 23, the 2002 single-payer initiative in Oregon. The insurance industry outspent the proponents of Proposition 186 by three to one, and the proponents of Measure 23 by ten to one.

I have no idea how much the insurance industry spent to defeat the Patient Protection Act, a bill introduced by Senator Paul Wellstone in 1994, but it was no doubt a lot of money. The industry's campaign to defeat this bill included helping Republicans fundraise,¹³⁴ and, at least in Minnesota, pressuring insurance company employees to call members of Congress. On July 20,

1994, the Minneapolis *Star Tribune* reported that Blue Cross Blue Shield of Minnesota's (BCBSM) had been caught urging its employees to lobby against the Patient Protection Act that Senator Wellstone had just introduced with support from the American Medical Association. Worse, the employees had been told to hide their connection to BCBSM. The memo asking BCBSM employees to do this came from BCBSM's "legislative director," Tom Lehman. The letter had gone to all BCBSM employees in Minnesota's Third Congressional District, which was represented by Representative Jim Ramstad (R-MN), who was considering sponsoring the Wellstone bill in the House of Representatives. According to a spokesman for Ramstad, Ramstad had gotten only 20 calls, all positive, regarding the Patient Protection Act prior to the mailing of the Lehman memo. After Lehman's memo went out, Ramstad's office got 58 calls, all opposing the Patient Protection Act.¹³⁵ Polling data suggest that the vast majority of Americans consider the money spent on lobbying like this to be a waste of premium dollars.

If Canada's single-payer, and the traditional Medicare program in the U.S., do not pay for expensive advertisements and sales forces, do not underwrite, do not pay their managers millions of dollars and send them on junkets to exotic places, do not lobby politicians and take out ads to defeat federal legislation (which is what the U.S. insurance industry did to Bill Clinton's Health Security Act), do not take out ads to defeat initiatives on state ballots (which is what the U.S. insurance industry did to defeat a 1994 single-payer initiative in California and a 2002 single-payer initiative in Oregon), do not tell doctors how to practice medicine, and do not have to make a profit for stockholders, is it any wonder that these public insurers are vastly more efficient than private-sector insurers?

Administrative waste generated by multiple payers in the provider sector

In the previous section, we examined the effect that multiple payers have on administrative expenditures by insurers. In this section, we examine the effect of multiple payers on the administrative expenditures of *doctors* and *hospitals*.

The administrative waste generated by multiple payers is probably higher for the provider sector than it is for the insurance sector. Whereas the insurance sector in a multiple-payer system wastes money on marketing, underwriting, policing doctors, lavish executive salaries and perks, lobbying, and profit, the provider sector wastes money (a) keeping track of every service and item in order to document it in a bill to an insurer, and (b) dealing with multiple insurers. I have seen no research describing the average number of payers clinics and hospitals deal with nor the average number of employees it takes to deal with these payers. However, I can cite a poll indicating that 95 percent of physicians believe managed care has increased their paperwork.¹³⁶ And I can pass on anecdotes, such as these, from the physician and hospital sectors reported by the lay media:

In my urban practice I participate in 29 different managed-care plans, each with its own panel of physicians, consultants, hospitals, and diagnostic facilities. . . . It . . . is a time-consuming burden to locate the consultants for each plan. . . . The snarled referral process depletes the physician's energy and drives up administrative costs. It can take hours to accomplish what used to be achieved with a simple note or telephone call to a trusted colleague. I have added one full-time administrative person whose time is almost entirely devoted to arranging managed-care referrals. The myriad plans, with complexities of primary and secondary billing, have also made my billing extraordinarily expensive and complex. What was once handled by one person now requires two-and-a-half employees, an expensive computer system, and expensive maintenance contracts for hardware and software. [Letter from a physician to the *New England Journal of Medicine*]¹³⁷

Some urban teaching hospitals must deal with as many as 100 different so-called utilization review firms, “all of whom have different criteria,” says Adrienne Levatino, vice president at the Illinois Hospital Association.¹³⁸

Large American hospitals (those with more than 400 or 500 beds) cope with payers totaling in the hundreds, and occasionally thousands, and they need 50 to 70 employees in their billing departments versus ten to 15 people in large Canadian hospitals (which deal with one payer primarily) and German hospitals (which deal with many payers, but these payers have to follow similar billing procedures).³⁴ One of the best pieces published by the U.S. media about the health-care reform debate was a 1993 series of articles in the *Philadelphia Inquirer* that examined the U.S., Canadian, and German systems by focusing on a single hospital in each country: Lankenau Hospital (475 beds) in Wynnewood, Pennsylvania; North York General Hospital (473 beds) in Toronto, Canada; and Schwabing Hospital (1,372 beds) in Munich, Germany. The centerpieces of these articles were detailed descriptions of the experiences of patients treated at these three hospitals. The articles also offered a rich picture of hospitals and the health-care systems in which they operated. I thought the following description of the billing departments of these three hospitals was priceless:

[T]he billing office [at Lankenau in Pennsylvania] was a blur of activity. There, dozens of hospital staffers were chasing after hundreds of pending hospital bills. Sitting in cubicles with computer terminals and reams of files, these employees tracked bills both old and new, some stretching back two years. In all, 53 people would spend this day at Lankenau making sure the hospital got the money it needs to operate. This was no easy task, considering how many ways there are in the U.S. to pay medical bills. . . . It’s such a complicated, time-consuming business that Lankenau’s finance section is larger than its departments of pediatrics or obstetrics or radiology. . . . Every plan [that Lankenau deals with] offered a different type of coverage. One had a \$1,500 deductible, another had a \$300 deductible plus a \$150 deductible for every hospital admission, and another had a \$125 deductible and 80 percent coverage until the patient spent another \$400, after which full coverage kicked in. North York General in Toronto doesn’t have to spend its time or money badgering insurance companies. Because its budget is almost totally funded by the government at the start of every year, it can make do with a dozen people in its billing office. . . . The German billing system is equally hassle-free, and Schwabing – with three times as many beds as Lankenau – needs only 18 people to do the job.¹³⁹

According to *U.S. News and World Report*, Riverside Methodist Hospitals, a 1,063-bed medical complex in Columbus, Ohio, needed 66 employees in its billing department as of 1992, twice the number it needed ten years earlier.¹⁴⁰ First prize for the highest number of payers a hospital or clinic has to suffer goes to the Mayo Clinic in Rochester, Minnesota. According to the *New York Times*,

³⁴ Because Canada’s national health insurance system does not cover everything for sale in the Canadian health system, two-thirds of Canadians have supplemental insurance. The insurance covers items like drugs and a private room in a hospital. For some patients hospitalized in Canada, the hospital may have to bill more than one insurer, but the calculations required are far simpler than those required of U.S. hospitals. Germany has a multiple-payer system, but the multiple insurers (called “sickness funds”) are heavily regulated. Among the regulations they must abide by are regulations that make coverage uniform. These regulations minimize overhead costs for *providers*; they do not appear to reduce the overhead costs of the German *insurers*. According to OECD data, insurer overhead as a percent of health expenditures in 1990 was higher in Germany than it was in the U.S., and much higher than it was in Canada (David U. Himmelstein and Steffie Woolhandler, *The National Health Program Book: A Source Guide for Advocates*, Common Courage Press, Monroe, ME, 1994,123).

“The billing office at Mayo deals with more than 2,400 insurers, each with its own standards. To ease the crunch, the 70 employees in the office have subspecialized, for example, with one in psychiatry and another in rehabilitation medicine. Together they make an average of almost 500 phone calls a day to insurers. . . .”¹⁴¹ (If Mayo is dealing with 2,400 payers, it must be dealing not only with the 1,500 to 2,000 U.S. insurers, but several hundred foreign payers as well.)

In addition to the bewildering differences in coverage among payers, doctors must cope as well with bewildering diversity in obligations imposed upon doctors by their various payers. Ironically, an Aetna attorney recently relied on this fact in arguing to a federal judge that the judge should not consolidate several lawsuits by physicians against several MCPs, including Aetna. According to Aetna, the lawsuits, which alleged fraud by the MCPs and which involved a total 600,000 U.S. doctors, should not be consolidated into a single class-action lawsuit because each MCP is unique in the rules it uses to control and reimburse doctors. Aetna, he said, uses 22,000 different physician fees and more than 1,500 different physician contracts.¹⁴²

In the early 1990s, before the HMO backlash, it was occasionally alleged that Medicare’s true overhead costs are higher than 2 to 3 percent because Medicare “offloads” administrative work onto doctors and hospitals at a greater rate than private-sector insurers do. It is true that Medicare’s paperwork for doctors and hospitals can be a royal pain, but there is no evidence that Medicare’s paperwork is more burdensome than the private sector’s. Because of the experts’ indifference to administrative costs, no studies on this question have been published, for or against this proposition, in the professional literature. The only study I’m aware of was a survey done by the American Medical Association in which doctors were asked how much time it takes them to prepare a Blue Shield claim versus a Medicare claim. The doctors indicated it took their staff about one hour for each type of claim.¹⁴³

Are the extra administrative costs of a managed-care, multiple-payer system wasteful?

None of the studies and newspaper articles we’ve reviewed attempted to distinguish the impact of *managed care* on administrative costs from the impact of *multiple payers*. However, the evidence indicates both features of our system inflate administrative costs for both sectors of the health-care industry – the insurance sector and the provider sector. When we compared administrative costs over time, we saw that they have risen during the period managed care spread, which strongly suggests managed care was the cause. And when we compared the administrative costs of single-payer to multiple-payer systems, we saw that single-payers generate much lower overhead costs.

Defenders of our system argue that all the money we spend on administrative costs is wholly or partially justified by benefits Americans allegedly derive from managed care and multiple payers. They argue that managed care improves quality of care and reduces costs. They claim multiple payers provide consumers with “choice of insurance company,” and this choice is valued by all or most consumers. Neither argument is valid. Let’s take the apologies for managed care first.

Here is an example of an ostensibly neutral health policy expert justifying the high administrative costs associated with managed care. Glenn Melnick, the Blue Cross-sponsored economist at USC we met earlier, offered this argument to the *Washington Post*: “Let’s say you have two hospitals, one that has a single administrator and one with a large administrative staff. If that staff is looking at the cost-effectiveness of health care and studying outcomes, its administrative costs will be higher, but its cost per patient will be lower.”¹⁴⁴ Melnick is implying that the enormous increase in hospital administrative costs that occurred during the era of managed care can be attributed to a large increase in scientists on hospital staffs who are finding ways to reduce hospital

costs while maintaining or improving “outcomes,” health policy jargon for the effectiveness of treatments given to patients.

There is no published evidence to support Melnick’s assumption that the primary cause of rising administrative costs at either the hospital or system level is an increase in scientists measuring “effectiveness of health care” and “outcomes.” Nor is there any published evidence to support Melnick’s claim that the additional administrative costs of hiring these scientists (as opposed to other types of hospital bureaucrats) has been more than offset by a decrease in hospital costs. Finally, there is little evidence to support Melnick’s claim that the alleged presence of these hospital scientists has improved quality of care for the average hospital patient. I will discuss what evidence we have on the effect of managed care in more detail in Chapter 9. I’ll summarize the scientific evidence here:

- (1) The evidence that managed care has saved America money is inconclusive; the fairest conclusion is that managed care has not saved any money.
- (2) The evidence on managed care’s impact on quality indicates managed care has, on balance, damaged quality.

In short, there is no good evidence supporting the claim by proponents of managed care that the extra administrative costs generated by managed care are justified by comparable benefits, either in the form of lower costs or improved quality.

Now let’s examine the claim that the mere existence of multiple insurance companies for consumers to choose from is a blessing. The claim that Americans get some benefit from having numerous insurance companies to choose from never comes from the average consumer. In my 15 years of talking to average Americans about our health-care system, I have never once heard this argument made. The argument is made only by experts, typically economists, talking to one another at conferences or in the pages of professional journals. “Argument” is actually too fancy a word for what they offer. They simply assert that Americans “value choice” of insurer; they offer no documentation and no elaboration. Here are two examples, the first from the United States General Accounting Office, and the second from Patricia Danzon, a conservative economist:

In the United States, multiple entities – some federal, some state, and some private – have a role in financing, administering and reimbursing the health-care system. The lack of a single entity managing the system results in piecemeal measures to control costs. On the other hand, the decentralized competitive system offers the possibility of greater consumer choice concerning the level and nature of health-care benefits for some Americans. It has also led to the development of innovative approaches to health-care delivery, like HMOs and managed care.¹⁴⁵

[T]he diversity of insurance plans that emerges in competitive insurance markets reflects the diversity of patient preferences. . . . The flip side of higher overhead costs accompanying a health-care market that offers choices among plans is that diverse consumer preferences are better satisfied than if all consumers must accept a uniform public plan.¹⁴⁶

The claims made here that “greater consumer choice” and “choices among plans” are benefits Americans value are examples of naked ideology at work. Evidence abounds that Americans value the right to choose their own *doctor*. But there is no scientific evidence, nor, to my knowledge, any anecdotal evidence, that Americans place any value, much less a high price, on the “right” to choose between, say, Blue Cross and Prudential. The traditional Medicare program is a “one-size-fits-all” insurance program, to quote the contemptuous phrase used by conservatives who

seek to privatize Medicare, yet the elderly who enjoy Medicare coverage are not clamoring for “choice” of insurer. Medicare is a very popular program (see further discussion in Chapter 11).

The claim that Americans value choice of insurer is further undermined by the fact that roughly half of all nonelderly insured don't have the option to choose among insurance companies. For these Americans, choice of health plan is non-existent because their employer tells them what plan will be available.³⁵ For those whose employer gives them choice, their options are rarely more than two or three, and, for most employees, these options long ago ceased to include a traditional insurer. The only Americans with lots of choices in the primary-insurance market (as opposed to insurance that supplements Medicare) are the four or five percent of us who have to buy health insurance on our own and who have the money to do so.

The only conceivable argument in favor of the claim that “Americans value choice of insurance company” is the raw conservative credo that the healthy should have the option to choose an insurance company that avoids the sick and thereby keeps its premiums below average. But this argument that “Americans” want choice so “we” can avoid having to subsidize the sick appeals only to a portion of the American populace. Judging from opinion surveys on related topics, this portion is a very small minority. Large majorities of Americans support traditional Medicare, which is a uniform public plan subsidized by all of us, and large majorities support national health insurance or the principles underlying national health insurance. Harris polls indicate, for example, that 91 percent of the nation in 1987, and 88 percent in 1994, felt that “everybody should have the right to get the best possible health care – as good as a millionaire gets.”⁴⁷

In fact, considerable anecdotal evidence exists that Americans view “choice among plans” as a liability. Unlike conservative economists who have nothing better to do with their time than shop on the Internet for health insurance, the average American is frustrated by the difficulty of shopping for health insurance in the chaotic American insurance bazaar. As we shall see in Chapter 8, the average American would much prefer a national, universal health insurance system that provided uniform coverage.

We may conclude this section, then, by observing that we pay higher administrative costs for the privilege of funneling our health-care dollar through hundreds of insurance companies, managed or unmanaged, and we incur administrative costs as well for the privilege of having these insurance companies tell our doctors how to practice medicine. Neither of these features – the multiplicity of insurers, and the use of managed care by insurers – can be justified on the ground that consumers want them and are benefiting from them. We may conclude, therefore, that the administrative expenditures associated with these features are wasted dollars.

Waste category number two: Excess capacity

Let me begin this section by giving you a concrete example of how excess capacity raises the cost of our health-care system. Researchers affiliated with two federal agencies, the National Institutes of Health and the Food and Drug Administration, published a study in 1990 demonstrating that 10,000 mammography machines were in use in the U.S. that year, but only 2,600 were needed. That meant that each mammogram facility was doing an average of six mammograms a day at a cost of about \$110 per mammogram. According to the authors, if there were fewer facilities and each one did 20 to 30 mammograms a day, the cost per mammogram would drop to \$50. The reason for this dramatic difference in price is that mammography facilities have very high

³⁵ Estimates of the percent of workers who have a choice of two or more plans vary, from 45 percent (1993 figure) to 60 percent (2001 figure) (Thomas Rice et al., “Workers and their health plans: Free to choose?” *Health Affairs* 2002;21(1):182-187).

fixed costs (costs that do not vary with the utilization rate of the machines); as these fixed costs are spread out over more mammograms, the cost per mammogram falls.¹⁴⁸ Observing these statistics, historian and managed-care proponent Paul Starr said, “Only in America are poor women denied a mammogram because there is too much equipment.”¹⁴⁹

Like the problem of excessive administrative costs, the problem of excess capacity – too many idle machines and facilities – is a woefully understudied phenomenon. Like excessive administrative costs, excess capacity is a relatively unpopular subject with the experts and the health-care industry because it places blame on the supply-side of the health-care sector (particularly hospitals) rather than consumers. Moreover, the persistent problem of excess capacity reveals a serious defect in the theory that competition works in the health-care industry and can be counted on to make the system efficient and keep price inflation to a minimum.

The literature on this subject consists of news stories and a very small number of scientific studies, most of it published prior to the mid-1990s when the MCP industry was in the last phase of its takeover of the health-care industry. This literature demonstrates that between the 1960s (and possibly earlier) and the 1990s, hospitals “competed” with one another not by lowering prices but by purchasing every conceivable medical device, regardless of whether the community in which this “competition” was occurring was already saturated with more than enough devices to meet demand in that community. This form of “competition” between hospitals was called “an arms race.”¹⁵⁰ The literature on the “arms race” suggests that it continued after the mid-1990s, the only difference being that by then the combatants had changed from individual hospitals to MCPs, hospital chains, and large physician groups.

To give you some idea of how the arms race works, consider this excerpt from an article that appeared in the *Wall Street Journal* back in 1990:

[Dateline] Kalamazoo, Mich. – When the two archrival hospitals here found out that both planned to launch helicopter ambulance services, they flew into action. Borgess Medical Center quickly found a copter, called photographers and was first to get pictures in the local paper. But Bronson Methodist Hospital struck back, getting its chopper into the air first and proudly proclaiming a nurse aboard every flight. Borgess retaliated three months later, boasting a doctor on every trip. Within a year, each hospital had upgraded to twin-engine choppers – making the announcement the same week. “There are only 90 helicopter ambulances in the whole country,” an exasperated executive of Upjohn Co., the city’s largest employers, said at the time, “and two of them are here. Not to mention two heart programs, two maternity wards, two state-of-the-art emergency rooms, and two radiology services. . . . In most businesses, competition cuts prices. But hospital bills in Kalamazoo . . . are the second highest in Michigan and among the highest in the nation. In general, hospital costs in two-hospital towns like Kalamazoo are 30 percent higher than in one-hospital communities. . . .”¹⁵¹

Or consider these excerpts from a *Wall Street Journal* article published in 1994:

The Gamma Knife is a medical device that costs \$3 million. It emits gamma radiation to treat brain tumors and lesions. But it is used on only a few types of tumors, and most of the 16 Gamma Knives in the U.S. are idle for all but two days a week. By some estimates, just six of them could have treated all American patients last year. . . . For people worried by runaway costs, the Gamma Knife is a troubling case. “It all comes down to a race to see who can have the better toys,” charges James Proffitt, health-benefits manager at McDonnell Douglas Corp. of St. Louis. . . . [I]n southern Florida, . . . two nearby hospitals are battling to see which can make the most of the Gamma Knife. A midsize community hospital, Doctors Hospital in Coral Gables, acted first, installing one last

October [1993]. On March 28 [1994], Miami's biggest teaching hospital, Jackson Memorial Medical Center, activated its Gamma Knife. Officials at both facilities concede it is ridiculous to have two such specialized machines only ten miles apart. Yet neither would dream of yielding to the other.¹⁵²

According to other media reports, the "arms race" also produced too many cardiac-catherization labs, cancer radiation facilities, rehabilitation services, magnetic resonance imagers, bone-marrow transplant facilities, neonatal intensive care units, and hospital beds.¹⁵³

This anecdotal evidence suggests a perverse hypothesis: That hospitals that have no competing hospitals nearby charge less than hospitals that do have competitors in their neighborhoods. Several studies confirmed this hypothesis. The *Wall Street Journal* reported on a survey that showed that "hospital costs in two-hospital towns . . . are 30 percent higher than in one-hospital communities."¹⁵⁴ A study involving the great majority

Table 6-6: Hospital fees rise as "competition" intensifies: Hospital costs in relation to number of competitors, 1982

| No. of neighboring hospitals within 24 km | Avg cost per patient day | Avg cost per patient admission |
|---|--------------------------|--------------------------------|
| 0 | \$325 | \$2,268 |
| 1 | \$331 | \$2,340 |
| 2-4 | \$340 | \$2,432 |
| 5-10 | \$362 | \$2,674 |
| 11+ | \$373 | \$2,859 |

Source: James C. Robinson and Harold S. Luft, "Competition and the cost of hospital care, 1972 to 1982," *Journal of the American Medical Association* 1987;257:3241-3245.

of U.S. hospitals documented this same goofy relationship between "competitors" and price for the whole country. The results of this study, shown in Table 6-6, indicate that hospital costs, whether measured as the cost of serving one patient for one day or as the cost per patient admitted, rose as the number of competitors within 24 kilometers rose (a kilometer is six-tenths of a mile). For example, hospitals that had eleven or more hospitals within 24 kilometers charged \$373 per day (see second column) while hospitals with no competitors within 24 kilometers charged only \$325 a day. This is, of course, Economics 101 turned upside down.

In the early 1990s, when the media was paying some attention to the excess-capacity issue, the consensus of expert and industry opinion was that the arms race was driven primarily by hospitals' efforts to please doctors.³⁶ Doctors, of course, are the people who decide whether to admit patients to hospitals, and, with a few exceptions such as maternity and emergency patients, patients usually go to the hospital their doctor refers them to. In the days before MCPs took power

³⁶ For example, Carolyn W. Madden offered this explanation in an influential health policy journal: "Competition among hospitals actually encouraged overbuilding because competition was quality- and technology-based rather than cost- or price-based. Hospitals needed to have the full range of available equipment and facilities in order to attract and retain a medical staff. . . ." ("Excess capacity: Markets, regulation, and values," *Health Services Research* 1999;33:1651-1682, 1653).

away from physicians, physician control over hospitalization gave doctors great leverage over hospitals. “I get threats all the time from doctors who say if I don’t give them what they want, they’ll go across town to Ohio State or Mount Carmel,” said Nancy Schlichting, CEO of Riverside Methodist Hospitals

in Columbus, Ohio.¹⁵⁵ The *Wall Street Journal* offered the same explanation for the rapid spread of the Gamma Knife. “Last fall, Mr. Proffitt of McDonnell Douglas [which merged with Boeing in 1997] . . . tried to block a Gamma Knife purchase in Kansas City, arguing that the few patients who needed it could go to medical centers in Chicago or Denver. But when a top neurosurgeon hinted that he might leave Kansas City if he didn’t get a Gamma Knife, opposition to the purchased collapsed.”¹⁵⁶

Now that MCPs have dethroned doctors, the media, for some reason, has lost interest in the excess-capacity issue. But anecdotal evidence,¹⁵⁷ and a few empirical studies, indicate the arms race continues. For example, Cindy Bryce and Kathryn Cline reported a rapid increase in supply of five types of medical machinery during the late 1980s and early 1990s in Pennsylvania. Bryce and Cline looked at data for lithotripters (machines which pulverize kidney stones with sound waves), magnetic resonance imagers (MRIs), cardiac catheterization labs (facilities that inject dye into hearts in order to look for blockages in coronary arteries), organ transplant facilities, and neonatal intensive care units.

Of these technologies, lithotripters appeared to be the most over-supplied. Bryce and Cline reported that lithotripters can perform up to 2,000 procedures annually, and that Canada’s lithotripters averaged more than 1,700 procedures in 1991. Prior to 1986, Pennsylvania had a regulation in place that limited the number of lithotripters in the state to five until such time as all five machines were performing at least 1,000 lithotripsy procedures annually. But when this regulation was repealed, the number of machines in the state shot up and utilization rates per machine fell. Between 1988 and 1994, the number of machines rose from six to 13, but the total number of procedures performed rose only 40 percent, resulting in a decline in the average annual utilization rate from 773 to 489 procedures per machine. In 1988, *two* of the *six* machines were doing more than 1,000 procedures annually. By 1994, *none* of the *13* lithotripters were doing more than 1,000 annually. The authors estimated that if five of the 13 machines were eliminated, the average cost of a procedure would fall from \$2,107 to \$1,331.¹⁵⁸

The Pennsylvania study was limited to five types of medical machinery in one state. Yet this study may be the broadest study of the cost of excess capacity published to date. No one has published an estimate of the cost of excess capacity for the whole country, much less for the U.S. and several other countries. So it is impossible to say with any confidence how much the excess-capacity problem contributes to the high cost of U.S. health care compared to other countries. But Table 6-7, which looks at just two types of machinery, suggests excess capacity accounts for at least some of the difference. The supply of CAT scanners and MRIs in the U.S. greatly exceeds that for all other nations with the exception of Japan. Japan’s stellar showing in this table may reflect the power of the MRI and scanner manufacturers in that country. It is impossible to tell from Table 6-7 what the appropriate number of these devices is. Judging from occasional stories of long waits for MRIs in Canada, Canada’s 1.3 MRIs per million people is too low.³⁷ On the other hand, the Bryce-Cline study of Pennsylvania’s excess capacity reported that MRIs in that state operated at only 60 to

³⁷ Some poor countries of the world don’t have even one MRI or CAT scanner. According to an Afghan pediatrician, “There is not a single CAT scan [he must have meant “scanner”], MRI or dialysis machine in the whole country [of Afghanistan]” (Tim Weiner, “A bazaar is newly abuzz and the talk is of a new era: After the Taliban, What?” *New York Times*, November 29, 2001, B5).

75 percent of the state's recommended volume level. This suggests that the 16 MRIs per million people in the U.S. is too high.

There are two differences between today's arms race and the race as it was conducted a decade ago. First, today's "competing" hospitals are more likely to be members of large MCPs or hospital chains than independent hospitals. Second, physician groups are more likely to be participants in the arms race than they were a decade ago. During the 1990s, many physicians, upset by their inability to raise their incomes faster than inflation, opened clinics and same-day surgery centers that drew patients away from

Table 6-7: Compared to other countries, the U.S. supply of imaging devices is very high: CT scanners and MRIs per million people in eight nations

| Country | CAT scanners (1996) | Magnetic resonance imagers (1996) |
|-----------|---------------------|-----------------------------------|
| Japan | 69.7 | 18.8 |
| US | 26.9 ^(c) | 16.0 ^(a) |
| Australia | 18.4 ^(b) | 2.9 ^(a) |
| Germany | 16.4 | 5.7 |
| Italy | 16.9 ^(b) | 3.1 ^(b) |
| France | 9.4 | 2.3 |
| Canada | 7.9 ^(a) | 1.3 ^(a) |
| UK | 6.3 ^(c) | 3.4 ^(a) |

- (a) 1995 data
- (b) 1994 data
- (c) 1993 data

Sources: 1998 *Commonwealth Fund International Health Policy Survey*, Commonwealth Fund, (October 1998); figures for Italy are from Gerard Anderson, "In search of value: An international comparison of cost, access, and outcomes," *Health Affairs* 1997;16(6):163-171.

hospitals. These facilities house expensive diagnostic and treatment equipment that used to be seen primarily in hospitals. The doctors setting up these facilities are typically those who work in money-making hospital departments such as cardiac care, cancer treatment, and imaging (MRI scans are an example of imaging). Doctors who work in money-losing hospital departments, such as emergency and mental health services, are not the ones setting up clinics which compete with hospitals.

Now, let's test your ability to separate useful analysis from ideology. What's wrong with these statements?

The bottom line, economists say, is that the nation's health spending can be controlled only if the public eases up in its demand for the latest technology, regardless of the price (article in the *St. Paul Pioneer Press*).¹⁵⁹

Economists concede that they have pinned the blame on technology mainly by eliminating other factors that might account for spiraling costs. "It's just hard to imagine what [the driving force] is, if not technology," said Joseph P. Newhouse, professor of health policy and management at Harvard University (article in *National Journal*).¹⁶⁰

The authors of these statements clearly subscribe to the volume-is-the-problem school of thought. They believe that excessive volume of services, notably high-tech services, is the sole or primary cause of health inflation. Excessive administrative costs, excess capacity, price-gouging, and fraud, by their lights, are nonexistent or secondary problems. The first statement quoted above is particularly reckless. It points its finger at “the public” and says we must “ease up in [our] demand for the latest technology.” The uninformed reader would conclude from this statement that our intellectual betters have lots of studies in their files indicating that excessive *demand*, driven by stupid and irresponsible patients, is the prime cause of health-care inflation, and that supply-side waste has nothing to do with health-care inflation. (Note how this argument attempts to validate the over-insured excuse; us stupid patients would demand a lot fewer unnecessary MRIs etc. if we had to pay for them out of our own pockets.) As I noted earlier, some doctors order, and some patients ask for, unnecessary services, and I am quite sure that some of these unnecessary services are MRI scans and other types of high-tech medicine. But to suggest that the entire health-care inflation problem can be pinned on excessive use of high-tech services is inexcusable. But experts and reporters make that mistake routinely.

Because excess capacity is difficult to measure, and because our health policy experts are not all that concerned about it, we have little solid data with which to estimate the total cost of excess capacity. But the data we do have support the conclusion that excess capacity exists and is adding to the cost of health care in America.

7

Waste In the System: High Fees and Prices, and Fraud

Introduction

In this chapter, we continue our examination of the waste in the U.S. health-care system. In Chapter 6, we reviewed the evidence indicating that America wastes a lot of money on administrative expenditures and excess capacity. In this chapter we review the third and fourth categories of waste listed in Table 6-1 – excessive fees and prices, and fraud.

Excessive fees and prices: Overview

When economists investigate whether the sellers in a given market have the power to set their prices so far above their costs that they can make unreasonably high profits, they begin by asking whether the market in question is competitive. There is general agreement (but by no means universal agreement) among economists and health policy experts that competition does not work well in the health-care industry. This general agreement was clear even before MCPs had taken over the industry. Back then it was commonplace for experts to state that the entire U.S. health-care industry was inefficient because it was subject neither to the laws of competition nor to effective regulation. The Congressional Budget Office observed, for example, “[H]ealth care markets are not truly competitive and therefore do not work very well.”¹⁶¹ Former U.S. Surgeon General C. Everett Koop said, “We have a system that is distinguished by a virtual absence of self-regulation on the part of those who provide care . . . but distinguished as well by the absence of such natural marketplace controls as competition in regard to price, quality, or service.”¹⁶² Alain Enthoven and Richard Kronick, authors of an article laying out the blueprint for managed competition, said, “[W]e have a system that is neither efficient nor fair.”¹⁶³ As we shall see in the next chapter, the spread of managed care, and the consolidation of the health-care industry that it triggered, weakened what little competition existed in the industry.

True competition, which means competition for customers on both price and quality (not “competition” in the form of promiscuous advertising or an “arms race”) thrives only when both of the following conditions are met: (1) buyers and sellers are so numerous that no seller or buyer can influence price or quality; (2) buyers are well informed about both price and quality differences. These conditions rarely prevail in the health-care industry. The hospital, drug, equipment, and insurer markets are often so highly consolidated that one or a few sellers dominate. When a few sellers confront numerous, atomized buyers, sellers can dictate or at least influence their own prices, and they can get away with inferior quality. In rural areas, doctors and hospitals often have monopoly status (monopoly means one seller). But the second requirement is equally important. If buyers can’t distinguish the price or the quality of one seller from another, competition will be weak even where sellers are numerous. In most sectors of the health-care industry, buyers – the patients who buy medical care and the consumers and employers who pay insurance premiums – have little

or no information about the quality of the goods and services they are buying. Making price comparisons of medical services and tests is very difficult in most markets.³⁸

Because competition is weak throughout much of the health-care industry, it is possible that profiteering occurs throughout much of the industry. However, the physician and drug sectors are the only sectors for which extensive evidence indicates profiteering is a chronic problem, decade in and decade out. Therefore, I focus on these two sectors in this section on excessive prices.³⁹

Excessive physician fees

As of 1996, U.S. physicians took home \$199,000 a year (after expenses, and before taxes).¹⁶⁴ In its analysis of competition within the market for physician services, the Congressional Budget Office concluded that physicians are overpaid. The CBO didn't actually say "overpaid." They used the more formal language of economists; they said doctors were paid an amount "above the return needed to attract the appropriate supply" of physicians.¹⁶⁵ The CBO based this conclusion on three types of evidence: the large number of qualified applicants to medical school who are turned away; research indicating that investments in medical education produce larger returns than investments in training for "most other occupations"; and the difference between what U.S. doctors make and what doctors in other countries make.

Let's look at the international evidence first. As usual, the data are limited, but they are of excellent quality and very consistent. Studies of physician incomes and the fees they charge indicate U.S. physicians make much more money than do physicians anywhere else in the world. Table 7-1 compares U.S. physician incomes (after expenses but before taxes) to incomes in five other countries in 1965 and 1991. You can see that U.S. doctors make 70 to 75 percent more than German and Canadian doctors, and three times what doctors in Australia, France, and the U.K. make.⁴⁰ To repeat: These income figures are gross income minus expenses. This means that the extra income of U.S. physicians is pure gravy. It represents, in other words, profit or net income far in excess of that necessary to induce a sufficient number of qualified people to become doctors.

Two studies of fees paid to U.S. and Canadian physicians indicate Canadian doctors are paid less than half as much, on average, for the identical service as U.S. doctors. Table 7-2 presents the later of these two studies. This study, done by Welch et al., compared doctor fees paid by the four

³⁸ It is impossible, for example, to find a list of prices that hospitals in Minnesota charge for their services. Minnesota is not unusual. One of the few reports listing hospital prices that I'm aware of – a 1983 report published by what was then called the Council of Community Hospitals – stated, "[V]ery few communities in the United States even have the data available to produce hospital price information" (*Twin Cities Hospital Prices*, 1983, Council of Community Hospitals, Minneapolis, MN, 11). Moreover, said the report, only in the Twin Cities are the hospital price data available "by case mix group," which means prices for more complex patients are separated from prices for simpler cases. This report listed prices charged by 32 hospitals in the Twin Cities area for 25 procedures covering the period April 1982 through February 1983. Prices varied greatly. For example, the price of a cataract operation, with no complications, ranged from \$1,068 at Lakeview Memorial Hospital to \$2,436 at St. Paul-Ramsey Medical Center (now called Regions Hospital). The number of operations performed could not explain this price difference. Lakeview Memorial did 47 uncomplicated cataract operations while St. Paul-Ramsey performed 51 during the study period.

³⁹ Excessively high prices is not the only category of waste affected by the absence of strong competitive forces throughout most of the health-care industry. The first two types of waste listed in Table 6-1 – excessive administrative costs and excess capacity – also owe their existence to feeble competitive forces. In a truly competitive industry, suppliers couldn't pay unnecessarily high administrative and capacity costs; they'd be driven out of business. It is conceivable that a truly competitive industry would also do a better job of addressing fraud, the fourth category of waste listed in Table 6-1.

⁴⁰ Thanks to the power of MCPs, growth in U.S. physician income slowed considerably in the 1990s (Gary Baldwin, "AMA finds physicians making less money," *American Medical News*, June 7, 1999, 9).

largest Canadian provinces (Ontario, Quebec, British Columbia, and Alberta)⁴¹ in 1992 with the fees paid to U.S. doctors by Medicare. Welch et al. concluded that Canadian fees were 59 percent of U.S. Medicare fees. Then they noted that U.S. private insurer fees were 150 percent of Medicare's fees. If we do the arithmetic, that means Canada's fees were 39 percent of U.S. private-sector fees in 1992!⁴² Welch et al. noted, however, that 13.1 percent of the difference between U.S. and Canadian fees could be attributed to the higher overhead costs of American doctors. Since we have already discussed that type of waste earlier in this chapter and are here.

Table 7-1: U.S. physicians are the highest paid in the world: Average physician pre-tax income in six nations (dollars)

| | 1965 ^(a) | 1991 | Percent change | Physicians/10,000 people | |
|----------------|---------------------|------------------------|----------------|--------------------------|------|
| | | | | 1991 | 1998 |
| United States | 125,218 | 171,000 | 37% | 2.5 | 2.7 |
| Germany | 85,006 | 101,640 ^(b) | 20% | 3.1 | 3.5 |
| Canada | 82,243 | 96,512 | 17% | 2.1 | 2.1 |
| Australia | 65,160 | 59,340 | -9% | 2.3 | n.a |
| France | 50,943 | 56,524 | 11% | 2.7 | 3.0 |
| United Kingdom | n.a. | 53,381 | n.a. | 1.7 | 1.7 |

(a) Measured in 1991 dollars, after expenses. The actual incomes were much lower in 1965. For example, the actual average income of U.S. physicians in 1965 was \$28,960.

(b) Figure is for 1992.

Sources: Income data from *1998 Commonwealth Fund International Health Policy Survey*, Commonwealth Fund (October 1998); physicians-per-10,000-residents figures from <http://www.oecd.org/oecd/pages/home/displaygeneral/0,3380,EN-search-0-nodirectorate-4-5-no-0,FF.html>, accessed October 23, 2001.

⁴¹ Welch et al. noted that the fees paid by the other Canadian provinces not included in this study were almost identical to those reported for the largest four provinces.

⁴² This study was done, incidentally, for the Health Care Financing Administration (HCFA), the old name for the agency that runs Medicare and Medicaid. The study was done in the early 1990s and published early in 1993, just as the entire health policy establishment was rushing to embrace managed competition. HCFA, like most health policy experts and foundations that fund health policy research, has shown little interest since 1993 in studying price controls or single-payer systems.

Table 7-2: Canadian fees for medical services are barely more than half of U.S. Medicare fees: Canadian and Medicare fees for selected medical services, 1992 (dollars)

| Type of service | Canadian fee* | Medicare fee | Canadian-to-Medicare ratio |
|--|---------------|--------------|----------------------------|
| Office visit, established patient | \$22.34 | \$31.00 | 0.72 |
| Emergency room visit | 19.47 | 46.19 | 0.42 |
| Coronary artery bypass graft (three grafts) | 998.38 | 2,225.25 | 0.45 |
| Total knee replacement | 553.78 | 1,815.73 | 0.30 |
| Transurethral resection of prostate | 327.46 | 801.69 | 0.41 |
| Remove cataract, insert lens | 388.57 | 940.57 | 0.41 |
| Colonoscopy | 138.65 | 262.89 | 0.53 |
| Chest X-ray, two views | 5.40 | 10.54 | 0.51 |
| Left hand catheter, coronary angiography | 239.78 | 434.01 | 0.55 |

* Welch et al. made two adjustments to the Canadian fees. First, they converted the Canadian fees to equivalent U.S. dollars (the Canadian dollar has for decades been worth less than the U.S. dollar). Then they raised Canadian fees by 13.6 percent to reflect the higher overhead costs of American doctors. I saw no point in obscuring the true difference between Canadian and U.S. doctor fees just because the American multiple-payer system imposes higher administrative costs on U.S. doctors. To undo this correction, I multiplied the Canadian fees presented by Welch et al. by 0.88.

Source: Medicare fee data is from W. Pete Welch et al., "Physician fee levels: Medicare versus Canada," *Health Care Financing Review* 1993;14(3):41-54, Table 1; Canadian fee figures and Canadian-to-Medicare ratio figures are my calculations based on data presented in Welch et al., Table 1.

focusing on excessive fees and prices, we need to take this 13 percent into account. If we adjust the 59 percent figure to reverse Welch et. al's inflation of Canadian fees by 13 percent, we get 52 percent. In other words, in 1992 Canadian doctors were being paid 52 percent of what Medicare paid physicians in the U.S. that year. If we divide the 52 percent figure into the American private sector rate (150 percent of Medicare's rates), we get 35 percent. In other words, American insurance companies were paying American doctors three times what Canadian doctors were being paid.

The only other study that attempted to compare U.S. and Canadian fees compared the fees paid in Iowa by both private- and public-sector insurers (not just Medicare) to those paid in the Canadian province of Manitoba in 1985, and extrapolated those findings to all of America and the U.S. They concluded that Manitoba doctors were paid 46 percent of what Iowa doctors were paid and that the average Canadian doctor was paid 42 percent of what American doctors were paid.¹⁶⁶

What could justify paying America's doctors two or three times as much as doctors in other countries? We have already discussed and rejected the argument that the quality of care in the U.S. is superior to – never mind twice as good as – the quality available in other countries. We saw there was no scientific evidence to support that claim, and even some evidence suggesting U.S. quality is slightly inferior. Go back and look at Table 5-11, the table that showed differences in survival rates of Manitobans and New Englanders following ten types of surgery. You see rates listed for

transurethral prostatectomy and coronary artery bypass surgery, procedures that also show up in Table 7-2.⁴³ Notice that the three-year death rate among New Englanders shown in Table 5-11 was worse for both of these types of surgery. Yet the study by Welch et al. indicates Canadian surgeons were paid less than half of what U.S. surgeons were paid for these procedures. Data like contradict the claim that the fees and incomes of U.S. physicians are double and triple those of doctors in other countries because quality of care in the U.S. is double or triple that delivered in other countries.

Nor can it be argued that America's unusually high physician payments are necessary to induce a sufficient number of Americans to become doctors. The data on physician supply shown in Table 7-1 indicate the supply of physicians in the U.S. is neither particularly high nor particularly low. France, for example, with physician incomes one-third of the U.S. level, manages to produce more doctors per 10,000 residents than the U.S. does.

In a truly competitive market, the high incomes of doctors would attract an influx of new doctors, and this influx would drive physician fees and incomes down to the point where physician incomes were roughly equal to the incomes of other professions with similar training costs. According to the Congressional Budget Office, this has not happened, in part because the supply of new physicians is constrained by the admissions policies of the nation's medical schools, which are in turned influenced by the American Medical Association. "[T]he number of qualified applicants for medical school is far greater than the number of student slots available," said the CBO, "so the entry limits probably matter."¹⁶⁷ During the 1990s, applications to medical schools exceeded slots at medical schools by a factor of two or three to one. The peak occurred in 1996 when 46,968 students applied for 16,200 openings. Officials representing the nation's 125 medical schools confirm the CBO's statement that the people being rejected by medical schools are by and large qualified. "The application process is expensive, time-consuming and ego-bruising, so people don't apply to medical school unless they have a reasonable chance of acceptance," said Dr. Jordan J. Cohen, president of the Association of American Medical Colleges.¹⁶⁸

I occasionally hear people argue that U.S. doctors should make as much money as they do because they graduate from medical school with large debts. There is no question that medical students graduate with huge debts; medical school graduates averaged \$90,000 of debt in the late 1990s.¹⁶⁹ But does a debt of \$90,000 acquired at the beginning of a physician's career justify an income that is so high that the \$90,000 debt is repaid dozens of times over by the time the physician retires? Of course not.⁴⁴

⁴³ Tables 5-11 and 7-2 use different terms for the same procedure – "transurethral prostatectomy" and "transurethral resection of the prostate."

⁴⁴ There are three ways to document my assertion that a typical medical school debt is paid many times over by the time a typical U.S. physician retires. First, we can refer to the two studies cited by the CBO in support of its statement that the return on investment in a medical degree is much higher than it is for other professions. Second, we can cite Welch et al. They said that even if Canadian medical school graduates had no debt at all (which is an incorrect assumption), differences in debt among U.S. and Canadian doctors would explain just 1.5 percent of the huge differences in physician fees in the two countries. Third, we can use some commonsense and some fourth grade arithmetic to demonstrate that the huge incomes physicians get more than compensate them for their medical school debt. Here's the arithmetic. A typical physician will practice for 35 years – from about age 30 to age 65. During those 35 years, the typical U.S. doctor will be paid \$120,000 to \$170,000 more than doctors in other countries. If our sole concern is ensuring that U.S. physicians are paid enough to reimburse them for their \$90,000 in debt, do we need to pay them \$70,000 to \$120,000 more per year every year for 35 years to accomplish that? No. If it is important to America that our physicians, unlike other professions, enter the work force debt-free, there are ways

We may conclude, then, that U.S. physicians are paid far more than physicians anywhere else in the world, and that this difference cannot be explained by greater quality of medical care in the U.S., by an unusually small supply of physicians in the U.S., nor by the debt that the average U.S. doctor bears upon graduation from medical school. Moreover, only a small portion of the difference in fees and gross incomes between doctors in the U.S. and elsewhere can be attributed to higher overhead for U.S. doctors. The evidence indicates, in short, that American doctors are overpaid, and they are overpaid because America is the only country in the industrialized world that lets doctors charge most patients (the uninsured and those insured by private-sector insurers) whatever they want.

Excessive drug prices

Americans pay much higher prices for prescription drugs than do citizens of other countries. Even the American drug manufacturers admit this. Whether we look at drug *costs*, which reflect both volume and price, or just drug *prices*, we see the same picture – Americans are paying through the nose for prescription drugs. Table 7-3 indicates drug *costs* (expenditures on drugs per person) are much higher in the U.S. than they are in other nations. Table 7-4 indicates drug *prices* are much higher in the U.S. Table 7-4 indicates, for example, that Prilosec, a heavily advertised drug used to treat heartburn, sells for half as much in Canada, Britain, and Australia as it sells for in the U.S., and that Mexico sells the drug for a third of what it costs in the U.S.

The campaign to force the big drug companies to sell AIDS drugs at a price affordable to Third World countries has revealed some astonishing differences in the price at which drug companies sell drugs in different countries. Under pressure from AIDS activists, drug manufacturers recently agreed to sell a year's supply of the "AIDS cocktail" for one patient for \$1,000. This was far below the \$10,000 to \$15,000 charged in industrialized countries. However, it was still higher than the \$600 per year per patient that an Indian manufacturer said it could provide the drugs for. The manufacturer – Cipla Ltd. of Bombay – made the offer to Doctors Without Borders, a group that had called on the drug multinationals to reduce the price of their AIDS medicine.¹⁷⁰

Like defenders of excessive administrative costs and physician fees, defenders of excessive drug prices claim they are justified because they benefit Americans. The benefit, they say, is research – research by the drug industry on new drugs that cure disease. Any reduction in drug prices, say these advocates, will inevitably

to accomplish that that don't rely on overpaying them throughout their entire careers. We could, for example, subsidize medical education even more than we do today. Or we could, with Medicare-style limits on fees, reduce physician incomes to a level that would still suffice to attract the necessary number of physicians – let's say, using the 1991 figures shown in Table 7-1 – from \$171,000 (the U.S. level) to the German level of about \$100,000, and then add to that sum about \$3,000 a year so that over 35 years physicians would be paid back their \$90,000 debt.

Table 7-3: Drug costs are very high in the U.S.: Prescription drugs costs per capita in five countries, 1997*

| | |
|----------------|-------|
| United States | \$319 |
| Canada | \$264 |
| United Kingdom | \$233 |
| Australia | \$218 |
| New Zealand | \$207 |

* All figures in U.S. dollars.

Source: 1998 Commonwealth Fund International Health Policy Survey, Commonwealth Fund (October 1998).

Table 7-4: Drug prices are very high in the U.S.: Cost of ten best-selling prescription drugs* in five countries, 1999

| Rank | Drug | Condition | US | Canada | Great Britain | Australia | Mexico |
|------|----------|-------------|---------|---------|---------------|-----------|--------|
| 1 | Prilosec | Heartburn | \$3.31 | \$1.47 | \$1.67 | \$1.29 | \$.99 |
| 2 | Prozac | Depression | \$2.27 | \$1.07 | \$1.08 | \$.82 | \$.79 |
| 3 | Lipitor | Cholesterol | \$2.54 | \$1.34 | \$1.67 | \$1.67 | \$3.60 |
| 4 | Prevacid | Ulcer | \$3.13 | \$1.34 | \$.82 | \$.83 | \$1.18 |
| 5 | Epogen | Anemia | \$23.40 | \$21.44 | \$27.48 | \$29.24 | NA |
| 6 | Zocor | Cholesterol | \$3.16 | \$1.47 | \$1.73 | \$1.75 | \$3.66 |
| 7 | Zoloft | Depression | \$1.98 | \$1.07 | \$.95 | \$.84 | \$1.96 |
| 8 | Zyprexa | Mood disor. | \$5.27 | \$3.39 | \$2.86 | \$2.63 | NA |
| 9 | Claritin | Allergies | \$1.96 | \$1.11 | \$.41 | \$.48 | \$.92 |
| 10 | Paxil | Depression | \$2.22 | \$1.13 | \$1.70 | \$.82 | \$1.83 |

* The ten best-selling drugs were determined by sales volume in the U.S. in the first eight months of 1999.

Source: "Americans pay more; here's why," *USA Today*, November 10, 1999, 1.

lead to less research on life-saving and life-improving drugs. The most aggressive proponent of this argument is, of course, the drug industry. The industry has been making this argument since at least 1959 when Senator Estes Kefauver (D-TN) opened his investigation into the high price of prescription drugs. The industry has promoted this argument even more vigorously since 1993 when President Bill Clinton called drug prices "shocking" and implied he might endorse drug price controls. In 1994, the industry even changed the name of its trade group from the Pharmaceutical Manufacturers Association to the grammatically tortured Pharmaceutical Research and Manufacturers of America (PhRMA).

The argument that research on new drugs will be significantly reduced if drug prices are lowered is true only if all three of the following assumptions are true:

Any effort to reduce drug prices will inevitably reduce drug industry revenue;
 Any reduction in revenues must inevitably come out of research and development (R and D) expenditures, not other types of expenditures such as marketing, lobbying, and profit; and

The drug industry finances all or most research.

None of these assumptions is true.

The first assumption (that any reduction in drug prices must lead to a reduction in industry revenues) may not be true if drug-price reduction is limited to Americans without drug coverage. At least two studies have confirmed that if prices are reduced only for those Americans who have no health insurance or who have insurance that doesn't cover drugs, drug sales to this population will rise, and the result will be little or no net change in revenues. One of these studies was done by Alan Sager and Deborah Socolar at Boston University. In a report prepared for a coalition of eight Northeastern states, Sager and Socolar concluded that if the residents in these states with no drug coverage (this amounted to 23 percent of all residents in these states) were allowed to buy prescription drugs at a 42-percent discount, the increased sales that this price cut would trigger would cause the drug industry's total revenues to remain unchanged. Because the cost of producing the additional drugs would be about 5 cents for each dollar of additional drugs produced, profits would not be substantially reduced.¹⁷¹

But let's assume that the first assumption *is* true – that drug industry revenues would be substantially reduced by any price control proposal – and ask whether reduced revenues must inevitably lead to reduced research. For this to happen, the last two assumptions would have to be true – drug industry R and D expenditures would have to fall, and all or most R and D would have to be done by the drug industry.

Table 7-5 indicates that research expenditures constitute a small proportion of all drug industry expenditures – somewhere in the range of 11 to 17 percent. “Research and development” accounted for only 15 percent of the drug industry's expenditures in 1992, while administration (42 percent) and profit (13 percent) accounted for a total of 55 percent of all industry spending.⁴⁵ Fifty-five percent is an enormous piece of the pie compared to the little 15-percent slice the drug industry claims is going to research. Similarly, the 1997 figures shown in Table 7-5 (which represent averages for two large drug manufacturers) indicate the industry spent 36 percent on administration and 19 percent on profit for a total of 55 percent, compared to a measly 11 percent on R and D. (“Administration” is no doubt the category into which the drug industry's accountants enter the hundreds of millions of dollars the industry spends on lobbying and campaign contributions. In the period 1999-2000, the industry spent \$177 million on lobbying and \$20 million on campaign contributions, two thirds of which went to Republicans.¹⁷²) The 17-percent figure for research shown for 1999 is from PhRMA's web site. Obviously, the industry's claim that any drop in its revenues must come out of the tiny slice allocated

⁴⁵ In this discussion of drug industry expenditures, the definition of “administrative costs” differs slightly from the definition used in the discussion of insurer and provider administrative costs in Chapter 6. In Chapter 6, administrative costs referred to all non-medical expenditures, including profit. In this discussion of the drug industry, I am separating profit out from administrative costs in order to allow the reader to see how big drug industry profits are.

Table 7-5: The drug industry spends more than half of its revenues on administration, marketing, and profit: Allocation of drug manufacturer costs, 1992 and 1997; proportion of expenditures on research, 1999

| | <u>1992</u> ^(a) | <u>1997</u> ^(b) | <u>1999</u> |
|--------------------------|----------------------------|----------------------------|-------------|
| Materials and production | 30% | 34% | |
| Administration | 42% | 36% | |
| Research and development | 15% | 11% | 17% |
| Profit | 13% | 19% | |
| Total | 100% | 100% | |

(a) The 1992 data were described by the Minnesota Department of Health as representative of the “U.S. drug manufacturer” (p. 87). This document distinguished marketing from administration; it indicated that marketing accounted for 20 percent of drug industry expenditures while other administrative costs accounted for 22 percent.

(b) The 1997 figures are averages for Merck and Pfizer.

Sources: 1992 data from *Prescription Drug Study: A Report to the Minnesota Legislature on the Prescription Drug Market*, Minnesota Department of Health (April 1994), 88; 1997 data from Rhoda H. Karpatkin, “Are prescription drugs too expensive?” *Consumer Reports*, October 1999, 7; 1999 figure for research is from PhRMA’s web site (the web site didn’t indicate what proportion was spent on the other categories, so only the 17-percent figure for research is shown).

to research is not credible given the enormous slice allocated to marketing, administration, and profit. To my eye, the 40 percent or so of revenues spent on administration is huge. U.S. hospitals spend 25 percent of their revenues on administrative costs (including profit or, in the case of nonprofit hospitals, surplus),¹⁷³ private-sector insurers spend 15 to 35 percent, and Medicare spends 2 to 3 percent. However, because there are significant differences between hospitals and insurers on the one hand and drug manufacturers on the other, it would be more appropriate to compare the administrative costs of the drug industry with those of other manufacturers. The health policy literature does not provide such a comparison. In fact, the health policy literature on drug-industry overhead costs is even thinner than the scrawny literature on *insurance* and *provider* administrative costs. It is, in other words, virtually nonexistent.

However, we do have data comparing the *profits* of the drug industry to the profits of other industries, including other manufacturing industries. Table 7-6 presents data from annual reports by *Fortune* magazine on the financial performance of the “Fortune 500” (the largest 500 U.S. for-profit corporations).⁴⁶ From 1961 through 1999, with the exception of five years, the entire Fortune 500 (including the drug industry) had profits as a percent of sales (“revenues” is synonymous with “sales”) between 3 and 5 percent. The exceptions were three years in which Fortune 500 profits were between 5.0 and 5.5 percent, and two years when profits fell to 2.4 and 2.9 percent (1992 and 1993 respectively). In other words, the average gargantuan U.S. corporation has managed to get by

⁴⁶ *Fortune* published its first “directory” of the largest U.S. corporations in July 1956. In its June 1962 report (which contained data on the 1961 performance of the Fortune 500), *Fortune* listed the drug industry as a separate industry for the first time (it had been combined with “chemical companies” prior to that). The *Fortune* reports provide data on the drug industry’s profits, the profits of two or three dozen other industries (the total number of industries grew as the years went by), and the profits for the Fortune 500 as a whole for every year since 1961.

on a profit of about 4 percent of its sales, decade in and decade out. But since 1961, the drug industry has enjoyed profits *double to quadruple* the Fortune 500 median, decade in, decade out.

The post-1961 history of drug industry profits falls into two phases – 1961 to 1981, and the post-1981 era. Throughout the entire 1961-81 period, the drug industry was either the first- or second-most profitable industry – usually it was in second place. But since 1981, the drug industry has been number one. Table 7-6 presents the post-1980 data. The second column indicates, for example, that the drug industry made a 9.1

Table 7-6: Drug industry profits are huge compared to those of other large corporations: Drug company profits as a percent of sales compared to profits of Fortune 500 companies, 1981-1999

| <u>Year</u> | <u>Profits as percent of sales</u> | <u>Profitability rank^(a)</u> | <u>Multiple of F500^(b)</u> |
|-------------|------------------------------------|---|---------------------------------------|
| 1981 | 9.1% | #2 | 2.0 |
| 1982 | 9.9% | #1 | 2.8 |
| 1983 | 10.4% | #1 | 2.7 |
| 1984 | 10.0% | #1 | 2.2 |
| 1985 | 10.4% | #1 | 2.7 |
| 1986 | 13.1% | #1 | 3.2 |
| 1987 | 13.2% | #1 | 2.9 |
| 1988 | 13.5% | #1 | 2.9 |
| 1989 | 13.0% | #1 | 2.8 |
| 1990 | 13.6% | #1 | 3.3 |
| 1991 | 12.8% | #1 | 4.0 |
| 1992 | 11.5% | #1 | 4.3 |
| 1993 | 12.5% | #1 | 4.3 |
| 1994 | 16.1% | #1 | 3.5 |
| 1995 | 14.4% | #1 | 3.0 |
| 1996 | 17.1% | #1 | 3.4 |
| 1997 | 16.1% | #1 | 3.3 |
| 1998 | 18.5% | #1 | 4.2 |
| 1999 | 18.6% | #1 | 3.7 |

(a) The number of industries ranked varied over the years. The numbers in this column indicate the drug manufacturing industry has been the most profitable industry since 1982.

(b) The numbers in this column are derived by dividing the drug industry's return on sales by the median return on sales for the entire Fortune 500. For example, the 1999 figure of 3.7 is derived by dividing the drug industry's return of 18.6 percent by the median return for the entire Fortune 500 of 5.0 percent.

Sources: Figures shown in columns 1 and 2 are from *Fortune's* annual reports on the Fortune 500, 1981 to 2000. Column 3 is based on calculations done by the author using figures reported in *Fortune*.

percent profit in 1981; the third column indicates this profit was the second highest among all industries; and the fourth column indicates the drug industry's 9.1 percent return was 2.0 times the

Fortune 500 median. You can see that since 1981, the drug industry's profitability has improved. While the Fortune 500 median rate of return plugged along at a boring 4 to 5 percent (figures not shown), the drug industry's profits soared into the lower teens in the 1980s, and into the upper teens in the 1990s.⁴⁷

The industry's assertion that research is the only place it can cut looks even more ridiculous when we examine the industry's claim that it spends 15 percent of its revenues on research and development. The drug industry's argument, you recall, is that it has armies of scientists doing *basic* research – high-risk research into cures for new diseases – and it is this research which will dry up if their profits are cut. *Applied* research, which includes research on how to create a slightly different version of a drug of which a dozen versions are already on the market, or how to manufacture a capsule version of a drug currently on the market in pill form, is not the sort of high-risk research that requires huge profits in order to induce Americans to keep buying drug company stock. But experts estimate that a large portion of drug industry research expenditures are in fact devoted to research on “me too” drugs.

As is the case with insurance-company administrative costs, no reliable studies have been done to determine how much of the drug industry's R and D costs are devoted to basic research. The best we can do is determine what portion of new drugs approved by the U.S. Food and Drug Administration are “breakthrough” drugs, and then estimate what portion of these were financed primarily by drug company research. This is unquestionably a crude method, but, crude as it is, it is more credible than the threats of the drug industry that research into life-saving drugs will cease if their profits are reduced.

Over the last two decades, the FDA has annually approved two to three dozen new drugs for sale in the U.S. Of the 311 new drugs approved by the FDA during the 1990s, only 134 (43 percent) were given “priority review” status by the FDA, a status conferred on drugs that provide “significant improvement compared to marketed products.”¹⁷⁴ This means that about 60 percent of the drugs the FDA approves each year are me-too drugs.

Does that mean that 60 percent of drug industry research expenditures are for me-too drugs? Probably not because me-too drugs are less expensive to bring to market than breakthrough drugs, although no one knows for sure because the drug industry doesn't allow independent investigators to audit its books. One of the drug industry's favorite researchers, Joseph DiMasi, has indicated that roughly 40 percent of drug industry research expenditures are spent on me-too drugs. DiMasi is the director of economic analysis at the Tufts University's Center for the Study of Drug Development, which is heavily funded by the drug industry, and he is the coauthor of a controversial study that claimed to find that the drug industry incurs an average cost of \$500 million for each drug that gets approval from the FDA. When journalist Merrill Goozner asked DiMasi whether it “would be fair to say that 40 percent of industry research and development is aimed at me-too drugs,” DiMasi replied, “That's a reasonable assumption.”¹⁷⁵

To make matters worse (from the drug industry's point of view), the industry can't claim credit for the discovery of most breakthrough drugs. That credit goes to the taxpayer. The chief financier of breakthrough research, according to numerous studies and all observers including PhRMA, is the U.S. government. “Pharmaceutical companies conduct some of [the] basic research,” said the drug industry in its newsletter *Patient Matters*, “but most is conducted by the

⁴⁷ For about half the years since 1961, *Fortune's* surveys also reported industry profits as a percent of industry assets. For most of those years, *Fortune* also reported profits as a percent of *stockholder equity* in the industry. The drug industry's profitability vis a vis other industries looks just as good if return on assets is used instead of return on sales. If we use return on stockholder equity as the measure of profitability, the drug industry looks just as good in the post-1985 era, and not quite as good prior to 1985 (during the 1969-1984 period, the drug industry typically ranked number 3 on this measure).

federal government at the National Institutes of Health (NIH) or at universities.”¹⁷⁶ A 1995 study at the Massachusetts Institute of Technology, for example, found that, of the 14 new drugs identified by drug industry officials as the most significant drugs introduced over the previous 25 years, eleven “had their roots in studies paid for by the government.”¹⁷⁷ In other words, for these eleven drugs, the government did the basic research and incurred the risk that this research would produce no useful information.

According to Senator Bill Frist (R-TN), who was a physician before he became a senator, tax-financed research has played a prominent role in the advancement of medical science for more than a half-century. “Since World War II, government-funded research has sparked a stunning record of scientific and medical advances,” wrote Frist in an article for the *Journal of the American Medical Association*. “The development of vaccines and their translation into the daily practice of medicine have helped reduce the incidence of, and in some cases eradicate, diseases such as smallpox, hepatitis B virus, measles, and polio. New treatments have been developed to treat cancer, heart disease, and mental illness.”¹⁷⁸

When we began this discussion of whether the drug industry really would have no choice but to cut research into new cures for disease if its profits were reduced, we noted that 55 percent of drug industry revenues went for marketing, administration, and profit versus roughly 15 percent for research. But now that we’ve determined that perhaps 40 percent of this 15 percent is research on me-too drugs and only 60 percent is for basic research, the drug industry’s claim looks even more ridiculous. Sixty percent of 15 percent is 9 percent; it appears, in short, that roughly 9 percent of drug industry revenues support basic research. The drug industry is essentially arguing that if its profits are cut it’ll have to cut this little 9-percent slice rather than the obese 55-percent marketing-administration-profit slice.

It appears, moreover, that the proportion of drug industry R and D expenditures devoted to basic research is dwindling. According to Gardiner Harris, reporting in the *Wall Street Journal*, the drug industry is doing less basic research in house and is relying ever more heavily on research from small, independent companies that concentrate exclusively or primarily on research. “[T]he pharmaceutical industry is gradually shifting the core of its business away from the unpredictable and increasingly expensive task of creating drugs and toward the steadier business of marketing them,” wrote Harris. “With more and more of the industry’s research being conducted in biotech labs, its core competency increasingly is marketing, not discovery.”¹⁷⁹

To sum up, all three of the three statements that had to be true in order for the drug industry’s claim to be true are in fact false. A reduction in industry prices may not reduce total industry revenues because the increased volume of sales may offset reduced prices. But even if industry revenues are cut, the industry must demonstrate that the cut must come out of the 9 percent or so spent on basic research rather than the 55 percent spent on administrative expenditures and profit. The enormity of drug industry *profits* indicates that drug prices are high because the drug industry is profiteering; the obesity of the drug industry’s budget for *marketing and other administrative* costs indicates the industry is also extremely wasteful. Finally, even if price controls lead to reduced drug industry revenues, and even if the industry really had no choice but to cut back on the small slice of expenditures devoted to basic research, this would not mean the end of basic research in America. The U.S. government funds most basic research. If more funding were desirable, it would make much more sense to pay for it through taxes than through sky-high drug prices.

Biased drug research

More tax-financed drug research may turn out to be very desirable regardless of whether the drug industry reduces its expenditures on research. That's because drug research has become increasingly untrustworthy over the last decade. This problem can be attributed to two developments: A decline in the proportion of drug research funded by taxes and an increase in the proportion funded by the pharmaceutical companies, and the drug industry's effort to increase its influence over the researchers it hires.

The creeping privatization of research is of relatively recent vintage. It was set off by the decline in government funding, primarily *federal* funding, of R and D that began midway through President Reagan's term in office. Reagan's large tax cuts and his increase in military spending led to a cut in domestic spending that was about equal to the increase in military spending. By 1988, Reagan's priorities had caused a reduction (measured in inflation-adjusted dollars) in federal spending on R and D of all types. In that same year, total spending on R and D by U.S. corporations, including drug companies, rose substantially and continued to rise until about 1992 when it leveled off.^{180,48}

As the drug industry became the largest source of drug research dollars, it used its financial clout to increase its influence over the scientists that performed its research. Twenty years ago, drug manufacturers would contract with scientists, often physicians, at medical centers (clinics and hospitals) on university campuses to do their research for them, and these scientists would design the experiments and find the patients necessary for the experiments. But over the last decade manufacturers have shifted a large portion of their research to for-profit, private-sector firms, including advertising agencies, in order to enhance their control over researchers' final product.¹⁸¹ This shift in turn put more pressure on academic medical centers to play produce reports more to the liking of the drug manufacturers. By the late 1990s, the drug industry's efforts to influence drug researchers had become so aggressive and widespread that a national debate about drug industry tactics erupted within medical journals and the media. In an article about a "government conference" convened in 2000 to discuss the problem, the *New York Times* reported, "The huge influx of money into biomedical research is creating unacceptable conflicts of interest for scientists and is eroding the public's trust in the data. . . ."¹⁸²

The corrupting effect of corporate money on research resembles the corrupting effect that MCP money has had on the U.S. health-care system. It is pervasive, manifests itself in myriad ways, and is often hard to detect. This subject demands a lot more space than the few paragraphs I give it here. However, unlike many other issues I've raised in this book, this one has been covered reasonably well by the media. For readers interested in this subject, I refer you to excellent articles on this subject by Goozner¹⁸³ and Eyal and Press.¹⁸⁴ Here I offer just a few examples of the evidence that drug industry pressure is damaging the quality of drug research.

Drug industry money influences research because recipients of the money know what results the donor wants, and self-interest puts pressure on recipients to produce a product pleasing to donors. If the drug industry payment is made to support *basic* research, the interests of the drug company and of the public need not be in conflict. The scientist either will or won't find a new drug

⁴⁸ An important secondary cause of corporate control over academia was federal legislation enacted in the 1980s that permitted universities to patent, and therefore profit from, their inventions, and legislation encouraging corporations to invest in academic research.

that reduces tumor size in animals, for example. The potential for corruption is more likely to arise after the basic research has been done, that is, after the scientist has determined that drug A inhibits cancer cell growth in a test tube or reduces tumor size in mice. Now the issue is whether drug A will do the same thing in humans without creating serious side effects and, if so, whether drug A is more effective, and less toxic, than other anti-cancer drugs already on the market.

Research indicates that the source of funds for applied research can make a big difference, not only in the outcome of the investigation, but in whether the scientific community or the public even learns of the outcome. The *Archives of Internal Medicine* reported an example of how drug money leads scientists to conduct biased experiments. The authors of this study reviewed 52 scientific papers describing a total of 56 experiments comparing one nonsteroidal anti-inflammatory drug (NSAID) to another (these drugs are used to treat arthritis). All these studies had one thing in common: One of the NSAIDs under examination was manufactured by the drug company that financed the study. The authors called this drug the “manufacturer-associated drug.” The authors found that 48 percent of the experiments were rigged (the authors didn’t use that word) by a very simple tactic: The authors used dosages of drugs that were not equivalent. Guess which drug was administered in a higher dosage? Yes, the manufacturer-associated drug.

The paper found other examples of bias. For example, it found that only 2 percent of the subjects in the experiments were over 64, even though NSAIDs are used primarily to treat the elderly. For another example, it reported that papers reporting on 22 of the 56 experiments asserted that one NSAID was less toxic than the other, and of these, 19 were the manufacturer-associated drug. Worse yet, “In almost half of these trials, this claim of less toxicity was not supported by a test of statistical significance,”¹⁸⁵ a test so fundamental to Western science that every introductory course in statistics teaches it.

Some scientists who refuse to rig their studies and produce results that don’t flatter their corporate benefactor’s product have discovered how brutal their sugar daddy can be. Betty Dong, a clinical pharmacist at the University of California, San Francisco, may be the best known victim of drug-industry retribution. In the 1980s she did some preliminary research which indicated that Synthroid, a drug used to treat hypothyroidism, was more effective than its competitors. The manufacturer of Synthroid, then known as Boots Pharmaceutical, offered Dong \$250,000 to conduct a more rigorous study. She accepted the money, did the research, and discovered that Synthroid was no more effective than three cheaper hyperthyroidism drugs. The company, by now called Knoll Pharmaceutical, unleashed a vicious campaign against Dong. It refused to permit her to publish her results; cleaned up her data and published its own study with more favorable findings; attacked Dong’s expertise; and attacked her study when it was finally published in the *Journal of the American Medical Association*.

Editors of medical journals have also been the victims of drug industry retribution. The *Annals of Internal Medicine* published a paper in 1992 which demonstrated that drug advertisements in medical journals were often misleading. Drug companies stopped advertising in the *Annals*, costing the journal \$1 million to \$1.5 million. According to the *New York Times*, the lost revenue was “a factor in” the resignation of the journal’s co-editor, Dr. Suzanne Fletcher, now a professor at Harvard Medical School.¹⁸⁶

These examples of the corrupting influence of drug industry money are limited to its effect on research. Drug industry money is used in other ways to the detriment of patients, including pressing the FDA to approve drugs that shouldn’t be approved, bribing doctors to prescribe their drugs,¹⁸⁷ and inducing doctors to sign articles for submission to scientific journals written by drug company employees or contractors.¹⁸⁸ These examples of corruption cannot be fixed by having the government finance more drug research; they will continue as long as the drug industry sells drugs, as long as drug manufacturers are permitted to be as big as they are, and as long drug manufacturers can charge whatever they want.

Fraud

Health-care fraud that adds to the cost of health care falls into three categories:

- * fooling a patient into undergoing, and a payer into paying for, services or goods that were not needed;
- * fooling an insurer or other payer into paying for services that were never rendered or goods that were never provided; and
- * fooling a patient or payer into paying more for a service or good than they would have had they known what the item was worth.⁴⁹

In my 15 years of monitoring the U.S. health-care system, I've read some very strange stories. But none was stranger than this story told first by ABC's "Prime Time Live" in the summer of 1991, and later that year by *Newsweek* magazine. It's an example of the first type of fraud (fooling patients into accepting services they don't need). Here is how the *Newsweek* article began:

Sid Harrell, a retired Army medical technician in Live Oak, Texas, was chewing a pork chop in front of the television one evening last April when he looked out the front window and saw a pair of beefy private-security agents confronting his wife and his 14-year-old grandson, Jeremy. The men announced that the child would have to come with them. Mrs. Harrell asked why, but they weren't sure themselves. "You'll have to call Colonial Hills," one of them explained.

Colonial Hills is a private psychiatric hospital in San Antonio [owned by National Medical Enterprises, a multi-state hospital chain]. The Harrells had recently sent Jeremy's troubled 12-year-old brother to Colonial Hills for treatment (the Harrells are the boys' legal guardians). Jeremy himself was well adjusted and getting good grades in school. But Mrs. Harrell has testified that when she called Colonial Hills to clear up the apparent confusion, a counselor told her the hospital was seizing Jeremy under the state's involuntary-commitment law to evaluate and treat him for drug abuse. Mrs. Harrell became hysterical, but Jeremy assured her he would be fine, and Mr. Harrell reluctantly let the agents take him away.

The doctor who had ordered Jeremy detained had never met him; investigators determined he was acting solely on the basis of the younger boy's remarks. Yet, according to the Harrells, the hospital held Jeremy for five days, and released him only after a state senator secured a court order. The doctor has since resigned and been stripped of his Texas medical license.¹⁸⁹

The story of Jeremy's kidnapping caused other people to accuse other National Medical Enterprises hospitals of kidnapping them or holding them after they indicated they wanted to leave. By the end of 1992, National Medical found itself the subject of several lawsuits filed by patients and

⁴⁹ Note that all three of these bulleted clauses begin with "fooling." The difference between fraud and the examples of excessive price and unnecessary service discussed earlier is that fraud requires intention on the part of the seller to deceive. A doctor who hospitalizes an asthma patient who other physicians think could have been treated in a less expensive, non-hospital setting, is not guilty of fraud. Similarly, a drug company that sells a drug at 20 times the cost of producing the drug is not guilty of fraud; the person paying the outrageous price was not fooled into thinking the price was lower or that the drug was something that it was not.

There is, of course, a fourth category of health-care fraud that does not immediately add to the cost of health care – the deliberate denial of necessary services to patients. Because I am discussing wasteful behaviors that *add* to the cost of health care, I do not discuss the problem of fraudulent rationing here.

ten insurance companies, and the object of investigations by 14 state and federal agencies.¹⁹⁰ These investigations revealed that National Medical's chief executive, Richard Eamer, who earned \$20 million in 1991, put enormous pressure on his hospital directors to turn a large profit. One of the allegations in the lawsuits was that Eamer's hospitals paid "bounty hunter" fees of up to \$2,000 per patient lured into a National Medical hospital, and that some of the recipients of these fees were probation officers and clergymen. Jeremy, the little boy described in the *Newsweek* story, was, it appears, the target of a bounty hunter.

This first category of fraud – getting patients and insurers to pay for unnecessary services – is usually accomplished without the strong-arm tactics used against Jeremy and his guardians. For example, an ophthalmologist who billed his state Medicaid program a million dollars over five years for cataract operations was convicted of operating on patients without cataracts or with cataracts too small to warrant surgery. The doctor told his patients cataracts were contagious. In one case, his unnecessary surgery on the one good eye of a 57-year-old woman left her completely blind.¹⁹¹ Here's another example of fraudulent sale of unnecessary services: HealthSpan, a large hospital chain in Minnesota, paid \$3 million to settle charges by the Minnesota attorney general, a U.S. attorney, and the Department of Health and Human Services that HealthSpan had sent fully equipped ambulances to carry nursing home patients to their doctors' offices when much less expensive vans would have sufficed. HealthSpan billed Medicare and Medicaid \$156 to \$196 per ambulance trip when it should have billed \$32 to \$34 for van service. According to government investigators, 36 percent of the ambulance trips provided by HealthSpan over a three-and-a-half year period should have been made by vans.¹⁹²

The second category of fraud (billing for services that were never rendered) is generally easier to detect than the first category of fraud (billing for unnecessary services) because it is generally easier to determine that a service was or was not *provided* than it is to determine that the service was not *necessary*. The psychiatrist who billed Medicaid for almost 24 hours of work per day for an entire year, and the physician who billed for services for people who were dead at the time of the alleged service, were, to take two examples, easier to detect and prosecute than, for example, HealthSpan's scheme to use ambulances instead of vans.¹⁹³

But some forms of billing for services never rendered can be very difficult to detect and, therefore, very expensive. It may be that scam artists who are not health professionals – people who don't even see patients – are billing for services never rendered at a greater rate than crooks in the health professions are. According to government fraud investigators and private-sector insurers, the nation's insurance industry is being bilked out of perhaps billions of dollars annually by phony clinics and equipment suppliers and companies pretending to be the billing agencies for real clinics. These fake providers and billing agencies steal patient medical records, either by going through the trash of clinics and hospitals, bribing nurses and others who have access to patient files, or burglarizing doctors' offices, and then send bills to insurance companies for treatments never rendered by anyone. These bandits operate for a few months, then shut down, and reopen with a new name and new address. The *New York Times* quotes Ron Poindexter, director of the fraud division of the Florida Department of Insurance, saying, "In terms of health-care fraud, this is the biggest thing on our plate. It's out of control; it's draining our resources."¹⁹⁴

The most common form of the third category of fraud – charging more than the good or service warranted – is usually accomplished by billing for a good or service that is more expensive than the actual good or service provided. For example, federal investigators have caught suppliers of nursing home equipment billing Medicare and Medicaid \$859 for orthotic body jackets (jackets that help frail patients stand or sit upright) when in fact what they delivered was a \$50 wheelchair pad with restraining shoulder straps.

When physicians commit this third type of fraud, it is called “upcoding.” Physicians have to enter a code on the claim forms they submit to Medicare, Medicaid and other fee-for-service insurers to indicate what type of service they are billing for. The most commonly used coding system is published by the American Medical Association in a thick book entitled *Current Procedural Terminology*. The CPT, as it is known, contains more than 7,200 codes to describe all the treatments that doctors can give patients these days. Many conditions have several codes. For example, removal of a small mole has one code and removal of a large mole has another. Thus, removing a small mole but placing the code for removal of a large mole on the claim form would constitute upcoding – and fraud.

Sometimes, however, this third form of fraud (inducing payers to pay too much) is accomplished by inducing two payers to pay for the same item. Suppliers of nursing homes, for example, have been known to bill both the nursing home and Medicare for the same item.¹⁹⁵

So what does all this fraud cost? Because fraud is, by its nature, difficult to detect, no one knows for sure. The most commonly cited number is 10 percent. That estimate comes from a 1992 report to Congress by the U.S. General Accounting Office. The GAO noted how difficult it was to measure the cost of fraud, and then said fraud accounts for “some 10 percent” of total health-care spending.¹⁹⁶ According to the National Health Care Anti-Fraud Association (NCCHA), a coalition of private-sector insurers and law enforcement agencies, people in the insurance industry believe 3 to 5 percent is more accurate. Whatever the true fraction, the total number of dollars lost is enormous.

The total cost of waste

We saw in Chapters 4 and 5 that the evidence doesn’t support the common excuses for the high cost of the U.S. health-care system. In chapter 6 and this chapter, we reviewed the evidence supporting the statement that the U.S. health-care system is wasteful. We reviewed evidence of excessive administrative costs, excess capacity, excessively high fees and prices, and fraud. It is difficult to say with precision what the total cost of this waste is, and impossible to state with any precision what portion of the difference between the per capita cost of the U.S. system and those of other countries is attributable to these four types of waste. A rigorous analysis of the cost of all types of waste combined has never been done for any one country, much less several countries at once. My educated guess is that nearly all of the difference between U.S. per capita health expenditures and those of the more expensive foreign health systems (e.g., the Swiss, German, French, and Canadian systems) can be attributed to waste. I say that because the evidence indicates these countries are not achieving their 35- to 50-percent-lower costs by sacrificing quality. I’m not willing to make the same guess if the comparison country is one of the lower-spending countries such as Britain.

We can, however, offer some estimates for three of the waste categories (see Table 7-8). Administrative waste absorbs somewhere between 10 and 15 percent of total health-care spending. I base this estimate primarily on the 1991 study done by the U.S. General Accounting Office which asked the question, How much could the U.S. save in administrative costs if we adopted a single-payer system like Canada’s? (I would have preferred that the GAO had been asked to study the administrative savings achievable by expanding Medicare to cover all Americans, but for some reason that was not how the request was phrased.) The GAO estimated savings of 9.5 percent, roughly half from reduced overhead in the insurance sector and half from reduced overhead in the provider sector. The research on administrative costs that we examined back in Chapter 5 strongly suggests that the spread of managed care since 1991, the year the GAO used for its analysis, has

added to the nation's administrative costs. For that reason, I show a range of 10- to 15-percent savings in administrative costs in Table 7-8.

Table 7-8: America wastes roughly 20 to 40 percent of its health-care dollar on administrative waste, excess capacity, excessively high fees and prices, and fraud

| Type of waste | Cost |
|----------------------------|-----------------------|
| Administrative waste | 10-15% |
| Insurance company overhead | |
| Provider overhead | |
| Excess capacity | |
| High fees and prices | 10-15% ^(a) |
| High fees | 9-13% |
| High drug prices | 1-3% |
| Fraud | 3-10% |
| Total | 20-40% ^(b) |

(a) To avoid suggesting that this total is precise, I rounded the upper bound number to 15 percent.

(b) To avoid suggesting that this total is precise, I rounded the lower bound number to 20 percent.

I make no attempt to estimate the waste from excess capacity because the data upon which to base such an estimate is so sparse and fragmentary. But to give you some idea of how much money may be wasted, consider the data from the Pennsylvania study we talked about in our discussion of the arms race between hospitals in Chapter 6. You recall that that study examined the supply and demand for lithotriptors (machines which pulverize kidney stones with sound waves), MRIs, cardiac catheterization labs, organ transplant facilities, and neonatal intensive care units, and that the authors concluded all five types of devices were in excess supply. The authors estimated that Pennsylvania premium payers and taxpayers paid roughly \$100 million annually for the excess supply of three of these devices – lithotriptors, MRIs, and catheterization labs – in the early 1990s. If the rest of the nation had an excess supply equal to Pennsylvania's, the total cost to the country would have been \$2 billion. Two billion dollars is a small portion of the \$800 billion the U.S. was paying annually for health care back in the early 1990s. But the \$2 billion represents the excess cost of just three devices. In view of the hundreds of other types of devices and facilities that might be in excess supply, we should view \$2 billion as merely the tiny tip of a very large iceberg.

I estimate the total cost of excessive physician fees and drug prices to be in the range of 9 to 15 percent. We saw in Table 3-2 that expenditures on physician services account for 22 percent, and expenditures on prescription drugs account for 9 percent, of health-care spending. If U.S. physician fees were closer to those prevailing in the rest of the industrialized world, expenditures on physicians would fall by 40 percent (if German and Canadian physician incomes were the benchmark) to (65 percent if French and Australian incomes were the benchmark).⁵⁰ If we multiply 40 and 65 percent

⁵⁰ Estimating the waste due to excessive physician fees is complicated by the fact that two-thirds of U.S. physicians are specialists compared to about half in other countries. A rigorous analysis of the savings achievable by reducing physician incomes to levels in other countries would have to determine if Americans benefit from our greater

times the 22-percent share of the U.S. health-care bill that goes to doctors, we get a reduction in total spending of 9 to 13 percent.

The figures in Table 7-3 indicate that per capita spending on prescription drugs ranges from 17 percent lower in Canada to 35 percent lower in New Zealand relative to the US.⁵¹ In order to avoid the impression that my methodology is precise, I have used a range of 15 to 35 percent to calculate a range of drug savings to enter into Table 7-8. Multiplying these percentages times the 9 percent spent on drugs in the U.S. (see Table 3-2) yields an estimate of 1 to 3 percent of total health spending saved with drug price controls.

As we saw in the discussion of fraud in the last chapter, estimates are soft, and range from 3 to 10 percent.

As I've indicated in Table 7-8, the total cost of the three types of waste for which I've estimated a range comes to 20 to 40 percent. This 20-to-40-percent range is, it bears repeating, a soft estimate of total waste in the system. Each of the three categories for which I made estimates (administrative waste, high fees and prices, and fraud) is difficult to measure precisely. In the case of administrative waste and excess fees and prices, estimates are complicated by counter arguments from defenders of the system that America's high administrative costs and high fees and prices buy something of value. In the case of fraud, the problem is complex because we're measuring something which is, by design, difficult to detect.

Although this exercise in calculating waste in the U.S. system does not give us a hard estimate of total waste, it does give us some sense of how costly the waste is, whatever it's true dimension. If we agree that the problem we are trying to solve is universal health insurance for no more than we're paying today, we need only eliminate the first category of waste – the administrative waste – to solve that problem. According to the GAO report I mentioned earlier, a universal health insurance system with no copayments and deductibles would add 9 percent to total U.S. health-care spending, and a single-payer system would cut administrative costs by 9.5 percent.¹⁹⁷ If this estimate is correct (see further discussion in Chapter 11), then merely eliminating administrative waste in the current system would permit us to meet our goal of universal coverage with no additional expenditures. Eliminating the other forms of waste would permit us to cut total health-care spending substantially.

abundance of specialists and, if we did, adjust for differences in the ratio of specialists to primary care doctors. I make no attempt to do that here.

⁵¹ It would be preferable to be comparing an average drug *price* for these countries rather than an average drug *expenditure*, but comparisons of the average price for thousands of drugs for multiple countries apparently don't exist.

8

The Clash Between Public and Expert Opinion

Overview of diagnoses and prescriptions

In the last four chapters, I have reviewed the various explanations – the true and the bogus – for why U.S. health-care costs are so high. In the three chapters that follow this one, I will examine the health-care reform proposals now under debate – managed competition, high-deductible policies, tax credits, and a single-payer system. In this chapter, I will review the evidence that the public shares my perception of the problem and of the solution, and that the public’s perceptions contrast sharply with those of experts. The public does not buy the experts’ claim that volume of services is excessive, and, therefore, the public does not buy the experts’ argument that a solution to the health-care crisis must include mechanisms to cut back on the volume of services. The public sees waste in the system as the main problem, and, logically enough, is sympathetic to a single-payer system. For anyone who wants to build a new American health-care system, this difference between public and expert opinion is critical. The health-care crisis won’t be solved with a system that contradicts the values of most Americans.

In Table 8-1, I have arrayed the various explanations for the high cost of U.S. health care that I reviewed in the last four chapters. In the top half of the table you see the six common excuses for high costs that I examined in Chapters 4 and 5. In the bottom half you see the four categories of waste I reviewed in Chapters 6 and 7. These ten explanations fall roughly into two categories – explanations that blame *patients* and *doctors* for inflating the *volume* of medical services sold, and explanations that blame the *health-care industry* for inefficiency, fraud, and overcharging, all of which force the *price* of medical services and health insurance to rise.

The choice one makes between the excessive-volume and excessive-price explanations is important, because that choice dictates your choice of solution. Your decision tree looks something like this:

(1) Select excessive volume or excessive price as the primary problem.

(2) If you select excessive volume as the primary problem, you’re saying you think underuse is a rather insignificant problem, that the health-care industry is reasonably efficient, and that the four categories of waste I’ve discussed either don’t exist or cost relatively little compared to the excess volume problem. In that event, you have no choice (assuming you want to control health-care inflation) but to endorse competition between either MCPs or large-deductible plans.⁵² If you select excessive volume, then you must decide whether you think excessive volume is caused primarily by physicians and the

⁵² You could, of course, propose that some government agency be placed in charge of rationing health care, but that idea is about as repugnant as letting MCPs ration services. Because this is a bad idea, and because this idea has no proponents, I don’t discuss it.

Table 8-1: The ten explanations reviewed so far

| <u>Explanation</u> | <u>Culprit</u> |
|---|----------------------|
| The six common excuses | |
| (1) Americans get too many medical services | |
| (a) because doctors order too many services | Doctors |
| (b) because patients demand too many services | Patients |
| (2) Americans are older | Patients |
| Americans have worse lifestyles | Patients |
| (4) Americans sue for malpractice too often | Patients |
| (5) Americans are more violent | Patients, attackers |
| (6) U.S. quality is superior | (not applicable) |
| The four categories of waste | |
| Administrative waste | Insurance industry |
| Excess capacity | Hospitals, doctors |
| Excessively high fees and prices | Health-care industry |
| Fraud | Health-care industry |

fee-for- service system (as HMO advocates do), or by patients and low-deductible insurance policies (as large-deductible advocates do). If you blame physicians and fee-for-service, you must endorse MCPs. If you blame patients and low deductibles, then you must endorse some version of the large-deductible proposals.

(3) If you select excessive price or any of the four categories of waste shown in Table 8-1 as the primary problem, you must choose a single-payer system, or, at minimum, one of the components of a single-payer system, e.g., price controls for drug companies or budgets for hospitals.⁵³

Fortunately for single-payer advocates, the public sees waste in the system, and the high prices generated by waste, as the primary problem. The public does not see unnecessary services as a big issue and is, therefore, opposed to attacking volume of services with either the managed care meat ax or the large-deductible meat ax. But the opinion of experts – the politicians, big business execs, pundits, and think-tank types who dominate the health-care reform debate – is inconsistent with public opinion. The experts think volume of services is the main problem. The only significant division of opinion among experts is whether the alleged overuse of medical services is primarily the fault of doctors or of patients.

⁵³ If you've chosen waste and excessive price as the primary problem, you don't get to select competition as a solution because, by concluding the multiple-payer system is wasteful, you've already admitted competition can't eliminate administrative waste, excess capacity, high prices, and fraud.

Evidence of the clash between ordinary people and experts

The gap between expert and public opinion began to emerge about the time the current health-care reform debate began, which is to say in the late 1980s. The gap was obvious by the early 1990s. The spread of MCPs in the late 1980s and early 1990s, and the inflation lull of the mid-1990s, gave experts the sensation that their biases in favor of managed care were warranted. However, the spread of MCPs during that period gave a rapidly growing portion of the public real-life experiences with managed care, experiences which were often irritating or infuriating. As the data in Table 8-2 indicate, polling data as early as 1990 revealed public distaste for managed care, the great hope of experts. Other polls, including the one shown in Table 5-3, demonstrated that majorities of Americans believed that waste, fraud and overcharging by doctors, hospitals and drug companies, not “overuse” of health care, were the most important causes of health-care inflation. Waste, fraud and abuse within the health-care system are not the favorite topics of the experts.

The earliest analysis of the expert-public opinion split that I know of was published in April 1992 by the Public Agenda Foundation, a think tank founded by pollster Daniel Yankelovich and former Secretary of State Cyrus Vance. The Foundation asked experts and ordinary people to identify the health-care system’s main problems. The Foundation’s report indicates the Foundation assumed experts must be right, and any divergence of public opinion from expert opinion must reflect stupidity on the part of the public. The report, entitled *Faulty Diagnosis: Public Misconceptions About Health Care Reform*, concluded that the experts believed overuse of health services was the main problem, and the public was wrong for not capitulating to this point of view.

The American public believes that the country’s health-care system is riddled with waste and greed. Consequently, they are not eager to talk about hard choices, or to consider solutions that will increase their own costs or reduce the services they get. Nor are they ready to relinquish the miracles of modern medicine.¹⁹⁸

Until these differences [between expert and public opinion] are fully understood, and until leadership and media take steps to address them, the debate on health care will likely result in continued political gridlock – with the public and leaders talking past each other. . . .¹⁹⁹

In November 1992, Knight Ridder Newspapers ran an article about the Public Agenda study as well as polls by Harris and Gallup. The article began:

Policy-makers and the public are worlds apart on the most controversial element of health-care change: limiting the medical services that people can receive. Most government, business and health industry leaders believe it will be impossible to control costs. . . unless people with insurance sacrifice some choices. Yet the

Table 8-2: Americans have never approved of managed care: Results of polls

Before 1993 (the year the White House endorsed managed competition)

A 1990 Gallup poll found that 75 percent of Americans supported a national health insurance program but only 30 percent did so if the program limited their choice of physician.

A 1992 Gallup poll found that only 20 percent of the population agreed that control of health-care inflation requires "limits on what health care is available to the average person."

The same Gallup poll reported that 61 percent disagree that insurance companies should be able to decide which services they will pay for.

A 1992 poll conducted by Robert Blendon at Harvard demonstrated that "about half of all Americans feel that joining a health plan that restricts their choice of physicians . . . is not a desirable method of controlling high health costs."

After 1993

A 1994 *Newsweek* Poll found 76 percent of Americans were unwilling to accept restrictions on their choice of doctor or hospital even if such restrictions would bring down health-care costs.

A 1995 poll of Minnesotans conducted by the Minnesota Health Data Institute found that traditional health plans outscored HMOs on four quality-of-care measures.

A 1996 Yankelovich poll of insured Californians found that 55 percent thought quality of care had declined.

A 1997 Lou Harris poll found that 54 percent of Americans believed the spread of managed care was harmful to them.

According to a 1997 poll funded by the Kaiser Foundation and others, 55 percent thought that managed care plans are more interested in saving money than providing the best care, and two thirds of these based their opinion on their own experiences or on the comments of family members and friends, not on media stories.

According to a 1998 *Washington Post*-ABC News poll, 60 percent of American adults favored "tougher government regulation of managed care programs like HMOs," and of these, 63 percent still favored tougher regulation even if "it raised [their] own health-care costs." Only 27 percent of adults opposed tougher regulation.

public roundly rejects limits.

The article defined policy-makers to include "major insurers, hospital chief executives, physician leaders, state officials, federal regulators, key congressional staff, members of Congress, corporate executives, and union leaders." According to the article, the Harris poll indicated that 63 percent of these "policy-makers believe high-tech medical services must eventually be rationed," but the Gallup survey found "that only 20 percent of the public believes there should be limits on the care an average person can receive." Interestingly, the Harris poll showed that the subset of "policy-makers" that was most likely to endorse rationing was "major insurers"; 95 percent of this group thought care must be rationed, compared to 50 percent for "union leaders," the least likely of the policy-maker groups to support rationing.²⁰⁰ But even the 50-percent figure for union leaders was way above the 20 percent figure for the general public.

In a 1995 article for *Health Affairs*, Yankelovich attributed the defeat of the Clinton plan to the gap in expert and public opinion and to Clinton's failure to engage ordinary people in the formulation of his plan. "President Clinton's reform plan was not shaped by discussion with citizens. . .," wrote Yankelovich. "The plan was the product of experts and experts alone. Technical experts designed it, special interests argued it, political leaders sold it, journalists more interested in its political ramifications than its contents kibitzed it, advertising attacked it."²⁰¹ Yankelovich didn't say so, but precisely the same could be said of the entire managed care project from its inception. Paul Ellwood and other experts designed it, Ted Kennedy and Richard Nixon sold it to Congress, HMOs sold it to employers, employers forced or cajoled their employees into enrolling in HMOs, and reporters lay asleep at the switch until they were awakened by the HMO

backlash. Ordinary citizens were never asked by policymakers if they thought turning the health-care system over to MCPs was a good idea. When, in the late 1980s, ordinary people were finally asked by pollsters for their opinion, they said clearly they were not happy with managed care.⁵⁴

Yankelovich went on to say, however, that even if the Clintons had done a good job of engaging the public in a discussion of their plan, the public would have rejected it because public perceptions of the problem are so different from the perceptions of the experts who designed the Clintons' bill. "What really angers Americans," wrote Yankelovich, "are the causes of rising health costs, as they perceive them." Citing his own polls, Yankelovich said the public perceives "hospital costs, . . . malpractice suits . . . , physician fees . . . , fraud and abuse in the health-care system . . . , and the costs of medications" as the primary causes of health-care inflation.

Given this perception, it is not surprising that most Americans resist making sacrifices. . . . The vast majority rejects the idea that the explosion of health costs must lead . . . to "limits on what health care is available to the average person." Only 20 percent of adults nationwide endorse this view, *while an impressive 77 percent majority insists that the cure to rising costs is "to cut the waste, high profits, and fraud in medicine."* . . . Since the public blames the system, not itself, it understandably rejects calls for sacrifice. . . . This perspective puts the public on a collision course with the majority of experts. In the experts' view, the two main causes of rising costs are the aging of the population and the explosive costs of new technologies and medical advances. The majority of the public brushes aside both of these explanations (emphasis added).²⁰²

The chasm between expert and public views continued into the late 1990s, several years after it had become apparent that managed care was a bust. "Health policy experts are constantly talking about rationing and setting limits and balancing costs and the benefits of care, but for the average American those are just ridiculous notions," said Larry Levitt, an analyst at the Kaiser Family Foundation, in a 1999 interview with the *Washington Post*.²⁰³

The public supports single-payer

The polling data we have just reviewed indicates Americans perceive waste and price-gouging as the primary causes of health-care inflation, and reject the claim that excessive use of medical services is the problem. Those perceptions suggest the public would support a single-payer system. We have less data on what solutions the public supports than we have on the public's perception of the causes of the health crisis, but the data we have tell us a large majority of Americans will support a single-payer over other options if they are exposed to a fair debate among proponents of those options. I base this conclusion primarily on polling data and the results of a few focus groups and "citizens juries," and secondarily on my own experience talking to thousands of Minnesotans over the last 15 years.

Table 8-3 shows the results of three polls, taken back in the late 1980s and early 1990s before managed competition became the darling of the chattering classes, before single-payer was driven into the wilderness, and before pollsters stopped asking about single-payer. These polls indicate that roughly two-thirds of Americans supported a single-payer then. The Harvard poll

⁵⁴ To be precise, what the polls conducted prior to the HMO backlash indicated was that people were not happy with the tools managed care uses, e.g., restrictions on their choice of doctor, financial incentives for doctors, and denial of services. Prior to the backlash, polls which used the phrase "managed care" instead of a phrase depicting one of managed care's tools tended to evoke a less critical, more ambivalent reaction.

asked Americans if they would be willing to swap the U.S. system for the Canadian system; sixty-one percent said they would. The *Wall Street Journal*-NBC poll described single-payer in general terms; sixty-nine percent of Americans said they would endorse a single-payer. Interestingly, a 1997 survey of medical students, residents, and medical school faculty produced results similar to those shown in Table 8-3. According to the article about this survey, which appeared in the *New England Journal of Medicine*, “Overall, 57.1 percent thought that a single-payer system with universal coverage was the best health-care system for the most people for a fixed amount of money. A total of 21.7 percent favored managed care, and 18.7 percent preferred a fee-for-service system (2.5 percent did not state a preference).”²⁰⁴

Table 8-3: Majorities favor single-payer in polls

| | For single-payer | Opposed to single-payer |
|---|------------------|-------------------------|
| Harvard University poll (1988) | 61% | 37% |
| <i>Wall Street Journal</i> -NBC poll (1991) | 69% | 20% |
| CBS- <i>New York Times</i> poll (1993) | 59% | 41% |

Sources: Robert J. Blendon, “Three systems: A comparative survey,” *Health Management Quarterly* 1989;11(1):2-10, Exhibit 5, 5, for Harvard poll results; *Wall Street Journal*, June 28, 1991, A4, for *Wall Street Journal*-NBC poll results; *American Health Line* April 19, 1993 for CBS-*New York Times* results.

The widespread support for Medicare is also an indication of American support for a single-payer system. As I noted in Chapter 6, Medicare resembles a single-payer system because it is the sole source of financing for medical care for the nation’s elderly and disabled, and because it sets limits on what doctors and hospitals can charge. Surveys which find high levels of public support for Medicare are numerous. For example, in 2000, 88 percent of nonelderly American adults said it was “important” to them that Medicare “will still be providing health coverage for seniors” when they retire;²⁰⁵ in 2001, 70 percent of adults wanted more money spent on Medicare, 26 wanted spending kept where it was, and only 2 percent supported a cut;²⁰⁶ and in 2000, 97 percent of adults said it was “important” to “preserve Medicare for the future.”²⁰⁷

But polls are not the most reliable evidence available on public opinion about how to solve the health-care crisis. Polls that don’t describe single-payer accurately, particularly those that use loaded phrases to describe single-payer, have reported support for single-payer in the 40-to-50-percent range. But survey evidence is not the only evidence available. The most compelling evidence in favor of my claim that a majority of Americans would support a single-payer system if they were exposed to a fair debate are the results of a few public hearings and “citizens juries” at which participants were exposed to presentations on single-payer, managed competition, and other proposals.

These events include town hall meetings in the fall of 1993 in Minnesota and New York, a citizens jury sponsored by the Jefferson Center in 1993, and the 1996 Minneapolis *StarTribune*-KTCA citizens jury I described at the beginning of this book. Single-payer won by landslides at all of these events.

In the Twin Cities, the *Star Tribune* sponsored “roundtables” in more than 100 neighborhoods in November 1993 to discuss the managed competition bills introduced by President Clinton and Senator David Durenberger (R-MN), the late Senator Paul Wellstone’s (D-MN) single-payer bill, and the Heritage Foundation’s version of the MSA proposal. More than 1,000 people

participated. To facilitate discussion at these meetings, the *Star Tribune* published a 36-page insert which contained information on the health-care crisis plus arguments for each of the four major plans. The *Star Tribune* stacked the deck against single-payer; it was the only proposal for which the *Star Tribune* published a rebuttal, in this case, from the Health Insurance Association of America. Nevertheless, when the votes of the 220 participants who filled out questionnaires were counted, single-payer won handily with 43 percent of the vote. In distant second place was Clinton's plan at 16 percent. The MSA proposal got 15 percent, and something the *Star Tribune* called "pure managed competition" (presumably Durenberger's proposal) got 4 percent.²⁰⁸

A series of less structured town hall meetings took place in New York at about the same time as the *Star Tribune* was conducting its roundtables. The New York meetings were hosted by a state task force chaired by New York's Commissioner of Health, Mark Chassin (yes, the same guy who used to do appropriateness studies for the Rand Corporation) and New York's Commissioner of Social Services. In its December 12, 1993 edition, *Newsday* reported that the hearings revealed widespread hostility to Clinton's plan and "overwhelming" support for single-payer. "Consumers, doctors, hospital chiefs and insurers have a message for Governor Mario Cuomo about President Clinton's health-care plan: New York can find its own better way." *Newsday* said the supporters of a single-payer plan among consumers constituted "an overwhelming majority" of those who spoke. Dr. Chassin was quoted saying, "It's pretty remarkable that almost unanimously the consumer representatives described their support for a single-payer approach. I was surprised by the magnitude of that proportion."²⁰⁹

At the beginning of this book, I described my role in a 1996 citizens jury experiment in Minnesota in which single-payer won eight votes, managed competition three votes, and MSAs no votes. A similar vote took place on a citizens jury convened three years earlier in Washington, DC by the Jefferson Center, a nonprofit organization that had been experimenting with citizens juries since the late 1970s. The Jefferson Center would expose a representative group of Americans to proponents of various solutions to a problem, and then publish the jury's conclusions. The Center convened a meeting of 24 Americans from 15 states to discuss health policy during the week of October 10 to 14, 1993, less than a month after Bill Clinton had presented his managed competition plan in a televised address to Congress. The jurors included a grain handler from New Jersey, a court clerk from New York, a retired insurance agent from Florida, a retired nurse from Louisiana, a carpenter from Wisconsin, a janitor from Minnesota, a legal secretary from Texas, an electrical contractor from Nevada, and an antique dealer from California.

Although the Jefferson Center's goal was to give ordinary people a voice in the debates about significant issues facing the country, the agenda the Center made the jury follow was stacked against single-payer. For starters, the jury was told its sole purpose was to discuss two questions: "Do we need health-care reform in America?" and "Is the Clinton plan the way to get the health-care reform we need?" There would be no vote on single-payer, the Republican version of managed competition, MSAs, or anything other than Clinton's plan. Ned Crosby, the founder of the Center and co-moderator of the proceedings, later told Mike Casper, Wellstone's former policy advisor, that he framed the question for the jury narrowly in order to "gain legitimacy" in Washington and to ensure that Clinton administration officials would participate (former U.S. Representative Toby Moffett, Clinton's point man to the jury, had apparently warned Crosby he would not participate if single-payer were on the agenda).²¹⁰ A second obstacle to single-payer was the witness list – it consisted almost entirely of proponents of either the Clinton plan or one of the Republicans' plans. Of the 28 witnesses listed in the Jefferson Center report on this jury, only two witnesses had indicated support for single-payer – Gail Shearer of Consumers Union (Consumers Union publishes *Consumer Reports*, which had endorsed a single-payer system in 1992), and Senator Wellstone.²¹¹

But despite the handicaps imposed on the single-payer proposal, it wound up getting a thorough hearing because the jurors demanded it. The demand came after Senator Wellstone presented the case for his single-payer legislation. Wellstone was one of three Senators who testified. The others were Senator Durenberger, who presented the Republican-and-conservative-Democrat version of managed competition (known as “Clinton lite”), and Senator Don Nickels (R-OK) who argued for MSAs. As William Raspberry reported in the *Washington Post*, the Durenberger and Nickels proposals were “dismissed without a vote.”²¹² “[O]nly the single-payer approach led [the jury] to want to hear more,” reported the Jefferson Center’s newsletter. “By votes of 22-0, the jurors invited Wellstone back for two more question periods.”²¹³

By the jury’s fifth and last day of deliberation, it was clear that most jurors were not happy with the Clinton plan and that many would like to vote on single-payer. But the jury was reluctant to embarrass their hosts by rewriting the agenda, and so they concluded their formal deliberations voting only on the two questions put to them by the Jefferson Center. On the question of whether American needed health-care reform, the jury voted unanimously in the affirmative. On the question of whether the Clinton plan was the way to get the necessary health-care reform, 19 jurors said no and 5 said yes. Immediately after the close of the jury’s proceedings, Roger Mudd, a reporter then with ABC News who had been hired to produce a documentary on the jury, observed that a majority of the jurors seemed to support single-payer. He then asked the jurors, “Why the hell didn’t you have a formal vote on the Wellstone plan?” Kathleen Hall Jamieson, a professor at the University of Pennsylvania’s Annenberg School of Communications who had co-moderated with Crosby, then asked the jurors, “How many would have voted for the Wellstone plan?” Seventeen raised their hands.²¹⁴

The jury clearly understood what they were rejecting and what they were endorsing. They agreed on 25 criteria they wanted any health reform plan to meet. These criteria included comprehensive coverage for all Americans, freedom to choose one’s doctor, minimal “bureaucracy and paperwork,” “use [of] price guidelines to hold down costs,” and reduction in “fraud, waste and abuse.” These criteria said nary a word about competition. The jury obviously didn’t believe the Clinton and Republican claims that competition would reduce price and protect patients.

As Dr. Chassin was impressed by the extent of the support for single-payer in New York, so Jefferson Center staff expressed amazement at their jury’s support for single-payer. “The whole damn world seems to think the Clinton plan is the way to go,” said Bob Meeks, president of the Jefferson Center. “Yet they [the jurors] like the single-payer system, which isn’t even getting considered in Washington.”²¹⁵ I got a similar reaction from a woman who helped organize the 1996 *Star Tribune*-KTCA TV citizen forum that I described in Chapter 1. “Were you surprised by the vote?” she asked me as the meeting was breaking up, implying that she was surprised. I said I was surprised only that people were willing to make a decision after a few hours of debate. I was not surprised that most of the forum participants favored single-payer.

Conclusions

The surprise that people experience when they learn of the public’s support for single-payer is due (a) to the great chasm between the opinion of experts and the opinion of average people, and (b) to the great differences in power between the relatively small group of experts and the large but unorganized public. The experts think excessive volume of services is the problem, and that either MCPs or large-deductible plans are the solution. The public, on the other hand, thinks *price*, and the waste and fraud that drive price up, are the primary culprits, and, therefore, there is no need for patients to suffer the outrages of managed care nor the deprivations induced by large deductibles. Because the experts have money and media access, they have enormous power to frame the debate

that the public does not have. Therefore, anyone who attempts to comprehend the U.S. health policy debate by listening to the mainstream media is easily fooled into thinking the experts are correct and reflect public opinion. The evidence I presented in Chapters 4 through 7 indicates the experts are incorrect. The evidence in this chapter indicates the experts do not represent public opinion.

Why Managed Competition Can't Work

Introduction

As the HMO backlash unfolded in the latter half of the 1990s, managed competition advocates and other defenders of the MCP industry hastened to assure the public that the problems of the new MCP-dominated system were fixable. Paul Ellwood, Alain Enthoven and other MCP advocates argued that the new system was a “work in progress” that just needed a few adjustments. Specifically, they argued that merely having MCPs take over the health-care system was not enough. They said inflation could be brought under control only if employees were placed under even more financial pressure to choose MCPs, preferably HMOs, than they were already under. And they argued that damage to quality of care was in fact minimal, and to the extent that it was occurring, it could be reversed by the introduction of MCP report cards. If they said anything at all about the destruction of patient privacy wrought by MCPs, it was merely to observe that MCPs and other owners of patient databases should take steps to reduce the risk that patient records would be accidentally publicized.

In this chapter I demonstrate that the current system is incapable of containing cost because it cannot address the waste I described in Chapters 6 and 7, and it cannot stop itself from damaging quality and privacy. I demonstrate, moreover, that no amount of tinkering (for example, putting more pressure on employees to buy HMO policies, giving patients the right to appeal MCP denials of care, and giving patients the right to sue their MCP) can change these facts. The current system is not a “work in progress” toward a more perfect system; it is the natural outcome of a foolish theory that became de facto U.S. health policy with no public discussion beforehand.

Some readers may wonder why this chapter is necessary. Isn't the recent performance of the current system evidence enough of its inferiority and incorrigibility?

For the average American, the answer is probably yes. But some very influential groups and individuals are still attracted to managed competition or, at least, managed care. George W. Bush and Congressional Republicans still want to turn Medicare into a showcase for managed competition, many large employers still subscribe to the notion that someone has to tell doctors what services can and cannot be ordered, and many within the health policy community continue to deny managed care has done harm to quality of care or, at minimum, they continue to insist that whatever is wrong with the current form of managed competition is fixable. For example, a conference of leading health policy experts convened by the Institute of Medicine (an agency within the National Academy of Sciences) in late 1997 (which is to say, after the HMO backlash materialized) concluded that managed care is not only not a problem but may in fact deserve some credit for improving quality of care. In a report on the conference, two experts present at the conference wrote:

The workshop participants agreed . . . [i]t is . . . probably impossible . . . to “fix” one component of health-care organizations without addressing systems as a whole – or, as one speaker remonstrated, “trying to fix the parts when the whole chassis is broken.” The “broken chassis” in question, moreover, is not managed care. The patterns of practice we contend with today were largely established under fee-for-practice [*sic*] medicine, and the transition to managed care has generally held quality constant or, in some instances, has improved it.²¹⁶

Managed competition has taken a dreadful beating, but it's not dead yet. Although its proponents are way out of line with public thinking, they are powerful enough to force us all to continue debating whether the current system is as bad as I and many others say it is, and whether the system's defects can be eliminated with a little tweaking. It is essential, therefore, that anyone who seeks to understand the modern health-care reform debate understand the arguments for managed care and managed competition.

Readers of this book who still maintain some sympathy for managed care may have the opposite problem. For them, the very fact that MCPs took over the system may cause them to resist my arguments that MCPs are inefficient, pose a threat to patients, and are incapable of changing their ways. "If MCPs are so bad," these readers may ask, "why did so many employers accept them, and if managed competition is such a stupid theory, why did so many politicians, employers, and experts endorse it?" This is an understandable response. So I begin my dissection of the dubious logic behind the current system with an analysis of how that logic evolved and why it escaped anything resembling sustained and rational criticism until long after MCPs had taken over the system.

The assumptions underlying managed competition

"Health maintenance strategy" is the phrase Paul Ellwood used to describe his proposal to Nixon in the early 1970s. "Managed competition" is the name given to the theory developed by Stanford professor Alain Enthoven in the 1980s and endorsed by Ellwood and others in the early 1990s. Managed competition theory is a little more elaborate than Ellwood's health maintenance strategy. Ellwood's health maintenance strategy and Enthoven's managed competition theory both start with the assumption that volume of health services is the main problem. They also share the assumption that HMOs are better than other types of insurance companies at reducing volume because HMO doctors are exposed to financial incentives that allegedly induce the doctors to cut out unnecessary services and to place more emphasis on preventive services. Ellwood's proposal and managed competition theory also share the assumption that report cards on HMOs and other insurers that use managed care tactics are essential to protect consumers against abuse, and that such report cards are technologically and financially feasible. Finally, both Ellwood's proposal and managed competition share the unspoken premise that the administrative costs created by managed care, and by the cost of creating report cards, are relatively small and have little effect on total costs.

The theory of managed competition appeared when it did – in the late 1980s – because by then it was clear to everyone, even HMO advocates, that the spread of HMOs and the conversion of many traditional insurers into MCPs was having no effect on inflation. Obviously, something more than a takeover of the insurance industry by MCPs was needed. In a pair of articles for the *New England Journal of Medicine* published in 1989, Enthoven and his colleague Richard Kronick argued that HMOs and managed care were wonderful inventions, but their mere appearance was insufficient to bring inflation under control. What was needed, argued Enthoven and Kronick, was stronger competition within the insurance industry. Competition could be strengthened, they said, if it were "managed."

They stated, in essence, that two features had to be added to Ellwood's simple strategy of subsidizing HMOs and publishing report cards. First, they argued, even though lower-cost HMOs were available, a majority of insured Americans were staying away from HMOs and were instead buying insurance from traditional insurers and less tightly managed MCPs because Americans were not sufficiently motivated to seek out the lowest-cost insurance. This lack of "cost consciousness," they said, was due to federal tax law which failed to count the employer's premium payments as part of employee income. If this tax-financed subsidy for the purchase of health insurance were

removed, they argued, Americans would get even madder than they already were about the high cost of health insurance, and would be even more motivated to abandon their non-HMO insurers and enroll with cheaper HMOs. Secondly, said Enthoven and Kronick, consumers should be bunched into big buying coalitions so that they would have the power to negotiate with the big insurance companies, power they didn't have unless they worked for a very large corporation. Like Ellwood before them, Enthoven and Kronick also endorsed MCP report cards. Like Ellwood, they offered no information on how report cards would be produced, whether they could be used, and what they would cost.

To sum up, here are the assumptions, some explicit and some implicit, that Enthoven and Kronick relied on:

Volume, not price, is the main problem;

Capitation and bonuses for denying care will save money without harming patients because capitation and bonuses cause the self-interest of doctors to become identical to that of patients, and together doctors and patients will cut volume by eliminating unnecessary services and increasing preventive and other services that keep patients healthy;

Even if capitation and bonuses do threaten quality, quality will not decline because someone will some day concoct, and consumers will then use, mammoth report cards on the quality of thousands of medical services provided by MCP doctors;

Administrative costs will remain unaffected by the spread of managed care, and by the need to construct report cards;

Many more consumers will enroll in more tightly managed HMOs if their tax subsidies are eliminated, which will save money; and

Consumers would have more power to negotiate lower premiums if they were represented by huge buying coalitions.

The first four of these assumptions were endorsed by Ellwood and the early disciples of HMOs. Assumptions 5 and 6 were added by Enthoven and Kronick. The six assumptions together constitute managed competition. Assumption 1 (that volume is the main problem) is not irrational; it's just wrong – it's not supported by the evidence (see Chapter 4). But assumptions 2, 3, and 4 are worse than wrong; they defy commonsense. Assumption 5 (that eliminating tax subsidies will make consumers more willing to enroll in HMOs) is rational, but the assumption that this by itself will have a significant effect on costs is wrong. Moreover, eliminating the tax subsidy could have no effect at all on the problem of declining quality and privacy. Only assumption 6 holds any promise, but this promise is limited to the inflation problem; huge buying coalitions can do little to stop the degradation of quality and privacy caused by the current system.

The flabbiness of the first four premises, and the significance of these premises (they were the girders upon which the current system, Ellwood's 1970 proposal, and Enthoven's theory of managed competition rested) meant MCPs and managed competition had to fail. But why wasn't this obvious in 1970, or even 1990? Why were so many intelligent people seduced by the claims made for HMOs and managed competition? Why did we have to suffer through three decades of managed care before it dawned on the nation's opinion-makers that a system built around MCPs was going to fail? Why didn't policy-makers and reporters question the assumptions underlying HMO propaganda long before HMOs and MCPs took control of the system? Explaining the spread of HMOs and the ascendance of managed competition ideology is worth a book in its own right. In this chapter, I concentrate on the three most important factors that permitted MCPs to escape criticism until it was too late.

The first factor is what I'll call the "HMO halo" conferred upon the nation's earliest HMOs by the support HMOs got from populist organizations and unions and, conversely, by the hostility directed at HMOs by the American Medical Association. This halo seduced many policy makers and reporters into thinking HMOs were run by people who were more altruistic than the people who ran traditional insurance companies, and that this altruism would survive once HMOs were transformed from a few small, community-controlled organizations into huge corporations accountable primarily to large employers and to Wall Street.

The second factor that contributed to uncritical thinking about HMOs, and eventually all MCPs, was the ability of HMOs and many MCPs to keep their premiums 5 to 10 percent below those of traditional insurers. At first glance, this fact would seem to constitute proof that MCPs were capable of rolling back health-care inflation. But this impression was misleading. MCPs, it turned out, could keep their premiums slightly lower only because they had three advantages over traditional insurers that had nothing to do with efficiency. First, they enrolled healthier people. Second, they rationed health care (by which I mean they denied *necessary* services), something traditional insurers couldn't do because they didn't have control over doctors as MCPs did.⁵⁵ Third, MCPs shifted costs onto other payers, including traditional insurers, taxpayers, and patients and their families, using methods that were less available or completely unavailable to traditional insurers (such as extracting large discounts from hospitals, which forced the hospitals to raise their rates for less powerful payers). These three HMO advantages – healthier enrollees, the power to ration, and the ability to shift costs – were not obvious to casual observers (a class into which many so-called experts fall), and, of course, MCP supporters did not go out of their way to call attention to them.

The third factor which seduced a lot of smart people into thinking MCPs could perform as advertised was the unusually steep decline in health-care inflation that occurred during the mid-1990s, just as MCPs were completing their takeover of the market. This inflation lull did not last, of course, but for a few years in the 1990s the lull was hailed by MCP advocates as solid evidence that MCPs really were more efficient than traditional insurers.

These three factors – the HMO halo effect, lower HMO premiums, and the mid-1990s inflation lull – created a willingness among policy-makers, academics, and reporters to accept uncritically the strange assumptions articulated by HMO and managed-competition proponents. Of course, as the MCP industry grew and accrued more and more economic and political power, it became increasingly difficult for critics of the industry to be heard above the din of industry propaganda. The cumulative effect of the HMO halo, lower HMO premiums, the mid-1990s inflation lull, and oceans of MCP money thrown behind the effort to promote managed competition proved to be overwhelming. With all that going for them, it is little wonder that managed competition theorists managed to pull off a great illusion – for awhile, anyway. In the following sections, I examine in more detail the HMO halo, lower HMO premiums, and the 1990s inflation lull.

The origin of the HMO halo

Managed competition would not have been developed (or, if it had been, it would never have become famous) if there had been no HMO industry; there probably would have been no

⁵⁵ "Rationing," as I use the word in this book, and as it is used by most observers, does not refer to decisions by insurers, public or private, that certain types of medical goods and services falls outside the coverage authorized by law (in the case of public insurers) or by the contract between the insurer and the enrollee (in the case of private-sector insurance companies). If, for example, I buy an insurance policy that does not cover mental health services, my insurer is not guilty of rationing if it refuses to reimburse me for the cost of a visit to a psychiatrist.

HMO industry if there had been no HMO Act of 1973; and there almost certainly would have been no HMO Act of 1973 if there had been no HMOs for the proponents of the HMO Act of 1973 to brag about. HMOs and, by the 1980s, other types of MCPs, were the centerpiece of managed competition. So we begin our inquiry into the first phase of the evolution of managed competition with an analysis of the track record of the 30 to 40 HMOs that existed in 1970, the year Paul Ellwood convinced the Nixon administration to support legislation subsidizing the creation of an HMO industry.⁵⁶

Today, promotion of MCPs is associated primarily with the Republican Party. Since 1994, Republicans in Congress have successfully fought off legislation to protect patients from MCPs (the first patient protection bill was introduced by Senator Paul Wellstone in 1994). Since 1995, Republicans have promoted the notion that Medicare can save money if seniors are pushed, with financial pressure, into HMOs (former House Speaker Newt Gingrich was promoting this idea by 1995). Thus, newcomers to the health-care reform debate may be shocked to learn that the HMO concept was passionately supported during the 1930s by union workers, poor farmers, consumers, and a few altruistic doctors, many of whom drew their inspiration from the populist and co-op movements of the late 1800's and early 1900's. Michael Shadid, a physician and Syrian immigrant who started one of the earliest HMOs in Elk City, Oklahoma in 1927, and who did some consulting for the founders of Group Health Cooperative of Puget Sound in Seattle, ran for office as a member of the Socialist Party. The father of Maurice McKay, the director of Group Health in the Twin Cities, was an organizer for the Industrial Workers of the World.²¹⁷ (Someone told me a decade ago that McKay was known as "the commie from Como," an allusion to the fact that Group Health's headquarters were, at that time, on Como Avenue in St. Paul.) For many liberals and progressives, the role that populist groups played in establishing the early HMOs created a halo over the HMO concept. By the same token, the hatred of HMOs exhibited by the American Medical Association added luster to this halo.

Community groups, unions, and farm groups supported the formation of HMOs, called "prepaid group practices" prior to 1970, for the same reason they supported food co-ops, milk co-ops, and electricity co-ops, namely, to meet a basic human need with a community-controlled enterprise. They most definitely were not in it to make big bucks. Dr. Shadid organized the cooperative in Oklahoma to provide hospital services (including inpatient physician services) for the same reason the Baylor University Hospital developed the first hospital insurance program two years later – to make it feasible for ordinary people, many of whom were poor, to get medical care when they needed it. There was a significant difference, however, between Shadid's co-op and the Baylor University insurance plan: Shadid's co-op was controlled by the townspeople and farmers who bought a share in the co-op, whereas the teachers who paid \$6 in annual premiums to the Baylor plan gained no voice in the running of the hospital nor the insurance company that took their money.

The Group Health Cooperative of Puget Sound, which merged with Kaiser Permanente in 1997, was formed in 1945 by unions, co-ops, and the Washington Grange (a populist farm organization). The motive was not moolah, power or market share. The spark leading to the creation of this HMO was the refusal of Washington's doctor-owned Blue Shield plan to pay for treatment of what even then were called "pre-existing conditions" (diseases and illnesses that existed

⁵⁶Joseph Falkson put the number of HMOs operating in the U.S. in 1970 at 39 (*HMOs and the Politics of Health System Reform*, American Hospital Association, Chicago, IL 1980, 197); Mayer and Mayer put the number at "between 28 and 39" (Thomas R. Mayer and Gloria Gilbert Mayer, "HMOs: Origins and development," *New England Journal of Medicine* 1985;312:590-594).

before the patient signed up for insurance). As the following excerpts indicate, the preamble to Group Health's bylaws expressed classic populist values:

The Cooperative shall endeavor:

to develop some of the most outstanding hospitals and medical centers to be found anywhere, with special attention devoted to preventive medicine.

to serve the greatest possible number of people under consumer cooperative principles without discrimination. . . . [and]

(f) to educate the public as to the value of the cooperative method of health protection, and to promote other projects in the interest of public health.²¹⁸

I love the sentiments expressed in this preamble. I know I would have enjoyed working with the people who wrote it.

The nation's first urban HMO, Group Health Association of Washington, DC, founded in 1937, was organized by employees of the Home Owner's Loan Corporation because these employees were acutely aware that many of their customers had incurred huge medical bills during the Depression, and that these bills forced people out of their homes when they could no longer keep up their mortgage payments.

Citizen groups were not the only advocates of prepaid practice groups. Large employers in rural areas played an equally significant (perhaps a more significant) role in the creation of the first generation of prepaid practice groups in the first half of the 20th Century. As one observer put it,

One of the most powerful forces leading to these arrangements was the practice of recruiting people to work in isolated areas such as sugar and pineapple plantations in Hawaii; lumber camps in Michigan, Wisconsin, and Washington State; mines on the iron ranges of northern Minnesota; and railroads just about anywhere.²¹⁹

The motives of the plantation owners and the timber, mining, railroad, and construction companies that started prepaid practice groups in isolated areas were a little less altruistic than those of the citizens who started the Elk City and Puget Sound co-ops. Their motives were to attract and retain healthy workers in remote areas with few or no doctors and hospitals. The most famous of these company-formed prepaid group practices were those started by Henry Kaiser, the construction and shipbuilding magnate who made his millions during the Depression and the Second World War. Kaiser used prepaid practice groups during the Depression to provide medical care to workers building an aqueduct in the Southern California desert (its purpose was to bring water from the Colorado River to Los Angeles). He did so again to provide medical care to workers who built the Grand Coulee Dam in Washington, and yet again to provide care to 90,000 workers employed at his shipbuilding plants in San Francisco during World War II. The San Francisco prepaid practice group eventually became Kaiser-Permanente Health Care Program, for decades the nation's largest HMO and, along with Group Health of Puget Sound, one of the most respected HMOs in the country. Note again: Kaiser's original goal was not to make money on his HMO, to become the CEO of a great big corporation, nor to become famous on Wall Street. His goals were quite pragmatic: to make sure his workers had access to doctors when they needed them.

Thus, when Paul Ellwood began to peddle HMOs in the early 1970s, he was proposing an idea that had the endorsement not only of some progressive employers, but of groups representing America's dispossessed as well. These endorsements created the impression that HMOs were unique in the insurance world – public-spirited organizations that were adept at protecting patients

from unnecessary services and delivering preventive services that doctors in the fee-for-service sector wouldn't think of providing.

Lower premiums and the illusion of greater HMO efficiency

The ability of most HMOs to keep their premiums slightly below those of traditional insurers was another significant factor that contributed to the widespread acceptance of the strange assumptions underlying the theory of managed competition. Whether HMO premiums were always lower than those of traditional insurers is not clear to me. I have seen reports suggesting that HMO premiums prior to the 1980s were often equal to those of traditional insurers. But I have no doubt that the typical HMO's premium eventually fell below that of the typical traditional insurer (this probably occurred in the early 1980s), and that many non-HMO MCPs were also able to charge less than traditional insurers. I'm positive of this because I know a majority of Americans never liked managed care. That means there was absolutely no way HMOs could have made such huge inroads into the health insurance market if their premiums had not eventually fallen below those of traditional insurers. The great majority of Americans who enrolled in HMOs did so for one reason, and one reason only: to save money.

The HMOs' ability to keep their premiums low was not due, as HMO advocates would have us believe, to greater HMO efficiency. If anything, HMOs were less efficient than traditional insurers. As we have seen, the spread of HMOs drove up administrative costs, at least for providers and possibly for insurers as well. To repeat: HMOs, and to some extent the less tightly managed insurers, were able to reduce their costs enough to keep their premiums below those of traditional insurers because they enjoyed "favorable selection" (which means they enrolled healthier people), they shifted costs to other payers, and they rationed.

The possibility that HMOs enjoyed two of these advantages (favorable selection and the ability to ration) was acknowledged as early as 1978. That year, in an article for the *New England Journal of Medicine*, Harold Luft, who would subsequently become a fan of managed care, reviewed all the reliable studies published in the previous 25 years on the subject of how HMOs save money. He found only five solid studies, most of which reported data from the 1960s. On the basis of these studies, all of which compared Kaiser-Permanente to traditional insurers, Luft concluded that HMOs did indeed have lower total costs (defined as premiums plus out-of-pocket costs incurred by patients, both for treatment in the HMO and outside of it), and that HMOs achieved their savings primarily via reduced hospitalizations and, to a minor extent, by not having to pay for services that patients sought outside of the HMO. He reported finding some evidence that HMOs cut "nondiscretionary" hospital services. (Translation: Kaiser denied necessary care to some of its patients.) Citing studies other than the five involving Kaiser, Luft concluded that out-of-plan use "ranges from less than 1 percent in some studies to about 8 percent." (Luft didn't indicate whether he meant 1 to 8 percent of *patients* went outside the plan, or that 1 to 8 percent of all *services* were obtained out-of-plan; I suspect he meant the former.)

Luft concluded that California HMOs were cutting their total costs by 10 to 40 percent compared to traditional insurers, but he warned that these savings might be illusory because they could reflect "undertreatment," and because they could simply reflect the better health status of people who enroll in HMOs.²²⁰ Interestingly, Luft said nothing at all about the possibility that HMOs were extracting large discounts from doctors and hospitals or engaging in other practices that shifted costs to other payers. This suggests that cost-shifting was not a common HMO cost-control tactic in the 1960s.

Luft's conclusion that HMOs might cut total costs by 10 to 40 percent was widely quoted over the next decade by managed-care advocates, but without Luft's caveats about favorable

selection, undertreatment, and out-of-plan visits. (This should remind you of another myth promoted by HMO advocates – the myth that one-fourth of all medical care sold in the U.S. is unnecessary.) Alain Enthoven was perhaps the worst abuser of Luft's conclusion. In a 1978 article, he claimed that Luft's assessment was based on "many comparison studies" (there were only five, all involving Kaiser), and that Luft had concluded HMO savings could not be explained by other factors such as "out-of-plan utilization, differences in age and sex composition, previous health status, or government subsidies."²²¹ Enthoven's remarks were wildly inaccurate; Luft's paper said nothing of the sort – Luft didn't even discuss "government subsidies." Enthoven repeated this false characterization of Luft's study in subsequent papers, including his widely read 1989 paper laying out his theory of managed competition.²²² Because Enthoven's inexcusable distortions of Luft's work appeared in the *New England Journal of Medicine* and other prominent journals, they played an important role in convincing policy makers, reporters, and other health policy experts that HMOs really were more efficient than traditional insurers.

The evidence that HMOs and other MCPs enroll healthier people

Subsequent research indicated that Luft was justified in warning his readers that HMOs might be saving money by enrolling healthier people. In a review of the literature in 1987, Fred Hellinger concluded that HMOs clearly benefit from favorable selection.²²³ In another review published in 1995, Hellinger confirmed this conclusion for both HMOs and non-HMO MCPs.²²⁴ A report by what used to be called the Physician Payment Review Commission (PPRC, now called the Medicare Payment Advisory Commission), an agency that advises Congress on health-care issues, concluded that the research firmly establishes that seniors who leave the traditional fee-for-service (FFS) Medicare program to enroll in Medicare HMOs are much healthier than seniors who stay in traditional FFS Medicare.

The differences in health status reported by some of these studies are huge. Original research by the PPRC demonstrated that seniors who enroll in HMOs cost those HMOs only 56 percent of what it costs Medicare to take care of the sicker seniors who stayed with traditional Medicare.²²⁵ Another study, which examined data on more than 400,000 seniors, reported that seniors who enrolled in Florida Medicare HMOs during the period 1990-93 were half as expensive to care for as seniors who stayed in traditional FFS Medicare. Specifically, this study found that HMO seniors incurred only \$693 in hospital costs in the year before they joined an HMO compared to \$1,260 incurred by seniors who stayed in traditional Medicare. To make matters worse, the study found that those seniors who enrolled in HMOs tended to stay enrolled only as long as they were healthy. When they got sick, they disenrolled and returned to traditional Medicare, thus saving their HMOs lots of money and driving up the cost of traditional Medicare. This study was entitled, appropriately enough, "The Medicare-HMO revolving door – The healthy go in and the sick go out."²²⁶

A reasonable interpretation of the "revolving door" study is that seniors in HMOs returned to traditional Medicare when they got sick because their HMO refused to give them the services they needed. A subsequent study confirmed that hypothesis. The study reported that Florida HMO disenrollees were four times as likely as seniors who enrolled in traditional Medicare to have hip and knee replacements in the three months after they left their HMOs. The authors concluded, "These data provide indirect evidence that Medicare HMOs . . . are rationing [hip and knee replacement surgery] and that beneficiaries respond by returning to the FFS [Medicare] system to seek care."²²⁷

We don't have any studies indicating how much money favorable selection has saved the average HMO serving the *nonelderly* (we know only that the nonelderly who enroll in HMOs are healthier). The studies comparing *seniors* who enroll in Medicare HMOs to seniors who stay in

traditional Medicare indicate the HMOs are saving somewhere between 10 to 45 percent thanks to favorable selection. What we can say is that by the 1980s, and possibly much earlier, favorable selection was helping HMOs and non-HMO MCPs in the nonelderly market keep their premiums at or below the levels of traditional insurers, and that, in a market where a difference between premiums of even a few percentage points can swing big chunks of market share to lower-priced insurers, favorable selection played a very important role in permitting MCPs to take over the U.S. insurance market.

Subsequent evidence also indicated either that Luft's estimate that only 1 to 8 percent of HMO enrollees sought care outside of their HMO's network was too low, or that it had risen between the 1960s and the post-1970s era. A 1995 study by Davis et al. found that "17 percent of managed care enrollees reported using services outside of their plan in the past twelve months" and that these out-of-plan users reported "an average of four out-of-plan visits within the past year for services not covered by their plan."²²⁸ A 1996 survey by *Consumer Reports* found that 18 percent of enrollees in MCPs reported seeking medical services outside their plan networks (the magazine didn't say over what period).²²⁹ Commonsense indicates out-of-plan use is evidence of dissatisfaction. The study by Davis et al. specifically made that finding. This means that HMOs are not simply the passive beneficiaries of patient out-of-network care-seeking. It means HMOs are doing something to provoke it, such as refusing to pay for joint-replacement surgery to people who need it.

The evidence that MCPs benefited from cost-shifting

Although managed competition advocates argued that excessive volume was the main cause of inflation, and although they had virtually nothing to say about excessive prices charged by doctors, hospitals, drug companies, and equipment manufacturers, in fact HMOs and other MCPs used their market power to extract low prices from providers, drug companies, and equipment suppliers. Because large market share is needed to extract big discounts,²³⁰ it is unlikely that HMOs were extracting these hefty discounts in the 1970s when they were small and just beginning to spread. During that decade, favorable selection and denial of services were probably the HMOs' most important advantages over traditional insurers.

But between the early 1980s, by which time many HMOs had acquired substantial market share within their local markets, and the mid-1990s, by which time extracting discounts had become more difficult, discounts contributed significantly to the ability of MCPs to keep their premiums below those of traditional insurers. This practice resulted in cost-shifting. Doctors, hospitals, and drug companies would make up for the revenues they gave away to MCPs by charging higher prices to less powerful payers, including traditional insurers and the uninsured.²³¹ But by the mid-1990s, cost-shifting was more difficult (a) because the entire health insurance industry had become controlled by large MCPs, all of which were demanding discounts. Finding a weak buyer upon which to shift costs was now much more difficult. Another factor which made cost-shifting more difficult by the mid-1990s was the great consolidation among providers that had occurred by then. Merger madness had given many doctors and hospitals so much negotiating clout they could ignore, or at least minimize, MCPs' demands for discounts.

The size of the discounts extracted by MCPs is hard to ascertain because MCPs are so secretive; most contracts between MCPs and providers require the providers to stay mum about how much they're being paid. But the few studies available indicate MCPs extracted enormous discounts in the 1980s and early 1990s when they were taking over the industry. Table 9-1 shows the discounts Twin Cities hospitals gave to three types of payers (Medicare, Medicaid, and HMOs) compared to the average for all payers in 1981 and 1982, and to Medicare, Medicaid, HMOs, and all

other payers in 1990. You can see that HMOs got much larger discounts than traditional private-sector insurers did in all three years. This is clearest in the 1990 data because that data breaks out the non-HMO, private-sector insurers from all other payers. HMOs forced the hospitals to cut their rates by 38 percent while all other private-sector payers got an average discount of only 3 percent. Table 9-2 indicates that a year later HMOs nationally were forcing *drug manufacturers* to charge only 72 percent of the list price for drugs.

But discounting was not the only method MCPs used to shift costs off themselves and on to others. Other tactics included using financial incentives that encourage HMO doctors to classify injured enrollees as injured on the job so that their expenses could be billed to workers compensation programs;²³² avoiding their share of research expenses,²³³ charity care,²³⁴ and graduate medical expenses even while being subsidized by Medicare for graduate medical expenses; provoking enrollees to pay for care outside of HMO networks; billing Medicare for billions of dollars (equal to approximately 5 to 10 percent of total Medicare payments to HMOs) in administrative costs that should have been

Table 9-1: Discounts offered to four types of payers by Twin Cities hospitals, 1990: HMOs extract large discounts from hospitals, traditional insurers get almost no discount

| Payer | Discount* | | 1990 |
|------------------|-----------|-------|-------|
| | 1981 | 1982 | |
| Medicaid | 12.8% | 15.7% | 54.1% |
| HMOs | 8.6% | 10.2% | 37.6% |
| Medicare | 10.6% | 15.7% | 36.3% |
| All other payers | 3.2% | | |
| All payers | 6.5% | 9.4% | |

* The 1981 and 1982 discounts are for 26 Twin Cities hospitals, whereas the discounts shown for 1990 are for four Minneapolis hospitals.

Sources: 1981 and 1982 figures from Allan N. Johnson et al., "Cost-shifting: The discount dilemma," *Journal of Health Politics, Policy and Law* 1984;9(2):251-260; 1990 figures from Katherine Hiduchenko, "Do Health Maintenance Organizations control costs or shift costs?" *New England Journal of Medicine*, letter, 1993;328:971.

Table 9-2: Prices paid by various types of prescription drug purchasers, 1991: MCPs extract large discounts from drug manufacturers

| | |
|-------------------------|--------|
| Average wholesale price | \$1.00 |
| Independent pharmacies | .87 |
| Chain pharmacies | .78 |
| Managed care plans | .72 |
| Hospitals | .60 |
| Government programs | .50 |

Source: *Prescription Drug Study: A Report to the Minnesota Legislature on the Prescription Drug Market*, Minnesota Department of Health, 1994, Figure 2.10.

billed to private payers,²³⁵ and failing to reimburse Veterans Affairs Hospitals for services rendered by VA hospitals to Medicare HMO enrollees.²³⁶

The evidence that MCPs ration care

In addition to favorable selection and cost-shifting, the evidence indicates MCPs have enjoyed a third advantage over traditional insurers – they save money by rationing. The evidence that MCPs ration falls into three categories: anecdotal evidence (aka “HMO horror stories”), polling and focus group data, and scientific studies of the quality of MCP care versus care provided by doctors paid by traditional FFS insurers.

The anecdotal evidence grew rapidly in the 1990s as more Americans enrolled in MCPs. By 1995, media coverage of MCPs, which had been unduly positive, turned decidedly negative, and “HMO horror stories” were the primary type of evidence reported. *Time’s* cover story, “The soul of an HMO,” *Glamour’s* “What killed Karin Smith?” and a column in the *New York Times* entitled “Torture by HMO,” all published in 1996, were typical of the terrible stories told about MCPs in 1996 and subsequent years. In July 1996, the *New York Times* described the MCP industry’s publicity as “a hailstorm of stories about necessary care being denied, about so-called gag rules that prevent physicians from telling patients alternative and usually more expensive treatment, and about 24-hour ‘drive through’ maternity stays.”²³⁷ In early 1997, John Iglehart, editor of *Health Affairs* and a member of the Jackson Hole Group, observed that the managed care industry’s publicity was by then “continuous and overwhelmingly negative.”²³⁸ In 1998, the *New York Times* declared in a headline on the front page, “Reality of the HMO system doesn’t live up to the dream.”²³⁹

By 1996 the media was describing the appearance of an “HMO backlash.” “HMO backlash” (*St. Paul Pioneer Press*, 1996), “Managed care: National leap of faith” (*Chicago Tribune*, 1996), and “Backlash against HMOs” (*Time*, 1997) were typical of the headlines. The most immediate and visible manifestation of the backlash was the explosion in “patient protection” bills introduced in Congress and state legislatures. “In 1996 alone,” reported Tom Bodenheimer in an article for the *New England Journal of Medicine*, “1,000 pieces of legislation attempting to regulate or weaken HMOs were introduced in state legislatures, and 56 laws were passed in 35 states.”²⁴⁰ Many of these early patient protection bills dealt with “drive-through deliveries” (delivery of newborns with only one day of hospitalization). Many states passed laws requiring MCPs to let new mothers stay in the hospital for at least 48 hours. Other problems addressed by patient protection were retaliation by MCPs against doctors for advocating for their patients, and refusal to pay for emergency services because the MCP, with the benefit of hindsight, decided the patient did not need ER services. By the late 1990s, the question of whether patients had the right to sue MCPs dominated the patient protection debate. By 1999, lawsuits against MCPs on behalf of doctors were also drawing headlines.

Another manifestation of the HMO backlash was the appearance of hostile statements about MCPs and managed care in media of all forms – in op-eds, statements by politicians, news stories, TV dramas and sitcoms, best-selling novels, movies, cartoons, and jokes heard at work, on the Internet, and on late-night TV talk shows. One the most frequently cited manifestations of public anger at MCPs was the reaction of movie-goers to a furious comment about HMOs by the actress Helen Hunt in the 1997 movie, “As Good as It Gets.” Hunt played the role of a single mother being courted by a screwball fiction writer played by Jack Nicholson. In an early scene in the movie, we see Hunt in her kitchen explaining her anger at her HMO’s refusal to pay for treatments for her son’s asthma. “HMO bastards pieces of crap,” she shouted (Hunt actually used another four-letter word for “crap”). According to several columnists who saw the movie, audiences applauded Hunt’s blue streak. “Justified or not, anger with managed care has penetrated American culture so deeply

that it drowned out long and well-funded protests by insurance and business lobbyists,” reported the *Washington Post* in a 1999 article entitled, “How HMOs became the enemy: From nonprofit ideals to corporate horror stories.” “Even in a country with ebbing faith in many of its basic institutions, managed care holds an exceptionally low berth in public esteem,” said the article.²⁴¹

In the early years of the backlash, the MCP industry and its supporters blamed everyone but themselves for the industry’s awful publicity. They denied that HMO horror stories were as numerous as reporters, politicians, and the public claimed. Instead, they blamed doctors allegedly disgruntled about loss of income as opposed to loss of authority to do right by their patients, consumers who had allegedly been pampered by the former fee-for-service system, politicians looking for attention, and reporters making mountains out of molehills. Ellwood, for example, denounced “HMO bashing” in a 1996 interview with *Modern Healthcare*,²⁴² and “attack by anecdote” in a 1996 interview with the *New York Times Magazine*.²⁴³ In the summer of 1996, *Modern Healthcare* reported one of the strangest events in the modern health-care reform debate:

Officials of the Health Insurance Association of America [the trade group for the indemnity insurers that use some managed care tactics but have not morphed completely into HMOs] and the Blue Cross and Blue Shield Association summoned reporters to a press briefing in Washington. But it wasn’t to answer questions. They wanted reporters to tell them why the managed care industry is getting such bad press.²⁴⁴

The horrendous publicity MCPs were getting by 1996 was not due to a conspiracy among reporters. The bad publicity, and the public backlash against MCPs, was inspired by widespread rationing.

The second category of evidence indicating that MCPs ration – data on consumer attitudes – is also extensive. We reviewed some of the polling data in Chapter 8; those data indicate that Americans did not approve of managed care tactics before or after MCPs became dominant. Several surveys done annually during the 1990s documented the increase in the proportion of Americans who believed that MCPs were damaging quality of care. For example, the Harris Poll reported that the percentage of Americans who thought managed care harmed the quality of medical care rose from 39 to 59 percent between 1995 and 2000.²⁴⁵

Focus-group data confirm the polling data. One of the most rigorously done studies of consumer perceptions of the new system was done by the Picker Institute for the American Hospital Association. Based on discussions with more than 300 adults in 31 focus groups in 12 states between May and September 1996, the Picker Institute reached these conclusions:

Few people . . . perceive there to be a planned system of health care that operates in their behalf. . . . If a system is in operation at all, it is seen as one designed to block access, reduce quality, and limit spending for care at the *expense* of patients. What’s more, this impression comes *not* from sensational media accounts or the scare campaigns of special interest lobbying groups, but largely from personal experience. Patient after patient tells stories of their struggles to get past the many “gatekeepers” in the system or to get insurance or managed care approval for the care they and their doctors think they need. They talk about how assertive they must be to get answers and the frustrations of trying to coordinate care among many different specialists – and many of them worry about what will happen if and when they are too sick to manage such things on their own behalf. And they describe a feeling of being abandoned when they are released from the hospital – like “jumping off into nowhere,” as one patient described it (emphasis in original).²⁴⁶

The third category of evidence – scientific studies – provides compelling evidence that MCPs ration. Patchy evidence suggests that MCPs began to ration much more aggressively in the

1990s. If this in fact occurred, I believe it happened then because MCPs were losing their favorable-selection and discounting advantages. The MCP industry's ability to cherry-pick their enrollees began to disappear as the industry's market share grew. When the industry was small, it was easier to avoid sick people. But by the mid-1990s, when the industry's market share had grown to encompass 95 percent of the non-elderly insured population, avoiding the sick was much more difficult. Similarly, extracting large discounts from providers was easier for the HMOs in the 1980s when they were the only ones doing it than it was for the MCPs of the 1990s. By the 1990s, nearly the entire insurance industry was engaging in the practice of demanding discounts, and doctors and hospitals, with no one left to shift costs to, were becoming increasingly unwilling to provide discounts. By the 1990s, the ability to ration was probably more important to MCPs than either cherry-picking or discounting. If this theory is correct, it would explain the timing of the HMO backlash.

We have already reviewed two scientific study that demonstrated HMOs ration – the “Medicare revolving door” study and the joint-replacement study, both of which examined HMO behavior between 1990 and 1993. Tables 9-3 and 9-4 present data from another study, this one of a national MCP that operated in 47 states. Table 9-3 indicates that hospital services were cut in the 1990s not by denying *admission* (MCPs had already cut admission rates during the preceding three decades), but by cutting down on the *number of days patients could stay* once they had been admitted. We see that nearly all – 96.6 percent – of patients for whom requests were made were allowed to be admitted to the hospital by the MCP's utilization-review gnomes. This MCP achieved its savings by refusing to authorize a large portion of the days-in-hospital that the patients' doctors asked for. You can see that mental health patients suffered the biggest cutbacks in hospital days; only 54 percent of the total mental health days requested by doctors were approved by the MCP. My jaw dropped when I saw the data in Table 9-4. This table shows that total days authorized by utilization reviewers working for this MCP dropped substantially between 1990 and 1993. The drop was enormous for mental health patients. In 1993, the average number of hospital days authorized for mental health patients was 10.88, down from 20.72 in 1990.

The MCP industry's aggressive effort to limit hospital use, and the belt-tightening by hospitals that ensued, unquestionably damaged the quality of care in U.S. hospitals. A

Table 9-3: Outcome of physician requests to a national MCP for hospitalization, January 1989 through December 1993: Utilization review reduces hospital services primarily by reducing the number of days patients can stay in the hospital, not by denying hospital care completely

| | |
|---|-------|
| Request for admission denied | 0.4% |
| Outpatient care or case mgmt authorized instead | 3.1% |
| Inpatient care authorized | 96.6% |
| Percent of inpatient days authorized for | |
| Obstetric admissions | 92.9% |
| Medical admissions | 86.0% |
| Surgical admissions | 83.4% |
| Mental health admissions | 54.0% |

Source: Thomas M. Wickizer and Daniel Lessler, “Effects of utilization management on patterns of hospital care among privately insured adult patients,” *Medical Care* 1998;36:1545-1554, Table 1.

Table 9-4: Number of hospital days authorized by a national MCP, 1990 and 1993: MCPs reduced lengths of stay substantially between 1990 and 1993, especially for mental health patients

| | <u>Obstetric</u> | <u>Medical</u> | <u>Surgical</u> | <u>Mental health</u> |
|------|------------------|----------------|-----------------|----------------------|
| 1990 | 2.82 days | 6.81 days | 4.66 days | 20.72 days |
| 1993 | 2.38 days | 5.22 days | 3.99 days | 10.88 days |

Source: Thomas M. Wickizer and Daniel Lessler, "Effects of utilization management on patterns of hospital care among privately insured adult patients," *Medical Care* 1998;36:1545-1554, Table 5.

number of studies attest to this conclusion. For example, in a subsequent article, Wickizer and Lessler, the authors of the study presented in Tables 9-3 and 9-4, sought to determine what impact shortened length-of-stay had on readmission rates for patients with cardiovascular disease who underwent surgery. They reported an association between reductions in length-of-stay below those requested by the patients' physician and 60-day readmission rates. The authors reported that when utilization reviewers reduced the length-of-stay by two or more days, the patient's odds of being readmitted to the hospital within 60 days was 2.6 times that of patients who were permitted to stay in the hospital as long as their doctor recommended.²⁴⁷

Studies comparing the number of *non-hospital* services MCP and FFS patients get also suggest that many of the Americans who migrated from FFS to MCP plans in the early 1990s encountered a lot more resistance to their demands for health care than they had been used to. Table 9-5 presents data on utilization of physician services by depressed patients during the late 1980s and early 1990s. The data indicate that depressed HMO and FFS patients were equally likely to have at least one visit to a mental health professional, but that FFS patients got many more visits than HMO patients did (14 versus 9 over six months). Table 9-6 indicates Medicare patients insured in HMOs received only 13 home health visits after being hospitalized compared to 19 for patients who stayed in traditional FFS Medicare. The study cited in Table 9-6 found that the difference in number of visits damaged the health of the HMO patients. The HMO patients were less likely to recover numerous functions (including the ability to bathe, eat, and manage medications by themselves) than were FFS beneficiaries. By cutting back on home health visits, HMOs saved themselves about \$400 per patient.

Even preventive services, services which MCPs were supposed to be so good at providing, apparently took a hit during the late 1980s or early 1990s. According to a study which compared the rate at which HMOs and FFS plans provided preventives services to women (including breast exams and Pap smears), HMOs provided more such services in 1987 but had "lost this comparative advantage" by 1992. By 1992, HMOs and FFS plans were providing equal amounts of preventive services.²⁴⁸

In 1995, I began the long process of tracking down and reading all published studies comparing the quality of HMO care to FFS care. Four years later, my research was published in the *American Journal of Public Health*. I reported finding a total of 34 rigorously conducted studies done between 1980 and 1996. These 34 studies reported a total of 44 comparisons of HMO and FFS doctors. Table 9-7 shows the results. You see that HMO doctors outperformed FFS doctors in only four of the comparisons but were worse in 21. Thirty-four studies over 16 years is not a lot of research, but it confirmed the anecdotal and survey data – the advent of HMOs reduced the quality of care American patients receive.

Several of the studies I reviewed drew substantial coverage by the media when they were published. The media gave extensive coverage to a study by John Ware, Jr. and his colleagues when it appeared in the *Journal of the American Medical Association* in 1996. The study was unusually well done. It had a large sample size drawn from three cities – Boston, Chicago, and Los Angeles. The study found that elderly patients were *twice* as likely to suffer deterioration in their health over a *four-year* period (not a decade or a lifetime) if they were enrolled in an HMO than if they were enrolled in traditional

Table 9-5: Probability and number of mental health visits by depressed HMO and FFS patients: FFS patients get more visits^(a)

| | Probability of mental health visit in 6 months ^(b) | No. visits among those with visits ^(c) | Psychological health prior to start of study ^(d) |
|-----|---|---|---|
| HMO | 50% | 9 | .34 |
| FFS | 56% | 14 | .32 |

(a) The data for this study were collected over a two-year period that occurred some time between 1986 and 1991. The authors do not indicate what two years these were.

(b) The difference between these scores was statistically significant.

(c) The difference between these scores was statistically significant, and was due primarily to higher utilization rates by patients of psychiatrists. There were only minor differences in utilization rates of patients of general medical providers (family practice and internal medicine doctors).

(d) These scores are a composite measure of psychological health. Higher score is worse. The difference between these scores was not statistically significant (in other words, HMO and FFS patients were equally sick).

Source: Roland Sturm et al., "Mental health care utilization in prepaid and fee-for-service plans among depressed patients in the Medical Outcomes Study," *Health Services Research* 1995;30:319-340.

Table 9-6: Number of home health-care visits received by hospitalized FFS and HMO Medicare patients within 60 days after discharge from the hospital during period 1989 to 1991: FFS patients get many more visits

| | |
|---------------|-------------|
| FFS patients: | 18.8 visits |
| HMO patients: | 12.7 visits |

Source: Peter W. Shaughnessy et al., "Home health care outcomes under capitated and fee-for-service payment," *Health Care Financing Review* 1994;16(1):187-222.

Table 9-7: Scientific data: A review of the scientific studies indicates HMOs rarely offer better care and frequently offer inferior care

Number of comparisons in which

| | |
|-----------------------------------|----|
| HMO care was better than FFS care | 4 |
| HMO and FFS care were equivalent | 19 |
| HMO care was worse than FFS care | 21 |
| Total number of comparisons | 44 |

Source: Kip Sullivan, "Managed care plan performance since 1980: Another look at two literature reviews," *American Journal of Public Health* 1999;89:1003-1008.

fee-for-service Medicare.²⁴⁹

These three types of data – the anecdotal reports, the opinion surveys and focus groups, and scientific studies – support the conclusion that MCPs do not merely cut out unnecessary services, but rather that they deny necessary medical care to substantial numbers of patients. This ability to ration helped MCPs keep their premiums relatively low and take market share from traditional insurers. That MCPs ration should come as no surprise. The instruments available to MCPs to cut back on volume of service are terribly blunt. Financial incentives, utilization review, and increased workloads may lead to some reduction in unnecessary services, but they must inevitably cut out necessary care as well. The tools of managed care resemble a hatchet more than a scalpel.

The mid-1990s inflation lull

During the 1970s and early 1980s, the HMO halo effect was the primary cause of the myth that MCPs save money. By at least the 1980s, MCPs' lower premiums, caused by favorable selection, cost-shifting, and rationing, constituted a second factor fueling the myth of MCP efficiency. Around 1992, a third factor appeared which, for a few years, totally seduced the nation's policy makers and pundits into accepting the argument that MCPs save money. That was the appearance of an unusually steep and prolonged decline in health-care inflation. The decline was obvious whether one measured inflation by gauging year-to-year changes in premiums paid by large employers, or changes in total U.S. health-care spending.

Throughout the late 1980s and early 1990s, health-care inflation had been torrid despite the fact that a majority of Americans under 65 were insured by MCPs. As late as 1993, Alain Enthoven, inventor of the theory of managed competition, published an article in *Health Affairs* entitled, "Why managed care has failed to contain health costs."²⁵⁰ In 1993 and 1994, the Congressional Budget Office released studies saying that managed competition bills introduced by President Clinton and Representative Jim Cooper (D-TN) would *raise*, not lower, total spending on health care.²⁵¹

But a slowdown in premium inflation began in 1992, and it turned out to be unusually sharp and prolonged. The rate fell sharply, from 10.9 percent in 1992 to 0.5 percent in 1996.²⁵² The five years over which this inflation lull lasted was also unusually long; prior to 1992, premium inflation tended to fluctuate in three-year cycles – inflation would be high for three years, then low for the next three years. But this welcome cooling of inflation had little to do with managed care. The slowdown was caused by several other factors, the most important of which were a halving of the general inflation rate beginning in 1991 and a merger avalanche that began in 1990 and continued into 1996. In Minnesota, where the merger madness struck about a year before it hit most states,

the market share of the largest four health insurers rose from 64 percent in 1992 to 80 percent in 1994.²⁵³

Tables 9-8 and 9-9 present data on consolidation at the national level over the decade 1987 to 1997 for the insurer and provider sectors respectively. You can see that consolidation accelerated in 1990, then soared in 1993, the year Bill Clinton, many other state and federal politicians, and numerous large employers endorsed managed competition legislation. Anticipating that they might soon be forced, either by employers or by managed competition legislation, to join or become a huge MCP or provider

Table 9-8: As managed care spread, the insurance industry consolidated: Value of HMO mergers and acquisitions, 1987-1997, millions of dollars

| | |
|-------|--------|
| 1987: | 17 |
| 1988: | 72 |
| 1989: | 1 |
| 1990: | 12 |
| 1991: | 309 |
| 1992: | 2,285 |
| 1993: | 1,317 |
| 1994: | 4,426 |
| 1995: | 1,327 |
| 1996: | 13,318 |
| 1997: | 3,269 |

Source: Srijia Srinivasan et al., "Wall Street's love affair with health care," *Health Affairs* 1998;17(4):126-131.

Table 9-9: As managed care spread, the provider sector consolidated: Value of health services* mergers and acquisitions, 1987-1997, millions of dollars

| | |
|-------|--------|
| 1987: | 4,247 |
| 1988: | 8,501 |
| 1989: | 5,560 |
| 1990: | 1,298 |
| 1991: | 2,048 |
| 1992: | 6,096 |
| 1993: | 17,535 |
| 1994: | 21,240 |
| 1995: | 14,582 |
| 1996: | 26,924 |
| 1997: | 19,296 |

* The authors of this study defined "health services companies" as follows: "offices and clinics of doctors of medicine or osteopathy, dentists, or other health-care providers; nursing and personal care facilities; hospitals' medical and dental laboratories; home health-care services, and miscellaneous health and allied services."

Source: Srijia Srinivasan et al., "Wall Street's love affair with health care," *Health Affairs* 1998;17(4):126-131.

network (such as a hospital or clinic chain), insurers and providers all over the country set off on a feverish quest for size. If you were an insurer, you wanted large size in order to maximize your ability to squash provider fees and force doctors to ration services. If you were a provider, you sought large size in order to be attractive to MCPs (MCPs disdain solo practitioners because they have so little "market share") and to have some negotiating power with them. You could acquire size either by attracting more "customers" or by being part of a merger. Both tactics, especially seizing market share quickly, require artificially low prices. These prices couldn't last forever, however, and they didn't. Losses became intolerable throughout the health-care industry in 1996, and by 1997 insurers were jacking up premiums even though the underlying inflation rate remained very low.⁵⁷

One consequence of the merger avalanche was increased consolidation among providers, especially among hospitals. This reduced the power of MCPs to extract discounts from providers and to tell doctors how to practice medicine. The health-care inflation we have seen since 1997 was, therefore, caused not only by MCPs raising premiums to make up for losses sustained during the 1992-96 inflation lull, but by clinics and hospitals using their newfound market power to extract higher reimbursements from MCPs.

The resumption of high inflation after 1996 was not foreseen by MCP advocates in 1995 and 1996. By 1995, many MCP proponents had convinced themselves that the inflation lull was a permanent reduction in inflation which had been caused by the spread of managed care tactics. By 1997, Enthoven, who only four years earlier had conceded managed care wasn't saving money, was asserting, "Since the early 1990s cost pressures have moderated significantly, and there is no explanation except competitive markets and managed care."²⁵⁴ The argument that the spread of managed care explained the 1992-96 slowdown was quickly accepted among experts and reporters as well. But, as we saw in Chapter 2, the happy consensus was short-lived. By 2000, when premium inflation was back to double digits, a noticeable change in elite opinion had materialized. Employers, most Democrats, some Republicans, and many within the health policy community ceased claiming that the mid-1990s inflation lull was evidence of MCP efficiency. Only the MCP industry and some Republicans at the national level persisted in claiming that MCPs could save money.

Managed competition cannot be rescued

The HMO halo effect, MCPs' generally lower premiums, and the 1992-96 inflation lull helped conceal the irrationality of the assumptions underlying Ellwood's health maintenance strategy and Enthoven's managed competition theory. But the illusion could not last forever. By the mid-1990s, MCPs had lost their cherry-picking and cost-shifting advantages. Moreover, their reliance on rationing, which appears to have increased in the early 1990s, had created great hostility among consumers by 1995. And by the late 1990s, it was clear that the cooling of inflation that began in

⁵⁷ I cordially invite readers to consult an article I wrote for *Health Affairs* in which I present the evidence for my conclusion that the 1990s inflation lull had nothing to do with managed care ("On the 'efficiency' of managed care plans," *Health Affairs* 2000;19(4):139-148).

1992 had only been temporary. The contrast between what MCP advocates promised and what they delivered was now painfully obvious.

It is not possible to close the gap between what MCP advocates promised and what they delivered, either with respect to cost or quality. Let's look at cost first. MCPs are incapable of reducing any of the four categories of waste that I discussed in Chapters 6 and 7, with the possible exception of high physician fees and high drug prices. I say "with the *possible* exception" because, although it is clear MCPs, especially large ones, can force doctors and drug companies to cut their prices, it is likely that doctors and drug companies recoup from weaker payers a substantial portion of the discounts they give to MCPs. As we saw in Chapter 7, physician incomes and drug prices in the U.S. remained very high in the 1990s by international standards despite the dominance of MCPs in that decade.

The fact of the matter is that the options available to MCPs to cut costs are quite limited. MCPs can attempt to cut costs at the expense of *patients* by rationing more aggressively; they can attempt to cut costs at the expense of *providers* by demanding even bigger discounts; or they can attempt cut costs at their *own* expense by cutting back on administrative costs. But none of these strategies are feasible. Public hostility to MCP rationing and the growing threat of patient protection legislation and lawsuits will prohibit more aggressive rationing. Anger among doctors and hospital administrators, and greater consolidation among providers, will make further cuts in provider reimbursements very difficult to achieve. And MCPs have little leeway to cut back on administrative costs. If they reduce marketing expenditures, their sales decline. If they reduce activities required to "manage care," their medical costs will rise.

Similarly, the gap between what MCP advocates said would happen to quality and what did happen cannot be closed. The argument that capitation would somehow make doctors better doctors by inducing them to cut out unnecessary services and beef up preventive services had neither logic nor evidence behind it, and nothing can turn that sow's ear into silk now. The notion that utilization review – the second-guessing of doctors by people who don't see the patient – would cut out only the unnecessary services and leave necessary services alone was also illogical, and nothing can fix that logic now.

The argument that a few additional "reforms" (report cards, purchasing coalitions, and termination of tax subsidies) will force the MCP industry to become efficient and provide high-quality care is absurd. The argument that the current system can't really control inflation until consumers are stripped of their tax subsidy is perhaps the most absurd. Consumers are already furious about the high cost of health insurance, and have reluctantly enrolled in ostensibly lower-cost MCPs by the tens of millions over the last decade, and still inflation runs wild. All the loss of the tax subsidy will do is torque consumer frustration with the current system to a higher level. Given the enormous power and inefficiency of the MCP industry, even the most infuriated consumer will be unable to make much of a dent in health insurance premiums. It is possible that bunching consumers into large purchasing groups could make a noticeable difference in premium inflation, but if that did happen, it would almost certainly come at the expense of quality of care. Although public resistance to rationing is intense today, rationing is nevertheless the line of least resistance for MCPs today.

The claim by Ellwood et al. that the decline in quality of care will be reversed on that happy day when MCP report cards are published has no credibility today. The inability of Ellwood and other report card proponents to say more than a few words about report cards should have been a clue to the impracticality of this idea when it was first floated. Ellwood, Enthoven and other architects of managed competition said virtually nothing about how to prepare report cards, whether consumers would put up with the loss of medical privacy report cards would require, whether anyone could actually use report cards, and what it would cost to prepare report cards on hundreds

of insurance companies insuring thousands of different medical services. Managed care advocates have been prattling about report cards for three decades now, and useful report cards still do not exist.⁵⁸

This is not merely my opinion. Experts all over the country agree. For example, Janet Corrigan, who is currently director of health-care services at the Institute of Medicine and used to work for the National Committee for Quality Assurance (a group started by the HMO industry and now run by big employers that does research on report cards), told *Time* magazine in 1998, “Even if employers were willing to spend a few dollars more to buy quality, . . . there is really no way to identify it in the marketplace.”²⁵⁵ Ellwood himself said in 1999, “We’ve been talking about quality improvement for 30 or 40 years without much to show for it.”²⁵⁶ Because of the enormous cost and complexity of MCP report cards, we may be certain that useful report cards will never exist.

Enthoven’s purchasing coalition proposal is the only piece of managed competition theory that makes any sense. Purchasing coalitions could give consumers and employers power commensurate with that of the big MCPs. But as long as useful report cards are nonexistent, giving purchasers power equal to that of the big insurers is a mixed blessing. If purchasing coalitions were big enough, they could force MCPs to lower their premiums. But without report cards to punish those MCPs that financed their premium reductions by letting quality deteriorate, the efforts of purchasing coalitions to push costs down would inevitably lead to a decline in quality.

Finally, we may dismiss the notion that the passage of more “patient protection” legislation will somehow bring an end to the decline in quality brought about by the spread of managed care. The debate about “patient protection” legislation has created the illusion that the passage of more

⁵⁸ If you were to ask any of the numerous health policy experts who claim MCP report cards are possible why none have come into existence yet, they’d probably cite the great expense and the great difficulty report-card makers would encounter trying to collect data on millions of patients to measure the quality of care they got. In theory, these problems are surmountable. But there is one problem that report card theorists never talk about which is not surmountable. I call it the “bundled product” problem. The reason no useful MCP report card will ever appear, even if we as a society decide we don’t mind the huge expense and the destruction of patient privacy required to produce report cards, is that an insurance policy sold by an MCP is a *bundled* product, not a single product. When you buy a health insurance policy from an MCP, you’re buying thousands of medical treatments, not a single treatment for a single disease or condition. To make the problem this poses clear, consider this analogy: Imagine you have a thousand dollars to spend next year at department stores, but you can only spend it at one store. Your task, in effect, is to figure out from which department store you will buy a \$1,000 gift certificate. Imagine moreover that “experts” have decided that you should make this decision based on department store report cards listing grades for the thousands of items in those stores. Would you tell the experts they’re nuts? You should. Report cards on these department stores would be useful only in the extremely unlikely event that Kmart, for example, got A’s on everything – A’s on its TVs, toasters, thermos jugs, work gloves, jelly rolls etc. –

while Penny’s got B’s on everything, Sears got Cs on everything, etc. That just doesn’t happen, not in the department store business, and not in the MCP business. Grades are inevitably mixed, which means you can’t say MCP A is better than MCP B “on everything” or “on average” just because it happens to get A’s on its treatment of, say, cleft palates while MCP B gets B’s.

This little exercise illustrates one more reason why managed care is a bad idea – it forces us to choose one army of doctors over another, usually before we even know what type of medical care we will need.

laws can force MCPs to stop degrading quality. Of the reforms that fall under the rubric of “patient protection,” the most debated, and the one with the most potential to do good, is one which gives consumers the right to sue MCPs if they deny necessary services, or if the behavior of MCPs causes doctors to provide inferior care. It is likely that this reform will cause MCPs to swear off some of the more visible activities that lead to rationing and inferior care, and that this change will protect some patients against some of the more egregious forms of patient abuse by MCPs. But the vast majority of cases of inferior care cannot be stopped by merely establishing the right to sue. The ways in which MCPs and their doctors can damage quality of care are just too numerous and too difficult for patients to spot, and in the case of inferior care that patients *can* spot, often too difficult and expensive to prove in court (see Appendix B).

In sum, managed care has not worked, and no amount of tinkering can make it work. It cannot save money because it drives up administrative costs, and it can't help but damage the quality of care because managed care methods are so crude. Nothing can be done to change these facts.

Why High-deductible Policies and Tax Credits Won't Work

A very short history of large-deductible proposals

In the early 1970s, the single-payer and HMO proposals were the most visible proposals in the health-care reform debate. The single-payer proposal had the support of prominent Democrats and labor unions, and the HMO proposal drew the support of the unlikely coalition of Walter Reuther, Ted Kennedy, Paul Ellwood, and Richard Nixon. A third proposal – requiring employers to offer policies with large deductibles – surfaced back then, but it got little attention because it did not attract the support of someone as powerful as Kennedy or Nixon. Martin Feldstein, a professor of economics at Harvard and later chairman of Ronald Reagan's Council of Economic Advisers, tried to persuade Nixon to adopt this proposal, but Nixon turned him down. For the next two decades, conservatives who supported policies with large deductibles – often called “catastrophic” coverage – got little respect from the nation's political and business leaders. Managed care's star shone so bright that catastrophic coverage, like single-payer, could hardly be seen.

But conservatives never abandoned the large-deductible approach, and when health-care reform returned to the public agenda in the early 1990s, they were ready with a sweetened version of catastrophic coverage they called the “medical savings account.” By the late 1990s, advocates of large-deductible policies were much more likely to use the phrases “defined-contribution plan” and “consumer-driven plan” than “medical savings account.” MSAs, defined-contribution plans, and “consumer-driven” plans are difficult to explain. However, they have the support of a movement that is almost as powerful today as the HMO movement was a decade ago. Anyone who seeks to understand and influence the current health policy debate needs to understand these concepts. Therefore, I encourage the reader to slog through the next 15 pages. I will try to make it as painless as possible.

MSAs

The MSA, like the HMO, was heavily promoted by a handful of groups and individuals. Unlike the handful of HMO advocates, which included liberals and conservatives, the small band of MSA advocates consisted almost exclusively of conservatives. The short list of groups and individuals who brought the MSA to public attention in the early 1990s includes Golden Rule Insurance Company, John Goodman (affiliated with the National Center for Policy Analysis), the Cato Institute, the Heritage Foundation, the American Medical Association, former Representative Bob Michel (R-IL), former Speaker Newt Gingrich (R-GA), and former Senator Phil Gramm (R-TX). Representative Michel introduced what may have been the first MSA legislation in 1992. By early 1994, the MSA was part of “[a]ll the leading Republican health system reform proposals,” according to *American Medical News*.²⁵⁷ Democrats opposed MSAs for several reasons, the most important of which was their fear that MSAs would siphon healthy and wealthy people away from low-deductible insurers and drive up the cost of insurance for the sick who refused to abandon low-deductible insurers.

But when Republicans took control of Congress in 1995, they made enactment of MSA legislation a high priority. They got a law passed out of Congress in 1995 that would have permitted

Medicare beneficiaries to leave traditional Medicare and enroll in MSAs. Primarily because this bill cut \$270 billion from Medicare over the next seven years, President Bill Clinton vetoed it. But in 1996, Republicans succeeded in enacting a law that permitted the sale of MSAs to the nonelderly, and another law in 1997 that permitted Medicare beneficiaries to enroll in MSAs. In order to get Clinton's support for these bills, Republicans had to limit the number of MSAs that could be sold. The 1996 law said MSAs could only be sold to workers who were either self-employed or employed in a business with 50 or fewer employees, and the total number sold could not exceed 750,000. The 1997 law introducing MSAs into Medicare limited the number of Medicare beneficiaries who could enroll in an MSA plan to 390,000.

It is probably clear to the reader why it took an act of Congress to permit Medicare to enroll seniors in MSAs: Federal law prohibited Medicare from offering private-sector insurance other than HMO coverage. But it may not be so clear why it took an act of Congress to motivate the insurance industry to start selling MSAs to the nonelderly. If insurance policies with large deductibles were so attractive, why couldn't the insurance industry just take it upon itself to start selling them?

The answer is that most Americans are not attracted to catastrophic coverage policies despite their generally lower premiums. "[T]he average citizen hates high-deductible coverage," reported *American Medical News*, paraphrasing Robert Blendon, a health policy expert and pollster.²⁵⁸ Employers who pay for all or most of the cost of insurance premiums might be attracted to the lower premiums of large-deductible policies, but if their employees despised such policies, employers weren't about to offer them. To get employees to accept high-deductible policies, conservatives had to give them a financial incentive to do so. Conservatives came up with two incentives: A contribution from employers to employees which would defray a portion of the medical costs not covered because of the large deductible: and a change in the tax law to ensure that the IRS didn't treat this employer contribution as income earned by the employee. This second incentive required a change in federal tax laws, something that could be accomplished only by an act of Congress.

To illustrate these two incentives, let me describe for you an unbelievably sweet MSA plan adopted by Jersey City, NJ in 1994, two years before Congress enacted the legislation permitting tax-subsidized MSAs. In a 1994 op-ed in the *Wall Street Journal*, Bret Schundler, then mayor of Jersey City, claimed he was going to reduce, ever so slightly, the city's premiums for health insurance on its 2,500 employees by switching them to MSA policies sold by Golden Rule. Schundler stated that family coverage from Jersey City's traditional insurer (it had a \$200 deductible) cost \$6,800 annually per employee, which was \$2,100 higher than the \$4,700 price of the MSA policy with a \$2,000 deductible he claimed Golden Rule was going to charge. Of the \$2,100 the city would save on each employee, the city would hand over \$2,000 to each employee that the employee could use to pay for the first \$2,000 of medical expenses incurred by the employee's family. If employees didn't use this \$2,000 gift from the city for medical expenses, they were entitled to keep it. One problem, noted Schundler, is that the \$2,000 gift would count as taxable income. Nevertheless, claimed Schundler, everyone was going to be better off.²⁵⁹

If in fact Jersey City got such a good offer from Golden Rule, and if in fact Jersey City handed nearly all of its savings over to its employees, there is no question that the city was slightly better off and that most Jersey City employees were better off under this deal, even though the city's \$2,000 gift to its employees counted as income subject to the payroll tax and as income subject to the state and federal personal income tax. The city was better off because it saved \$100 per employee. And most employees – the healthiest employees – were better off because they banked some portion of the \$2,000 contribution from the city.

To see why most employees were better off, let's calculate the savings for a typical healthy employee with healthy dependents, whom we'll call Mary Robust, and a sick employee with sick dependents whom we'll call Judy Sickly. Assume both employees pay 15 percent of their gross

incomes in payroll taxes,⁵⁹ and another 15 percent in income taxes. Assume furthermore that Mary's family incurs only \$500 in medical bills per year while Judy's family incurs \$4,000 per year.

Under the old Jersey City health plan, none of the city's contribution (that is, premium payments) toward Mary's and Judy's health insurance affected their payroll and income taxes. Now, a portion of the contribution – the \$2,000 gift to help defray their large deductible – is subject to taxes, in this case, a 30 percent tax, which amounts to \$600. In effect, then, Mary and Judy got a gift of only \$1,400 from the city, not \$2,000.

At the end of the year, Mary Robust is \$1,100 richer while Judy Sickly is \$400 poorer (see Table 10-1). Although Mary's deductible has risen from \$200 to \$2,000, and that has forced her to pay her entire \$500 medical bills out of pocket, her after-tax gift from the city of \$1,400 more than offsets her increased out-of-pocket payments. For Judy, on the other hand, the \$1,400 contribution from the city does not offset her greater

Table 10-1: Large deductibles leave the chronically sick worse off: A comparison of two hypothetical Jersey City employees under the policies described by Mayor Schundler* (\$s)

| | Mary Robust | | Judy Sickly | |
|------------------------|-------------|-------|-------------|--------|
| | Old policy | MSA | Old policy | MSA |
| Gift from Jersey City | 0 | 1,400 | 0 | 1,400 |
| Out-of-pocket payments | -200 | -500 | -200 | -2,000 |
| Net gain or loss | -200 | 900 | -200 | -600 |

* Mayor Schundler described the old policy as having a \$200 deductible and the new policy as an MSA with a \$2,000 deductible accompanied by a \$2,000 gift from Jersey City. This comparison assumes Mary and Judy each paid 30 percent in payroll and state and federal income taxes, which reduced the value of the city's gift from \$2,000 to \$1,400.

exposure due to the increase in the deductible from \$200 to \$2,000. Under her former insurance policy with its \$200 deductible, Judy was out only \$200. Now, she is out \$600, or \$400 more than she was out under her old policy. Why? Because her \$1,400 (after-tax) gift from the city left her exposed to \$600 of the \$2,000 deductible in Golden Rule's MSA policy.

If Jersey City's \$2,000 gift to its employees had been exempt from taxes, even Judy Sickly would have been better off with the MSA. She would have had no out-of-pocket payments because the city's \$2,000 contribution would have paid for her \$2,000 deductible. Zero out-of-pocket costs is better than the \$200 out-of-pocket costs Judy incurred under her previous low-deductible policy. Note, however, that Judy and other sick people like her could never benefit as much from the new MSA as Mary did. If the \$2,000 gift had been exempt from taxes, Mary would have been \$1,100 better off (the \$2,000 gift minus \$500 in out-of-pocket payments minus the \$200 Mary was out under her old policy), or more than six times more than the \$200 improvement Judy enjoyed.

Be careful not to conclude from this example that all people who incur annual medical bills that exceed the MSA deductible are worse off with MSAs. That's not necessarily so. I was careful to describe Judy Sickly's family as *chronically* ill – sick year in and year out. People who run up big medical bills only once in a while, say, one year in ten, might still be better off with an MSA. To illustrate, let's calculate Mary Robust's income and outgo over a ten-year period in which she suffers

⁵⁹ This assumes that the employer's half of Social Security taxes is ultimately paid by the employee in the form of reduced wages. This is an assumption most economists agree with

only one year of high medical bills under the scenario shown in Table 10-1 (that is, \$500 bills in nine of those ten years, and no tax exemption for the \$2,000 contribution from the city). According to our previous calculations, Mary was \$1,100 better off each year under the MSA. For nine of the ten years, Mary socks away \$1,100 more in savings than she had under her old policy. Over nine years, this builds up to 9,900 in principle plus several hundred more dollars in interest for a total of, let's say, \$10,500. Then, in her tenth year, Mary incurs \$4,000 in medical bills, or even, for that matter, \$50,000 in medical bills. Whichever it is, \$4,000 or \$50,000, Mary's only exposure is for the first \$2,000. Because she would have been out at least \$200 under her old policy, her net loss in this tenth year is \$1,800. If we subtract this \$1,800 loss from the \$10,500 she built up over the previous nine years, she's still \$8,700 better off than she would have been under Jersey City's old policy.

This Jersey City example illustrates the significant impact the tax break on the employer's contribution has on employees who enroll in MSAs. It also illustrates how MSAs favor the healthy over the occasionally sick, and the occasionally sick over the chronically sick.

Unfortunately for MSA advocates, MSAs as sweet as the one Schundler described are virtually nonexistent elsewhere in the country. First, the savings Schundler claimed he was getting by switching from a low-deductible policy to catastrophic coverage appear to be unusually high given the size of the deductible, possibly because Golden Rule was low-balling its premiums in order to have a place to show case MSAs, and possibly because Golden Rule knew Schundler was a very conservative Republican who supported MSAs and that he had plans to run for governor of New Jersey.⁶⁰ Second, Jersey City was unusually generous with the savings it got from Golden Rule – it gave nearly all of it to its employees, something a less ideologically motivated employer (or an employer facing a weaker union) might not have done. Third, the deductible Jersey City adopted – \$2,000 for family coverage – was low by the standards of leading MSA advocates. Under more normal conditions, employers don't get low-ball offers like the one Golden Rule apparently gave Schundler, employers don't give away the entire savings they achieve by switching from low-deductible to high-deductible plans, and MSA deductibles for families are typically in the \$3,000 to \$4,500 range, not the \$2,000 range. All of that means that employers are rarely in a position to make gifts to their employees that match the \$3,000-to-\$4,000 deductibles typical of family MSAs. Under the typical MSA arrangement, the employer's contribution is not as large as the employees' deductible, which means employees are exposed to the risk of having to pay a large portion of their huge deductible out of their own pockets.

Thus, in the real world as it existed in 1994, as opposed to the unusual circumstances then-Mayor Schundler described, MSA advocates had good reason to think MSAs wouldn't be very attractive to the nation's employees if employer contributions were not exempted from taxes. And to make that happen, they needed an act of Congress. An exemption from income taxes, but not payroll taxes, was granted by the 1996 MSA legislation.

Under the pilot program for the nonelderly established by that legislation, MSAs had to have deductibles of at least \$1,500 but not more than \$2,250 for individuals, and at least \$3,000 but not more than \$4,500 for families. Employer contributions to these plans were exempted from income taxes if the employee used them for medical expenditures, but these employer contributions could not exceed 65 percent of the deductible for individual MSAs and 75 percent for family MSAs. These employer contributions had to be deposited in "accounts," typically managed by banks (hence the name "medical savings accounts"). The banks had to monitor withdrawals from these accounts and report to the IRS which withdrawals were for medical expenses and which were not.

⁶⁰ According to *American Medical News*, "The Congressional Budget Office says MSA backers sharply overstate the premium savings of switching from low- to high-deductible policies" (Harris Meyer, "GOP reformers push medical IRA plans," *American Medical News*, January 3, 1994, 1, 28).

Withdrawals for nonmedical expenditures were subject to a 15 percent penalty tax and had to be added to the employee's taxable income. However, after the enrollee reached the age of 65, whatever amount had been built up in the MSA could be withdrawn for any reason without facing the 15-percent penalty.

Despite the favorable tax treatment of MSAs, the employees of eligible firms did not swoon over them. According to the Internal Revenue Service, only 47,000 MSAs were opened in 1997.²⁶⁰ This total grew to just 62,000 by the year 2000.²⁶¹ Among the factors cited for the low level of interest in MSAs were consumer distaste for high-deductible policies and the unusually tight labor market of the late 1990s. When employers are having a hard time keeping employees, they are less likely to force them to accept a complex, high-deductible policy they don't want. The traditional tendency of smaller employers not to offer health insurance was unquestionably another factor.

The MSAs created for Medicare recipients in the 1997 legislation followed the same principles. Medicare was required to give seniors who enrolled in MSAs a contribution (just as Jersey City gave its employees a contribution) to help them defray the costs to which the large deductible exposed them. The contribution was to be the difference between what Medicare was paying per senior under the traditional Medicare program (about \$6,000 by the year 2000) and the premium that an MSA company like Golden Rule would charge to insure one senior with coverage that included deductibles that could run as high as \$6,000. If the premium for such catastrophic coverage were \$4,000, for example, then Medicare's contribution to seniors' medical savings account would be \$2,000. That in turn means seniors would be exposed to the risk of paying out of pocket for medical expenditures that exceeded \$2,000 a year until they hit the \$6,000 cap.

The advent of “defined-contribution” plans

When Congress created the MSA pilot project for the nonelderly in 1996, the HMO backlash was just beginning, and the illusion that managed care was making a permanent dent in premium inflation had reached the height of its potency. But by the end of the 1990s, the MCP industry's reputation had been severely damaged, first by the consumer backlash and then by the return of double-digit inflation in premiums. The inability of the MCP industry to prevent premium inflation from soaring back toward the double-digit range shocked the business community and the pundits. Almost overnight, business consultants and entrepreneurs within the insurance industry realized that MSA-style policies might be attractive to mid-size and large employers even if the employer contributions to employees weren't exempt from income taxes.

By 1999, the media, especially business magazines, were buzzing about a close facsimile of the MSA – something called the “defined contribution” plan. The phrase “defined contribution,” first used in the pension field, is the opposite of a “defined benefit.” Two decades ago, when employers began to shift away from guaranteeing a certain-sized *pension* – a defined benefit – to guaranteeing only a certain-sized *contribution* to employee pensions, employers started calling their new pension-payment method the “defined contribution” method. Similarly, as employers and the business press in the late 1990s began discussing a shift away from guaranteeing employees standard health insurance coverage to guaranteeing only a certain amount of money that employees could use to buy insurance, the old method came to be thought of as a “defined benefit” and the new method as a “defined contribution.”

By 2000, several DC plans had been founded, and by 2002 they were insuring in excess of a million people (out of 175 million covered by employer-sponsored health insurance).²⁶² In March 2001, eight of these plans formed a trade group called the Consumer Driven Health Care

Association.⁶¹ The press release announcing this group said its goal is to “develop awareness of new approaches to health benefit programs.” The founding organizations of this group have names you’ve never heard of: Definity Health, Destiny Health, HealthAllies, HealthMarket, Lumenos, Myhealthbank, Sageo and Vivius. In April 2001, Blue Cross of California introduced the first DC plan sponsored by “a major insurer,” according to the *San Francisco Chronicle*.²⁶³ In December 2001, the *New York Times* reported that Aetna, Human, Cigna, United Health Group, and Wellpoint Health Networks were all preparing to market DC plans.²⁶⁴

Like “managed care,” the “defined contribution” genre is difficult to define precisely. In its crudest form, “defined contribution” refers to a business giving its employees a voucher and telling the employees to go shop for insurance on their own. Xerox Corporation talked publicly about to do this in 1999, but quickly dropped the idea after its employees objected.²⁶⁵ But that is not what most observers have in mind when they talk about “defined contribution” plans or methods. For most observers, the phrase “defined contribution” refers to more than a donation of funds by employers to employees. For most observers, the phrase refers to an insurance policy that is the rough equivalent of an MSA.

Under a defined-contribution (DC) plan, employers contribute a set amount of money to each employee, employees use that money to buy medical services directly from providers, employees pay for any medical expenses over roughly \$2,000 but under \$3,000 to \$5,000 out of their own pocket, and the DC plan pays for everything over \$3,000-5,000 per year.⁶² As is the case with an MSA, the employer’s contribution under a DC plan can be used by the employee only for medical care or health insurance. If it is used for other purposes, the employer’s contribution would no longer be treated as the equivalent of a premium payment, that is to say, as a payment for which the employer does not need to pay Social Security taxes and upon which the employee doesn’t have to pay income taxes.⁶³

The obsession with volume

Like MCP advocates, high-deductible advocates (by which I now mean proponents of both MSAs and DC plans) think the main cause of health-care inflation is excessive use of medical

⁶¹ Some observers distinguish “consumer-driven” plans from “defined-contribution” plans. They define DC plans as a type of consumer-driven plan. According to this usage, all consumer-driven plans permit consumers to go to a web site and custom-design their own coverage and designate their own doctors, but only DC plans combine this feature with a high deductible.

⁶² Most DC plans have web sites that give customers information on how much doctors charge, the price of brand name versus generic drugs, and information on treatments for various diseases. For a year or two in the late 1990s, this feature of DC plans caused the business and general media to refer to DC plans as “e-health plans.” That phrase began to disappear after the dot-com industry tanked in 2000. In the wake of the dot-com bust, HealtheCare, a seller of DC plans, changed its name to Definity. DC plans are sometimes referred to as “health savings account,” “health banks,” and “personal care accounts.”

⁶³ In June 2002, under pressure from the Wye River Group (a coalition of DC-plan advocates), the IRS issued a ruling allowing employers to make DC plans slightly more attractive to employees in two respects. First, the ruling made it clear that employer contributions would be tax exempt even if employees were allowed to accumulate unused portions of the contribution from year to year. Second, the ruling made it clear employer contributions would remain tax exempt even if employers permitted employees to take unused portions of their contributions with them after they left the company so long as the employee used that portion only for insurance or medical care (Amy Snow Landa, “Internal Revenue Service gives OK for consumer-directed health plans,” *American Medical News*, July 29, 2002, http://www.ama-assn.org/sci-pubs/amnews/pick_02/gvsa0729.htm, accessed December 2, 2002).

services, not excessive prices for those services. This view is clearly on display in the following statements by three of the nation's most prominent high-deductible advocates:

The United States is the only country in the world where people can consume medical care almost without limit, unconstrained by market prices or by government rationing.²⁶⁶ (John Goodman and Gerald Musgrave, 1994)

The potential demand for health care is virtually unlimited. Even if there were a limit to what medical science can do (which, over time, there isn't), there is an almost endless list of ailments that can motivate our desire to spend. . . . Even when the illnesses are not real, our minds have incredible power to convince that they are.²⁶⁷ (John Goodman and Gerald Musgrave, 1994)

Imagine that we all carried grocery insurance. In return for a monthly premium, our grocery-insurance policy would pay for most of the things we put into our market baskets. How would this affect our food-purchasing habits? In my case, the answer is simple. Not only would I eat better, but so would my dog. In fact, if every American had grocery insurance, no grocery store in the country would sell dog food. Nothing less than steak would do. But that's just for starters. The supermarket would be stocked with expensive gourmet and specialty items, its aisles would be swarming with solicitous salespersons eagerly catering to the customer's every whim, and besides delivering groceries to our doors, some of these insurance-financed supermarkets would send along a chef to cook the meals Very soon, the cost of grocery insurance would begin to climb.²⁶⁸ (Senator Phil Gramm, R-TX, 1994)

John E. McManus, Republican staff director on the House Ways and Means health subcommittee, was apparently impressed with Senator Gramm's grocery insurance analogy. At a health policy conference in 2002, hosted by UC Irvine's graduate school of management, McManus said Medicare beneficiaries would have to pay a larger share of their medical costs. Why? "Imagine if you had grocery insurance, and every time you went to the market your insurance paid 80 percent of it," he said. "You'd eat a whole lot differently – and so would your dog."²⁶⁹

These statements offer not one word about the high price of medical service, nor about the problem of under-treatment even for insured people. All the blame lies on volume of services (it's excessive) and, ultimately, on patients (doctors and drug companies apparently have no role in persuading patients to accept treatment). Patients are like idiots in a grocery store spending someone else's money. We are gluttons for medical care, so much so that we even invent a substantial portion of our afflictions in order to savor the experience of undergoing unnecessary medical treatments. And our gluttony knows no limit because we are overinsured. Ergo, we rush around the medical supermarket filling our carts with services we don't need and then, like the fat heads we are, we wonder why our "grocery insurance" premiums are so high.

The impact of high-deductible plans on the health system: three issues

Americans are never going to be fond of high-deductible policies. They don't like high deductibles, and they have a hard time understanding high-deductible policies and the tax breaks that make them financially advantageous for some people. But that doesn't mean high-deductible insurers won't take over the health-care industry. After all, Americans opposed managed care tactics, but that didn't stop MCPs from taking over the market. The back-breaking cost of MCP policies, the tendency of employers to shift ever-larger portions of the premiums to employees, and the tendency of some employers to dictate to their employees that they shall accept the lowest-cost

plan available, could very well force tens of millions of workers out of low-deductible policies into high-deductible policies.

Before high-deductible plans break out of their tiny niche and begin to gobble up market share, policy makers and the public should debate three issues: (1) whether high-deductible plans will damage quality of care by using managed-care tactics; (2) whether high-deductible plans will damage quality by causing people to self-ration; and (3) whether the damage to quality of care will be offset by a reduction in the cost of health care in America.

Question 1: Will high-deductible plans rely on managed-care tactics?

Both MSA and DC-plan advocates proclaim their hostility toward managed care and make statements that lead you to conclude that MSA and DC plans would not use managed care. For example, in their 1994 book promoting MSAs, John Goodman and Gerald Musgrave were very critical of managed care – they called it a “bureaucratic solution” and derisively referred to utilization review as “corporate approval” – and they described MSAs as an alternative to managed care.²⁷⁰ Goodman and Musgrave even entitled their book *Patient Power* to emphasize their message that patients would regain their authority to make decisions that was taken from them by MCPs. This deliberately cultivated impression that large-deductible plans wouldn’t use managed care is probably the most important reason why the AMA and many doctors support MSAs. As *American Medical News* put it, critics of MSAs “suspect that the opportunity to sabotage managed care is what’s turned so many doctors into avid MSA backers.”²⁷¹

Because DC plans and the MCPs that are selling high-deductible plans are not always forthright about how managed their policies are, it is difficult to know how extensively they rely on managed care to control utilization by patients enrolled in their large-deductible plans. It is crystal clear, however, that many of the new DC plans are using managed care. Destiny Health, a DC plan headquartered in Chicago, relies not only on doctor networks, but on a company called Advance PCS to run its drug formulary, and on United Behavioral Health (UBH) to manage its mental health and substance abuse services.²⁷² (UBH, a subsidiary of United Health Group, the nation’s largest health insurance company, is the company that withheld medical care from the depressed woman with an eating disorder whose case I describe in Appendix B.) Vivius is also using managed care. According to *HR Today*, a magazine for human resources executives,

Vivius borrows elements from both managed care and traditional indemnity-based systems. Like an HMO, physicians and hospitals will provide medical services to system members for a *fixed monthly fee*. Employees do not have to submit claim forms. . . . Employees . . . access a Vivius web site listing the names and the monthly, *capitated* fees charged by *participating* physicians, hospitals and other providers (emphasis added).²⁷³

Clearly, Vivius limits patient choice of doctor, and doctors are paid a set fee per patient per month, which means the doctor has the usual HMO incentive to deny services.

However, DC plans do not advertise their use of managed-care tactics. To the contrary, they advertise themselves as “consumer-driven,” a phrase deliberately chosen to appeal to Americans fed up with managed care. Definity Health, for example, included in its promotional material a picture of the front cover of the November 8, 1999 edition of *Newsweek* which depicts a furious woman in a hospital gown, her face turned to the heavens and her fists clenched, under the words, “HMO Hell.” On its web site, Vivius states, “With Vivius, you’ll have complete control over health-care decisions for you and your family.”²⁷⁴ The use of euphemisms like “consumer-driven” and “empowering consumers,” and the concealment of the role that managed care plays in DC plans, are having an

effect. *American Medical News* described Definity Health as “an alternative to managed care.”²⁷⁵ The *San Francisco Chronicle* recently offered this misleading description of DC plans:

Employees will soon play a bigger role in managing their own health care – and its cost – through what's being touted as the next big thing in health coverage. *It's not some new form of health maintenance organization, or HMO, the oldest and most restrictive form of managed care. Nor is it a different version of the preferred provider organization, or PPO – the "managed care lite" plan that has grown in popularity in recent years because of its flexibility. This new plan is just entering the marketplace, but it is still so new that no one can agree what to call it. "Defined contribution," "health banks" and "self-directed care" are some of the terms being tossed around (emphasis added).*²⁷⁶

The first clue that ought to alert reporters to the possibility that DC plans use managed-care tactics is their use of networks of doctors. If DC plans really do intend to abandon managed care, why do they persist in using the technique, pioneered by HMOs, of limiting the doctors patients can choose from? There are only two possible reasons: Either the plans want negotiating clout with doctors to push physician fees down, or they want negotiating clout to force doctors to accept financial incentives to deny care and other managed-care rules. I believe both reasons apply.

If high-deductible plans do begin to take substantial market share away from low-deductible MCPs, we have every reason to believe that the use of managed-care tactics will become even more common within the high-deductible wing of the insurance industry than it is today. Just as traditional fee-for-service insurers were forced by HMOs to become MCPs, so high-deductible plans that refuse to use managed care will be forced to do so. The process by which this will occur will closely resemble the process by which MCPs forced non-MCPs to adopt managed care.

The transformation of the high-deductible health insurance industry into a high-deductible *managed-care* health insurance industry may not occur immediately. Like the MCP industry before them, the high-deductible plan industry will almost certainly begin its industrial career benefiting from favorable selection, and that in turn may give the budding high-deductible industry sufficiently lower costs to gain market share without having to resort to aggressive managed-care methods. I say it's “almost certain” the industry will enjoy favorable selection because MSAs and DC plans are so new we don't have any solid research to indicate what the health status is of the million or so people who have enrolled in these plans. All we have to go on is commonsense, arithmetic, and the logic espoused by high-deductible advocates themselves. Commonsense and a little arithmetic (such as the calculations we did in analyzing the Jersey City MSA) tells us that the chronically ill will lose if they are forced into high-deductible policies and, absent compulsion, will stay away from these policies. The only reason the chronically ill would not avoid large-deductible policies would be if they were given subsidies, either by their employer or the taxpayer, that would offset their losses sufficiently to keep them enrolled in a high-deductible plan. But to date, no legislation has been passed to do that, and no movement among employers has arisen to do that.

High-deductible advocates agree with these observations. MSA-advocates Goodman and Musgrave concede that people “with recurring large medical bills over many years” would lose money if they were insured by an MSA. They concede that “most of those people would be disadvantaged. . . .” The solution, they argue, is “a per-condition deductible, which would be paid only once for an extended illness.”²⁷⁷ “With a per-condition deductible,” they explain, “a person diagnosed with cancer would pay the deductible only once, and insurance would pay all of the remaining costs of the cancer treatments, even if those costs were incurred over many years.”²⁷⁸ Do I hear you asking, What would it cost to provide such a fancy form of MSA for the nation's chronically ill? Good question. But Goodman and Musgrave don't bother to answer it. This

cavalier attitude toward the chronically sick tells you where the priorities of high-deductible advocates lie.

But just as MCPs' favorable-selection advantage weakened as they increased their market share, so the favorable-selection advantage enjoyed by the fledgling high-deductible industry will wane as it increases its market share. This will happen for the simple reason that it will be more and more difficult to avoid sick people. This will put great pressure on any high-deductible insurers that are not using managed care to use it, and it will put pressure on those large-deductible plans that are already using managed care to use it more aggressively.⁶⁴ Americans will then live in the worst of all possible health systems – a system that exposes them to both high deductibles *and* managed care.

Question 2: Will high deductibles cause people to forgo necessary care?

As we saw earlier in this chapter, high-deductible advocates think the American public routinely gets unnecessary medical care and they expect that high deductibles will cut the volume of services consumed. Their expectation that some reduction in use of services will occur is certainly reasonable: Numerous studies indicate that raising deductibles and copayments reduces use of services, including preventive services, especially among low-income people.²⁷⁹ The problem is that the eliminated services include both necessary services and unnecessary services. Robert Brook, the Rand researcher we met during the discussion of appropriateness studies, criticized MSA deductibles for discouraging appropriate medical services. “Economic incentives do change behavior,” he told *American Medical News*, “but they reduce appropriate and inappropriate care equally.”²⁸⁰

High-deductible advocates have no answer to this charge. In their book, *Patient Power*, Goodman and Musgrave ask the question, “How do we know people would not forgo needed medical care. . . ?” Here is their answer:

We don't. The theory behind medical savings accounts is that people should have a store of personal funds with which to purchase medical care. And because the money they spent would be their own, they would have strong incentives to make prudent decisions. Undoubtedly, some of their decisions would be wrong. But many decisions made under the current system also are wrong.²⁸¹

There you have it: The wrongs of the current system justify replacing it with an equally dangerous system.

Some high-deductible proponents, no doubt recognizing that the Goodman-Musgrave admission that high deductibles could cause self-rationing is not good PR, take a different tack: They make the false claim that scientific evidence exists proving that high deductibles won't damage the health of patients. The Cato Institute's Mike Tanner wrote, “Critics say consumers will forgo necessary or preventive care to save money in their medical savings accounts, but studies show that MSAs do not deter preventive care. Rather, savings result from reduced use of optional services and cost-based selection among competing providers.”²⁸² If by “studies” Tanner meant studies published in reputable scientific journals, he was wrong on all counts: No studies demonstrate that MSAs won't deter preventive care; no studies demonstrate that MSAs reduce only “optional”

⁶⁴ I believe high-deductible insurers will use managed care tactics not only to keep their over-the-deductible costs down, but to keep their under-the-deductible costs down as well. The reason is simple: An insurer that forces its insured population to reduce costs under the deductible will see a smaller proportion of its insured population spend past the \$3,000 mark (or whatever the deductible is).

medical care; and no studies demonstrate MSAs empower consumers to negotiate discounts from doctors, hospitals, and drug companies. As the Minnesota Department of Health put it in a report released one year prior to the publication of Tanner's confident assurances, "[A] search of the peer review literature reveals no scholarly data on the benefits or risks associated with medical savings accounts."²⁸³ This is in contrast to the substantial body of research which indicates large out-of-pocket costs cause people to forgo necessary care.

In 1995 (a year after *Patient Power* was published), Goodman and Mark Pauly argued that the solution to "high risk" sick people avoiding MSAs, or signing up and exposing themselves to pressure to forgo necessary care, is tax-financed subsidies. But just as Goodman and Musgrave offered no estimate of what it would cost to insure sick people with "per-condition deductibles," so Goodman and Pauly refused to offer any information on how much these subsidies for "high risk" individuals would cost, nor what it would cost to hire bureaucrats to determine who is a "high risk" patient deserving of the subsidy.²⁸⁴

Question 3: Will high-deductible policies save money?

Will this new system be any less expensive than the current one? The few studies we have on this question, which I will review shortly, indicate the answer is, "Probably not." The waste in the current system – excessive administrative costs, excess capacity, high fees and prices, and fraud – will persist. There may be a slight reduction in administrative costs because patients won't be filing claims on the first \$3,000 (or whatever the average deductible will be) of services they get, but this savings will be offset to some degree, perhaps completely, by an increase in administrative costs due to the expense of administering bank accounts (in the case of MSAs⁶⁵) and due to the expense of audits (by the IRS or some other agency) of MSA and DC-plan withdrawals to ensure that withdrawals are for medical expenditures, not vacations or some other purpose that does not qualify for the tax exemption. And there will be a substantial increase in costs if Congress raises taxes to give subsidies to low-income and sick people who enroll in high-deductible plans.

If the spread of high-deductible policies saves any money at all, it will be in the form of reduced *volume* of services, not reduced prices. This is conceded by large-deductible advocates, implicitly more often than explicitly. But a few high-deductible advocates go out on a limb and assert that the *price* of medical services will also drop because consumers, now more "cost conscious" because they are paying the first \$3,000 or whatever in annual medical costs, will negotiate with their doctors, hospitals, and drug companies and will extract discounts from them that the huge MCPs have been unable to extract. This expectation, stated this broadly, is laughable. It is possible patients will have modest success reducing the price of medical services sold under the following conditions: (1) the service is not an emergency service; (2) the patient is of sound mind and has the energy and the means to "shop" for the best price, or the patient has caretakers who are willing to do that; (3) the medical service is relatively uncomplicated and is used frequently (e.g., pediatric services and dental care) and, conversely, is not a once-in-a-lifetime purchase (e.g., a hysterectomy); and (4) the providers of these services are not consolidated into a few huge networks or corporations, but, are, rather, small and numerous. But only a small portion of the market for health goods and services meets these four criteria.

⁶⁵ According to the *Wall Street Journal*, "First-year fees for [MSA] accountholders can range from a low of \$12 to as much as \$105" (George Anders, "Medical savings accounts are proving a tough sell," *Wall Street Journal*, May 22, 1997, A16). If the average fee were \$50, and all 100 million U.S. households opened an MSA, the bank fees would come to \$5 billion.

What little reliable research has been done on high-deductible plans suggests that the reduction in expenditures due to reduced use of health care will be so modest at the system level as to have little or no effect on total expenditures. The most comprehensive study of the effect of high-deductible policies on total spending appeared in the *Journal of the American Medical Association* in 1996. It examined the effect of MSAs on total spending by the insured population under 65 (which excludes, obviously, the elderly and the uninsured). The study concluded that if this entire population were *forced* into MSAs, total expenditures for this group would fall between 0 and 13 percent. However, the study found that if people were given a choice about whether to switch to an MSA, the change in total health spending would range between plus 1 percent to minus 2 percent.²⁸⁵ And this relatively favorable estimate, like all other published studies of high-deductible plans, failed to factor in the new administrative costs that MSAs would generate – the fees banks would charge to open medical savings accounts, and the costs to the IRS of auditing a percent of these accounts to ensure that withdrawals are for medical expenditures.

The conclusions of the *JAMA* study are consistent with three studies on the impact of the 1997 legislation adding MSAs to Medicare. Studies by the Congressional Budget Office and Lewin-VHI concluded MSAs would raise, not lower, Medicare costs.²⁸⁶ According to a third study by Kendix and Lubitz, “There is no scenario in our simulations where Medicare saves money when private insurers offer MSAs to Medicare beneficiaries.”²⁸⁷ Kendix and Lubitz noted moreover that “none of our calculations includes cost of administration.”²⁸⁸

To my knowledge, the only published estimate of how much high-deductible plans could save the whole country (as opposed to the insured nonelderly and the insured elderly) appeared in Goodman and Musgrave’s *Patient Power*. Goodman and Musgrave concluded the savings would be immense – apparently on the order of 13 to 24 percent. Here I will say only that the explanation they offered for their estimate (it took all of three pages in a small paperback book) amounted to junk science. For documentation of this statement, please see Appendix C.

The reliable literature, then, supports the conclusion that high-deductible plans cannot save society as a whole any money and may in fact increase system-wide expenditures on health care. If compulsion is used, and all of society is forced into high-deductible policies, then the savings achieved in the form of reduced use of services will be offset by the increase in taxes or employer payments needed to finance subsidies for the chronically ill and the low-income acutely ill (either in the form of outright payments or higher premiums for policies with “per-condition deductibles”). As high-deductible advocates concede, these subsidies will be needed to prevent the chronically ill and low-income patients from being driven into poverty and/or bankruptcy by out-of-pocket payments for medical bills. If society is *not* prepared to use compulsion, and instead prefers to give people a choice between high- and low-deductible plans, then the savings from reduced use of services will be less, and this savings will be offset by the increased cost of premiums for low-deductible plans as the healthy migrate disproportionately to high-deductible plans and the sick stay, in disproportionate numbers, with low-deductible plans.

If we limit the discussion solely to MSAs as opposed to defined-contribution plans, the probability that society as a whole will save any money is even slimmer, with or without compulsion. That’s because MSAs permit money originally designated as health-care dollars to flow out of the health-care system. Whereas employees enrolled in DC plans can only use the unused portion of their employer contributions for health insurance or medical care, MSA enrollees under 65 can withdraw money from their MSA accounts for vacations and other nonmedical expenditures if they’re willing to pay the 15 percent penalty and to pay income taxes on the nonmedical withdrawals. MSA enrollees over 64 can withdraw any built-up savings in their accounts without paying the 15-percent penalty.

Another way to visualize the limited impact of high-deductible policies on total health-care costs is to ask, What portion of the nation's health expenditures are small expenditures that fail to exceed the \$2,000 or \$3,000 deductible in high-deductible policies? According to high-deductible advocates, it's these below-the-deductible expenditures that will cause patients to haggle over price with their drug company or forgo a medical service ordered by their doctor. By the same logic, once patients have exceeded the deductible, they no longer have an incentive to bargain over price or to forgo medical services. To offer some examples of what happens after patients hit their deductible: Gunshot and stroke victims will no longer have an incentive to ask their ambulance driver to take them to the lowest-cost hospital; arthritis sufferers will no longer have an incentive to stop using their anti-inflammatory drugs, switch to a generic version, or call the manufacturer of their drugs and demand a discount; stroke victims will no longer have an incentive to forgo stroke rehabilitation services and to "shop" for the lowest-cost stroke rehab facility before being discharged from the hospital; and mental health patients will no longer have an incentive to overcome their problems in 30 therapy sessions rather than five.

So what portion of the nation's health-care bill can be attributed to annual expenditures that fall beneath the typical high deductible? Unfortunately, we can't say what a "typical" high deductible is because the high-deductible industry is so new. We do have some data, however, on the distribution of medical expenditures. In its evaluation of Representative Michel's 1992 MSA bill, the Congressional Budget Office reported that only 15 percent of the U.S. population would have medical expenditures above \$2,500, but these people would account for 83 percent of total national health-care expenditures.²⁸⁹ In other words, the incentive for patients to be "prudent" about medical expenditures would have applied to just 17 percent of all health-care spending in 1992 if all Americans had been forced into MSAs with \$2,500 deductibles.

Here we go again

By now, I hope you're experiencing déjà vu. Don't the arguments from high-deductible gurus sound just like the undocumented prattle the nation heard from HMO proponents in the early 1970s? Like the HMO advocates before them, high-deductible advocates say volume is the main problem when in fact price is the main problem, and they claim their proposal will save money without damaging quality, but they can't point to any credible studies to back up their claims. HMO advocates said, almost as an afterthought, that report cards would protect patients from HMO rationing, but they never offered even a superficial explanation of how report cards would work, what they would cost, and whether the cost would swamp the savings HMOs would extract from patients. Similarly, MSA advocates claim, almost as an afterthought, that "per-condition deductibles" and tax-financed subsidies will protect the chronically ill from self-imposed rationing and bankruptcy, but they make no attempt to estimate the cost of these proposals, much less estimate whether these costs will swamp the savings they believe high-deductible policies will achieve. HMO and high-deductible proponents also have in common a tendency to make lavish use of euphemisms. We know now that "health maintenance organizations" don't maintain health just because HMO doctors are paid by capitation, and we can predict with certainty that high-deductible plans won't be "consumer-driven" just because the consumers are exposed to large deductibles.

Another important similarity between MCPs and high-deductible plans is consumer attitudes: Majorities of consumers did not approve of HMOs, and preliminary evidence suggests a majority of consumers don't like MSAs and DC plans. As one writer put it, "The dead elephant in the living room that supporters [of DC plans] don't like to acknowledge is the fact that most polls show consumers prefer the current employer-based health system over a defined-contribution one."²⁹⁰ "Consumers are not behind consumer-driven health care. It's the consultants and the e-

plans [another phrase for DC plans],” argues Jon Gable, vice president of health systems studies with the Health Research and Educational Trust in Washington, D.C.²⁹¹

Consumer resistance to DC plans may prove to be more effective than it was to MCPs for the simple reason that one of the defects in DC plans – the huge deductible – is much more obvious to consumers than are the defects in MCPs. However, I’m not holding my breath. Because health insurance is so expensive, and because employers are beginning to shift more of the cost to employees, it is conceivable that large numbers of healthy employees will be willing to accept DC plans in exchange for even 5- or 10-percent cuts in their premium and medical-care expenditures.

But the most important similarity between the HMO and high-deductible movements is that they both received critical support from big employers and the insurance industry. Employers and the managed-care wing of the insurance industry supported managed care in its early years, and a similar alliance – employers and the high-deductible wing of the insurance industry – is now emerging in support of high-deductible plans, especially DC plans. In 2001, the Pacific Business Group on Health, a coalition of 44 big California-based companies that did as much to promote managed competition as any business group in the country, announced it had decided to contract with Definity, a DC plan. “We believe this selection . . . will change the course of how health care is delivered, not just in California but in the country,” gushed a spokesman for the coalition.²⁹²

Because consumers don’t like high deductibles, and because the U.S. labor market was tight during the late 1990s when premium inflation returned, employers have been reluctant to push their employees into DC plans. However, numerous reports in the business press and general media indicated many employers would begin to switch employees into DC plans as soon as the next recession arrived and the unemployment rate rose. For example, *HR Today* reported, “Ironically, the thing most likely to give defined-contribution health accounts a boost will be a slowdown in the economy. A slowdown would cool the currently overheated job market and make firms less worried about alienating top talent with this new – and, at first, confusing – approach to delivering health benefits.”²⁹³ The recession that high-deductible advocates were waiting for began in March 2001, and was officially recognized shortly after the terrorist attacks on New York and Washington in September 2001.

As the power of the employer-insurance-industry alliance guaranteed the nation would have to suffer through an experiment with managed care, so I fear that power means the nation will have to suffer through an experiment with high deductibles. I pray the high-deductible experiment will be a lot shorter, and lot less painful, than the HMO experiment.

A short history of tax credits

I include a brief analysis of tax credits in this chapter because support for tax credits comes primarily, although not exclusively, from the same people who support MSAs and DC plans, namely, the insurance industry and their conservative allies in Congress. Moreover, tax credits are like MSAs in that both rely on tax breaks.⁶⁶

America’s conservatives tend to propose tax breaks (deductions or credits) instead of government programs whenever public opinion forces them to adopt a position on a pressing social issue. Thus, for example, when Democrats pushed national health insurance back onto the front burner in the early 1970s, Republicans, the American Medical Association, and the Health Insurance

⁶⁶ For the sake of simplicity, I do not discuss proposals that rely on tax *deductions*. The defects of tax deductions are similar to those of tax *credits*. The most important difference between the two is that deductions are more regressive than credits, which means they are more beneficial to the wealthy than the middle class, and more beneficial to the middle class than the poor.

Association of America supported legislation that would give employers and individuals tax breaks if they purchased health insurance.

The lowly tax credit made a modest comeback in the early 1990s when public pressure for some solution to health-care inflation forced conservatives to propose something resembling a health policy. The Heritage Foundation, one of numerous conservative think tanks, published a tax credit proposal in 1991,²⁹⁴ but there were, at first, few takers among Republicans. A single event, however, overcame Republican inertia. That was the November 1991 election of Democrat Harris Wofford, who campaigned on national health insurance, to the Pennsylvania Senate seat that Senator John Heinz (R-PA) had occupied before he was killed in a helicopter crash. Wofford was 40 percentage points behind Republican candidate Richard Thornburgh in August 1991, but he won the election with 55 percent of the vote. Post-election surveys showed that half of Pennsylvania's voters said "national health insurance" was one of their top two concerns. Politicians throughout American interpreted Wofford's election to mean Americans wanted Congress to rein in health-care inflation and provide coverage to the uninsured. As George Bush I put it, "One of the messages in Pennsylvania: try to help people with health care."²⁹⁵

The day after Wofford's election, several Senate Republicans introduced a bill to establish refundable tax credits for people who bought health insurance. (A refundable credit is one that is available not only to people who pay income taxes but also to people who have incomes too low to owe any taxes.) Three months later, President Bush revealed that he too had a solution to the health-care crisis. He called for tax credits for low-income people and tax deductions for higher-income people. Bush's tax credits were relatively large – \$1,250 a year for an individual and \$3,750 for a family. He proposed to pay for them with cuts in Medicare and Medicaid.²⁹⁶ Late in his 2000 campaign for the presidency, George W. Bush announced his support for even smaller credits. He said he would support refundable tax credits worth up to \$1,000 for individuals earning up to \$15,000 a year and credits worth up to \$2,000 for families earning up to \$30,000.⁶⁷ Of course by the time George W. Bush had proposed these credits, health-care inflation made them worth even less than they would have been when his father proposed tax credits in 1992. Bush's proposed tax credit was within the range of credits then being proposed by members of Congress. According to a 2001 report by the Congressional Budget Office, "A number of tax credit proposals were introduced in the 106th Congress. Those proposed credits were typically refundable and ranged from \$500 to \$1,200 for individual policies and \$2,000 to \$3,600 for family coverage."²⁹⁷ Bush reaffirmed his tax credit proposal again in January 2002, at which time he announced he was raising the credit for families to \$3,000.²⁹⁸

Why tax credits are ineffective

Tax credits are, at best, a hoax, and at worst a subsidy to the bloated insurance industry. If the credits are low, we may refer to them as a hoax – they will accomplish little because they will be too low to induce the uninsured to buy health insurance. If they are high enough to reduce the uninsured rate, they will cost a bundle and do nothing to reduce the gross inefficiency of the health insurance industry. As the Congressional Budget Office put it, "The amount of a tax credit would have to be fairly large – approaching the full cost of the premium – to induce a large proportion of the uninsured population to buy insurance."²⁹⁹ The tax credits proposed by the Republicans over the last decade have come nowhere near equaling the cost of insurance. George W. Bush's proposed credit illustrates the problem.

⁶⁷ Under the Bush plan, the value of the credit would begin to drop at \$15,000 for individuals and \$30,000 for families and disappear completely at \$45,000 and \$60,000 respectively.

Since insurance costs \$1,500 to \$2,000 for healthy individuals, and \$6,000 to \$7,000 for healthy families buying policies on their own, and a lot more than that for sick people, it doesn't take a genius to understand why Bush's proposal will do little to reduce the uninsured rate. Remember, these are credits for people who have to buy insurance on their own, not through an employer. That means premiums are much higher than they are even for employers. Dr. Judith Feder, dean of policy studies at Georgetown University, said Bush's plan was like "giving a ten-foot rope to people in a 30-foot hole."³⁰⁰ Just as a short rope will be useless to someone in a deep hole, so a tax credit worth a fraction of the cost of insurance is useless to low-income and poor people.

The ineffectiveness of the Bush proposal was illustrated by two studies that demonstrated the difficulty Americans have buying individual policies. A study done by Families USA (FUSA) examined the difficulty *healthy* people have finding insurance that is both adequate and affordable. A study by Georgetown University's Institute for Health Care Research and Policy tested the reaction of health insurance companies to applications by people with mild to severe illnesses.

The study by FUSA analyzed two types of insurance policies in 25 states for healthy 25-year-old and 55-year-old women. The first type of policy was one that cost \$1,000 (the maximum amount of the tax credit for an individual under the Bush proposal); the second was a "standard plan," which FUSA defined to mean a plan equal in coverage to that in the Blue Cross Blue Shield Preferred Provider Organization plan offered to federal employees. FUSA found serious problems with both plans. The \$1,000 plans were often unavailable in the 25 states studied, and when they were available, the coverage they offered was terrible. The standard plans, on the other hand, were sometimes unavailable and always very expensive.

Tables 10-2 and 10-3 summarize the findings for both types of plans. Table 10-2 indicates that healthy women cannot get a \$1,000 policy in many states (18 of the 25 states did not have \$1,000 policies for sale for 55-year-old women). What is not reported in Table 10-2 is that FUSA found that those policies that were for sale did not cover doctor visits, prescription drugs, emergency services, or mental health services in several states. Table 10-3 reports the cost of the *lowest-priced* policies that met the "standard plan" definition in each of the 25 states. You can see that adequate policies were available in 21 of the 25 states for healthy women, but the premiums were far above the maximum \$1,000 tax credit proposed by Bush. Remember, the full \$1,000 credit would be available only to low-income people. So, to take the worst case shown, a 55-year-old

Table 10-2: Bush's \$1,000 tax credit will buy a policies with shrunken coverage for younger, healthy individuals, and no plan at all for many older and sicker people: Deductibles in, and availability of, insurance policies for healthy women that cost \$1,000 a year in 25 states, 2001

| State | Deductible for healthy, non-smoking female (\$) | |
|---------------|---|-------------|
| | 25-year-old | 55-year-old |
| Alaska | 1,000 | na* |
| Arizona | 750 | \$5,000 |
| Arkansas | 750 | na |
| California | 500 | na |
| Florida | 2,500 | na |
| Illinois | 1,000 | na |
| Iowa | 500 | \$5,000 |
| Louisiana | 1,000 | na |
| Maine | na | na |
| Massachusetts | na | na |

| | | |
|---------------|-------|---------|
| Mississippi | 500 | na |
| Montana | 5,000 | na |
| New Jersey | na | na |
| New Mexico | 5,000 | na |
| New York | na | na |
| North Dakota | 500 | \$2,500 |
| Oklahoma | 500 | \$5,000 |
| Oregon | 1,000 | \$5,000 |
| Pennsylvania | 750 | na |
| South Dakota | 1,000 | na |
| Tennessee | 750 | \$2,500 |
| Vermont | na | na |
| West Virginia | na | na |

Source: Families USA, *A Ten-Foot Rope for a 40-Foot Hole*, Families USA Foundation, Washington, DC, September 2001, Table 1, 6.

healthy Alaska woman (God help her if she's sick), earning \$15,000 a year, would have to pay half her annual income – \$7,964 – in addition to Bush's \$1,000 credit, in order to buy insurance. To take the best case shown, a healthy 25-year-old South Dakota woman, earning \$15,000 a year, would have to pay \$524 out of her own pocket to buy insurance.

Whereas the FUSA study assumed the applicants were healthy, the study by Georgetown University assumed the applicants suffered from conditions ranging from hay fever to AIDS. The investigators asked 19 health insurance companies across the U.S. to indicate how they would respond to applications for individual health insurance from seven fictitious individuals. According to *American Medical News*,

Table 10-3: Bush's \$1,000 tax credit will contribute only a small fraction of the cost of adequate health insurance for healthy individuals, and an even smaller fraction for sick people: Premiums for "standard plans"^(a) for healthy women in 25 states, 2001, (\$)

| <u>State</u> | <u>Premium for healthy, non-smoking female</u> | |
|---------------|--|--------------------|
| | <u>25-year-old</u> | <u>55-year-old</u> |
| Alaska | 3,996 | 8,964 |
| Arizona | 2,340 | 2,892 |
| Arkansas | 2,028 | 4,548 |
| California | 1,375 | 3,096 |
| Florida | 1,776 | 2,488 |
| Illinois | 1,488 | 3,444 |
| Iowa | 1,932 | 3,852 |
| Louisiana | 3,144 | 7,044 |
| Maine | 3,941 | 5,132 |
| Massachusetts | 3,168 | 6,130 |
| Mississippi | 2,256 | 5,052 |

| | | |
|---------------|-------------------|-------|
| Montana | 1,788 | 5,448 |
| New Jersey | 4,608 | 4,608 |
| New Mexico | 1,788 | 4,500 |
| New York | na ^(b) | na |
| North Dakota | na | na |
| Oklahoma | 2,088 | 4,692 |
| Oregon | 1,608 | 3,612 |
| Pennsylvania | 2,412 | 5,388 |
| South Dakota | 1,524 | 3,420 |
| Tennessee | 2,208 | 4,932 |
| Texas | 3,132 | 6,240 |
| Utah | na | na |
| Vermont | na | na |
| West Virginia | 1,703 | 3,924 |

(a) FUSA defined the standard plan as follows: It “could not have a deductible higher than the \$250 deductible in the . . . BC/BS [Blue Cross Blue Shield] PPO [Preferred Provider Organization, a type of MCP]. In addition, the plan had to be equivalent to the [BCBS PPO] in at least two of the following four measures: (1) copayments for doctor’s office visits of \$15 or less; (2) coinsurance for inpatient and outpatient services no higher than 20 percent (the [BCBS PPO] has a lower coinsurance rate of 10 percent); (3) prescription drug coverage with coinsurance no higher than 25 percent or flat copayments no higher than \$12 for generics and \$20 for brand name drugs. . . ; or (4) annual out-of-pocket limit of \$3,000 or less” (p. 2).

(b) na means “not available.”

Source: Families USA, *A Ten-Foot Rope for a 40-Foot Hole*, Families USA Foundation, Washington, DC, September 2001, Table 2, 7.

The results showed that even the most healthy hypothetical applicant was rejected by some insurers, and all were frequently offered plans with riders barring coverage for their pre-existing health conditions, higher premiums than a completely healthy individual would face, or larger cost-sharing responsibilities than they requested. One character, a man with AIDS, was rejected by all insurers.³⁰¹

I know from personal experience how high insurers can set premiums for even healthy individuals. In 1997 I helped a 58-year-old St. Paul woman write a letter of complaint to Cigna after Cigna quoted her a price of \$23,692 for health insurance with a \$250 deductible and no drug coverage. The premium would have fallen to \$18,156 if she had been willing to accept a \$2,000 deductible. The woman was going through a divorce and needed to know what her premiums would be in order to negotiate an agreement on alimony with her soon-to-be ex-husband. She wrote Cigna because that was the insurer that insured her and her husband through 3M, the husband’s employer. This woman had been healthy all her life and was still healthy. She said the only medical services she had gotten in recent years was an MRI on her neck to examine a spur, three biopsies on breast tissue that revealed no cancer, and some psychiatric counseling to deal with her grief over the divorce. However, her sister and mother had cancer, a fact she had to report to Cigna’s underwriters. Those facts no doubt perturbed the actuaries at Cigna. When I saw Cigna’s premiums, I told Florence, “Why doesn’t Cigna just come right out and tell you they don’t want your business?”

Summary

Many employers may soon push their employees into MSAs and DC plans. If they do, I won't blame them. The American system of making employers and employees pay for health insurance is irrational. While we're at it, why don't we finance all other government programs off the backs of employers and employees? However, I do criticize employers who justify their behavior by claiming their switch to high-deductible plans is an act of altruism – that it will reduce the cost of the U.S. health-care system and won't harm patients. That is hokum. I make the same predictions now about large-deductible plans that I made about MCPs in the early 1990s: They won't save the system any money, and they will damage quality of care.

Tax credits at, least, won't harm patients. They will, however, enrich the insurance industry, and they will serve as a fig leaf for politicians who wish to conceal their disinterest in solving the American health-care crisis.

Why Medicare for Everyone Is the Best Plan

How a single-payer addresses waste

Table 11-1 lists the information shown in Table 7-8 – the four types of waste and the cost of each type of waste as a percent of total health spending – along with the mechanisms a single-payer uses to minimize the waste. You can see that the solution to administrative waste is one payer, the solution to excess capacity is budgets for hospitals, the solution to excessive prices is price controls, and the solution to fraud is one payer and aggressive enforcement of the law. I’ll review each of these solutions one at a time, and, as I go, compare the ability of a single-payer, managed competition, and high-deductible-plan systems to get at the waste.

The solution to high administrative costs, in both the insurer and provider sectors, is one payer that does not use managed-care tactics. When a single-payer with low overhead like Medicare’s replaces America’s 1,000-plus health insurance companies, administrative costs will fall substantially. Overhead in the *insurance* sector will drop because the one payer will have much lower overhead costs than any private-sector insurer – be it an MCP or high-deductible insurer – could ever achieve (1 to 2 percent for a single public insurer versus 15 to 35 percent for private insurers). And overhead in the *provider* sector will drop because (a) the public single payer won’t be using managed care tactics which waste so much of the provider sector’s time and money, and (b) because providers will have to deal with only one payer, not hundreds or thousands. A system that relies on multiple payers, be they MCPs or high-deductible plans can do little

Table 11-1: How a single-payer addresses waste

| <u>Type of waste</u> | <u>Cost</u> | <u>Solution under single-payer</u> |
|---|-------------|------------------------------------|
| Administrative waste | 10-15% | One payer |
| Insurance company overhead | | |
| Provider (doctor and hospital) overhead | | |
| Excess capacity | ? | Budgets for hospitals* |
| High fees and prices | 10-15% | Price controls |
| High fees | | |
| High drug prices | | |
| Fraud | 3-10% | One payer plus enforcement |

* For the sake of simplicity, I describe the budgets necessary to reduce excess capacity as “budgets for hospitals.” In fact, these budgets will have to extend beyond hospitals to any clinic or entity that makes capital purchases (machines or buildings) in excess of, say, \$1 million. Hospitals are the biggest purchasers of capital equipment, but they are not the only ones. Clinics and freestanding imaging centers, for example, buy MRIs, which cost several million dollars per copy.

to reduce provider overhead. And, of course, a system of MCPs will do nothing to reduce that portion of provider overhead that is caused by MCPs’ managed-care tactics.

The solution to excess capacity is to give the single-payer the authority to approve budgets for hospitals and any other entity that buys expensive equipment such as MRIs (a threshold expenditure could be set at, say, \$1 million). Think back to the battle between the two Miami-area hospitals over the Gamma Knife that we discussed in Chapter 6. You recall that a hospital in Coral Gables, Florida installed one of these expensive machines in October 1993, and a Miami hospital ten miles to the north installed another Gamma Knife five months later. Obviously, the MCP-dominated insurance industry in Florida was powerless to stop this senseless arms race. An insurance industry dominated by large-deductible insurers would be equally powerless. Only a single-payer, or some other government agency authorized to set budgets for hospitals, could have stopped the madness. Under a single-payer system, both hospitals would have submitted budgets to the single payer, and the single-payer board would have determined how many Gamma Knives the Miami area needed and which hospital or hospitals would be the best place to house the devices.

The solution to high fees and prices is price controls – limits on what doctors can charge for services, and ceilings on what drug companies can charge for drugs. The current MCP-run system has slowed the growth of physician fees (it hasn't reduced them) and has had no system-wide impact on drug prices. The superior effectiveness of price controls over managed competition and high-deductible plans is clearest with respect to drug prices. The current MCP-dominated system has proven that MCPs can only reduce drug prices for themselves (as opposed to all of society), and even this minor victory has been achieved at considerable cost. One type of cost has been the administrative costs associated with formularies. These costs include the costs MCPs incur constructing and enforcing formularies, and the costs physicians and pharmacists incur keeping track of, and prescribing according to, the umpteen formularies their various patients have to abide by. For doctors, administrative costs generated by formularies include the cost of arguing with an MCP factotum about whether the patient can be allowed to use a non-formulary drug. But not all such appeals succeed, so we must list a second type of cost associated with formularies: the cost to patients of being forced to give up access to drugs that are not on MCP drug formularies.⁶⁸

If high-deductible plans eschewed managed-care tactics, including formularies, high-deductible devotees could fairly claim that a system of high-deductible plans would lower the current system's overhead costs to some extent because the new system would not use managed care and formularies. But at this date it does not appear that high-deductible insurers will abandon managed care tactics. But regardless of whether the new high-deductible insurers abandon managed care, fees for many physicians (notably, physicians in large groups and in rural areas where competition among physicians is weak) and prices for most drugs would continue to rise. Some high-deductible advocates would have us believe that individual patients will be forced by their high deductibles to go "shopping" for physicians and drugs, and that they will return from their shopping trip having successfully forced large clinics such as the Mayo Clinic and gigantic drug companies like Merck to agree to reduced fees and prices. This is nonsense. The best we can expect is that patients will occasionally succeed in getting doctors in small practices (say, doctors in one- to three-doctor clinics) to lower their fees, especially if the patients live on low incomes. The big boys – the big clinics, the hospital chains, and the multinational drug companies – will tell the vast majority of "shoppers" to accept their prices or buzz off.

⁶⁸ If we could state with confidence that MCP formularies are based on rigorous scientific evidence about which drugs are the most effective and the safest, we wouldn't have to treat the loss of patient choice as a cost of the MCP system's method of controlling drug expenditures. But MCP formularies are based primarily on the kickbacks MCPs get from drug companies, not on science.

There is no perfect solution to fraud, the fourth category of waste shown in Table 11-1. Fraud will afflict any type of insurance system. But the best solution is a single-payer plus an adequate budget for law enforcement. A single-payer will be better at detecting two types of fraud than a multiple-payer system. I'm talking about the second and third of the three types of fraud we discussed in Chapter 7 – billing for services never rendered, and overcharging by double billing (charging two different insurers for the same service). If doctors and other providers have to send their bills to one payer rather than hundreds of payers, overcharging by double billing becomes very risky because it will be very easy to detect. Billing for services never rendered becomes more difficult as well. It is much easier, for example, for a doctor to claim he worked 36 hours per day last year, or did an unheard-of number of operations last year, and get away with it if he submits his bills to, say, 50 payers rather than one. The one payer's computer could be programmed to warn investigators of any provider who claims to provide an impossibly high number of services. The remaining type of fraud discussed in Chapter 7 – billing for unnecessary services – would not necessarily be any easier to detect under a single-payer than under managed competition or a regime of high-deductible insurers.

To sum up, on every one of the four types of waste, a single-payer, armed with the tools described in Table 11-1, will outperform managed competition and high-deductible insurers. Moreover, a single-payer will not be saving money at the expense of patients. Under managed competition, MCPs save money by denying services to patients, and in the course of doing so, they invade patient privacy.⁶⁹ Under the high-deductible proposal, insurance companies save money by inducing patients to self-ration.

Research confirms single-payer saves money

Few reliable studies have sought to determine how a single-payer or managed-competition system would affect total health-care spending in the U.S., and none have asked that question about high-deductible proposals. Only a half-dozen peer-reviewed or government-funded studies of system-wide savings achievable by a single-payer system have been published, and none of these attempted to measure the impact of a true single-payer; they measured only the *administrative* savings a single-payer could achieve, and ignored the savings a single-payer would achieve via hospital budgets, ceilings on physician fees and drug prices, and reduced fraud. Even fewer reliable studies have been published on the effect of managed competition on total expenditures.

With one exception, all of the reliable research on the system-wide impact of single-payer and managed-competition systems was done between 1991 and 1993. The exception was research on single-payer savings published by two leaders of Physicians for a National Health Program, David Himmelstein and Steffie Woolhandler, in 1986.³⁰² The reason that the bulk of the research on single-payer and managed-competition proposals appeared between 1991 and 1993 is that those were the years when single-payer and managed competition bills were introduced in Congress. The single-payer forces got out of the chute first. Representative Marty Russo (D-IL) introduced a single-payer bill (HR 1300, The Universal Health Care Act of 1991) in March 1991. In 1992, Senator Paul Wellstone introduced the companion to the Russo bill in the Senate (S 2320). In 1993, Representative Jim McDermott (D-WA) and Senator Wellstone introduced slightly different versions of the Russo bill (HR 1300 and S 491). Managed competition bills were introduced in 1992 by Representative Jim Cooper (D-TN), and by Cooper, President Clinton and others in 1993.

⁶⁹ This occurs because MCPs demand that doctors turn over patient medical records in order for MCPs to assess doctors' decisions to order services.

Research on these bills generated headlines – headlines that were exhilarating for single-payer advocates and discouraging for managed competition buffs. Check out these headlines about research by the U.S. General Accounting Office and the Congressional Budget Office:

- “GAO backs health care based on Canadian plan.”³⁰³
- “Single-payer plan saves most: CBO report says proposal also would serve most people.”³⁰⁴
- “Budget office study says single-payer health plan would be least expensive.”³⁰⁵
- “Budget chief sees no health cost cuts in ‘managed care.’”³⁰⁶
- “CBO puts high price on managed competition.”³⁰⁷

These are not selective samplings of the headlines. *All* the research, and *all* the headlines about the research, say the same thing: Single-payer is far less expensive than managed competition. The reverse has never happened. No headline has ever appeared describing research that said managed competition would cost less than a single-payer system.

Research by the GAO comparing the administrative costs of the U.S. and Canadian systems was typical of the research done on single-payer systems back then. It examined only the administrative savings achievable by a single-payer; it made no effort to determine the extent to which a single-payer could reduce excess capacity, high fees and prices, and fraud. The GAO’s findings are shown in Table 11-2. The GAO concluded that if the U.S. had administrative costs as low as Canada’s that U.S. total spending would fall by 9.5 percent. Roughly half of that savings would come from reduced overhead in the U.S. insurer sector, and the other half from reduced overhead for doctors and hospitals. The GAO also estimated how much it would increase U.S. total spending to guarantee first-dollar coverage to all Americans, including the uninsured. The GAO concluded that would increase total spending by 9.0 percent. In other words, the GAO found that the administrative savings alone under a single-payer would be so extensive we could cover not only the uninsured for what we’re paying now, but could eliminate deductibles and copayments for the insured, and still cut total spending by half a percentage point. Because the market share of the MCP industry continued to rise after 1991, the year the GAO used for its analysis, it is reasonable to conclude that the administrative costs generated by managed care have risen since 1991 and that the

Table 11-2: The administrative savings from a single-payer would be enough to cover the uninsured and underinsured: Estimates of the percentage change in total health-care spending due to single-payer savings in administrative costs, 1991

| | Insurers | Physicians | Hospitals | Total |
|------------------------------|----------|------------|-----------|-------|
| Administrative savings | -4.8% | -2.1% | -2.6% | -9.5% |
| Cost of additional insurance | | | | 9.0% |
| Newly insured | | | | 2.6% |
| Currently insured | | | | 6.5% |
| Net change | | | | -0.5% |

Source: My calculations using the dollar figures reported in U.S. General Accounting, *Canadian Health Insurance: Lessons for the United States*, Washington, DC, 1991, 63, Table 5.1.

reduction in total spending due to a cut in administrative costs under a single-payer today would be higher than the 9.5 percent reduction estimated by the GAO. The potential savings today are probably somewhere between 10 and 15 percent.

Of course, administrative waste is not the only type of waste a single-payer can reduce. Imagine how much more we could save if we were to give an American single payer the authority to set hospital budgets and limits on physician fees and drug prices. Back in Chapter 7, I refrained from guesstimating the savings a single-payer could achieve by cutting back on excess capacity (with hospital budgets) because the evidence on this issue is so poor. But I did estimate that price controls on physician fees and drug prices could cut another 10 to 15 percent off total spending. If administrative savings amount to 10 percent of the national bill, and price controls take off another 10 percent, the total savings comes to 20 percent, and we haven't even subtracted any savings achieved in the realm of excess capacity or fraud.

Depending on our definition of universal coverage, a 20-percent cut in national spending would be more than enough to pay for universal coverage. If our goal is to extend coverage typically held by employed Americans (that is, coverage with deductibles and copayments) to the uninsured, we would need to free up only about 3 percent of total expenditures.⁷⁰ If we want to provide *all* Americans with *first-dollar* insurance (insurance with no deductibles or copayments) we'd have to free up a total of about 9 percent of all health-care expenditures, according to the GAO report we just reviewed.⁷¹ If we include long-term care in our definition of universal coverage, we'd have to free

⁷⁰ The GAO study on Canada presented in Table 11-2 concluded that insuring the uninsured with typical American coverage (that is, coverage with deductibles and copays) would cost 2 percent of total health care spending. Other studies estimate the cost to be slightly higher. For example, a 1997 study, which assumed the uninsured would get coverage with typical deductibles and copayments, estimated a range of 2 to 3 percent (Pamela Farley Short et al., "The effect of universal coverage on health expenditures for the uninsured," *Medical Care* 1997;35:95-113). For this reason, I use 3 percent as my estimate.

⁷¹ These estimates – 3 percent to extend first-dollar coverage only to the uninsured, and 9 percent for universal first-dollar coverage etc. – and the estimates reported in the preceding footnote do not take into account the effect that eliminating managed care will have on utilization rates, nor on the effect that insuring the uninsured will have on cost due to improved health among the uninsured. The first factor (higher utilization rates) will increase costs. The second factor (improved health) will reduce costs. Because solid data on both factors are scarce, it is difficult to know whether the net effect will be an increase or decrease in total spending. I have seen several studies that attempted to determine the reduction in utilization caused by managed care; I have seen no system-wide studies of the effect universal insurance will have on the health of the uninsured and, therefore, total spending. I discuss one of the managed-care utilization studies in the next paragraph.

In my vision of single-payer, managed-care tactics would be outlawed. However, some single-payer proposals permit HMOs to continue to exist. But because few people would enroll in an HMO if they could get free care or nearly free care from non-HMO doctors, it is safe to assume that utilization of medical services will increase almost as much under a single-payer proposal that permits HMOs as one that does not. The increase in costs due to higher utilization in a managed-care-free environment will be relatively small compared to the savings a single-payer will achieve. According to the Congressional Budget Office, HMOs – the tightest form of managed care plans – reduce utilization rates below levels seen in traditional, unmanaged fee-for-service insurance companies by 8 percent. The CBO found that non-HMO MCPs do not reduce utilization rates (Congressional Budget Office, *The Effects of Managed Care and Managed Competition*, Washington, DC, 1995). But since only 30 percent of Americans are enrolled in HMOs, the reversal of this 8-percent reduction isn't going to affect the entire population. System-wide, eliminating managed care insurers would mean only a 3.2 percent increase in utilization (1.08 times .30 equals 3.2 percent). To repeat: This 3.2 percent increase may be offset, partially or completely, by savings caused by the improved health of the formerly uninsured.

If we take the most conservative assumption – that improved health in the uninsured has no cost-reducing effect – then the total cost of insuring the uninsured with insurance that includes deductibles and copayments will be about 6 percent of current total expenditures (3 percent for increased utilization due to the reduction of out-of-pocket payments and 3 percent due to the elimination of managed care). Similarly, if we take the most conservative assumption, the total cost of extending first-dollar coverage to all Americans will be 12 percent (9 percent due to the elimination of out-of-pocket payments plus 3 percent due to the elimination of managed care).

up perhaps another 10 percent of current health-care expenditures.⁷² To sum up, if we want universal coverage with deductibles and copayments and coverage for long-term care services, we'd need the equivalent of about 13 percent of current health-care spending. If we want universal first-dollar coverage plus coverage for long-term care, we would need the equivalent of about 20 percent of total spending. As we saw in Table 11-1, 20 percent is a conservative estimate of what an American single-payer could save. We could save 20 percent from cuts in administrative waste and high fees and prices alone.

Research on managed competition and high-deductible policies

Unlike the single-payer bills introduced in Congress, the managed competition bills were never certified by any credible research to save money. One of the most damaging studies was a CBO study comparing Representative Russo's 1992 single-payer bill and Representative Jim Cooper's 1992 managed competition bill. The CBO reported that Russo's bill would have cut national spending by 9 percent seven years after enactment, whereas Cooper's managed competition bill would have increased spending by 1 percent seven years later. As if that weren't bad enough, the CBO reported that Russo's single-payer bill would have reduced the uninsured rate in the U.S. to zero whereas Cooper's bill would have reduced the number of uninsured only by one-third.³⁰⁸ For me, the choice between these two bills is obvious. Do I want the bill that costs more, takes away my choice of doctor, and doesn't insure everyone, or the one that costs less, doesn't push me into HMOs, and insures everyone? The question answers itself.

As I indicated in Chapter 10, reliable research on the impact of a high-deductible system on total U.S. spending is nonexistent. All we have are a few studies that looked at how making MSAs available to certain subpopulations – the non-elderly insured, Medicare beneficiaries, and federal employees – would affect total spending on these populations. As we saw in Chapter 10, this research concludes that high-deductible plans will save no money for the health-care system if people are given a choice of whether to enroll in an MSA. If sick people are forced into MSAs and bankrupted by their medical expenses, they will become eligible for Medicaid. If the cost to the taxpayer of insuring these people is added to the cost of MSAs, and if the cost to the taxpayer of paying for subsidies for low-income MSA enrollees is added to the cost of MSAs, and if the cost of paying for each bank account that will have to be opened for each MSA is added to the cost of MSAs, the MSA proposal may well mean American health-care costs will increase, not fall.

Privacy and democracy: Two other reasons to support single-payer

A single-payer system has two other advantages over the current MCP-run system: (1) By eliminating MCPs that use utilization review, a single-payer system will enhance patient privacy; and (2) by reducing the health insurance industry to a shadow of its former self and by reducing the incentive for providers and drug companies to get big, a single-payer system will augment the

⁷² I derive this estimate using the only good proposal for a national long-term care plan I know of – the proposal laid out by the Pepper Commission in 1990. This commission, officially known as the U.S. Bipartisan Commission on Comprehensive Health Care, made proposals to solve the crisis in both the health-care sector, as it is traditionally defined, and the long-term care sector (The Pepper Commission, *A Call to Action*, US Government Printing Office, Washington DC, 1990). It's proposal to make nursing-home and home health care affordable to everyone was pretty good. The commission estimated that this program would have cost \$43 billion had it been implemented in 1990 (see page 130), which amounted to just under 7 percent of the \$647 billion the commission estimated the U.S. would spend on health care that year (see page 65). To be on the safe side, I'm estimating a good national long-term care insurance program would cost about 10 percent of total spending today.

influence of public opinion over health policy at the expense of the gigantic MCPs, hospital chains, clinics and drug companies that dominate the health policy debate today.

Patient privacy has been virtually destroyed by MCPs, in particular, by their use of utilization review. Under the traditional insurance system, patient privacy was violated, but only to the extent necessary to prevent fraud. Traditional insurers did not demand that doctors send them patient files in order to argue with doctors about their decisions. Before MCPs took over, doctors and hospitals submitted claim forms to insurers listing a few publicly available facts about the patient (name, sex, and address) plus the patient's age and a few codes to indicate what services were rendered. Thus, an insurance company employee receiving the claim form would know that Dr. X performed an angiogram on Jane Doe. But the insurance company employee would not learn other facts that would typically appear in a heart patient's file, for example, that the angiogram was ordered because Ms. Doe had been experiencing chest pain with exertion for the past six months, and that the angiogram found 90 percent occlusion in one of her coronary arteries. To take another example: The employee of a traditional insurance company could learn from a typical claim form that John Doe underwent treatment for depression; the employee would *not* learn that John Doe was physically abused as a child, has nightmares about aggressive animals, and often thinks about committing suicide.

Between the formation of the traditional health insurance industry in 1929 and its demise at the hands of MCPs in the 1990s, Americans came to accept the minimal invasion of patient privacy required by traditional insurers. Traditional insurers would demand information from patients at two points – when people applied for insurance, and after they received medical care and filed a claim. For large groups (typically employees in firms with more than 50 to 100 employees), traditional insurers would ask only for a few bits of information such as name, address, age, and sex. For individuals and for most small groups, traditional insurers would also “underwrite,” that is they would ask for information about the applicants' health history and use that information to decide (a) whether to insure the person or group and (b) what premium to charge if the insurer accepted the application. When patients got medical care, someone (the patient or the doctor) would submit a claim form. The claim form did not include data from medical records. Except in rare cases when the traditional insurers felt fraud was being committed against them, they paid the claim without asking for data from patient medical records.

The MCP industry changed the rules. It continued to extract health history data from individual and small-group applicants the way the traditional insurers had, but it vastly expanded the amount of medical data it extracted from doctors (usually without patients knowing it), both before, during, and after treatment. Utilization review and drug formularies require doctors to deliver to MCP employees information about patients typically found only in medical records. According to industry observer Jon Gabel, these tactics spread like wildfire during the 1980s and early 1990s. “Such techniques were so rare in 1977,” says Gabel, “that few references to them exist in the literature. By 1988 nearly 70 percent of workers with job-based health coverage were enrolled in a plan with preadmission review, and about one-fifth were in a plan with a primary care gatekeeper. By 1998 prospective utilization review techniques were so widespread that the major national surveys ceased to ask about their presence.”³⁰⁹

MCPs can be brazen in their demands for information. For example, a psychiatrist told me Blue Cross Blue Shield of Minnesota demanded that he turn over his notes on a depressed patient in order to determine whether the patient really was depressed.

A system built around sellers of large-deductible policies may well turn out to be just as invasive of patient privacy as the current system. Large-deductible insurers will unquestionably want to continue the time-honored practice of cherry-picking, which means they'll have to continue

underwriting as aggressively as the MCPs do. And the early evidence indicates large-deductible insurers intend to keep managing care as aggressively as MCPs have.

A single-payer system would not underwrite, that is, it would not ask Americans numerous questions about their health history before insuring them, and it would not manage care. For these reasons, a single-payer system would be much less invasive of patient privacy than either MCPs or large-deductible insurers.

In addition to lower cost, better quality, and improved privacy, a single-payer system will give ordinary people greater influence over health policy than is possible under either an MCP or large-deductible regime. There are two reasons for this. First, social control of industry pricing decisions is formalized under a single-payer system. No longer will Americans be exhorted to influence industry decisions through dysfunctional health-care markets as consumers. Instead, we will be influencing health policy decisions as voters. Second, the power of the various players in the health-care industry will be reduced by a single-payer system.

The main loss of industry power will occur in the insurance industry. Its power will be reduced to a tiny fraction of its current level. Under all single-payer proposals, non-HMO health insurers will be allowed to sell only a small number of non-essential health and health-related services. (Some single-payer bills permit HMOs to exist. I think that is not a good idea, but I don't get upset about it because it's hard to imagine many people signing up with HMOs under a system in which people are free to go to any doctor they want and have the doctor's fees paid for by the single-payer.) Under some single-payer proposals, health insurance companies would be allowed to process claims, as they do now for Medicare, if they can demonstrate that they can do so more efficiently than the government can. In either case, the insurance industry will have a much reduced revenue stream from which to skim money to finance lobbyists, advertisements, and other activities designed to influence the public and members of Congress.

A single-payer system may appreciably reduce the political power of physicians, hospitals, and drug companies by reducing their incomes, and, in the case of hospitals and drug companies, prohibiting any reimbursements for lobbying and limiting reimbursements for advertising. I say "may" because no one can guarantee that the new regulators will take steps to stop these industries from lobbying. I am constantly amazed that so-called "regulated" utilities have oodles of money to advertise and lobby legislators and regulators.

The argument for building on Medicare

If you agree with me that a single-payer system scores better than a managed-care or large-deductible system on cost, quality, privacy, and democracy, then you're ready to think about the politics of establishing a single-payer. How should we go about enacting a single-payer system? Should we introduce a bill to establish the complete single-payer system, or should we establish a single-payer in phases? If we phase a single-payer in, should we use Medicare as a cornerstone around which to build a complete single-payer? Should we concentrate on the federal or state level?

There is no reason why we can't employ all strategies simultaneously. There is no reason why we couldn't simultaneously introduce single-payer bills and bills that enact components of a single-payer, and there's no reason why we couldn't simultaneously introduce both types of single-payer bills in Congress and state legislatures. But if I were restricted to one strategy, I would endorse a phased in federal strategy using Medicare as the cornerstone. The reason I prefer to build in stages is that it avoids rousing all the enemies of a full-blown single-payer bill at once. The complete Russo-McDermott-Wellstone single-payer bills, and the single-payer bills introduced in many state legislatures during the 1990s, infuriated every powerful interest at once – the health insurance industry (which didn't want to be put out of existence), the doctor organizations,

hospitals, drug companies, and equipment manufacturers (which hated the thought of lost income from budgets and price controls), employers (who disliked the payroll taxes virtually all single-payer bills relied on to some degree), and conservatives (who disliked tax increases to pay for the uninsured). If we were to take on, for example, just the issue of price controls on drugs, we would have “only” the powerful drug industry fighting us tooth and claw. Conservative groups that are not players in the health-care industry would join the drug industry (the Chamber of Commerce, for example, can always be counted on to take the wrong side in any aspect of the health reform debate), but these groups would not fight with the ferocity of someone whose interests are being attacked directly.

I prefer to build on Medicare rather than start from scratch because Medicare is a known commodity, it is very popular, and it has already demonstrated its efficiency. America’s familiarity with Medicare is its greatest asset to the single-payer movement. It’s a lot easier to explain what “Medicare for all” means than it is to explain “universal coverage under a single-payer plan.” Moreover, Medicare already resembles a single-payer. First, it is the only payer for Medicare beneficiaries (for the services covered by Medicare) for the entire elderly population and a portion of the disabled population. As the sole payer for this population, Medicare enjoys the extremely low overhead costs typical of all single-payer insurers. Second, Medicare sets limits on what physicians and hospitals can charge.

These single-payer features have allowed Medicare to outperform the private sector. Medicare’s greater efficiency is not obvious if you merely compare the growth rates in *total* spending by Medicare and the private-sector, something Republican members of Congress did during the 1992-1996 inflation lull and for a few years thereafter, to justify their claim that Medicare needed to be turned over to the allegedly efficient MCP industry. If we compare growth in *total* spending by Medicare with growth in *total* spending by the nation’s health insurance industry during the 1992-1996 period, the insurance industry appeared to be more efficient than Medicare. During that time, growth in premiums, and in the nation’s total health-care bill, slowed considerably, but Medicare’s growth rate did not. Consequently, during those years Medicare’s annual growth in total expenditures was higher than the private sector’s. As I have already explained, the slowdown in private-sector spending during the inflation lull was caused primarily by the merger avalanche that ripped through the industry beginning in 1992. Medicare, thankfully, was not part of the industry and was spared the upheaval, and the need to low-ball prices, created by merger fever in the private sector. Republicans, nevertheless, used the private-sector’s brief period of apparent superiority over Medicare as an excuse to call for the privatization of Medicare. Although Republicans continue to press for the privatization of Medicare, we have heard no more nonsense from them about the private sector’s allegedly lower inflation rate since the late 1990s, which is when premium inflation came roaring back.

But a comparison of year-to-year changes in *total* expenditures by Medicare and the insurance industry tells us little about the relative efficiency of Medicare and the health insurance industry because enrollment in Medicare is usually growing faster than enrollment in private-sector plans. The only useful comparison is one which compares growth rates in *per person* spending, not total spending. On this basis, Medicare wins. Between 1969 and 1997, the annual average increase in per capita spending by the insurance industry was 11.4 percent versus 10.4 percent for Medicare.³¹⁰ The difference would have been even greater if the period of comparison had been limited to the post-1983 period. Medicare did not have authority to control spending on hospitals until 1984, and didn’t have authority to impose price controls on doctors until 1992. All Medicare could do before these dates was reimburse hospitals according to the costs hospitals claimed they incurred, and reimburse doctors according to their “usual and customary” fee.

Even per-person-expenditure comparisons, however, are not perfectly comparable. Medicare’s numbers include payment for limited coverage of long-term care that few private policies cover. On the other hand, Medicare’s numbers do not include payments for drugs consumed outside a hospital, which most private policies do cover. But when long-term care and drug expenditures are removed, Medicare continues to outperform the private sector. The Urban Institute compared growth in per capita expenditures for Medicare and the private sector for the decade covering 1984 to 1993 with long-term care and drug expenditures subtracted out. Medicare outperformed the private sector eight out of those ten years.³¹¹

Medicare has achieved greater efficiency than the private sector has with low overhead costs and the ability to set limits on what it pays doctors and hospitals. Medicare has always outperformed the private sector in the insurer overhead department because Medicare doesn’t spend money on all the administrative functions private-sector insurers do. We went over this in Chapter 6. Table 11-3 makes the point again in a slightly different and perhaps more memorable way. It compares the number of Aetna Humana, and Medicare employees (the Aetna and Medicare figures are for 2000, the Humana figures are for 2002). Medicare, as always, was the nation’s largest health insurer in 2000, public or private, and Aetna was the nation’s largest private-sector health insurer. (United Health Group is now the nation’s largest private insurer.). The first thing you notice about Table 11-3 is that Aetna had ten times as many staff as Medicare, yet Aetna insured half the number of people Medicare did. Aetna insured 483 people for every employee, while Medicare insured 10,000 people for every employee. The Medicare figure of 10,000 people insured per employee is 21 times more than the Aetna figure of 483. In other words, if we measure efficiency by comparing the ratio of the number of employees to the number of insured, Medicare is 21 times more efficient than Aetna.⁷³ Humana’s employee-to-insured ratio is nearly identical to Aetna’s.

The other advantage Medicare has had over the private sector has been its ability to set relatively low payment rates to hospitals and doctors. Since the late 1980s, Medicare has been paying doctors and hospitals approximately 70 percent of the rate private insurers pay.⁷⁴

11-3: Private-sector insurers are much less efficient than Medicare: Comparison of Aetna, Humana, and Medicare, people insured per employee

| | <u>Number of employees</u> | <u>Number of insured</u> | <u>Number of insured per employee</u> |
|-----------------|----------------------------|--------------------------|---------------------------------------|
| Aetna (2000) | 40,000 | 19.3 million | 483 |
| Humana (2001) | 13,500 | 6.6 million | 488 |
| Medicare (2000) | 4,000* | 40.0 million | 10,000 |

⁷³ Since 1977, when HCFA (now the Centers for Medicare and Medicaid Services) was created, HCFA’s total number of employees has always hovered around 4,000. This fact was stated in an open letter to Congress from 14 well known health policy experts published in the January/February 1999 edition of *Health Affairs*. “When HCFA was created in 1977,” they wrote, “Medicare spending totaled \$21.5 billion, the number of beneficiaries served was twenty-six million, and the agency had a staff of about 4,000 full-time-equivalent workers. By 1997 Medicare spending had increased almost tenfold to \$207 billion, the number of beneficiaries served had grown to thirty-nine million, but the agency’s workforce was actually smaller than it had been two decades earlier” (Stuart Butler et al., “Crisis facing HCFA and million of Americans,” *Health Affairs* 1999;18(1):8-11, 9).

⁷⁴ In 1990, Medicare paid doctors 70 percent of the private-sector rate. In 1996, Medicare paid doctors 71 percent of the private rate (Physician Payment Review Commission, *Annual Report to Congress 1996*, Washington, DC, 1996). In 1990, Medicare paid hospitals at a rate equal to 70 percent of the private-sector rate (my calculations based on figures presented in Congressional Budget Office, *Single-Payer and All-Payer Health Insurance Systems Using Medicare’s Payment Rates*, Washington, DC, 7).

* Gormley and Boccuti (see “sources” below) stated that the Health Care Financing Administration (HCFA, the former name for the agency that runs Medicare) had 4,219 employees in 1999. Because the number of employees for Aetna was obviously rounded off, I rounded off the numbers for Humana and HCFA as well.

Sources: Aetna statistics are from Bill Brubaker, “Aetna’s unmet claims,” *Washington Post*, February 25, 2001, F1; Humana’s number of insured is from “Humana will cut 2,300 jobs, 3 centers,” *Chicago Tribune*, December 6, 2002, <http://www.chicagotribune.com/features/health/chi-212060260dec06.0.7574395.story?coll=chi-leisurefamily-hed>; Humana’s work force figure is derived by the author from numbers reported in the *Chicago Tribune* article; Medicare insured number from Earl Dirk Hoffman et al., “Overview of the Medicare and Medicaid programs,” *Health Care Financing Review* 2000;22(1):175-193; Medicare employees figure is from William T. Gormley, Jr., and Cristine Boccuti, “HCFA and the states: Politics and intergovernmental leverage,” *Journal of Health Politics, Policy, and Law* 2001;26(3):557-580.

Medicare is more efficient than the private sector even though Medicare labors under the disadvantage of having to pay MCPs that enroll Medicare beneficiaries far more, somewhere in the range of 5 to 40 percent more, than it would cost Medicare’s traditional program to insure those beneficiaries. In short, Medicare is grossly overpaying the Medicare HMOs that now enroll 14 percent of all Medicare beneficiaries. Congress did not intentionally authorize these subsidies. In fact, in 1983 when Congress changed the way Medicare was to pay Medicare HMOs in order to encourage more HMOs to participate in Medicare, Congress deliberately instructed Medicare to pay Medicare HMOs only 95 percent of what Medicare paid clinics and hospitals which served traditional FFS Medicare enrollees. For example, if the average cost of insuring a senior in the traditional Medicare program was \$6,000, Medicare had to pay Medicare HMOs \$5,700 (.95 times \$6,000) for each senior they enrolled. Congress did this because it was under the illusion that HMOs were more efficient than FFS insurers, including traditional Medicare, and that paying HMOs 95 percent of the per capita cost of insuring the average FFS Medicare enrollee would give HMOs a sufficient incentive to participate in Medicare while at the same time saving Medicare some money. The 95-percent rate took effect in 1985.

What Congress didn’t anticipate was that Medicare HMOs would enroll disproportionately healthy seniors. As we saw in Chapter 9, the seniors Medicare HMOs enrolled were so much healthier than the average FFS Medicare seniors that they cost the HMOs only 55 to 90 percent of what it cost FFS Medicare to insure an average Medicare FFS enrollee. That means that Congress should have authorized Medicare to pay HMOs far less than 95 percent of the FFS per capita cost; the appropriate rate was probably in the range of 75 to 80 percent. By paying HMOs 95 percent instead of 75 to 80 percent, Medicare in effect gave the average HMO a subsidy on the order of 15 to 20 percent.⁷⁵ Despite this handicap, Medicare has contained costs more effectively than private-sector insurers have.

Medicare is not simply cheaper than the private sector. It is more efficient, which means its lower costs are not due to lower quality. Like studies comparing the quality of national health-care systems, studies comparing the quality of the entire Medicare program with the quality of the entire private-sector insurance industry are extremely rare. The one such study I am familiar with was

⁷⁵ In the 1997 Congress attempted to ratchet the 95-percent rate down to 92.2 percent over the period 1998 to 2002. For a variety of reasons, this attempt failed. Today, it appears the rate is *higher* than 95 percent. Nevertheless, the MCP industry continues to lobby for even larger subsidies.

based on a survey of adults over 18 conducted in 2001. The authors of the study divided adults into five categories: those 19 to 64 years of age insured by private-sector group coverage (i.e., employer-sponsored coverage); those age 65 and older insured by Medicare (traditional Medicare and Medicare HMOs); disabled Medicare beneficiaries under age 65; adults insured by Medicaid; and the uninsured. Because the survey did not segregate the responses of elderly people enrolled in Medicare's traditional program from those enrolled in Medicare HMOs, the study's comparisons of private-sector insurers with Medicare was biased in favor of the private sector. Nevertheless, Medicare outperformed the private insurance industry on ten out of twelve measures of quality used in the study. Table 11-4 presents the results for these twelve measures for just the private-sector-insured adults and the Medicare elderly.

Note that the results shown in Table 11-4 are not adjusted for differences in income, health status, and coverage. This is significant because the elderly Medicare beneficiaries were three times as likely to rate their health as fair or poor, were more than twice as likely to have incomes below 200 percent of the federal poverty level, and had worse coverage for a higher premium on average than the nonelderly privately insured. Why is this important? Research shows that people who are sick tend to rate their insurance and their medical care worse than do people who are healthy, and that lower-income people tend to report more access problems than do upper-income people. And commonsense tells us that people who pay more and get less extensive coverage in return should be more likely to complain about their insurance. (The authors did not attempt to quantify how much worse Medicare coverage was. Citing previous research, they merely observed that "Medicare beneficiaries have less comprehensive benefits and often pay higher out-of-pocket premiums than those covered by employer plans pay, and their Part B premiums exceed premiums paid directly by employees for employer coverage."³¹²) Yet, despite these enormous advantages for the private sector – the people it insured were much healthier, much wealthier, and had better coverage that often cost them less – the private sector lost on all but two measures of quality shown in Table 11-4. For example, 64 percent of Medicare beneficiaries rated their insurance "excellent" versus 54 percent of the privately-insured nonelderly. Perhaps most amazingly, Medicare elderly were slightly less likely to report going without care because of cost. Even though they had

Table 11-4: Medicare provides higher quality coverage than the private-sector insurers do: Experiences with insurance and medical care under private-sector and Medicare coverage, unadjusted for income, health status, or drug coverage, 2001

| | Private insurance (ages 19-64) | Medicare elderly (ages 65 and older) |
|--|-----------------------------------|---|
| Insurance is excellent or very good | 54% | 64% |
| Negative insurance experiences ^(a) | 61% | 43% |
| Paid a lot out of pocket for Rx or dental | 37% | 31% |
| Had difficulty getting referral to specialist | 9% | 2% |
| Very satisfied with care | 51% | 62% |
| Rated physician as excellent | 37% | 39% |
| Very confident of future ability to get care | 37% | 50% |
| Went without needed care in past year due to costs ^(b) | 22% | 18% |
| Did not go to dentist in past year due to costs | 18% | 8% |
| Had problems with medical bills in past year ^(c) | 25% | 16% |
| Total out-of-pocket costs >\$500 | 39% | 47% |
| Total out-of-pocket costs > 5% of income | 10% | 29% |

(a) Percents represent respondents who said yes to one of these three statements: “Plan did not pay anything for care respondent thought was covered;” “Plan covered only a part of service;” and, “Reached limit on what plan paid for specific illness/injury.” Private-sector insurers lost by large margins on all three of these three statements.

(b) Percents represent respondents who said yes to one of these four statements: “Did not fill prescription;” “Did not get needed specialist care;” “Skipped recommended test or follow-up;” and, “Had a medical problem, did not visit doctor or clinic.” Private-sector insurers lost to Medicare by small margins on the last three statements, and tied with Medicare on the first one.

(c) Percents represent respondents who said yes to one of these three statements: “Not able to pay bills;” “Contacted by a collection agency for bills;” and, “Had to change way of life to pay bills.”

Source: Karen Davis et al., “Medicare versus private insurance: Rhetoric and reality,” *Health Affairs* (Web Exclusives), October 9, 2002, http://www.healthaffairs.org/WebExclusives/Davis_Web_Excl_100902.htm, Exhibit 2, accessed December 5, 2002.

lower incomes, worse coverage, and higher out-of-pocket expenditures, the percent of Medicare elderly who went without care because of costs (18 percent) was below the comparable figure for those insured by the private sector (22 percent). The private sector managed to win only on the last two measures which indicated the Medicare-insured were likely to pay more out of pocket than the privately insured. Obviously, these two measures were heavily influenced by the much worse financial condition of Medicare beneficiaries. Arguably, these last two measures were so biased in favor of the private sector they shouldn't be treated as useful quality measures.

When the authors of this study adjusted ten of the twelve scores for differences in income, health status, and presence or absence of drug coverage (Medicare elderly tended to have it less

often), the private sector performance looked even worse relative to Medicare's than it looks in Table 11-4. Table 11-5 presents these results in terms of odds ratios. Medicare walloped the private sector on all eight of the measures for which score differences were statistically significant (which means the differences in scores were subjected to a test to ensure that they weren't a fluke). Only on the last measure – out-of-pocket costs exceeded 5 percent of income – did the private sector win, and this difference wasn't statistically significant.

The first line indicates, for example, that elderly Medicare recipients were 2.66 times as likely as private-sector insured to say they think their insurance is excellent. The second line indicates, conversely, that Medicare recipients were only a third as likely as the privately insured to say they had had a negative experience with Medicare in the past year. The second-largest difference appeared in response to a question about the respondents' confidence "of future ability to get care"; Medicare respondents were twice as likely to say they were confident as the privately-insured were. These are enormous differences.

The authors suggested that the Medicare elderly's more positive evaluation of their insurance and access to care could reflect their more stable coverage. Ninety-nine percent of the Medicare respondents said they had been insured the entire preceding year while only 92 percent of the privately insured said that (not shown in their tables nor in Tables 11-4 and 11-5). The authors noted, moreover, that a substantial portion of these 92 percent (they didn't say what portion) had changed plans during the preceding year, which often means changing physicians. I would add that the much greater discontinuity in insurer and physician might have affected responses on the quality-of-care questions as well as the responses to the insurance and access questions.

In short, Medicare resembles a single-payer system in the most important respect – it is more efficient than private-sector insurers of any type. Its overhead costs are much lower, its provider reimbursements are lower, and the quality of its coverage and medical care is better than the private sector's.

Medicare differs, however, from an ideal version of a single-payer system in several ways. The most glaring difference is that Medicare cannot set budgets for hospitals. The reason for that is, of course, that Medicare only insures the 40 million elderly and disabled Medicare beneficiaries, not the entire U.S. population of 280 million. Because Medicare insures only one-seventh of the U.S. population, Congress has never debated, much less acted on, a proposal to let Medicare control hospital spending for the entire population. Medicare has had to settle for what I call "mini-budgets" – payments that cover all costs associated with each hospitalized patient. For example, Medicare has a set payment for patients who are hospitalized for hip fracture surgery. If the patient is particularly healthy and the surgery produces no complications and, therefore, the Medicare payment exceeds the hospital's actual costs, the hospital keeps the difference. Conversely, if the patient is sick, the surgery causes complications, the patient has to stay a long time in the hospital, and the patient ends up costing the hospital more than its Medicare payment, the hospital has to absorb the loss. This mini-budget method is much more expensive to administer than a single annual budget covering all services a hospital provides in one year.

Table 11-5: Medicare provides higher quality coverage than the private-sector insurers do: Experiences with insurance and medical care under private-sector and Medicare coverage expressed as odds ratios (Medicare score divided by private-sector score), adjusted for income, health status, and drug coverage, 2001

| | <u>Odds ratio</u> |
|---|-------------------|
| Insurance is excellent | 2.66* |
| Negative insurance experiences ^(a) | 0.32* |
| Paid a lot out of pocket for Rx or dental | 0.43* |
| Very satisfied with care | 1.70* |
| Rated physician as excellent | 1.37* |
| Very confident of future ability to get care | 2.04* |
| Went without needed care in past year due to costs ^(b) | 0.33* |
| Had problems with medical bills in past year ^(c) | 0.25* |
| Total out-of-pocket costs >\$500 | 0.82 |
| Total out-of-pocket costs > 5% of income | 1.15 |

* Statistically significant

(a) Percents represent respondents who said yes to one of these three statements: “Plan did not pay anything for care respondent thought was covered;” “Plan covered only a part of service;” and, “Reached limit on what plan paid for specific illness/injury.” Private-sector insurers lost by large margins on all three of these three statements.

(b) Percents represent respondents who said yes to one of these four statements: “Did not fill prescription;” “Did not get needed specialist care;” “Skipped recommended test or follow-up;” and, “Had a medical problem, did not visit doctor or clinic.” Private-sector insurers lost to Medicare by small margins on the last three statements, and tied with Medicare on the first one.

(c) Percents represent respondents who said yes to one of these three statements: “Not able to pay bills;” “Contacted by a collection agency for bills;” and, “Had to change way of life to pay bills.”

Source: Karen Davis et al., “Medicare versus private insurance: Rhetoric and reality,” *Health Affairs* (Web Exclusives), October 9, 2002, http://www.healthaffairs.org/WebExclusives/Davis_Web_Excl_100902.htm, Exhibits 3-5, accessed December 5, 2002.

Another difference between Medicare and an ideal single-payer program is that Medicare allows HMOs to insure Medicare beneficiaries. Thanks to huge overpayments from Medicare, most HMOs can afford to add drug coverage to their Medicare coverage for little or no additional premium, and this added benefit has caused millions of seniors to enroll in HMOs. Even if HMOs were saving the taxpayer money, they should be booted from the Medicare program because of the damage they’ve done to quality of care and patient privacy. But they don’t save Medicare money – they are costing Medicare money. They should be booted out of Medicare immediately.⁷⁶

⁷⁶ A similar question is whether Medicare should reduce the role of insurers as claims administrators. Throughout its history, Medicare has contracted for claims-processing services with the nation’s big insurers. Congress should order a study of whether Medicare would save money processing claims itself. Conservatives might want this

A third discrepancy between an ideal single-payer and Medicare is that Medicare's coverage has significant holes in it. The biggest hole is long-term care, and the next biggest is drugs. The out-of-pocket costs that seniors have to pay for hospital and physician services constitute smaller, but still obnoxious, gaps in Medicare's coverage.

Based on complaints from doctors who are sympathetic to a single-payer system, I suspect that Medicare has recently begun to impose too many documentation requirements on doctors. These requirements may be no worse than those private-sector insurers impose, but that's no excuse.⁷⁷ Medicare's paperwork may be excessive, and if so, it should be cut back.

We also need to explore ways to enhance citizen participation in Medicare's decision-making processes. Currently, the average citizen has very little involvement in the making of Medicare policy. Congress functions as Medicare's board of directors, and because Congress is at least somewhat accountable to voters, the public does have much more influence over Medicare than we have over the boards of the big MCPs. But that's not good enough. We should consider creating regional, state, and local citizen boards that would have advisory, and for some issues, decision-making authority. For example, the decision about how many emergency rooms a state or metropolitan area should have, and where those ERs should be, should have extensive input from residents of the area affected. The decision about the number of ERs would have to be made within limits set by national and state citizen boards on hospital spending. However, the decision about where those ERs should be should be entirely up to local residents and should not require national oversight unless the local board violates basic principles of fairness (by, for example, depriving some communities of access to timely emergency services). On the other hand, larger questions affecting the whole nation, such as what services will be covered and how much physicians should be paid, should be made by a national board.

However, despite its defects, Medicare is the most efficient insurer in the country, and is unquestionably the most popular. In any case, it's the closest thing America has to a single-payer. We should build a single-payer system for all Americans around Medicare. Specifically, we should fill the coverage gaps in Medicare, drop Medicare's eligibility age from 65 to zero, give Medicare the authority to set hospital budgets and drug price controls, kick the MCPs out of the program, and reduce Medicare's paperwork. We could then legitimately claim to have the world's best health-care system.

Getting from here to there: Defending traditional Medicare

Unfortunately, the first step we must take in creating a Medicare-for-all program is a defensive one. If we're going to have a Medicare program we want to build on, we must stop the Republicans and their cheerleaders in the health policy community from privatizing Medicare. Since 1995, Republicans have campaigned to convert Medicare from a traditional fee-for-service insurance program into a voucher plan that would force low- and middle-income seniors into MCPs. In its essentials, the plan is nothing more or less than managed competition for Medicare enrollees. Republicans began their campaign by announcing that Medicare will face a financial "crisis" when the baby boomers begin to retire in 2010. Rather than address the obvious problem – the need for more revenue, and revenue from a source other than the regressive payroll tax – Republicans chose

study to examine the question of whether Medicare would be more efficient if all Medicare functions were contracted out. Since we've seen that private-sector insurers have much higher overhead than Medicare, it's difficult to see why the taxpayer should finance yet another study on this issue. However, if it made it easier to enact a Medicare-for-all program, or even to expand Medicare, I would not oppose such a study.

⁷⁷ According to an early 1990s survey of physicians by the American Medical Association, it took doctors equal amounts of time to file Medicare and Blue Shield claims.

to attack Medicare as inefficient and in need of “modernization,” code for “lets make the elderly suffer managed care medicine as the nonelderly have for the last two decades.”

The “crisis” talk is scare talk. One could say, with as much logic, that the nation’s elementary schools faced a “crisis” in the 1950s when the first baby boomers entered elementary school, or that the Pentagon faced a financial crisis during the war in Afghanistan. There was of course no financial “crisis” in public education in the 1950s, and the Pentagon never came close to “bankruptcy” in the months after September 11, 2001. America found the money to give elementary education to the baby boomers, and America found the money to overthrow the Taliban in Afghanistan. Yes, the retirement of the baby boomers will mean Medicare needs more money. But, absent more evidence, one may not leap from that simple conclusion to the conclusion that the existing Medicare program is inefficient and suffering a “crisis.”

Despite evidence that MCPs do not save money for the nonelderly and in fact raise the cost of the Medicare program, Republicans have pressed ahead with their privatization, managed competition scheme. The complete Republican plan was formally unveiled until 1999. However, on October 24, 1995, the public got a sneak preview of what Republicans had in mind for Medicare when Newt Gingrich was caught explaining the plan to a private meeting of Blue Cross Blue Shield executives. According to news accounts as well as a videotape of Gingrich’s speech later released by the AFL-CIO, Gingrich said the traditional Medicare program “would wither on the vine” under the Republican proposal as seniors were induced to leave it and enroll with private-sector insurers.

Republicans began their campaign with legislation that would make it easier for MCPs of all stripes (not just HMOs) to qualify as Medicare insurers and to induce seniors to leave traditional Medicare. This legislation, which created a new “Medicare+Choice” (pronounced “Medicare plus choice”) program within Medicare, became law in 1997 as part of the 1997 Balanced Budget Act (the same law that set up the pilot MSA project within Medicare). Medicare+Choice has been a bust. The nation’s bloated MCPs still can’t make a buck off America’s elderly despite their huge subsidies from the taxpayer and are pulling out of the Medicare program all over the country. Republicans, however, persevere. Their solution is to throw more money at the MCPs in hope that they won’t leave Medicare. They are supported in this effort by most health policy experts. As one member of the health policy establishment put it in 2001, “Remarkably, the policy community’s faith in the competitive model has persisted despite the acutely disappointing performance of Medicare+Choice.”³¹³

When they enacted Medicare+Choice, Republicans were well aware that Medicare+Choice alone was not going to get them what they wanted. They knew that the 1997 law left out a key ingredient of managed competition – financial pressure to induce people to leave their fee-for-service insurer (in this case, traditional Medicare) and enroll in MCPs. Republicans recognized that without financial pressure on seniors to leave traditional Medicare, most seniors would not want to give up traditional Medicare even if more MCPs joined Medicare. Republicans revealed their solution to this “problem” early in 1999 at the final meetings of a temporary commission known as the National Bipartisan Commission on the Future of Medicare. At these meetings, they announced their support for a proposal to strip seniors of their right to whatever care they needed under Medicare and to replace that right with a voucher that seniors would have to use to buy health insurance. This voucher could be used to pay the premium for either a private-sector policy or for access to the traditional Medicare program. You heard me correctly: Republicans want to force the traditional Medicare program to charge a premium. The voucher would be worth just enough to buy an MCP policy but nowhere near enough to pay traditional Medicare’s premium. Why would traditional Medicare be more expensive under managed competition? We answered that question back in Chapter 9 when we explained how MCPs were able to keep their premiums below those of

traditional insurers. MCPs enroll healthier people than traditional insurers do, and MCPs ration care and cost shift in ways that simply aren't available to traditional insurers.

Republicans on the Bipartisan Commission failed to line up the requisite super-majority (eleven of 17 votes) required to endorse their voucher scheme, and the idea sank from public view when the commission disbanded in March 1999. But 18 months later, George W. Bush revived this awful idea. He endorsed the voucher scheme in September 2000 during his campaign for the presidency. Bush, like other Republicans, doesn't use the word "voucher" to explain his proposal. He claims, rather, that he is merely attempting to give seniors "more choice," as if seniors have been clamoring for something other than Medicare to insure them. He does not mention, and at times explicitly denies the existence of, the financial compulsion that lies at the heart of his proposal. "You can choose to keep your current Medicare benefit, exactly the way it is, or . . . you can add to it and you can improve it," he said when he endorsed the Republican voucher scheme on September 5, 2000. "It's your choice." On July 13, 2001, he said, "No change, no threats, no problems," by way of explaining his plan to "modernize" Medicare.

Just as there has never been substantial public support for managed competition, so there is now very little public support for the right-wing's Medicare voucher scheme. "[T]he public has not entirely warmed up to a . . . voucher plan for Medicare," reported the Kaiser Family Foundation in 1996 in a press release explaining a poll it cosponsored with Harvard University. "[O]nly 32 percent favor mandatory vouchers that would be used to purchase private health insurance, while 64 percent favor keeping Medicare as it is today."³¹⁴ But neither the absence of public support nor the dismal performance of MCPs has embarrassed Republicans and health policy experts into abandoning their fantasy that vouchers and competition will improve Medicare. Bruce Vladeck, who administered Medicare early in the Clinton years, offered these acid remarks about the voucher plan: "There is a consensus among the policy elite, the think-tank folks, the academics, but if you tried these ideas with the public, they'd think you were insane. If you listen to beneficiaries, it's not 'choice' they're asking for – they want additional benefits."³¹⁵ This gap between public and expert opinion on whether to turn Medicare into a managed-competition show case is huge. This gap is an asset for those of us working for a Medicare-for-all program. It is the reason why Republicans will fail in their campaign to privatize Medicare.

The most immediate task before those of us who want to preserve traditional Medicare is to prevent Republicans from giving even more money to Medicare MCPs. If Medicare MCPs cannot afford to offer drug coverage for little or no premium, seniors won't enroll in MCPs, and the Medicare+Program will, to use Newt Gingrich's words, "wither on the vine." If, on the other hand, Republicans succeed in increasing the size of the MCP welfare check from Medicare, more seniors, desperate for relief from rising drug costs, will give up traditional Medicare and enroll in MCPs. Republicans will use the increased enrollment in MCPs to confuse the public into thinking MCPs are more efficient than traditional Medicare.

Getting there from here: Phasing in Medicare-for-all

I became a proponent of a phasing in single-payer system 1995. By that time, the national single-payer movement had failed to get a single-payer bill out of either house of Congress, and had succeeded in getting single-payer legislation passed out of just one house in only five state legislatures. In California in 1994, proponents of Proposition 186, a single-payer initiative, were outspent by opponents by a ratio of three to one, and the initiative lost three to one – 73 to 27 percent. In Minnesota, COACT and HCCM had been granted only a single hearing in the state legislature on our single-payer bill, and because we knew we would have lost a lopsided vote if the committee had been asked to vote on our bill, our chief author declined to ask for a vote. I

concluded in 1995, and still believe today, that unless the distribution of power between the proponents and opponents of single-payer changes dramatically, we will never get a single-payer system all at once.⁷⁸

Fortunately for those of us who think the phased-in approach makes sense, there is nothing inherent in the way single-payer systems work that requires that they be enacted all at once. Canada, for example, began phasing in its single-payer system by establishing single-payer, hospital-only insurance, province by province. Once all provinces had set up hospital insurance programs, Canada began phasing in physician insurance, again province by province. Still later, Canada phased in price controls on brand-name drugs. Once you realize that the components of a Medicare-for-all system, or any other ideal single-payer system, can be enacted separately, you can begin to think about alternatives to a strategy of enacting the whole enchilada at once.

Here are the main components of an ideal single-payer system:

- extending coverage to the uninsured (all at once or in stages);
- replacing the insurance industry with one payer;
- giving the one payer or some other government agency the authority to regulate hospital charges (which is not quite the same as setting budgets for hospitals);
- giving the one payer or some other government agency the authority to set limits on doctor fees; and
- giving the one payer or some other government agency the authority to set limits on drug prices.

These five components could be implemented separately or together, and, if separately, in any order. We could, for example, take on first the task of subjecting drug companies to price controls. Obviously, since we haven't created a single-payer yet, some entity other than the not-yet-created single-payer would have to administer the drug price controls. Since I'm suggesting we build on Medicare, Medicare would be the obvious federal agency to take on the task of administering the controls. Similarly, we could pass legislation giving Medicare, or some government agency other than the future single-payer, the authority to set limits on physician fees (after negotiating with physician groups) and hospital charges (after holding hearings at which hospitals present evidence in support of their proposed charges). Once we've done that, we could make Medicare the nation's single-payer by lowering Medicare's eligibility age from 65 to zero, and outlawing the sale of health insurance for any service already covered by Medicare. If we wanted to, we could solve the uninsured problem at the same time by setting up a tax system to replace the current system of voluntarily buying insurance, or we could postpone solving the uninsured problem and deal with it separately.⁷⁹ Once Medicare was responsible for insuring all or most Americans, we could give

⁷⁸ Of all the events that could significantly enhance the power of the single-payer movement, the most likely to occur in the near term is the entry of the AFL-CIO into the ranks of the single-payer movement. The AFL-CIO has never endorsed single-payer and shows no signs of doing so today. But the rising cost of health insurance has worried union leaders for a decade. The double-digit inflation of the early 2000s is causing some union leaders to think seriously about a single-payer system.

⁷⁹ If we decided to postpone solving the uninsured problem, this phase of installing a single-payer could be accomplished one of two ways. We could simply authorize Medicare to begin selling insurance to the nonelderly. Because Medicare is so much more efficient than the private sector, Medicare would probably be able to undersell the private sector and, to quote Newt Gingrich one more time, the private sector would "wither on the vine." But this is not a certain outcome in the current U.S. market where cherry-picking is so rampant. It's possible that Medicare would get stuck

Medicare the authority to set budgets for hospitals, not merely control what hospitals charge for particular services.

Or we could do everything in reverse order. We could insure the uninsured first (by enrolling them either in Medicare or Medicaid), make Medicare the sole payer, and then give Medicare the authority to set hospital budgets, physician fees, and drug prices. Moral of story: The components of a single-payer system need not be installed in any particular order. In my view, the only order that makes sense is one that maximizes the likelihood of victory.

Because the issue of drug prices is so hot now, and will remain so until price controls are enacted, it seems logical to attack the problem of drug prices first. Because the elderly account for most drug purchases, and because Republicans have made it clear they do not intend to enact drug coverage without privatizing Medicare at the same time, the opening battle for drug price controls will probably be fought as part of the war to expand Medicare's coverage to drugs without privatizing Medicare. Once Medicare has the authority to set limits on what drug companies can charge seniors for drugs, we can take on a campaign to extend that authority to drugs purchased by the nonelderly.

A next logical step would be to give Medicare or, if politically necessary, some other government agency (possibly state agencies) the authority to set limits on hospital and physician fees. We would still be functioning within a multiple-payer system, but that's fine; price controls are entirely feasible within multiple-payer systems. Under such systems, all insurers are required to pay hospitals, doctors, and drug companies the same price; they don't get to cut deals just for themselves.

With the cost of health care thus diminished, we could tackle the single-payer and uninsured components, perhaps on two separate tracks. While we fight for legislation making Medicare the sole payer in this country, we could also, for example, fight for legislation expanding *Medicaid* to cover all of the poor, not just some of the poor.

When we get to the point of insuring everyone, we'll have to deal with the issue of how to finance universal coverage. Note that the issue of taxes becomes an issue for single-payer advocates only at the point at which we propose to insure everyone. If we're only focusing on the cost-containment mechanisms of single-payer – one payer, budgets, and price controls – taxes is not an issue. In concept, the question of how to finance universal coverage is a pretty simple issue. The major tax questions raised by any new government program – health-related or otherwise – relate to the *fairness* and *sufficiency* of the taxes, and those fairness and sufficiency issues must be addressed regardless of whether we make coverage universal under a single-payer, managed competition, high-deductible or any other system. I believe, and the people I've worked with in Minnesota believe, that universal coverage under any system, including a single-payer system, should be paid for with progressive taxes, which means taxes that take a rising proportion of income as the taxpayer's income rises. The only progressive taxes in America, at either the local, state or federal level, are the personal income and estate taxes. But estate taxes raise far too little money to function as the

with sicker nonelderly Americans, just as traditional Medicare now gets stuck with the sicker seniors that Medicare MCPs don't want or can't attract. To prevent that outcome, this scenario would also require other reforms, including community rating and laws requiring insurers to accept all applications. A second way to achieve the conversion to a single-payer would be to outlaw the sale of insurance which duplicates Medicare's coverage, and require that Medicare be the sole seller of health insurance to the nonelderly. People wouldn't have to buy health insurance, but if they wanted to, they'd have to buy it from Medicare. This slightly less "voluntary" version of single-payer would reduce the risk that Medicare would end up insuring only the sick nonelderly.

primary source of funding for a universal health insurance program. That leaves the income tax as the only tax that qualifies as both progressive and capable of raising sufficient income to finance universal coverage.

Dealing with Canada-bashing

In Chapter 1, I described a debate between an advocate of managed competition, an advocate of MSAs, and me advocating single-payer, that took place in October 1996. Single-payer won the votes of eight of the 14 participating citizens, managed competition got three votes, and MSAs got zero. Not once during the three-and-a-half hours of discussion did I use the word “Canadian-style system” to describe the single-payer system I was proposing. But when the Minneapolis *Star Tribune* reported on this forum nine days later, the headline read, “Canadian-style care starting to look more attractive to panelists.”³¹⁶

Regardless of our strategy – introducing legislation that establishes a complete single-payer system, or introducing several bills that establish a single-payer system in pieces – our opponents and, to a lesser extent, the media will convey to the public the impression that our proposed American single-payer looks exactly like Canada’s system. It is quite misleading to describe the single-payer proposals put forth by American single-payer advocates as “Canadian-style” or “Canadian-anything” plans. For that reason, I never use terminology that suggests American single-payer advocates want to install “the Canadian system” in America. Canada’s system is, of course, an example of a single-payer system, and, as we saw in Chapter 5, Canada’s health-care system may be slightly superior to ours. But there is a huge difference between Canada’s single-payer and the system proposed by American single-payer advocates: American single-payer advocates are proposing that America continue to outspend Canada and the rest of the world by almost the same huge margins that prevail today. In Table 3-3, we saw that the U.S. spent \$4,270 per person in 1998, far more than second-place Switzerland (\$2,740) or fifth-place Canada (\$2,250). The CBO found that the single-payer bill introduced by Representative Russo in 1991 would have cut total U.S. health expenditures by 9 percent. A 9-percent cut in spending levels in 1998 would have reduced U.S. per capita spending from \$4,270 to \$3,886. The latter number is still a whole lot more – 73 percent more – than Canada’s \$2,250. Even if we cut spending in the U.S. by 20 percent, which I think is quite feasible, and added no money back into the system to insure the uninsured and those without long-term care, American per capita expenditure levels would still be 52 percent above Canada’s. But neither I nor any other American single-payer advocate is proposing a net reduction in excess of 10 percent.⁸⁰

The difference between Canada’s spending level and the spending levels proposed by American single-payer advocates is very important. If the public understands that American single-payer proponents want American to continue to spend 70 to 80 percent more than Canada, they are not likely to give credibility to claims by single-payer opponents that every alleged blemish in the Canadian system will inevitably be reproduced in an American single-payer. But this difference in spending levels is easily obscured by phrases like “Canadian-style plan.” Opponents of an American

⁸⁰ If waste in the U.S. system is conservatively estimated to be 20 to 40 percent, one could make the argument that single-payer supporters should propose more than a 10-percent cut. I have never asked the Congressional sponsors of single-payer legislation, or single-payer supporters in states other than Minnesota, why they didn’t propose single-payer legislation that would cut more than 10 percent out of the total U.S. health-care bill. I assume their reasoning was identical to mine and that of other Minnesota single-payer advocates, which is: (1) solid evidence on savings achievable by a single-payer is limited to savings on administrative waste, and that evidence indicates savings on this type of waste is on the order of 10 to 15 percent; and (2) opposition to single-payer rises, and the opportunity for scare-mongering by opponents increases, as the size of the proposed cut under single-payer rises.

single-payer plan will compare any American single-payer bill to Canada's system, and will offer exaggerations and falsehoods about Canada's system, no matter what proponents say or do. But that doesn't mean single-payer proponents should make it easy for opponents to get away with obfuscations and lies. But that's what we do by claiming, or letting the media claim, that we want a "Canadian-style" system in America. The first solution to Canada-bashing, then, is not to describe the Medicare-for-all plan as a "Canadian" plan.

That doesn't mean we can or must completely avoid talking about the health systems of Canada and other nations in the course of explaining why a single-payer system is a good system. In fact, some pro-single-payer arguments presented in this book cannot be made without resort to data from other nations. The experience of other countries is particularly useful in documenting three assertions: that the quality of the U.S. system can't explain its high cost (recall, for example, the infant mortality rates for 29 countries in Table 5-10 which showed the U.S. ranked 23rd); that U.S. doctors and hospitals have high administrative costs (the only way to know whether a single payer reduces overhead costs for providers is to compare the overhead costs of U.S. providers to providers in a single-payer system such as Canada's); and that physician fees and drug prices are very high in the U.S. Information from other countries, even though it is limited to these three subjects, may lead even sympathetic listeners to the mistaken conclusion that American single-payer advocates want to bring an exact replica of Canada's health-care system to the U.S. It's important, therefore, that single-payer advocates make it clear that we support an *American* single-payer system – a Medicare-for-all system, if you will – that will continue to spend at levels even with or slightly below the current U.S. spending level.

But even if we make this clear, single-payer opponents will still engage in Canada-bashing. The most common criticism I've heard over the years is the assertion that medical care is rationed in Canada. A second, common criticism is that Canadians must wait for most medical services and, as a result, many drive to the U.S. for health care. A less common myth is that doctors are leaving Canada "in droves" and coming to the U.S. A fourth criticism is that medical care is inferior in Canada.

My short answer to all of these allegations, as I've just indicated, is that the hysterical assumptions about Canada are not relevant because I'm not proposing to bring Canada's system down to the U.S. in a box next week. I'm proposing, rather, an American plan that retains America's whopping expenditure levels. If I have time for a longer answer, I'll offer a few statistics comparing the U.S. and Canadian systems. I have assembled a few of the more telling statistics, some of which we discussed in Chapter 5, in Table 11-6 below. Then I conclude, "Can you imagine what a fantastic system Canada would have if Canada were spending \$4,270 per person instead of \$2,250? That's the system we'll have under an American single-payer."

The claim that Canadians are denied health care, that Canadian patients and doctors come to the U.S. in large numbers, and that Canadian medical care is inferior are all nonsense. We saw in Table 4-2 that Americans are far more likely to say they were denied medical care than Canadians are. We saw in Table 4-4 that Canadians see their doctors more often than Americans do, which suggests Canada's supply of doctors is not suffering from the alleged hemorrhaging of doctors south to The Land of HMOs. Several studies of cross-border patient traffic have concluded that the traffic is miniscule and goes both ways. For example, the GAO reported:

Recent data show, however, that there is very little border-jumping. The Pepper Commission [the bipartisan commission which issued a report on the American system in 1990] and the American Medical Association recently conducted informal surveys of American hospital administrators expecting high numbers of Canadian patients. Both groups concluded that few Canadians seek care at American medical centers. Canadians

accounted for less than 1 percent of total admissions in each of the nine border hospitals surveyed by the Association. The

Table 11-6: The quality of Canada's system is as good if not better than the quality of the U.S. system: Comparisons of the U.S. and Canadian health-care systems

* Canada's uninsured rate has been zero since 1971; America's has ranged from about 11 to 16 percent.

* In 1995, our infant mortality rate (the percent of babies who die in their first year) was 8.0 per 1,000 births (19th in the industrialized world) while Canada's was 6.0 (13th). We ranked 20th in male longevity and 19th in female longevity while Canada ranked fourth in both categories (Anderson, *Health Affairs*, 1997).

* A 1995 survey of Americans and Canadians revealed that 12 percent of Americans and 8 percent of Canadians were unable "to get needed medical care" and that 30 percent of Americans and 16 percent of Canadians said they "postponed needed medical care." The survey also found that Americans spent an average of \$993 out of their own pockets for health care compared to \$302 for Canadians (Donelan et al., *Health Affairs*, 1996).

* A 1997 poll found that Canadians and Americans were equally likely to say their hospital services are excellent, but that Canadians were more likely to say their physician services are excellent (37 percent) than Americans were (29 percent) (*The 1998 Commonwealth Fund International Health Policy Survey*, Commonwealth Fund, 1998).

* A study conducted jointly by Canadians and Americans found that Canadian mortality rates were lower for eight of ten types of surgery (including bypass surgery), slightly higher for open prostatectomy, and almost identical for hip fracture repair (Roos et al., *Health Affairs*, 1992);

* A study conducted by the U.S. General Accounting Office reported that Canadians are 5 percent more likely to survive lung cancer than Americans, 4 percent less likely to survive breast cancer, and equally likely to survive colon cancer and Hodgkin's disease (Gorey et al., *American Journal of Public Health*, 1997);

* A study of the quality of care of patients with end-stage renal disease concluded, "Manitoba patients were more than twice as likely to receive kidney transplants as U.S. . . . patients. No patients in Manitoba used reprocessed dialyzers, compared with 57 percent of U.S. . . . patients. After adjustment for all casemix and treatment variables, the mortality rate was 47 percent higher in the United States" (Hornberger et al., *Medical Care*, 1997);

* In 1996, the average Canadian saw a doctor 6.5 times while the average American saw a doctor 6.0 times; in 1995, the average hospitalized Canadian spent 12.2 days in the hospital while the average hospitalized American stayed just 8.0 days (*The 1998 Commonwealth Fund International Health Policy Survey*, Commonwealth Fund, 1998);

* The average leukemia patient waits nine months for a bone marrow transplant in America versus ten months in Canada (Silberman et al., *New England Journal of Medicine*, 1994), and Americans

wait five weeks for a knee-replacement surgery while Canadians wait 12 weeks (Coyte et al, *New England Journal of Medicine*, 1994).

Pepper Commission identified Buffalo General hospital, with about 3 percent Canadian admissions, as having the largest share of Canadian patients.³¹⁷

Other estimates report even lower percentages of U.S. hospital admissions attributable to Canadians. According to an article written by two Americans and a Canadian, "[T]he largest hospital network in the [Detroit] region reported that only about 35 of its 35,000 annual admissions were for Canadian residents for 1992-1994."³¹⁸ Detroit, like Buffalo, is right on the U.S.-Canadian border, and its hospitals, therefore, are as convenient for many Canadians as some Canadian hospitals. Yet only 35 of 35,000 admissions – a tenth of one percent – were for Canadians. And of the tiny percent of Canadians who seek treatment in America, most do so because it is convenient or medically necessary to do so. In other words, they either live near a U.S. facility such as Buffalo General, or they are traveling in the U.S. when they get sick.

The only criticism of Canada with any truth to it is the one about waiting lines. For a very small fraction of medical services, waiting lines have developed in Canada. Only on rare occasions are the wait times health-threatening. The province of Ontario recently had to send a small fraction of its cancer patients to the U.S. for radiation therapy because of a shortage of radiation therapists. It is difficult to imagine how the U.S. could suffer from a similar shortage due to the implementation of a single-payer system if the U.S. health expenditure levels remain as high as they are now.

Predictions and closing comments

We've come to the end of our grand tour of the U.S. health-care reform debate. We've seen how our jerry-built health-care system took shape after the Great Depression, and how it fell apart. The first sign that all was not well was the rapid growth in the number of uninsured beginning in the late 1970s. The second unmistakable sign was the double-digit inflation of the late 1980s. The merger madness of the early 1990s and the HMO backlash of the late 1990s were also symptoms of a health-care system suffering from a fundamental disease. The return of double-digit inflation around 2000 was the equivalent of a two-by-four over the head. Even formally ardent managed-care advocates got the message: The American experiment with MCPs has been a bust.

We've examined and rejected the bad advice from the experts about how to get out of this mess. We've seen that the experts' favorite explanation – that Americans get too many medical services – is not supported by the evidence, and that the only fair statement to make about the evidence is that it indicates underuse is at least as prevalent, and may be more prevalent, than overuse. And even if the overuse excuse were correct, we've seen that the experts' solutions to overuse – managed competition and high-deductible policies – are incapable of cutting health-care inflation but are quite capable of damaging quality of care. Managed competition and high-deductible policies are incapable of cutting health-care inflation precisely because they address the wrong problem – volume of services – rather than the real problem – the *price* at which health-care services are sold and the administrative waste, excess capacity, and fraud that force prices up.

If the U.S. had money to burn and no problems other than a sick health-care system to worry about, a single-payer system would not be imperative. We could just raise taxes to whatever level is necessary to ensure that all Americans have health insurance at the outlandish price at which insurance is sold today. But, of course, our resources are finite, and we have numerous other

problems demanding their share of our national resources. Given this reality, it is fair to say that a single-payer system is the best solution to the health-care crisis, morally and financially.

The problem is, single-payer has not yet proven to be politically viable. But that's going to change. At the end of Chapter 2, I predicted that the U.S. would eventually adopt price controls and would probably also adopt a single-payer financing mechanism, but only after muddling through a phase, lasting a decade or two, in which we experiment with high-deductible plans and tax credits. I doubt a single-payer will be adopted in one act of Congress. I predict that a combination of forces will push Congress, and some state legislatures, to enact a single-payer system in stages. The most important of these forces will be the outcome of the national debate about campaign finance reform, American public opinion about health policy, the inability of the health-care system to contain cost, and the aging of the population. I think of the last two forces as slabs forming a gigantic tectonic plate that is slowly but inevitably ramming up against the tectonic plate of public opinion. Sooner or later the pressure created by these two massive plates grinding into one another will create an earthquake or a series of quakes.

The corrupting influence of money on politics will affect the timing of the earthquake. But big money won't stop the quake; it will only delay it. The aging of the population is inevitable, and the health-care system, left to its own devices, is incapable of preventing itself from wasting money and overcharging. The aging population and the inflation-producing tendencies of the system will push health spending up inexorably. But American public opinion is not going to change either. Americans are furious about health-care costs now, and are only going to become more so. Moreover, a big majority of the American public has long held that health care is a right, or if not a right, then a necessity of life that all Americans should have access to in order to participate in our economy and democracy. In 1995, pollster Daniel Yankelovich wrote, "A 1938 Gallup poll reported that 81 percent of adults nationwide believed that 'government should be responsible for medical care for people who can't afford it.' Fifty-three years later the number was 80 percent – a remarkably stable conviction."³¹⁹ Finally, public opinion will not permit the health insurance industry to solve its inflation problem by managing doctors as aggressively as it did during the 1990s. Polls and citizen jury experiments indicate Americans object to cost-control tactics favored by the experts and the dominant insurers that focus on cutting volume of services, and support tactics that concentrate on controlling price.

The only question is when the tension between rising costs and public opinion will erupt into political action, and whether the upheaval that resolves this tension will occur all at once or in a series of smaller quakes. If true campaign finance reform is enacted, the tension will be resolved sooner rather than later. With or without campaign finance reform, I believe the likeliest scenario is a series of reforms that culminate first in expenditure controls (wielded over a multiple-payer system), and then, finally, a true Medicare-for-all program.

The first of these reforms will involve Medicare. I predict Republicans will make a half-hearted effort to privatize Medicare by telling Democrats there will be no Medicare drug coverage without privatization, they will encounter a hurricane of criticism from Democrats and the public, Republicans will back off, and they'll agree to extending Medicare coverage to prescription drugs without "modernizing" Medicare. The debate provoked by the Republican privatization campaign will reveal to one and all how closely aligned the public is with American single-payer advocates. The Republican habit of describing their Medicare plans in euphemisms (e.g., "giving seniors choice" and "modernizing Medicare") has so far prevented a real debate about Medicare privatization from occurring. But as soon as Republicans hold hearings on their voucher plan, a real debate will occur. If Republicans argue that the nation's elderly use too many services and should be pushed into MCPs, the public will express its disapproval, and Democrats will eat Republicans alive. If Republicans argue instead that elderly Americans use too much health care and need the bracing

influence of \$3,000 deductibles, Democrats will also eat the Republicans' lunch. This debate might not be a model of clarity, but it will reveal the basic positions of the opposing camps – the camp which thinks volume is the problem and that competition between insurers of some stripe is the answer, and the camp representing the majority of the public which thinks overcharging and waste are the main problems and that expenditure controls and/or one payer are the answer.

Beyond this battle over Medicare privatization, my crystal ball gets cloudier. I see two possible developments. I see state legislatures enacting components of single-payer systems (drug price controls or large drug-buying coalitions which negotiate low prices with drug companies being the most likely), which will legitimize single-payer and enhance the probability of it being taken seriously by Congress. And I see a gradual consolidation of America's purchasers of health insurance into fewer and bigger buyers, including an expansion of Medicare by lowering the age at which Americans become eligible, an expansion of Medicaid by raising the income below which Americans become eligible, and perhaps a consolidation of employers into large buying groups. If this development takes off, and buyers of health insurance become bigger and fewer, the notion that we're better off with just one buyer will gain more and more credibility.

Citizens and citizen organizations can play a significant role in hastening real reform by keeping the suffering the current system causes in the public eye, and by helping the public, legislators, and the media understand what the real issues are. The media and some newcomers to the health-care reform debate often approach the debate with tunnel vision and to become preoccupied with secondary issues. If they're looking at the problem, they focus on horror stories – this uninsured person died, that HMO patient was kicked out of the hospital too soon, etc. If they're looking at reform proposals, they tend to ask whether a particular type of medical service will be covered under this or that "reform" bill, or whether this or that bill is "politically feasible." These are legitimate issues, but they are not the most fundamental issues. The most fundamental questions are, What are the causes of health-care inflation, and how do we address those causes? If you've read this book, you now know the answer to those questions. I urge you to get involved in the fight for a Medicare-for-all program.

Appendix A

Derivation of My Estimate That Insurance Industry Overhead Averages 15 to 35 Percent

My estimate that the average overhead of U.S. private-sector health plans is in the range of 15-to-35 percent is based on several sources. I discuss them briefly in this appendix.

The official estimate of insurance industry overhead is 12 to 14 percent. This is the estimate of the Centers for Medicare and Medicaid Services (CMS). CMS (which, until 2000 was known as the Health Care Financing Administration) prepares reports annually on how much the U.S. spends on health care. CMS is to national health expenditures what the Organization for Economic Cooperation and Development is to the health expenditures of the industrialized World – it is the mother lode and the original source of health expenditure data.

Table 3-2 shows you the categories of expenditures CMS uses. You'll notice an "insurance overhead" category in Table 3-2. CMS breaks this category into separate subcategories for public and private insurers. CMS also provides total revenues for public and private insurers. Dividing one number into another gives you overhead as a percentage of revenues. This percent ranged between 12 and 14 during the 1990s. But the CMS's 12-to-14-percent figure is low compared to other reports, including financial reports by the health insurance industry itself. The reason, apparently, is that CMS uses a definition of administrative costs that permits some administrative expenditures to be treated as medical expenditures on the ground that they benefited patients somehow. I and many others define administrative costs as costs that do not directly finance health care for patients.

The most straightforward way to calculate overhead is to ask, "What portion of an insurance company's or public program's revenues is paid out to doctors, hospitals and other providers of health care, and what portion is retained by the insurer?" This method does not require haggling over whether a portion of an insurance company's overhead is somehow benefiting patients. Here, the test is simply, What's left over after you paid off claims? Whatever that is, we're going to call it overhead or administrative expenditures. This method is widely used on Wall Street. The ratio of medical expenditures to revenues is so commonly used by Wall Street in evaluating the profitability of MCPs that it has a name – it's called the "medical loss ratio."

I'm unaware of any studies which seek to calculate an average medical loss ratio for the entire health insurance industry – another testament to the lack of interest among experts in the general subject of administrative costs. Here I focus on the nation's four largest insurers (all MCPs) as of 2002. As you can see in Table A-1, United Health Group was the largest private-sector insurer, followed by Aetna, Wellpoint, and Cigna. Together, these four giants insured 57 million people. Table A-1 also lists the overheads – the administrative expenses as a percent of premiums – of these four companies.

These numbers were reported by the companies in filings with the Securities Exchange Commission. They range from 18 percent for United Health Group to 33 percent for Cigna. These figures are far above the 12 to 14 percent reported by CMS.

Table A-1: The four largest health insurance companies and their overhead

| Company | Number of people insured* | Overhead* |
|---------------------|---------------------------|------------|
| United Health Group | 16.2 million | 18% |
| Aetna | 14.4 million | 25% |
| Cigna | 13.3 million | 33% |
| <u>Wellpoint</u> | <u>13.1 million</u> | <u>25%</u> |
| Total | 57.0 million | |

* Data on number insured is for 2002; data on overhead is for 1999.

* Overhead is defined as the percent of revenues not spent on medical care.

Sources: Enrollment data from Milt Freudenheim, "Cigna to feel major loss in customers," *New York Times*, October 29, 2002, C4; overhead figures from Steffie Woolhandler and David U. Himmelstein with Ida Hellander, *Bleeding the Patient: The Consequences of Corporate Health Care*, Common Courage Press, Monroe, ME, 2001, 109.

The only study I'm aware of which sought to calculate an average medical-loss ratio for a substantial portion of the health insurance industry was done a decade ago. The study examined the 1991 non-medical costs of the for-profit "commercial" insurance industry, which meant that all non-profit insurers (notably, Blue Cross Blue Shield companies) and all HMOs were excluded. To give you an idea of which companies were included, the five largest were Prudential Insurance, American Family Life, Principal Mutual Life, Aetna, and Health Care Services. By 1991, some of these insurers qualified as MCPs (that is, they were using utilization review and perhaps other managed-care tools, but, because they did not limit their enrollee's choice of physician, they were not

Table A-2: Administrative costs of traditional insurance companies,^(a) 1991

| | Dollars (billions) | As % of total company expenditures ^(b) |
|------------------------------|--------------------|---|
| Commissions | 8.1 | 12.2% |
| Salaries, wages and benefits | 6.3 | 9.5% |
| Rent and other expenditures | 2.1 | 3.2% |
| Printing, postage and phone | 1.0 | 1.5% |
| Advertising | 0.4 | 0.1% |
| Total | 17.7 | 26.7% |

(a) The source used the term "commercial" insurance companies, defined to mean all for-profit insurers (which, at that time, excluded all Blue Cross Blue Shield companies) that were not HMOs.

(b) Total expenditures by commercial insurance companies in 1991 was \$66.3 billion.

Source: Administrative and total expenditures are from Robert Brandon et al., "Premiums without benefits: waste and inefficiency in the commercial health insurance industry," *International Journal of Health Services* 1991;21:265-283; administrative expenditures as a percent of total expenditures were calculated by the author.

HMOs). For some reason, the study did not include profit in its definition of overhead, possibly because the source upon which the study was based, *Best's Insurance Reports 1991*, did not report profits. Table A-2 below presents the results. You can see that total overhead, not including profit, was almost 27 percent of expenditures, which are generally very close to revenues. Adding profit might well have pushed the overhead figure over 30 percent.

In an article published in 2000, Pauly and Percy presented the results of three studies, broken down by group versus individual insurance, which examined a subset of the nation's health insurance companies. A study by a federal agency which examined 1987 data reported an overhead of 34 percent of premiums for insurers selling group insurance, and 43 percent for insurers selling individual insurance. A 1997 study using estimated 1995 medical-loss data provided by the Health Insurance Association of America (the trade group for the less tightly managed MCPs) reported a 13-percent overhead for group insurers and a 35-percent overhead for individual insurers. And a study of medical-loss ratios by the National Association of Insurance Commissioners (which represents state insurance industry regulators) for the decade 1988 to 1997 reported a 17-percent overhead for insurers selling group coverage in 1995 and a 40-percent overhead for insurers selling individual policies that year.³²⁰ Pauly and Percy also reported that 7 percent of the 148 million nonelderly people covered by private insurance in 1996 were covered with individual policies. Thus, a weighted average of the group and individual overheads reported by these three studies would be closer to the lower group overhead figure than to the individual overhead figure.

Two studies done on Minnesota insurers are consistent with the national studies I just discussed. The most reliable of these two studies was a 2001 report by Minnesota's Attorney General on Allina, a company which, until 2001, consisted of both an HMO called Medica and a hospital chain. The report revealed that the Medica's overhead was "at least" 18 percent in 1998, "at least" 19 percent in 1999, and 19 percent in 2000.³²¹ The Attorney General's estimates are consistent with a document Allina sent to my former employer, Minnesota COACT, in the mid-1990s announcing that Allina customers could expect to get back, on average, 82 percent of the premiums they paid in the form of health-care payments, which means 18 percent was retained by Allina for non-health payments. These 18- and 19-percent figures are much higher than the 13-percent overhead Allina reported to Minnesota's Department of Health for each of those three years.³²²

Another study indicates that Medica's overhead may be much higher than 19 percent. However, because this study was not based on an independent audit, it is not as reliable as the Attorney General's report on Allina. This second study was done by a retired accountant for the Minnesota Physician Patient Alliance (MPPA). (I'm a board member of MPPA.) The accountant went to the Minnesota Department of Health (the agency that regulated HMOs) and asked to see the annual expenditure reports filed by Medica and Minnesota's second- and third-largest HMOs – HealthPartners, and Blue Plus. On the basis of these reports, the accountant concluded the administrative costs of these HMOs averaged somewhere between 12 and 31 percent. The range was this broad because the accountant was unable to determine whether all of the expenditures in a category called "other professional services" should have been treated as medical expenses. This category, per Department of Health instructions, mixes up health-care *professionals* (such as dentists, psychologists, and nurses) with *administrative* employees (janitors, "quality assurance analysts, administrative supervisors, secretaries . . . , and medical records clerks"). This kitchen-sink category accounted for 19 percent of the three HMOs' expenditures. That's why the upper and lower bounds of the accountant's estimate spanned 19 percentage points.³²³

This "other professional expenditures" category appears to be the category into which Minnesota's HMOs began shoveling administrative expenses in the early 1990s as Minnesota's

single-payer movement began criticizing HMOs for high overhead costs. Between 1980 and 1991, HMO reports to the Department of Health revealed a rapid increase in the proportion of HMO revenues going to administrative costs. But, beginning in the early 1990s, these reports suddenly began to show a leveling off of administrative costs and a rapid increase in “other professional expenses.” In 1993, the Citizens League, a corporation-funded good government group, reported:

Medica made an important change in its 1992 annual statement to the Department of Health. . . . In previous years, Medica reported all of the management fee paid to United HealthCare [the national insurance company that Medica hired to “manage” Medica] as an administrative expense. For 1992, Medica allocated a portion of the management fee to medical services. It argued that fees for quality assurance, nurses, and related medical management services provided by United were medical, rather than administrative, costs.³²⁴

Allan Baumgarten, who publishes analyses of the insurance industries of several states, wrote in his 1994 report about Minnesota’s HMOs:

Frankly, . . . some HMOs keep changing their allocation of costs to administration and medical care, and it is hard to be confident that the figures in the state filings portray an accurate picture. . . . Other HMOs have apparently picked up on [Medica’s accounting] change and have also reallocated portions of their management fees paid for utilization review, medical management or sometimes provider relations, to medical costs. This year Group Health [one of two HMOs making up HealthPartners] took note of what others were doing and moved \$9 million in clinic operating costs from administrative to medical costs. The result: its administrative costs per commercial member per month went from \$15.71 in 1992 to \$10.98 in 1993.³²⁵

These bookkeeping games no doubt explain how some HMOs elsewhere in the country can claim to have overhead costs below my 15-to-35 percent estimate, or, in some case, even below the 12-to-14-percent average reported by CMS. In a debate about whether for-profit or nonprofit HMOs are more efficient, representatives of Group Health Cooperative of Puget Sound, a non-profit HMO, claimed their HMO had administrative costs that ranged between 7 and 9 percent of its revenues over a five-year period.³²⁶ The CEO of a for-profit HMO countered with the argument that nonprofit HMOs define some of their “claims processing, provider relations, provider contracting, and membership services [as] medical expenses.”³²⁷ Whether this is true of all nonprofit HMOs, I can’t say. It is certainly true of Minnesota’s HMOs, all of which are nonprofit by law.

The 15-to-35-percent range is my estimate of the range for the *average* overhead for the entire private-sector health insurance industry. Some insurers (such as Group Health of Puget Sound) might fall below the 15-percent boundary, and some definitely fall above 35 percent. For example, the Fort Lauderdale *Sun-Sentinel* reported that some Florida Medicaid HMOs “spend nearly half their budgets on administrative and other non-medical costs.”³²⁸

If the nation’s health policy experts had put as much time and energy into estimating overhead costs as they have into estimating overuse and managed care’s impact on it, we would now be in a position to make a much more accurate estimate of the cost of insurance industry overhead. However, that hasn’t happened. The data we do have is, however, good enough to support my conclusion that the industry overhead average is somewhere between 15 and 35 percent of revenues. Whatever the true average is – 15 percent, 25 percent, 35 percent – it is far, far above Medicare’s 2 to 3 percent figure.

Appendix B

Three Examples of Patients Harmed by Managed-Care Plans Who Could Not Sue

Introduction

In Chapter 9, I argued that legislation granting patients the right to sue MCPs will not make a substantial reduction in the rate at which MCPs deny care or provide inferior care to patients. I referred the reader to this appendix for evidence of how difficult it is for people who have been abused by an MCP to sue. In this appendix, I describe the battles of three patients I worked with that illustrate how easy it is for MCPs to get away with shoddy care.

Kate versus United Behavioral Systems

Malpractice victim number one was a thin, shy and fastidiously polite woman in her thirties whom I will call Kate because she was deathly afraid of anyone ever finding out the depth of her mental health problems. She was given up for adoption by her mother when she was born because her mother was in poor health, but she never developed a close relationship with her adoptive parents. By the time she was 20, Kate suffered from severe depression. By the time she was 30, she was suffering from bronchitis, sinusitis, and an eating disorder (she would alternate between starving herself and going on eating binges).

In 1992, this vulnerable woman was clobbered with two heavy-duty stressors. She discovered, after a long search, who her birth mother was and, to her dismay, that her birth mother had died in a car crash when Kate was two. On November 4 of that same year, her younger brother Jim (the son of her adoptive parents) attempted to kill his girlfriend, and then himself (he was successful at neither). As it turned out, November 4 was also the date of Kate's first appointment at the Metrodome Square Clinic in Minneapolis, a mental health clinic run by what was then called United Behavioral Systems (UBS), a subsidiary of United HealthCare, at that time the nation's second-largest private-sector health insurer after Aetna. Kate was supposed to show up at 11:00 am to take several tests to see what types of services she qualified for (God forbid she should have met a real live therapist right off the bat). But when she woke up on the morning of November 4, she found a message from her brother Jim's girlfriend on her answering machine saying Jim had attempted to kill her and had been taken by ambulance to a hospital because "he wasn't breathing."

Kate was distraught, not just for Jim's sake but for the sake of Jim's two small children. Reasonably enough, Kate wondered whether that day might be the wrong day to take tests designed to assess her emotional state. She phoned a social worker with whom she had been in therapy and asked for her advice. The social worker told her she should keep her appointment but to inform staff at the clinic of what she was going through and let the clinic decide whether she should take the tests that day. But, in part because she was so shy and in large part because the clinic staff had no time for her, she was unable to get any Metrodome Square Clinic staff to discuss this question with her. She took the tests, but even after turning her answer sheets in she could not get anyone at the clinic to talk to her about the distress she was going through at that moment. A receptionist gave her another appointment and told her to come back. Kate left the clinic in tears.

This brusque treatment characterized the remainder of Kate's encounters with UBS and the Metrodome Clinic. The clinic's various personnel refused to diagnose her with depression even

though Kate scored 37 on the Beck Depression Inventory, a score which indicated “extremely severe depression,” and even though seven other mental health therapists (three of whom Kate saw after being rejected by the clinic) stated in writing that she was severely depressed. The clinic insisted that Kate suffered an eating disorder only, and claimed that group therapy on Saturdays was sufficient to treat this disorder. Kate had a hard enough time developing relationships with therapists in one-on-one settings. She was petrified at the thought of group therapy. Although she protested, UBS and the clinic refused to diagnose depression and refused to authorize individual therapy for treatment of any condition.

If you believe the AMA-Chamber-of-Commerce rhetoric about malpractice suits, you're no doubt thinking Kate merely needed to call an attorney and she'd be in court suing the clinic in no time. But, for two reasons, a lawsuit was out of the question. First, Kate could not have expected a large jury award had she sued. She did not commit suicide, and was not disfigured or maimed as a result of UBS's failure to diagnose her accurately. For this reason, and because proving that Kate was depressed and that UBS failed to diagnose depression would require Kate's attorney to pay several psychiatrists or psychologists to testify on Kate's behalf, no attorney would have wanted to take Kate's case. But there was an even more basic reason why Kate never sued. She, like so many other mental health patients in America, could not imagine testifying to a judge or, worse, to a judge and a jury, about her mental state, nor the pain and humiliation UBS put her through. For this reason, Kate never gave a lawsuit a moment's thought.

Barbara Herold versus Allina

The subject of my second horror story had a reaction similar to Kate's. Her name (her real name) was Barbara Herold. Her father, 80-year-old Joseph K, who was insured by Allina, Minnesota's largest HMO, was carelessly misdiagnosed by his Allina doctor and, as a result, he died. (Barb asked me not to reveal her father's last name in order to ensure that her mother's identity was never exposed.) Joseph's injury occurred on Sunday, December 1, 1996. That morning, he slipped on the ice on the sidewalk leading up to his house in Minneapolis while he was feeding the birds in his yard. Joseph was accustomed to physical activity; he played golf in the summer time and drove himself anywhere he needed to go. But this active man died the next Friday, December 6. According to the Hennepin County Medical Examiner's Office, Joseph's death was due to “cardiopulmonary complications” caused by his fall.

Joseph's injuries that Sunday morning hardly suggested his fall would prove to be fatal. A fractured rib, diagnosed that morning in a hospital emergency room, was the extent of his injuries. Fractured ribs can be very painful, so painful you don't want to breath, but they are ordinarily not life threatening. The main risk you run with a rib fracture is that lack of ventilation in the lung, caused by shallow breathing, will permit an infection of the lung to set in. Joseph was told by the doctor at the hospital to see his primary care doctor on Monday. But on Monday, when he went to his Allina clinic to see his doctor, the doctor was not in. A substitute doctor did nothing more than listen to Joseph's lungs to see if they were clear. Although Joseph told the doctor that he had severe chest pain and weakness in his legs, the substitute doctor did not take Joe's temperature or his blood pressure.

Joseph's regular doctor could not see him until about noon on Thursday, about 18 hours before Joseph would die. By then, Joseph was manifesting obvious signs of a severe infection. He was hoarse, had a temperature, was vomiting, and suffered explosive diarrhea that his wife had to clean up because he was too weak to move unassisted. But Joseph's regular doctor took no action when Joseph visited him in a wheel chair on Thursday. He sent Joseph home with instructions (as he put it in Joseph's medical record) to “call or return to the office if not improving.” Joseph's wife

Jerry was flabbergasted at the doctor's inaction, and phoned Barb to tell her she intended to take Joseph to an emergency room. Knowing that HMOs will force patients to eat the costs of emergency room visits that the HMO later determines were not warranted, Barb urged Jerry not to do that until she, Barb, had spoken to Joseph's doctor herself.

Barb reached Joseph's doctor at about 2:30 Thursday afternoon. She reminded the doctor of the terrible symptoms Joseph was suffering and asked why he had done nothing. "He might have the flu," the doctor replied. Realizing this doctor was not about to hospitalize her father, Barb now switched strategies and sought to get the doctor to admit her father to a nursing home. The doctor casually replied that he would send a "nurse evaluator" to see Joseph the next morning. Barb, who lived in Rochester, a two-hour drive south of Minneapolis, spent the remainder of the day making calls to nursing homes near her parents' home so that Joseph could move immediately into a home once the Allina nurse authorized nursing home care. Barb did not trust Allina to find her father a decent nursing home that would be near enough that his wife could visit him regularly.

The next morning, Barb drove through a snowstorm to Minneapolis. She checked out the nursing home she had investigated by phone the previous day, then drove over to her parents' house. She arrived at 9:00 am and walked in. Neither parent was in sight. Her mother emerged from the kitchen.

"Where's Pop?" Barb asked.

"He's gone. He's dead," replied her mother. "They've already taken him away."

Joe had died at about 6:30 that morning. Barb called the Allina nurse to tell her it was too late to do any evaluating. The nurse must have passed the word on to Joseph's doctor, because he called that afternoon. He said he was "shocked." Oddly, the doctor left the country several months after Barb requested her father's medical records. Neither Barb nor her mother ever received an apology from Allina.

Two physicians who examined Joseph's records at my request concluded that Joseph probably died of an infection that got out of control. They based their conclusion on Joseph's symptoms, and his rapid decline. Both thought Joseph's care had been substandard. As I've already mentioned, the county medical examiner found Joseph died from complications of his fall.

Barb and I discussed a malpractice suit at some length. Barb and her three siblings were interested enough in a lawsuit that I spoke to two attorneys about Joseph's case. One turned me down, and the other hinted he might turn me down after he got more familiar with the case. The attorneys said they were unlikely to take the case because of Joseph's age. They said a large portion of the damages awarded to patients are damages for lost years of employment, and that they could not risk sinking \$20,000 to \$40,000 in developing the suit because the award might not cover their costs. Remember, attorneys usually take negligence cases (malpractice is negligence committed by doctors) on a "contingency basis," which means they get nothing if the plaintiff loses and one-third of the award if the plaintiff wins.

I could tell from the lawyers' questions that they were also concerned by the fact that the physicians who had reviewed Joseph's file were not certain about the immediate cause of death; they could only say Joseph *probably* died from an infection. The county medical examiner's statement that Joseph died as a result of his fall was not the equivalent of a statement that he died because of medical treatment he didn't get after his fall. The attorneys gave me the impression that they reasoned as follows: They multiplied a relatively small award times a relatively high risk of not being able to prove that Joseph died of an infection due to lack of medical care, and concluded the case was not worth taking.

But Barb faced an even more intractable problem in the form of her mother's fear of having to testify. Jerry was so traumatized by the sudden loss of her husband that she was often unable to discuss Joseph's death even with Barb, even in the privacy of her own home. Barb said her mother

would sometimes respond to Barb's questions about her father's last days with dead silence, as if her gears had just frozen up inside. Barb knew there was no point in asking her mother how she would feel about testifying. She wouldn't do it. Because Jerry was the only witness, other than Joseph's negligent doctor, who observed Joseph's awful symptoms, her testimony would have been essential. Barb and her siblings never sued.

Linda Harris versus Park Nicollet Clinic

On March 5, 1998, Linda Harris, a Minneapolis resident in her thirties, noticed painful swelling in her right cheek. During the first three weeks of this infection, she was unable to get either her primary care doctor or her ear-nose-and-throat doctor at Park Nicollet Clinic (Minnesota's second-largest clinic after the Mayo Clinic) to do anything to diagnose or treat her infection. This was no minor infection. Three weeks after it began, the infection had grown to the size of a chicken egg, and Linda had stopped sleeping. Four weeks after it began, the entire right side of her face was swollen and she had stopped eating because she couldn't get her jaws to open wide enough to admit food into her mouth. At this point the swelling was so severe that her lower jaw was jutting leftward. On March 30, a Park Nicollet nurse rejected Linda's request to see an ENT doctor immediately and scheduled an appointment for her for the next day with Linda's regular ENT doctor. On March 31, this doctor initially refused to take any action. After Linda badgered him "to do something," the doctor ordered a CAT scan, which showed (upon analysis the next day) that Linda had severe infection in the salivary duct in her right cheek, possibly caused by a stone in the duct.

But Linda's ENT doctor still refused to hospitalize her. Amazingly, he insisted her primary care doctor should do that. On April 2, Linda vomited violently through a slit between her teeth, and was finally admitted to a hospital where she was placed on intravenous antibiotics for four days. The refusal of Linda's doctors to order any test to determine the nature of her infection until March 31, and her ENT doctor's refusal to admit her to a hospital right away, extended Linda's terrible pain for perhaps a week. Linda gradually recovered fully.

I knew even before talking to an attorney that the likelihood of a lawyer wanting to sue for Linda was low. She had suffered outrageous pain for an inexcusably long time, but she had suffered no lasting harm, which means damages would be too low to sustain an attorney's interest in a lawsuit. The two attorneys I spoke to about Barb Herold's case expressed even less interest in taking Linda's case, for precisely the reasons I anticipated.

Conclusions

The three cases I've just reviewed reveal why it is so easy for MCPs to harm patients and get away with it. Enormous obstacles stand between victims of malpractice and initiation of a lawsuit. In two of these cases, the primary obstacle was the unwillingness of the victims or survivors to proceed. I realize this picture of shy and scared Americans expressing horror at having to testify contradicts the image of the voracious American patient who sues at the drop of a hat. But precisely because shy and traumatized people like Kate and Jerry don't appear in courtrooms, the public never hears about them.

In all three cases, "insufficient" damage to the patient constituted another significant barrier to the courtroom. None of the three patients suffered enough damage to make a suit worthwhile. Kate suffered "mere" emotional pain and prolongation of the damage done to her physically by her eating disorder. Joseph K. suffered the ultimate loss, but his suffering was (mercifully) short, and he

was 80 years old, which means he didn't lose a penny in foregone wages. Linda suffered "mere" excruciating pain, her pain was over in a matter of weeks, and she suffered no lasting damage.

A third significant obstacle is the difficulty victims often have in proving (a) that the physician violated the standard of care (this is difficult because American law requires that the standard be proven with the testimony of one or several physicians, which is expensive, and physicians in the same community are often reluctant to testify against one another), and (b) that the violation of the standard of care resulted in harm to the patient. The standard of care that applied to the three cases I've reported would not have been easy to articulate, and the violation of these standards was not as obvious as it is, for example, in cases where the wrong leg is cut off or a sponge is left in the abdomen after surgery. The issues in the cases of Kate, Joseph, and Linda were much more complex. Did Kate have the symptoms of depression in addition to an eating disorder, and if so, what should UBS have done for her? Were Joseph's symptoms of infection obvious enough that his doctor should have known Joseph had to be hospitalized immediately? Were Linda's symptoms of infection serious enough that her doctors should have ordered tests sooner and admitted her to the hospital sooner? I'm somewhat confident that with enough money these three patients could have proven violation of the standard of care, and resulting harm. But that's the rub. Resources for any lawsuit are not infinite, and attorneys have to make judgments about whether they can prove certain assertions to a judge or jury within the constraints of a budget determined by the damages they think they can get.

My personal knowledge of these three cases strengthens my belief that the California and Harvard studies discussed in Chapter 5, which showed that 4 and 2 percent of malpractice victims, respectively, sue, were sound studies. Large numbers of people who are harmed by malpractice never sue. There is, however, an opposite problem: Too many people with no grounds to sue do sue. These legally groundless claims are often brought by people who suffered an injury while being treated, but the injury was not caused by physician negligence. Accidents do happen, and sometimes no one is to blame. This problem of groundless lawsuits is less common than the problem of true victims not suing, but that is no consolation to the doctors who suffer the emotional and financial pain of being sued.

Taken together, these problems – victims of negligence not suing, and people who were not hurt or who were hurt through no fault of the doctor – mean our malpractice system is not good at identifying and compensating real victims of malpractice. I support wholeheartedly further research about how to improve the malpractice system.

However, America should also spend a lot more time researching and debating two other methods of reducing malpractice costs: Reducing medical errors, and creating a national insurance program. The impact of reducing all medical errors is obvious – fewer errors means fewer malpractice suits. In 1999, the Institute of Medicine created headlines across the country when it released a study saying 44,000 to 98,000 Americans die from medical errors every year. The IOM said this problem is so serious that it warrants a national campaign to address it.³²⁹ A national health insurance program would reduce the number of malpractice suits because victims of malpractice (and people who mistakenly think their injuries were the result of negligence) would know that their medical care would be paid for throughout their lives even if they didn't sue. In other words, guaranteeing payment of future medical bills would no longer be an incentive to sue a physician for malpractice.

Appendix C

Analysis of Goodman-Musgrave Estimate of Savings from MSAs

The only estimate I've ever seen of how much high-deductible proponents think high-deductible policies could save for the whole country – the insured plus the uninsured – was a poorly documented argument presented by John Goodman and Gerald Musgrave in their 1994 book, *Patient Power*. They claimed that a system in which all Americans, including those in Medicare and Medicaid as well as the uninsured, were insured by medical savings accounts (MSAs) would cut both administrative costs and the volume of services. Note that this means that many Americans, primarily the sick, would be forced into MSAs. (Note also: Goodman and Musgrave made no assumptions about *price* reductions; they did not assume that patients would bargain with hospital chains and drug companies and thereby reduce price.) Goodman and Musgrave claimed the total savings would come to somewhere between \$94 billion and \$168 billion.

Because they didn't specify the year for which they were making their estimates (which tells you something about how casual their research was), I can't convert these numbers into percentage reductions. They relied on three different studies, all published in different years. To estimate the administrative savings, they relied on a 1991 report by the U.S. General Accounting Office, which estimated administrative spending by the U.S. and Ontario, Canada's largest province, for 1991. If in fact Goodman and Musgrave were estimating MSA savings for 1991, then their lower-range estimate of \$94 billion in savings would amount to a 13 percent reduction in total spending, and the upper-range estimate of \$168 billion would amount to a 24-percent reduction in total spending. These are huge reductions, bigger even than the 5 to 10 percent reductions estimated by the GAO and the Congressional Budget Office for single-payer bills introduced in Congress.

The components of the Goodman-Musgrave estimate are shown in Table B-1. You see that Goodman and Musgrave calculated three numbers – savings from reduced administrative costs, savings from cuts in *volume* (not the price) of medical services delivered to patients, and additional spending required to insure the uninsured. Note that Goodman and Musgrave made no effort to estimate the cost of the fancy insurance policies – policies with “per condition deductibles” – they said would be necessary for those with high medical bills. For the two savings figures shown in Table B-1 (administrative savings and cuts in volume), they calculated low and high estimates. The \$12 billion estimate of the cost of insuring the uninsured is low but in the ballpark given the assumptions underlying it (early 1990s date, and coverage with deductibles and copayments). But the two savings figures are unquestionably overstated. Let's take up the administrative cost estimate first.

Unlike managed-care advocates, who seem never to have heard of the concept of “administrative costs,” MSA advocates have my undying respect for having the brains to recognize that the current system has high administrative costs. Unfortunately, my appreciation must be mixed with criticism; MSA advocates call attention to the MSA's ability to reduce some administrative costs but, like managed-care advocates before them, they utterly ignore obvious increases in other types of administrative costs, notably bank

Table B-1: Goodman-Musgrave estimate of the cost of universal MSA-style insurance: They predict enormous savings through reduced administrative costs and reduced volume of medical services

| Adjustment | Change in costs (billions) | |
|-------------------------------------|----------------------------|---------------|
| | Low estimate | High estimate |
| Savings in administrative costs | | |
| Insurance overhead | -\$8 | -\$17 |
| Physician overhead | -\$5 | -\$10 |
| Hospital overhead | -\$3 | -\$6 |
| Subtotal | -\$16 | -\$33 |
| Savings from cuts in volume* | -\$90 | -\$147 |
| Cost of insuring the uninsured | +\$12 | +\$12 |
| Net change in total health spending | -\$94 | -\$168 |

* Goodman and Musgrave entitled this entry “behavioral response.” his phrase connotes two activities – reducing services, and negotiating price discounts with doctors, hospitals and drug companies. But Goodman and Musgrave based their estimates of the savings in this category upon a study that examined only the impact of large deductibles on the *volume* of services patients seek. The study did not attempt to measure the ability of patients to negotiate lower prices from providers. Therefore, I conclude that my title for this item is more accurate than “behavioral response.”

Source: John C. Goodman and Gerald L. Musgrave, *Patient Power: The Free-Enterprise Alternative to Clinton’s Health Plan*, Cato Institute, Washington, DC, 1994, Table 5.6, 100.

fees and new tax-law enforcement costs, that will be caused by the adoption of their proposal.

Goodman and Musgrave assume, correctly, that if all Americans are insured with MSAs the administrative costs of insurers and providers will fall because they won’t have to cope with all those claims for services that patients have to pay for out of their own pocket. Whether these savings will be as big as Goodman and Musgrave say they’ll be is anyone’s guess. They didn’t do any independent research to arrive at their estimates. They simply took estimates of differences in U.S. and Canadian administrative costs prepared by the U.S. General Accounting Office and, with no explanation, claimed half of these differences for the low estimate of savings achievable by MSAs, and higher fractions for the high estimate.

But, inexplicably, Goodman and Musgrave neglected to estimate the additional administrative costs that will be created when 100 million American households open 100 million bank accounts to hold their MSA deposits. Bank accounts do not grow on trees. They are provided by banks, and banks charge fees for them. Moreover, strangely enough, Goodman and Musgrave neglected to estimate the additional costs required to monitor MSAs to ensure that MSA funds are being used only for approved medical expenses, not unapproved medical expenses or expenditures that have nothing to do with medicine. This monitoring agency will, moreover, have to have an appeal process in place, just as insurance companies do, to handle appeals from patients who disagree with the agency’s determination that a particular expenditure did not qualify as an “appropriate medical expenditure.”

The Internal Revenue Service would presumably play the role of monitor and manager of the appeals process. The IRS already does some spot checking of tax returns of people who deduct approved medical expenses in excess of 7.5 percent of their income. The IRS maintains a list of approved medical expenditures, but the opportunities for confusion among patients and IRS auditors are myriad. The list of approved expenditures includes, for example, acupuncture, but not

the Chinese herbs that many acupuncturists also use. The number of Americans who will have to be audited by the IRS (or some other agency) will rise dramatically if all 280 million Americans are covered by MSAs. I don't know whether the cost of all those MSA bank fees and of more IRS auditors will completely offset the savings from reduced paperwork that MSAs will permit. I do know you can't trust any estimate of MSA savings that doesn't even acknowledge that these costs will be incurred by a health insurance program that relies on MSAs.

Goodman and Musgrave state that the other savings figure – the enormous reduction in medical expenditures shown in Table-appendix B – is “based” on a study conducted by the Rand Corporation between 1974 and 1982 which examined differences in demand for medical care between people who faced large out-of-pocket expenditures and those who faced small or zero out-of-pocket expenditures. This study, which did not include any elderly or disabled people, confirmed the obvious – people who face large deductibles will seek fewer health-care services than people who do not. Since the families who participated in this study didn't attempt to arm-wrestle their doctors, hospitals, and the manufacturers of their drugs into giving them lower prices, the Rand study has nothing at all to say about how successful patients might be if they ever attempted to negotiate lower prices. Goodman and Musgrave, in other words, assumed (correctly) that any savings in medical expenditures would be achieved entirely via reductions in the *volume* of medical services purchased, not in their *price*. And, as I noted above, MSA advocates either admit they don't know whether such a huge cut in medical services would harm those who suffered the cuts, or they assert without documentation that no one would be harmed.

There are, in sum, three big problems with the Goodman-Musgrave methodology. Their estimate of reduced administrative costs due to a reduction in claims insurers have to cope with is based on guesses; they fail to account for the additional costs caused by bank fees and the cost to the IRS or some other agency of monitoring MSAs; and their estimate of savings in reduced volume of services is unaccompanied by any evidence that such savings could be achieved without harming patients.

¹ Glenn Howatt, “Canadian-style care starting to look more attractive to panelists,” *Minneapolis Star Tribune*, October 9, 1996, A15.

² Author's calculation based on figures reported in Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*, Basic Books, New York, 1982, 270.

³ Robert Cunningham III and Robert M. Cunningham, Jr., *The Blues: A History of the Blue Cross and Blue Shield System*, Northern Illinois University Press, DeKalb, IL, 1997.

⁴ Thomas Bodenheimer and Kevin Grumbach, “Paying for health care,” *Journal of the American Medical Association* 1994;634-639.

⁵ *Ibid.*

⁶ Cunningham and Cunningham, Jr., *op cit.*, 81.

⁷ Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*, Basic Books, New York, 1982, 313.

⁸ Marilyn Moon, “Medicare matters: Building on a record of accomplishments,” *Health Care Financing Review* 2000;22(1):9-22.

⁹ All three statistics are from Starr, *op cit.* The 1929 figure is at p. 262. Starr reports that the percent of GNP spent on health care in 1945 was 4 percent (p. 281), and 4.5 percent in 1950 (p. 335). The figure for 1970 is also at p. 335.

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¹² Kenneth M. Coughlin, “After 20 years, HMOs are still challenged to deliver quality,” *Business and Health*, January 1993, 17-23, 17.

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