# THE IMPERATIVE OF ENACTING HEALTH REFORM NOW:

## An Economic Perspective

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**Statement presented to the**

**U.S. SENATE FINANCE COMMITTEE HEARING ON**

**"HEALTH CARE REFORM: AN ECONOMIC PERSPECTIVE"**

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My name is Uwe Reinhardt. I am Professor of Economics and Public Affairs with a joint-appointment at the Woodrow Wilson School of Public and International Affairs and the Department of Economics of Princeton University. My research during the past several decades has focused mainly on health economics and policy, although I also teach courses in general economics and financial management.

I would like to thank you, Senator Baucus, for holding this important Hearing on the economics of health reform. It is an honor to sit at this table to contribute to that exploration.

I also would like to congratulate you, and thank you and your staff, for the vision and great effort that went into your recently released white paper *Call To Action*, which I have read.

**The overarching theme of my presentation today is that the reform of our health system – especially the extension of reliable health insurance coverage to the currently uninsured – should indeed receive the highest priority in the Congress and the new Administration.**

**As I shall argue below, in the decade ahead our traditional employment-based health insurance system is likely to deteriorate drastically for low-wage employees. While the measures you propose to shore up that system can arrest the pace of this deterioration, you are to be applauded for proposing to put in place also a reliable parallel health-insurance system that can capture Americans displaced by the employment-based system and provide them with the financial security citizens in all other industrialized nations have long enjoyed.**

**Furthermore, this is one of those rare windows of opportunity in which several factors come together to make health-reform a real possibility, at long last:**

1. **a financially distressed and anxious electorate shell-shocked by the economic turmoil that the financial markets have visited on the real economy,**

2. **a President-Elect deeply and personally committed to improving the health-care experience of Americans and thus likely to provide strong presidential leadership that is the *sine qua non* of successful health-reform, and**

3. **a Congress whose working majority now is equally committed to making health reform a reality and agreeing with the President-Elect on the principles and major design parameters for the needed reforms.**

My formal written statement, which I have submitted to your Committee for inclusion in the official record of this Hearing, falls into several distinct parts, to wit:

*I.* a few brief comments on the reform proposals put forth in your *Call for Action;*

II. a section on the economic imperative of moving towards universal health insurance coverage now;

III. some thoughts on the imperative of attaining better cost-effectiveness for American health care;

IV. a critical reaction to the argument, often made, that we must have better cost control for American health care before admitting millions more to the club of well insured people.

As an American *citizen* whose social ethic was forged in countries with health systems based on the *Principle of Social Solidarity* – Germany and Canada -- I naturally hold ingrained views on the *moral dimensions* of the issues before this Committee. In my role as an *economist*, however, I shall try not to dwell in this testimony on those moral dimensions, which in any event are well understood by the members of this Committee and their staff.

## I. SOME BRIEF COMMENTS ON THE PROPOSALS IN *CALL FOR ACTION*

For starters, I would like to express my full support for the broad outlines of your health-reform proposals in *Call to Action*. Although that may come across as pandering, I can say this with a straight face, as I had published in the early 1990s a health reform proposal with similar building blocks. For the record, I have appended that paper hereto as Appendix A.

**The basic Design Parameters:** Specifically, I then had advocated the following features that were designed to build health reform on the existing American system, rather than to scrap it and replace it with an entirely new approach. Prominent among these features were:

1. a mandate on the individual to be insured administered to the extent possible through the tax system;

2. building on the present system, rather than scrapping it;

3. a reorganization of the market for individual health insurance through what then was generally called a "Health Insurance Purchasing Cooperative (HIPC)" and your proposal calls a "Health Insurance Exchange";

4. choice of insurance carriers and policies through either an employer or through the HIPC;

5. The inclusion in that choice of a government-run health insurance plan for Americans under age 65 (in my proposal simply by permitting a buy-in into Medicare or Medicaid);

6. Means-tested public subsidies for the purchase of health insurance.

In addition to these features, I had also advocated the elimination of the unseemly price discrimination that is rampart throughout the American health system – a

feature more commonly known as “cost shifting” among payers. I shall return to that issue later in this Statement.

In view of the similarity of these design parameters with those embedded in your *Call for Action* it should come as no surprise that I support wholeheartedly the proposal you have put before the Senate. That proposal can look to the already operating Massachusetts plan for empirical support. It is also fully compatible with the proposal put forth during the election campaign by President-Elect Obama, whose support and leadership on this issue will be crucial to successful health reform.

Yours is a pragmatic approach adapted to the unique history of health insurance of this country and solidly build on it. That should make it more acceptable, because it forces no one to give up what they currently have and yet gives Americans added choices in the market for health insurance. Harry and Louise need not be exercised at the prospect of it, other than being put on notice that freeloading in health care is not acceptable.

**The Issue of Mandating Insurance**: Although the proposal to mandate the purchase of health insurance on the individual is likely to be the most controversial design feature proposed in *Call to Action*, I have always favored it for a very simple reason: people who expect society to come to their rescue with possibly hundreds of thousands of dollars of health care in case they fall seriously ill should be required, when they are healthy, to make contributions based on their ability to pay into a health insurance fund that will then pay for such care. Simply to go uninsured when healthy is to freeload off others when sick. It violates the basic tenets of civic conduct and fairness.

Furthermore, from a strictly economic perspective, leaving the individual free to choose whether or not to be insured is incompatible with a reorganization of the insurance market that imposes *community rating* and *guaranteed issue* on health insurers. Such an approach would invite egregious adverse risk selection on the part of the insured, who could afford to go without insurance when healthy in the comfort of knowing that they are entitled to health insurance at a community-rated premium when sick. As every economist and actuary appreciates, this type of adverse risk selection ultimately leads to the so-called “death spiral” of the community-rated risk pools.

The only way to curb such adverse risk selection under voluntary insurance coverage would be to impose a long waiting period – say, 5 years or more – between an application for insurance and a community rated premium, and offering only medically-underwritten insurance with very high premiums in the meantime. One could even contemplate outright denial of certain kinds of care.

**The Health Insurance Exchange**: Another feature of your proposal may trigger accusations of a “government take-over” of health care or of a regulator coming between you and your health insurer” will be the Health Insurance Exchange you propose. Harry and Louise may come back from retirement.

Your proposal is nothing of the sort.

In effect, the Exchange you propose is merely the analogue of a farmer’s market for health insurance policies. These policies are so-called “contingent financial contracts” that pay benefits when certain contingencies – here illness – occur. When these

contingencies are defined by smart lawyers in pages of fine print, the contracts become very complex.

As the nation is learning belatedly, but to its great dismay, such complicated financial contracts should be supervised by someone to make sure the contract is sound and that there are adequate reserves to honor it. In large corporations the employee benefit divisions of the human resources department perform that monitoring function. For smaller business firms and for individuals, the Insurance Exchange is an efficient substitute for the employee-benefit department of large corporations. It should be seen as such and not at all described misleadingly as a "government take-over" of health care.

**Subsidies to Small Businesses**: Like President-Elect Obama's proposal advanced in the election campaign, your proposal provides for subsidies to small business firms to help them offer employment-based health insurance to their employees.

By virtue of their low number employees, small business firms have two strikes against them in the market for health insurance.

First, a relatively large part of their premium goes for marketing (including broker commissions) and other overhead costs of insurers. For them the so-called "loss ratio" of insurers – the fraction of the premium "lost" for the payment of health benefits – can be 70% or less.

Second, the premiums charged small business firms are experience-rated (medically underwritten) over the firm's small number of employees. If one or two have fallen seriously ill in one year, it can substantially drive up the premium for all employees in the following year.

These two factors, of course, could be reduced in importance if these firms could join larger risk pools offered through the Health Insurance Exchange. For that reason, the mere size of a small business firm may not be the proper benchmark for the granting of a public subsidy toward health insurance.

As I shall show in the next section, the proper criterion is <u>not</u> firm size but the size of the average wage base that financed employer-provided health insurance. A small law-, engineering-, architectural- or business-consulting firm paying mainly high average salaries is less in need of a public subsidy toward health insurance than a medium size firm with primarily low-paid workers.

**Therefore, I urge the Committee to revisit the issue of subsidies to small business firms to make sure that public funds are targeted on actual need of support, rather than a convenient administrative definition.**

## II. SAILING INTO A PERFECT STORM: THE ECONOMIC IMPERATIVE OF MOVING TO UNIVERSAL COVERAGE NOW

One reason for putting in place now a health insurance system parallel to our traditional employment-based system is that the latter is now sailing into a perfect storm.

That storm will leave parts of the system in tatters, especially among low-wage employers.

**Health Care and Competitiveness:** Although it seems counterintuitive to many business executives, the storm whereof I speak is not that employer-paid health insurance makes American business *uncompetitive* in the global market place. Few economists buy into that story, for reasons I explain in more detail in Appendix B to this Statement.

The distinguished late leader of the United Auto Workers (UAW) Douglas Fraser understood economic theory in this regard when he remarked in a debate with an auto executive[1]:

> "Before you start weeping for the auto companies and all they pay for medical insurance, let me tell you how the system works. All company bargainers worth their salt keep their eye on the *total labor cost*, and when they pay an admittedly horrendous amount for health care, that's money that can't be spent for higher [cash] wages or higher pensions or other fringe benefits. So we directly, the union and its members, feel the costs of the health care system." (Italics added).

Regardless who actually writes the check for the insurance premium to the insurance company, or puts money into a firm's self-insurance pool, all of a family's health spending, including all other cost of living, must be covered out of what economists call the "gross wage base" or the "price of labor" in their analyses. Accountants would think of it as the sum of all the debits an employer makes for an employee to the account "Payroll Expense."

That sum includes all fringe benefits -- including health insurance-- whether officially paid by the employer or the employee. It includes all taxes taken out of the gross wage, whether withheld from employees or officially paid by the employer (e.g., the employer's share of payroll taxes). Finally, that sum includes the employee's cash take-come pay which, in turn, supports all of the spending on any item made by the employee and the family he or she supports.

**Thus, the perfect storm into which more and more Americans are sailing in health care is fueled by the fact that the gross wage base that supports the living expenses of most American families tends to grow at an annual compound rate of less than half the rate at which total health spending per capita grows in this country. Simple arithmetic dictates that this differential growth will inexorably price more and more lower-income Americans out of health insurance. No mechanism is in sight now that could eliminate this divergence in growth rate over the next half decade or more.**

As is shown in Exhibit 1 below, according to the well-known *Milliman Medical Index* regularly published by the benefit-consulting firm Milliman, Inc. the total annual health care cost of a typical privately insured American family of four is now $15,600[2] The exponent on the equation In Exhibit 1 indicates that the average annual compound growth rate of this index has been 8.9%. It has been closer to 8% since 2004.

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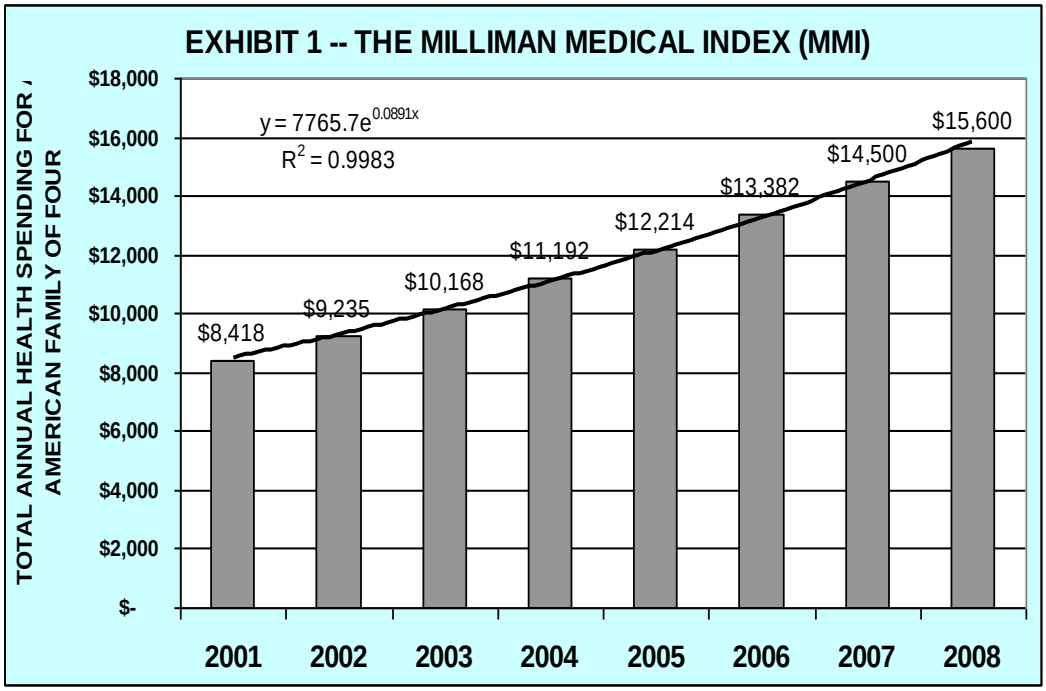
[1] Douglas Fraser, "A National Health Policy Debate," *Dartmouth Medical School Alumni Magazine* (Summer, 1989): 10.

[2] http://www.milliman.com/expertise/healthcare/products-tools/mmi/pdfs/milliman-medical-index-2008.pdf

The total of $15,600 for 2008 represents the sum of (1) the part of the health insurance premium paid by the employer, (2) the part of the premium paid by the employee and (3) the family's out-of-pocket spending for health care. In 2008, the total employment-based premium for family coverage averages about $12,600, of which an average of 26% is contributed by the employee.[3] Out-of-pocket spending therefore appears to average around $3,000.

Regardless of the relative size of these three components, and regardless of who writes the check for it, the entire total health spending on 2008 of $15,600 for the family must be supported by the family's 2008 gross wage base in the labor market, as I have defined that term.




Consider now a family of four with a current, 2008 total gross wage base of $60,000. It could be a two-earner household with a take-home pay between $35,000 and $40,000. It would not be a destitute American family. Rather, it would be a family in the lower-middle income classes. The median money income of American households under age 65 currently is slightly more than $55,000 which means that about half of all such households have a money income below that figure.

A household's money income is, of course, lower than the gross wage base that begets that income. Even so, it seems safe to say that roughly a quarter to a third of American households now derive their money income from a gross wage base of $60,000 or less.

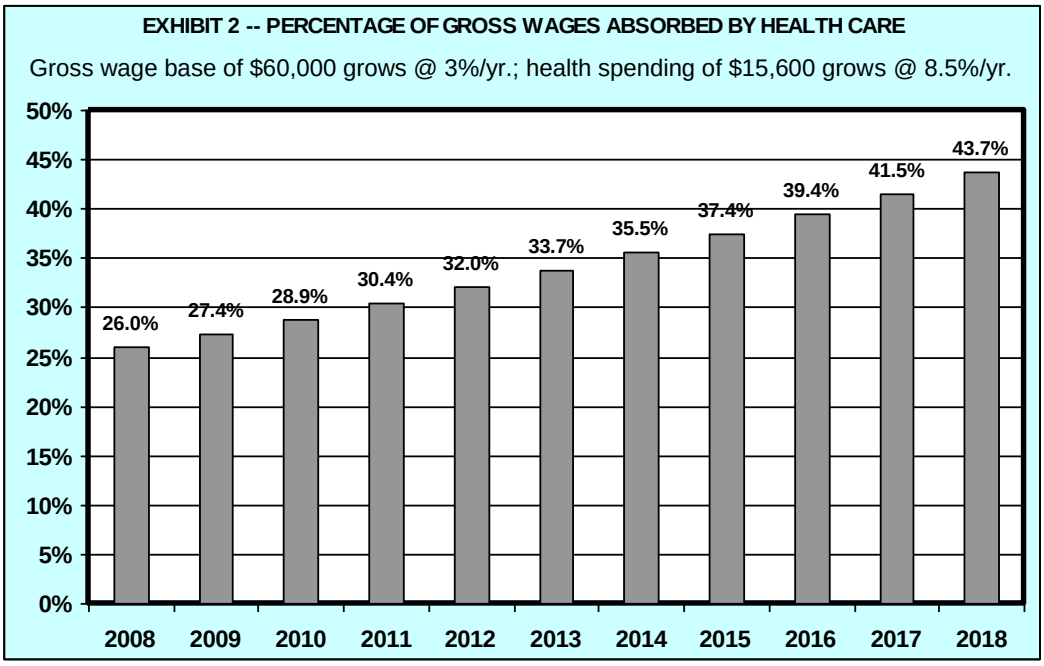
Assume now the skill levels of the family's breadwinners is such that their gross wage base will grow at an annual compound growth rate of 3%, roughly the annual

[3] The Henry J. Kaiser Family Foundation and Health Education Research trust 2008 Survey of Employer Health Benefits; Exhibit 2 (http://ehbs.kff.org/images/abstract/7814.pdf).

compound rate at which average weekly nominal wages (not adjusted for inflation) have grown for the whole U.S. over the past two decades.[4] At that rate, the wage base would have grown from $60,000 in 2008 to $80,600 by 2018.

But if health spending for the typical family continued to grow at an annual compound rate between 8% and 9% -- say, 8.5% -- then the total health spending for such a family ten years hence would be $35,300. That would be as much as 44% of the family's projected gross wage base of $80,600 in 2018.

Exhibit 2 below illustrates how the bite that health spending takes out of the gross wage base grows inexorably over time. For the many American families with a gross wage base of less than the $60,000 gross wage base assumed for this numerical illustration, the picture would be correspondingly direer.




These economic trends – the disparate growth between health spending and the wage base that must support it -- will confront American health policy makers in the decade ahead with two quite uncomfortable options.

**Option A**: One option would be to ask Americans in the upper half of the nation's distribution of income to step up to the cashier's window, there to support with higher taxes the traditional health care of families in the lower half of that distribution.

**Option B:** A second option would be to allow the American health system to evolve even more than it already has towards a two- or multi-tiered system, with bare-bones health care and substantial rationing of health care in the lower tiers

[4] See the Economic Report of the President to the Congress 2008, Table B-47 (http://www.gpoaccess.gov/eop/2008/B47.xls).

and the luxurious, no-holds-barred health care most Americans have hitherto enjoyed for families in the upper tiers.

Americans generally believe that the rationing of health care is something countenanced only by other nations. In fact, however, we have already for some time been rationing timely health care for uninsured Americans through the price mechanism, in spite of the safety net provided by the emergency rooms of hospitals and whatever uncompensated care is rendered by physicians. As Hadley et al. have reported in a recent paper published in Health Affairs, health spending per capita for people under age 65 with private health insurance is about $3,915 in 2008.[5] The comparable number for uninsured Americans is $1,686. Unless one assumes that the lower figure represents the right amount of care and the higher figure is driven mainly by waste, one is entitled to conclude that rationing heath care by price and ability to pay has represented a time honored feature of our health system.

Through its inaction so far, Congress has tacitly ratified that approach to rationing. Is Congress prepared to make it official U.S. health policy? If not, then the plight of the uninsured must be addressed by Congress soon.

## III. THE IMPERATIVE OF GREATER COSYT-EFFECTIVENESS

In their policy analyses, economists typically do not advocate just "cost control" or "spending control," which is always interpreted by providers as a legislated reduction in the quality of care.

Instead, economists advocate greater "cost-effectiveness." By this term is meant minimizing the total treatment cost of achieving a given clinical outcome (e.g., reducing blood pressure by a given number of points or wrestling one extra quality-adjusted life year (QALY) from nature through medical intervention.) The flip side of the term is getting better value for the health care dollar. It is heartening to see that this facet of health reform has been given so much attention in your white paper *Call to Action*, with many examples of questionable practices.

**Inexplicable Variations in Medicare Spending Per Beneficiary**: The exhibit below dramatizes the need for greater attention to cost-effectiveness.

This exhibit is taken directly from the final report of the New Jersey Governor's Commission on Rationalizing Health Care Resources (2008), which I had the privilege to chair last year. Shown in this table are the total payments Medicare made in the period 1999-2003 in the last two years of life of deceased Medicare beneficiaries who resided in the hospital market areas of the New Jersey hospitals shown in column 1. These payments are standardized so that they average 1 for the United States. These data were provided to the Commission by John H. Wennberg, M.D., the pioneering researcher who, along with his research associates at Dartmouth University Medical School has alerted the nation for over two decade now with large variations in the use of health care per capita over small geographic areas, such as New Jersey, and over the Unites States as a whole.[6]

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[5] Jack Hadley, John Holohan, Teresa Coughlin, and Dawn Miller, "Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs," *Health Affairs*, September/October 2008; 27(5): w399-w415; Exhibit 1..

[6] See ((http://www.dartmouthatlas.org/).

**Table 6.1:**
**Medicare Payments for Inpatient Care During the Last Two Years of Life of Medicare Beneficiaries (Ratio of New Jersey Hospital's Data to Comparable U.S. Average, 1999-2003)**

| | Inpatient Reimbursements | Hospital Days | Reimbursements per Day | CMS Technical Quality Score |
|---|---|---|---|---|
| St. Michaels Medical Center | 3.21 | 2.34 | 1.37 | 0.91 |
| Kimball Medical Center | 2.32 | 1.26 | 1.83 | 0.95 |
| Raritan Bay medical Center | 1.86 | 1.85 | 1.01 | 0.81 |
| Christ Hospital | 1.83 | 1.83 | 1 | 0.59 |
| St. Mary's Hospital Hoboken | 1.75 | 1.72 | 1.02 | 0.74 |
| Beth Israel Hospital | 1.58 | 1.86 | 0.85 | 0.83 |
| Overlook Hospital | 1.27 | 1.36 | 0.94 | 0.90 |
| Medical Center at Princeton | 1.17 | 1.26 | 0.93 | 0.94 |
| Atlantic Medical Center | 1.11 | 1.12 | 0.97 | 0.89 |

**Source**: Data supplied to the Commission by John H. Wennberg, M.D., Director of the Dartmouth Atlas Project, December 2006.

The number 3.21 for St. Michaels Medical Center in the exhibit indicates that, on average, Medicare spent over three times as much per Medicare beneficiary residing in that hospital's market area than Medicare did on average for all deceased Medicare beneficiaries in the U.S. during the period 1999-2003. By contrast, Medicare spent only 1.11 times as much as the national average for similar Medicare beneficiaries in the Atlantic Medical Center hospital market area of New Jersey. Dr. Wennberg has found similarly large variations in Medicare spending across hospital market areas – for example, in California.[7]

Because these are averages over many patients, they cannot be written off with the protest so often lodged by physicians that "every patient is different," which makes such data meaningless. Furthermore, because Medicare fees are the same across hospitals in New Jersey, these data represent difference in the use of real health care resources, such as patient days in the hospital, days spent in the intensive care unit (ICU) and physician visits per patient.

If one asks hospital executives, as I have, to justify these enormous variations in resource use, they tend to shrug their shoulders with the argument that hospitals are the free workshops of the attending physicians over whose resource use hospital executives have no control. The variations, explain these executives, reflect the different medical practice styles of the attending physicians, who have the authority to conscript the hospital's resources at will. That there is something to the executives' arguments can be inferred also from the fact that quite substantial differences can be observed also in the cost per patient treated for a particular medical condition by different physicians affiliated with the same hospital.

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[7] Laurence C. Baker, Elliott S. Fisher, and John E. Wennberg, "Variations In Hospital Resource Use For Medicare And Privately Insured Populations In California," *Health Affairs*, March/April 2008; 27(2): w123-w134.

After a cocktail or two these executives will go on to explain that economic motives, in the face of the piece-rate (fee-for-service) payment system used for physician compensation, has much to do with the practice style physicians "prefer." That circumstance has persuaded many health policy analysts that a comprehensive health reform must include a bold effort at reforming our payment system for providers.

The dominant thinking is that compensation for care should take the form of one bundled payment for all of the ambulatory and inpatient services and supplies going into the treatment of an episode of illness. I notice that, Mr. Chairman, you call for that reform as well in *Call to Action*. Unfortunately, that approach raises many conceptual and practical problems that must first be overcome through experimentation.

As you also note in your white paper, Mr. Chairman, Dr. Wennberg and his associates have found similarly wide, inexplicable variations in Medicare spending per beneficiary statistically adjusted to be similar across hospital market areas with the entire United States[8]. Broadly speaking, Medicare tends to spend twice as much per beneficiary in the Sun Belt than it does in the Wheat Belt, although there are variations within these broad categories as well.

Research by other associates of Dr. Wennberg – notably Elliot Fischer and colleagues – has failed to detect any correlation between these variations in spending and commensurate variations in either clinical practice processes, clinical outcomes or even patient satisfaction.[9] One pair of researchers has even found a negative correlation between spending variations and the quality of care.[10]

**Variations in Private Sector Payments:** Lest it be said that Medicare is a sloppy purchaser of health care – a common accusation -- let it be noted that similar variations in per-capita spending are found also in the private sector. The only difference between the sectors is that Medicare makes its spending data freely available to health services researchers while private insurers generally do not.

Upon my request as Chair of the previously cited Commission, two private insurers were kind enough to extract some data on payments to hospitals for the Commission. The next two exhibits, taken directly from the Commission's final report, show truly stunning variations in the total payments an insurer pays to different hospitals across a state for the same standard treatment. These payment data, it must be emphasized, do not reflect hospital "charges," that is, the list prices that no insurer ever pays. They are the actual payments made by the insurers to different hospitals in a state for the procedures listed in the table.

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[8] John E. Wennberg et al., *Dartmouth Atlas of Health Care 1999*, AHA Press, 1999 Chapter 1,Table, pp. 33-34 ((http://www.dartmouthatlas.org/).

[9] Fisher ES, Wennberg DE, Stoke TA, Gottlieb DJ, Lucas FL, Pander EL. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. *Ann Intern Med* 2003; 138:273-87., and Fisher ES, Wennberg DE, Stoke TA, Gottlieb DJ, Lucas FL, Pander EL. The implications of regional variations in Medicare spending. Part 2: health outcomes

[10] Katherine Baicker and Amitabh Chandra, "Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care*," Health Affairs Web Exclusive*, April 7, 2004

## Table 6.5:
### Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

| | Appendectomy[1] | CABG[2] |
|---|---|---|
| Hospital A | $1,800 | $33,000 |
| Hospital B | $2,900 | $54,600 |
| Hospital C | $4,700 | $64,500 |
| Hospital D | $9,500 | $72,300 |
| Hospital E | $13,700 | $99,800 |

[1] Cost per case (DRG 167)
[2] Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

## Table 6.4:
### Payments by a N.J. Insurer to Various Hospitals for Four Standards Services, 2007[47]

| | Normal Delivery[1] | CABG[2] | Appendectomy[3] | Hip Replacement[4] |
|---|---|---|---|---|
| Hospital A | $2,178 | $26,342 | $2,708 | $3,330 |
| Hospital B | $2,787 | $32,127 | $2,852 | $3,444 |
| Hospital C | $2,906 | $34,277 | $3,320 | $4,200 |
| Hospital D | $3,187 | $36,792 | $3,412 | $4,230 |
| Hospital E | $3,276 | $37,019 | $3,524 | $5,028 |
| Hospital F | $3,629 | $45,343 | $4,230 | $5,787 |

[1] Mother only, case rate.
[2] Coronary Bypass with Cardiac Catheterization (DRG 547), tertiary hospitals only.
[3] Surgical per diem (DRG 167) with average length of stay of 2 days
[4] Surgical per diem for Total Hip replacement, average length of stay 3 days.

Critics of the Medicare program decry that program as a "dumb price setter." But are the payments described in the two exhibits evidence of a smarter pricing system? What social benefits are actually achieved with this pervasive price discrimination? [11]

Without further research, based on additional data from the insurers, it is not exactly clear what drives these huge variations in payments by private insurers for the same health care services. Is it merely the relative bargaining strength of different hospitals, that is, differences in the negotiated *prices* for the particular services going

[11] For a fuller explanation of the bizarre ways in which American hospitals price their products, see Uwe E. Reinhardt, "The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy," *Health Affairs*, January/February 2006; 25(1): 57-69.

into these standard procedures? Or are these payment variations also driven by underlying differences of the preferred practice styles of the physicians affiliated with these hospitals, which means differences in the *use of real resources* in performing the procedures listed in the two tables above.

**Eliminating Price Discrimination**: It would be one thing if the price discrimination typical of American health care were designed to achieve a higher social purpose – such as the old sliding fee schedules for physicians' services based on the patient's ability to pay. But the price discrimination we now observe in American health care appears to be related mainly to the relative bargaining strength of payers and providers. Indeed, under this system uninsured patients – the weakest payers – often are charged the highest prices for hospital care and prescription drugs.

In my health-reform appended as Appendix A, I had advocated a different payment system. Under that system all hospitals would be forced to base their prices for privately-insured and self-paying patients on the *relative values* inherent in the DRGs used by Medicare. Similarly all physicians would have to base their prices for such patients on the relative values inherent in the Medicare physician fee schedule. If price competition among providers were to be encouraged, each hospital and every doctor could then be free to set the monetary conversion factor that would convert the relative value points into that provider's dollar fees. It would base price competition among providers on a simple, easily understood number that could be posted electronically. A long run goal of this pricing system would be that a given provider of care would charge every patient the same fee for the same service, assuming universal health insurance coverage. The approach would vastly simplify the administration of our payment system and reduce its cost.

While, as noted, the ultimate goal of payment reform has long been thought to be more extensive bundling of the fees for the individual goods and services going into the treatment of standard episodes of illness into one large, bundled fee for the entire treatment, it will be years before current experiments with that approach[12] have progressed to the point where widespread bundling of payments becomes a reality in American health care. In the meantime, the more easily implemented payment reform I advocate may warrant consideration.

**The Need for Greater Transparency and Accountability:** At the moment, the American tax- and premium payer and patients have absolutely no idea why the cost of health care varies so much across their state and the United States. Nor can anyone explain to them what extra benefits they may or may not receive for an average health spending per capita which, as you note in a table in your white paper, is about twice as high in purchasing power parity dollars as the comparable figure in Canada and Europe.

In the face of the general economic distress now befalling many American families through no fault of their own, and the fact that ever more families are inexorably being priced out of health care by health spending that grows over twice as rapidly as the wage base that supports it, several questions come to mind.

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[12] For a demonstration project aimed at bundled payments for health care, see Prometheus Payment, Inc. at website http://www.prometheuspayment.org/.

First, how is it that over some two decades during which Dr. Wennberg's studies have been well publicized, the providers of health care – and especially the medical profession – have never been challenged by either the Congress or by private payers to explain the hitherto unexplained large variations in per capita health spending across the United States?

Second, how is it that the allocation by public and private payers to operations research in health care (otherwise known as "health services research") that could help drive the U.S. health sector towards greater cost-effectiveness has remained miniscule to this day? Specifically, why has Congress never allocated funds specifically to inquire further into the spending variations identified by Dr. Wennberg and his associates?

Finally, how is it that even without being challenged by the rest of society, the providers of health care – especially the medical profession, whose members are the central decision makers in health care – have never felt morally obligated to explain and justify the variations in resource use?

It is to be hoped that, as part of the health reforms now being contemplated by the new Administration and the Congress, the posture of "business as usual" in the health care sector will be abandoned in favor of a *serious*, concerted effort to harvest the economies every student of the American health sector agrees are there to be harvested.

Alas, a concerted drive to greater cost-effectiveness in American health care is a monumental challenge that must overcome both institutional inertia and what I have described for years as Alfred E. Neuman's Cosmic Health Care Equation:

**Every Dollar Health Spending = Someone's Health-Care Income**
(including fraud, waste and abuse)

It will take ingenuity, tenacity and, for legislators, *courage* to tackle this challenge, but tackling the challenge the nation must at long last.

## III. BETTER COST-EFFECTIVENESS BEFORE UNIVERSAL COVERAGE?

Many commentators on health reforms in the past have demanded that we eliminate the pervasive waste in American health care first before letting even more Americans join the club of the well insured. This objection to health reform undoubtedly will be trotted out once again in the months ahead.

. Those who argue that cost control must come before universal coverage may soothe their conscience with the thought that our hospitals' emergency rooms are a good enough substitute for regular health insurance. They are wrong.

First, that system, where it still works, does not deliver timely, cost-effective health care. Research has shown that many hospitalizations and, indeed, deaths could have been avoided through earlier medical intervention.

Second, only in America do we expect hospitals to serve large numbers of patients without being paid for that care at all or, in the case of Medicaid, getting paid

less than it actually costs to render the care. No other country in the industrialized world relies on such an approach, which begets the sometimes unseemly game of cost- and patient-shifting that absorbs an enormous amount of human effort and ingenuity in this country, but has no socially redeeming economic value. It is a game in which “nice guys finish last,” meaning that hospitals that make heroic efforts to serve the poor and uninsured often end up in perpetual financial distress and with dilapidated facilities as society’s reward for that effort.

Finally, the haphazard catastrophic insurance system for the uninsured, kept in place in part by an unfounded government mandate (EMTALA), is likely to fray at the edges as more and more Americans are squeezed out of the employment-based insurance system by the wage—health-spending squeeze described above.

Finally, I cannot resist noting here the irony that those who would make universal health insurance coverage take a backseat to cost control invariably are well protected by comprehensive health insurance coverage. It is a comfortable perch from which to make that argument.

# APPENDIX A

# An "All-American" Health Reform Proposal

***Reforming the U.S. health care system is frequently thought of in absolutist terms: managed competition versus rate regulation; federal versus state administration; and business mandates versus individual insurance purchases. While these choices must be resolved over the long run, the transition to a new health care system will take several years and require more flexible solutions. The "All-American" Deal offers just that. It requires individual households to be insured and allows businesses to voluntarily offer health insurance; relies on the federal income tax system to collect income-based premiums and transfer funds to states through risk-adjusted payments; and lets states manage the disbursement of funds for uninsured residents.***

By Uwe E. Reinhardt

The current debate on the reform of our health system tends to polarize the options. The either-or questions frequently presented include: Should we pursue regulated (managed) competition based chiefly on prepaid capitation, or a regulated, all-payer system based chiefly on fee-for-service payment to providers? Should ours be a federal- or a state-administered health system? Should we mandate business to provide health insurance for employed Americans and their families, or should that mandate be placed on individual households themselves?

These are pertinent questions for a long-run solution. In the short run, however, the choices are unlikely to be as neat. What's needed is a system to take us from where we are now to wherever we may choose to go. The strategy proposed here is designed as such a flexible transition.

This strategy does not commit the nation to either regulated managed competition or regulated, negotiated all-payer rates. It allows some room and time for experimentation with both approaches at the state level. Yet it provides universal health insurance coverage and various forms of cost control, including implicit budgeting. Because the media insist that every proposal have a catchy name, I dub it the "All-American Deal," to signify that it is not just some foreign import. The specifics of the All-American Deal are as follows:

- It would not mandate business to procure health insurance for employees. Instead, it would mandate individual households to be insured, but allow business firms to offer their employees health insurance on a voluntary basis. That design feature should minimize the opposition of small business to health reform.
- It would rely on the federal income-tax or payroll-tax mechanism as a convenient vehicle for the collection of income-based *premiums*, (not to be confused with taxes!), but it would use the states to manage the disbursement of these funds to the providers of health care. The federal government would transfer funds it has collected to the states through risk-adjusted capitation payments that could and, in many instances would, be supplemented by the states with their own levies. The size of the federal fund would implicitly act as a partial budget cap on the health system, although it would not be an air-tight global cap.
- States could manage the disbursement of their health fund for residents not otherwise insured in one of three ways: (1) buy these residents into the federal Medicare program; (2) buy these residents into a qualifying state-run Medicaid program; or (3) fold them into a genuine managed competition administered by a state-run or state-chartered Health Insurance Purchasing Cooperative (HIPC).

## Defining the Terms

Here is a thumbnail sketch of how such an approach might work (See

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Figure 1). A clear distinction is made between the task of collecting the funds in an insurance pool from that of disbursing the funds to the providers of health care. One should always treat these two facets separately when thinking about health care reform, because any financing system for health care could be coupled with any number of alternative disbursement systems. This is an important point often lost in the debate on health policy when, for example, "managed care" or "managed competition" is presented as a complete health insurance program that is an alternative to "play-or-pay" financing. "Managed competition" per se is not a health insurance program at all; it is merely a particular form of cost control that could be attached to any mechanism of financing.

Figure 1 illustrates this point. The health insurance fund at the center could be a publicly administered insurance program, such as Medicare, or the health insurance purchasing cooperative (HIPC) called for by managed competition. The diagram shows that any health insurance fund, privately or publicly administered, is fed solely by private households. Business firms and government merely function as pumping stations along the way, for ultimately they never pay anything for health care. Any outlays for health care they do make always will be recouped from private households in the form of taxes, if government is the pumping station, or in the form of higher prices or lower take-home pay for workers if private employers act as the pumping station.

## Financing: Two Approaches

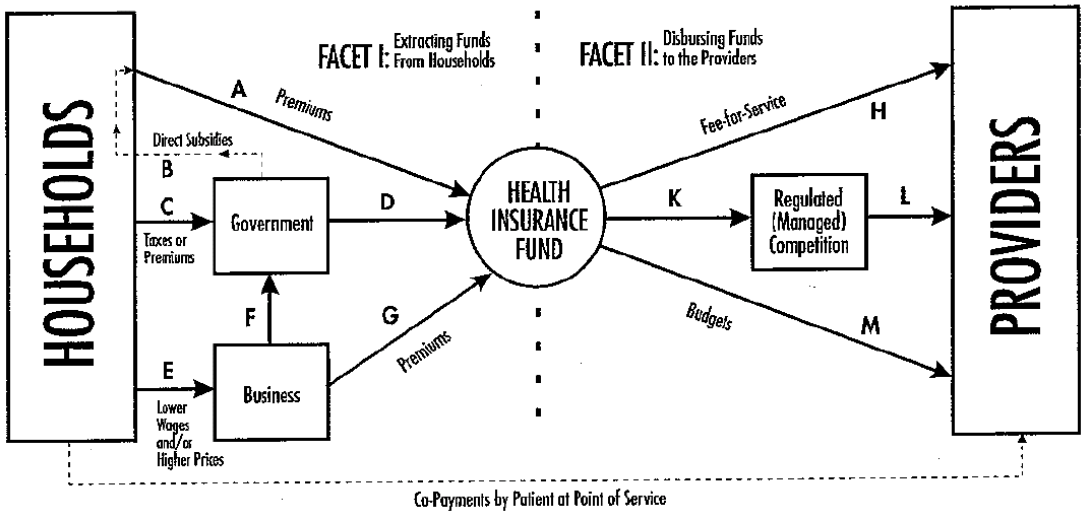
Under the All-American Plan, either the federal government or private employers, or both, could function as the chief pumping station. If government played that role, households would pay an income-based premium, probably along with their income tax, although the premium itself would not really be a tax and should certainly not be described as such in the political arena (Summers, 1988).

On the other hand, if business were selected as the chief pumping station, employers would collect an income-based premium from payroll and remit these premiums to the health insurance fund, such as a publicly administered health insurance program like Medicare, or a state-run HIPC. Our major foreign competitors, Japan and Germany, widely employ this mechanism to finance health care. Once again, however, health-insurance premiums collected at the nexus of the payroll ought not to be described to the public as an ordinary payroll tax.

If government were to be the chief conduit for financing health care, one would include among the income tax forms one strictly devoted to health insurance. On it the taxpayer would indicate either that the household has a private insurance policy at least as generous as a federally specified basic comprehensive package (and attach evidence of that coverage), or enter and pay an income-based premium for the basic package that would be then auto-

**Figure 1**

# The Two Facets of Health Care Financing



matically bestowed upon that taxpayer's household. I call this financing mechanism the "Fail Safe" policy. If written evidence of an adequate private policy were attached to the health insurance form, the household would, of course, be excused from the income-based premium.

As already noted, this payment would be collected in conjunction with the income tax, but it ought not to be confused with a bona fide tax. It is merely a mandated *premium* for which the households receive a well-defined and personal benefit — comprehensive, portable health insurance coverage. A skillful politician ought to be able to make this point clear to the general public.

The income-based premium rate "X" could be a flat percentage of adjusted gross income, or it could be made to increase progressively with income. For example, it might be set close to zero for very low-income households and might reach at its peak, for high-income households, a level equal to the percentage of the gross domestic product the nation spends on health care. The wealthiest households, therefore, might prefer to purchase private insurance policies, particularly if the industry figured out a way to make them available without the enormous administrative loading charges now added to premiums for individual policies. That tendency could be curbed if an upper limit were placed on a family's annual premium.

## Additional Financing

Any system of income-based health insurance premiums requires some transfers of income from high- to low-income households, because the contributions made by the latter will not cover the full cost of their premiums. It is therefore desirable to look at supplementary sources of financing for these required cross-subsidies.

Households above a certain minimum income might be asked to pay, on some line of the regular 1040 tax form, a small, progressive, earmarked indigent care tax (perhaps an average one percent or so of taxable income). I would call it "Membership Fee for the Club of Civilized Nations," so named since the 37 million uninsured Americans are an anomaly among industrialized nations. These funds would be needed to supplement the modest income-based premiums collected from low-income families.

Additional funds might be extracted from earmarked taxes on alcohol, tobacco and gasoline, products known to contribute directly to the nation's health bill. A case can be made for collecting directly from the manufacturers or importers of firearms a very stiff excise tax per gun, with near prohibitive taxes on submachine and machine guns. Distress over the mayhem caused by firearms may have progressed to the point at which a visionary politician could sell such taxes to the body politic.

As noted, many industrialized nations, notably Germany and Japan, collect premiums through the workplace, mainly because payrolls are managed by highly competent people who have little incentive to cheat on behalf of employees. By contrast, income tax forms typically are filled in by less competent individuals who have more powerful incentives to evade taxes.

Politicians frequently prefer health insurance mandates on business to income-based premiums because these premiums are so widely misunderstood as regular payroll taxes. In fact, however, mandated benefits typically are shifted backwards to the employees' paychecks in any event. If an employer spends an average of, say, $4,000 for an employee's health insurance, then the bulk of that amount will be shifted backwards to highly paid and poorly paid employees alike, which makes the mandate highly regressive. Income-based premiums taken out of workers' paychecks are not nearly as regressive.

***Households above a certain minimum income could be asked to pay a small indigent care tax.***

Some savings could probably be squeezed from the Medicare program. Ideally, one would fuse part A (hospital care) and Part B (physician care) into one program and collect from the elderly an *income-related* premium for the package, if only to eliminate the sizable federal subsidy toward health care the high-income elderly now receive. Unfortunately, the political power of that group may stand in the way of that approach, as was so vividly illustrated by the 1989 repeal of the Medicare Catastrophic Care Act.

A case can be made on grounds of both equity and economic efficiency to include in an employee's taxable income part or all of the health insurance premiums paid by an employer on behalf of that employee, at least for employees with an income of $50,000 or more (Butler, 1992; Enthoven and Kronick, 1989). It has been estimated that the elimination of this tax exclusion would yield an estimated $50-to-$60 billion in additional federal taxes, and about $20 billion in additional Social Security taxes. If one phased

out the exclusion, starting, say, at annual incomes of $50,000, with a complete elimination of the exclusion at incomes of $80,000 or more, the added tax yield would, of course, be commensurately less. But it may still be in excess of $25 billion.

Whatever the source of the additional funds that would be required by universal coverage in the short run, Americans must at long last ask themselves whether nation with a $6 trillion economy can really stare some 37 million mainly low-income Americans in the eyes and say: "Sorry folks, we are too poor a nation to extend to you the financial protection every other industrialized nation has been able to extend to its citizens." Among the millions of uninsured are many working mothers and their children. How can we stand by idly, letting these mothers toil on our behalf without health insurance?

## Disbursing the Funds

Approaches to the cash-disbursement and cost-control facet of the Fail Safe system could fall into one of two major categories: purely federal programs and federal-state partnerships.

Under a purely federal program, the federal government could use its Fail Safe fund simply to enroll all Americans who are not privately insured in the federal Medicare program. One major advantage of that approach is its administrative simplicity. All of the requisite infrastructure has already been provided for and is fully operational. Furthermore, all health care providers are fully familiar with the operation of that system. Finally, the approach would provide government with considerable clout on the demand side of the health care market.

One major political disadvantage of the approach, however, is that it concentrates so much power in the federal government. Although Americans sometimes express a preference for that approach in opinion surveys, it is not clear how well an actual move in that direction would be received. Furthermore, while the Medicare program has been able to control the prices it pays for health care, it has had much more difficulty with controlling the volume of services under that fee-for-service system. It is true that other countries have been able to control costs better than has the U.S. with fee-for-service systems. But these countries also use other forms of cost control — capacity limitation and budgets — and they, too, now chafe under the problem of controlling the volume of services.

The federal route, however, is by no means the only cash-disbursement and cost-control option one could couple with the Fail Safe financing mechanism. An alternative would be for the federal government merely to collect funds into a Fail Safe pool and then to distribute that fund to the states in the form of capitation payments adjusted for age, sex, other measurable risk factors and regional cost variations. A mechanism for such risk-adjusted capitation payments already exists for the current Medicare program — the so-called average annual per capita cost (AAPCC), although this adjuster is far from perfect. The individual state could then disburse these capitations (possibly supplemented with state funds) to providers in a manner that suits local customs and preferences, and the existing delivery system.

There are several ways to do this:

**1. Medicare Buy-In:** Some states might prefer to buy their uninsured families into the federal Medicare program. Under this opt-in strategy, a state choosing that option would return the capitation received from the federal Fail Safe program to the federal government and, possibly, be asked to add some funds. This gives states the option of transferring administrative responsibility for health care to the federal government.

**2. Traditional State Insurance Program:** Other states might prefer to run their own public health insurance program — for example, a modified Medicaid program that owns up to the federal standards spelled out for the Fail Safe program. This would still be a government-run disbursement system, albeit a decentralized one.

**3. Managed Competition:** States could also have their uninsured select from a roster of competing private insurance plans under the approach now widely known as managed competition or regulated competition. Under that concept, originally proposed by Princeton's Herman and Anne Somers (Somers and Somers, 1972) and further refined by Minnesota physician Paul Ellwood, MD, Stanford economist Alain C. Enthoven, and a group of analysts known as the Jackson Hole Group, rival networks of doctors and hospitals, such as health maintenance organizations, would be made to bid for enrollees on the basis of a prepaid capitation payment for a specified, basic package of health benefits, all under the supervision of a HIPC.

The HIPC in a region could be the state's health department, or, alternatively, a semi-autonomous, not-for-profit organization chartered by the state. It would coordinate the premium bids submitted by the plans and also collect from each competing plan information on patient satisfaction and clinical outcomes (such

as mortality rates from surgery). That information would be conveyed to consumers, along with the premium bids. The states of California, Colorado, and Florida seem ready to move in that direction.

If the Fail Safe financing scheme outlined above were coupled with some form of managed competition, large parts of the current private insurance industry would survive health care reform. For the approach to work, however, the industry would have to use its extensive resources to enhance the value-to-cost ratio in health care through managed competition and managed care rather than using them to exclude sick Americans from insurance coverage through medical underwriting.

Whether managed competition actually will control costs, as its proponents insist, remains to be seen. The approach has been tried only in small, local experiments — for example, in the California Public Employees Retirement System (CalPERS) — with some encouraging early results. It is not clear, however, how dependent the cost savings of these relatively small, local experiments have been on the ability of providers to shift costs to other payers in the area, nor is it clear whether the savings registered early in the life of these experiments can be sustained over the long run. The cost savings under full-fledged national managed competition are still hypothetical estimates.

## Global Budgets

It is virtually impossible to impose an air-tight national budget upon all types of health spending in a nation as geographically far-flung and as economically heterogenous as is the United States, particular in a health system with multiple payers and approaches to cost control. Absent a single-payer system (such as Canada's) for all health benefits and for the entire nation, attempts at top-down budgeting probably will have to be limited to controlling only segments of national health spending.

***Doctors and hospitals should reveal their fees in terms patients can understand.***

The federal Medicare program has achieved some apparent success with that approach by imposing on Part B of the Medicare program a so-called volume performance standard, which is really an expenditure target. That approach links updates in the fees paid by Medicare in one fiscal year to the degree of deviation from a predetermined expenditure target for the fiscal period two years earlier.

Under the Fail Safe system proposed here, the total funds collected by the federal government via income-based premiums and sundry additional outright taxes would constitute a powerful implicit national budget of sorts. The amount of money in that fund would limit the risk-adjusted capitation payments to the states and, thereby, inevitably the spending by the states on their residents without private health insurance. States still could, of course, spend more on health care if they want. The system would not directly impact that part of health spending which would occur outside the federal-state Fail Safe system. But the spending level of that presumably large system would undoubtedly provide highly visible benchmarks for private-sector spending, and would thereby indirectly exert budgetary discipline upon the whole health system. It can be argued that this less powerful approach to top-down national budgeting would be an easier political sell than other alternatives now being contemplated.

## Streamlining Fee-For-Service

It would probably take more than half a decade to fold the bulk of the American population into managed competition, even if most states chose to move in that direction. In the meantime, it would be helpful if doctors and hospitals were forced to reveal their fees more visibly in terms that patients and their insurers can easily understand.

Traditionally, American doctors and hospitals have billed their patients for each of thousands of distinct services and procedures. These fees, however, have not been based on common fee schedules, nor even common lists of procedures. This lack of uniformity has made it virtually impossible to compare the prices charged by different doctors and hospitals. The resulting lack of price transparency has made a mockery of the idea, so popular among economic theorists, that patients should "shop around" for low-cost doctors and hospitals.

Even a state embracing the concept of managed competition would presumably allow some fee-for-service carriers among the competing plans. In states not moving to managed competition, of course, fee-for-service payment would remain the dominant mode. To facilitate better price transparency in that environment, the government should impose at least common relative value scales, if not common fee schedules, upon all doctors and hospitals. A relative value scale expresses the fees for all procedures as a relative of the

fee for some base unit, for example, a routine, follow-up office visit or an appendectomy. A relative value scale becomes a fee schedule only if the dollar value for the base unit (the so-called "conversion factor") has been set.

***Common relative value scales would greatly reduce administrative hassle.***

Relative value scales of this sort have already been developed by the federal Medicare program for both doctors and hospitals. For hospitals, the government introduced a system of flat fees for some 500 diagnostic-related groups (DRGs) of cases. These fees are based on average accounting costs per case and are based on a well-defined set of relative values that could be extended by law to all private payers as well. For physicians, the Medicare program has developed the so-called resource-based relative value scale, which is based on the estimated relative real resource costs of producing the 7,000 or so procedures in the catalog of physician services. That scale, too, should be extended by law to all private payers.

A policy of imposing common relative value scales upon all payers and providers in the health system would not, of course, be the same as outright price controls, if the government permitted physicians and hospitals to apply their own monetary conversion factors for private patients. In doing this, providers would be able to set the absolute monetary value of the base procedures and, thus, of all other procedures on the list. If these rates were set by each physician and hospital at the beginning of the year, they could then be published in the local newspapers and made available via an 800 number.

Chances are that the publication of this simple price index would drive doctor and hospital fees towards more uniform levels, even without direct price regulation by the government. At least during a transition period towards government-mandated uniformity in fee schedules, this idea may be worth a try. One could, of course, couple the imposition of the federal relative value scales upon the private sector with a ceiling on the conversion factor set for private payers. That would be a partial move toward a true all-payer system based on common fee schedules adhered to by all private payers within a region.

Common relative value scales would greatly reduce the administrative hassle now bedeviling American health care, for they would facilitate the use of electronic billing based on common claims forms and common software. The chaos now reigning in the private fee-for-service sector makes electronic billing difficult and has added billions of dollars to annual health care costs.

## Avoiding Adverse Risk Selection

In the absence of sanctions, the Fail Safe component of the dual-track health insurance system outlined above would be subject to adverse-risk selection. Business firms with relatively older or sicker or lower-wage employees probably would prefer to dump the latter into the federal Fail Safe system, while firms with younger or healthier or better-paid workers would prefer their own private coverage. Similarly, healthy people would tend to favor actuarially fairly priced private insurance; chronically ill persons would gravitate toward the Fail Safe system, driving up its average cost. Such trends could destabilize the system.

Other nations that do operate dual-track insurance systems — for example, Germany — have dealt with that problem by making switches between the two systems cumbersome, slow, and expensive. A German family that opts out of the statutory, semi-private health insurance into the commercial, private system can return to the statutory system only under very rare circumstances, such as a lapse into extreme poverty, (Reinhardt, 1990).

In the dynamic American economy, where a family's economic fortunes can fluctuate substantially over time, it would be difficult to outlaw returns to the Fail Safe system. Even so, it would probably be possible to make the process of switching sufficiently cumbersome and risky to avoid the clever and highly destabilizing cream-skimming that has been the Achilles heel of any multiple-track insurance system, notably the current one.

Finally, business firms that already are offering their employees health insurance might be discouraged from dumping their employees into the Fail Safe pool by a mandate forcing them to increase their workers take-home pay by an amount equal to the health insurance premiums they have hitherto paid (and presumably taken out of their employees' take-home pay).

## The Best vs. The Good

Could the plan outlined above — private insurance alongside the federal-state Fail Safe system — officially sanction a two- or multi-tiered health care system in the United States? It might. Some tiers are in-

herent in the very ideas of "choice", "managed competition" and "supplemental insurance." But the system proposed here would be so much better than the multiple-tier system now in place, which literally offers nothing or brutal rationing as its lowest tier.

Furthermore, Americans favor or at least tolerate a multi-tier approach in many other important human services sectors, notably in education and in jurisprudence. For example, Americans from the entire ideological spectrum, including those who profess belief in the concept of public education, send their children to the nation's better endowed and highly selective private schools, if they have the means to do so. The prospect of being able to impose a truly egalitarian health system upon such a nation appears dim. One should not evaluate proposed health care reforms by highly exacting ideal standards that are unlikely ever to be reached in practice. As Senator Daniel Patrick Moynihan of New York has put it so aptly, in matters of social policy many well-meaning people too often have let the [hypothetical] best become the enemy of the [achievable] good. That approach may make well-meaning people feel good; but it usually ends up hurting the poor.

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# APPENDIX B

## WHO PAYS FOR EMPLOYER-PROVIDED HEALTH INSURANCE?

Currently, employment-based health insurance accounts for about one third of total national health spending. The premiums for the group policies that provide this insurance average $12,600 for family coverage and $4,704 for single coverage. Of those total premiums employees pay through withholds from their paychecks an average of 26% for family coverage and 15% for single coverage. For the remainder, the employer writes the check to the insurance company.[13]

**The question is: who ultimately pays for the employer's part of the premium -- customers in the form of higher prices, owners in the form of lower returns to their investment in the company or employees in the form of lower take-come pay?**

**The Common Perception among Non-Economists**: Most non-economists seem to believe firmly that when an employer pays X% of the health insurance premium for an employee and the latter contributes the balance, that X% is shifted by the employer either forward in the form of higher prices or backwards to the firm's owners in the form of lower return to owners' equity. Because financial capital is globally mobile, the argument goes, employers do not have the market power to shift much if anything of the employer-paid share of health insurance premiums to the firm's owners. Therefore, the argument continues, these costs necessarily must be shifted forward into higher output prices, which can render the firm uncompetitive in the global market for output. All told then, the argument concludes, employers find themselves increasingly desperate in the face of rapidly rising health care cost, especially in the midst of a global recession.

**The Economist's Theory on Fringe Benefits**: Economists do not quite buy this story line.[14] Both economic theory and a considerable body of empirical research suggests to economists that over the longer run, the bulk of the employer-paid health insurance premiums actually is shifted back to employees in the form of lower cash take-home pay. It is an indirect hit on the employee's pocket book, in addition to the direct contributions to health insurance employees make by means of explicit withholds from the paycheck.

The formal theory underlying this argument is rather involved, but is available from the author upon request.[15] Broadly speaking, the argument is as follows.

First, in the face of an exquisitely mobile global capital market, one firm's or one country's firms' ability to lower the rate of return to capital through backward-shifting

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[13] The Henry J. Kaiser Family Foundation and Health Education Research trust 2008 Survey of Employer Health Benefits; Exhibit 2 (http://ehbs.kff.org/images/abstract/7814.pdf).

[14] See, for example, the author's **"**Health care spending and American competitiveness," *Health Affairs*, Winter 1989; 8(4): 5-21.

[15] E-mail reinhard@princeton.edu with Subject: "Senate Testimony - EPHI."

employer-paid health insurance premiums is quite limited. Financial capital can too easily flow to the country in which it earns the highest expected rate of return.

Second, if a firm sells its output in a highly price-competitive global market for that output, then its ability to shift those costs forward in the form of higher prices is very limited as well. Customers around the world are selfish. No customer anywhere will pay more for a product just because it covers health insurance for employees.

Finally, however, labor is rooted locally and, for the most part, not very mobile among countries – certainly not as globally mobile as is capita or are global customers for output. Thus labor, being the least mobile factor, turns out to be the sitting duck to which the bulk of the cost of fringe benefits can be shifted in the form of lower cash take-home pay.

The precise degree to which the cost of fringe benefits can be shifted back to employees depends crucially on what economists call the "wage sensitivity of the supply of labor," that is, the degree to which employees will actually reduce their supply of labor in response to wage cuts. While that elasticity may be high for individual firms – because workers can quit and work for other firms nearby – economists have found that for the economy as a whole the wage-sensitivity of the aggregate supply of labor to the economy is actually quite low. It means that the cost of fringe benefits can indeed be shifted back to employees in the form of lower cash take-home pay without reducing much the level of employment offered by workers. It means, however, that take-home pay can deteriorate quite a bit and workers will still show up for work.

There are some exceptions to the assumed backward shift.

**The Short Run:** First, the economic theory alluded to in the preceding discussion assumes adjustments over the longer run to increasing health insurance premiums paid by employers. Economists do recognize that, in the short run, take-come pay is "sticky downward," as the jargon goes, which means that short run shocks in the health insurance premiums paid by employers may well be absorbed by owners in the form of lower retained earnings.

**Retiree health Benefits**: Second, the preceding discussion applies to health insurance for active workers, not to retiree health benefits. The cost of retiree health care does have to be shifted either to owners or to customers. If they are shifted to customers – either in the form of higher output prices or by cutting the quality of output at given prices – the firm will see its market shrink. If they are shifted to owners – through lower retained and reinvested earnings – then the firm will gradually strangle the capacity of the firm to innovate and replace capital equipment. The traditional American auto companies represent classic examples of this possibility. They literally have been suffocating under the weight of their retiree health benefits, which has absorbed the bulk of these firms' net cash flow from operations in the past decade or so.

**Monopoly in the Output Market:** Third, if a firm enjoys a monopoly in its output market, then it can more easily shift the cost of fringe benefits into higher output prices, especially when the demand for output is relatively price-insensitive ("price inelastic"). Public utilities that produce basic necessities – such as water or power – have been classic examples of this possibility.

**Labor Monopolies (Unions):** Fourth, the late UAW leader Douglas Fraser's theory notwithstanding, if a firm's work force is organized into a union with very strong

bargaining power – which economists call a “labor monopoly” – then employees through their union representatives at the bargaining table may be able to resist any backward shift of the cost of fringe benefits into their cash take-home pay. Such a policy on the part of the union, however, is myopic and will be paid for by reduced employment. Indeed, unless the firm then enjoys a monopoly in the output market, such a bargaining posture can easily drive a firm, over time, to its gradual demise. This tendency, too, is illustrated by the traditional auto companies who now literally face bankruptcy.