Nevada's Health

An Analysis of Health Care Options
for Nevada's Working Uninsured

Prepared for
Nevada Policy Research Institute

by
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This study attempts to explain health care problems that face Nevada and advise a solution to expanding health care access for Nevada residents. It will discuss issues such as cost shifting, tort reform, and mandates. It will also look at recent attempts by Oregon and California to cap medical costs, as well as review numerous other proposals. An analysis will be made regarding the feasibility of possible solutions to make health care affordable to all Nevada residents.

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INTRODUCTION

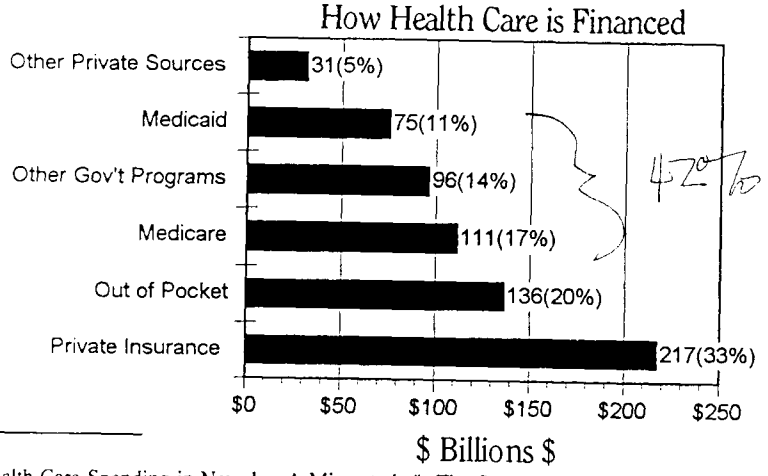
Health Care in America

It is estimated that this year in America, the private and public sectors will spend 666 billion dollars (14 percent of our Gross National Product) on health care. Despite this staggering commitment of resources, 35.7 million people, or approximately 13.5 percent of all Americans, are lacking medical insurance. Without insurance coverage or ready cash, uninsured persons may be denied hospital care, even in cases of emergency.

Controlling rising health care costs is a complicated matter. Health care cost-drivers include pharmaceutical costs and medical and product liability insurance, as well as community expectations for innovative (but not necessarily cost-beneficial) services. Anti-trust laws prohibit companies from forming coalitions which might result in the monopolization of certain goods. In past years, many have blamed hospitals for escalating costs. Hospital costs, however, are affected by change in energy prices, general inflation, patient occupancy rate, labor costs, and the degree of qualification of its administrators—costs that largely are beyond control. As health care analyst Sean Sullivan stated, *"Efforts to control total health care spending by pushing down on hospital rates are increasingly like pushing on a string."* [1]

In a broad sense, as we look at the history of advances in modern medicine from the development of antibiotics to the technology which produced Magnetic Resonance Imaging, we can begin to understand the general problem. This brisk march of technology, with its attendant basic research, has been as costly as it has been beneficial to mankind. These costs are ultimately passed along to the health care consumer, who is unable to bear the burden alone. Thus it seems that the government has some role in the general welfare by underwriting at least some of the cost of progress.

The enormous cost, broken down by funding category is graphically presented in **Figure 1.**[2]



[1] Sullivan, Sean. "Health Care Spending in Nevada: A Microstudy." The State Factor. Vol 17, No. 1. Washington, D.C: American Legislative Exchange Council, 1991.

[2] Rashi Fein. "Health Care Reform," *Scientific American*, November 1992. p 51.

The State of Health Care in Nevada

In 1989, Nevada spent $2,757 on per capita health care, ranking it fourth-highest in the nation. Total spending on health care in Nevada has increased 251 percent over the past ten years, more than any other state except Arizona. This rate of growth in spending is 50 percent higher than the national average.[3]

Approximately 17 percent of Nevada's residents lack health insurance. This exceeds the national average of 13.5 percent. In 1988, Nevada placed eighth in the nation for having the largest percentage of its population uninsured; a result of 87 percent growth in the number of its uninsured between 1980 and 1988. This rate increase was three times the national rate.[4] Roughly two out of every three of these uninsured people were in working households and, for the most part, employed by small businesses which did not provide health insurance coverage. These are individuals who were not classified uninsurable.[5]

A survey taken by the American Hospital Association in 1989 contains two important conclusions:[6] Nevada hospitals are above the national average in the availability of costly high-tech medical services, and Nevada hospitals experience high rates of utilization of these services. It follows that even if the unit costs of some services (such as trauma centers, cardiac catheterization laboratories, and organ and tissue transplant centers) could be lowered, high utilization would still accrue high costs.

Nevada's demographics are changing. From 1980 to 1989, Nevada experienced a higher rate of growth in population than did any other state. Nevada's population grew by 40 percent, four times the national average.[7] Most significantly, the number of elderly residing in Nevada has increased. Between 1980 and 1989, the population of persons aged 65 years and older grew 85 percent, the most of any state. Nevada's rate of growth of the elderly is four times the national average. The proportion of the elderly to the rest of the population is growing, as well. Ten years ago, the elderly represented only 8 percent of Nevada's population. Now they represent 11 percent (compared to 12. 5 percent of the American population).[8]

Nevada's changing demographic situation goes hand-in-hand with its high growth in medical spending. These changes are significant in that the care for the elderly tends to be

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[3]Jensen, Gail A. "Regulating the Content of Health Plans: A Review of the Evidence." Conference: American Health Policy: Critical Issues for Reform. Washington, D.C: American Enterprise Institute, Oct. 3-4, 1991.

[4]Sullivan, Sean. "Health Care Spending in Nevada: A Microstudy," The State Factor. Vol. 17, No. 1. Washington, D.C: American Legislative Exchange Council, 1991.

[5]Sam Brunelli, "Health Care Spending in Nevada: A Microstudy," ALEC, The State Factor, Vol. 17, Num. 1, January, 1991.

[6]Sullivan, "Health Care Spending in Nevada: A Microstudy."

[7]*Ibid.*

[8]Nishimura, Yumiko, Junko Takagi, and Aki Yoshikawa. Race Against Time: The Impending Crisis. Vol. 2 Stanford: Asia/Pacific Research Center, 1992.

more expensive than that given to younger people. Consequently, the growth in the population of the aged will be an important factor in Nevada's strategy for health care reform. A 1991 an American Legislative Exchange Council study found that Nevada's Medicare patients ranked second in the nation for their need of expensive, specialty care and as many as 43 percent of elderly persons residing in Nevada will have need of nursing home care sometime before they die.[9]

ANALYSIS

Before reviewing the major issues of health care delivery it will be helpful to review how care delivery has evolved over the past eighty years. A historical review will shed light on the complex nature of our health care system and on the many conflicts that have arisen over the allocation of services.

A Historical Review

Early in this century, as medical technology began to develop, medical care shifted to hospital-based delivery. In the 1920's there was no insurance for hospitalization and medical care costs were paid directly from patients' wages and savings. During The Great Depression, as family incomes dropped, so did hospital earnings. Between 1929 and 1930, average hospital receipts dropped from an average of $200 per patient to less than $60.[10] Hospitals accrued an enormous amount of bad debt. Though doctors could be flexible in providing care to indigent patients, hospitals could not. In order to stay open, hospitals needed to find a new source of finance.

In 1929, the concept of insurance was applied to health care delivery by Baylor University Hospital in Dallas, Texas. Baylor contracted a group of school teachers to give Baylor a monthly advance payment in exchange for Baylor's guarantee to provide medical care for all teachers in that group. The contract model created by Baylor University Hospital became the cornerstone of economic salvation for other nonprofit hospitals in the country. In 1932, it became the model for Blue Cross plans. [11]

The adoption of insurance financing, or third party payer system, by hospitals revolutionized the hospital based health care industry. Since the patient no longer had to pay expenses directly, a critical determinant of consumer demand—price—was removed. Thus, early health insurance plans created the precedent for the future. New hospital-based plans were a unique concept of insurance; they differed from property or auto indemnity policies which capped coverage at a specified amount. Health policies provided unlimited utilization of covered services regardless of cost. As enacted, they provided first dollar coverage for hospitalization. As a result, patients were shielded from high out-of-pocket expenditures.

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[9] Ibid.

[10] Wasley, Terree P. What Has Government Done to Our Health Care? Washington, D.C: Cato Institute, 1992.

[11] Ibid.

Furthermore, a bias in favor of hospital-based treatment was created; one had to be hospitalized to receive coverage. Health care costs soared. Under the new health care system policy-holders had little incentive to demand the best value for their money; and service providers had little incentive to be efficient. Consumers were not motivated to search for the most efficient suppliers because they were not directly paying the cost.

The next important mile marker in the entrenchment of pre-paid plans was the establishment of employer-provided health insurance. Responding to the actions of local co-operatives and unions, companies began to offer employment-based health care in 1942. Growth in group enrollment was due in part to wartime wage and price controls that prohibited employers from increasing salaries to attract workers. Employers found that, in place of higher salaries, they could offer health benefits to attract workers. Encouraging this practice, the IRS ruled that health insurance was a legitimate cost of doing business: corporate insurance costs could be deducted from taxable business income. Total enrollment in group hospital plans grew from less than 7 million to about 26 million subscribers from 1942 to 1945.[12]

The government's involvement in health care began with validation of tax deductibility of corporate insurance premiums, then expanded into many more areas after World War II. The Office of Scientific Research and Development, the National Institute of Mental Health, the Veteran's Administration Hospital System, and the Commission on Hospital Care were just a few of the agencies established to advance the field of medicine. The establishment of Medicare and Medicaid in 1965 cemented the nation's commitment to government involvement in medical care and institutionalized the third-party payer system. Joseph Califano, President Johnson's domestic policy advisor, explained the administration's belief that expanding hospital staff, health services, and medical research would increase the overall medical supply and ultimately reduce overall medical costs. [13] These policy makers did not accept that basic economic principles of supply and demand are skewed in a market that is dominated by federal regulations, powerful professional alliances, and third-party payers.

The creators of Medicare and Medicaid attempted to achieve two goals. The first was to increase access to health care for the elderly and the indigent. The second was to retain consumer choice. As created, Medicare consists of two parts. Part A provides hospital insurance to the nation's elderly over the age of 65. Part B is voluntary. Also known as Supplementary Medical Insurance, Part B covers physician services and is funded by premiums and federal revenues. Soon after Medicare, Medicaid was introduced to cover persons in poverty, regardless of age. Medicaid is financed by matching federal and state funds and administered by the states. These plans were structured so that covered persons could seek care from the provider of his or her choice. In order to make the Medicare and Medicaid systems appealing and acceptable to both health care providers and recipients, they were structured after existing free-market insurance models which were based on traditional supply and demand considerations. Both plans provided first-dollar coverage. The combined

[12] Ibid.

[13] Ibid., p 61.

effect of these two provisions was the loss of patients' and providers' incentive to control costs. Good intention not withstanding, no consideration was given to capping cost; it was only given to the qualifications of the recipient (the poor and the elderly).[14]

Before 1940, health care input (expenditures into the system) and output (production or results from the system) both rose; presumably because of the introduction of more sophisticated treatment. The cost of hospital care per capita, adjusted for inflation, rose from 1929 to 1940 at the rate of 5% per year; the number of occupied beds, at 2.4% a year. Thus, the inflation adjusted cost per patient day rose very moderately. During this "Great Society" period, input (money injected into the system) skyrocketed. Hospital personnel per occupied bed multiplied by nearly seven-fold and the inflation adjusted cost per patient day rose an astounding 26-fold. The federal government's assumption of responsibility for hospital and medical care of the elderly and the poor provided a fresh and inexhaustible pool of money, and there was no shortage of takers.[15] What in fact happened was "bureaucratic displacement" where public expenditures into the programs expanded rapidly, without a corresponding increase in efficiency and tangible health benefit. The effect was immediate. The volume of hospital services reimbursed on a cost-plus-labor basis grew 75 percent. Hospital spending, which averaged 8.8 percent annual growth between 1960 and 1965, nearly doubled between 1965 and 1970, to 15 percent annual growth. Sharp rises occurred in hospital staffing, wages, and the purchase of new equipment and supplies.[16] Providers essentially had a U.S. Government guaranteed blank check with which to pay for increased services.

Cost Shifting

As costs have soared, major third-party payers have responded differently. Premium increases adequate to cover the cost of claims occurred in the private sector—this resulted in higher cost to individuals and corporations. In the government sector, payment caps less than the actual cost of care were instituted. Since much of the Medicare and Medicaid system is highly regulated and mandated, a serious problem resulted. The dilemma is that the average citizen's ability to pay for medical care has not grown commensurately to the rise in medical costs. Similarly, state and federal contributions to Medicare and Medicaid funds have not grown proportionately to health care costs. We are, in essence, in the same situation as before the third-party payer system was instituted.

In an attempt to counter losses from incompletely paid charges to Medicare, Medicaid, and an ever increasing number of indigent patients, hospitals employ a technique known as "cost shifting" to balance their books. Hospitals pass unpaid charges on to insured individuals in the form of higher service fees. By inflating the price paid by insured individuals, providers make up for unpaid costs of uninsured persons. For insured individuals, the result of cost shifting is an increase in prices of as much as ten to fifteen percent. At Stanford

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[14] Milton Friedman, "Gammon's Law Points to Health Care Solution," Wall Street Journal, November 12, 1991.

[15] Ibid. pp 1-23.

[16] Wasley, Terree What Has Government Done to Our Health Care? Washington, D.C: Cato Institute, 1992.

Medical Center, collection rates on Medi-Cal, California's Medicaid program, are about 63 cents on each dollar billed; down from 80 cents five years ago. Stanford Medical Center has little choice but to increase the fees to other patients. Its non-discounted room rates rose 14 percent in 1988 and 23 percent in 1989.[17]

Though cost-shifting is arguably equitable or inequitable depending on the viewpoint, understanding how it came to be and how it works are crucial to understanding the problem. As the real cost of care rose and the number of entitled beneficiaries increased, the system attained *critical mass.* Private medical insurance premiums rise to offset the costs of the insurance carrier, the net result is an increased cost to business or private payee. The added economic fallout may include a decrease in the workforce as business attempts to compensate for the escalating medical (overhead) costs or an individual dropping his coverage because of inability to afford it. With business failure comes unemployment and a rise in the numbers of people unable to afford adequate health care. A high percentage of these people inevitably are counted among the population of entitled beneficiaries; and, thus, more pressure is exerted on the health care delivery system. Thus, the cry for "health care reform" has become the economic and political issue of this decade.[18]

Consumer Information

Ideally, health care consumers can enter the medical care market and purchase high quality, reasonably priced care. This assumes that consumers can recognize quality and that they know which prices are reasonable. This, however, is not always the case. A consumer is not always able to evaluate a service accurately nor is he always perfectly informed of provider quality. The consumer's lack of information hinders him in his attempt to discern a bargain provider from an unreasonably priced one. Furthermore, because he is not paying the full cost of care, it does not pay a consumer to invest time and energy to find out which supplier is the lowest cost. Obtaining information on providers can prove costly (restrictions on advertising make it more costly).[19] The provider, for his part, is knowledgeable of the consumer's inability to evaluate quality and care and has little incentive to manage care efficiently.

Nevada has made progress toward addressing the issue of consumers' lack of information. Its establishment of the Division of Health Resources and Cost Review in 1985 attempts to implement a uniform health care cost information system by which consumers may be informed of comparative health costs. Armed with statistics on provider quality and costs, Nevada's consumers are empowered to make educated purchases of care. Nevada could go further in its action by requiring full public disclosure of providers' prices and performance.

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[17]Crewman, Glean. "Coaxing the Stanford Elephant to Dance." New York Times Business. Sun., Nov. 11, 1990.

[18]Sam Brunelli pp. 19-21

[19]Newhouse, Joseph P. The Economics of Medical Care: A Policy Perspective. Reading: Addison-Wesley Publishing Company,1978.

Are Doctors the Problem?

Despite the sharp rise in the number and income of physicians, it is worth noting, first, that the cost of physicians' services accounts for only about one-fifth (20%) of total health-care costs; and, second, that the share is less than it has historically been.

In 1929, the cost of physicians' services was about 27% of total health costs; after World War II, about 25%. Despite the popular belief that, *"Doctors make too much money!"*, relative to the total cost of medicine, the portion awarded to the physician has decreased overall during the periods of greatest medical cost expansion. It is also true that an ever increasing share of the physician's gross income is absorbed by escalating overhead such as malpractice insurance and staff to comply with ever-expanding government requirements in record keeping and occupational safety. In a general sense, the better explanation for the greater cost is presumably due to a combination of more expensive and greater administrative expenses at levels other than the physician.[20]

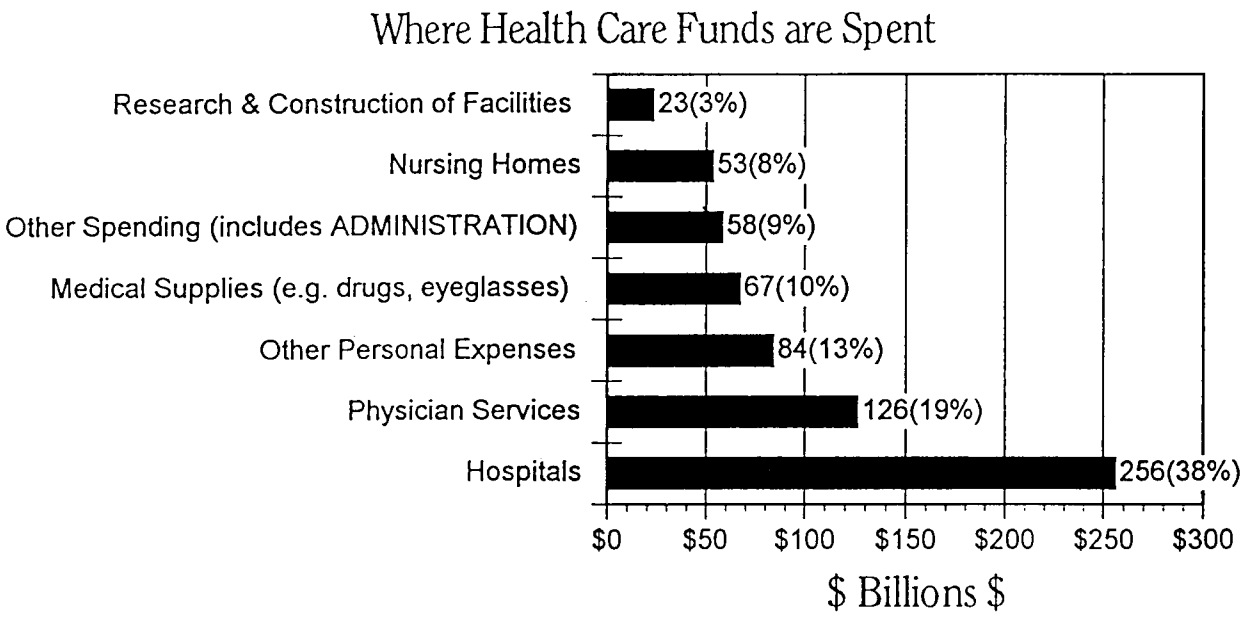

Figure 2[21]

Medical–Legal Screening Panel

In 1985, the Nevada legislature passed a measure that would establish screening panels to review all medical malpractice claims. The inspiration behind the measure was a desire to reduce malpractice liability costs. Malpractice insurance premiums alone make up about one percent of total medical spending. Between 1980 and 1985, malpractice premiums in Nevada

[20]Tanner, Michael. "Health Care Reform: The Good, the Bad, and the Ugly." Policy Analysis, Cato Institute (Nov. 24, 1992).

[21]Rashi Fien, p 51..

grew an average of 22 percent each year.[22] In a national survey taken in 1986, more than one third of all physicians reported that they had been sued at least once in their careers. Professional liability claims rose from 3.2 claims per 100 physicians, before 1981, to 9.2 claims per 100 physicians in 1986.[23]

Nevada has achieved substantial success with its screening panel. The number of malpractice cases reaching court has dropped considerably and malpractice premiums have stabilized. Three insurers in Nevada actually reduced their basic premiums by 10 percent in 1988.[24]

Two Competing Visions Which Drive the Health Care Dilemma

Before discussing existing solutions to the health care crisis of rising costs and limited access to care, it will be useful to consider the basic ideological differences that underlie various health care reform proposals. The creation of an effective and self-sustaining program for Nevada requires an understanding of the competing interests that shape policy formation.

The polarity of the health care debate closely resembles that of the Constitutional Convention. The Federalists propounded a strong central government. They were opposed by the Anti-Federalists, who were advocates of State and individuals' self determination. Though the Federalists' views prevailed in the ratification of the Constitution, the underlying issue of central bureaucratic control and individual choice continues today in the health care debate.

Those who hold to "individualistic visions" of health care argue that consumer choice is self-determined; and, therefore, responsibility for health care is the individual's. Proponents adhere to values that promote empowerment of the individual, competition, and private property. Rather than excessively tampering with the normal operation of free markets by regulating prices, the individualist generally seeks to provide the disadvantaged with the extra purchasing power they need to buy into the market on the same terms as the more fortunate majority.

The bureaucratic view holds to equality, social justice, and community. The "bureaucratic vision" looks to community responsibility for equal provision of health care by heavily regulating, or entirely eliminating, most vestiges of the free market. This approach tends to suggest varying degrees of control, restrictions on supply, distribution of goods and services, and/or price controls. One predictable outcome is, as tighter regulations and controls are imposed, that more and more of the natural efficiency of sound markets is lost.

The difference in the two visions is not so much in the motivation of those people who

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[22]Sullivan, Sean. "Health Care Spending in Nevada: A Microstudy." The State Factor. Vol. 17, No. 1. Washington, D.C: American Legislative Exchange Council, 1991.

[23]Wasley, Terree P. What Has Government Done to Our Health Care? Washington, D.C: Cato Institute, 1992.

[24]Sullivan, Sean. "Health Care Spending in Nevada: A Microstudy." The State Factor. Vol. 17, No. 1. Washington, D.C: American Legislative Exchange Council, 1991.

initiate or support any given program nor in the premise of the program, but in economics. If a private venture is unsuccessful, its backers must either shut it down or finance its losses out of their own pockets, Thus, the program is either terminated promptly or radically restructured in response to market forces. If a government-backed venture is unsuccessful, its resolution most often does not include termination of the failed program. Instead, the program backers contend that the apparent lack of success is simply a result of not carrying the program far enough; and if they are persuasive enough, they will draw further from the deep pockets of the taxpaying public to finance a continuation and/or expansion of the failing program. These factors are very much in play in our present system of entitlement health care programs which have reached their practical limits on strained national and state budgets...hence forcing the search for viable reforms.[25]

But philosophical premise and ensuing structural complications aside, it must be noted that the American culture has placed tremendous value on human life and abhors pain and suffering. Americans, more than most cultures, care about the needs and welfare of their fellow man. It is understandable, then, that America has come to believe that health care must be available to everyone who needs such care, in fact, human beings have a "right" to such care! It, therefore, follows that health care can not be allocated, dispensed, or constrained by the factors that govern the rules of free enterprise because the American psyche will not accept these constraints.

The competing interests of central control and free enterprise are very apparent in the discussion of various health care solutions. Controversy has not disappeared between persons seeking a central, government-controlled health system and persons advocating free market solutions and individual choice in coverage.

PROPOSALS

The Oregon Health Plan

The State of Oregon, which has utilized a greater Medicaid federal share, has sought a solution to health care coverage expense by attempting to limit the amount of health care for which the government should pay. The Oregon Health Plan proposal has the distinction of being the country's first overt medical rationing system.

But, in fact, this plan offered expanded numbers of Oregonians eligibility for health care under Medicaid. It accomplished this by capping the number of medical conditions that are covered by means of a simply understood prioritized list. The Oregon Plan is based on a list of 709 medical services ranked from highest to lowest priority. Highest priority services range from treatments to prevent death in patients able to recover to critical preventive care procedures (such as mammograms). Low on the list are conditions that get better by themselves and conditions where treatment is generally futile.

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[25] "The Best and the Worst Ideas for Health Care Reform," National Center for Policy Analysis, Dallas, Texas, June 1992, pp. 1-28.

At present, two-thirds of the state's poor receive a broad range of medical treatment. The other third gets nothing at all. The uninsured patient [according to Jack Hadley of the Georgetown University School of Medicine] arrives at the hospital sicker than the one with health insurance; and he dies in the hospital more frequently than the insured. The new plan will cover all Oregonians at or under the poverty line for all of up to 709 medical services. Patients will be eligible for as many treatments as the legislature allocates funding. In the first year the budget funded all the ranked services down to #587.[26]

Patients already on the Medicaid rolls may regret the loss of those lower ranked treatments but, thanks to all of the money saved plus another $30 million from the state, an additional 120,000 uninsured people will finally be admitted to care. The Oregon Medicaid Plan dovetails with a new state health plan which is being developed for small business, a program that mirrors the health benefits of the Medicaid Program.

The reform drew national attention when it resulted in four consecutive years of insurance premium reductions and reduced cost of medical care. The phenomenon of "cost shifting" remains a major drawback to the Oregon Plan.

The California (Wilson) Proposal

In California, Governor Wilson proposed the state-wide organization of a Voluntary Small-Employer Insurance Purchasing Pool. The purpose of his proposal is to bring small employers into the health insurance market.

Most small employers with few employees can not afford to provide employee insurance. A small employer's premiums can be easily affected by a single, large employee claim and his premiums tend to be expensive. Wilson attempts to address the problem of risk allocation by pooling hundreds of small employers into one large insurance purchasing pool. Pooled, small employers can share the risk of a few high-risk employees with all of the participating businesses. The pool would be able to negotiate for lower premiums with better success, than a single small employer would be able to negotiate by himself.

California has placed the purchasing pool proposal under the direction of the Major Risk Medical Insurance Program (MRMIP). The MRMIP will select and contract with a limited number of insurance carriers to provide coverage to small employers who have joined the purchasing pool. Neither small employers nor carriers will be required to participate: those who find it economically advantageous may do so.

There are several specific cost-containment measures in Wilson's Plan. Standardizing billing and enrollment procedures is one measure expected to bring cost savings. All participating businesses will use standardized forms for billing and enrollment. With fewer types of forms, bureaucratic efficiency may be improved.

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[26]Jane Bryant Quinn, "Woe the Reformers," Newsweek, October 19, 1992.

The MRMIP claims that 15 to 20 percent of common medical procedures are unnecessary or used inappropriately. A state commission, in consultation with the California Medical Association, hopes to reduce excess utilization. It will develop guidelines for doctors that will distinguish between suggested procedures and unnecessary ones. Compliance with the guidelines will be optional. The MRMIP also intends to merge Workers Compensation benefits with general health care coverage and design new approaches to medical malpractice litigation problems.

The Small Group Purchasing Pool plan will allow more Californians to gain health care coverage. It may also reduce overall health care expenditures by decreasing utilization and increasing bureaucratic efficiency. However, despite its positive elements, the plan contains no details to assure large savings.[27] Additionally, though the voluntary nature of the plan is laudable, it is this very proposal that threatens to undermine the plan's success. Low-risk small employers will probably not find it advantageous to join a pool of higher-risk employers for whom premiums are more expensive. Consequently, there is the economic constraint of adverse selection. The purchasing pool will be most attractive to high-risk employers who hope to share their risk with others. Given this constraint, it may not be possible for any voluntary system to compete with less expensive options on the basis of efficiency.[28] Adverse selection may counterbalance any reduction of risk gained by the pooling of many small businesses.[29]

Managed Health Care Competition

Instead of health care systems with a greater degree of government control and rationing, many businesses are supporting " Managed Competition" proposals, first developed by Professor Alain Enthoven of Stanford University and University of California Professor Richard Kronick.[30] Under such a system, employers and public payers would bargain with competing managed health care plans for affordable delivery to all. In order to control costs, managed competition would expand the current system of health maintenance organizations and restrain the use of some modalities of medical treatment.

Similar to the "Play or Pay" proposal, managed competition systems mandate all employers to provide health care coverage to employees. Businesses would also be required to pay into a regional health care purchasing corporation, which would negotiate the purchase of various kinds of health care plans from competing HMOs and networks of independent physicians and hospitals. Low-income or unemployed individuals would receive government subsidies to buy health care coverage.

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[27]Izumi, Lance. "California's Health Care Reform Proposals: Are They Worse Than the Disease?" Briefings, Golden State center for Policy Studies (June 15, 1992).

[28]Luft, Harold S. "Problems and Prospects in Multiple Option Health Plan Settings." Conference: American Health Policy: Critical Issues for Reform. Washington, D.C: American Enterprise Institute, Oct. 3-4, 1991.

[29]Sullivan, Sean. "Health Care Spending in Nevada: A Microstudy." The State Factor. Vol. 17, No. 1. Washington, D.C: American Legislative Exchange Council, 1991.

[30]Susan Garland, "A Prescription for Reform," *Business Week*, October 7, 1991, P.59.

Managed competition supporters contend that this approach strikes a reasonable balance between free enterprise and government regulation. They believe that health care companies are also committed to control costs while employees are given coverage options.

Critics counter that government's role in mandating minimum coverage and setting price standards will lead to substantially higher costs and tax increases in the future. In addition, since hundreds of small insurers will be eliminated by a managed competition system, less market power will be given to individuals and companies to shop for the best health care package. Another criticism is the transition time it could take to set up organized delivery systems and purchasing corporations, with resulting administrative difficulties during this period.

On a state level, a modified managed competition proposal has been offered in California by State Insurance Commissioner John Garamendi.[31] Under this plan, private/public health insurance purchasing corporations (Hips) would be established in various regions of the state. These corporations would certify health plans offered by HMOs, PPOs and other health delivery organizations. The plans would be required to offer a defined set of basic benefits to everyone in that region. Consumers would be able to choose from all the health plans certified by the health insurance purchasing corporations and pay only for services not included in a basic-benefit package.

In the California proposal, health care providers would be paid by the Hips based on the number of individuals enrolled in the provider's plan. Funding would be by payroll taxes paid by both employers and employees. All employers would pay a 7.65 percent payroll tax, while employees would pay a tax equal to 1.4 percent of their wages. The total cost is estimated to be $34 billion, based on an annual cost of $1,260 per person for the guaranteed benefit package.[32] Cost containment would be provided by the overall state health care budget in addition to informed consumer selecting the health plan of their choice.

According to analysis completed by Golden State Center for Policy Studies:

> *"...the HIPCs could become an absolute central planning organization for the micromanagement of state health care services. The HIPCs also oversteps their mere purchasing-facilitator role for special populations, or in rural areas where competition was not feasible or appropriate. In such cases, they would play a greater role in organizing the direct delivery of care. They would do this by directly funding hospitals and making direct payments to doctors through fee schedules. This looks very much like the state-centered Canadian system."*

[31] Lance Izumi, California's Health Care Reform Proposals: Are they Worse than the Disease?" Briefings. The Claremont Institute. Sacramento, Ca, June 15, 1992, p 10..

[32] Ibid., p 12.

Health and Wellness Savings Accounts

The Health and Wellness Savings Plan one of the most unusual plans to come to the health care reform debate. It is the creation of Patrick Rooney, Chairman of the Board of Golden Rule Insurance Company, and is presently being examined by the Health Care Finance Administration for national application (although its state level applications are obvious). Currently, many employers in the U.S. pay about $4500 for an insurance policy that covers a worker and his or her family (some pay less, some pay more). The deductible is usually somewhere between $100 and $250. Under this plan, business would provide high deductible catastrophic insurance coverage. In January of every year the employer would deposit the savings of $2000–$3000 into a Health and Wellness Savings Account (sometimes called Medical Savings Accounts, Medical IRA, or Personal Health Accounts). In the event of illness, money would be applied to treatment first from the savings account and upon depletion, the insurance benefit. From an insurance standpoint, it is estimated that administrative savings alone would pay for the program. Any money remaining in the account at the end of the year may be withdrawn from the account as a year end bonus, or rolled over to a savings account or IRA and accumulated over several years.

There are several advantages, chief among them, it will not cost the government anything. In fact, it would lead to substantial savings to the state. With MSAs, escalating increases in insurance premiums for employers would stop. The higher the deduction, the more stable the price from year to year. Deductibles and co-payments would no longer exist since the MSAs would cover them and the money saved from not using them stays with the employee. The incentives also promote disease prevention on the part of the individual. Family and individual health can be translated over time in tangible ways. Over 20-25 years a sizable nest-egg could accumulate to be used at the employee's discretion.[33] Paperwork would be significantly reduced for both insurance companies and doctors alike since nearly 70% of health care spending, at present, occurs in the first $3000. All medical procedures that cost less would become over-the-counter transactions. In addition, supporters of the plan also argue that the working poor who do not qualify for Medicare and Medicaid would be helped. If someone loses a job, money remaining in the account could be used to buy insurance while looking for work.[34]

Critics of this plan say that it is too dependent on the federal government to change current tax law so that people can deduct their health care expenses from their taxes, a privilege that currently exists only for businesses. Several bills before Congress to incorporate this concept into law are sponsored by an array of bipartisan legislators. Finally, employers who are presently finding it difficult to provide health care coverage for their employees would probably not opt for this program on a voluntary basis.[35]

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[33]Newt Gingrich, "A Necessary Revolution in Health Care," Address given to The American Hospital Association, January 1992.

[34]"The Best and Worst Ideas for Health Care," Address given to The American Hospital Association, January 1992.

[35]John Carson, "Personal Health Accounts: A New Idea in Medical Care," The Seattle Times, October 25, 1992.

Consumer Choice in Health Care

Ironically, there is a program already in existence which:

- •gives the consumer a wide choice of health plans,
- •is individually driven rather than employer driven, and
- •relies on free-market competition to controls costs.

It is the system known as the Federal Employee Health Benefits Program (FEHBP). FEHBP allows federal employees and residents of Washington, D.C. to choose from a variety of competitive health plan options to obtain the best coverage for the best price. It has been termed "user friendly" for all, from blue collar messengers on Capitol Hill to the President himself.

Federal employees can choose from among 400 health care plans which compete for subscribers. Every fall (during a four week period known as "open season") federal employees receive a simple form listing all of the plans available in their area. After reviewing privately generated consumer guides on each plan, they decide on the plan best suited to their needs based on the stated premium price and the employee benefits package. The federal government contributes to the plan according to a formula with a maximum dollar limit. Under this formula the government will contribute 60% of the "simple average" of the premiums for individual and family coverage of the six largest plans available in the program. Federal employees then pay the difference.

The advantages of the program are many:

- •There are no mandated benefits pushing up costs
- •There is little government generated "red tape"
- •It removes responsibility from the employers for providing coverage
- •Insurance companies must compete for clients, thus utilizing the best qualities of a free and competitive marketplace
- •Union insurance carriers are included among the providers
- •Managed care is among the options for coverage
- •Private sector consumer information is made available
- •Coverage is guaranteed
- •Premium rate increases have remained below 10%
- •It is simple and inexpensive to administer

Congress explicitly based FEHBP on the twin principles of consumer choice and market competition. Lawmakers have emphasized these principles within the federal system covering themselves, even while many of these lawmakers seem to reject the same principles when considering a new system for all other Americans. Driven by the same dynamics of consumer choice and market competition that work so well in the rest of the economy, such a consumer based system would mean affordable and adequate coverage for every American. Shouldn't the program that's available for Congress and its employees be made available to

non-federally employed citizens?[36]

Universal Health Care

Universal Heath Care is the ultimate hybrid. UH combines the benefit caps of private insurance with the bureaucratic ideology of socialism. In many other developed countries (Sweden, Canada, the United Kingdom) hospitals or area health authorities are given a fixed budget allocation and are required to deliver health care within that budget. Although the idea of living within a budget sounds reasonable on the surface, in practice "global budgeting" is simply a euphemism for health care rationing. By limiting the medical budget appropriation, governments force health care rationing.

There is considerable evidence that when health care is rationed, the principle victims are the poor, the elderly, racial minorities and people who live in rural areas. Moveover, there is no evidence that global budgets lead to greater efficiency or efficacy in health care delivery.[37] To the contrary, they almost certainly encourage inefficiency. Consider the experience of Britain, New Zealand and Canada:

- Currently, the number of people waiting for surgery totals more than one million in Britain,[38] 50,000 in New Zealand[39], and 260,000 in Canada.[40]
- Although those waiting represent a small percent of the total population (1 to 2 percent), they presumably represent a large portion of those who need access to modern medical technology.
- Yet, in spite of the lengthy waiting lists, at any one time, about one-fifth of all hospital beds remain empty in all three countries and another one-fourth are being used as an expensive nursing home by non-acute elderly patients.[41]

Miscellaneous Considerations

Guaranteed Issue

Under these guidelines, insurers are required by law to provide coverage to any employer group which applies for insurance. This requirement is usually coupled with limits on how much an insurer can vary the premiums it charges different applicants. Insurers are required to sell policies at fixed prices with no reservation regarding previous health history

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[36] P. Roy Vogelos, "Play or Pay": How to Stifle medical Progress," Wall Street Journal, October 20, 1992.

[37] National Center for Policy Analysis, *Policy Backgrounder* #118, June 10.1992, pp 11-13.

[38] Patricia Day and Rudolph Klein, "Britain's Health Care Experiment," *Health Affairs*, Fall 1991. p 43. & 44.

[39] *Choices For Health Care: Report of the Health Benefits Review*, (Wellington, New Zealand: Health Benefits Review Committee, 1986), p 78-79.

[40] John C. Goodman and Gerald Musgrave, "Twenty Myths About National Health Insurance," National Center for Policy Analysis, *NCPA Policy Report*, number 128, December 1991.

[41] Ibid

or pre-existing illness. These restrictions can be called underwriting restrictions because they limit the flexibility of insurers in setting the initial premium for coverage.

All of these restrictions are, in effect, price controls. Essentially, under these guidelines, insurers would overcharge low risk (healthy) participants in order to undercharge high risk (sick) participants.

According to one estimate, only 1 percent of Americans under the age of 65 are uninsurable. Yet in an attempt to make health insurance more affordable for this 1 percent, guaranteed issue reforms would impose price controls and raise premiums for the other 99 percent. Contrary to widespread impressions, most of the 35 to 35 million people who are currently uninsured are healthy, not sick. Sixty percent of the uninsured are under age 30, and in the healthiest population age groups.[42] They have below average incomes and few assets. As a result they tend to be very sensitive to premium prices and have judged the price too high relative to benefits.

Community Rating

Community rating is an extreme form of guaranteed issue. It is usually applied to employment based risk pools. The health care costs of individuals with employer group insurance are generally spread only over the members of a particular group who effectively constitute the risk pool for the insurance. Everyone in the risk pool is charged the same amount regardless of health history or present state of health. Community rating is an way of "cost-shifting" from sicker employees to healthy employees. Risk pools are often created by the insurers themselves. The small risk pools of employer groups explains why small or medium sized firms see huge increases in their health insurance premiums or cancellation of coverage even if only one worker incurs major medical bills.

NEVADA'S CURRENT SITUATION

Mandates

Nevada presently mandates approximately twenty different kinds of services. Passed into law by pressure from health care providers and advocates for specific health problems, mandates effectively guarantee markets for the providers of mandated services, not for the consumer. Nevada's mandates include provisions for chiropractors, newborn and adopted children, alcohol and drug abuse, reconstructive surgery after mastectomies, and psychologist services. By imposing mandates, Nevada dictates services employers must purchase. Though some persons may gain coverage for specialty services, mandates cause many persons to lose coverage altogether. Mandates increase the number of services policies must cover, thereby raising premium prices by as much as 50 percent for individuals and 75 percent for families. Most small employers are priced right out of the health insurance market.

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[42] Jill D. Foley, *Uninsured in the United States: The Non-elderly Population Without Health Insurance* (Washington, D.C: Employee Benefits Research Institute, April 1991), p 16.

Furthermore, mandates affect self-insured employers differentially from those who contract out. The 1974 ERISA[43] gives self-insured plans an exemption from all state laws pertaining to insurance, including premium tax laws.[44] Thus, self-insured employers avoid state mandates and premium taxes. The health insurance market has been perverted: large employers can escape the burdens of mandates and taxation but small employers cannot. Small employers must pay both higher premium taxes.

Tax Laws

Nevada's tax laws distort its health care market further. The taxation of insurance premiums in Nevada serves only to raise the ultimate cost of care for the consumer. Insurance companies do not pay the cost of taxation; they simply pass the tax on to consumers in the form of higher premium prices.

Federal tax exemption allowances also affect Nevada's health care market. The post-World War II IRS ruling that businesses could deduct 100 percent of the cost of employee insurance from taxable business income has led to an increase in employer demand for expensive policies with extravagant benefits. The preponderance of employer-provided coverage for fringe benefits has had inflationary effects on the relative cost of premiums for others, who must pay for insurance with after-tax dollars.

It is interesting to note the disparity the IRS ruling has caused. For example, lack of insurance is ten times greater among self-employed individuals than among individuals who work for others.[45] While a self-employed individual may deduct 25 percent of his health insurance, everyone else who does not receive employer-provided insurance (i.e. part-time workers, students, the unemployed) can receive no deductions. Individuals may only deduct medical expenses if expenses exceed 7.5 percent of their adjusted gross income. Fewer than 5 percent of taxpayers qualify in this category.[46]

Certificate of Need

Other factors affecting Nevada's health care market are the regulations on managed care and those on medical facility expansion (Certificate Of Need (CON) laws). Providers must be allowed to contract directly with employers to allow cost savings to reach employees. Providers must also be allowed to determine when expansion is needed and be able to form partnerships with other providers. Nevada's CON laws, which require providers to secure

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[43]ERISA is the acronym for the Employee Retirement Income Security Act of 1974. ERISA permits a firm to run its own health insurance plan (called self-insured plan), rather than buying a plan from a traditional insurance company. The advantage of a self-insured plan under ERISA is that it is regulated by federal law and is thus exempt from costly regulations imposed by states on traditional insurance plans.

[44]Jensen, Gail A. "Regulating the Content of Health Plans: A Review of the Evidence." Conference: American Health Policy: Critical Issues for Reform. Washington, D.C: American Enterprise Institute, Oct. 3-4, 1991.

[45]Tanner, Michael. "Health Care Reform: The Good, the Bad, and the Ugly." Policy Analysis, Cato Institute (Nov. 24, 1992).

[46]Ibid.

state permission for expansion, are medical market barriers to entry. The laws have also make technological innovation highly politicized. Expansion is more a political issue than an economic one.

Changes must be made in Nevada's health care system. Nevada's growing population of both young and old indicates that the demand for basic and long-term care services will rise in the future. Efforts must be made to include the 17 percent of Nevada's population who currently find themselves outside of any care system. The need for long-term care for the elderly must also be addressed.

Allowing the Market to Work

Nevada must relax its anti-competitive regulations to allow care providers to achieve the greatest efficiency in delivery of care. Managed care providers are able to charge lower costs per capita by achieving greater economies of scale than those achieved by traditional providers. By bringing together many purchasers, following uniform claims procedures, and contracting directly with practitioners, managed care organizations may offer lower overall costs while maintaining high-volume and high quality care. Only by allowing providers to share expensive equipment and technology, can services be offered at a reduced rate.

Mandates decrease efficiency. Nevada employers are forced to purchase expensive policies which may cover unwanted services and do not reflect their employees' true demand. Mandates encourage overall medical expenditures by expanding coverage to new services. Eliminating mandates would empower the consumer to choose services independently and increase market efficiency. The maintenance of Nevada's Division of Health Resources and Cost Review and the elimination of mandates are important factors which will enable consumers to freely choose efficient and inexpensive care.

Reductions in Nevada's per capita expenditures can be achieved by distinguishing beneficial services from those which result in small added value. Oregon's innovations in Medicaid are worthy of notice. Changes Oregon has made with these types of covered care, such as eliminating the coverage of costly, unnecessary services or restricting the coverage of services that offer little or no benefit, promise to lower Oregon's overall spending. Similarly, restructuring of Nevada's Medicaid system offers a viable, cost-effective solution to reducing costs and expanding indigent care. Restructuring would also reduce cost-shifting by providing new sources of funding for indigent care.

Expanded, Affordable Access

Another way to expand coverage to more people is to make the private market more affordable. Nevada can do this by removing its tax on insurance premiums. Taxation of insurance premiums in Nevada only serves to raise the ultimate cost of care for consumers: insurance companies simply pass the cost of taxation on to the consumer in the form of higher premium prices.

Nevada must change its tax laws. The tax on premiums places a heavy burden on

insurance companies and employees without employer-based coverage. Tax reform could effectively lower health insurance premium costs. Furthermore, tax shelters for employers providing employee insurance must be capped. The allowance of unlimited deductions for the cost of insurance provides incentive for employers to purchase high-cost policies with extravagant benefits. The demand for such policies encourages the utilization of care and increases medical costs for everyone.

Nevada's efforts in tort reform have already brought about reduced medical costs. Malpractice screening panels have shown to be an effective way to reduce the number of litigation suits brought to court. It is important that this effective screening process continue. Further discussion is necessary to develop additional means by which the number of suits brought to trial and the amounts awarded can be reduced.

A FUTURE FOR NEVADA

As Nevada lawmakers and Governor Bob Miller begin this year's legislative session, 17 percent of their constituents remain uninsured. During the legislative session, measures to expand affordable access to all Nevada residents will be discussed. Debates will arise over sensitive issues such as the elimination of mandated benefits, the removal of health insurance premium taxes, and the capping of tax shelters for employer-provided coverage.

Amidst the talk that surrounds the health care debate, one essential is paramount: the need for less regulation in the health care market. A market-based approach will be self-sustaining and will contribute least to Nevada's budgetary problems. Ultimately, the best solution will be one that is free-market oriented and satisfies the diverse health care needs of Nevada residents.

Regardless of the health care reforms adopted, the following points should be considered:

1. Caution should be exercised in mandates and bureaucratic expansion for three reasons:
    a. Small business will oppose it vehemently because it could spell bankruptcy for them.
    b. Big corporations will oppose them as a means of their dumping workers into what would amount to Medicare for the middle class.
    c. It's a step toward more government control and hidden cost shifts.

2. Exposing hidden costs in billing will speed meaningful reform by raising the level of public outrage. Determining the actual cost of care along with itemizing the"imposed outrages" of Medicare, Medicaid, liability insurance, and administrative maintenance are necessary disclosures.

3. A "paperless system" with one entry point, maintained electronically will minimize mistakes, administrative oversight, and bureaucratic red tape.

4. Incentives for reducing taxpayer and consumer cost should be built into the system.

5. The system should be "consumer friendly."

6. Consumer information should be readily available to bring free-market competitiveness to the arena of health care, namely, comparative costs for like procedures.

A study recently published by the Department of Health Care Policy at Harvard Medical School, reported that poor access to health care leads to higher hospitalization for ailments that can easily be treated with routine visits to the doctor. People without health insurance or who are covered by state Medicaid programs are 49% to 79% more likely than the privately insured to be hospitalized for conditions such as asthma, diabetes and high blood pressure that typically are managed with outpatient care. The findings underscore the economic as well as the human costs of inequities in the health care system. The results also suggest that some costs of expanding coverage to the 35 million uninsured Americans could be recouped in savings by reaching patients early in their illness when treatment is easier and less expensive.[47]

[47]Ron Winslow, "Poor Access to Health Care May Result in Higher Hospitalization, Study Finds," Wall Street Journal, November 4, 1992).