

Rhode Island Can Afford Health Care for All

Appendix II: QUESTIONS AND ANSWERS ABOUT CONSOLIDATED FINANCING FOR RHODE ISLAND

Many questions have been raised concerning health care for all reforms. We have inventoried many of those questions and prepared answers to them.

1. Why can't Rhode Island just wait for federal reform?

First, because Congress is not going to act. Why not? There are several reasons:

Certainly, many were burned by the failure of the Clintons' proposals in 1993-1994, and now regard health reform as a political third rail.

More important, because the states, their needs, and politics are extremely diverse. So the liberal states and the conservative states can't agree on health reform. Nor can the rich and poor states. Nor can the states with lots of uninsured people or just a few. Nor can the states with high health costs or low costs.

Most important, Congress does not know what to do. The lack of evidence on which types of reforms would contain cost and cover all Americans was one of the main reasons, though largely unacknowledged, for the failure of the Clintons' proposals in 1993 and 1994.

The states could provide that information. They are supposed to be the laboratories of democracy. But federal law now makes it hard for states to develop and test new approaches carefully, before a crisis hits.

Since the federal government is not able or willing to act to reform health care, it must get out of the states' way.

Second, Rhode Island cannot wait to address the pressing problems of high costs and lack of coverage because the state will eventually have to grapple with designing its own reforms in any case. States differ greatly in their health care delivery systems and resources. For example, among the states in 1999, Rhode Island ranked 5th highest in patient care physicians per resident— with 2 times as

many as Idaho, the lowest ranked state.ⁱ And federal data show that spending on the state's caregivers in 1998, per resident, was 4th highest in Rhode Island, 65 percent higher than in Idaho—the lowest cost state.ⁱⁱ

No single path to reform will work for such diverse states.

Third, Rhode Island cannot wait for federal reform because of the dangers posed by high and rising health care costs here. High costs are

- disadvantaging the state economically by raising the cost of doing business,
- draining family, business, and government resources that could be used to meet many other needs,
- encouraging ineffective, risky, and trust-destroying practices aimed at cutting costs,
- de-stabilizing fine health care organizations, and
- driving down levels of private health coverage, adding to the ranks of the uninsured.

And if this state does not move to contain its 4th highest-in-the-nation health costs, then any eventual federal reforms are likely to hit hard, requiring abrupt—and thus harmful— spending cuts in Rhode Island to finance greater equity in health care expenditures and resources.

2. Can we really do this on our own?

Sure. We have the doctors and the dollars—and the competence and compassion—to finance the care that works for all the people who need it.

Federal waivers would be required to liberate the states to experiment carefully. Waivers would be needed to better use existing Medicaid and Medicare funds. Another waiver would be needed to relax the stranglehold which the 1974 Employee Retirement Income Security Act (ERISA) now has on state reform. Today, ERISA blocks states from many health care reforms that affect large employers, those that self-insure against health costs. Some large national corporations and unions like the ERISA prohibition because they think it gives them more control over health costs, more control over bargaining benefits, and more freedom from the cost of complying with individual state requirements. They are short-sighted.

Maryland's recent experience with its one-state all-payor experiment in hospital payments does suggest that the durability even of a reform that had been successful for decades can be threatened by competition from across state borders, and by other factors.

But this is not a reason to refrain from trying new things. If they really do work, they are likely to catch on.

3. If Rhode Island promises cost control and universal coverage in one state, won't people without health insurance move here from other states?

That is always a small potential danger. Some Americans have moved to Canada in recent decades to win guarantees of health care coverage.

But the danger is largely exaggerated. Rhode Island has little to fear. Where would the newcomers live? Compared to most of the country, the cost of housing here is high, as is the cost of living generally. Little new housing is being built. What jobs would the new arrivals find? A few people might move here, but for \$7 billion, we can work that out also. (Also, please note that this fear runs counter to the fear that these reforms won't work.)

4. If Rhode Island legislates cost control and universal coverage, won't business flee?

Why would they? Most Rhode Island employers would face a lower overall cost of doing business owing to the cut in health care costs. That makes it less expensive to live in Rhode Island, so employers would face less pressure to raise wages or salaries, and employees would enjoy higher standards of living, other things equal.

Additionally, employers that now offer health insurance would experience a freeze in their regressive payments for health insurance. The new one percent payroll tax they would face would be less costly to most employers than the expense of a steady rise in private health insurance—which have been rising by 12 to 15 percent or more for many employers, and are projected to continue steep increases.

In past years, many employers that did not provide health insurance complained bitterly that mandates to provide insurance (such as those in Massachusetts' 1988 Dukakis universal health insurance law or the Clintons' 1993 proposal) would unfairly burden smaller businesses whose payrolls were large shares of their total costs, and that operated in competitive industries. But it would be right to ask employers who do not yet provide health insurance to begin paying their fair shares. A payroll tax is much more fair than insurance financing.

(In other words, this plan is good for business. It does not burden small businesses with a crushing employer mandate to provide insurance—an unfair

and regressive tax, and a tax on jobs. It uses the money that's already available. Gradually, it does ask businesses not yet pulling their weight to begin to pay something affordable toward health insurance—but only a payroll tax. This is a low cost for businesses with low-wage workers—the kinds of businesses that don't provide health insurance.)

Therefore, as it became necessary, over time, to raise health care spending to keep pace with inflation, one candidate for generating the needed money would be to gradually increase the payroll tax. But employers' frozen health insurance contributions would be credited against such tax liabilities in excess of the one percent levied on all employers.

5. Everyone knows that the government can't do anything right, so how can it run the health care system?

While funding would be public, care would be private. No one wants government to run health care delivery. Our proposal is for the money to be pooled in one reservoir. Care for all people would be financed from that reservoir. Doctors, hospital administrators, and others would determine how the money is actually spent to provide care.

The alternative to public reform is continued private price increases, hospital closings, insecurity, medical meltdown, and anarchy.

6. Isn't this a radical approach? Health insurance covers most people today—and between two-thirds and three-quarters of uninsured people are working or are dependents of people who are working—so why not simply require that all employers buy health insurance for their workers and dependents?

This is a practical approach, not a radical approach. What is radically foolish is to imagine that it is possible to continue to rely on private insurance. Most uninsured people do work, and there are important reasons why their employers are not able to afford health insurance for them. These reasons include the regressive nature of financing, low profit margins, and the relatively high burden that insurance financing imposes on firms that are labor intensive and employ large numbers of lower-wage workers.

As bad as are the financial prospects for relying on insurance expansions to cover everyone, the political prospects are even worse. Witness the fury of small business against the Massachusetts universal health care law of 1988 and against the Clintons' proposals of 1993.

Private health insurance through the job does cover most people today, but the number with private insurance fell steadily for much of the 1990s. Only the explosive growth in coverage by the Medicaid program has prevented the number of uninsured people nationally from rising even higher than it has.

One of the main reasons people are losing health insurance is that many of the jobs that provide health insurance seem to be shrinking, while jobs that provide health insurance seem to be increasing. Further, as reason would suggest and as Kronick and Gilmer have shown,ⁱⁱⁱ higher cost means lower insurance coverage. The rise in health costs predicted for the years ahead can therefore be expected to result in lower rates of insurance.

7. How will we cover unemployed people?

All permanent residents of Rhode Island would qualify for coverage. Each covered person would receive a card that certified that they were insured. All cards would be backed financially by the \$7 billion pooled in the trust fund's reservoir.

8. Won't this approach mean bureaucratic control over health care?

No. It means less bureaucratic control over health care. Today, HMOs and insurers can constrain physicians' decisions and have even tried to gag physicians and prevent them from discussing some treatment options with patients. Today, price competition without a free market is resulting in payment methods that actually reward the doctors and hospitals that give less care to patients. Today, an HMO's stock price goes up when the share of its revenue devoted to patient care goes down. Today, HMOs and insurers use "economic credentialing" of doctors, terminating their contracts if they prescribe high levels of services, but without considering how sick the doctors' patients are— and thus are making doctors increasingly reluctant to accept sicker patients.

Less bureaucratic control will be reflected in less administrative spending. This approach means much less bureaucratic or administrative spending and control. Ironically, in health care, most of today's bureaucracy is private, not public.

9. But how can there be less bureaucracy when the \$7 billion in Rhode Island health spending would be controlled by a new government agency?

All health spending would be collected in one reservoir or trust fund. The trustees—those who must spend the money—would negotiate with doctors, hospitals, and other groups about fair and adequate ways to pay for care. The evidence from every other nation is clear that this method means less bureaucracy and less administrative waste.

Having one payor won't mean government-run health care. The state's multitude of doctors, hospitals, and other caregivers would continue to work independently but would be paid from a single pool of funds. This is similar to the long-standing role of Medicare in paying for hospital care. Medicare has never run hospitals. It has simply provided a single source of payment to the nation's multitude of independent hospitals for serving seniors and citizens with disabilities.

10. But how can we trust state politicians with \$7 billion in health care spending?

The State House would not control the money. The trustees would be insulated from political pressure by long-term appointments. The legislature and the governor could not interfere with how the \$7 billion would be spent. The trustees' obligation would be to finance health care for all with the available money.

Each year, the trustees might require additional money to keep pace with costs of legitimate inflation. Then, they would have to go to the legislature to request the additional money. Those who sought more money for health care would therefore have to compete with those who sought more money for education for schools, roads, criminal justice—or tax cuts.

Spending \$7 billion a year on anything will always have some political aspects. Health care is about life and death, but it is also about money, prestige, and power. The challenge is set up arrangements for collecting the money and for paying caregivers that cover all citizens of the Commonwealth and that contain cost, while assuring the best quality of care.

It is clear that today's arrangements are failing. First, costs rise. Expanding Medicaid to cover more people costs money. So will covering the teaching hospitals' deficits or providing a new prescription drug benefit by traditional methods.

Second, more people risk loss of coverage. The number of uninsured people may have been cut recently, but at the cost of still higher spending. But higher premiums in the future will mean further cuts in private insurance coverage. Things will worsen at the bottom of the next recession.

Today's traditional solutions of managed care, price competition, and hospital closings have not saved money or covered more people. Our state faces higher costs, more uninsured people, and probably both.

Today's HMOs and insurance companies cannot be trusted to fix health care. We must therefore construct other arrangements that we can trust.

11. *Won't this approach mean rationing of vitally needed care?*

This approach will make available enough money to provide the care that works to all the patients who need it.

While spending less overall, this approach actually makes more money available for patient care.

Doctors and hospitals and other caregivers will still have to spend money carefully, but they will have enough to spend.

Britain rations a good deal. Canada rations less. Both do so because their economies are not in good shape and they don't have much money to spend on health care. But Rhode Island spending per person is almost three times that of Britain (\$5053 vs. \$1763 in 2000). So we will not ration. We will spend money carefully, and we will not waste it.

12. *Who needs a tax increase? We are over-taxed already. How can you seriously propose another tax increase when so many politicians want to cut taxes?*

Because winning serious cost control and health care for all requires a tax increase. But because it is a substitute for existing out-of-pocket spending by sick people—and that out-of-pocket spending is really a tax on sickness, it is unfair to call this a tax increase. It's a substitute tax—it asks us to pay more when we are healthy and less when we are sick.

And what does this buy?

First, guaranteed health care for each person. If you lose your job, you keep your health insurance. And you don't have to worry that you might lose your job because you've gotten too costly to insure.

Second, a huge boost in dollars for health care and a huge cut in dollars for bureaucratic waste. Some tax increases lead to more bureaucracy. This tax substitute is the keystone to buying less bureaucracy.

Are we over-taxed already? Compared to when? How do our tax rates compare with those of past years?

Compared to who? How do our tax rates compare with those in other nations?

And compared to what? What value do we get for our tax dollars?

13. Won't this approach lower the quality of health care?

No. It will improve both quality and quantity of care. First, everyone will have coverage.

Second, nearly everyone today is under-insured, but that will stop. Most of the increase in cost of new coverage, indeed, will go to round out the benefits with prescription drugs, home health care, and other services—for people who already have insurance. They will get more than twice as much additional care as previously uninsured people.

Third, the share of the health care dollar going to medical care will rise, and the share going to administration will fall. And the share of caregivers' time—for physicians, nurses, social workers, pharmacists, and many others—used for paperwork will fall, so the amount of time devoted to patients can rise.

Fourth, physicians, hospitals, and other caregivers will be paid adequate sums to provide needed care. They will not be paid in ways that allow them to make more money by giving less care. They will be free to focus on patients' clinical needs.

Fifth, patients will have free choice of caregivers. So patients will vote with their feet based on caregivers' quality—including their competence, compassion, and accessibility—since the cost of care will no longer be an issue. Under one option for delivering care, patients would choose networks of caregivers (re-oriented versions of HMOs), which would all be paid the same risk-adjusted price, and would compete only by quality of care.

14. What's the hurry? Aren't health costs under control? Why plan all these big changes now? If it's not broke, don't fix it!

It is broken. Health care costs are resuming an upward spiral. Hospitals are closing and survivors are demanding still more money. Some people in Congress are talking seriously about raising the age of Medicare eligibility from 65 to 67. Other people in Congress are talking seriously about spending many additional billions on prescription drug coverage. Medicaid is expanding its coverage, but this also costs more money. What will happen at the bottom of the next recession?

The cost of more money for business as usual is insupportable.

We can win health care for all of us—and at a cost we can all afford—but we have to work for that. It won't fall into our laps today.

15. Even if it is broken now, shouldn't we just wait until a crisis arises. Everyone knows that Americans are conservative and don't entertain big changes until it's almost too late.

Many of us are fond of paraphrasing Winston Churchill, who said that he could always trust the Americans to do what's right—after they had first tried everything else.

According to Doyle, Victor Fuchs of Stanford “believes that comprehensive reform of the U.S. medical system will come only after a major political crisis as might accompany war, depression or widespread civil unrest. Such a crisis might arise and medical costs reach ever higher and threaten Social Security, Medicare and other popular programs; there could be political upheaval of such magnitude that medical reform will seem to be the easy solution.”^{iv}

All this would be comforting were it not the most dangerous idea alive in health care today.

It is true that the political pressure to act is low today. But the need to act is high. When a crisis does arrive, the political pressure to act will be high but the ability to act—successfully—will be low.

Imagine a depression and the accompanying political upheaval. Money to finance health care will be in short supply. Still, many would expect single payor reforms to restore the health care they had known before the crisis. When expectations exceed resources, disappointment is inevitable.

Worse, hurried, half-baked, and ill-coordinated attempts to respond to the next crisis could easily make things worse, and alienate patients, taxpayers, and caregivers alike. We don't need more reasons for cynicism, mistrust, and alienation in our nation.

It is dangerous to put reform efforts on hold until the inevitable crisis hits. This is the time to prepare, in accord with another old saying: “Dig a well before you are thirsty.” When the crisis hits, people and politicians will demand simple answers to complicated questions, and they will want them yesterday. There will be no time to plan and test and tinker and modify.

16. *Health care is so complicated. How can you hope to fix it with one simple plan?* ^v

We recognize the complexity. The plan we have offered is a beginning of financing reform, not the end. It outlines a sound method of pooling available dollars, paying caregivers in simpler ways, and using the savings to expand benefits very substantially.

A host of questions must still be addressed. What will be specific methods of paying hospitals, doctors, and other caregivers? How will spending on care be kept at the level of available revenue? How will caregivers and researchers be encouraged to discover more cost-reducing technologies and fewer cost-increasing technologies?

And as many other questions must be answered when we look beyond financing care to the actual delivery of care to sick people. How will care be organized—will HMOs still have a role, for example?

Some of these questions can be answered well today. Others require more work. But one of the most important jobs ahead of us is to start the work now, while we still have time, before Rhode Island health care melts down.

17. *But that's socialized medicine you're talking about!*

No, it is not. Socialized medicine means that doctors work for the government or that hospitals are owned by the government. We are not proposing anything like that.

We are proposing that everyone would have health insurance. Providing health care for all encourages us to acknowledge our common vulnerability and mortality and to care for and about each other. This is a social commitment that we owe one another when we are sick, aging, vulnerable, and dying.

18. But the Clintons already tried to institute a universal health care system and they failed miserably. If they couldn't succeed with all their clout and resources how can we?

Of course, they failed. They struck out swinging on three successive pitches: First, their plan would have raised spending substantially because it required a mandate on all employers to provide health insurance. This angered small business (justifiably) and increased costs (unjustifiably).

Second, they attempted a one-size fits all states national solution. The states are so different. Some are liberal and others conservative. Some are wealthy and others are poor. Some have high health costs and others low. Some have lots of uninsured people and others have few.

Third, they promoted a top-down federal solution before Congress or anyone else had any confidence in their ideas. Their solution was largely untried anywhere in the world.

On top of this, when the insurance industry, the right wing ideologues, or others criticized their bill—sometimes with justification and other times without justification—they did a terrible job of fighting back or of setting the record straight.

The Clintons' failure means that their diagnoses or treatments failed. It does not mean there is no need for a cure—or that a cure is impossible.

19. But they are having so much trouble in Canada. Canadian doctors are coming here. Canadian nurses are coming here. Canadian patients are flooding into Buffalo and Detroit. So how can you propose a Canadian plan for Rhode Island?

First, we are not proposing a Canadian plan. We are proposing a Rhode Island plan. Our state will have to craft its own arrangements—its own methods of paying doctors and hospitals and all the rest.

Second, most Canadians like their health care very much. They have a terrific deal, overall: affordable and high-quality care for everyone. A small number of Canadian physicians move to the USA. Naturally, they are the ones who did not like conditions in Canada. The overwhelming share of Canadian physicians remain in Canada. On balance, they seem to like things there.

Lately, Canadian health care has exhibited some strains. These are attributable to one thing: not enough money for care. Why not? Because the Canadian economy has not been in good shape for some years. As a result, Canadians

made a decision to slow the rate of increase in their health care spending. Today, many Canadians feel that these restraints may have been too tight, and spending can be expected to rise in at least some provinces.

It is worth noting that while some Canadians come to the USA for care, some Americans move to Canada to become eligible for health insurance. And many Americans travel to Canada to buy medications there because the prices are lower.

20. I don't want my payments for health care to be used to buy services for people who don't take care of themselves.

That's understandable. But that is how insurance through the job works now. Most health problems are caused by bad luck or inevitable aging. Most health costs have little to do with taking care of ourselves. After all, the medical researchers can't seem to decide about whether caffeine, eggs, or butter are bad for us. How can we take care of ourselves if we don't know what to do?

Is there anyone who hasn't sometimes eaten too much, drunk too much, run a yellow light, and the like? Most of us will need costly care if we are lucky enough to live long enough to become old and sick.

Instead of focusing on what other people get, why not concentrate on what you will get, such as more care at lower cost; and more trustworthy care because doctors will be liberated to think about what services you need, not about what services will make them more money. In health care, most of us seek confidence that we will be able to get the right care when we are sick, and that we will have competent doctors who are looking out for our best interests. These are what the current arrangements are taking away from us. Our proposals are designed to restore good care.

21. The health care reforms that you propose sound good, but everything has its problems. What happens if something goes wrong. Aren't you asking us to bet a lot on a good idea but an untried one?

Many of the things we describe have been tried in many nations. We borrow some pieces here and there and combine them with ideas of our own. The plan we set out is not the final, perfect plan. It is the first step toward reform. Going further will take a lot of hard work.

Some people approach health care reform system as though they were going to buy a car or stereo. They want to buy the perfect system, that comes with a ten-year warranty and they can return it if it isn't always in perfect working order.

But we are talking about complicated health care matters that involve money, power, organizational design, and life and death. Therefore, health reform is not a consumer purchase. It is about a long-term political fight. It is about creating a human system, one that, no matter how perfect it starts out, will inevitably break down and need fixing and which will require vigilance to maintain.

22. Isn't this just another utopian plan?

This is actually the most realistic approach because it contains cost, covers everyone, and protects quality.

And it is the most realistic approach because it avoids the extremes of Panglossian fantasy that our present health care world is the best of all possible health care worlds, on one hand, and of apocalyptic crisis engendering heavenly health care reform, on the other hand.

Instead, this reform—like any other thing worth having—will have to be earned. It will require a great deal of hard work. The benefits will not simply fall into our laps. We will have to plan carefully, implement prudently, and evaluate honestly. We will have to work with patients, caregivers, payors, and other stakeholders. Everyone's legitimate concerns will have to be considered and, when possible, addressed.

In the real world, we have to choose among real alternatives. Today's popular remedies—managed care, price competition, and hospital closings—are not saving money. They are resulting in rising numbers of uninsured people. They are enticing physicians and hospitals to withhold care from patients and to market to healthier people in order to cut costs, and to game and sometimes abuse the methods of payment in order to raise revenue. It would be unkind and imprudent to abandon our patients and our health care to the tender mercies of a failed market.

In the real world, the choice is among these remedies popular today, even more extreme market solutions like medical savings accounts, and an all payor – health care for all plan like that described here.

If you don't like this health care for all plan, you will probably be forced to accept a real world of managed care and price competition in which comprehensive market failure results in less care for fewer people at greater cost. In time, this will become manifestly intolerable for everyone.

Politically, that is clearly not yet so. Most people's second choice is to do nothing, as at least one observer and student of health care suggests.^{vi} But the job of health care analysts is not to decide what is possible politically today, but to try to figure out what might just work better than today's arrangements.

23. Is this plan then nothing more than a call for reckless experimentation on our precious health care services?

Today's health care debates are surprisingly sterile. That is partly because we have so few new ideas, and even fewer ways to make them work. We know much more about probable problems than we do about possible solutions.

Consider other fields, such as public education, that are about as important as health care. We see huge ferment. Supporters of school choice, small schools, charter schools, teacher testing, mentoring, student testing, portfolio assessment, and other ideas are winning the right to experiment, to test their ideas. We have admitted the need to do better, and have embraced the possibility that we actually can do better.

Nothing similar is found in health care. Instead, we witness sterile and largely ideological dominance of managed care and price competition. No fall-back position has been prepared against the very real chance that they will fail.

The plan advanced in this report embodies two ideas. One is an outline of a specific financing reform that promises universal coverage in combination with cost control. The other is that we must get off the dime and start tinkering with many new approaches, so we are not caught unprepared by a health care Pearl Harbor.

Notes to Appendix II

ⁱ American Medical Association data, as reported in *Health, United States, 2001*, Hyattsville, Md.: National Center for Health Statistics, 2002, Table 100.

ⁱⁱ Calculations from United States Health Care Financing Administration, 1980-1998 State Health Care Expenditures Estimates, 29 September 2000, <http://www.hcfa.gov/stats/nhe-oact/stateestimates/>.

ⁱⁱⁱ Richard Kronick and Todd Gilmer, "Explaining the Decline in Insurance Coverage, 1979 – 1995," *Health Affairs*, Vol. 18, No. 2 (March-April 1999), pp. 30-47.

^{iv} Roger Doyle, "Health Care Costs," *Scientific American*, April 1999, <http://www.sciam.com/1999/0499issue/0499numbers.html>.

^v See, for example, Alan Sager, Deborah Socolar, David Ford, and Robert Brand, "More Care at Less Cost," *Boston Globe*, Focus section, 25 April 1999.

^{vi} This insight is generally attributed to Stuart Altman.