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CONTENDING WITH THE SOARING COSTS OF HEALTH CARE

by Richard Leshner

The cost of health care for employers in the United States has grown explosively in recent years, placing severe strain on both the public and private sectors, and posing a threat to the US economy.

A typical company spent about 22% more on health care for its employees in 1990 than the year before. Over the last two years health care costs have risen, on average, an incredible 43%. Many companies now spend an amount equal to one-fourth of their net earnings buying medical coverage for their employees. According to a survey of 1,955 employers conducted by Foster Higgins & Company of New York, an average business firm spent \$3,161 per employee for medical care in 1990, up from \$2,600 in 1989. Costs have become prohibitive for many small businesses. Approximately two-thirds of the 31 million Americans who don't have health insurance are employed, but their employers can't afford to provide them with insurance.

The business community recognizes the critical need to do something about the surge in health care costs. But while the problem is obvious, the solution is far from clear. Many people seem to be seeking a "magic bullet" solution—simple, neat and painless. Political and budgetary realities suggest such hopes are illusory.

Root Causes

The most obvious reason for our medical care cost dilemma is our presumption that everyone is entitled to extensive medical services, regardless of his or her ability to pay. Other industrial nations, including those with national health care systems, routinely deny expensive care to certain groups of citizens: They won't, for example, provide kidney dialysis to older patients; they deny infants with severe disabilities heroic lifesaving measures; they limit organ transplants to recipients likely to survive many years, or don't make them available at all. What all this means, in effect, is that thousands of patients each year are told to go home and die because their lives aren't worth

saving. It's difficult to imagine the US ever enforcing such an arbitrary system.

Americans not only want advanced medical care—we want it now. In countries with national health care systems, elective surgeries are commonly delayed for months or years. Again, it's difficult to imagine us putting up with such restrictions.

Another reason for our sky-rocketing medical bills is the tab for research and development of new medicines, therapies and medical equipment. We take pride that the United States is the world's most fecund source of medical research. A disproportionate percentage of important medical breakthroughs are achieved in American universities and laboratories. But the cost of such innovations is very high.

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Finally, no analysis of our soaring medical costs would be complete without reference to our rapacious legal system, in which every negative medical outcome is viewed as cause for action and all too often produces exorbitant awards. These costs are factored into the fees of every physician and medical facility. Of course, many of the negative medical outcomes are themselves the offshoot of medical progress—in that the individuals who suffer severe trauma or medical injury would have been denied heroic measures in any other country, and left to die. American doctors who push their craft to its outer limits to save lives all too often get sued for their trouble.

Remedial Options

Virtually everyone finds the status quo unacceptable. There is, however, no consensus as to remedy. Though the debate is not clearly defined, it seems to center broadly on whether to enact some sort of comprehensive, national health care plan, or to pursue incremental reforms as opportunity permits.

Congress has been rebuffed in the past year on two health benefits issues—the Medicare Catastrophic Act, and Section 89 of the Internal Revenue Code—and will want to see a greater degree of consensus than currently exists before moving forward with legislation.* Many looked to the Pepper Commission, which was comprised of 12 key Congressional players in the health care debate and three private sector representatives, with the hope a consensus would emerge. But the Commission's recommendations regarding access to health care were approved by a bare 8-7 margin, and were attacked by left and right.

Further complicating the situation at the national level, and in many states as well, are budgetary pressures which limit what government can do to address health care problems. This has led to an increased focus on employers as the "financial" source of a solution.

In Washington and in various states, commissions are studying health care reform. Unfortunately, many of them have focused on mandated employer-provided health insurance as the solution—a policy which is fraught with negative side effects. A study released in October 1990 by the Partnership on Health Care and Employment found that many workers—estimated at 630,000 to 3.5 million—would lose their jobs if all employers were required to provide health insurance. The study found a total of 5.4 million to 8.6 million jobs—6.8 percent to 10.8 percent of the nation's workforce—"at risk" in some way through wage cuts, losses in other benefits, or job elimination. Most of the negative impact would be felt in small firms with 25 or fewer employees.

Employer mandates assume there are lots of businesses which can afford health insurance but are refusing to provide it. Yet the great majority of businesses that don't provide health insurance are smaller firms that simply cannot afford it. Faced with requirements that they extend it nonetheless, they would simply lay off workers, cut back hours, or eliminate other fringe benefits in order to absorb the additional cost.

These same small businesses were responsible for more than 60 percent of new jobs created in the 1980s. Mandated health insurance would have its greatest impact on people at the margins of the workforce, the same people the policy is intended to help. Small employers also hire about 66 percent of first-time workers and traditionally have employed twice as many young workers as large firms. These inexperienced workers have low skill levels and relatively lower rates of productivity; they are the most likely to lose their jobs.

The same problems obtain in proposals to require employers to provide coverage to employees or pay an alternative tax, the so-called "pay or play" mandate. Massachusetts enacted such a requirement in 1988 and other states are likely to consider similar proposals in 1991. The Pepper Commission also recommended a "pay or play" mandate with the contention that this approach would be less burdensome on low-wage industries. But small businesses are generally labor-intensive; thus, payroll taxes fall more heavily on them, adding to the marginal disincentives to expand their workforces. High payroll taxes not only deter employment, but bear no relationship to a firm's profitability. They must be paid regardless of the company's financial situation.

Incremental Reform

There's a better way: an incremental approach which recognizes the complexity of our health care challenge, and permits a variety of solutions for different aspects of it. This approach involves (1) addressing the factors driving up the costs of health care; (2) making it easier for business, especially small business, to offer health insurance; and (3) ensuring that indigent and medically uninsurable people have access to health care.

With regard to the first, one option is to reform the small group health insurance market where forces of tough competition have driven carriers to stricter underwriting practices for small business. Competition on the basis of risk selection has reduced availability of insurance for many small employers. We must return to the traditional concept of insurance—the broad spreading of risk. To achieve that, insurers must change their underwriting practices to accept all employees when providing

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group insurance to a company; guarantee renewal of a group at pooled rates, once a company has been accepted; impose no new pre-existing condition limitations on a person who has been continuously insured, even when that person changes employment or coverage; and provide a reinsurance mechanism to spread risks among participating insurers and HMOs.

With regard to reducing the burden on small business, we need to deal with an unfortunate trend among states to require employers to provide specific levels of extra medical coverage—for example, for chiropractic coverage, drug and alcohol abuse, and psychiatric care. However desirable these benefits may be, they increase insurance costs by 20-30 percent. There are now more than 700 such mandates nationwide. The Health Insurance Association of America estimates that, all other factors aside, some 16% of small businesses not now offering health insurance would do so were these mandates eliminated.

Finally, reform of the Medicaid system is needed. In 1988, only 42% of the population with income below the poverty level qualified for Medicaid. Because of the costs of reform to both federal and state governments, an incremental approach is necessary.

The U.S. Chamber of Commerce is part of a broad-based coalition whose participants include the American Medical Association, the American Hospital Association,

the Children's Defense Fund, the Health Insurance Association of America, and the Blue Cross/Blue Shield Association. We successfully supported an incremental expansion of Medicaid eligibility for poor children that was included in the 1990 budget. Some may not consider poor children a natural constituency of the business community. Our concern reflects the fact that the health costs to business do not occur in a vacuum, but are part and parcel of a greater societal problem. Public sector deficiencies are now being thrust upon and made up by private payers in the form of cost-shifting.

Incremental reform at the state and national level is necessary to address the health care crisis in our country. No "universal" or "comprehensive" remedy is feasible in light of today's budget constraints. In any event, it would likely do much more harm than good.

*The Medicare Catastrophic Coverage Act was passed in June 1988—and then repealed in November 1989, amidst a storm of protest. The so-called Section 89 rules, enacted as part of 1986 tax legislation, were scheduled to go into effect December 1, 1989. They would have required employers to prove their employee-benefit plans provide roughly equal benefits for all their employees. Business groups opposed the rules as burdensome and too complicated, and Congress finally repealed them in the fall of 1989, before they ever became operative.

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