MISSING ELEMENTS IN THE HEALTHCARE DEBATE

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For many years, the country has been engaged in heated debates over how to contain rapidly escalating healthcare costs while simultaneously providing access to health care for the uninsured. On the surface, these goals would appear to be incompatible, but both can be achieved with a little creative thinking. That creative thinking must address five rather contentious issues involving cross-subsidization that no one has wanted to discuss in a serious way for decades. Until we confront these issues directly, however, any meaningful progress toward expanding access while simultaneously containing the growth in costs will be impeded.

It is important to note that the five types of cross-subsidization have nothing to do with unpreventable factors. People who are sick or are injured have their care subsidized by the healthy and uninjured. This is one of the basic functions of insurance. With life insurance:, for example octogenarians subsidize people who die prematurely. Similarly, people who don't have flood or earthquake damage to their homes subsidize the costs of those who do. And so on.

By providing health insurance to the 40 million or so people who currently have none, the United States has the opportunity to join the rest of the industrialized world in engaging in an appropriate form of cross-subsidization--one in which a society's healthy members subsidize the healthcare costs of their fellow citizens who, through no (or minimal) fault of their own, are unhealthy. Indeed, many would argue that this form of cross-subsidization is one hallmark of a civilized society.

But engaging in this sort of cross-subsidization does not imply that all forms of cross-subsidization in a healthcare system are beneficial. Rather, in each of the following five instances the financial flows need to be restructured so that each party (individual or institution) pays its fair share.

Issue #1. Subsidies for Overweight People and Smokers

We know that many forms of illness, such as diabetes and heart disease, are associated with excessive weight. Similarly, we know that a variety of illnesses are linked with smoking (add lung cancer and emphysema, among others, to the above list).

It is true that some people are overweight because of an uncontrollable factor, such as their genetic makeup. Clearly, their higher healthcare costs should be subsidized. But uncontrollable factors are not the issue. According to the Centers for Disease Control in Atlanta, in 1991, 49 states had fewer than 15 percent of their residents overweight. In 2000, only one state, Colorado, was in this category. In 1991, no state had more than 20 percent of its citizens overweight; in 2000, 20 states did. This "obesity epidemic" is due entirely to controllable factors, such as diet and life style.

There is no benefit that accrues to society from having people who maintain their weight at appropriate levels subsidize their fellow citizens who do not. Nor is there a benefit to society from having nonsmokers subsidize smokers. Indeed, it could be argued that the presence of such subsidies contributes to the continuation of individuals' unhealthy lifestyles by keeping their healthcare premiums artificially low.

The solution: Differentiate healthcare premiums on the basis of body mass index and smoking habits. While this step would not address a variety of other preventable illnesses (such as those due to alcohol and drug abuse), these two elements alone would go a long way toward eliminating inappropriate cross-subsidization in healthcare premiums.

Some observers have argued that attempting to police everyone's weight and smoking habits would be impossible, and that taxing the offending substances is an easier way to achieve the desired result. However, taxing the offending substances is feasible with tobacco and alcohol, but less so with obesity-inducing food and drink. Likewise, it is impossible to tax a sedentary lifestyle. Instead, while retaining the various "sin taxes" that currently exist, we also must find a way to reflect unhealthy lifestyles in healthcare premiums.

One approach would be to charge everyone initially the premium associated with obesity and smoking, and then to give people the ability to reduce their premiums by obtaining annual statements from their physicians confirming that they are not smoking and maintaining an appropriate body mass. Such an approach would not be perfect, and there no doubt would be slippages, but it would go a long way toward eliminating the inappropriate cross-subsidization that currently exists.

Issue #2: Subsidies for Large Families

At the moment, most health plans have two premium levels: one for single people and one for married couples. Some plans have three levels, with the third distinguishing between couples with and without children. With this premium structure, single people and small families subsidize large families.

It is hard to understand the rationale for this premium structure. Automobile insurers don't charge one premium for a family with one car and another for a family with several cars. Someone with, say, five cars pays automobile insurance for five cars (perhaps with a :fleet" discount, but that is all). Similarly, life insurance companies charge by the life, not by the family. With health insurance, other than some minor administrative savings, there are no economies of scale based on family size--as family size goes up, so, too, do healthcare costs.

The solution: Charge a separate premium for each individual.

Because of double-digit premium inflation, many employers, who a short while ago paid each employee's entire healthcare premium, are now asking employees to cost-share. Thus, the timing is ideal for an approach that provides a fair way to structure premiums. When employees had all of their premiums paid by their employer, the premium structure was of little consequence. When asked to pay a portion of the premium, however, it is likely that many single employees or employees with small families will oppose subsidizing their fellow workers with large families.

Issue #3. Subsidies for Nonprofit Hospitals

At present, U.S. taxpayers provide subsidies to nonprofit hospitals totaling hundreds of millions of dollars a year. Every nonprofit hospital receives an exemption from property, excise, sales, and income taxes. Although these hospitals frequently complain about the financial burdens they face in meeting the healthcare needs of the uninsured, they in fact *should* be providing such care in exchange for their subsidies. But some hospitals reap the benefits of tax exemptions without making a corresponding contribution, while others make contributions that exceed their tax exemption. . Many hospitals in low-income neighborhoods, for instance, provide considerable care to the uninsured, and, as a result, incur unreimbursed costs far greater than their tax exemption, while their counterparts in more affluent neighborhoods frequently enjoy the opposite arrangement.

As we move ahead with efforts to provide insurance coverage for the millions of people who currently are without it., we must be careful to avoid a solution that uses incremental taxpayer dollars alone to fund the associated costs. To do so would create a multimillion dollar annual (i.e., ongoing) windfall gain for many nonprofit hospitals.

The solution: Require nonprofit hospitals in each state to pay their total tax forgiveness into a special fund for the uninsured. The monies in this fund can then be used to help pay insurance premiums for the currently uninsured. It is unlikely that this fund will cover the total cost of those premiums, but it will help. More important, with the presence of such a fund, hospitals that provide a great deal of care to the uninsured will receive payments from the fund in excess of the amount they pay into it, while hospitals that provide little such care will not.

By making the fund self-liquidating each year, a state would be able to redistribute tax forgiveness dollars appropriately among its nonprofit hospitals. More generally, as society seeks ways to pay for the costs of the currently uninsured, the presence of such a fund would lessen the burden that otherwise would be placed on taxpayers.

Nonprofit hospitals in affluent areas no doubt will oppose this idea, but if they live up to their charitable obligations, they will be financially neutral. Otherwise, their tax forgiveness dollars would be distributed--appropriately--to those hospitals that spend more than their tax forgiveness in providing care for the uninsured. While such an approach is not consistent with the *letter* of Chapter 501.c.3 of the tax code, it is quite consistent with its *spirit*.

Issue 4. Subsidies for Physician Training

At most of the country's several hundred teaching hospitals, the cost of graduate medical education totals tens of millions of dollars a year. Yet, at present, Medicare is the only insurer that helps pay for GME. As a result, HMOs and others insurers receive the benefit of a cadre of well-trained physicians at no cost. Not only are these insurers free riders, but their subsidies come from the financially precarious Medicare Trust Fund.

Underlying this issue is a much broader health policy question: As a society, do we wish to pay all (or a por-

tion) of the cost of physician training? This is a complicated question with many cross-subsidization elements, and will require considerable time to resolve.

In the meantime, GME Is like a lighthouse: no one wants to help pay for its operating costs. Since a ship can "consume" the light without paying for it, why offer to pay one's fair share? Therefore, the solution is to have ship owners pay for lighthouse operating costs via taxation. A similar approach is appropriate for health insurers who receive the benefits of graduate medical education.

The solution: Require all health insurance companies to pay a percentage of their premium revenue into a fund for GME. The amount would be relatively easy to determine and, of course, would need to be matched by an equivalent reduction in Medicare's payments, so that total GME payments to teaching hospitals remained constant.

An approach of this sort would allow Medicare to devote more of its resources to its primary mission: covering the healthcare costs of the elderly. In an era of skyrocketing costs for an aging population, such an approach also would help to ensure the financial viability of the Medicare Trust Fund.

Issue #5. Subsidies for Brand-Name Pharmaceuticals

The real problem with pharmaceuticals--the substantial cost difference between generic and brand-name drugs--is reflected only minimally, if at all, in most copayment schemes. Copayments also force low-income patients to choose between filling (or refilling) a prescription and spending their limited resources on food, clothing, or shelter. Moreover, in most instances, patients do not determine their pharmaceutical needs; they rely on the judgment of their physicians.

The solution: Eliminate all copayments for pharmaceuticals. Instead, when there is a generic equivalent for a brand-name drug, require patients who want the brand-name drug to pay the full amount of the cost difference (rather than a copayment). When a Fortune 10 company instituted a policy like this, the number of its employees using generic drugs rose from 50 percent to 99 percent. Before the change, these employees had no incentive to request a generic substitute. Once the new policy was put in place, however, they immediately began asking their physicians if a generic substitute were available and using it when it was. The resulting cost savings were substantial.

Implementing the Changes

Clearly, eliminating or minimizing each of these forms of cross-subsidization will require considerable analysis and debate to make sure that we design an appropriately structured approach. Although there will be opposition to almost any approach, it nevertheless should be relatively easy to implement changes that address the first two areas of cross-subsidization. Overweight people and smokers have little political clout, and large families would have a difficult time mobilizing any opposition. Thus, it should be possible to move ahead on these two issues without much difficulty.

By contrast, progress on the last three issues will require a great deal of political will. With each, there is a powerful lobby in opposition: associations representing nonprofit hospitals, managed care plans, and pharmaceutical firms. However, with health insurance premiums skyrocketing, and with pharmaceutical costs growing even faster, the time is ripe for significant change.

Happily, if the political will can be mustered to move ahead on these last three issues, none would be especially difficult to implement. Clearly, some analytical effort will be required for each solution to become fully developed. In each instance, however, there is an overarching premise: to avoid cross-subsidization when there are no societal benefits to justify it. If this premise is accepted, the debate can become considerably more focused than it otherwise might be.

It's time to ask healthcare's free riders--the obese, the smokers, and the large families-to pay their fair share. And it's time to do away with inappropriate financial support for the vested interests of hospitals, managed care plans, and pharmaceutical companies. Doing so can move us ahead considerably in our quest for universal access to health care at a reasonable cost.