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ROUNDTABLE DISCUSSION ON THE ECONOMICS OF HEALTH CARE

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JOINT ECONOMIC COMMITTEE CONGRESS OF THE UNITED STATES

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TUESDAY, AUGUST 2, 1994

SUBMISSIONS FOR THE RECORD

ROUNDTABLE DISCUSSION ON THE ECONOMICS OF HEALTH CARE

TUESDAY, AUGUST 2, 1994

CONGRESS OF THE UNITED STATES,
JOINT ECONOMIC COMMITTEE,
Washington, DC.

The Committee met, pursuant to notice, at 10:10 a.m., in room 2255, Rayburn House Office Building, the Honorable Lee H. Hamilton (Member of the Committee) presiding.

Present: Representative Hamilton.

Also present: Patricia Ruggles and George Foy, professional staff members.

OPENING STATEMENT OF REPRESENTATIVE HAMILTON, MEMBER

REPRESENTATIVE HAMILTON. We will come to order.

Today is another in a series of roundtable conversations that the Joint Economic Committee is holding with prominent economists to discuss economic policy. Today's topic, the economics of health care, is one of the more important policy issues of the 1990s.

We are pleased to have as our guest Dr. Mark Pauly, Benheim Professor and Chairman of the Health Care Systems Department at The Wharton School, University of Pennsylvania. Dr. Pauly is also the Director of Research at the Leonard Davis Institute of Health Economics and a member of the National Academy of Science's Institute of Medicine.

Over the years, Dr. Pauly has made important contributions in the economics of health care. He was a coauthor of *Responsible National Health Insurance* in 1992, and he has published numerous articles on health care in leading journals.

Welcome. We look forward to a good discussion. The way we proceed is to let you begin with any comments that you want to make for a few minutes, and then we will turn to questions and comments.

STATEMENT OF MARK V. PAULY, PH.D., BENHEIM PROFESSOR AND CHAIRMAN, DEPARTMENT OF HEALTH CARE SYSTEMS AND ECONOMICS, THE WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA; DIRECTOR OF RESEARCH, LEONARD DAVIS INSTITUTE OF HEALTH ECONOMICS, AND A MEMBER OF THE NATIONAL ACADEMY OF SCIENCE'S INSTITUTE OF MEDICINE

DR. PAULY. Thank you, Congressman.

I was asked to comment on the impact of rising medical care costs on the economy and what might be done about it. I am happy to do that, and I have tried in my brief written outline to make a few provocative statements about that.

There has been a change in the attitude of analysts toward the two objectives of controlling health care costs and universal coverage. When I first started doing research on this industry 25 years ago, professors of medicine, professors of public health, and advocates of health care were very much concerned about the extent of insurance coverage and weren't particularly concerned about rising costs, so I brought the dismal economic message that we can't afford everything.

As I view what has happened in the debate—of course, you can never characterize all economists—there seems to be almost a role reversal in which economists are more concerned about impacts on insurance coverage and on quality and which former editors of medical journals, professors for public health, physicians for national health insurance, are much more concerned about rising costs.

So I may eventually slip into what I feel more passionate about, the question of universal coverage, but I am going to try to stick to questions of cost in what I say now.

Five quick observations here and a little bit of discussion of each.

First, at least as I view the data, the rising medical services costs that we have experienced more or less are from the beginning of time up to the present, or at least as far back as we have data, have been driven almost entirely by two factors. One is what we call new technology, which doesn't necessarily mean just fancy machines with blinking lights, but all the different ways people change how they render medical care. That has been an important component, probably the most important component.

The second most important component has been wage growth for health workers, which has outpaced wage growth for workers in the economy and profits for health-care firms, although they are a relatively small portion of the total. So those are the two things.

There is growth in wage rates and growth in change of technology that have been cost increasing. The other things you hear about that are problems with the health-care sector—waste, insurer administrative costs, or poor health—although they are reasons costs are high, there is no strong reason to believe that they are the reasons why costs are growing.

So the basic message is, if you want to cut medical spending growth, effectively you are talking about either cutting health-care employment growth, because the technology has caused more people to be employed in this industry, or cutting the growth in health-worker wages.

Removing waste, improving health or cutting insurer administrative costs will, at best, have a one-time effect. For instance, take Dr. Koop's suggestion to tell people to live in a healthier fashion and help them to be healthier with preventive care. That is fine. Suppose that there are ten people who are sick and using resources, somehow we might reduce that number to nine by making them be healthier.

In the year we do that, we cut the health growth by 10 percent, but then if the same technology is applied to the nine people the year after, the rate of growth stays on the same track. So health-care cost growth is a bit more durable than you might think.

Second, from an economic point of view, a high GNP share for medical care or growing medical service spending are not per se harmful to the economy. Other things grow more rapidly than GNP—home computers; the total service sector, as a matter of fact—and the scholarly statement that I make in my comments here is, so what?

Some things grow faster than average. Some things grow slower than average. That has no particular impact for the economy as a whole, how people decide to spend their income, on which type of consumption. We do spend a larger share of GNP on medical care than do the Japanese, but since the shares have to add up to 100 percent, we know they spend more on something else than we do.

I picked seafood, which turns out to be true. They spend a much larger share on seafood than we do and I ask the rhetorical question, why do medical services impoverish, but fish enrich an economy? There is more to it than that.

To get more serious about this, although those are serious comments, the way in which spending grows actually has some important implications or impacts on the economy and there are two different ways to do it. You could slow the growth of health spending by slowing the growth of health-worker wages, and that is what a lot of managed care firms effectively do; they get better deals from hospitals and from doctors who——

REPRESENTATIVE HAMILTON. We have bells and I don't know what they are. Go ahead.

DR. PAULY. I am used to working with doctors whose beepers are always going off, so I will ignore it.

Health-worker wages have grown more rapidly and if you want to slow down the growth of health-care spending by getting better deals with the hospital, oftentimes that must mean that the hospital then gives somewhat smaller raises to its nurses, or the rest of its staff, and the doctor's income rises less rapidly.

The main point I want to make is from the viewpoint of the economy as a whole, which is pretty neutral. It just represents a redistribution of

profits or surplus from one set of consumers to another, and putting it back the other way wouldn't really help the economy as a whole.

To give a somewhat concrete example, suppose you were running an automobile company and you already buy generous health insurance for your workers, but you wonder what would happen if we lowered the share of GNP going to health care from 14 percent to 9 percent, a 5 percent reduction.

Suppose that happened because it came out of wages paid to health workers—doctors, nurses, lab techs, and so on—will that help your company?

You might imagine, if people spend 5 percent less on medical care, they will have 5 percent more to spend on Oldsmobiles, but the problem is that if the way in which the cost is reduced is by taking income away from doctors and nurses, what ordinary consumers have to spend on automobiles is just offset by the fact that health-care workers have that much less.

Now, as everybody knows, doctors don't buy Oldsmobiles; they buy BMW's, but nurses probably do. The other way to cut the growth of health-care spending is by cutting the growth in the flow of inputs into the health-care sector, which is mostly people—a labor-intensive industry.

So you can cut the growth in employment in health care—one of the most rapidly growing sectors of the economy. It seems to me, if you want to cut the growth of spending, since one person's spending is another person's income or another person's job, effectively you cut the growth of jobs. That is not bad if and only if the people who would otherwise have taken jobs in the health-care sector now take jobs elsewhere in the economy where they are doing something more valuable.

My big fear is, number one, a lot of people who work in hospitals don't wear white coats and are not highly skilled, and it is not obvious what else they will do. It is also not obvious because nobody has really proved that if we took the smart people who go to medical school and nursing school and told them to do something else, they might go to law school.

I don't know what that might do for the economy as a whole, but we don't really have knowledge what they might do that would be more helpful. So there is at least some impact on jobs that needs to be taken into account.

A few other quick comments.

The implication in the way of my first two remarks about the economy as a whole and the growth of health-care spending is that the natural tendency of scoring proposals in terms of whether or not they are guaranteed to control costs better than some other proposal, I will be blunt, I think that is fairly silly. The real objective of reform ought to be to get health-care spending to grow at the right rate, which to an economist, or to my mother, means the rate at which benefits and costs balance.

But we really don't know what that rate is, so simply observing such a plan has spending controls built into it and they are likely to be more effective than some other plan doesn't tell you whether the first plan is better than the second until you know the services that will be additionally cut by the first plan are, in some sense, not worth what they cost.

Since nobody knows that, it is discouraging to come to judgment, but it also is important to be skeptical.

So the fundamental issue, I think, if you are thinking about controlling spending growth, is to pick a strategy that will control spending growth appropriately.

There are two strategies that I can think of. One is to have the government decide which services are worth what they cost, set up a national commission of smart people and have them do a good job. Still, a lot of it is tea leaf reviewing, especially when you are talking about new technology. Nobody quite knows what it is good for yet. But have the commissions decide and use that to set up national targets that would be binding. That is one approach.

The other is to change incentives so that citizens decide to buy only services that are worth what they cost. It may not be surprising to learn that many economists are skeptical of the ability of government to pick out the right rate of growth and cost, even for the average person. Also, you need to take into account that people are different, so different people may have different preferences as to whether they would rather spend their raise on better medical care for themselves or on a big-screen TV.

One member of my family suffers from kidney stones. There is a cheap way to treat kidney stones—take painkillers and suffer. There is an expensive way—a lithotripter—an ultrasonic jewelry cleaner—that breaks up the kidney stones inside, and I could see her preference would be for the less painful one.

It helps to be a professor. You can afford the insurance that will do that, but other people might prefer to bite the bullet in order to have lower costs. Either way, the person is not going to die from the kidney stones, so it is not a matter of life and death. It is a matter of preferences, so I am skeptical about the ability of government to make the right choices for each person.

My big fear about government cost-containment programs is not that they won't work, but that they will and they will, at a minimum, reduce the ability of people to choose different things, and maybe make it a crime to spend your own money on your family's health care.

The alternative arrangement, which I call competition among managed care firms, to distinguish it from managed competition, says what I said initially, let's try to restructure things so that people know what they are doing and that they are paying prices that reflect the costs of what they are doing.

So the essential notion is to provide good information either to individuals or to people who choose on their behalf, like benefits managers,

about what you get in different health-care plans. Take away what economists think is the number one distortion in that choice—the tax break.

If the employer sends in the check for the premium rather than the employee, take that away, at least at the margin, by capping it, although I would like to recover all of those funds to subsidize the uninsured, but not everybody feels that way. But at least cap it so that people know what they are buying when they choose one health plan compared to another and are paying the full price, and then let people choose. A central idea is if one health plan—let's call it the Regency Health Plan—decides it wants to add the latest technology without limit, the latest medicine for a migraine headache, or the medicine that will keep you from getting nauseated when you are on chemotherapy, or medicine that will keep you from getting an infection when you are being treated for cancer. The Regency Health Plan might adopt that technology as its strategy right away, if it is new, if it is good.

In another health plan—my colleagues in the Wharton marketing department tell me that I have no future with them—my suggested slogan was, "Last year's technology at last year's premiums." In any event, the second plan would have a premium that would be lower and grow less rapidly than others, and the fundamental notion is to let consumers decide.

If we think that low-income people won't be able to afford as much as high-income people, to some extent that is a fact of life in a society where we permit there to be low-income people, but we can supplement it to some extent.

So I guess the final solution is the solution that ended the Vietnam War: Declare victory and pull out.

The strategy that has been suggested for controlling health-care costs are HMOs, or other forms of managed care. I think HMO's are a good idea and do save costs somewhat, but we don't have evidence that they control the rate of growth in cost. They probably don't control the rate of growth in cost as much as some price regulatory scheme that somebody could think up.

You can always think of a sufficiently Draconian version of price or premium regulation. But economics say, so what, and the CBO scoring of cost savings, even if accurate, I would allege, is useless as a guide to policy, since they only score costs and not benefits.

That is the main message about health-care costs. The implications for me, at least in terms of what I think is a good idea, go roughly as follows: Remove or at least cap the tax subsidy. We know that will cause people to choose more cost-containing indemnity plans. We hope that it will cause them to choose more cost-containing HMOs, although it is sort of embarrassing, because we don't really have any research on that subject to prove it.

The government ought to contain its own costs and get government spending under control. I believe that there is still some value for a

national commission, not I need a job, but a national commission to set targets for health spending growth as a way of informing people about what some experts think would be a reasonable increase for your HMO's premium next year.

Promulgate that; maybe, require insurers that can't meet the target to send out their premium notices printed in red ink or something so that people know and explain why, but let people spend money on their health care, if they want.

I favor an individual mandate to obtain insurance, and the form of insurance that I think is most appropriate is not uniform benefits; rather it is income-related catastrophic coverage.

Finally, I think those things can be financed or subsidized best by lump-sum, closed-end, risk-related tax credits.

Thank you.

[The prepared statement of Mr. Pauly starts on p. 23 of Submissions for the Record:

REPRESENTATIVE HAMILTON. Very good.

Let's go over some of these items. You mentioned at the end that you favored the individual mandates. I presume then that you reject the employer mandate?

DR. PAULY. I think the individual mandate is preferable to the employer mandates. There are a lot of things that are better than the status quo.

REPRESENTATIVE HAMILTON. Why don't you like the individual mandate, and why do you like——

DR. PAULY. The other way around.

There are three reasons, I think. The first is actually outside my area of direct expertise and part of yours. Economists here, I think almost to a person, believe that employer mandates are not paid by the boss—we can argue how much—but close to 100 percent of the cost of a mandated employer payment comes out of worker wages, so it is paid by individuals anyway.

REPRESENTATIVE HAMILTON. So the employer mandate, in effect, is going to decrease the wage of the worker?

DR. PAULY. If you give employers a six-year advance warning, they probably won't have to cut wages. As my dry cleaner said, when he found papers on health reform in my suit coat, when I asked what it would mean to him, he said, "That will be my workers' raises for the next five years." That is probably going to happen.

It is the same as if you required the workers to pay, and the main difference, I think, is that the employer mandate is duplicitous. It makes it look to ordinary people like the boss is paying; it is not coming out of their pockets, but it ultimately will.

The other problem is that employer mandates enshrine the employer payment mechanism as the only way to pay for health insurance, and

although I think in a lot of cases that is a sensible way to do it, I would like there to be a lot more flexibility.

REPRESENTATIVE HAMILTON. What percentage of the American people today get their health insurance through their employer?

DR. PAULY. Something like two-thirds, approximately.

REPRESENTATIVE HAMILTON. Well, the thing you hear about employer mandates all the time from the employers is job loss.

DR. PAULY. That is the other thing. I didn't get to my third.

For people who have wages high enough above the minimum wage, the main consequence is that, as I describe, they will just lose their raises. For people near minimum wage, if the money wage cannot fall below the minimum wage—the Administration has indicated some flexibility on that—but if the minimum wage stays put at X dollars an hour, then you have to lay people off, so you would have some job loss.

REPRESENTATIVE HAMILTON. But your major concern is not that?

DR. PAULY. That is right. If you look at the basis of anybody's estimates of the amount of job loss, including the Administration's, they essentially assume that the money wages fall or adjust to offset. That is why people don't get fired.

REPRESENTATIVE HAMILTON. The proposals that are floating around are more than employer mandates; you have the employer mandate, but you also have subsidies for the smaller businessman.

DR. PAULY. I think you need subsidies for low-income people. The size of the firm shouldn't be important.

REPRESENTATIVE HAMILTON. But that is the way it is constructed. An employer with less than 100 or 50 employees, or whatever the number is, you get a subsidy of some kind. What is wrong with that?

DR. PAULY. From an equity point of view, first of all, the object ought to be to subsidize low-income people. There are a lot of low-income people who work in large firms and there are a fair number of high-income people who work in small firms, so you shouldn't make the subsidy conditional on the size of the firm.

Also, it sets up economic distortions. If the only way I can get a subsidy for my workers, which is how it is going to work if they are low wage, is by having a small firm, if I have a hundred-person firm, I'll split it into two or three.

REPRESENTATIVE HAMILTON. So you will have a lot of gaming of the system?

DR. PAULY. I wouldn't necessarily call it gaming. It is the way rational people respond to subsidies. They try to qualify for the maximum. Whereas, an individual mandate, which says that people have to get insurance somehow and you base a subsidy on their family income, wouldn't have that kind of distortion. Low-income people would get subsidies whether they are the janitor at GM, or whether they are a low-wage worker at Pizza Hut.

REPRESENTATIVE HAMILTON. How would the individual mandate work? We pass a law saying that everybody in the country must have health insurance?

DR. PAULY. The version that I advocate has important differences from the Chafee bill. You pass a law saying that every person has to obtain insurance somehow and then you have to specify what the insurance is.

As I have said, I favor requiring or insuring that low-income people get generous coverage, but upper-income people could get catastrophic policies. But whatever it is, you have such a law. Then the only trick is to enforce the law.

For people who are workers, I think you can use the employer to enforce it so that it would work. Effectively, it is a mandate with a requirement to pay a certain amount, like a payroll tax, and you would basically say, if I come to work for your firm, if your firm doesn't have health insurance offered to all its employees, I would have to show when I fill out my W-4 form that I have health insurance, that I got it somehow.

If the firm offers it or helps people to buy it, it would happen automatically and the backup would be to say, if this person doesn't show they have bought health insurance, we propose to have an additional amount withheld from their wages and an additional tax that would go to a government contracted and fallback insurer.

If you didn't want to bother to satisfy the individual mandate, the strategy for you would be to do nothing, and then the government would, in effect, collect a premium from you and choose an insurer for you.

REPRESENTATIVE HAMILTON. For the low-income people, you would have a direct government subsidy. How would that work?

DR. PAULY. I think the easiest way is through a system of tax credits or vouchers. The government would determine some decent policy for low-income people in each area. For people below 100 percent of the poverty line, they would essentially get a voucher equal to the premium for the plan.

If they didn't want to do anything, they would be automatically enrolled with that plan. The virtue of a voucher is that if they wanted to take a little bit of their income and use it to buy a slightly different plan, they would be able to do so.

REPRESENTATIVE HAMILTON. You favor universal coverage?

DR. PAULY. Yes.

REPRESENTATIVE HAMILTON. Can you get to universal coverage without a mandate?

DR. PAULY. I don't think so. You can get there without a mandate if you are willing to subsidize insurance 100 percent. But set that one aside, as well as full tax finance. Obviously, how far short you fall depends on how much money you put into subsidies.

Most of the programs that talk about universal access do envision some subsidy. The hardest group to deal with, I think, are not the poor uninsured; almost all of us want to pay for them, at least until the bill comes due.

It is the middle-income uninsured. Maybe, one-third of the uninsured are above 200 percent of the poverty line and something like 16 percent are above 400 percent of the poverty line—these are people who, by all definitions, can afford health insurance, in the sense that others in their income categories, the great majority of them, do get health insurance.

There are people who, for various reasons, have chosen not to have insurance, and I think it doesn't make sense to subsidize them, so the only alternative is to compel them to get insurance; otherwise, if they don't and they get sick, or worse yet, their children get sick, it bothers the rest of us and we end up paying for it.

So I am not in favor of compulsion. There was a point in my life after I got my degree when I was uninsured, but that was before I got my first real job. I was young and my wife was young and that summer we had only wedding gifts to live on, so we took a chance and we survived. I shouldn't have been allowed to do that. It wouldn't have cost all that much, especially relative to my future income, but somebody should have made me buy insurance just in case.

REPRESENTATIVE HAMILTON. What about the benefit package? If I heard you correctly a moment ago, you would have a catastrophic benefit for higher income people. Is that right? The lower down you go on income, the more the benefit package?

DR. PAULY. That is right.

The simplest way to think of it is that your maximum out-of-pocket payment that you would be allowed to experience would be some percentage of your income. You could make it fancier than that, but that is the simplest idea. So, say, 10 percent of your income, and for people probably below the poverty line, you would want to phase that down to zero. Ten percent of your income is all that you would have to pay, and people would be required to buy coverage at least as generous as that. They could buy more generous coverage if they wanted, but——

REPRESENTATIVE HAMILTON. You would not have to pay more than a certain percentage of your income?

DR. PAULY. No. The premium you would pay for the coverage depends on the pattern of subsidies that the government chooses to offer, and for upper-middle income people, presumably they would pay the full premium themselves.

It is the risk of the amount of medical expense for which you would be at-risk and out-of-pocket would be tied to your family income. The rationale for that, why is it better than a uniform policy?

The problem with a uniform policy is that if you put cost sharing in it—which many economists think is a good idea—you keep running into the dilemma that if it is good enough to affect people's behavior, it is too stingy for poor or low-income people. Whereas, if you don't want

to run the risk that somebody might be deterred from using some services if they are low income, then you end up giving a professor at Wharton insurance coverage that makes me want to go to the doctor whenever I have an ache or pain. That is the extreme case.

If you really want to equalize use of medical care, you have to give people unequal insurance coverage. You want to arm low-income people with, in a sense, better required insurance coverage than upper-income people.

I have never understood the rationale for a uniform benefit package on that score. I understand the set of coverage services could be uniform, but it seems to me that the extent of coverage would be well advised to vary with the need for coverage.

REPRESENTATIVE HAMILTON. What would you do if you were a Member of Congress today on health care? You know the packages we will be confronted with. What would you do?

DR. PAULY. I think I would take one of the individual mandate proposals, or almost individual mandate proposals, and try to fix it up to look like what we proposed in responsible national health insurance, either Chafee or Nichols. There are some things about those proposals that I think deserve to be fixed, but the idea of an individual mandate—here I am sort of weak on details—but some have, if not income-related catastrophic coverage, two or three steps where poor people get more generous coverage. That is probably decent enough.

The main thing at least that the Chafee bill lacks, in my view, is getting the subsidies right. The essential idea is that you want to subsidize low-income people, whether they pay for their insurance nominally, or whether their employer does, and then that avoids the problem people fear that if you have an individual mandate, employers would drop out—because the only way a person could get a subsidy is to pay for it directly themselves.

Under Chafee, you would cause employers to drop group coverage and for lots of people group insurance coverage is one of the greatest inventions known to mankind.

REPRESENTATIVE HAMILTON. You said that you would cap the tax subsidy as part of your package.

DR. PAULY. Yes, sir.

REPRESENTATIVE HAMILTON. With regard to government spending, I don't know that I got your point. How do you contain costs?

DR. PAULY. I don't have any terrific ideas there. I am not sure anybody does, other than to say that managed care does seem to be fairly effective. We have mostly tried it out, at least on a population-wide basis, for poor people, including some experience in Philadelphia, which I have been persuaded has been good. It seems to work pretty well in terms of providing decent care at lower cost than the alternative.

I think the same thing could be done for Medicare. Define, in a sense—that is your business not mine—but politics aside, define a basic Medicare coverage as some decent HMO, more like store brand cola

rather than Coca-Cola, but something like that. In effect, allow people through some kind of voucher arrangement to choose other versions, if they wish, and essentially use the power of the managed-care model to try and contain costs there. Ultimately, there is no easy answer.

If you want to hold down what government is spending on its clients, the people it buys insurance for, if it really wants to hold down spending, it is going to have to buy them less and take the heat.

REPRESENTATIVE HAMILTON. Let me go back to individual mandates for a moment. If you have an individual mandate, of course, you take a certain element of freedom away from the individual, don't you? They cannot refuse to have health insurance.

DR. PAULY. That is right, although you take freedom away from them if you have an employer mandate as well, because then that says you are not allowed to take a job that doesn't carry health insurance.

Mandates, period, take freedom away. They take away the freedom to be uninsured. That is a freedom that I don't think we ought to preserve, at least up to the level of catastrophic coverage.

REPRESENTATIVE HAMILTON. Give me your thoughts with regard to insurance reforms, and I am thinking particularly of this community rating proposal.

DR. PAULY. There are some things that could be done for insurance reform that I think would be a good idea. The main one is to make sure that people don't lose their insurance in the middle of an episode of illness.

Some kind of guaranteed renewability for a limited time period would do that, where, say you had a heart attack and it was the month before your insurance policy was due for renewal. For two or three or four years thereafter, the insurer would have to write you at a premium that reflects the experience of the average person in your age category, not your own experience. But then after that, or for new people, the insurer would be allowed to charge higher premiums to people with chronic illness, and that is contrary to community rating.

So this is a sort of modified risk rating. What is wrong with community rating? Community rating, I think, is a stupid way to try and achieve a good objective. The good objective is that we don't want people who experience a bad event becoming a bad risk, to have to have their income that they could spend on other things greatly reduced.

If you have mandatory coverage, they will get coverage, but, especially for middle-income people, if somebody gets diabetes or has a heart attack, you don't want the insurance premium jumping 500 to 600 percent.

Community rating prevents that because it says the insurer has to charge everybody the same premium. It does solve the problem that your insurance premium won't jump, but it creates other problems.

Two important ones are, first, it will make insurers unenthusiastic about retaining you as a customer, so they put the cardiologist office up

three flights of stairs to discourage the high-risk people. I think you want to have insurers eager to sell to high-risk people and the only real way to do that is, sooner or later, allow them to collect what they think those people will cost.

To the extent that it applies to discretionary coverage that you can either choose to buy or not, it will result in high-risk people buying all the coverage they can, and low-risk people getting by with the basic minimum; so it distorts the market for insurance.

My suggestion is to allow insurers within some limits to risk rate, but then for those people who are charged with what society regards as inappropriately high premiums, subsidize them either by a high-risk pool—if the premium you are being quoted is 200 percent, you can go to a high-risk pool and buy decent insurance for some subsidized amount—or, I think, it is not outside the realm of possibility to offer subsidies to people individually based on their risk level.

REPRESENTATIVE HAMILTON. Let me ask you about this trigger idea. I guess it is a method of trying to avoid a mandate, anyway.

DR. PAULY. If it goes much longer, I will be on Medicare before it goes off. Then I won't care.

REPRESENTATIVE HAMILTON. What do you think of the triggers?

DR. PAULY. I can't comment on the politics of it. The economics of it tells me that it is going to prolong what has already been a prolonged period of uncertainty for employers, for insurers, for health-care providers. Although for a little while, it never hurts to shake people up, and I think that is probably going to be harmful.

If you don't know when the trigger is going to go off, if you are a company that offers health insurance to employees now, but what you are going to do depends on what your competitors in the labor market are doing, not knowing whether they will be required to offer insurance or not makes planning more difficult.

It is easy for me to say and hard for anybody to do. I am not in favor of rushing to do things in a hurry, but I would rather see Congress think long and act quickly, rather than think briefly and act slowly.

REPRESENTATIVE HAMILTON. If you have a hard trigger, it is going to happen.

DR. PAULY. I suppose, as far as anything is guaranteed to happen. Medicare catastrophic shows that nothing is ever certain. But then, I don't see the point of a hard trigger, exactly. I suppose, you could say that we are going to do this at some date in the future, to give people time to adjust, but that is really just a matter of whether you think the adjustment costs are that serious. I guess, I am not persuaded that they are.

REPRESENTATIVE HAMILTON. The idea is that you want to get universal coverage. You will make changes in market. You will try to achieve universal coverage, but if you don't, then you will kick in with a hard trigger and require it.

DR. PAULY. That then makes everybody bet on what will happen to the pattern of insurance coverage under insurance market reform. I think the problem with community rating, based on both my own calculations and experience in New York, is that it ends up not increasing the number of people who are insured or reducing the number of uninsured. It just substitutes.

So Fonzy drops coverage and Mr. Cunningham gets coverage.

I think even a hard trigger, based on a contingency, still leaves people in limbo in terms of the planning. I guess, for the universal coverage part, it seems to me that the bullets that need to be bitten are not really going to be any softer five years from now than they are now.

REPRESENTATIVE HAMILTON. You saw the Gephardt plan?

DR. PAULY. I read about it in the papers.

REPRESENTATIVE HAMILTON. What is your reaction? That is all I have done is read about it in the papers.

DR. PAULY. It has an employer mandate in it that I think is very problematic.

REPRESENTATIVE HAMILTON. How about the expansion of Medicare that is a big part of it?

DR. PAULY. I would rather, as I have already said, allow low-income people to get help, but have them be able to choose more than just Medicare as the policy that would be available to them. That is on the negative side.

On the positive side, though, I think it may be salutary to make available in that bill and in some of the other bills a government-sanctioned insurer, whether it is Medicare or the federal employees plan. We don't trust private insurers, and a lot of things that they have done haven't covered them with glory; at least as far as we can tell.

I think the fundamental problem is that people don't trust insurers. We all have that visceral reaction. One way to make people feel better about the private insurance market is to have available a government insurance policy, or one the government has said is a decent policy. Have market competition where there is a government entrant and if the policy that is chosen in the political process ends up being better than the market and beats out the private policies, that is fine. But at least it will keep them honest.

So there may be a role for a government-run, if not, at least, government-sanctioned option.

REPRESENTATIVE HAMILTON. On your statement that you began with on costs, is technology the chief reason for the rising health-care costs?

DR. PAULY. That is what we think.

REPRESENTATIVE HAMILTON. What other factors are present?

DR. PAULY. Roughly speaking, if you take real growth in health-care spending—if I can do this off the top of my head—real growth in health-care spending per capita is 5 to 6 percent a year; population adds 1 percent. Per capita is about 5 percent.

Of that, 0.4 of 1 percent, we think, is demographic change. It is there every year, but it is not a big deal. My own research suggests that if you take the remainder, it splits something like one-third rising input prices in the health-care sector faster than for the economy as a whole. All we really know is that it is a greater use of inputs, but we call that technology.

If you ask what does that translate into concretely, I have to say nobody knows for sure. We know that some expensive technology has spread more rapidly in the United States than in other countries.

There is also, I think, a fair amount of evidence that low-tech technological change has been important. It certainly has not been greater quantity of hospital care. That has been going south, and physician contacts have been pretty stable, so it is really——

REPRESENTATIVE HAMILTON. What does the supply of physicians in the country look like? Are we getting a lot more of them?

DR. PAULY. I guess, I don't know for sure. It has not changed dramatically from what it has been.

REPRESENTATIVE HAMILTON. They are advertising now.

DR. PAULY. Beginning in the late 1960s when one Congressman couldn't get a doctor to make a house call on Friday night, they passed a law subsidizing medical schools and requiring them to crank out more doctors to get the subsidy.

REPRESENTATIVE HAMILTON. Are we cranking out more?

DR. PAULY. It is not much different now than it was five or six years ago, but compared to what it was twenty-five years ago, the rate of adding new doctors has substantially increased. It is not all positive. For one thing, it was public money that paid for a lot of these medical educations——

REPRESENTATIVE HAMILTON. Do you think it should be public policy to educate more doctors?

DR. PAULY. I don't think there is much evidence that more are needed.

REPRESENTATIVE HAMILTON. Nurses?

DR. PAULY. My general view on that is pretty much a straight economist view. Rather than try to mess around with the market for some input, why not get the demand straightened out first, and then, certainly for nurses—maybe, physicians are different—but there is pretty good evidence that that market responds with alacrity to changing demand conditions——

REPRESENTATIVE HAMILTON. Does that mean we don't subsidize doctor education?

DR. PAULY. It is awful hard to say no subsidies, so you may want to offer some subsidies to low-income families to help them afford medical education.

REPRESENTATIVE HAMILTON. I heard about a fellow the other day who called up a doctor, never had an appointment with him before; the doc-

tor was retired. He called him at 9:00 o'clock and the doctor said come in, I will see you at 10:30.

DR. PAULY. I think that is good, but we paid a price for it. The reason for subsidizing medical education is the usual argument for subsidizing lots of kinds of education: Deserving and qualified people can't borrow the money.

There is no particular reason to believe that just because a physician was trained with money that wasn't entirely his or her own, they are going to charge low prices once they get out in practice——

REPRESENTATIVE HAMILTON. So the more doctors you have doesn't necessarily mean the doctor's fee goes down?

DR. PAULY. No.

REPRESENTATIVE HAMILTON. It must be a restraining factor.

DR. PAULY. It helps, but there may be better ways of restraining than flooding the market with doctors. It helps for access to physician services for people with good coverage and the spread of HMOs. They kick doctors around. Twenty-five years ago, it was hard to do that because there weren't very many doctors. Now, with them rather eager to even work for a salary, it makes it much easier to organize a managed care plan.

REPRESENTATIVE HAMILTON. One of the things you hear with constituents today is that people say you really shouldn't enact any health-care reform, that the market is taking care of things. How do you react to that?

DR. PAULY. I think there is certainly some suggestive evidence. The trouble is that the real data doesn't come in until three years after the fact. But there is suggestive evidence that the rate of growth in unit prices and maybe in private health-care spending is slowing down.

I don't think that is enough. I think removing or capping the tax subsidy so that when people spend money on new technology, they are spending a hundred cents of their own money, that would be an additional help. But there is evidence that cost growth is slowing down.

That goes along with my initial statement. I don't think that it is so important to be concerned with what is happening to health-care cost as to what is happening to access to insurance coverage.

I will almost be willing to let the prices and the spending take care of themselves, as I said, if you once remove the subsidy, which is like throwing gasoline on the fire.

REPRESENTATIVE HAMILTON. You don't have much confidence in cost controls by government. Does that mean, for example, cost restraints that we have put into the Medicare system, do you think that is not effective——

DR. PAULY. No. I think they can work, given enough nerve and given the right political setting; they can work to hold down costs. I think they did in Medicare. I think the DRG system slowed the rate of growth

of Part A for quite awhile. Of course, it meant people went home from the hospital sooner——

REPRESENTATIVE HAMILTON. How do you evaluate the Medicare experience with cost control?

DR. PAULY. On balance, I think it was probably a sensible thing for Medicare to do. It is a sensible thing for any insurer to say, "We have decided for whatever reason that we want to spend less and provide a little less."

In the case of Medicare Part A, the main consequence wasn't that people died or were sick, but was that they were sent home sooner and their family had to care for them. Probably, whatever extra costs were imposed on the family were more than offset by what Medicare saved, so I think any insurer ought to be allowed to do that.

I am skeptical of a decision where every insurer has to do that, regardless of what its customers want. I think the main fear I have of spending limits and such is not that they won't work, because I think certainly with enough nerve they can work, but that they won't cause the right things to be foregone.

REPRESENTATIVE HAMILTON. What do you mean, with enough nerve?

DR. PAULY. If you look at what tends to happen, not so much in medical care, the only period we really have—and it is now fading into golden memory—is the Nixon economic stabilization program.

The medical-care cost controls then were actually fairly effective, but they were known to be temporary, and, of course, when they were taken off, things exploded. But the general tendency, I think, over time, is for it to be politically more and more difficult to keep those lids on, and even that happened to some extent.

REPRESENTATIVE HAMILTON. You have had this reduction in the rate of growth of health-care costs in the last year or so?

DR. PAULY. Of the unit price, yes.

REPRESENTATIVE HAMILTON. Is that in your mind pretty firm evidence that the market is working to solve the problem of runaway health-care costs?

DR. PAULY. No. I wouldn't bet on that.

REPRESENTATIVE HAMILTON. You can't conclude that yet?

DR. PAULY. It is a question of what you mean by solving. I think it is firm evidence for the proposition that things can't go on like this forever and the market will prevent that from happening. It is not evidence, I think, for the proposition that the rate of growth is at the ideal level.

REPRESENTATIVE HAMILTON. Why is it now happening?

DR. PAULY. That is a good question. Partly, we are not sure what it is. We know that the medical part of the CPI has slowed down. A sizable chunk of that is due to the fact that the overall rate of inflation fell, so the real rate of growth in the medical CPI, although it has fallen some, hasn't fallen as much as did the nominal rate.

Drug prices seem to go through cycles and they went through a cycle up and they were due for a cycle down and now are cycling down. The physician part, I think, is due to the spread of more competitive insurance arrangements that have been extracting lower prices.

The hospital part, we are not quite sure what caused this, but the ebb and flow of new technologies were in a flat period where not a lot of expensive new technologies are coming out. We are not quite sure whether that is just one of those things.

The successor to the MRI didn't turn out to be such a great piece of equipment anyway, so we have had a breathing period, or whether it is because there is much more skepticism on the part of insurers.

The short answer is nobody knows for sure. It is hard to trace this slowdown to something that is permanently changed, which we know augers well for the future.

REPRESENTATIVE HAMILTON. In any event, from your standpoint, with regard to the question of controlling costs, you pretty much reject the idea of price controls. You reject the idea of global budgets; you put your confidence in market reforms; is that correct?

DR. PAULY. Market reforms: The main part being the tax subsidy and secondary being whatever things we need to do to make insurance markets work better. I might strike a blow as well for not going the other direction and having any willing provider laws passed that would hobble the ability of HMO's to do what they want to do.

REPRESENTATIVE HAMILTON. What about the proposal to cap the premiums? That was in the President's proposal originally.

What is wrong with that? People will say to you, what is wrong with it is, it will force rationing. Is that right? Is that simplistic, or do you think that is right?

DR. PAULY. I think that is right. There will be some technologies, probably not existing technologies, but probably new ones that will come on more slowly and be less extensively diffused, especially under a proposal like the President's, which at one point was going to have no real growth in health insurance premiums; things that we see that sound like good ideas.

There is a new drug for migraine headaches, but compared to aspirin at $4.00 a bottle, it is $200 a month. Would a HMO be able to offer that with a spending cap?

I don't think so, but they might offer it without a spending cap and it might be worth it. So this is not anything that depends on really extensive or sophisticated economic studies. It is just the basic punchline of economics; if people are spending their own money with good information, why not believe that they are doing what is best for them.

REPRESENTATIVE HAMILTON. What do you think about the medical saving accounts? That is part of some of the bills that you have expressed approval of. That is in the Ways and Means Committee bill, isn't it?

DR. PAULY. I think it is, yes. Compared to doing nothing at all, I think it is better and it may be better than some of the other proposals, but

fundamentally I think that it is a distraction from the real reform, which is to remove the distortion.

In effect, what the medical savings account does, although it can get complicated, is to extend the tax break for health care from insured health care, to apply basically to all health care whether insured or out-of-pocket, which probably means people would be less likely to buy lavish insurance policies.

On the other hand, it means that for those expenses that are now under a deductible, you are going to be paying for those expenses with tax-subsidized dollars; whereas, under the current arrangement, you won't.

REPRESENTATIVE HAMILTON. And it doesn't help the poor at all. They don't pay taxes.

DR. PAULY. Not in and of itself. The credit version in the Nichols bill, I think, is more preferable on that score than the tax deduction or tax exclusion version. The fundamental problem with it, I think, is that it is a distraction there. The real purpose ought to be to take away subsidies, not introduce more of them.

The argument I made in a recent study that I did on this, if you think that it is politically unfeasible to eliminate the tax break for the middle class that we currently get for our health insurance, it probably is better to broaden it to all kinds of health-care spending, and for that matter to the self-employed, but preferable yet would be to remove all those tax breaks. If you wish, and you want to please Senator Gramm, take the money you have saved and use it to cut the marginal tax rates for the middle class so that it doesn't have to go to government, although I think if we are subsidizing health insurance for low-income people, there is some amount of money that is needed there.

REPRESENTATIVE HAMILTON. Have you looked at the claims for savings in the Medicare or Medicaid program that is a part of many of the plans? You get huge savings in Medicare in the year 1995 to 2000. Under the President's plan, it is $118 billion. Do you have any reaction to that?

DR. PAULY. I think it could be done. As I read it, it is a kind of Medicaidization of Medicare. Medicaid produced savings, especially in the Reagan years, in large part, by reducing prices it paid to providers, hospitals and doctors. That meant it was hard to find a doctor, but when you found one, he was cheap, and Medicare certainly could do that.

I am not sure the elderly would be too happy with that happening because it would reduce their access. But the main problem I have with, at least, for instance, the savings in the Clinton bill is that they are so enormous in prospect, it is hard to believe that you could wring that much out of the system and not have some fairly serious consequences for access.

Moreover, based on some work I did for the Advisory Council on Social Security some years ago, we 50-year-olds need those Medicare

savings to build up the Part A Trust Fund. We can't have that spent right now.

Whenever I write tuition checks for my kids, I make them promise that they will support me when I am old and gray.

REPRESENTATIVE HAMILTON. Good luck.

In any event, the Medicare-Medicaid reductions that are claimed in these plans would, you believe, lead to a reduction in the quality of care and in access?

DR. PAULY. I think so, yes.

REPRESENTATIVE HAMILTON. So they are inflated?

DR. PAULY. I am not sure they are inflated. If you want to say——

REPRESENTATIVE HAMILTON. It can be done?

DR. PAULY. Yes. It is a question of will, if there is enough will to do it politically and whether it is desirable or not. It is not obvious to me why the elderly necessarily have to bear that burden to finance universal coverage for the rest of the population.

You could certainly think of revamping the whole system and saying the well-to-do elderly shouldn't be receiving government subsidies. They really didn't pay for Medicare in their working lives, so we ought to income-condition the whole thing, and you could tap a huge pot of money.

But if you stick with the standard Medicare model, it is not particularly obvious why it is efficient or equitable to take benefits away from the elderly and people on Medicaid in order to implement universal coverage.

REPRESENTATIVE HAMILTON. You have been a health economist for how long?

DR. PAULY. Twenty-five years or more.

REPRESENTATIVE HAMILTON. Why did you go into the field? It wasn't that big a deal 25 years ago.

DR. PAULY. Two reasons. I was interested in government spending. Public finance was my area. And the second shows the power of incentives; it was when the government started the National Center for Health Services Research, and grants were available to finance penurious doctoral students, and then I got stuck, but for that I would be an expert on education.

REPRESENTATIVE HAMILTON. If you were trying to predict what the health-care system of the United States would be like 5 or 10 years from now, what would you say?

DR. PAULY. I think the safest prediction is much more variegated than it used to be. It used to be that Dr. Welby only got Blue Cross/Blue Shield and that was about it. Now, we are seeing a variety of different ways of organizing the financing and delivery and that seems to be filling in the spectrum from pure HMO's to pure fee-for-service, with all sorts of things in between.

Assuming that there is no interference, I think that variety will proliferate and it depends on how diverse peoples' preferences are, but I think they are fairly diverse in terms of how they want to do it.

REPRESENTATIVE HAMILTON. Do you think we will, in fact, have universal coverage?

DR. PAULY. I think so. My sermon on this subject, which I will deliver now in short form, is the one thing that is missing, I think, is that if you are going to have universal coverage, the people—especially the low middle-income people who currently are the largest part of the uninsured—either have to pay for their insurance entirely themselves or somebody else has to pay for them.

If we reject the first one because a $34,000 family can't afford $6,000, somebody else has to pay for them. That is us upper-income people. The problem has been that such people have not been persuaded to pony up the extra money for other peoples' insurance.

My sermon basically says that they ought to because it is right, but I would have a hard time convincing, say, one of my Wharton colleagues in the Finance Department, who is not as altruistic as I am as to why it would be worthwhile to pay these extra taxes. I couldn't even say with much definition how much good it would do for the poor and lower-income people if they had to have insurance.

We are so smug in saying that it is obvious that God wants us to have everybody insured. We haven't put much effort into defining what the benefits would be in terms of health or welfare of people if they were insured. In terms of putting a campaign together to persuade middle-income people, I have to say that I think the President and the First Lady are doing it wrong, theoretically, maybe not politically, by trying to persuade the middle class that they will gain directly from universal coverage, because they won't. They ought to try to persuade them that they will gain indirectly by having clean consciences.

REPRESENTATIVE HAMILTON. You said something about a national commission. What role do you see for a national commission?

DR. PAULY. I see it essentially as a provider of information. The problem that almost everybody has—providers, insurers and ordinary citizens—in judging new technology, is how good is it, what is it worth and what are its consequences going to be for total system costs? You can figure out what a cat scanner will cost, but you don't know what it will do further on down the line.

In some ways, this just builds on things that the government already has through the Office of Technology Assessment. I think raising that activity to a higher level of coming to some judgment about what might be a sensible addition to the package of coverage would be helpful for allowing people to have confidence when they look at their own insurance policy, whether it is in line with that.

REPRESENTATIVE HAMILTON. Okay.

Do you have anything else that you would like to add for our record that I haven't covered?

DR. PAULY. I don't think so.

REPRESENTATIVE HAMILTON. Mr. Pauly, we are very pleased to have had you. We thank you for coming by and visiting with us this morning . It was a pleasure to have you.

DR. PAULY. I enjoyed it. Thank you.

[Whereupon, at 11:15 a.m., the Committee adjourned, subject to the call of the Chair.]

SUBMISSIONS FOR THE RECORD

PREPARED STATEMENT OF MARK V. PAULY, PH.D.

Propositions to be discussed:

I. RISING MEDICAL SERVICES COSTS ARE ALMOST ENTIRELY DUE TO NEW TECHNOLOGY AND WAGE GROWTH FOR HEALTH WORKERS, NOT ADDITIONAL WASTE, ADDITIONAL INSURER ADMINISTRATIVE COSTS, OR POORER HEALTH.

Implications: To cut medical spending growth, we must cut the rate of growth in either health-care employment or health-worker wages. Removing waste, improving health, or cutting insurer administrative cost will, at best, have a "one time" effect.

II. A HIGH GNP SHARE FOR MEDICAL CARE OR GROWTH MEDICAL SERVICES SPENDING ARE NOT PER SE HARMFUL TO THE ECONOMY.

Spending on home computers, or on services other than medical care have rising faster than GNP. So what?

We spend a larger share of GNP on medical care than do the Japanese, but less on seafood. Why do medical services impoverish but fish enrich an economy?

To the extent that spending growth is high because health-worker wages or health profits grow faster than prices in general, this does not harm the economy; it only redistributes profits (e.g., from buyers of drugs to widows who own Merck stock). Will lower medical spending increase the demand for Oldsmobiles?

Cutting health spending growth by cutting the growth of employment in the health sector will be good for the economy if and only if there are jobs in other parts of the economy whose outputs are more valuable than the treatment of disease, We do not know this to be true, although it probably is.

III. HEALTH REFORM PLANS SHOULD BE JUDGED NOT ON WHETHER THEY CONTROL "COSTS" (SPENDING) BETTER THAN OTHERS BUT ON WHETHER THEY CAUSE THE PROPER GROWTH IN SPENDING TO OCCUR.

Cutting costs by prohibiting or discouraging medical spending on services that are worth more than what they cost is not helpful to anyone.

IV. TWO WAYS TO CONTROL SPENDING GROWTH: HAVE THE GOVERNMENT DECIDE WHICH SERVICES ARE WORTH WHAT THEY COST, OR CHANGE INCENTIVES SO THAT CITIZENS DECIDE TO BUY ONLY SERVICES WORTH WHAT THEY COST.

Economists are highly skeptical of the ability of government to pick out the right rate of growth in cost for economy as a whole, much less the right rate for each person with different preferences (example: lithotripsy vs. surgery vs. painkillers for kidney stones).

The ideal arrangement: competition among managed care firms (without the Jackson Hole oversell): Remove all tax subsidies so people pay what their insurance and medical services cost. Imagine different health plans, some HMO and some fee for service, at different premiums to reflect different tech-

nologies: Regency Health Plan vs "Last year's technology at last year's premiums." Let consumers get good information, and then let them decide what they value.

V. HMOs ARE A GOOD IDEA, BUT THEY MAY NOT CONTROL THE RATE OF GROWTH IN COST AS MUCH AS PRICE REGULATION. ECONOMICS SAYS, "SO WHAT?" CBO SCORING, EVEN IF ACCURATE, IS USELESS AS A GUIDE TO POLICY SINCE THEY ONLY SCORE COSTS, NOT BENEFITS.

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