EQUICARE: A MODEL FOR QUALITY HEALTH CARE AND CONSUMER CHOICE IN STATE HEALTH SYSTEM REFORM

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This proposal for health system reform, known as Equiricare, was developed for the 1994 gubernatorial primary race in Pennsylvania. But incomplete access, inadequacies in public programs, inefficiencies in care, and other problems experienced in Pennsylvania are not unique to that state. While Pennsylvania data and financing plans support the case for this type of reform, the proposal could be adopted in any state.

INTRODUCTION

For a while, health care was the issue of the day. Although much of the fervor has died down, the problems still remain. Most Americans have what is the best quality health care in the world. However, significant issues still need to be addressed, most notably regarding complete access to care—bringing into the system the many individuals who are uninsured or underinsured—and in the delivery of more efficient and effective care for all. There is great opportunity for productive change. But care must be taken to refrain from “fixing” the parts of the system that are not broken and to preserve the innovation and high quality that have characterized American health care.

The Clinton administration has promised to allow states flexibility in experimenting with health system reform. Congress, too, seems committed to the idea of state flexibility, but with less concern for federal standards than the President’s initial proposal. What follows is a health care plan designed for Penn-
sylvania, but which could be adapted to any state. It meets current federal standards, but goes much farther to build on what have been the strengths of the current health system. Equicare is a progressive, proconsumer, market-based approach never tried before. Why the name Equicare? It is premised on equity principles, providing access for all by empowering each individual and family to freely choose health insurance tailored to their needs.

This plan proposes universal access through guaranteed health insurance coverage. The vast majority of families and individuals would “break even” or gain financially compared with where they stand today, while having more and better options in choosing their health coverage. People who need financial assistance would be provided with vouchers or tax credits (depending on their income) for the purchase of health insurance. There would be insurance industry reform to ensure the fair treatment of consumers. The current employment-based approach to health benefits would be reformed. No one need ever fear losing coverage. Competition, not rationing or government-imposed price controls, would be the force for cost containment.

Some experts claim that market-based health care has been tried and has failed. They are wrong. A genuine market-based universal system has never really been tried.

Briefly, here is how Equicare would work. The state would assure that every citizen (as an individual or family member) has access to health care by providing a financial structure that allows everyone to purchase their own private insurance. In return, individuals and families would be required to obtain insurance. In an invigorated health insurance marketplace, they would be able to choose and purchase the coverage they need and want. However, those eligible would continue to participate in Medicare.

Employers would get out of the business of assuming risk for health care. This is not to say they would have no involvement; they would be encouraged to act as brokers in presenting plans to their employees for their consideration, thus maintaining the beneficial effects of large-group purchasing. They could continue to offer health insurance exactly as they have been, including self-insurance.

While Equicare would require all Pennsylvanians to purchase their own insurance, it also would provide the resources for indi-
individuals and families to do so through either "health insurance wages," vouchers, or tax credits. Employers of more than twenty-five employees who are currently providing health insurance benefits would pay their employees tax-exempt health insurance wages from the funds they currently allocate for health benefits, less ten percent for a state fund for vouchers, as described below. Small employers (with less than twenty-five employees) that currently provide health insurance benefits would be required to do the same but only for those employees earning more than $25,000 per year. Employees of small businesses who earn less than $25,000 and all others who earn less than $25,000 per year and do not receive health insurance wages (including all medical assistance recipients) would receive vouchers from the state to purchase insurance. Those earning more than $25,000 but less than $40,000 per year who do not receive health insurance wages would receive state income tax credits to help defray the cost of health insurance.

Individuals and families would then be able to purchase insurance from the source of their choice. Any remaining health wages could be used for out-of-pocket health care expenses (for example, deductibles or copayments) or other forms of health-related insurance, such as long-term care insurance. In effect, health care resources in the hands of individuals and families under this plan are a "medi-save" account free from income taxes.

Employers who provide health insurance wages would still be able to deduct these amounts from their corporate taxes, but would not be liable for fluctuating premium costs and would not have to spend time and money watching utilization. Nor would they have to make decisions about the content of policies, because the employees would be the purchasers.

I. One State's Experience: Who Are the Uninsured and Underinsured in Pennsylvania?

The first priority of health system reform must be to provide access to adequate care for the uninsured and those without sufficient health coverage, integrating them into an improved system that serves all. So, we must consider why people are uninsured. In Pennsylvania, the Governor's 1992 report to the Pennsylvania Economic Development Partnership on managed competition estimated that 1.2 million Pennsylvanians are unin-
sured.¹ According to the most comprehensive study done to date—the 1988 Lewin and Associates report for the Pennsylvania Health Care Cost Containment Council (PHCCCC)—most (approximately seventy percent) of the uninsured are the working poor and their dependents (incomes below 150% of the poverty level) who do not qualify for medical assistance (MA). More than one-half of uninsured adults are employed full or part time. Approximately thirty-six percent of the low-income uninsured are seventeen years old or younger, and one out of every five is less than six years old.² The proportion of uninsured in Pennsylvania is at approximately the national average.³ A 1994 study by Kaagan Research Associates for Pennsylvania Blue Cross and Blue Shield reinforced the findings of the PHCCCC report.⁴

People are uninsured for many reasons. Some (of all income levels) are employed by small businesses that do not offer health insurance for employees. In Pennsylvania, it is estimated that nineteen percent of businesses with less than fifty employees (which employ 331,440 full-time workers) do not provide coverage.⁵ For some, it is a matter of personal choice. National statistics show that young people who pay medical expenses out of their pockets rather than purchase insurance constitute almost three-fifths of the much-cited thirty-seven million Americans without health insurance. Nationally, almost forty-six percent of the uninsured have incomes of more than $20,000 per year, seventeen percent make more than $40,000 per year, and many are self-employed.⁶

Some workers are only temporarily uninsured, lacking coverage for five months or less until they find new jobs.⁷ Two-thirds

¹. REPORT TO THE PENNSYLVANIA ECON. DEV. PARTNERSHIP, GOVERNOR ROBERT P. CASEY, CHAIRMAN, MANAGED COMPETITION: A HEALTH CARE SYSTEM FOR PENNSYLVANIA 4 (Nov. 1992) [hereinafter "GOVERNOR’S REPORT"].

². PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL, HEALTH CARE FOR THE MEDICALLY INDIGENT IN PENNSYLVANIA 1-2 (Lewin and Assocs. ed., 1988) [hereinafter "PHCCCC REPORT"]. Note, however, that these data predate the 1993 implementation of a children’s health insurance program in Pennsylvania.

³. Id. at 8.

⁴. PENNSYLVANIA BLUE CROSS AND BLUE SHIELD, HEALTH INSURANCE COVERAGE IN PENNSYLVANIA AND CHARACTERISTICS OF THE UNINSURED POPULATION (Kaagan Research Assocs., 1994) [hereinafter “PA. BCBS REPORT”].

⁵. WIDENER-BURROWS & ASSOC'S., PENNSYLVANIA BLUE SHIELD STUDY (Nov. 1991).


⁷. Id.
lack insurance for less than one year; only fifteen to eighteen percent lack insurance for more than two years. More than seventy-three percent of new employees who do receive coverage at work have to wait an average of three months before they are eligible for benefits, so they remain temporarily uninsured even after they start working. Again, many of the uninsured are those low-income families and individuals with assets or incomes that are too high for medical assistance eligibility. Some uninsured Pennsylvanians are eligible for Medicaid but have not enrolled, while others are eligible for special insurance programs for low- and moderate-income people but have not applied. Finally, some individuals have medical conditions that make them uninsurable in the eyes of insurers.

This is not to say that the uninsured are not receiving at least some care. They are. But it is often too little, too late, and usually the least efficient and most costly care, such as care in the hospital emergency room. In Pennsylvania, the uninsured use emergency room care three times more often than the insured. About ten percent of the low-income uninsured use an emergency room as their usual source of health care. The medical assistance population also overutilizes the emergency room. Together, the uninsured and those receiving MA identified an emergency room or hospital outpatient department as their usual care site in twenty and twenty-four percent of cases, respectively, versus seven percent for the privately insured. Nationally, after rates steadily increased for the period from 1985 to 1993, hospitals reported a decline in emergency department visits in 1994, due to managed care and for other reasons. This decline, however, was largest in the Pacific region. The East and Central regions continued to report increased emergency room utilization. Delays in care due to an inability to pay often lead to more expensive care that might have been avoided altogether or at least lessened with ongoing primary care.

A. Some Context: Health Care in Pennsylvania Today

It is important to understand how health care dollars are spent in Pennsylvania and what they buy. Total 1992-93 state...
health appropriations were $5.07 billion; federal health care appropriations for Pennsylvania were $3.8 billion. According to the Governor’s managed competition report, total health spending by Pennsylvanians in 1990 amounted to $30.5 billion, thirty-two percent of which was paid for by individuals, twenty-eight percent by businesses, and forty percent by federal, state, and local governments. Total health spending for 1993 had been projected at $41 billion, and, in fact, a recent report put the figure for total personal health care expenditures in Pennsylvania at $41.5 billion for the year.

Traditional measures of health status in Pennsylvania were not unlike those for the nation: current life expectancy is 73.5 years (73.7 years for the nation); the infant mortality rate is 10.5 deaths per 1000 live births (10.4 for the nation); and low-birthweight babies constitute 6.9% of all births in Pennsylvania (the same for the nation). However, Pennsylvania statistics were higher in three key areas: hospital admissions per 1000 in population (155.1 in the state versus 135.9 nationally), outpatient hospital visits per 1000 (1280.6 versus 1057.5), and, perhaps most notably, emergency room visits per 1000 (403.4 versus 361.5).

B. Pennsylvania Medical Assistance

About 1.5 million Pennsylvanians received health care in 1992-93 through medical assistance, which includes the federal and state jointly funded Medicaid program for low-income adults and children, and the state-funded health care program for general assistance recipients. More than 1.6 million Pennsylvanians received benefits in 1993-94. These programs constituted about eighteen percent of the state’s total budget for 1992-93, approximately $3 billion. Nationally, Medicaid expenditures have more than doubled since 1989.

Numbers on medical assistance spending in Pennsylvania, however, belie an important fact—the medical assistance shortfall, which is the difference between the actual cost of serving MA patients and what the state pays for that care. Like

12. GOVERNOR’S REPORT, supra note 1, at 3.
13. Id. at 5.
15. GOVERNOR’S REPORT, supra note 1, at Appendix C-4.
charity and bad debt costs, this difference is shifted to private-pay patients, particularly through higher admission and other charges, like those ten-dollar aspirins many have seen on their hospital bills. While conclusive data on these costs is not available, a public-payor survey conducted by the Hospital Research Foundation to estimate the MA shortfalls reported that statewide payments to Pennsylvania hospitals amounted to only seventy-five percent of costs for hospital inpatient care and forty-nine percent of costs for hospital outpatient care in 1987. The Hospital Association of Pennsylvania estimated that in 1991, contractual allowances (the difference between a hospital’s actual charges and the amount of payment received from insurers such as medical assistance, Medicare, and Blue Cross) were about forty-five percent of gross patient revenue. That is to say, forty-five cents on every dollar was lost due to these underpayments. The PHCCCC puts that loss at about $7.5 billion.

Charity and bad debt costs for acute care hospitals (for the uninsured and insured alike) were estimated at $311.4 million in 1985. The PHCCCC estimates a more recent figure to be closer to $500 million. These costs, in addition to the MA shortfall, are also absorbed by the system in the form of cost-shifting to private-pay patients. In a properly reformed health care system with explicit and comprehensive financing, these hidden costs would not exist. Prices would fall as shortfalls and cost-shifting were eliminated. As providers would be paid the actual cost of care for all patients, ten-dollar aspirin charges should disappear. Requiring individuals to be responsible for their health care as part of the social contract to protect the interests of the community is socially correct, just as it is right to require automobile insurance. But in the car insurance example, the requirement has not been enforced. Instead, an explicit cost-shifting mechanism was developed (uninsured motorist coverage) at the expense of individuals who do their part. This undermines the requirement in principle, is unfair, and diminishes the effectiveness of the system. Equicare solves this problem with enforcement provisions, addressed below.

In the medical assistance program, the first Pennsylvania Medicaid managed care experience served 200,000 MA recipi-

17. PHCCCC REPORT, supra note 2, at 3-4 to 3-5.
18. Telephone Interview with James Magee of the Pennsylvania Health Care Cost Containment Council (July 21, 1993) [hereinafter “Magee”].
19. PHCCCC REPORT, supra note 2, at Exhibit 3.1.
ents and included the HealthPASS program. 21 One national study has shown that Medicaid managed care per-member costs were five to fifteen percent lower than conventional Medicaid program per-member costs, attributable to less emergency room use and lower hospital rates. 22 But other studies show savings only with staff- or group-model health maintenance organizations (HMOs), or raise questions about savings. 23

HealthPASS, started in 1986 and due to expire in December 1996, is a “Medicaid-only prepaid managed care program” for parts of Philadelphia. 24 HealthPASS has saved some costs: in a comprehensive review conducted by the Government Accounting Office in 1993, the Pennsylvania Department of Public Welfare had estimated that from July 1989 through December 1991, HealthPASS saved the state $26.3 million and the federal government $15.1 million. Projected savings for 1992 were $15.2 and $9.5 million, respectively. 25 But segregated approaches to care do not seem to be an answer to what ails us. Poverty and social ills from violence and drugs to AIDS and homelessness strain our health care system like no other system in the world. 26 No system works harder or spends more to try to keep up. For example, it costs about $63,000 to treat a drug-exposed baby for just the first five years of life, and it is estimated that nationally there are at least 375,000 such babies, for a total cost of about $25 billion. This problem, like most of our other problems, barely exists in other countries. 27 We must do better.

II. Equicare: Quality Health Care and Consumer Choice

As a proconsumer, market-based approach to health system reform, Equicare puts policy into practice on a state level, build-

25. Id. at 16.
27. Id.
ing on some concepts from Mark Pauly and others28 and the Heritage Foundation's national approach to health reform.29

Under Equicare, state government is neither a player on the field (running or wholly financing health care) nor a spectator (doing nothing) but, rather, a referee assuring access and providing appropriate oversight and regulation. In this context, the delivery of health care is largely left to providers and the health care industry.

Acute care medical assistance would be folded into Equicare, but Pennsylvanians would continue to participate in Medicare. Long-term care, about thirty percent of the medical assistance budget ($1.75 billion per year), would continue to be provided. Eventually, if meaningful private insurance products develop for long-term care, a voucher approach should be examined for this as well.

Here is how Equicare would meet its goal of quality health care for all.

**Universal access/responsibility to obtain coverage**

The state would create a structure that assures that all Pennsylvanians have access to health care and would provide financial and other assistance as necessary. In return, individuals and families would be required to obtain insurance (though they could do so through employment or other groups). The state would verify this by requiring all families and individuals to submit proof of coverage (or a request for assistance with a demonstration of need) with their state tax return, even if they have no tax liability.

Society has a right to require that individuals be responsible for their health care. The days of cost-shifting will be gone: there will be no more shortfalls, charity care, or uncompensated care. Gone would be, for example, the free ride of Timothy McCoy, who dropped his insurance coverage because of the expense, came to need an operation for a herniated disk, was surprised that the hospital absorbed the $20,000 cost, but, at age thirty-four with a salary of $30,000 a year, still refused to purchase insurance30—his experience under the current system

proved that it was economically wiser to go "bare." The resulting system will be a more equitable one—everyone who can will contribute, and all will have their basic needs met.

**Guaranteed basic health coverage**

Not having insurance or having insufficient insurance can result in delayed care and sicker patients. It often also means an eventual need for more expensive and inefficient care and, again, ultimately shifts the cost to the community. A minimum level of health insurance would be required. Individuals will select their plans based on their needs, à la "cafeteria" style insurance plans. Individuals could purchase insurance from whatever sources they like, including employers who choose to continue to offer it or to serve as a broker of coverage options. To ensure that each family or individual is well protected, health insurance tax credits or vouchers will be issued by the state, based upon income.31

The state would require that the basic minimum insurance policy include the following categories of coverage: basic inpatient and outpatient care, physician and other licensed practitioner services, diagnostic tests, preventive care, emergency care, home health care, and prescription drugs. Voucher levels would reflect national average monthly premiums for a particular year; minimum policies would reflect at least the comprehensiveness and depth of current policies of average cost.32

**Elimination of unfair tax incentives**

Requiring individuals to purchase their own insurance replaces the current system in which health insurance is tax-exempt income only to those whose employers provide it, without any limits or considerations of need. Individuals who have employer-provided insurance receive a tax break that those without such insurance do not, irrespective of income, and the use of pretax dollars has encouraged people to overinsurance. Under Equicare, the system would rely on progressive financing and contain incentives for cost consciousness and for economic development in the state.

Families or individuals not receiving health insurance wages and with an income below $25,000 per year, medical assistance

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31. See Pauly, supra note 28, at 9-12.
32. See infra part III.
recipients, the unemployed, and anyone else demonstrating financial need would receive a state-issued voucher to purchase health insurance. Those with vouchers would purchase insurance from among the same health insurance options as everyone else.33 Physicians and other health care providers who routinely refuse to accept Medicaid patients because of low reimbursement levels would be reimbursed at the same level to treat (what was) this population. Providers may not want to care for poor patients for other (unethical) reasons, but there would no longer be a financial disincentive for doing so. Persons receiving no health insurance wages but earning between $25,000 and $40,000 per year would receive a state income tax credit to help defray the costs of health insurance.

The Department of Insurance would contract with the lowest bidder among insurers to choose one who would serve as a “fallback insurer,” providing coverage to those who fail to buy their own insurance but would not be eligible for a voucher.34 The premium plus a penalty for not securing coverage would be collected through the state tax system.

As mentioned above, employers would get out of the business of assuming risk for health care. This is not to say they would have no involvement: they would be able, and encouraged, to act as brokers in presenting health insurance plans to their employees for their consideration, thus maintaining the beneficial effect of large-group purchasing. They could offer health insurance, including a self-insured plan, as an employee benefit, and employees would have the option of using the health insurance wages to purchase those plans.

Employers with more than twenty-five employees would be required to pay as income to employees ninety percent of the money they are now paying toward health insurance premiums. This nontaxed income would be separately designated as a line item on the paycheck, and as health insurance wages on state tax forms at the end of the year. Employers with less than twenty-five workers would qualify for small business assistance, under which they would only have to turn over funds to employees earning more than $25,000 per year. Most of these health insurance wages would remain in the hands of employees for the purchase of insurance and would cover other health care expenses. All employers who pay health insurance wages would

33. See Pauly, supra note 28, at 13-14; Butler, supra note 29, at 3.
34. See Pauly, supra note 28, at 11.
turn over to the state ten percent of their premium costs under the current system to help fund vouchers for the poor and currently uninsured. Most families would end up at least breaking even, if not gaining financially because of this new source of income. Tax preference for health benefits would not be lost; instead, families would find themselves in a new and, in most cases, better financial situation with respect to their health care expenses.

The employer who offers coverage could still deduct the amount applied to premiums and, therefore, would have an incentive to make the offer. However, it would not be liable for changing premium costs, spending time and money tracking utilization, or making decisions about the content of policies, because employees would be the purchasers. Employers and employees will come to negotiate about total compensation packages, and those employers who offer attractive allotments for insurance, and therefore higher total compensation packages, would compete more successfully for employees. Subject to Internal Revenue Service waiver, health insurance wages, now a form of income, would be free from federal income taxation. By state law, health insurance wages would not be subject to state or local personal income or wage tax.

*Portability of coverage, without formal ties to employment*

Like life insurance or a mortgage, health coverage should not be lost because of a job change. Under these reforms, coverage would not be formally tied to employment. Consumers could select coverage from anywhere, including an employer if it is offered. If they purchase insurance on their own, they will automatically be able to carry that coverage from job to job. If they choose to be covered through an employer, they will have the right to continue that coverage if they change employment. The Consolidated Omnibus Budget Reconciliation Act of 1985,35 which currently provides for the continuation of group insurance coverage for certain employees and their dependents, exemplifies this type of scheme; however, this is a time-limited extension that runs for only eighteen or thirty-six months, depending on the qualifying event.

Free choice for consumers and cost containment through competition and the market

Consumers would be free to choose whatever health plan they prefer and would serve as a force for cost control by seeking the best price, level, and quality of coverage. Some would be willing to restrict their choice of doctor, for example, in order to get the cost savings associated with an HMO. Individuals could choose plans that are tailored to their needs. Thus, single men would not get stuck with policies that include prenatal care, childless couples could decline pediatric coverage, and so on, as people address their changing needs over the years. Health insurers and providers would compete in innovative ways and respond to patient demand.

In the Federal Employee Health Benefits Program (FEHBP), covering ten million federal workers and their families plus retirees, a wide range of plans is offered and strong competition has held down cost increases to approximately one-third to one-half less than increases in company-sponsored plans.\(^\text{36}\) Costs are also kept low because the FEHBP is not subject to state-mandated benefit laws,\(^\text{37}\) which require plans to include, as a matter of law, particular services and coverage for certain types of providers. Equicare includes the strengths of the federal program, but goes much farther.

Real health security for the elderly

As detailed under section III below, Equicare would build into health reform a new level of health security for the elderly. Under Equicare, nearly 1.3 million of Pennsylvania’s 1.8 million citizens over the age of sixty-five—seniors with incomes below $25,000 per year—would receive a voucher for the private purchase of “Medigap” insurance covering the costs left uncovered by the federal Medicare program. Consistent with the overall Equicare approach, seniors would be able to choose from a variety of levels of fee-for-service or managed care plans and, depending on that choice, could retain some of the voucher amount for out-of-pocket expenses. This major increase in health resources for the elderly would replace the PACE program, a limited, leaky safety net program covering prescriptions


\(^{37}\) Id. at 16.
for a much smaller percentage of the elderly population in Pennsylvania (single people with annual incomes below $13,000 and couples with incomes below $16,200).38

Increase consumer awareness of health care choices and costs

Once a third party is no longer the purchaser, real markets in health care would develop. Today, many patients have no incentive to care about costs—someone else picks up the tab. Often, patients have no idea what their employers pay for health care premiums, let alone for a particular procedure or test. Likewise, health care providers usually have no incentive to think about or discuss costs.

How would consumers choose under Equicare? They would select a comprehensive plan after shopping around and, if they desire, after seeking advice from an expert, as they currently do for other forms of insurance and as federal workers now do for health plans. Health advisors or trusted sellers might include plan sponsors, such as unions, religious groups, or membership organizations; employee benefits consultants; consumer organizations; doctors; or insurance brokers.39 But because individuals would choose among various plans on the basis of cost, quality, and type of coverage desired, they would have a stake in their health care like never before. They might choose a plan with high copayments and deductibles in order to minimize premium costs and would, therefore, come to care about whether a specific service was truly needed, encouraging dialogues with providers that would make them more informed consumers.

Studies have shown that the less a patient pays (or even knows) about health care costs and the more “subsidizing” that occurs, the more consumption and costs go up.40 For example, based upon an analysis of medical insurance expenditures among the insured (per person and of similar age), the lowest costs were found for individuals who insured themselves, followed by large-group, small-group, Medicaid (acute care only), and Medicare (with drugs and supplemental insurance) populations.41

39. See Butler, supra note 29, at 6-7.
40. Willard G. Manning et al., Health Insurance and the Demand for Medical Care: Evidence From a Randomized Experiment, AM. ECON. REV., June 1987, at 251, 269.
41. Id. at 263.
No rationing

No government-imposed global budgets. No price controls. No government rationing.

Commentators use varying definitions for the term "rationing." Some define health care rationing to mean practices that limit the supply or accessibility of medical services or goods.\textsuperscript{42} This definition, however, is so overbroad as to be largely unhelpful. It includes, for example, not providing ineffective treatment or a referral that a patient might nonetheless want, or not providing futile care.\textsuperscript{43} Likewise, some people say the large number of uninsured results from implicit rationing, but this confuses rationing with access issues. Incorporating the notion of beneficial care into the definition of rationing—that is, as the deliberate restriction of beneficial medical care\textsuperscript{44}—is still of limited assistance. Under this view, compliance with a patient’s refusal of treatment based on an advance directive is rationing. So, too, might be adherence to a clinical practice guideline that does not recommend screening of certain populations, or not acceding to medically inappropriate patient demands for specific care or a referral to a specialist.

Irrespective of consensus on an overarching definition of rationing, however, an example of policy that is, and should be, flatly rejected by Americans is a random restriction on care based on age, such as dialysis prohibitions that providers in Britain have integrated into the standard of care because of governmental cost constraints. Neither should Americans accept limits in research, innovation, and quality.

We do currently see price controls in the form of the Medicare system’s prospective payment diagnostic reimbursement groups and they have not worked—Medicare costs overall have spiraled out of control and are the focus of intense budget de-


bate. Medicare for Pennsylvanians would remain intact under Equicare, an issue for another day.

**Protecting consumer choice through appropriate insurance regulation**

In a strongly competitive market, insurers that try to charge excessive fees will not be able to compete. But with true competition comes a need for some regulation to safeguard the interests of consumers. Under Equicare all insurers would have to adhere to state standards that protect consumers against fraud and abuse. The following "game rules" would be put in place as added responsibilities for the Department of Insurance to enforce.

All health plans would be required to guarantee renewal, with premium increases that do not exceed the average for all participants, ensuring that people can "transport" their coverage and keep their coverage at reasonable rates should they become sick. All individuals currently insured would have the option of continuing with their current plan, even if the plan is offered through an employer. Insurers would be permitted to use risk rating, but only within legislated limits: insurers could not charge more than twenty-five percent above or below the average charged for new enrollees. So, sick families could not be charged more than twenty-five percent above the rate charged similar families of average health.

A patient protection fund, financed by insurers and self-insurers and administered by the Department of Insurance, would be established as a backup to any health insurance plan that becomes insolvent, to assure continuity of coverage. The state would also oversee advertising claims to protect consumers.

**Elimination of waste**

This reformed system could encourage healthier individuals to choose health insurance plans with lower premiums and higher deductibles and copayments. Thus, individuals might pay for more of their actual medical expenses out of their own pockets.


This could also increase consumerism as well as lower administrative costs, as fewer claims would be made.

It is also clear that the current systems, especially current government programs, foster irrationality in health care decisions, such as the Medicare requirement that favors oxygen administration in the hospital (at a cost of $900 per day) over oxygen at home (at $250 per day).

Clinical autonomy and reduced paperwork for health care providers

Physicians have been an easy target for the wrong kinds of cost containment—when looking for a quick fix, their clinical judgments are second-guessed on the basis of cost factors. Utilization review, with its forms and toll-free telephone lines, has become big business. If proper incentives and real competition can be built into the health care system, there would be less obsession with bureaucratic cost control.

Third-party payers have a right to ensure medical appropriateness, but must do so in a scientifically based manner and with much more attention to the quality of care. It is, however, the physician who ultimately bears responsibility for the patient’s welfare. That is as it should be—but the flip side is that the physician’s clinical authority and the physician-patient relationship must be preserved. The system must ensure true quality review and not just cost savings, and research on new approaches to review, such as profiling patterns of care instead of case-by-case scrutiny, is needed.

Practice guidelines should also be further developed and used. “Cookbook” medicine should never replace the art and science of medicine, but practice guidelines developed by physicians for physicians have the potential to improve medical practice, help reduce adverse events that could become the subject of litigation, and reduce so-called defensive medicine.

Excessive paperwork and claims forms create aggravation and high costs. Under Equicare, a model reimbursement form for claims would be developed for use by all plans to replace the current paper hodgepodge of 1500 to 2000 different claims forms that now exist nationally.

No state mandates for specific services or provider types

Current state-mandated benefit laws, which greatly drive up unnecessary utilization and costs, would be eliminated and con-
sumers would be able to choose the health benefits that they value instead of having to accept a plan that includes specific coverage they do not want but that was mandated by the state. This is no small matter. Pennsylvania has twenty-two such laws. Maryland mandates thirty-three different services and provider types, including, for example, alcoholism treatment and in vitro fertilization. It has been estimated that these mandates increase the costs of an average health care plan by seventeen to twenty-seven percent.

State laws restricting selective contracting and managed care plans should also be eliminated. Under “any willing provider” statutes, for example, managed care organizations are required to accept any provider willing to abide by the terms of the managed care contract. However, limitations on the types and numbers of providers and the ability to select cost-conscious providers are ways in which managed care organizations control costs. A recent study found that administrative costs alone for a typical Independent Practice Association, or IPA, model HMO would rise by forty-three percent under an “any willing provider” mandate.

**Government administration**

The State’s Departments of Health and Insurance would have responsibility for the selected new functions required by Equicare. The Department of Health would put into place the necessary structure to set the stage for Equicare: obtaining Employee Retirement Income Security Act, Medicaid, and IRS waivers; establishing an ad hoc clinical advisory board to determine minimum benefits levels with community input; establishing a board to finalize the health insurance voucher and credit rates; and disassembling the Department of Aging’s PACE program (replaced under Equicare with a voucher for the purchase of “Medigap” insurance by most of the state’s elderly, as explained above), the current state bureaucracies involved in the direct provision of care through health centers, drug and alcohol pro-


50. *Congressional Budget Office, Effects of Managed Care: An Update* 10 (Mar. 1994).

grams, and the massive Department of Public Welfare's Medical Assistance bureaucracy (except for an income verification and distribution of voucher and insurance information function that could be retained by the Department of Public Welfare).

The Department of Health would administer the long-term care component of Medicaid, and would oversee the rerouting of state and federal funds that would be used to pay for the uninsured. This plan would leave in place preventive health services (including school health services), health support services, health research, in-home services for the elderly, and the state mental health/mental retardation systems. The health care data collection and dissemination functions of the Pennsylvania Health Care Cost Containment Council, as well as a new emphasis on activities in public education about health insurance options, would be integrated into the Department of Health.

The Department of Insurance would oversee the new insurance regulations detailed above.

III. FINANCING EQUICARE

Equicare would provide for the uninsured, provide financial assistance through vouchers or tax credits (depending on income) to those who need it, and give tax preference for the purchase of health insurance for all those presently with employer-paid health insurance wages. The money needed to do this would come through the rationalizing of health care costs (making financing explicit and eliminating reimbursement shortfalls and uncompensated care); the use of current state and federal funds; and the reduction of overall costs (eliminating the bureaucracy and waste of Medicaid and getting the state out of the business of providing care through, for example, health centers and drug and alcohol centers). It would be augmented by personal resources gained from the new treatment of health insurance wages, allowing most families to break even or gain financially while raising dollars for the state.

Savings would also be achieved through increased consumer awareness and cost sharing, real competition for health insurance, incentives for preventive care, screening and wellness programs, incentives for providers to control costs, and the slowing of the overall growth of costs.

Because this is real reform of the entire system, the state would have significant savings. A slower rate of growth can be anticipated for Equicare voucher spending as compared with the
soaring costs of the current medical assistance program. Equicare would limit the growth of voucher costs (aside from demographic changes) to the average rate of increase of privately purchased health insurance. As the present Federal Employee Health Benefits Program demonstrates, consumer choice and market power do work in health care.

The likely influx of new business could potentially produce substantial additional revenues to support Equicare and other state projects, although this new business tax revenue has not been relied on in determining the feasibility of Equicare.

This is how the dollars for Equicare add up.\textsuperscript{52}

\textit{Equicare funding}

Funding for Equicare would come from redirecting existing state and federal dollars from the bureaucracies already in place and from the uninsured coverage pool of already allocated employer dollars, as described below. Existing funding for medical assistance, with the exception of long-term care (thirty percent of the 1993-94 MA budget, according to the Pennsylvania Bureau of Financial Operations' Division of Budget), would be transferred to Equicare, as would the public funds listed in Appendix 1. Total state and federal funds would provide $4.5 billion for Equicare. The ten percent contribution from health insurance wages would provide $1.15 billion, for a total of more than $5.6 billion. The estimated total cost of Equicare is $5.5 billion.

\textit{Equicare costs}

\textbf{Vouchers}

Equicare will assure that all Pennsylvanians have basic health insurance coverage without the bureaucracy and waste of the current system. Pennsylvanians must demonstrate proof of coverage, thus eliminating the need for the system and the state to "absorb" the inefficient costs of the uninsured. The (tax-free) vouchers, which are based upon income level, would provide funds for lower-income families\textsuperscript{53} and individuals who do not receive health insurance wages to purchase a basic health insur-

\textsuperscript{52} These numbers are based upon 1993 statistics, which were relevant for the 1994 gubernatorial primary.

\textsuperscript{53} The term "family" is based upon current legal definitions. For example, domestic partners would not qualify as a family, but rather as two individuals.

http://lawecommons.luc.edu/annals/vol5/iss1/8
Equicare: State Health System Reform

Equicare vouchers would be provided annually, based on age and annual income, as follows:

**Und er 65 years of age**

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual Income</th>
<th>Voucher Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families earning less than $25,000 per year</td>
<td>$4200</td>
<td></td>
</tr>
<tr>
<td>Individuals earning less than $15,000</td>
<td>$1700</td>
<td></td>
</tr>
<tr>
<td>Individuals earning $15,000 to $24,999</td>
<td>$1200</td>
<td></td>
</tr>
</tbody>
</table>

**65 years old and over**

(Would continue to receive Medicare; vouchers would be used for Medigap policies)

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual Income</th>
<th>Voucher Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals earning less than $15,000</td>
<td>$1000</td>
<td></td>
</tr>
<tr>
<td>Individuals earning $15,000 to $25,000</td>
<td>$800</td>
<td></td>
</tr>
</tbody>
</table>

These voucher levels reflect an assessment that nonelderly low-income families and individuals would be able to select from a range of quality health insurance plans (all meeting the minimum coverage categories) for a first-year cost of $4200 and $1700, respectively, based on estimated national average monthly premiums for 1994, by plan type:

**National Average Premiums**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Individual Monthly</th>
<th>Annual</th>
<th>Family Monthly</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional (Indemnity) Insurance</td>
<td>$149</td>
<td>$1788</td>
<td>$351</td>
<td>$4212</td>
</tr>
<tr>
<td>Group/Staff HMO</td>
<td>$130</td>
<td>$1560</td>
<td>$348</td>
<td>$4176</td>
</tr>
</tbody>
</table>

The total cost of the vouchers is estimated at approximately $5.3 billion, as indicated in Appendix 2.

**Tax credits**

Persons receiving no health insurance wages but earning between $25,000 and $40,000 per year would receive a state income tax credit to help defray the costs of their health insurance. These credits would reduce the Pennsylvania personal income tax as follows:

---

54. As explained in the next section, Equicare's tax credits will assist middle-income Pennsylvanians who do not receive health insurance wages from an employer.

ANNUAL INCOME | TAX CREDIT
---|---
(Under 65 years of age)
Individuals earning $25,000 to $34,999 | $500
Individuals earning $35,000 to $39,999 | $300
Families earning $25,000 to $39,999 | Full tax liability up to $1000

Precise data does not exist for estimating the total cost of these tax credits. Based on available data on the number of Pennsylvanians employed by small businesses offering no health benefits and national data regarding the income breakdown of the uninsured, this financing estimate assumes that there would be 200,000 Pennsylvanians eligible for tax credits for health insurance at an average cost of $500 per credit. Using these assumptions, the total cost of the tax credit program to the state, then, would be $100 million in the initial year.

Health insurance wages

Pennsylvanians who receive health insurance benefits from their employers would receive ninety percent of those current benefits in the form of pretax health insurance wages, designated as an additional line item of compensation and declared (but treated as tax-free) on state and federal income tax forms. The remaining ten percent would be paid by employers into a state uninsured coverage pool to help defray the costs of the vouchers and tax credits, which ensure universal coverage. This ten percent is estimated at $1.15 billion, based on total estimated employer-paid health premiums in Pennsylvania in 1993 of $11.5 billion. These figures are derived from an estimated employer share (twenty-eight percent) of the total 1993 state health expenditures of approximately $41 billion.

CONCLUSION

Equicare, based on Pennsylvania data, would provide a consumer-oriented, market-based state model worth trying. It would assure access to health care by providing a structure that allows each individual or family to purchase coverage that is tailored to their specific needs. The same advantages in buying insurance for cars, home, and life would come to health care. The cost of insurance would in many cases come down. Segregated approaches to care would end. And, most importantly, quality and efficient care would be available to all.
### APPENDIX 1

**Sources of Funding for Equicare Based on State and Federal Health Care Appropriations, 1992-1993**

**State:**
- Medical Assistance: $3,018,885,000
- Children's Health Ins: 29,300,000
- PACE: 200,000,000
- Health Treatment Services: 37,572,000
- Drug & Alcohol Services: 32,941,000

**Federal:**
- Medical Assistance: 2,828,351,000
- Children's Health Ins: 4,800,000
- Health Treatment Services: 753,000
- Drug & Alcohol Services: 76,146,000

**Total Existing Funds:**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>State:</td>
<td>3,318,698,000</td>
</tr>
<tr>
<td>Federal:</td>
<td>2,910,050,000</td>
</tr>
<tr>
<td></td>
<td>6,228,748,000</td>
</tr>
</tbody>
</table>

**Total Medical Assistance:** 5,847,236,000

**Adjust for Long-Term Care (1):**
- 30.0%

**Adjustment:** (1,754,170,800)

**Available Existing Funds:**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>State:</td>
<td>4,474,577,200</td>
</tr>
<tr>
<td>Federal:</td>
<td>1,150,000,000</td>
</tr>
<tr>
<td></td>
<td>5,624,577,200</td>
</tr>
</tbody>
</table>

**Total Revenue for Equicare:**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>State:</td>
<td>5,366,051,985</td>
</tr>
<tr>
<td>Federal:</td>
<td>100,000,000</td>
</tr>
<tr>
<td>Medical Assistance Admin (3)</td>
<td>100,000,000</td>
</tr>
<tr>
<td></td>
<td>5,566,051,985</td>
</tr>
</tbody>
</table>

**Surplus:** $58,525,215

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(1) Long term care under the Medical Assistance program will remain intact.
(2) Uninsured Coverage Premium Pool.
(3) Although it is expected that Equicare will be less costly to administer than the existing Medical Assistance Program, the same approximate amount of administrative costs have been used for these purposes.
### Appendix 2 Equicare Voucher Cost Estimate

#### Families (under 65 years old)

<table>
<thead>
<tr>
<th>Category</th>
<th>From: $</th>
<th>To: $</th>
<th>Voucher Level</th>
<th>Total Families</th>
<th>Subsidy Families</th>
<th>Non-Subsidy Families</th>
<th>Voucher Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>$0</td>
<td>$14,999</td>
<td>$4,200</td>
<td>437,637</td>
<td>437,637</td>
<td>0</td>
<td>$1,838,077,112</td>
</tr>
<tr>
<td>Category 2</td>
<td>$15,000</td>
<td>$24,999</td>
<td>$4,200</td>
<td>415,646</td>
<td>415,646</td>
<td>0</td>
<td>$1,745,712,272</td>
</tr>
<tr>
<td>Category 3</td>
<td>$25,000</td>
<td>$49,999</td>
<td>0</td>
<td>1,010,737</td>
<td>0</td>
<td>1,010,737</td>
<td>$0</td>
</tr>
<tr>
<td>Category 4</td>
<td>$50,000</td>
<td>$74,999</td>
<td>0</td>
<td>437,800</td>
<td>0</td>
<td>437,800</td>
<td>$0</td>
</tr>
<tr>
<td>Category 5</td>
<td>$75,000 and above</td>
<td>0</td>
<td>244,514</td>
<td>0</td>
<td>244,514</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,546,334</td>
<td>853,283</td>
<td>1,693,051</td>
<td>$3,583,789,384</td>
</tr>
</tbody>
</table>

#### Individuals (under 65 years old)

<table>
<thead>
<tr>
<th>Category</th>
<th>From: $</th>
<th>To: $</th>
<th>Voucher Level</th>
<th>Total Individuals</th>
<th>Subsidy Individuals</th>
<th>Non-Subsidy Individuals</th>
<th>Voucher Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>$0</td>
<td>$14,999</td>
<td>$1,700</td>
<td>209,839</td>
<td>209,839</td>
<td>0</td>
<td>$356,725,771</td>
</tr>
<tr>
<td>Category 2</td>
<td>$15,000</td>
<td>$24,999</td>
<td>$1,200</td>
<td>199,294</td>
<td>199,294</td>
<td>0</td>
<td>$239,152,953</td>
</tr>
<tr>
<td>Category 3</td>
<td>$25,000</td>
<td>$49,999</td>
<td>0</td>
<td>484,629</td>
<td>0</td>
<td>484,629</td>
<td>$0</td>
</tr>
<tr>
<td>Category 4</td>
<td>$50,000</td>
<td>$74,999</td>
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<td>209,917</td>
<td>0</td>
<td>209,917</td>
<td>$0</td>
</tr>
<tr>
<td>Category 5</td>
<td>$75,000 and above</td>
<td>0</td>
<td>117,240</td>
<td>0</td>
<td>117,240</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,220,918</td>
<td>409,133</td>
<td>811,785</td>
<td>$595,878,725</td>
</tr>
</tbody>
</table>

#### Individuals (age 65 and older)

<table>
<thead>
<tr>
<th>Category</th>
<th>From: $</th>
<th>To: $</th>
<th>Voucher Level</th>
<th>Total Individuals</th>
<th>Subsidy Individuals</th>
<th>Non-Subsidy Individuals</th>
<th>Voucher Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>$0</td>
<td>$14,999</td>
<td>$1,000</td>
<td>841,578</td>
<td>841,578</td>
<td>0</td>
<td>$841,578,235</td>
</tr>
<tr>
<td>Category 2</td>
<td>$15,000</td>
<td>$24,999</td>
<td>$800</td>
<td>431,007</td>
<td>431,007</td>
<td>0</td>
<td>$344,805,640</td>
</tr>
<tr>
<td>Category 3</td>
<td>$25,000</td>
<td>$49,999</td>
<td>$0</td>
<td>400,485</td>
<td>0</td>
<td>400,485</td>
<td>$0</td>
</tr>
<tr>
<td>Category 4</td>
<td>$50,000</td>
<td>$74,999</td>
<td>$0</td>
<td>98,164</td>
<td>0</td>
<td>98,164</td>
<td>$0</td>
</tr>
<tr>
<td>Category 5</td>
<td>$75,000 and above</td>
<td>$0</td>
<td>58,477</td>
<td>0</td>
<td>58,477</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,829,711</td>
<td>1,272,585</td>
<td>557,126</td>
<td>$1,186,383,876</td>
</tr>
</tbody>
</table>

**Totals:**

|                              | 5,596,963 | 2,535,001 | 3,061,962 | $5,366,051,985 |