

1989

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Recommended Citation

David Durenberger, *Health Care Financing: The Challenge for the Future*, 20 Loy. U. Chi. L. J. 705 (1989).
Available at: <http://lawcommons.luc.edu/lucj/vol20/iss3/2>

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Health Care Financing: The Challenge for the Future

*Senator David Durenberger**

Whenever I write about the future of health financing, I cannot help but think of the time in early 1983 right after Congress created Medicare Diagnostic Related Groups (DRGs). I was visiting the Houston Medical Center. After touring the facility, I sat down with the hospital's management, trustees, and staff. This man, who looked to be in his early 70s, wearing a surgical suit with one of those funny green hats on his head, came in and sat down in front of me. I launched into a little speech about DRGs, prospective payments, consumer choice, and all the new ideas floating around Congress for containing health care costs.

As I spoke, this little man in the green suit raised his finger and said, "Pardon me, son, but I've been all around the world and I've looked at health care in every developed country, and what you're proposing just won't work!" I realized then that I was standing there speaking with Dr. Michael DeBaky. I felt every bit the country kid from Collegeville, Minnesota, and I wondered, "What am I going to say to this famous surgeon, here in front of all his peers?" Finally, I said something like, "Well, maybe you're right . . . and maybe I'm right . . . or maybe 'right' is somewhere in between and that is what we have to find out."

Whatever "right" is, Congress faces increasingly tough constraints that are humbling. Because of the increasing life expectancy and the growing number of elderly citizens, health care costs will continue to spiral. Currently, about one-third of all health care dollars are spent caring for the 12 percent of our population over the age of 65. By the year 2000, just eleven years away, there will be over 17 million people over the age of 75, representing 6.3 percent of the population. The cost of care for this segment of the population only stands to increase.

Who is going to pay for all this health care? Not the baby boomers. For, contrary to the picture presented by Madison Avenue, these kids are not all yuppies with condos, fancy sports cars,

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and frequent trips to the Bahamas. Comprising about one-third of our population, these baby boomers are living through a stagnating economy and, as a tax base, they are not guaranteed to be able to pay for the retirement needs and health care of today's elderly, the ever increasing number of the oldest old, or even themselves.

In 1984, 70 percent of Americans between the ages of 25 and 34 earned less than \$20,000 per year. It is not getting better. In the 1950s, during the 10-year span from 25 to 35 years of age, the average American's annual income increased 188 percent. For that same period in the 1960s, the increase was 108 percent. But, a 25-year-old in 1970 saw personal income rise by only 16 percent by the age of 35.

There are costs of living, too — housing costs for example. In 1960, the average house payment accounted for 16 percent of a 30-year-old's income. In 1973, it reached 23 percent. In 1984, however, house payments took 44 percent of a 30-year-old's income. Also, look at net worth. For young families between the ages of 25 and 34, average inflation-adjusted net worth for the years 1977 to 1983 declined from \$18,804 to \$16,651. By comparison, the average net worth of all American households for the same period increased from \$41,000 to \$47,000. The reality is that the baby boomers are not saving.

So, who is going to pay the health care costs of the future? How about the baby boomers' children? The "baby bust"? For the first time, the coming generation — the baby bust — will not number more than their parents. The baby boomers are not replacing themselves with income earners and tax payers. The Social Security Administration estimates that to ensure the solvency of pension and disability funds for the baby boomers, real wages must double over today's level by the year 2015, and they must increase six-fold before the year 2060.

The poet Wordsworth wrote:

The world is too much with us . . .
Late and soon . . . getting and spending . . .
We lay waste our powers . . .
And little we see in the world that is ours.

I think that "laying waste" is what generational inequity is all about. What is our legacy? A massive national debt charged against the following generation's earnings to support our current consumption? An inadequate investment in education, leaving our youth unprepared to compete in the world marketplace?

Much of this can be blamed on our rejection of the values and

principles that shaped the ethic of past generations. Values that our parents taught us, such as live within your means and accept responsibility for your actions. These were the values of those who grew up during the depression and who fought in World War II. But, after the war, they determined that we, their children, would not have the same struggles. And so came the 30-year mortgage and the FHA home loan. As a beneficiary of this generous program, I was able to buy the average \$5,000 American home — nothing down, 30 years to pay, 4.5 percent interest, and all tax deductible. It was a deal we couldn't afford to refuse. We knew we had a good thing, so we did it with our homes, cars, health care — everything. Drinking, smoking, eating to excess, and someone else would foot the bill while we lived off the inflation created by this excess of demand over supply.

My home helped me start a business and educate my four sons. The home was my security system. But, reality is coming home to roost, along with my four sons who return because they cannot afford housing. A home today, just a small, average house, costs \$96,000, not \$5,000.

Our irresponsibility shows in our health care habits as well as our economic practices. Both are taking a heavy toll and costing more than we can afford. We drink, smoke, and drive with abandon, confident that good medical care will bail us out. But, by rescuing those who are reckless, we are rewarding reckless behavior. We have the "right" to get sick and the "right" to advanced medical intervention, but no one has the "right" to try to get us to change our lifestyle.

Now, however, it is time for choices to be made. Can we continue to subsidize the reckless behavior of others at the expense of the young, of the well, and of those whose health problems are not of their own making? Between coronaries and lung cancer, the total economic cost of smoking is \$41 billion per year, including \$4 billion in Medicare and Medicaid funds.

We have to reassess our values and teach a lesson: take responsibility for your actions. I know a county commissioner, an intelligent man, who complained to me about his insurance rates. They would be raised if he did not "buckle-up" in his car. He can live as he chooses, but not when the price so limits my choices. He must understand consequences. It is only fair that his rates go up, rather than mine.

It is gruesome irony that while medical technology and professional skill now give us boundless possibilities, our resources are

being rationed to those who can afford to pay for their own care. Choices must be made, but are we ready to stop subsidizing the imprudence of some to make access available to all?

One choice is to stop our tax subsidy of employer-paid health benefits for those who are not financially needy — to fund health care only for those who cannot afford it. Four years ago, it was estimated that the exclusion of employer-paid health benefits from the taxable income of an employee was worth about \$622 per year for employees earning between \$50,000 and \$100,000 per year. The savings for those whose income was between \$10,000 and \$15,000, was only \$83 per year. Is this the subsidy society intended? The justification was to encourage health insurance coverage. When health insurance could be purchased for \$25 a month, no one cared that the subsidies were larger for the well-off. Now, however, when premiums are \$150 to \$250 per month and when low-income families' decisions to insure will be influenced by the cost — that is, whether to buy health benefits or use the money for food and shelter — we must reexamine the subsidy.

The subsidy cost the government some \$50 billion in lost revenues in 1986 alone. Last session, I proposed the Health Equities and Incentives Act of 1986. It was designed to provide an equivalent subsidy for all — independent of employment. Every person should be encouraged to buy health protection and receive an income tax deduction for the cost of the premium, whether paid by the insured or by a third party.

Choices must be made. Despite what Dr. DeBaky said in 1983, things are different today in the way we dispense medical care. I would like to say to Dr. DeBaky that we know where we are going, that we are in charge, and that everything is under control, but I would not sound convincing. The fact is that we are rushing up to close rank, to get a glimmer of what is around the corner. To be honest, things are moving on their own — under their own energy. We try to do some fine tuning and maybe influence direction, but sometimes we are just along for the ride.

Right now, the ride is taking us to what I call a “consumer choice” environment where higher health care costs make buyers search for a deal. We now have options that, ten years ago, would have been called unrealistic. “Prudent purchasing” is the byword to alternative delivery systems, to the elimination of over-priced and over-used procedures, to providers' marketing themselves and their services, and to health care providers that are managed like other businesses — with an eye to efficiency and quality control.

This pro-competitive environment, assisted by the growing supply of physicians and changes in clinical practice, is leading us to a marketplace where providers no longer dominate and where consumers have new strength because of better information, new options, and new decision-making power.

The new competition has also placed providers under new regulations pertaining to costs and the provision of care. Restrictions instituted by the government as a purchaser of care have been seconded by the insurance industry and by private industry buyers of health care. Given its size and prominence, once the government made its pricing decisions, it drove the market. Other payers then had the nerve to negotiate. In Congress, we set dollar limits and left providers to adapt as they saw fit — within certain quality parameters set by regulation, but enforced by a purchaser in a buyer's market. What we are doing is converting our third-party payors into smart sponsors of a choice of private health plans and into smart buyers of health services. In Alain Enthoven's nomenclature, it is the beginning of the "managed competition" phase of the consumer choice revolution.

I am not talking about the lone consumer acting as a solitary, individual buyer on the demand side. Instead, this is an informed consumer with a sponsor negotiating a purchase in the consumer's best interest. This sponsor is assisted by the government's ensuring that information is accurate and not misleading. The government is also evaluating plans presented by a varied provider market, and it is reporting the results to the consumers. In addition, the government's management of this competitive market is not by means of unchanging rules or rigid and inflexible restrictions. Instead, management is by rules that are revised not only to prevent market failure, but also to meet the changing needs of the market and consumers.

On the demand side, managed competition means well-informed and active agents or "sponsors" who contract with organized health care plans. The government may or may not mandate choice of plans. The Federal Employees Health Benefit program is an example. On the supply side, the government's role in the provider market is to overcome natural attempts to avoid price competition and to avoid costly patients. Under managed competition, health plans will become efficient systems, organized to produce quality — matching resources to needs, arranging less costly care alternatives, and better utilizing allied professionals and technology.

All of this, however, presumes a level of competition and choice that is not yet present. To date, only 13 percent of our population is enrolled in competitive health plans. Also, we are still missing the real key to competition — cost conscious choices by every consumer where the additional cost of a more expensive choice is paid by the consumer in after-tax dollars and where money saved by a more economical choice goes into the consumer's pocket. In places such as Minnesota and California, especially with Kaiser Health Plans, we can see how well such a system already works.

One step at a time. The going is slow, but I think we are picking up speed. Prospective payment is on the road to capitation, bringing us closer to improved competition. Capitation is a payment alternative now being used for some Medicare beneficiaries and for Medicaid in some states. Perhaps, it is a sign of the times.

I expect that we will see major amendments to Medicare, Medicaid, and other health care delivery programs in the next several years. Currently, we are carefully monitoring the implementation of the Medicare catastrophic benefits enacted in 1988.

My own legislative interests include a tax policy change. For reasons of equity, we need to cap the tax exclusion for employer-paid health benefits. There is just no excuse for those who live below the poverty level not to receive basic health benefits under Medicaid.

Health care for the uninsured is also an issue we cannot avoid much longer. It must be addressed, if not for humanitarian reasons alone, then for our own self-interest. Delayed care or lack of needed care only results in more costly care at a later date. We need to make certain that everyone has coverage, so that we do not threaten punishment to get providers to take care of the poor, pregnant women, children, or anyone else for that matter. Delayed care or lack of needed care also impairs the employed and removes them from the roll as taxpayers; and the uninsured are employed taxpayers — 48 percent of the uninsured are employed full-time and 34 percent part-time.

State insurance pools for the medically uninsurable or mandated employer health care coverage are also possible solutions that have been discussed frequently. Whatever we do, it is imperative that we get children under the age of five and pregnant women health coverage as soon as possible. Again, if for no other reason, and I think there are many, we should do it for self-interest. A greater percentage of low-birthweight babies have long-term illnesses and

disabilities that eventually exact a far greater price than providing preventative care from the start.

In closing, I wonder how long we can turn our backs to the catastrophic injuries and illnesses of children. Ten to twenty million children suffer from some degree of chronic impairment. About 2 million are severely ill. Insurance is either not available or not affordable. About 10.2 million children under the age of 16 have no insurance and the rate is increasing alarmingly. Fifty percent of these children's families have employed parents who earn too much for Medicaid, but too little to afford private insurance. Whether subsidized or through a risk pool, we must make employer-sponsored health benefits reach more people.

In 1984, in California alone, about 9.7 percent of the children under the age of 15 were hospitalized. Only about one-half of one percent had hospital bills of more than \$50,000, with an average bill of \$100,000. Since 1985, states have had the option of covering all children below the poverty level, no matter what the family structure, but as of last December, 20 states still did not have this coverage. Most states have tied financial eligibility to Aid for Families with Dependent Children (AFDC) standards, but a woman earning a minimum wage with two children cannot get coverage — no coverage, even though she is at two-thirds of the 1986 federal poverty level for a family of three.

How can I describe the anguish of these families — an anguish that is heightened by an overwhelming financial burden taking its toll on the family life of all. Because of federal, state, and private funding restrictions and the lack of home care coverage, families are often presented with a painful dilemma — either leave the child institutionalized, where the bills will be paid, or bring the child home and risk financial ruin.

So, you have read some of what I know, some of what I think, and some of what appeals to me; yet, I wonder who is going to pay. One way or another, it will be the workers. If it is going to be our money, however, let us make sure we agree on values for the choices that must be made. Let us start making up front investments in our children, in the poor, the helpless, and those who need our help and protection. Let us not do it in a way that saddles our children and grandchildren with more debt, but let us find some of the money out of the excessive use of unnecessary and less appropriate medical services. Let us find other money in the middle class entitlements of unlimited health insurance subsidies, unlimited home mortgage subsidies, and other tax shelters that we

give to the relatively well-off. And finally, let us tax ourselves equitably to pay for the programs we authorize. Let us not "lay waste our powers."