Staff Paper 245

TOWARD PUBLIC JUDGEMENT ON HEALTH CARE REFORM: A COMMUNITY-BASED PUBLIC CHOICE PROPOSAL FOR IMPROVING HEALTH CARE *

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* This concept paper is designed to foster discussion among federal, state and local policymakers, interest group and community leaders, interested citizens, health care providers, insurance professionals, and large and small employers. The concept discussed is presented as means of developing a broader perspective and different direction not yet considered among the issues under debate in the policymaking arena. This proposal does not constitute an endorsement by Iowa State University.

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EXECUTIVE SUMMARY: ATTRIBUTES OF THE PUBLIC CHOICE PROPOSAL

* The Federal Government mandates that all U.S. citizens must be given access to a minimum level of health care. The Federal Government provides cost control and quality assurance guidelines for the states.
* States are given flexibility to determine guidelines for (1) minimum benefit coverage standards, (2) standardized forms for public health insurance pools and private benefit plans, (3) uniform payment rates, and (4) quality assurance and statewide performance evaluation.
* By public referendum vote, citizens in each county are given the opportunity to select and charter one of three new forms of community health insurance corporations or accept a fourth option by default. Each option assures that local community institutions have primary responsibility for cost control and quality of care and that all citizens in the county or multi-county area have access to minimum standards of health care established by the state and federal government.

COMMUNITY-BASED CHARTER OPTIONS

1. A COUNTYWIDE OR MULTI-COUNTY SAFETY NET INSURANCE POOL
2. A COUNTYWIDE OR MULTI-COUNTY SINGLE PAYER SYSTEM
3. A COUNTYWIDE OR MULTI-COUNTY ORGANIZED DELIVERY SYSTEM
4. A COUNTYWIDE OR MULTI-COUNTY COST RECOVERY TAX INCREMENT SYSTEM

CONSEQUENCES OF THE PUBLIC CHOICE PROPOSAL

* Stimulates reform and assures minimum health care for all citizens.
* The federal bureaucracy is reduced and local economic development is stimulated.
* The federal bureaucracy retains some control over health care costs.
* States are given an appropriate role in defining minimum standards and regulating local institutions.
* The state bureaucracy retains some control over health care costs.
* Local communities are given local control and flexibility in meeting local health care and health insurance needs.
* Citizens decide the preferred system for assuring universal access to health care in countywide referendums.
* New community-based institutions will develop and will gravitate toward institutional arrangements that are more effective and efficient in serving local, state and national needs.
* The President, Congress, governors and state legislators get credit for solving the problem. More importantly they would not be blamed for picking a single solution that is not favored in a given state or viewed to be detrimental within a large number of communities.
* This approach strengthens grassroots democracy, citizen and community responsibility and local experimentation and investment.

WHO WOULD LIKELY OPPOSE SUCH A PROPOSAL?

- Large institutional providers and insurers that would possess greater relative benefit and influence from centralized state or federal control of funding and benefit management decisions.
- Interest groups with affiliated insurance companies. In such cases, such organizations may have to choose between community economic development interests of the organization's local leaders/delegates and the profitability of the affiliated insurance company.

TOWARDS PUBLIC JUDGEMENT ON HEALTH CARE REFORM

Rising health costs and access to health insurance are nationwide concerns. However, the drafter of this concept believes that the solutions to many of the structural concerns being raised in regards to health care and insurance may be resolved more effectively by community-based institutional innovations coupled with supportive roles by state and federal government than by any single new statewide or nationwide program. This conclusion has become apparent from discussions with diverse community leaders in several recent statewide forums conducted as a part of the Iowa Public Policy Education Project. In response to expressed interest from community leaders, a new proposal concept that involves public choice has been developed.

WHY CONSIDER A COMMUNITY-BASED APPROACH?

The economic efficiency and effectiveness of federal versus state versus local health insurance institutional structures remains an open question. Recent debate on the structural solutions to health insurance access and affordability have focused on state and federal solutions--not community-based solutions. Designers of state and federal plans have even recently admitted that their plans may not work well in rural areas. Therefore, it would seem appropriate to develop and implement a carefully organized experiment of community demonstration projects to evaluate the effectiveness of selected structural alternatives in rural communities.

Compared to federal and state solutions, community-based solutions would likely be more responsive to local needs and would provide local flexibility. Such an approach would contribute to rural development which also is a major concern. Instead of building new federal and statewide bureaucracies, this approach would examine the feasibility of Community-based Health Insurance Corporations that would spread the necessary employees in each county, preserve local control and serve locally defined needs within state and federal guidelines? Following are four community-based structural alternatives that would assure universal coverage of all citizens.

OPTION 1: A COUNTY-WIDE OR MULTI-COUNTY SAFETY NET INSURANCE POOL

During the 1992 General Assembly, the Iowa Senate passed a version of a statewide public safety-net insurance pool. This proposal would examine the same concept as it would apply in a community-based approach. The average rural Iowa county has around 10,000 people. In such a county, there would be about 700 uninsured people that could be placed in the pool, if the uninsured are uniformly distributed across Iowa. Add to that number, the self-employed persons and small businesses that would be interested in lower premium costs. The pool may also add local individuals with high insurable risks assuming that state subsidies were continued and transferred to the community based insurance pools. City, county and school employees could also be added to the community-based pool under the principle that each group would have to be better off in the new larger pool than outside of it. The bottom line is that a county-wide health insurance pool with more than 2000 people could be formed in the average rural county. Such a county-wide insurance corporation would have potential economies of size of larger employer groups that presently have lower premium rates. Second, if the premiums are collected as an adjustment to state income or local property taxes, they become fully deductible for farmers and self-employed persons on their federal income taxes. Third, the paperwork and

administrative costs for local providers is reduced as the number of different insurance forms are reduced.

One version of this approach might potentially represent the equivalent of a county-wide play or pay system where all employers and resident citizens would be required to carry the minimum levels of health insurance. Individual premiums could be collected as a flat rate or graduated adjustment to the individual income tax or property tax, allowing full deductibility of health care premium costs. Such an approach would significantly reduce the number of insurance payers, benefits forms and administrative overhead costs for rural hospitals and providers. However employers who met minimum benefit/cost standards could be voluntarily excluded from the county-wide safety net pool. Residents treated from outside the county would still carry their own insurance coverage.

OPTION 2: A COUNTY-WIDE OR MULTI-COUNTY SINGLE-PAYER INSURANCE POOL

During the 1992 General Assembly, the Iowa House passed a statewide Canadian-style single-payer system proposal. Therefore, some legislative leaders may prefer forming a county-wide single payer group insurance pool compared to the previous option. In the rural community example, all 10,000 county residents would be required to pay into a county-wide insurance corporation in place of all other health insurance premiums. Employers would pay a payroll assessment into the county-wide insurance corporation. However, the employer would have no health care benefits to manage. This function would be transferred to the insurance company or local agency organized by the Community Health Insurance Corporation Board. Local businesses would be free to focus more management, labor and resources toward producing quality products and making a profit. Residents treated from outside the county would still carry their own insurance coverage. Premiums become fully deductible for the self-employed if they are collected as adjustments to state and local taxes. The paperwork and administrative costs for local providers is reduced as the number of different insurance forms are reduced.

OPTION 3: A COUNTY-WIDE OR MULTI-COUNTY ORGANIZED DELIVERY SYSTEM

The Iowa Leadership Consortium is a group of prominent Iowa employers, providers and insurers. This consortium recently recommended that an Iowa Health Commission board of seven people be established with the statewide authority to implement a play or pay plan, regulate all provider payments and to encourage and contract with local Organized Delivery Systems (ODS). Reportedly this approach is included as part of the health care proposals put forth by President-elect Bill Clinton. ODS's are private sector institutions set up by hospitals, insurers and/or employers. An ODS would be a private entity that would combine functions of employers, insurers, and providers. As a result, the incentives for quality health care and cost savings are shared. In contrast, many private institutions are presently attempting to lower their own costs by managed care and cost shifting to others. The ODS is an innovative private sector idea for reducing cost shifting and deserves examination along with the other concepts. However, local control and oversight for care of the indigent has been and arguably should

remain a role of local government as long as public funds are used to subsidize the care. Perhaps an ODS could also involve a community-based public-private sector partnership that would resolve these concerns.

This approach would also employ a county-wide play or pay system. All employers and all resident citizens would be required to carry the minimum insurance coverage. Individual premiums would be collected as a flat rate graduated adjustment to the individual income tax, allowing full deductibility of health care premium costs. Such an approach would also significantly reduce the number of insurance payers, benefits forms and administrative overhead costs for rural hospitals and providers. However employers who met minimum benefit/cost standards could be excluded from the county-wide Organized Delivery System Pool. Residents treated from outside the county would still carry their own insurance coverage.

OPTION 4: A COUNTY-WIDE OR MULTI-COUNTY COST RECOVERY TAX INCREMENT SYSTEM

This concept is based on the historical notion that county government is responsible for indigent health care expenses. This requires the local tax jurisdiction to cover the minimum defined health care expenses for all individuals that are not covered under other health insurance plans. Local government is also given increased powers to negotiate charges with local providers and to recover costs from individuals without insurance coverage and from state and federal programs for which the individual may qualify. However, if expenses for minimum health access exceed cost recovery, the local unit of government will be required to levy a local tax increment to pay for the uninsured and indigent care.

THE BOTTOM LINE: WHO SHOULD MAKE THE DECISIONS?

Each of the above community-based systems could materially contribute to resolving state and national health care concerns if demonstrations prove successful and if the demonstrations become more widely adopted in other communities. Perhaps the most important issue raised by contrasting the various approaches discussed above with the others being debated across the nation is "Who should decide the structure of our basic health care system and the benefits to be supported by public funds?" Should it be insurers, providers, employers, health consumers, diverse community leaders and respected citizens? Should it be Congress, the President's federal agencies, or "independent" federal commissions; state legislatures, the governors' administrative agencies, or "independent" state commissions; or local boards of community leaders, citizen referendums, or some combination?

One Iowa group has suggested that a single seven-member Iowa Health Commission dominated by insurers and providers be established to regulate Iowa's $7 billion dollar health care and insurance industry. This raises questions concerning potential conflicts of interests and the rationale for a single state or federal commission structure to set provider payment rates. We have a national currency, so there are merits for a Federal Reserve Board. There are merits for state commissions to regulate public utilities and other regional monopolies. But are there similar compelling reasons for a single state or federal health commission? Or is health care similar to education in that the service is locally demanded and locally supplied for the most

part. Each of the 218,000 uninsured Iowans and each of the 35 million uninsured Americans live in a community-based trade area of one or more local health care providers. Only when services become more specialized is there a need for regional or statewide health service provision.

For comparison, Iowans have decided that education--which is a $3 billion industry--appears to be too important to place under the control of a single state board. Iowa has one state board and 438 local school boards to assure universal access, manage quality and control costs. If something goes wrong the local citizens know who to call. Additional regional and state boards are organized for institutions with regional specialization or statewide higher educational service provision. The Legislature and Governor have not delegated funding decisions and payment systems for education to any specialized commission.

Let's compare the implications of having a single statewide Health Commission that regulates payments to all providers to having a system of dispersed control vested in community health insurance corporation boards in each of the state's 99 counties. Under the single commission concept, the average citizen would have more difficulty in contacting the decision-maker when a health quality problem developed. The Commission would likely be less responsive to individual citizen concerns than the concerns of large health providers, insurers and interest group lobbyists. Clearly if national or statewide safety net health insurance pools are established, only very larger insurers based in the state or national capitol will likely demonstrate capacity to bid on managing the public health insurance pool. If countywide or multi-countywide community health insurance corporations are established, small and large insurers would have an equal opportunity to bid for a portion of the state and national health insurance market.

Given, that rural communities have a disproportionate share of older aged citizens who have higher than average health care costs, the community health insurance concept is a ready made $5 to 10 million dollar rural development opportunity that most rural communities would not want to pass up. Instead of building a 100 story bureaucracy in Washington or each state capitol, why not first consider the feasibility of strengthening our communities by placing one floor of health insurance employees in each community. With today's communications and technologies, such a system could be as efficient and would provide opportunity for citizen input and local control.

A carefully designed project that demonstrates the merits and effectiveness of community-based structural solutions to the health care and health insurance concerns would provide valuable and effective health care and insurance models that have not yet been considered in the state and national debate. This approach would also discover important implications for rural communities as the nation moves forward in its national health care debate. Such an approach might even lead to national public choice proposal for health care reform that would allow local citizens and their community leaders to decide the structure of their local community health insurance institutions within appropriate federal and state regulations and standards.

The public choice approach forces each state to go through an Oregon style statewide public discussion and hearing process to gather input from diverse interests and citizens in prioritizing all possible public covered services and to establish an annual budget for state and federal government sponsored health programs. Local adjustments would be allowed within state

guidelines. Federal, state and local programs then would pay for the highest priority health care services until reaching the public budget limit. Those services deemed low priority would not be covered by public programs, however, individuals who wished to be covered above publicly defined minimum levels of insurance would still have the option to purchase additional coverage from private insurers. The Oregon plan expands the number of people covered by state and federal programs, thus reducing the number of uninsured. However, this approach requires sanction and a waiver from the federal government. Proponents of the Oregon plan argue that it rations health care according to a publicly determined priority of illnesses rather than by ability to pay. Objections are raised by (1) those who favor having the private insurers and providers decide the basic benefits, (2) those opposed to the public rationing concept and (3) those adversely affected by the rationing priorities. For example, more emphasis is placed on preventative prenatal care and less on expensive organ transplants. Some people needing organ transplants have died as a result.

THOUGHTS ON INCREASING CITIZEN AND COMMUNITY CHOICE

In today's society, most citizens have little choice in selecting their health insurer. The employer selects the insurance manager and the benefits are negotiated, therefore most people select the insurance coverage when they select their employer. Under a state or national commission, it is unclear whether citizens would have the same or more choices in picking their health insurance? However, if federal, state or local community-wide insurance pools were large enough to be divided and still achieve economies of size, why couldn't local citizens be given the opportunity to choose among three to five insurers and/or packages sanctioned by the state and local health insurance boards.

Community Insurance Corporations and/or Organized Delivery Systems could survey enrollees and specify several different levels of insurance benefits and allow several insurers to bid on all or part of the total county-wide insurance pool package. If a sufficient number of citizens didn't choose a particular insurer, the insurer would be dropped or the specific risks pooled on a multi-county basis to achieve economies of size. Adding consumer choice would add a market-oriented element to the federal, state or community-based approaches.

Health insurance costs are increasingly cited as a reason for the lack of U.S. competitiveness in global markets. Recently, a U.S. automaker claimed health insurance added $600 to the cost of each car. All of the previously outlined options allow businesses to exit health insurance management functions if they wish. They are then able to focus on producing quality goods and services more efficiently. Recent trends show employers reducing employee retirement contributions and employees moving to self-management of benefits. As a result, some people are questioning whether citizens should become more responsible for their own health and insurance? Others say demographics and competition are causing these trends and that self-management of benefits (consumer choice) will happen whether we like it or not. In an environment of international competition in plant location and investment, perhaps the time has come for the corporate culture of U.S. companies to demonstrate less paternal responsibility for their employees. If so, perhaps we are entering an era when citizens and communities once again must take the leadership in solving their own collective problems. Local citizens and communities--large and small--are at the front lines of dealing with access and affordability of

health care whether we like it or not. Perhaps state and federal government should play a supporting role in facilitating change rather than attempting to develop a single model for solving all the health problems of every citizen and community. Why should the federal or state government attempt to replace and/or duplicate what communities and local citizens could probably do better?

WHAT IS THE PROPER ROLE OF GOVERNMENT?

Regardless of the approach used, a basic principle of our democracy has been that it is the role of government--not the private sector--to define the rights of individuals and to regulate private sector market behavior to assure that the rights are protected. If we consider access to a minimum level of health care to be a right of all citizens, there is a role for government to be involved, regardless of whether we choose a structure with one state or federal program or 10,000 community-based health insurance corporations nationwide.

The role of markets and the private sector is to create an efficient and productive economy. Adam Smith theorized that this occurs as each individual and firm in the private sector acts in their own self-interest and greed. As a result, businesses do have an incentive to keep health care costs down and to limit the number of employees with high health risks. But someone must pay for those who are excluded when they cannot provide for their own minimum needs.

If access to minimum levels of health care is viewed by society to be a right of all citizens, then it can be argued that elected political institutions are the more appropriate repository for leadership on health care, because the very nature of the market-oriented private sector assures that those who cannot provide for themselves will do without. Presently, many experts argue that private sector leadership has resulted in overemphasis on more-profitable treatment strategies and under-emphasis of more cost effective preventive care strategies. Cost recovery is more difficult for consumer education, screening programs and other preventive measures. The Oregon experience seems to support this contention. When studies report that half of all illnesses are environment or lifestyle related, one begins to wonder why more emphasis has not been placed on prevention programs and incentives for individual responsibility.

Perhaps one reason is private sector profitability incentives. Some argue that citizens and communities should take or be given more responsibility for their own health care. Others hold that individuals have always held part of the responsibility. While many people may agree with the first statement, still others would argue that institutional barriers have clouded individual citizen and community responsibilities and the doctor patient relationships by distorting the consumer price signals on health care and by removing most of the consumer choice on what insurance benefits to hold. Micro-management and managed care further reduces consumer choice on decisions regarding which doctors you are allowed to see, what provider can charge for specific procedures, and what procedures will be paid for certain illnesses. Therefore, if citizens and communities are to be given more responsibility for their own health care, institutional structures that will allow this responsibility to be exercised must first be invented, demonstrated and practiced.

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