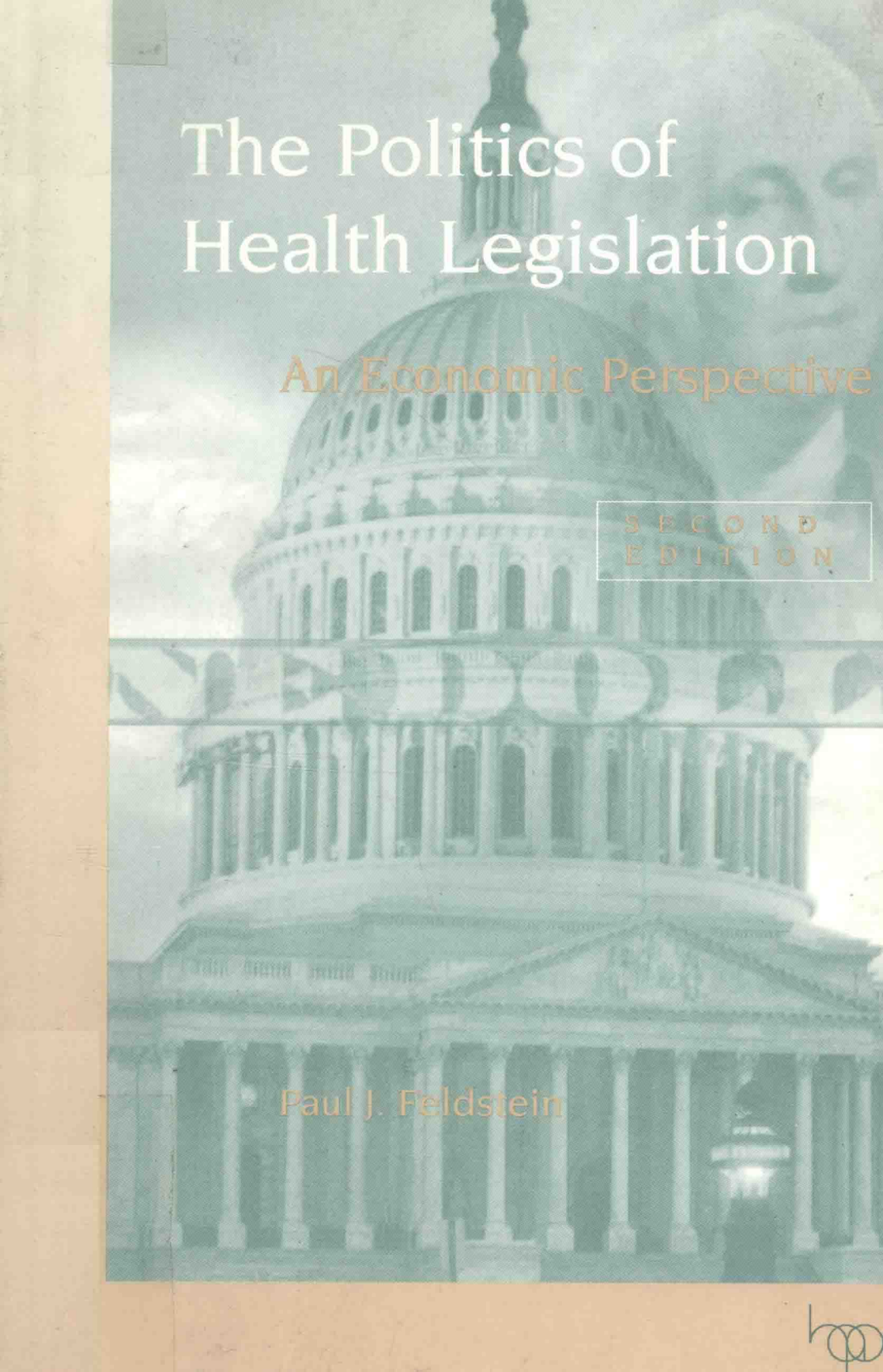

The Politics of Health Legislation

An Economic Perspective

SECOND EDITION

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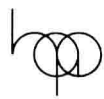

Health Administration Press
Chicago, Illinois 1996

00 99 98 97 96 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Feldstein, Paul J.
The politics of health legislation : an economic perspective / Paul J. Feldstein. — 2nd ed.
p. cm.
Includes index.
ISBN 1-56793-045-X
1. Medical economics—United States. 2. Medical policy—United States. 3. Medical laws and legislation—United States. I. Title.
RA410.53.F46 1996
338.4'33621'0973—dc20 96-11238
CIP

The paper used in this publication meets the minimum requirements of American National Standard for Information Sciences—Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984. ♾™

Health Administration Press
A division of the Foundation of the
American College of Healthcare Executives
One North Franklin Street
Chicago, IL 60606
312/424-2800

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To two special people,
Rita and Joseph Shore

PREFACE

MY INTEREST in health politics was first stimulated by economists who extended economic analysis into nontraditional areas, such as regulation and legislation. My 1979 book, *Health Associations and the Demand for Legislation,* focused on one aspect of the economic approach toward viewing health legislation, namely producer regulation. This book continues that analysis.

Producer regulation is only one activity of government. Here I also consider legislation directed toward controlling externalities, such as pollution and medical research, and toward making explicit redistributions among population groups, as occurred with Social Security and Medicare.

To be useful, an analytical framework for viewing legislative outcomes should be generalizable over a wide range of government activity. That is what I have attempted to do. My purpose, which may seem quite ambitious, has been to use the taxonomy of economics to explain legislative outcomes in the health field. An analytical framework should be explicit in its assumptions as to what motivates the various decision makers. Self-interest, among individuals, groups, and legislators, is assumed to be the underlying motive generating legislative change, thereby giving rise to the hypothesis referred to as the Self-Interest Paradigm.

Economics is exciting because it is a way of thinking. One can use economic analysis to explain various types of events, whether they be historical, current, or political. To the extent that the Self-Interest Paradigm illustrates an economic approach for explaining legislative outcomes and provides insight into previous health legislation, this book will have served its purpose. It is hoped that those interested in health policy find the discussions and analyses useful. To make this book suitable for a diverse audience, no prior knowledge of economics is assumed.

An author is always indebted to others for assistance, critiques, and comments. For the first edition, I particularly want to thank Jack Tobias,

Reference Librarian at the School of Public Health, University of Michigan, for his aid in locating various source materials. Jeremiah German, Stephen Crane, and Kathe Fox made detailed comments on the manuscript for which I am grateful. I was also fortunate to have received extensive and useful comments from an anonymous reviewer. Needless to say, not all of those who provided me with comments necessarily agreed with all the analyses presented here.

This second edition updates the material and references and also adds two new sections, a discussion of the changes to Medicare and Medicaid being proposed by the 1995 Republican Congress (Chapter 9) and a new chapter (Chapter 10) on healthcare reform, which discusses the failure of President Clinton's health reform proposal. These two redistributive proposals provide new material to test the validity of alternative legislative theories.

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Irvine, California

CONTENTS

CHAPTER

1

INTRODUCTION

In 1966, the first year of Medicare and Medicaid, total personal expenditures on medical care in the United States were approximately $40 billion. Almost 30 years later, personal medical expenditures had risen more than twentyfold, to almost a trillion dollars.[1] The rise in medical expenditures has exceeded the rate of inflation over that same period and has risen faster than any other sector of the economy. In 1966, 5.2 percent of our gross national product (GNP) went to medical care; almost 30 years later more than 14 percent of GNP was being spent on medical care.

The rapid rise in medical expenditures and its increasing share of this country's resources represent a massive redistribution of wealth. The flow of money has gone from the working population, who have had to pay for these increased expenditures, to healthcare providers. The burden on the working population of this shift of wealth has been both direct and indirect. When employees and their families have to pay higher prices for medical services and a larger premium contribution each month for their health insurance their awareness of their role in financing medical care becomes more obvious. However, the purchase of health insurance, by employers (with before-tax dollars) makes many employees believe that such insurance is "free," when, in actuality, the employee ends up paying for it through lower wages. The working population also finances the federal and state governments' medical expenditures,

which now represent about 44 percent of total medical expenditures, through higher taxes. These indirect methods of financing medical expenditures, through employer-paid health insurance and higher taxes, has, until recently, tended to make the financing burden less noticeable by the working population.

The rapid increase in medical expenditures was caused by several factors: the inflation that occurred in all sectors of the economy; the growth in the population of approximately 1 percent per year; the aging of the population; and, importantly, the medical innovations and improved treatment techniques that enable people to live longer, in less pain, and with fewer debilitating illnesses.

Despite this vast increase in medical expenditures, there are still many who are uninsured. Estimates are that 15 percent of the population, or 35 million people, are uninsured. Many others who are eligible for government programs serving the poor (Medicaid) receive inadequate access to medical care. And, there is concern that the huge increases in medical expenditures have not been well spent. Many believe that there has been inappropriate use of services and excessive inefficiency in the delivery of medical services. Physician incomes have been higher than necessary to attract new people to the health field; there has been unnecessary duplication of costly facilities and equipment; and there has been "too much use" of medical care, since the cost to patients has been greatly reduced by private insurance and government programs.

The federal government's role in healthcare increased dramatically in 1966. Federal expenditures under Medicare (healthcare for the elderly) and Medicaid (a federal-state matching program for payment of medical services to the poor) rose from $5.3 billion in 1966 to more than $290 billion in 1996. Initial expectations of the cost of these programs were greatly exceeded and a number of changes have been instituted to reduce expenditure growth. In the mid-1980s, hospital prices for serving Medicare patients were controlled as well as how fast they are permitted to increase each year. And yet, the Medicare Trust Fund is still estimated to go broke by 2002.

As states have seen their Medicaid expenditures rise from approximately $5 billion to about $60 billion a year (the federal government matches that amount), many have cut back on the eligibility definitions of those who are poor and receiving their medical benefits. And perhaps worst of all, after hundreds of billions of dollars have been spent on Medicare and Medicaid, it is widely acknowledged that Medicare does not meet the health needs of many elderly and that large segments of the poor do not have adequate access to needed medical care. Many elderly who depend on Medicare have to fall back on the state as Medicaid recipients.

Medicare and Medicaid are the two major healthcare redistributive programs. Neither of them have lived up to expectations. They have never been as efficient nor as equitable as they might be. The performance of these government programs, however, is the rule rather than the exception. Few if any federal (or, for that matter, state) programs are as efficient or as equitable as they might be.

It might be said that the extraordinary growth in medical expenditures could not have been anticipated; that the resultant inefficiencies in this sector and its poor economic performance are the result of rapid growth. If only the policymakers had known, payment systems would have been designed differently. If we were to do it all over again, a more "rational" system could be put into place.

These explanations are based on an assumption of ignorance on the part of well-meaning policymakers and legislators. The history of the health field since the late 1940s, however, should not be so easily dismissed or misinterpreted. Health legislation is a continuing process. Those who believe that future policies are likely to be more "rational" because well-meaning legislators and policymakers are now better informed are likely to be disappointed once again.

Health legislation and regulation are generally not based on ignorance. Instead, the type of legislation that is enacted (as well as not enacted) is the result of a very rational process. The resulting legislation and regulations are, for the most part, what was intended. If the legislation was "poorly designed," that is, the costs are greater than the presumed benefits or even greater than necessary for achieving its stated purpose, then why not assume that was the real intent of the legislation? This view does not mean to imply that all participants in the policy process have perfect information on the consequences of their actions, rather that the process is sufficiently rational to serve as the basis for understanding legislative outcomes.

Our purpose is to demonstrate that legislative and regulatory outcomes in healthcare are consistent with the hypothesis that individuals, groups, and legislators act to serve their own particular self-interest, *which in the case of legislators is to be reelected.* A basic assumption underlying this approach is that the legislation that was passed, and the design of that legislation, was as intended by the legislature.

An economic approach to politics is not new. Concerns about the use of government for selfish interest have existed as long as the idea of government itself. Moreover, they have been amply recorded: James Madison and Adam Smith wrote on the subject. More recent formalizations have been provided by such economists as Anthony Downs, James Buchanan, Gordon Tullock, Mancur Olson, George Stigler, Richard Posner, and Sam

Peltzman.[2] No new theoretical contributions are provided here. Instead, the economic approach for viewing legislative outcomes is applied to healthcare and used to provide an understanding of the type of health legislation this country has or has not had.

The approach used in this book to explain legislative outcomes—the "Self-Interest Paradigm"—assumes that individuals act according to self-interest, not necessarily in the public interest. Individuals, as legislators or voters, are assumed to act no differently when it comes to politics than they act in private economic markets; they pursue their self-interest. For example, legislators (and regulators) are assumed to act so as to maximize the political support they receive. Legislators require political support to be elected, which the late Sen. Everett Dirksen claimed is the first rule of politics; the second rule is to be reelected. Organized groups that are able to provide greater political support are expected to have greater political influence than groups or voters who are not organized. Organized groups seek to achieve through legislation what they cannot achieve through the marketplace. Such legislative benefits provide producers with greater incomes and organized, politically powerful, population groups with economic gains such as net subsidies or legislation mandating their social preferences.

The massive redistribution of wealth that has occurred in the medical care field has particularly benefited two groups: First the aged, who, as beneficiaries of the federal Medicare program, have received medical services whose value greatly exceeds what the aged have paid. The second group of beneficiaries are those employed in the medical sector, health-care suppliers, and health providers, such as hospitals and physicians, whose revenues have risen more than would otherwise have occurred. These two beneficiary groups have provided legislators with the necessary political support for receiving legislative benefits.

Which Theory of Legislation?

Alternative theories of legislative outcomes exist. At different ends of the spectrum are the "public interest" and the "economic" theories. The basic assumption underlying the public interest theory is that legislation is enacted because well-meaning legislators act according to what they believe is in the public interest. The outcome may not always be as satisfactory as desired because of ignorance or unexpected occurrences. The underlying motivations of the participants and legislators differ in each of these theories as do the theories' predictions and conclusions. While our emphasis is on applying the Self-Interest Paradigm, which is similar to economic theories, to the health sector, at times this approach

is contrasted with the public interest theory. The underlying hypotheses and predictions of the Self-Interest Paradigm are clarified when its explanations and predictions are contrasted with an opposing approach.

The public interest theory assumes that there are two basic objectives of government, to *improve efficiency* and, second, to *redistribute income in a more equitable manner.*

The reasons for market inefficiency, justifying government intervention according to the public interest theory, are twofold: *monopolization of a market,* such as a utility company being the sole supplier of electricity services for a region, and the *existence of externalities,* which may occur when, as a by-product of producing its product, a firm produces air or water pollution that harms members of the community. In both of these instances, the government can improve market efficiency if the costs (marginal) of producing the service are more closely aligned to the benefits (marginal) received from that service. In the case of the monopoly utility, the price of electricity may be regulated to bring it closer to the cost of producing electricity. When water or air pollution occurs, the government should assess the cost of such pollution and add it (via a tax) to the costs of the product sold by the firm, so that the purchasers of the product bear the full costs of the goods they buy.

The second objective of government, redistribution, is based on the values of society, namely, how equitable should be the distribution of resources? Should society decide that medical services should be more equitably distributed, then those with lower incomes would be expected to receive net benefits (their benefits exceed their costs or taxes) and those with higher incomes should incur net costs (their taxes exceed their benefits) from the legislation. Crucial to the evaluation of redistributive legislation is which population groups are eligible for the benefits and the types of taxes imposed to finance those benefits. When eligibility is by income and income taxes are used to finance the program's benefits, it is likely that redistribution occurs from high-income to low-income groups.

The government has three policy instruments it can use to achieve its two objectives: expenditures on a program, tax policy, and the use of regulations.[3] Further, each of these policy instruments can be directed to the demand (purchaser) or supply (provider) side of the market. For example, the government has subsidized (expenditure policy) medical schools to increase the number of physicians (supply side) and has also subsidized the purchase of medical services by the aged (demand side). Tax policy has benefited employees by excluding employer-paid health insurance from taxable income (demand side) and enabled not-for-profit hospitals to pay lower interest costs by issuing tax-exempt bonds (supply

side). State government regulations specify which medical services and practitioners must be included in health insurance sold in that state (demand side) and some states require government approval for building a hospital facility (supply side).

In contrast to the public interest theory, there is only one government objective to be achieved under the Self-Interest Paradigm, namely redistribution. However, redistribution is not meant to result in a more equitable redistribution of medical services. Instead, the power of the government is used to redistribute *wealth* to those able to offer political support, while financing that redistribution by imposing costs on those unable to offer political support. Those who are able to offer political support are typically middle-income and high-income groups, not those with low incomes. The same three policy instruments are used to achieve the wealth redistribution objective.

Thus these two theories have opposite predictions. In one case the policy instruments of government are meant to improve market efficiency and to achieve a more equitable distribution of medical services. According to the "economic" theory, the only objective is to use the policy instruments of government to increase one's wealth. To test which theory is more accurate, it is necessary to examine the objective to be achieved when one of the different policy instruments is used by government. Is it the efficiency and redistribution objective of the public interest theory or is it the redistribution of wealth of the Self-Interest Paradigm? If government policies result in greater market inefficiencies and the middle-income and high-income groups receive net benefits, while those with low incomes bear net costs, then the Self-Interest Paradigm is a more accurate description of the political process.

To be useful, a theory should be able to predict better than alternative theories. A theory does not have to be 100 percent correct to provide a useful framework for understanding health legislation. A theory that explains 70 percent of legislative outcomes in healthcare is preferable to one that can explain only 40 percent. Until a more accurate theory comes along, one that predicts better than random guesses is more useful than no theory at all. Although not 100 percent correct, such a theory still provides useful insights.

Another criterion to be used for determining which is a more useful theory is a theory's generalizability. Constructing a separate theory for each legislative outcome is not as useful as one theory that applies to a wide range of legislation. Unique legislative theories are not theories of legislation. Requiring a separate theory for each piece of legislation is admitting that there are no generalizable principles. If there are generalizable principles, a theory should be applicable for different types

of legislation; such a theory and its assumptions should provide greater understanding of the legislative process.

Economists have often been criticized because of their simplified assumptions and their disregard for the richness of detail and the complex interactions of personalities, aspects that others believe are necessary for understanding legislation. Many policy analysts emphasize the idiosyncrasies of individual legislators in determining the outcome of legislation. The case study approach often emphasizes the participants involved. The result is usually a chronological review of what occurred and why as the legislation moved through the various sub-committees and committees, and how it was amended as it made its way to final passage or defeat.

While case studies can make a valuable contribution to understanding a particular piece of legislation, they do not enable us to generalize across different types of legislation. Case studies may suggest some hypotheses, which can later be tested, but, by their emphasis on detail, generalizable principles are often neglected or downgraded. Further, without some generalizable principles of legislative outcomes to guide the investigator, case studies may neglect appropriate data. When the detail surrounding each piece of legislation achieves overriding importance, then it becomes difficult to develop generalizable principles. Unless one knows what to look for, the underlying motivations of the participants and the organizations they represent might never be questioned.

To construct a generalizable theory, it becomes necessary to simplify the determinants of legislation. Information regarding legislators' personalities and institutional settings may at times have great importance. However, if generalizable principles are to be developed it becomes necessary to cut through much of the detail.

Once generalizable hypotheses have been developed, incorporating institutional detail into the theory may improve its explanatory power. However, the main test of a theory is its ability to predict and to be able to do so, generalizable principles are necessary. Detail may serve to further illuminate what happened. But without a theory, detail merely provides interesting background information.

In constructing a theory of legislative outcome, certain simplifying assumptions regarding human behavior are necessary. For example, legislators are assumed to act *"as if"* they were solely interested in maximizing their chances for reelection. Knowledgeable students of the legislative process could immediately provide examples of legislators who were more interested in the public interest than in their own prospects for reelection. There are (and undoubtedly have been) legislators who "would rather be right than President." And some legislators are ignorant of the issues. However, if we are interested in predicting the legislature's