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The Simon Review

Reforming Health Care: The Paradoxes of Cost

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Paper # 16

Reforming Health Care

The Paradoxes of Cost

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When I accepted the gracious invitation to deliver the Dr. Arthur Grayson Distinguished Lecture this evening here at the Southern Illinois University School of Law, I anticipated two things, one of which has turned out to be true. First, I anticipated that I would feel a wonderful sense of homecoming upon returning to Illinois, where I was born and spent many of my summers growing up.

I realize that here in Carbondale, Moline, where I was born and spent summers with my maternal grandfather, seems somewhat far away. However, having lived and taught in New York and Connecticut for the last 40 years, I expected that coming here would produce warm feelings of nostalgia for Illinois—and indeed it has. On the outside, I may look like a gray-haired law professor but I assure you that, deep inside, is the little boy for whom the highlight of his year was accompanying his beloved grandfather through Illinois summer evenings as my grandfather inspected his drive-in movie theaters in Moline and Rock Island.

Although most folks associate Elvis Presley's film *Blue Hawaii* with the Aloha State, I associate that film with the Land of Lincoln, having watched it for 14 nights in a row in the summer of 1962 at my grandfather's Moline drive-in. When I accepted the invitation to speak here, I anticipated that, as I crossed into Illinois today, The King himself would be waiting for me at the border. And I firmly believe that he was.

But now let me confess the second assumption I held when I agreed to speak here

tonight: I assumed (incorrectly as it has turned out) that, by now, Congress would have adopted and the President would have signed federal health care legislation, and that I would be here tonight pontificating about the implications of this legislation. On this one, I guessed wrong.

So let me explore with you why my judgment on this score proved inaccurate. In the proverbial nutshell, whatever happens in Washington in the weeks and months ahead, the United States is fated for the indefinite future to conduct a prolonged and difficult national debate on health care. The reason for this protracted and arduous argument can be summarized in a single word: cost. Yet, paradoxically, the rhetoric of unspecified cost reduction is used to avoid the painful choices needed to prune health care outlays, choices that inevitably involve agonizing denials of medical services in a world of finite resources.

Medical costs cannot be controlled without denying something to somebody. Yet, paradoxically, the term “cost” is used in contemporary political discourse to avoid the difficult choices involved in such denials. It is easier to favor unspecified cost reductions, than to identify particular service denials that would actually reduce medical care expenditures. Elected officials are reluctant to deny medical services to cut costs, but health care costs cannot be meaningfully controlled without such service denials.

Our employer-based system of medical care is a major reason we confront this difficult situation. Yet, again paradoxically, the employer-based system, though flawed, is the best tool available to us to control medical care costs because employers must respond to competitive pressures in the marketplace and thus are better positioned than is government to implement the painful service denials necessary to curb health care outlays. However, even under the best

of circumstances, medical care costs are not a problem that will be solved, but rather are a reality to be permanently and painfully managed and controlled.

That was the nutshell version of my speech. Now comes the real thing.

The underlying economics of American medical care are at this point well-known. As a society, the United States spends substantially more on medical care than any other nation and those expenditures are rapidly increasing. If we simply project forward the current rate of American medical care inflation, at some point in the not-so-distant future, government-sponsored health care (Medicare for seniors, Medicaid for low income persons) will crowd out virtually all other government activities. Even if we discount these kinds of projections as overly-alarmist, increased government spending on medical care will hamper financially the federal and state governments or result in onerous tax burdens. The predictions for the private sector are equally dismal, as businesses and families will find increasing outlays for medical care squeezing their budgets. In recent years, the stagnation of cash wages for large segments of the American workforce has been caused in significant measure by the increasing costs of employer-provided medical care, costs that have compelled employers to restrain cash wages to remain competitive. Hence, the demand, from a variety of perspectives, that we control the “costs” of medical care.

However, true cost control entails pain. Consider, for example, Medicare’s outlays at the end of life. Roughly 30% of Medicare expenditures occur during the patient’s last year of life. Some of this end-of-life care is palliative and thus relatively inexpensive. Some of this care is for patients who die unexpectedly. However, the American medical system provides aggressive

treatment at the end-of-life, which other nations do not. We cannot reduce the burden of medical costs without curbing these end-of-life outlays for aggressive care. Nevertheless, most Americans, and certainly most Medicare recipients, are not prepared to confront this issue. It is easier to talk about unspecified “costs” than to terminate care.

The problem came into particular focus for me personally as my family simultaneously lost two friends to cancer. In one case, a friend my age was diagnosed with terminal cancer. This individual was covered by employer-provided medical insurance in the United States. He resisted his disease heroically and for two years received the full panoply of anti-cancer treatments before succumbing, as the physicians had predicted he would.

At the same time, a much younger man, the son-in-law of a friend of ours covered by Israel’s national health insurance, was also diagnosed with terminal cancer. Despite his youth and the fact that he was the father of a young child, the Israeli doctors made no effort to prolong his life.

The Israeli system did a better job of controlling costs than did the American medical system. But it did so by denying care. Despite all of the rhetoric about controlling medical costs, there is no willingness on the part of the American public or United States policymakers to specify the service denials required to control costs. Hence, we hear anodyne rhetoric about cost reduction, rhetoric with no substance because specifying substance would make clear the pain necessary to control our medical outlays.

Consider in this context the recent debate about whether the President proposed to establish “death panels.” President Obama countered this provocative characterization by

retorting that he only wants voluntary counseling for older persons confronting end-of-life issues. No one, the President assured us, wants to “pull the plug on Grandma because we’ve decided that it is too expensive to let her live anymore.”

The participants on both sides of this debate carefully avoided the crux of the issue, the need to control end-of-life outlays, particularly as Baby Boomers start queuing up in large numbers to meet the Grim Reaper. We will need “death panels” to control Medicare’s costs if, by such panels, we mean authoritative bodies curbing expensive end-of-life treatment from Medicare. In a world of finite resources, we cannot afford to provide infinite care.

Many senior citizens, notwithstanding the President’s assurances, believe that a serious effort to reduce Medicare costs would affect the medical services they will receive. These seniors are correct.

Another source of medical cost inflation in the United States is our use of advanced medical technology and treatments that the rest of the world considers elective. We Americans, for example, are the world’s heaviest consumers of MRI services and elective surgery. Here I invoke an example I know well: my own left knee. When knee pain made it impossible for me to ski, I was quickly whisked into an MRI and, shortly thereafter, had arthroscopic surgery at little out-of-pocket cost to me personally. I am now again endangering myself and others on the slopes. Like many members of the Woodstock generation, I have no intention of growing old gracefully. From my selfish perspective, I received today’s American medicine at its best.

A generation ago, I would instead have been told that my skiing days were over. In other

societies, the national health service would say this to me today or would put me onto a long waiting list.

In short, controlling medical outlays means taking away services. No one, liberal or conservative, Democrat or Republican, wants to discuss this reality. It is easier to talk about unspecified cost reductions, make vague calls for undefined sacrifices, or denounce “rationing” without explaining how to pay for unlimited medical outlays in a world of limited resources.

Well, you may ask, what about all of the avoidable administrative expenses and unnecessary procedures of the American medical system? I personally am skeptical of such diagnoses. Although there undoubtedly are savings to be achieved along these lines, I doubt that, by themselves, such savings can make more than a modest contribution to controlling medical costs.

But even if one is more optimistic about the savings potentially to be achieved by reducing administrative outlays and unnecessary medical procedures, another sobering truth suggests that such savings will not be obtained painlessly: every unnecessary administrator is a voter. Every provider of an unneeded service is somebody’s constituent. Savings that are easy to achieve are achieved easily, which is to say, they have already been implemented.

Another variant of the cost-reduction-is-easy theme invokes some of our nation’s most prestigious medical institutions, like the Mayo Clinic and the Cleveland Clinic. These institutions, we are told, consistently obtain better than average medical outcomes at substantially lower than average costs by changing the financial incentives of physicians. By eschewing the entrepreneurial, fee-for-service model of medicine, these institutions avoid unnecessary care



and provide better care.

Sounds good: Better care at lower cost. So why has there not been a clamor for medicine along these lines from employers providing insurance for their employees and from the recipients of medical services? It is because we have been down this road once already when we were told during the 1990s that managed care and health maintenance organizations were the solutions to our nation's health care challenges. The public hated it, which is why the Obama Administration carefully avoids these (quite accurate) descriptions of the models implemented by the Mayo and Cleveland Clinics. Yes, these prestigious institutions and some other providers satisfy medical care consumers at lower cost through a managed care model. However, on the whole, the American people resent their experiences with programs that provide care through large organizations and restrict patients' choices.

During the early 1970s, Robert Young portrayed on television Marcus Welby, M.D., the iconic family physician for my generation. Marcus Welby did not know about managed care. He practiced with a younger physician, to whom Dr. Welby imparted the same kindly insights he bestowed every week on his grateful patients. If Marcus Welby had worked for an HMO, he would not have been Marcus Welby—and Americans still expect to get their medical care from Marcus Welby.

Proponents of managed care often denounce American medical care as fragmented and uncoordinated. But another characterization is that our decentralized system encourages professional autonomy and patient choice.

Much attention was devoted this week to the proposal from Senator Snowe of Maine

that the so-called “public option” be triggered if the insurance industry fails to control premiums sufficiently to satisfy congressionally-mandated ratios of premiums to family incomes. Under this proposal, a federal insurance agency would spring into existence unless private insurers squeeze their medical insurance premiums enough to satisfy these legislatively-established ratios. Whatever the intent behind this proposal, its likely effect will be to force the insurance industry to pressure individuals to take their medical care through HMOs and other managed care arrangements that promise to reduce costs by denying services. At the same time, by forcing the insurance industry to make the difficult decisions necessary to confront costs, Congress would, under the Snowe proposal, insulate itself from the inevitable backlash as Americans learn that lower medical costs mean less medical services.

Moreover, although the physicians at the Mayo and Cleveland Clinics are among the nation’s (indeed, the world’s) outstanding caregivers, physicians themselves often respond poorly when placed into managed care organizations. In the late 1990s, many hospitals acquired family, internal medicine, and pediatric practices to integrate such practices into managed care networks centered around these hospitals. Many of these acquisitions of medical practices flopped. Physicians who in private practice embraced the financial incentives of fee-for-service medicine by providing aggressive care, reacted to their new standing as salaried employees in managed care networks by reducing inordinately their professional outputs. In these settings, at least, there was no Golden Mean.

Some participants in our current national debate about health care argue that universal

coverage is the gateway to controlling medical care costs. For the moment, let us put aside the inherent (perhaps deliberate) imprecision of terms like “universal coverage.” Those traveling under the banner of “universal coverage” can marshal compelling stories of uninsured individuals who failed up front to receive relatively simple forms of care, resulting in more serious and costly medical problems down the road. In these instances, comparatively cheap treatment earlier would have prevented more expensive treatment later. However, it does not follow from these genuinely troubling anecdotes that universal coverage will, in the short run or in the long run, save money.

Indeed, the evidence suggests otherwise. For example, Massachusetts’ innovative effort to approach universal coverage has proved substantially more expensive for the state treasury than had originally been predicted. This is not surprising; individuals previously lacking medical insurance use more medical services once they are covered. Availability increases usage. There may be strong arguments for universal coverage, but cost control is not among them.

Consider one final diagnosis of our medical cost problem—that there is no problem. The mere fact that a society spends more on a particular service or good is not evidence of a problem; it may also reflect reasonable preferences and opportunities. For example, Americans spend more on personal computers today than they did 50 years ago when such computers did not exist. Nevertheless, there is no sense of crisis about the portion of our gross national product absorbed by personal computers.

Similarly, the argument goes, it is not a problem that an aging population spends more on medical care but, rather, is a reflection of our preferences and opportunities as a society. It

is good, from this vantage, that we fixed my knee with technologies unavailable when I was a youngster sitting in my grandfather's drive-in. It is humane, from this perspective, that we fight to the end-of-life with expensive medical treatment, for we thereby reaffirm our commitment to human life. At a minimum, these are plausible choices about resource allocation.

Mushy moderate that I am, let me acknowledge the elements of truth in this analysis. Good modern medicine is, under any conceivable circumstance, labor-intensive and technologically-sophisticated, which is to say, expensive. An aging, affluent population will require more medical services as it grows older. Medical costs are not a problem that is going to be solved, but a reality to be continuously and permanently managed and controlled. Mr. Obama's rhetoric about being the last president to address health care is clever but unpersuasive. Presidents and the American public will grapple with health care policy into the indefinite future.

Indeed, the numbers indicate that health care costs must be managed and controlled as far as the eye can see. Such costs cannot be eliminated at a single stroke, nor can such costs be passively accepted. If escalating outlays on personal computers were reasonably perceived as depressing cash compensation for working Americans, we would identify this as a national challenge. If projections of continually increasing spending on personal computers showed government budgets overtaken by such spending, we would label this a social problem. So, too, if United States employers credibly viewed spiraling costs for personal computers as among their most daunting challenges. In that case, we would be talking about the need to control the costs of personal computer outlays.

To put this part of my argument another way, democratic government has many strengths, but saying “no” to voters is not one of them. Thus, we have the unedifying spectacle of elected officials promising to control medical costs painlessly. The absence of pain is a prescription for not controlling costs.

Because I criticize our political leaders for their unspecific discussion of health care costs, let me be specific in my criticism. Indeed, let me be bi-partisan in my criticism to demonstrate how widespread is the refusal to confront the pain inherent in genuine cost control.

On the Republican side, Governor Palin recently lambasted the President’s health care proposals, complaining that those proposals “will ultimately lead to rationing of...health care by...death panels.” The President, Governor Palin warned, would “empower unelected bureaucrats to make decisions affecting life or death health-care matters.” Instead, Governor Palin favors a consumer-driven strategy including vouchers for Medicare participants to purchase their own coverage from insurance companies and more competition in the insurance market by permitting individuals to buy their medical coverage across state lines.

I happen to think that both of these proposals merit consideration. However, neither is a prescription for painless cost control, because cost control cannot be painless. Suppose that Medicare recipients could purchase their own insurance coverage and all buyers of medical insurance could shop in a nationwide market. In such a world, costs would be controlled only if “unelected bureaucrats” in the insurance industry draw lines and deny services. In a world of finite resources, someone must say “no.” Governor Palin, I respectfully suggest, does not

confront this reality.

My Democratic exemplar of the refusal to face the inconvenient truth of cost control is the President himself. In his recent speech to Congress, he acknowledged that Medicare outlays must be curbed. However, he maintains that all that is needed is for an “independent commission of physicians and medical experts” to root out “waste and fraud.”

The President reiterated this theme during his blitz of television interviews over the recent weekend. Medical insurance premiums, he assured us, can be reduced by eliminating “waste.”

“Waste and fraud” are the bromides politicians conventionally invoke when they want to appear to be economizing. Of course, there is waste and fraud in government, government programs, and the medical system. However, if such waste and fraud were simple to eliminate, they would already have been eliminated. The harsh reality is that we cannot control the costs of Medicare without denying some, perhaps many, services to seniors. We cannot reduce insurance premiums without denying services to which Americans with insurance have become accustomed. President Obama, like Governor Palin, prefers to ignore this reality.

If this seems harsh on our elected officials, I soften my criticism with two observations. First, I was once an elected official myself, having spent a decade and one-half as an alderman of the City of New Haven. To quote Abe of my native Illinois, I can criticize politicians “with the greater freedom because,” having been “a politician myself, none can regard it as personal.”

Second, elected officials behave as they do largely because it corresponds to their constituents’ preferences. If the American people demanded of their public officials the

specification of painful sacrifices in the health care arena, such officials would deliver the goods. However, in my years as an elected officeholder, I do not remember a single voter who demanded more rigorous confrontation with budgetary realities. To be sure, constituents often pressed for lower taxes. However, when I asked them where to reduce municipal spending, the conversation invariably drifted into the kinds of vague generalities about cost savings that characterize our current national health care debate.

If I am correct that we need to control medical costs but no one wants to confront the specific denials inherent in effective cost control, then the next question becomes: Are there solutions to our quandary? To answer this question, we must first explore how we got where we are today.

It is interesting that, in a debate currently perceived as highly partisan in nature, there is a consensus among many experts of different ideological stripes that the Internal Revenue Code is an important cause of our problem by sheltering employees from health care costs. Under Section 106 of the Code, employer-provided health care, including employer-financed insurance premiums, is tax-free to the recipient employee, as is the care received through such employer-provided coverage. Historically, no consideration of health care policy led the federal government to exclude from employees' incomes employers' health care outlays. Rather, that income tax exclusion was established in a surprisingly casual fashion. Like many decisions with unanticipated consequences, the income tax exclusion of employer-provided medical care has now become entrenched, to the detriment of health care cost control. Employer-provided medical care, by virtue of its tax-free status, fuels higher costs by sheltering employees from

those costs.

Consider again my left knee. My employer pays substantial premiums for the medical insurance policy that paid for my MRI and my subsequent surgery. Neither these premiums nor the resources expended for my care were included in my income for tax purposes. In economic terms, these premiums and resources are largely invisible to employees. Consequently, employees have no direct incentive to demand of the employer that it scale back or refine its medical coverage. In my case, the system gave me no significant financial incentive to assess whether the preservation of my skiing career was really worth the cost.

By way of contrast, consider what would happen if, starting in 2010, employers' insurance premiums and other health care outlays for all Americans were reported on Form W-2 and were included in employees' incomes for tax purposes. This would force working Americans to confront the costs of medical care in a direct and personal way. This, in turn, would provoke honest discussion at the workplace about the benefits and price of medical care and would force employees to evaluate carefully the insurance they receive, just as we all must evaluate the outlays of personal and household budgets in a world of limited resources. If the costs of employer-financed medical care were made transparent to employees, trade-offs would be faced and difficult choices made, just as they are in the context of individual domestic expenditures.

Thus, the employer-based system as molded by the federal tax law is a major reason United States medical costs escalate—employees are sheltered from direct confrontation with the costs of the health care services they use. Controlling costs means confronting constraints.



In short, neither at the ballot box nor at the workplace do the American people face personally and directly the costs of medical care. Under these circumstances, the surprise is not that our medical outlays are so uncontrolled. The surprise is that the problem is not even worse than it is.

But here there is yet more paradox: Employers, because of the competitive pressures they encounter in the marketplace, confront costs better than governments. Thus, ironically, employer-provided medical care, a cause of our current quandary, is currently the best tool available to us for curbing medical outlays. Employers, required to respond to competitive pressures, are better positioned than governments to implement the painful service denials necessary to control health care costs.

For evidence that competitive pressures force employers to confront medical costs, let us start with the rapid growth of so-called “consumer-driven” health care devices in the workplace—health reimbursement arrangements, flexible spending accounts, and health savings accounts. The advantages and limitations of these devices would themselves justify another lecture. My point right now is that, whatever you may think of these devices, when implemented by employers they reflect a determination to control medical costs, a determination absent in the political system.

The same is true of the rapid growth of employer-sponsored wellness programs. These programs are still quite new and have not been subjected to systematic evaluation. On an anecdotal level, there are encouraging stories of employees who, through such wellness programs, have lost weight and stopped smoking. Employers report improved employee morale

from wellness programs, as well as reduced employee absenteeism. However, the main motivation for these programs is cost. By improving the health profiles of their respective workforces, employers sponsoring wellness programs hope to reduce their outlays for medical insurance premiums and other health care expenses.

Again, the issues raised by employer wellness programs could justify their own lecture. For example, despite their potential advantages, as such wellness programs develop they may inappropriately intrude the employers sponsoring them into employees' privacy and family lives. For now, however, the point is that employers are turning to wellness programs to reduce medical costs to stay competitive.

Consider finally deductibles, co-payments, and co-insurance provisions by which employees are required to share with their respective employers the costs of medical care. In this area, there is a dramatic difference between the private and public sectors. Private sector employees increasingly absorb part of the cost for their medical coverage and procedures, both to sensitize employees to such cost and to offset employers' financial burdens. In contrast, the recipients of government-financed medicine, including public employees, generally have much lower deductibles, co-payments, and co-insurance requirements. That difference reflects the contrasting dynamics of the marketplace and of politics: It is hard for elected officials to impose costs on their constituents. Private sector employers, however, must surmount costs to survive.

Where does this leave us? Let me suggest a modest five point program to begin to control medical costs while improving access to medical services. This modest program accepts the realities that elected officials are reluctant to deny medical services to reduce costs, health

care costs cannot be meaningfully controlled without such service denials, and, because of the competitive pressures employers confront in the marketplace, employer-provided health care represents our best tool for curbing health care outlays.

First, because it is health care we are discussing, our elected officials should be held to Hippocratic standards: Do no harm. Any innovation that weakens the system of employer-provided insurance should be resisted. Congress and the President seem determined to enact tax credits to assist lower income individuals to pay for medical insurance. If designed properly, I favor such credits. In this context, proper design means that, among other features, such credits should be available to help less affluent employees pay the deductibles, co-payments, and co-insurance required by their employer-sponsored medical plans.

Second, Congress should make permanent the federal subsidy for former employees who elect to pay for continued, post-employment health care coverage from their former employers, so-called COBRA coverage. For two decades, federal law has made employer-sponsored health care coverage available for former employees for specified periods after they terminate employment. Unless a firm has fewer than 20 employees, it must permit its former employees to pay to it the cost of continuing health care coverage. This right enables terminated employees to purchase—for a limited transition period—continuing medical care from their erstwhile employers at group rates, rather than pay the higher premiums typically charged for individual medical insurance policies.

In the American Recovery and Reinvestment Act of 2009 (colloquially known as the Stimulus Bill), Congress decided to subsidize employees' COBRA payments for continuing

medical coverage for employees who have been laid off. In particular, Congress provided for the federal Treasury to pay 65% of the former employee's continuation health care premium, with the employee only paying the remaining 35%. The result of this subsidy for involuntarily terminated employees has been a significant increase in the number of such terminated employees electing COBRA coverage from their former employers' health care plans. Although Congress enacted this federal subvention of COBRA premiums as a temporary emergency measure expiring next year, it should be made permanent.

Third, Congress should mandate on a delayed basis a higher eligibility age for Medicare, as well as increased co-payments and co-insurance for Medicare participants. As I have indicated, I see no possibility that Congress will impose costs on its constituents. If anything, Congress seems headed in the opposite direction and is likely to make Medicare drug coverage more financially attractive for Medicare participants. However, it is possible that Congress could schedule delayed cost curbs for Medicare in the form of a higher eligibility age to take effect in the future, along with larger co-payments and co-insurance requirements similarly to take effect on a deferred basis. Congress would thereby mandate Medicare cost savings for the future.

Here, an analogy suggests itself, namely, the Social Security reforms Congress and President Reagan agreed upon in 1983. The political dynamic then was the same as now: Elected officials do not like to impose costs on their constituents. However, to reduce future Social Security outlays, Congress passed and President Reagan signed deferred increases in the Social Security normal retirement age, starting 17 years later in 2000. These increases are

phased-in over 22 years and will culminate in 2022, when the Social Security normal retirement age, over this 22 year period, will have been increased in steps from 65 to 67. In effect, Congress and President Reagan put future Social Security cost savings on autopilot. The incremental increases in Social Security's normal retirement age, agreed upon in 1983, are now taking place automatically with nary a political ripple.

By way of contrast, the Medicare eligibility age remains at 65. Consequently, Medicare becomes available before full (though not early) Social Security retirement benefits. For example, individuals like me, born in 1950, will be Medicare eligible when we turn 65 but, by virtue of the 1983 reforms, will be entitled to full Social Security benefits only if we retire a year later at age 66. This gap is now scheduled to widen so that, when the 1983 changes are fully implemented in 2022, individuals born after 1959 will have to be 67 to receive full Social Security retirement benefits but will still receive Medicare coverage at age 65.

To reduce future Medicare outlays, I propose that, in emulation of the 1983 changes, Congress now legislate, effective 13 years hence, that the Social Security normal retirement age and the Medicare eligibility age be reunified at 67. At the same time, Congress should, on a delayed basis, phase in higher co-payments and co-insurance requirements for Medicare coverage, thereby requiring of Medicare recipients in the future larger financial contributions for their medical care—contributions comparable to those currently made by private sector employees.

Fourth, Congress should place a relatively high cap on the amount of employer-sponsored medical coverage that is income tax-free under Code Section 106, but should not

index that cap for inflation. Thus, gradually, more employer-provided health care will become taxable to the employees receiving such care, forcing them to confront the costs of such care.

Here again, a precedent is suggestive. In 1964, Congress limited the income tax exclusion for employer-provided group life insurance to the annual premium for the first \$50,000 of coverage. In 1964, \$50,000 was a lot of life insurance coverage and, consequently, this limit initially affected few employees.

Over the years, this cap has stayed the same, while the typical amount of employer-provided life insurance coverage has increased. Today, the formal rule remains as Congress adopted it in 1964, that is to say, the premium for the first \$50,000 of employer-provided group term life insurance coverage is income tax free to the insured employee. However, the policy has in practice come full circle given that today \$50,000 of group term life insurance is not very much. As a result, the typical middle income worker pays income tax on a significant part of his or her employer-financed life insurance—that is, the premium for coverage over \$50,000.

I suggest a similar long-term approach to Internal Revenue Code Section 106 and its income tax exclusion of employer-provided health care outlays, specifically, a high cap that will affect relatively few taxpayers today but that will, over time, make more Americans' employer-paid health care income taxable to them. In this way, Congress would spare its constituents current pain but gradually require that future Americans confront the costs of the employer-provided medical care they receive by including more employer-paid premiums in taxable income.

Finally, Congress should modify the Employee Retirement Income Security Act (ERISA) to

permit the states to regulate employer-provided health care plans. ERISA preemption is yet another topic that would justify its own lecture. For now, I observe that ERISA prevents the states from legislating as to employer-provided health care plans. If one favors experimentation in the area of health care (and I do), then Congress should activate the powers of our federal system by letting individual states innovate on their own. Of course, the same political dynamic that prevails in Washington also prevails in the state capitals. Elected officials do not like to impose costs on their constituents. However, one of the benefits of federalism is the possibility (albeit not the guarantee) that some of the fifty states will productively experiment.

The foregoing steps will not, by themselves, solve the problem of controlling medical costs, but such costs not are a problem that will be solved. Rather, such costs will be a permanent and continuous challenge to manage and control. These modest steps would point us in the right direction, that is, trying to control costs as we also try to expand accessibility.

Allow me to conclude by coming back to my childhood summers at my grandfather's Moline drive-in. When I told you that I saw *Blue Hawaii* 14 times, I did not quite tell you the whole truth. I actually saw the first two-thirds of *Blue Hawaii* 14 times. My grandfather always insisted that we leave before the movie ended. Consequently, I had no idea how the story came out.

Then, one day, 25 years later, I was sitting near a television and there he was, the King in Hawaii. Much to my wife's annoyance, I was adamant about staying to the end. And what a shock the end was: Elvis got the girl.

Like *Blue Hawaii*, I do not expect to see the end of our national debate about health care

costs for a long time. Indeed, it is likely that this prolonged debate will last beyond my lifetime. But the permanence of the problem does not absolve us from making our modest contribution to its management. As the Jewish sage Hillel wisely said: “Yours is not to complete the task, but neither are you free to desist from it.”



## NOTES

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\* Edward A. Zelinsky is the Morris and Annie Trachman Professor of Law at Benjamin N. Cardozo School of Law, Yeshiva University. This article is based on Professor Zelinsky's Dr. Arthur Grayson Distinguished Lecture at Southern Illinois University School of Law on September 24, 2009. Address correspondence to the author via e-mail at [zelinsky@yu.edu](mailto:zelinsky@yu.edu).