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HEALTH CARE REFORM STUDIES

III

Summary of Bipartisan Senate Working Group Proposal

A 15-member bipartisan working group comprised of members of the Senate Committees on Finance and Labor and Human Resources was established in July, 1989. Group members include Sens. Riegle, Mitchell, Rockefeller, Kennedy, Durenburger, Chafee and Hatch.

An options document was released on March 10, 1990. The purpose of the document is to assist the development of a consensus approach to the problem of access to health care for the uninsured and for bringing increases in health care costs under control. The proposal makes few specific recommendations, primarily listing the various options that the working group is considering. The document is being distributed to health care provider, labor, consumer and other interested groups for comment. The group hopes to develop legislation for introduction later this year.

Summary of Options:

- 1) Expand private coverage. Options under consideration include:
 - o employer role and strategies to mandate or encourage employer participation
 - o special provisions to assist small business
 - o mandatory and/or voluntary insurance market reform
 - o benefit package and premium responsibility
 - o individual responsibility
- 2) Expand public coverage for residual uninsured through two-part approach:
 - o expand Medicaid to cover all people with income below 100% of the Federal poverty level; and,
 - o create a new public program or build on Medicaid for those at or above 100% of poverty, using a sliding scale subsidy.
 - o Options include building on current Medicaid program vs. restructuring Medicaid.
- 3) Cost-containment options include:
 - o Federal regulatory cost controls
 - o national initiatives on effectiveness, quality, outcomes research, practice guidelines, education
 - o insurance market reforms
 - o medical liability reform
- 4) Financing options include redirecting existing health care expenditures and/or developing specific suggestions on new sources of funding

Working Group Options

GOAL: Ensure Health Care Coverage for all Uninsured People

APPROACH: Maximize private health care coverage: cover remaining uninsured through expanded public coverage

RATIONALE: Universal coverage would:

- o reduce costs for businesses currently providing coverage;
- o ensure fairer apportionment of payment responsibilities;
- o reduce costs for small businesses through insurance market reform; and,
- o maintain control over payment rates for public program participants.

PRIVATE COVERAGE

Part 1: INITIATIVES TO EXPAND PRIVATE COVERAGE

ISSUE: Mechanism

Option 1: Require all employers to provide health insurance coverage meeting Federal standards to employers and dependents.

OR

Option 2: Combined program of incentives and disincentives to provide coverage, such as offering employers the option of providing coverage or paying a fee set as a percentage of payroll. Fee would be used to cover part of the cost of public coverage for employer's workers and dependents. Incentives could include items in Option 3 below.

OR

Option 3: Provide employers only incentives to offer coverage, which could include:

- o pre-emption of state mandates;
- o subsidies to small business offering coverage for the first time;

- o grants to States offering programs to include coverage;
- o establishment of high risk pools for individuals unable to purchase insurance in current market because of ill health;
- o improvements in small employer insurance market;
- o improvement of deductibility of premiums paid by self-employed, credit to businesses with no taxable income offering coverage;
- o allowing employers to pay a part of the premium for coverage under a State's Medicaid plan or other public coverage.

AND / OR

Option 4: Establish a refundable tax credit to uninsured individuals to purchase coverage; encourage individual rather than employer selection of plan.

AND / OR

Option 5: Incentives/Mandates to individuals for purchase of employer provided health insurance, which could include:

- o Require employee to purchase for self and dependent.
- o Offer employee option of purchasing health insurance or payment of fee to be used in public program.

ISSUE: Benefit Package (Including Premium Responsibility)

Option 1: No package specified; employers contribute specified amount.

OR

Option 2: Package specified, employers contribute specified amount. Benefit package could include:

- o Catastrophic only
- o Basic only with emphasis on primary and preventive care; or,
- o Basic and catastrophic package.

OR

Option 3: Package specified under Option 2 above, but no employer contribution required.

ISSUE: Individual Participation in Program

Option 1: Uninsured individuals should be required to accept employer coverage.

OR

Option 2: Uninsured individuals should not be required to accept coverage.

ISSUE: Public Subsidy for Low-Income People

Option 1: Provide public subsidies for cost-sharing for low-income people.

OR

Option 2: Do not provide public subsidies for cost-sharing for low-income people.

Part 2: SPECIAL PROVISIONS FOR SMALL BUSINESS

Recommendation: Provide improved tax treatment for self-employed, greater opportunities for pooling, reform of small business insurance market, special treatment for new, small businesses, small business subsidies under certain circumstances. (NOTE: Working group has not yet defined "small business").

ISSUE: Mandatory vs. Voluntary Insurance Market Reform

Option 1: Voluntary insurance market reform, including:

- o allowing groups of small businesses to offer stripped-down basic plan to members of groups by exempting them from state mandates;
- o amending current ERISA rules prohibiting the formation of multi-employer trusts (METs) in certain circumstances;
- o allowing small business to buy-in to Medicaid or other public program;
- o providing seed money to states to establish small business pools; require states to establish subsidized high risk pools for uninsurable individuals and groups.

OR

Option 2: Require insurance companies to meet Federal or State standards to participate in small business market, including:

- o prohibiting medical underwriting;
- o community-rated coverage, acceptance of all applicants;
- o availability of managed care.

OR

Option 3: Require states to establish a new, state-sponsored insurance mechanism for small businesses; options:

- o insure all small businesses (could be through Medicaid), or
- o assure, through subsidies, that businesses participating in state pool pay no more than average private market costs.

B. PUBLIC COVERAGE

Part 1: INDIVIDUALS WITH INCOMES UNDER 100 PERCENT OF THE FEDERAL POVERTY LEVEL

Recommendation: Expand Medicaid to cover all individuals under the Federal poverty level regardless of their family composition (i.e., eliminate all categorical eligibility requirements).

ISSUE: Program Structure

Option 1: Keep current Medicaid system.

OR

Option 2: Modify current Medicaid system, for example:

- o Change benefit package to include preventive primary care or catastrophic benefits;
- o Allow state maximum flexibility to design innovative delivery systems;
- o Redesign reimbursement, paperwork, and claims procedures
- o Federalize benefits, including scope and duration;
- o Require enrollment in (or option to enroll in) managed care programs.

Part 2: INDIVIDUALS AT OR ABOVE 100 PERCENT OF THE FEDERAL POVERTY LEVEL WHO ARE NOT COVERED THROUGH PRIVATE COVERAGE

Recommendation: Create new public coverage either through existing Medicaid program or new public program.

Recommendation: Require individuals covered by this program to contribute toward the cost of coverage based on their ability to pay.

ISSUE: Program Structure

Option 1: State flexibility to establish program within Federal standards.

OR

Option 2: Federal requirement for State to provide coverage.

OR

Option 3: Federal program structured similar to Medicare.

All of the above Options could include the following:

- o health insurance pools;
- o extending Medicaid (e.g., Medicaid buy-in);
- o providing flexibility within delivery of services, (e.g., allow incentives for creative delivery systems such as community health centers);
- o requiring certain delivery systems; or,
- o high risk pools for uninsurable individuals.

ISSUE: Sources of Funding

Option 1: Federal

OR

Option 2: State

OR

Option 3: Federal/State combination

AND / OR

Option 4: Employer/employee contribution with any of the options

ISSUE: Benefits

Option 1: Benefits same as those established in Medicaid, including scope and duration.

OR

Option 2: Provide enhanced benefit structure.

OR

Option 3: Federalize (i.e., standardize) benefits.

ISSUE: Individual Participation in Program

Option 1: Uninsured individuals should be required to accept employer coverage.

OR

Option 2: Uninsured individuals should not be required to accept employer coverage.

III. COST CONTAINMENT

Option 1: Federal Government regulatory cost controls, for example:

- o rate-setting;
- o health planning and PRO oversight of private patients;
- o expenditure targets.

OR

Option 2: Alternative national initiatives.

- o Option 2A: Immediate actions to control costs, develop long-term strategies.
- + Use of Federal leverage to implement recently enacted outcomes research/standards development legislation as payment device.
- + Implementation of the Agency for Health Care Policy and Research treatment practice guidelines, which could be used to establish reimbursement differentials. Would result in some initial savings and reasonable assurance to the public and payors that physicians are providing quality and appropriate care for each dollar spent. (Rand Corporation research shows that 10-30 percent of major surgical procedures are inappropriate.)
- + Use of public program leverage to implement cost-effective systems of care. Encourage managed care options, for example, reimbursement differentials and revised HMO Act. Require beneficiaries to enroll in managed care programs.
- + Direct chronically and catastrophically ill individuals to "centers of excellence," so designated because of their high quality care and their economies of scale in treating many individuals of a similar condition. This would consolidate hospital capacity.
- + Encourage cooperative agreements between hospitals and community health centers or other ambulatory care providers to reduce emergency room treatment for non-emergency care.

- + Establish grant program to states, providers, and private payers to develop and implement innovative cost control methods.
- + Require providers to disclose standardized cost and quality data to assist in health care purchase decisions.
- + Establish a National Health Cost Inflation Review Commission to set annual voluntary targets, monitor cost increases, make recommendations.
- + Develop measures to make recipients of care more sensitive to the costs of care, e.g., standardizing an insurance package and capping the tax deduction at the cost of the basic package or structuring co-insurance payments to increase awareness of costs.

AND / OR

- o Option 2B: Insurance market reforms
 - + Shift insurance industry focus from risk selection to cost-effective delivery, managed care, provider negotiations.
 - + Anti-trust reforms to encourage self-regulation by providers and cooperative agreements between insurance companies and managed care providers.
 - + Create national coordination of benefits registry to prevent duplication of benefits and thus assure appropriate insurance premium rates.
 - + Pre-empt state regulation of the content of health insurance.

AND / OR

Option 3: Private market reforms

- o Modify current tax preferences to shift coverage to insurable events, create greater consumer awareness of cost of care and benefits.
- o Vouchers for individual rather than group purchase of coverage.
- o Enthoven approach: employer mandate to pay flat contribution toward health insurance coverage; employee encouraged to choose less expensive plans.

- o Require insurance companies to cover catastrophic illnesses, and certain preventive medical procedures such as mammograms and immunizations. This would leave individuals responsible for paying for regular doctor visits, e.g., a visit for a cold.

AND / OR

Option 4: Medical Liability Reform

- o Leave acknowledged problems to states for reform.
- o Federal government pre-empts the field in terms of certain traditional malpractice reforms. For example, the Federal government could initiate a uniform cap on non-economic damages, a Federal collateral source rule or a more uniform statute of limitations rule, and allow the use of health care practice guidelines as a defense.
- o Federal government gives states incentives to enact certain alternative dispute resolution procedures for medical malpractice claims. These alternatives may include a voluntary, parallel arbitration procedure or a mandated administrative alternative which removes malpractice claims from the judicial system.
- o Federal government enacts its own alternative dispute resolution procedure for medical malpractice claims. Could include a special fund, damage determination only, improved discipline process and enforcement for physician license boards.
- o Explore no-fault alternatives using accelerated compensable events or other methods which are analogous to the workers compensation system.
- o Patient protection reforms, explore alternative, more successful methods for deterring negligence by doctors and for preventing adverse events to patients. Anti-trust changes would be necessary to allow sanctions by review organizations and licensing boards.
- o Explore methods of reducing insurance rates for physicians, particularly OB/GYNs.

IV. FINANCING

Option 1: Utilizing the existing funds currently available in health care system today more effectively by private and public sector reforms

AND / OR

Option 2: Specific suggestions on new sources of funding for expanding access to care, e.g., new fees or revenues

V. PLAN IMPLEMENTATION

General issues for consideration:

- o Phase-in of overall plan.
- o Establish Commission to oversee implementation of plan.



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT


WASHINGTON, D.C. 20415

MAY 23 1990

OFFICE OF THE DIRECTOR

MEMORANDUM FOR THE TASK FORCE ON FEDERAL EMPLOYEE
HEALTH BENEFITS

FROM:


CONSTANCE BERRY NEWMAN
DIRECTOR

Subject:

Meeting of the Task Force on Federal
Employee Health Benefits

The accompanying material on trends in cost containment
was prepared by HHS for our meeting this Thursday.

Unfortunately, the paper arrived shortly after the OPM
materials were sent to you. .

Attachment

Trends in Cost Containment

This paper reviews current trends in private-sector cost containment initiatives. Special attention is given to sub-topics related to alternative delivery systems and employee behavior.

Introduction. Per-capita health care costs are rising faster than background inflation because of increasing volume, intensity, and technological sophistication of services delivered. For example, per-capita doctor visits has risen from 4 in 1980 to 6 today. The X-ray costing \$100 is now frequently bypassed in favor of magnetic resonance imaging costing \$500 or \$1,000. The latter example highlights the fact that much of what is called cost inflation represents increased quality or scope of medical practice; uncomplicated cost-control objectives pursued by employers or government payers may not be entirely adequate as a guide to social policy, since consumers may prefer and be willing to pay for some of the increasingly costly sophistication of modern medicine, even if that means foregoing other forms of consumption. Unfortunately, reliance on insurance and tax financing of health care bypasses normal market mechanisms normally used by consumers to signal preferences.

"Cost" in the context of employer-sponsored health benefits refers to total expenditure -- the cost of producing and delivering a given unit of health care services, times the volume or quantity of units delivered per unit of time. Efforts to control expenditure are directed at one or both factors. Utilization control, for example, focuses narrowly on volume. Other "managed care" measures discussed below attempt to look at wider issues affecting production efficiency.

Managed Care

Larger employers are now moving away from traditional indemnity health insurance toward arrangements that use incentives to guide and constrain physician practice styles. The shift from fee-for-service to capitation payment represents a radical change in incentives. A more indirect incentive occurs in the selection and retention by Preferred Provider Organizations (PPOs) of those physicians following a suitably cost-conscious practice style.

Employers are increasingly able to select among a growing number of competing health care plans and intermediaries specializing in managed care techniques.¹ Blue Cross-Blue Shield, Aetna, Travelers, and new organizations such as US Healthcare are working to form their own proprietary national networks of hospitals and physicians, each seeking the capability of serving multi-state

¹ This discussion neglects the plight of small employers who have a problem finding steady insurance coverage of any kind. Special forms of cost containment, for example, reducing the scope of state-mandated benefits, are relevant to this sector more than to large employers.

employers. These emerging networks seem intent on not just implementing, but also elaborating on the basic ideas behind PPOs and Health Maintenance Organizations (HMOs). The most recent mutant is the "Point-of-Service" (POS) plan, and HMO or PPO which allows enrollees to use non-participating providers but imposes a higher cost-sharing rate for the privilege.

The situation today is one of transition. Physicians in large cities often belong to many different PPO networks, each of which holds little if any leverage over physician practice styles. Leading proponents of the managed care movement see the next few years being a period of consolidation and strengthening of networks' operating capability. Both trends should contribute to increasing the economic clout of managed care organizations vis-a-vis physicians.

The success of managed care in slowing inflation will depend not only on being able to induce physicians to practice more frugally, but also on discovering the boundaries of cost-effective medicine. This suggests a need for research and development of new information about the effectiveness of particular medical procedures and treatments. (The federal government is now committed to making a significant investment in such research.) In the meanwhile, much progress can be made on the basis of available knowledge.

Physicians have mixed feeling about the movement toward managed care. Many see it as a threat to their economic interests or consider it to be inconsistent with a preferred style of medicine.²

Predicting the future. The financing and management structure of health care in the private sector is evolving rapidly, with progress occurring in the form of a multitude of uncoordinated and haphazard innovations. Formal studies of early PPOs are now of questionable utility because of these rapid changes. Quantitative estimates of the efficacy of group-model HMOs relative to fee-for-service practice developed by the Rand Health Insurance Study based on late 1970's data is now of questionable utility because of changes in both HMO and fee-for-service practice. It would be risky to forecast rates of progress of different delivery-financing approaches, and impossible to predict their respective future market shares, since those shares will reflect factors other than inherent economic efficiency. Nevertheless, a few things can be said about particular managed care entities.

Group-model HMOs. Because of the incentive effects of capitation financing and the ability of group HMOs to directly influence practice style of member physicians, this form offers the greatest potential for long-term economy.³ Institutional and legal barriers to full effective-

² Growing intellectual acceptance of managed care principles among physician associations and academic groups, combined with continued efforts to break down institutional and legal barriers to managed care, offer indications that organized resistance will become increasingly fragmented and irrelevant.

³ The Rand Health Insurance Experiment, by controlling effects due to biased selection, was able demonstrate significant economic superiority of one group-model HMO over fee-for-service medicine in efficiency of delivering care, with the most dramatic difference being in the well-known propensity of HMOs to reduce hospitalization. Quality of care delivered by the HMO was as good as quality delivered under fee-for-service.

ness (HMO Act restrictions, vulnerability to state mandates, over-emphasis on comprehensive and preventive care, community rating or shadow pricing instead of experience rating) are now being eliminated or revised in ways that suggest a future in which HMOs will be compete more successfully against organizations that cannot match HMOs' inherent efficiency advantage.

Individual Practice Associations (IPAs), PPOs, and POS Networks.⁴ As more and more physicians' economic well-being comes to depend on maintaining a satisfactory relationship with one or several networks, one may expect those physicians to conform increasingly to managed care protocols. In such circumstances, networks should be able to compete effectively with group HMOs. The outcome of an ongoing process of building effective networks serving the private sector should become evident within the next five years.

Managed indemnity plans. Indemnity plans that do not restrict enrollees choice of provider are now almost all practicing some form of utilization control. Methods of utilization review check physician decisions against rules on appropriateness of setting and treatment. (This basic technique has been shown to be effective, compared to the unfettered practice standards that were once the rule.) Pre-admission authorization and second opinions prior to surgery are further examples of standard control measures. Over the next several years, the relative advantages of these techniques could fade if, as appears to be the case, practice styles of physicians generally come to incorporate constraints first introduced through utilization review. At the same time, the function of simple utilization review could be assimilated by networks. (Networks attempt to induce physicians to follow economic practice patterns automatically, without having to be reminded on a case-by-case basis by utilization reviewers.)

HMO growth. Even assuming that institutional and philosophical changes allow the superior potential efficiency of group-model HMOs to be more fully realized in the form of significantly lower premiums compared to networks, this type of organization is limited in potential growth rate because of inherent difficulty, compared to other more loosely-organized networks, in expanding into new geographic areas. POS arrangements can assist an expanding HMO bridge geographic gaps, thereby improving its ability to market to employers with widely dispersed employees.

Other managed care measures. Private sector employers are increasingly adopting special "carve-out" arrangements for controlling mental health care and substance abuse benefits, an area of exploding costs. Increasing numbers of special-purpose companies offer gatekeeper services (often coordinated with Employee Assistance Programs), combined with referrals to network practition-

⁴ A growing number of networks allow enrollees to use non-member providers at a higher out-of-pocket cost to the enrollee. This arrangement appeals to those who seek lower premiums without having to give up access to a regular physician.

ers.⁵ To the extent that "carve-outs" tend to compartmentalize treatment, special efforts may be needed to coordinate treatment for individuals who need both medical and mental health services.

Other Approaches to Controlling Cost

Managed care innovations in the private sector seem promising. As they become more widely applied within Medicare and Medicaid, their benefits will be more widely felt. Nevertheless, it is an open question whether these innovations can produce an acceptable degree of long-term price stability given the unlimited potential for advances in sophisticated technology. If rapid inflation continues, other methods of cost containment -- some traditionally used by private-sector health insurance, others available only to government -- may come to be utilized.

Cost Sharing. Deductibles and coinsurance are the classic techniques used to encourage economizing. The Rand Health Insurance Study demonstrated the effectiveness of cost sharing in controlling total expenditure. The effect was observed to operate primarily by discouraging initial physician visits. Cost sharing had only a small effect on amount of hospitalization. The additional services consumed by those enrolled in free care plans was found to produce negligible benefit in terms of health status.⁶

Cost sharing is likely to retain an important function even though traditional fee-for-service indemnity medicine gives ground to advanced forms of managed care. For example, higher coinsurance and deductibles are imposed by point-of-service plans to encourage enrollees to stay "in plan." While some group-model HMOs have as a matter of principle avoided cost sharing, depending entirely on provider-controlled "rationing" of services, other HMOs use co-payments as a means of encouraging enrollees to use HMO resources wisely.

Controls. Direct volume targets and relative-value fee schedules are being introduced in Medicare. If these measures are not effective, more onerous controls can be expected. In a managed care environment, controls over total per-enrollee expenditure could be administered in principle. States attempting to cope with limited Medicaid budgets are looking to explicit rationing as a means of making allocations more rational. Oregon has proposed reducing Medicaid outlays on costly services such as transplants and spending more on basic services now denied to many with low incomes because already inadequate budgets are drained by a few extraordinary procedures, often for individuals with minimal chances of recovery or even survival.

⁵ This new form of management is now being resisted by psychiatrists who have prospered under loose and generous coverage of traditional indemnity plans. This contrasts to the generally supportive posture of associations representing other medical specialties with regard to managed care innovations.

⁶ This result applies to the general population. Cost sharing tied to income levels (for example, "deductible equal to the smaller of 1 percent of income or \$1,000") allows the advantages of significant cost sharing to be applied to middle and upper-income families while limiting the barrier posed to lower-income families.

Employee Behavior and Preferences.

The pace of movement to managed care and/or to increased cost sharing is influenced primarily by the relationship between employers and their employees. Moving from traditional forms of health insurance represents a difficult decision and considerable administrative effort. Cafeteria plans and flexible spending accounts have been used by employers to facilitate such transitions. Mergers between companies provide a cover for introducing managed health benefits. Increasingly, companies are reacting to cost increases that they consider no longer tolerable. Although companies shifting to managed care often limited that change to salaried workers, labor unions are becoming more receptive to the idea that they will be better off if the company's health care cost increases are slowed.

If an employer wishes to impose a single indemnity-type PPO in place of what had been an unconstrained indemnity plan, the main problem of persuasion and explanation may be mitigated by a cash trade-off. On the other hand, moving to managed care may be easier if an employer offers a choice of plans. The objective then is to contrive an employer contribution scheme under which employee decisions are guided by relative price incentives that conform with relative costs of different options.

From this standpoint, an employer contribution should be pegged to the most economical, least costly plan (possibly, but not necessarily an HMO). Employees choosing more expensive plans would then pay an amount related to incremental costs. Other common employer contribution schemes, for example, paying a fixed percentage of total cost of various plans, or contributing more than enough for an acceptable low-cost plan, reduce or dilute the appeal to employees of lower-cost plans, and thus retard migration to managed care.

DHHS/OASPE
May 22, 1990

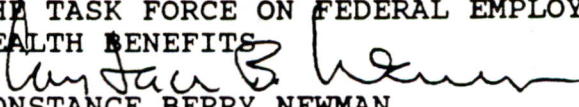


UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

May 17, 1990

MEMORANDUM FOR THE TASK FORCE ON FEDERAL EMPLOYEE
HEALTH BENEFITS

FROM: 
CONSTANCE BERRY NEWMAN
DIRECTOR

SUBJECT: Meeting of the Task Force on Federal
Employee Health Benefits

Our rescheduled meeting will be Thursday, May 24, at 10:30 in Room 180 of the Old Executive Office Building. Please call Mary Tsivgoulis at 456-2564 by close of business Tuesday, May 22, so she can arrange for clearance.

The purpose of the meeting is to discuss various efforts that others have made at controlling costs and improving quality and then to decide which particular approaches deserve further development to determine whether they should become a part of our reform proposal. Papers from HHS and OPM will be distributed next week.

I look forward to seeing you.



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

MAY 22 1990

MEMORANDUM FOR THE TASK FORCE ON FEDERAL EMPLOYEE
HEALTH BENEFITS

FROM:

Constance Berry Newman
CONSTANCE BERRY NEWMAN
DIRECTOR

SUBJECT:

Meeting of the Task Force on Federal
Employee Health Benefits

OPM has conducted a survey of private sector employers to assess how they have addressed the problem of controlling escalating health care costs while ensuring the need for quality care. Attached is a survey of the findings.

The overriding issue to be discussed at the next meeting is: Are there lessons from the private sector that should influence the design of a required FEHBP? Among the specific issues we could discuss are:

1. Should we have deductibles or premiums based on salary bands?
2. Should we have waiting periods?
3. Should we explore point of service options?
4. Should we use contractors to manage HMOs/networks of HMOs?
5. Should we contract with separate TPAs for substance abuse?
6. Should we look more closely at the availability of PPOs across the country or in particular geographic locations?
7. Do we need to review the standards in place now for quality assurance associated with PPOs?
8. How can we review the sub-contractors performance on large case management?

Attachment

Reform Recommendations Confirmed by Survey

1. OPM needs to retain the flexibility to design the delivery systems and benefits under a reformed program.
2. Self insurance provides OPM the control and discretion necessary to experiment and to move away from the more traditional/passive forms of contracting.
3. Cost sharing of the premium is necessary to get the subscribers involved in cost containment.
4. Employees and retirees have different health care needs and utilization experience, thus requiring separate benefits and rates for these two groups.
5. TPAs are being utilized through ASO contracts to process claims and perform certain administrative functions.
6. Too many indemnity plans and HMOs cause problems of administration and do very little for effective cost containment.
7. New and innovative delivery systems and cost containment efforts have to be explored and tested to obtain maximum savings.

OPM's Review of Private Sector Health Benefits Program Practices

Introduction

As part of the process of developing recommendations on specific benefit and cost containment designs as a part of the FEHB reform initiative, OPM surveyed a number of private sector employers to assess how they have addressed the problem of controlling escalating health care costs while ensuring that the need for quality care is met.

Our survey involved a review of how they have structured their health benefits programs, designed or changed their benefits packages and their health care delivery systems and what their experiences have been in developing effective cost containment measures. We selected a number of large companies to review which had been featured for cost containment efforts or innovative delivery systems and, which on a smaller scale, resembled the Federal Government in diversity of workforce and function, geographic dispersion, broad salary ranges, large numbers of retirees; etc.

The results, while not definitive, surfaced a number of recurring themes/issues. It was clear that none of the firms surveyed were confident that they had found the universal solution to the health care problem, or that the approach they had taken would work for their own firm for the long haul.

However, it is apparent that companies in the private sector are willing to experiment. Many times they are experimenting based less on what they know will work than on their experience with what has not worked. Different things work well or less well depending upon the company's particular situation.

The health benefits area is extremely dynamic. Most companies want the flexibility to change their programs as the health care environment changes, particularly in those areas affecting cost containment such as delivery system designs and benefit structures. The experiments we see taking place are relatively new. Companies are hopeful that initial gains can be sustained and broadened. However, at this time, there is no comprehensive body of data available that demonstrates that any one solution is the best or the final answer for the long haul.

Companies are concerned about balancing the needs of employees for quality health care programs with their own need to control unacceptable increases in their bottom-line health care costs. In situations where employees already share premium costs (or union involvement precludes that possibility), and co-payments, co-insurance and deductibles are already in place companies have focused increased attention on their delivery systems, refinements in benefit design, and cost containment at the provider level. Many companies have recognized the need to manage or limit choice and are beginning to structure their delivery models and design their benefit packages in such a way

as to channel employees into those systems and plans that work well for them and are also cost effective.

Companies are beginning to view themselves as active purchasers of group health insurance rather than passive contractors in a process over which they have no control. Private sector companies have leverage and they use it. They are beginning to determine the benefits, the delivery system, and the various types of cost containment components they want in place, and they are becoming assertive in this area with the industry. They recognize that they can only get a handle on their health care costs and maintain a quality health care program for their employees by retaining the flexibility and control necessary to (1) design alternative delivery systems, (2) tailor benefit packages, and (3) require effective administrative measures such as pre-admission certification and large case management as a part of the overall program. All of these are elements of an effective cost control program. None will work as well independent of the others and none are possible if the employer doesn't have the flexibility and the desire to develop the three necessary components of cost containment.

Self Insurance

The majority of employers we contacted or visited self insured and had done so for many years. The reasons for doing so varied from the desire to escape state premium taxes and state

mandated benefits to the most important--control over reserves. Although the results of our survey were obviously skewed because of the size of the employers we selected and the fact that large employers are the ones most likely to self insure, numerous companies have recognized the advantage of flexibility and control inherent in self insuring. We found no stronger advocate for self insurance than the Mobil Corporation. To quote Mobil on this point, "You will save money from self insurance We don't know of anyone moving away for self insurance who has tried it ... Question the motives of those who object to it." That sentiment was echoed by General Motors, which has the largest private health insurance plan in America.

Risk Sharing

Even though most of the firms we surveyed self-insure, those that have been experimenting with various delivery designs such as managed care networks, Preferred Provider Options (PPOs), Point of Service (POS) systems and linked or networked HMOs have looked to their contractors more and more to accept some of the risk associated with these relatively new design systems. In addition, as aggressive purchasers of services, companies view risk sharing as an opportunity to hold contractors accountable for the kinds of results and outcomes relating to the cost and quality of health care delivery that were agreed to at the point of purchase. Allied Signal

currently demonstrates the most dramatic experiment in risk shifting in its 3-year contract with Cigna, which includes an absolute cap on the premium rate of increase each year.

(However, when the contract is renegotiated they anticipate moving to even more risk sharing.) Other more conventional risk sharing arrangements currently in place, which vary from company to company, involve putting the contractor at risk for a percentage of administrative and/or claims expenses. One pattern has been for the company to self insure all claims costs but to share the risk for a portion of the administrative expenses if claims exceed a specified target.

Cost Containment

Cost containment measures are evidenced in a number of ways:

(1) transfer of costs to the employees through benefit design, (2) variations in the health care delivery systems, (3) administrative mechanisms, and (4) employee behavior. Private sector employers are using combinations of all four in their approaches in an effort to maximize the quality of health care available to employees, while at the same time controlling costs.

Transfer of Costs to Employees

Many firms that used to pay the entire premium and provide first dollar coverage no longer do so. They have shifted costs

to employees through a number of mechanisms such as deductibles, co-insurance and co-pays, waiting periods for pre-existing conditions, and limitations and exclusions. We also learned that a number of private sector employers require cost sharing on the premiums with at least some level of contribution on the part of the enrolled employee. A number of firms, such as Mobil and General Electric, set the employee premiums based on salary bands, with the highest paid employees paying the highest premium. Others, including Allied Signal, Philip Morris and General Electric index deductibles to salary levels.

Variations in Health Care Delivery Systems

The Marriott Corporation was quick to point out that they had a limited amount of money to invest in employees health benefits and, with a relatively low paid workforce, they could no longer consider weakening the benefits package with cost transferals. Instead, it looked for improved cost efficiency through an alternative delivery system and settled on a Point of Service Managed Care Option through an Administrative Service Only (ASO) contract with Prudential for 25 locations initially around the country. (A Point of Service Managed Care Option, at least in the case of Marriott, indicates that the subscriber has the choice of using designated preferred providers or providers of his/her choice at the time health care services are required. If preferred providers are used,

the deductible is waived and nominal co-payments are used rather than a 70/30 co-insurance split. Under some program designs, a preferred provider option could require a lock-in at the time of enrollment with no provider choice left to the subscriber at the time services are required. This would represent a distinct enrollment alternative to an employer's indemnity plan. "Managed Care" is more of a generic term and could denote a gatekeeper approach as found in many HMOs or PPOs or simply denote that some health care services are more closely scrutinized through measures such as pre-admission certifications and large case management. Some of the latter features of "managed care" could also be found in indemnity plans.)

Although Allied Signal had some success in managing health care costs through increased deductibles, co-insurance, employee contributions as well as some of the more traditional administrative measures like second surgical opinions and pre-hospital certifications; it entered into an arrangement with CIGNA Health Plans to offer a Point of Service Managed Care Option as an alternative to its indemnity plan and HMOs. The reason given their employees was honest and forthright. "Allied Signal has adopted [this option] to help control the Corporation's increasing medical costs while still providing employees and their families a quality health care program ... Generally, if you use the network for your health care needs, you will save money. That's because the plan provides

more coverage and higher benefit levels for network care ... And you will be helping control medical costs by making contributions toward your coverage - and if you go to the network, by using more cost-efficient medical services."

At one time, HMOs were promoted as the alternative delivery system to traditional indemnity plans. Since the law required it, employers throughout the country offered numerous HMOs and initially were relatively satisfied with their performance. Now, however, with the exception of Xerox Corporation, practically every employer we surveyed is disenchanted with the HMOs' recent performance in generating cost savings, their rate setting practices, their propensity to tailor their packages to attract the best enrollees, and/or the complications associated with administering large numbers of HMOs. The firms we surveyed have cut back on the number of HMOs they offer or they are in the process of doing so. Others are not offering HMOs where POS networks are available. Still others are using contractors to link their HMOs into networks to achieve greater control over the quality of care provided and benefits offered. Xerox, for example, has contracted with networks of selected HMOs managed by six "Health System Managers," in essence, putting their HMO option under the control of a Third Party Administrator (TPA). Employers like Marriott, AT&T, General Motors and General Electric have to one degree or another introduced or are moving to managed care approaches such as the preferred provider option or a point of service

option as an alternative to their traditional indemnity plans and HMO offerings. Allied Signal, for example, has over 80% of their 50,000 employees using a point of service option. It is interesting to note that, due to significant concerns about rising costs in the areas of psychiatric care and substance abuse, some firms have established separate pre-certification and case management programs for this coverage outside of the regular health insurance program. GM, for example, has contracted with a separate TPA just to manage its substance abuse program. It believes this approach to be so successful in controlling costs and improving the appropriateness of treatment that the company is considering bringing mental benefits under the same umbrella.

Why are employers moving in this direction? Mobil Corporation and Metropolitan Life, the contractor for Mobil's point of service managed care option, project that cost containment measures built into the system will keep health care cost increases for this option at about 2/3 those for the indemnity plan.

Administrative Mechanisms

These measures differ from the transfer of costs in that they do not transfer costs to employees directly, they are not benefit specific, nor are they necessarily a part of any particular delivery system. As the name implies, they are

purely administrative measures which can be implemented absent any other benefit or delivery system questions. They include utilization review techniques, second surgical opinions, hospital pre-certifications and large case management as well as incentives for outpatient or ambulatory surgery.

Employers such as Mobil and AT&T no longer use second surgical opinions since they did not prove to be cost effective. Our own experience with outpatient surgical incentives has been that they may well reduce in-hospital utilization but can easily be over-utilized if sufficient levels of co-payments are not retained to keep them from becoming too attractive.

Practically all the employers we talked with or visited use hospital pre-certification and large case management. The procedure varied among employers, e.g. some admissions are placed under case management by diagnosis and others came under case management after a certain dollar threshold had been met.

Long Range Cost Containment Measures

There is an additional category of cost containment measures which are assumed to yield some long-term financial benefit to the employer but evoke more in the way of potential long-term health benefits to employees -- wellness programs. These take the form of smoking cessation programs, hypertension/cholesterol/diabetes screening, weight control, stress management, exercise programs, etc. Opinions and approaches

vary among employers. Some employers offer nothing in this area while others offer numerous programs. General Electric, for example, offers wellness programs strictly as perks and did not view them as cost savings measures. Allied Signal views them as an employer responsibility. With one exception, none of the firms we surveyed supported the claims of wellness program proponents regarding reduced health benefits utilization and related costs savings. Coors has established a wellness program in an attempt to impact these areas; however, their program is unique in that lower benefits are paid unless persons assessed to be at risk agree to participate.

Employee Behavior: Managing Choice

Sophisticated employers are beginning to develop multifaceted strategies for attaining corporate benefit management goals.

The first step in such a plan frequently is to manage employee choice. While the starting point for virtually every employer we surveyed was a single indemnity plan with a few or many HMO options, most have now focused on programs which encourage or require employees to trade fee-for-service type total freedom of choice for more comprehensive benefits within a managed care delivery system of some sort.

The specific techniques vary among employers and include many of the cost containment measures already discussed. However,

it is the juxtaposition of these mechanisms which operate frequently to encourage employees to make the choices which management believes to be in the best interest of both the individuals and the organization.

For example, AT&T, which had always offered its employees first dollar coverage, recently bargained an 80%/20% coinsurance provision for out of network care while preserving first dollar coverage after a deductible within its soon to be established managed care networks. Marriott already has a point of service program in place which encourages employees to choose network providers by limiting benefits to 70% after a \$250 deductible for out of network care compared with 90% and no deductible within the network. General Electric has taken an entirely different approach to managing choice by limiting HMO offerings in geographic areas where it can offer a provider network instead.

Employees such as AT&T and General Electric believe that it is critical to build trust by establishing an atmosphere of concern for the individual health needs of their employees, while educating them that managed care of some type is in their best interest from a quality of care perspective. Only in such an atmosphere, they feel, can an effective consumer education program be introduced that addresses appropriateness of treatment.

Several other employers, including Mobil, expressed the opinion that ultimately it is the employee as the consumer of health care who can and should begin to restrict utilization based on informed decision making. All agreed that for such a program to produce positive results employees need to see educated consumerism as beneficial to their well being and that of their families rather than as a means of reducing employer health benefits costs.

Risk Pools in Private Sector

Typically, retirees under age 65 in the private sector keep the same indemnity plan they had as employees (but in some cases with a higher premium) and then acquire either a Medicare supplemental plan or a Medicare carve out after age 65.

Ford Aerospace bases the premium retirees pay on their years of service and Medicare status and offers a Medicare carve out for over age 65 retirees. Mobil, which bases its employee contributions on salary bands, charges retirees under age 65 the highest level of premiums for coverage and offers two Medicare supplements for those over age 65. Allied Signal and AT&T offer over age 65 retirees only Medicare carve outs. Marriott offers only a Medicare Supplement for which the retiree must pay the entire premium.

Observations

- Employers in the private sector are moving beyond the point of offering just indemnity plans and HMO alternatives. If anything, the number of HMOs is being reduced, plans are being weeded-out or consolidated into networks. Limiting choice for employees was a consistent theme throughout.
- Employers are concerned not only with bottom-line health program costs but have real quality of care and employee satisfaction concerns as well. This is evidenced in looking at some of the RFPs and selection criteria for contractors developed by employers like AT&T, Xerox, and General Motors.
- Employers are balancing their cost containment interests and their desire for a quality health program by moving beyond the transfer of costs to employees and experimenting with new and innovative delivery systems and administrative measures.
- HMO "networks," PPOs and point of service delivery options are in place now and seem to be working.
- We have concluded from what AT&T and others have told us, that there probably are no contractors who could set up a nationwide network of PPOs at this time. Various companies are strong in certain locations or geographic areas but not

in others. A regional approach is probably a must, particularly for a very large firm.

- ° Almost without exception, employers tell us that moving to PPOs, point of service options or networks requires extensive planning, takes longer than anticipated and requires a great deal of employee education to gain acceptance.
- ° Certain benefits, such as psychiatric and substance abuse probably need to be monitored separately under pre-admission certification and case management to be managed effectively.

Private Sector Employers Contacted/Visited

Mobil

Ford Aerospace

General Motors (visited)

General Electric

Allied Signal (visited)

Marriott

Philip Morris

AT&T

XEROX

Coors

Mobil

- ° Self insures basic indemnity plan -- ASO contract with Metropolitan to process claims;
- ° About 12% of employees in HMOs -- same employer contribution to HMO as for the indemnity plan;
- ° Point of Service (P.O.S.) Managed Care Option offered in California, Fairfax, and Dallas administered by Met. Met is at risk for some portion of the administrative charges associated with the ASO contract for this option;
- ° POS Option captured 20% of enrollment vs. the indemnity plan and the HMOs;
- ° Mobil plans to expand the POS Option to Houston and perhaps 10 other states where Met has preferred provider arrangements;
- ° Weeded out HMOs with low enrollment and weak financial foundations;
- ° Indemnity plan has deductibles based on salary of employee -- less than \$35,000 = \$150 per person/\$300 family, over \$35,000 = \$300 per person/\$600 family. 80/20 co-insurance with out-of-pocket maximum equalling \$2,000 per person/\$4,000 per family;
- ° POS Option has no deductible, a \$200 co-payment on all hospital admissions, and co-payments on office visits rather than a \$150 deductible and a straight 70/30 co-insurance on practically everything including in-hospital care -- i.e., a much richer benefits package (with some additional benefits like physical exams) than using non PPO providers and a somewhat richer package than the indemnity plan with its 80/20 split;
- ° Mobil is using the delivery system and benefit design of the POS Option as a major cost containment initiative currently. Mobil only uses pre-certification for psychiatric care and substance abuse currently.
- ° Retires under age 65 stay with the indemnity plan and pay the higher end of the salary band, currently \$175 per month for family coverage or 1/2 that amount for self only. At age 65, Mobil provides and pays the full cost of a Medicare supplemental policy which provides some additional hospital days (not the Part A deductible), 80% of prescription drugs and private duty nursing. There is a Senior Care Plan, costing \$37.00 per person, which covers full hospitalization, 50% of the Part A deductible

and the 20% of Part B not covered by Medicare (but not the Part B deductible);

- Mobil offers no Flexible Spending Accounts (FSAs) but allows employees to pay health benefit premiums with pre-tax dollars.

Ford Aerospace

- ° Offers a self insured indemnity plan and 10 HMOs to its 12,000 active employees and 3,300 retirees -- 2/3 of which are concentrated in California;
- ° ASO contract with John Hancock -- also aggregate stop loss insurance with same company -- no risk sharing other than this stop loss insurance;
- ° Deductible of \$150 self/\$300 family, co-insurance 80/20, out-of-pocket maximum of \$600 self/\$1,200 family, \$1 million maximum lifetime benefits.
- ° No second surgical opinion, pre-authorized hospital admissions for all admissions, case management required for psychiatric care even for outpatient visits or plan pays considerably less;
- ° No wellness programs, preventive medicine or LTC.
- ° No employee premium - company pays full premium (therefore, no FSA);

Increase deductibles every 3 years.

- ° Looking at PPOs, networks of HMOs, doesn't like results with HMOs;
- ° Actives and retirees in same plan but retirees pay based on years of service and Medicare status. No Medigap -- straight carve out.

GM

- Self insured indemnity plan fully paid by GM, no employee premium;
- ASO contracts with Blues and Metropolitan for indemnity plan;
- HMOs also offered with same rate of payment from GM, usually at no cost to employees;
- PPO arrangement administered by Blues and Metropolitan;
- GM solely at risk for all health benefit components -- no risk sharing;

1.9 million enrollees -- 18% in HMOs -- 18% in PPO Network

- Usual 80/20 split on indemnity plan after deductible of \$200 individual/\$250 family. Most service under PPO arrangement are provided at 100% with no deductible and some additional benefits.
- Managed care, pre-certification;
- Addt'l out-of-pocket incurred if members goes out of PPO network
- No retirees in PPOs -- don't allow;
- "Informal agreements" with Blues -- No HMO contracts;
- Substance abuse pulled out of mental health benefit and monitored by subcontract with Family Services of America;
- LTC offered -- did so under duress;
- Retirees get all benefits w/no cost sharing.

GE

- 250,000 employees;
- \$800 million a year for health benefits
- Self insured with 3 TPAs -- BC, Met. & CIGNA on regional basis; -- no risk sharing currently with TPAs;
- Offers one indemnity plan to all employees, 168 HMOs and networks of PPOs in some geographic areas;
- Pay related premiums, deductibles and catastrophic limitations;
- Employee pays same premium in Network or out of Network but coinsurance is higher out of Network;
- All carriers send health benefits data to central point - Medstat;
- Wellness programs offered as perk - not as cost savings measure;
- Substance abuse & mental health PPOs in 4-5 places -- only form of case management;
- Offer FSA -only 4% participate, currently risky with IRS rule on use it or lose it;
- Premiums paid w/pre-tax dollars;
- Hoping most regions will have 3-4 networks & 75% of employees will have access to them eventually;
- Retirees - under age 65, in with actives; over 65 Medigap;

Allied Signal

- 50,000 employees, 150,000 total enrollees;
- 45,000 retirees, 90,000 including their dependents;
- Current retirees in indemnity plan only; new retirees will be in P.O.S. option until 65 and then go to indemnity plan w/Medicare's carve out. 65 much more expensive than employees, 65 cost less than employees;
- Offered indemnity plan & HMOs but costs took off;
- Not self insured;
- Decided on Point of Service Option national contract with cost guaranteed by CIGNA/CIGNA also contracts as the TPA for the HMOs now;
- 22,000 MDs in network and "Centers for Excellence" used for transplants and major surgery;
- Benefits in network are richer than out of network, rather than adjusting premiums for differences in coverage, e.g. copays are lower and vision plan and preventive well baby care are in network only;
- Cost savings were derived from:
 - in-patient care reduced
 - hospital discounts
 - capitating primary care physician on a pm pm basis
try to avoid
discounted fee for service arrangements
discounted PPOs/capitated IPAs;
- Uses second surgical opinion, pre-admission certification and case management;
- Wellness is employer responsibility - not a perk;
- Substance abuse has limitations in network and only 60% coverage out of network;
- FSA for health benefits premiums to be used as pre-tax dollars only. (locked in for 1 year to avoid the IRS use or lose rule);
- Over 80% of employees are in the Network.

Marriott

- ° Has always self insured;
- ° 130,00 eligible employees, very transient with low wages;
- ° Employer had less than \$1,000 per employee to spend so affordability was big issue. No interest in cost shifting to employees;
- ° Employee pays 1/3, company pays 2/3;
- ° Offers indemnity plan, numerous (80) HMOs and Point of Service Plan with ASO contract with Prudential for first time in 1990. 25 locations around the country have the PSO option. No risk sharing currently with Prudential;
- ° Pre-admission certification and large case management used since 1985;
- ° 51% of employees are enrolled in HMOs;
- ° Richer benefits and more plan co-pays in PSO option than indemnity plan;
- ° Plan to expand the PSO option in 1992;

Retiree -- rule of 75, after age and length of service equals 75, dropped from employee program and offered a Medicare Supplement for which they must pay the full premium.

Philip Morris

- ° 165,000 employees;
- ° 2 Basic plus MM plans (one for salaried and one for union employees) with Aetna and Blue Cross and HMOs with usual 80/20 co-pays and deductibles;
- ° Self insured for 10-15 years with ASO contracts/No risk sharing with TPAs;
- ° No managed care other than pre-admission certification since 1986;
- ° Use Medstat to collect data;
- ° Premiums on pre-tax basis, no FSA in place except for child care;
- ° Exercise program - no wellness data;
- ° Same benefits plan as employees, no dental after 65, salaried employees get Medigap policy after age 65;
- ° HB Program costs were \$18 million in 1981, will be \$90 million this year;
- ° Plans to set deductibles according to salary, start case management, increase cost sharing on in-patient, start mail order prescription drugs.

AT&T

- ° Self insured -- assumes all risk -- ASO contracts for indemnity plans;
- ° Indemnity plans (Blue Cross and Travelers) plus HMOs (12% enrolled)
- ° Indemnity plans paid in full by company - no employee premium.
- ° Going to Point of Service Managed Care Network over next couple of years; RFPs put out last fall.
- ° Looking for risk sharing arrangements
- ° Managed care not a proven product.
- ° Current cost containment measures include pre-admission certification, concurrent review and large case management. Psychiatric care and substance abuse currently under managed care.
- ° 2nd surgical opinions did not prove to be cost effective and were dropped this year.
- ° Plan to cut back on HMOs (currently 250). Some have only 5-10 enrollees.
- ° FSAs for health benefits and dependent child care, 1.1% participation.
- ° Pre-tax dollars for health benefits premiums.
- ° Current retirees - same benefits as employees under age 65 with no premium paid by retirees; after 65, company pays Medicare Part B and full cost of carve out.

XEROX

- 55,000 active employees and 6,000 retirees;
- Xerox offers a self insured indemnity plan and approximately 170 HMOs.
- Started process of developing a network of HMOs three years ago -- about 40% of employees are currently enrolled in HMOs.
- Formal RFPs last year and received about 9 bids for "regional managers" for networks of HMOs -- settled on 6 regions which now offer 95 total network HMOs.
- Network of HMOs is called Health/Link (HL).
- HL just started in 1990 and about 55% enrolled in HL.
- Demographics were about same for HMO enrollments and indemnity plan but then again the workforce age is between 25 and 45.
- If subscriber has severe mental health problem, the HMOs' benefits are admittedly deficient and Xerox permits the employee to transfer at any time during the year to the indemnity plan.
- Each of the six "regional network managers" has assigned a staff person to Xerox to work with them on a daily basis.
- These 6 network managers decide on merits of plans in network, monitor quality assurance, do centralized billings between Xerox and the plans and help during open season.
- Xerox pays the member plans' community rates -- does not negotiate individually.
- Contracts are "open ended" with rates revised annually.
- Indemnity plan is self insured -- covers 25,000 people ASO contract with Prudential -- deductibles are governed by amount of salary, e.g. 1% of salary = deductible.
- FSA for dependent child care.
- HMO contribution by XEROX is same as that for indemnity plan.
- Retirees (5,000 total) have 1st dollar medical plan -- no HMO option available to them -- after age 65, retirees have a Medicare carve-out.

- ° Retirees have a separate plan from employees - no retiree contribution before or after age 65. After age 65 - company pay Part B premium, not the deductible & does pay co-insurance for retirees.
- ° Utilization review for mental health only -- employee dissatisfaction too high for very little return. When implemented this UR, they increased benefits for outpatient. Now outpatient utilization is equally high to avoid the inpatient pre-admission review.
- ° No risk sharing with Psychiatric Management Review for the mental health.
- ° No risk sharing with Prudential for indemnity plan either.
- ° PruTrace (data analysis) gives claims management information.
- ° No LTC
- ° Wellness Programs since late Seventies -smoking cessation, exercise, cholesterol screening, usual programs.
- ° Advice -- Work with key players well in advance of producing RFPs to determine what is attainable. They will send us a copy of their RFP.

Coors

- 32,000 employees -- average age 42 -- 77% in Denver/Golden area;
- Self insured, self administered Major Medical & Catastrophic benefit plan with no employee premium - no HMOs offered;
- Mental health is only area currently under case management and it is done by contract -- second surgical opinion in some cases;
- No real cost containment efforts otherwise;
- No retiree coverage after age 65;
- Primary reason we looked at Coors was their wellness program;
- Began wellness program in 1981 -- no baseline data -- didn't want employees thinking they were being manipulated. However, based on an engineering and computer model at University of Oregon, a 1988 study by Coors showed that health insurance costs for participants in the wellness programs were 13% less than non-participants' costs at a savings of \$3.2 million in 1988;
- Coors encourages employees and their spouses to have health risk appraisals done every 5 years -- covers 11 risk areas;
- Coors offers cholesterol screening, body fat measurements, treadmill screening, blood pressure and breast cancer screening, nutrition education, stress management, coronary risk i.d. and behavior modification, parenting skills, weight management, a 12 week smoking cessation program with an 85% success rate, prenatal programs, cardiac and orthopedic rehabilitation and back care programs;
- Company sees these as a "moral obligation."

HIAA

Health Insurance Association of America

HEALTH CARE FINANCING

FOR
ALL AMERICANS



Private Market Reform & Public Responsibility

HEALTH CARE FINANCING

FOR
ALL AMERICANS



Private Market Reform & Public Responsibility

1991



Health Care Financing for All Americans: A Synopsis

The Health Insurance Association of America (HIAA) has formulated a proposal to provide access to health care coverage for all Americans. HIAA's proposal focuses on expanding coverage through the workplace and expanding public coverage for the poor and the near poor. Its essential elements follow.

Reform of the Small- Employer Market

Reforms are needed to ensure the availability and reliability of private health insurance in the small-employer market. The aim of small-employer market reforms is to assure private coverage on a continuing basis for small employers and to assure that individual high-risk employees are not denied coverage. If an employer changes insurers or an employee changes jobs, new preexisting condition restrictions would not be imposed. Limits would apply to variations in premiums and premium increases.

Private Reinsurance

A private reinsurance mechanism for the small-employer health benefit market needs to be authorized. This would allow insurers to implement market reforms by permitting insurers to spread losses for high-risk individuals equitably across the market. Under the HIAA proposal, no employer would have to pay more than 150 percent of the relevant market averages for basic coverage.

State Pools for the Medically Uninsurable

State pools for medically uninsurable individuals who are not part of an employer group need to be established. Losses should be financed by state general revenues or other broad-based funding. If a state does not act, the U.S. Department of Health and Human Services (HHS) should be authorized to set up a federally funded pool in that state to pay for losses. The funds for the pool would come from funds that HHS would otherwise spend in that state.

Affordable Coverage

Insurers should be allowed to offer more affordable coverage to small employer groups. Insurers should be permitted to market lower-cost prototype plans; and insured employer plans should receive exemptions from costly state provider and service coverage mandates (such exemptions are given to self-insured plans).

Targeted Tax Assistance

Tax assistance must be targeted so that small employers and their financially vulnerable employees can afford health insurance coverage.

For example, the self-employed would find coverage more affordable if, instead of receiving a 25 percent deduction for the cost of health benefits, they received 100 percent, as do other employers (as long as they provide equal coverage for their employees). Financially vulnerable groups should receive new tax subsidies; such subsidies should be directed toward financially fragile employers and low-income employed individuals.

Expanded Public Coverage for the Poor and Near Poor

HIAA recommends expanding Medicaid to cover all those below the federal poverty level, regardless of family structure, age or employment status. Medicaid's link to welfare categorical restrictions should be eliminated. As an important first step, HIAA supports the recent enactment of phased-in coverage for poor children. The Medicaid "spend-down" program should be extended to all states and eligibility thresholds should be set to prevent impoverishment by medical expenses.

Low-income individuals above the poverty level should be allowed to "buy into" an income-related package of primary and preventive health care services. Also, the recent federal Medicaid "buy-out" requirement (which eventuated from HIAA's original proposal to authorize such state actions) should be implemented. States should pay the employee share of available employer group insurance where the average employee's premium costs are less than what the same benefit would cost on an average per capita basis under direct Medicaid financing. This will maximize state savings and avoid adverse selection between the public and private sectors.

Cost Containment

Moving forward with cost-containment efforts to make health care more affordable has become a national imperative. HIAA recommends promoting the development of managed care systems (HMOs, PPOs, point-of-service plans, and the like) that rationalize and integrate health delivery and financing; HIAA also supports such managed care mechanisms as utilization review and quality assurance. Government must be encouraged to create a climate hospitable to the growth of managed care, and to refrain from creating barriers to utilization review and other key cost-containment strategies.

Better methods for assessing the cost-effectiveness of new technologies and procedures are also needed, as are increased efforts to formulate medical practice guidelines and protocols. (The latter would encourage efficiency in physicians' practice styles.) Another way to control costs is to provide financial incentives for consumers, so that they will be cost-conscious when they select health plan alternatives, health care providers, and medical services. Efforts also must be made to reduce the incidence of malpractice and to reform the malpractice system, making it more efficient and assuring that victims are reasonably compensated.

Health Care Financing for All Americans

Introduction

Today, more than 30 million Americans have neither public nor private health care coverage. These Americans often have greater problems gaining access to the health care system than do those who have coverage. They may forgo necessary care or delay getting treatment until their problems worsen — and become more costly.

These individuals represent the widening gap in our nation's health care financing system. HIAA believes that policy makers must devise ways to close the gap. More precisely, government action is needed to provide the legislative and fiscal base that will enable a combination of public and private providers of health care coverage to meet the health care financing needs of all Americans.

The HIAA proposal takes into account the important policy implications of the relationship between income, the workplace, and health care coverage. The vast majority of Americans with adequate incomes have health coverage. Ninety percent of all nonelderly Americans with in-

comes of over three times the federal poverty level have some form of coverage. Approximately 150 million nonelderly in this country obtain health coverage through an employment-based plan.

Yet most individuals without health care coverage are in families with some involvement in the work force. In fact, 66 percent of the uninsured are full-time workers or are dependents of full-time workers. Another 14 percent either work half-time (18 to 34 hours a week) or belong to families with one or more part-time working members. (*Current Population Survey*, U.S. Dept. of Health and Human Services, March 1988 tabulations.)

Efforts to make coverage more available and more affordable should take into account the fact that most Americans receive their health care coverage through employment. A realistic approach is to focus on improving the ability of financially vulnerable employers to offer health insurance to their often low-income employees. In addition, low-income employees need direct government assistance so that they can afford their share of premiums.

To be cost effective, expansion strategies should build on existing coverage and target public coverage to the poor and near poor. Extending public coverage to higher income individuals will lead inevitably to unnecessary tax increases to support substitution of public coverage for private coverage.

HIAA also believes that efforts to expand the nation's health care financing system must be complemented by responsible cost-containment measures. HIAA's policy on cost containment includes an emphasis on the development of managed health care systems. It also calls for greater scrutiny of one of the major causes of high costs — the use of new, often unproven, technologies and procedures. HIAA also strongly

supports wellness and prevention activities, as well as economic incentives for the consumer to be "cost conscious" in the use of medical resources and in choosing a health plan.

Proposal

Reform of the Small-Employer Market

Those who are concerned with assuring the availability and reliability of health insurance coverage are paying increasing attention to the small-employer health benefit market. This is largely because a high proportion of workers without health care coverage — fully two-thirds — work for a business establishment with 25 or fewer employees at that establishment's location; but only one in three firms with fewer than 10 employees offers health benefits. (Figures 1 and 2.)

Increasingly, small employers seek relief from rising health care costs by an aggressive search for the lowest possible price for health care coverage. Those with healthy employees are more likely to seek, and to obtain, coverage at prices that reflect their low risk.

In turn, more and more insurers have found that to be price competitive for these low risk employers, they are less able to spread the costs of groups with employees at high risk of incurring large medical expenses broadly across the lower risk groups. This has led to a growing number of higher risk employers that cannot find coverage at an affordable price. Moreover, those employer groups that are at lower risk today, and thus initially obtain a lower premium, are likely to have employees who will develop expensive medical conditions. Those employers may then face large premium increases.

In general, then, small employers have greater difficulty than large employers in affording and sometimes even obtaining health coverage. Fur-

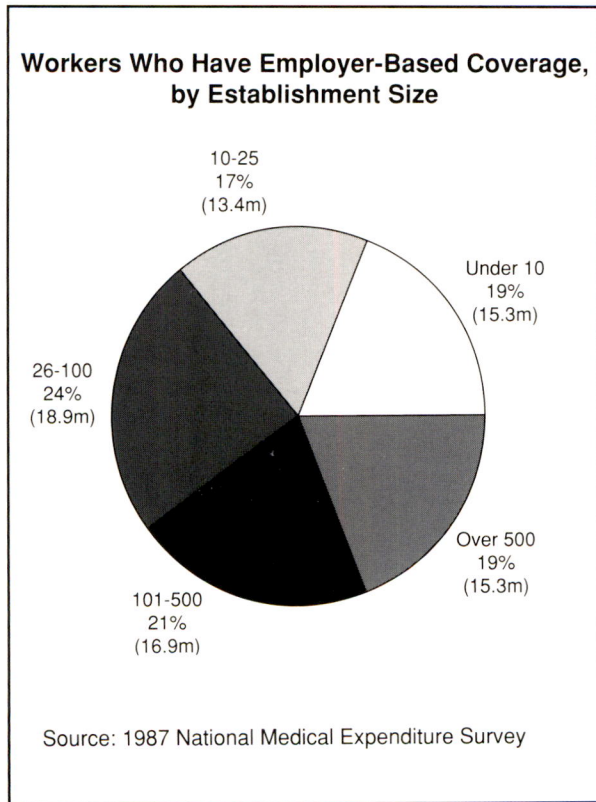


Figure 1

thermore, the greater frequency with which small employers change carriers and their workers change jobs exposes these individuals to greater risk of being left out of the system. Finally, small employers are highly sensitive to very large, unanticipated premium increases and may fail to obtain, or to retain, coverage in a marketplace where individual employer experience is highly unpredictable.

Substantial reforms are needed if health insurers are to serve the broader interests of small employers and their employees. Many recommendations are under discussion. But not all are of equal value.

One ill-advised proposal is to institute a flat "community rate" for all small employers. This would increase rates for the populations least able to pay, and younger workers (who on average earn less than older workers) would end

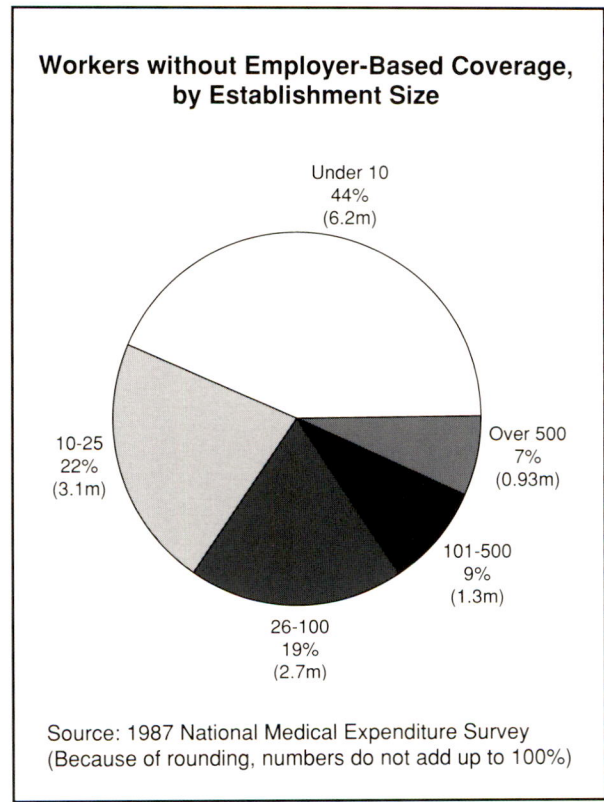


Figure 2

up subsidizing older, higher income workers. Subsidies could occur on a regional scale, too, because some community rating schemes fail to permit rate adjustment by geographic area: these would force lower cost, more efficient and often lower-income localities to subsidize higher cost, less efficient localities that often have higher per capita incomes. Community rating gives carriers little if any latitude to fine-tune their rates, thereby increasing the risk of insolvency.

There are far better avenues to reforming the small-employer health benefits market than community rating schemes. The best approach is a multi-faceted blend of private and public strategies that take into account the complexity and realities of health care financing. Accordingly, HIAA has developed a comprehensive set of legislative reforms that can be implemented while allowing a viable private marketplace.

HIAA recommends market reforms and reinsurance mechanisms to ensure fair access to, and continuity of coverage for, small employers and their employees. When enacted by the states, these reforms will introduce a greater degree of predictability and stability to the small-employer health benefit marketplace.

- *Guaranteed Availability.* All small-employer groups would be able to obtain private health insurance regardless of the health risk they present. A significant number of carriers in a state (defined by their small-employer market share) would be required to guarantee to issue health care coverage to any legitimate small-employer group. HIAA is willing to consider variations on this approach (in a given state) to enhance consumer choice.
- *Coverage of Whole Groups.* Coverage would be made available to entire employer groups; no small employer nor any insurer would be able to exclude from the group's coverage individuals who present high medical risks.
- *Renewability of Coverage.* At renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be canceled because of deteriorating health.
- *Continuity of Coverage.* Once a person is covered in the employer market and has satisfied an initial plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.
- *Premium Pricing Limits.* Insurance carriers would be required to limit how much their rates

could vary for groups similar in geography, demographic composition and plan design.

More specifically, a carrier's premiums for similar groups could not vary by more than 35 percent from the carrier's midpoint rate (halfway between the lowest and highest rate). There would also be a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increases to no more than 15 percent above the carrier's "trend" (the year-to-year increase in the lowest new business rate). Separate "trends" should be allowed for managed care and non-managed care to reflect health care cost/efficiency differences in these structures.

In order for these reforms to succeed, the implementing legislation will have to pertain to all competitors in the small-employer market. If any one company or segment of the market pursues such reforms independently, without rules for marketplace behavior spelled out in legislation, it might invite financial ruin. It is therefore important that states have the clear authority to impose these rules on all competitors in the small-employer marketplace. Within the scope of these rules, insurers would be allowed to use individual risk assessment and classification initially to assess risk, to set rates, and to determine for which individuals to purchase reinsurance.

Private Reinsurance

A private marketwide reinsurance system would make possible the reform of the small-employer market. Reinsurance means to "insure again." Under reinsurance, an insurance company, called the ceding or direct-writing insurer, purchases insurance from the reinsurer to cover all or part of the loss against which it protects its policy-

holder. The reinsurer is, in a sense, a silent partner of the original insurer. Reinsurance enables an insurer to accept a greater variety of risks. By sharing these risks with a reinsurer, the ceding insurer obtains an adequate spread within which the law of averages can operate.

Reinsurance will allow individual insurers (or other small-employer health plan entities) to implement reforms without facing high financial losses. Reinsurance will allow carriers to assure small-employer groups presenting a high health risk access to a basic set of benefits at a rate no higher than 50 percent above the applicable average market premium. For groups already covered by an insurance carrier, the premium pricing limits described above would pertain, and would in many cases limit a high-risk employer's rates to a level below the guaranteed marketwide maximum level of 50 percent above average.

Under this approach, a significant number of carriers in a state's small-employee health benefit market (defined by small-employer premium) would be required to guarantee to issue health coverage to any legitimate small-employer group applicant. Not all carriers would be required to guarantee to issue coverage, but they would be strongly encouraged to do so through better reinsurance terms for guaranteed issue carriers. Guaranteed issue carriers could reinsure entire high-risk small-employer groups at a reinsurance premium price of 150 percent of average market costs or reinsure high-risk individuals within groups at 500 percent of average market costs. (Individual reinsurance would include a \$5,000 deductible.)

To reduce the volume of reinsured claims, reinsurance would be on a three-year basis. (If reinsurance were permitted annually, carriers could declare more groups or individuals high-risk and utilize reinsurance more often, increas-

ing reinsurance losses to unacceptable levels.) Nonguaranteed issue carriers would be permitted only to reinsure new entrants to existing groups through individual reinsurance. This reflects the fact that under the "whole group" rule, all carriers would have to make coverage available to any new employees entering a group they already insure.

The reinsurer would cover the costs associated with reinsured cases. The process of reinsurance is invisible to employers and employees and is purely a transaction between the ceding insurer and the reinsurer.

In the aggregate, the cost of reinsured persons will exceed the reinsurance premiums; this is because reinsurance would be aimed at employer groups and employees known to be high risk, and because the premium price would be limited in order to encourage carriers to accept high risk applicants. Under this proposal, the reinsurer's losses would be spread equitably across all competitors in the private marketplace — both the guaranteed issue and nonguaranteed issue carriers.

Losses would be covered first through contributions from all carriers in the small-employer market. If losses were significantly higher than expected, a second "safety valve" of broad-based financing would be made available.

HIAA will aggressively pursue reinsurance and related small-employer market reform at the state level. HIAA will also recommend federal legislation to give states the authority, where necessary, to assure compliance with the market reforms outlined here and to finance the reinsurance system.

With HIAA's recommended market changes in place, the small employer will stand to benefit greatly from the rapidly evolving cost-management capacity. These reforms will encourage competition based more on efficiency and less

on selection. Competitors would no longer be allowed to draw business away from more efficient health benefit plans by offering temporarily low prices that rise sharply once an employee gets sick. Insurers that reduce inefficient operating expenses and that offer cost-effective financing systems and delivery systems will gain a larger share of what is an extremely price-sensitive market.

State Pools for Uninsurable Individuals

Even with increased employer-based coverage and with Medicaid expansions (see below), medically uninsurable individuals who are not part of an insured employer group would remain without coverage. High-risk pools should be established in the states so that coverage would become available to such individuals. Pool losses should be funded by general revenues or similar sources, which spread the cost broadly across society. (As of December 1990, 25 states had enacted broad-based pools for uninsurable individuals.)

Allow Insurers to Offer More Affordable Benefit Plans to Small-Employer Groups

Over the years, the list of state laws mandating benefits and providers has grown dramatically. There are about 800 such laws nationwide — and they mandate coverage of such disparate services and provider categories as chiropractic and podiatry, acupuncture, expansive inpatient mental health services (even where most cost effective alternatives exist), in vitro fertilization, and pastoral counseling. The cumulative effect of this hodgepodge of state laws is to increase the cost of health insurance, particularly for small employers who are most in need of affordable basic benefits and who are too small to self-insure and thus escape these mandates as larger employers often do.

One reason that mandated benefit laws increase the cost of coverage is that multi-state insurers must monitor and comply with so many different state rules and regulations. Insurers are precluded from developing lower-cost prototype plans that would be marketable across state lines. Instead, they are often forced to offer only “Cadillac” plans based on a multitude of mandates from many states.

Many of these benefits, are expensive in their own right. Taken together, mandated benefits in many states provide a package that many small employers simply cannot afford.

A 1989 study (conducted by Gail Jensen, then a health care economist with the University of Illinois, and now at the University of North Carolina) concluded that 16 percent of small employers not now providing health insurance would offer benefits in the absence of state mandates.

State-mandated benefit laws do not apply equally to all employer-sponsored health plans. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandated benefit laws and other forms of state insurance regulations. In general, only large employers have the financial resources or the risk-spreading base to self-insure; self-insurance allows multi-state employers not only to save administrative costs through plan uniformity but to pick and choose those benefits that are most desirable and cost effective. Employers too small to self-insure do not have this flexibility, and they are thus less likely to offer health insurance at all.

In 1985, the U.S. Supreme Court ruled that to put employee health benefit plans on the same footing as self-insured plans required congressional action. Moreover, in recent years, there also has been a proliferation of state actions that obstruct or hinder private-sector managed care efforts that would make health care coverage more affordable. These state bills are aimed at

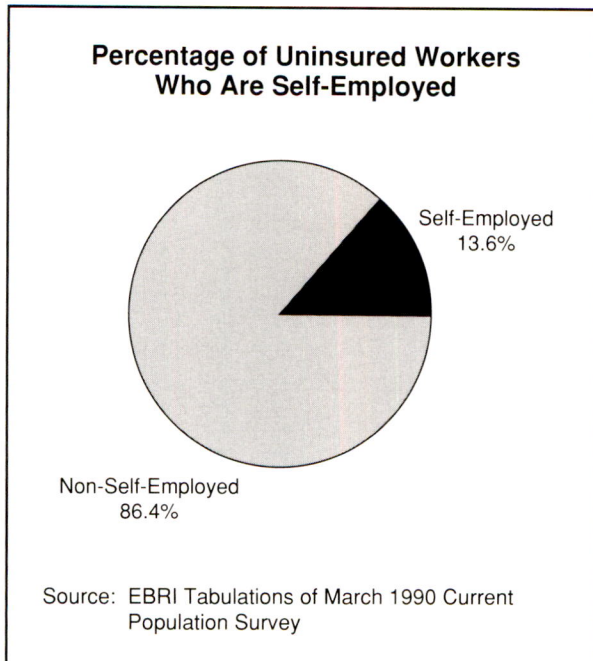


Figure 3

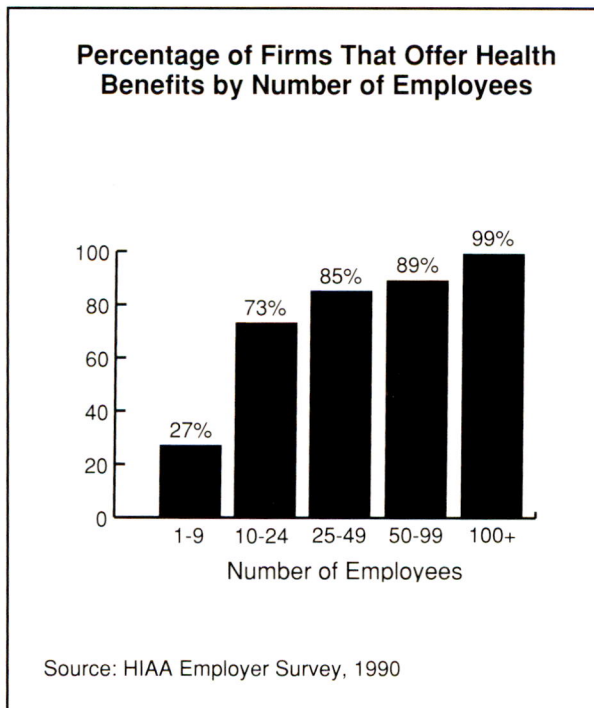


Figure 4

limiting contractual arrangements with cost-effective provider networks, as well as preventing or limiting insurers' ability to carry out effective utilization review programs. Again, small employers should be able to benefit from the same cost-management approaches as do larger employers.

Targeted Tax Assistance for Small Employers and Their Financially Vulnerable Employees

Small businesses tend to be younger, financially less stable and employ a lower wage work force. Thus, health benefits often represent a greater financial burden to small businesses, who are far less likely to offer them than are other employers. A 1989 HIAA survey found that only 27 percent of firms with fewer than 10 employees offer health benefits. Conversely, over 90 percent of firms with more than 25 employees offer health benefits. (Figures 3 and 4.)

Eleven percent of uninsured workers are self-employed. They are uninsured in part because self-employed workers receive only a 25 percent income tax deduction for the cost of health benefits. Other (incorporated) businesses receive a full 100 percent deduction.

The financial vulnerability of small employers and uninsured workers, as well as government fiscal realities, suggest that additional tax assistance should be carefully targeted to those populations most in need. For instance, government should direct new tax subsidies to assist employers and individuals with inadequate financial resources in purchasing private coverage. Sliding scale subsidies should be targeted, for example, to small employers paying average wages of less than \$18,000 annually. The subsidy rate for such employers should increase as the percent of total payroll going to hospital and medical benefits increases. A temporarily higher subsidy could be given to firms offering benefits for the first time.

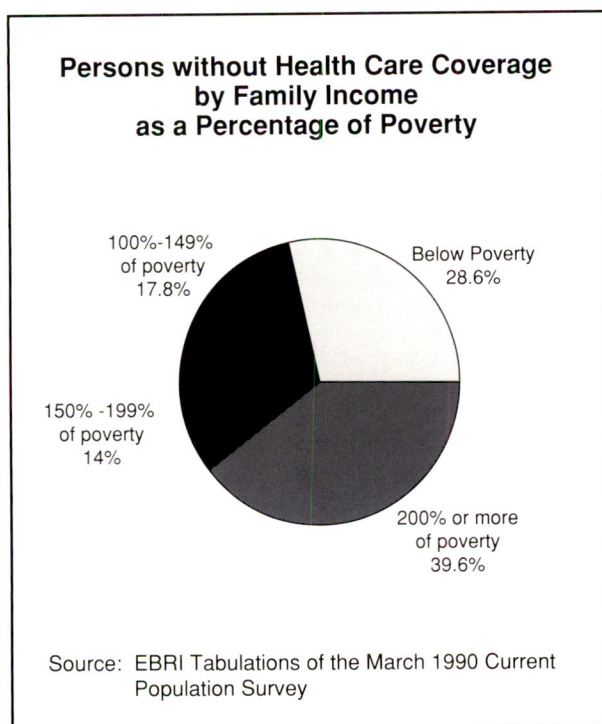


Figure 5

Subsidies should be targeted to low-income individuals and families. A refundable tax credit equaling 50 percent of the employee share of premium cost could be made available for taxpayers at or below the poverty level. Above poverty, the percentage credit would decrease as income rises and phase out completely at twice poverty. Advance payment of the tax credit through the employer should be made for employees with little or no income tax liability; and, government should extend to the self-employed the 100 percent tax deduction enjoyed by other employers (as long as they provide equal coverage for their employees, if they have any).

Expand Public Coverage for the Poor and Near Poor

Close to 29 percent of the uninsured have family incomes below the federal poverty level (\$10,560 for a family of three in 1990). Another 18 percent have incomes between one and one-and-a-half

times the federal poverty level. (Figure 5.) The current federal/state Medicaid program covers only four out of ten poor Americans. Many states do not have a medically needy program, and Medicaid income eligibility thresholds for the nonelderly generally fall far below the poverty level.

Because the poor and many of the near poor do not have the means to purchase coverage on their own, the health care financing responsibility for these populations rests largely with the government.

HIAA proposes that the Medicaid program be extended to cover all poor Americans regardless of age, family structure or employment status. To carry out this recommendation fully, Medicaid eligibility will have to be independent of such cash assistance programs as Aid to Families with Dependent Children (AFDC). Moreover, fiscal constraints suggest first priority should be phasing in coverage to all poor children under age 18. For poor workers who have access to employer-based private coverage, HIAA supports appropriate state implementation of recent federal legislation on a "buy-out" of employed individuals and their families from the Medicaid program. States should pay the poor employees' premium contributions and cost sharing (copays and deductibles) associated with available employer plans when Medicaid outlays would be reduced on an average per capita basis. This will help ease individuals' transition into economic self-reliance and often improve access to medical care.

Near-poor individuals who have family incomes between one and one-and-a-half times the federal poverty level should be allowed to "buy into" a package of primary and preventive care services only. Premiums would be based on a sliding scale related to their income. This would target government assistance to the primary and preventive services the near poor most often forgo

and for which employer-sponsored plans' cost-sharing sometimes presents a financial obstacle.

To assure that no American falls beneath the poverty level as a consequence of medical expenses, all states should deduct medical expenses from income when determining eligibility for Medicaid. "Medically needy" or "spend-down" programs (and many states have already adopted such programs) constitute a last-resort financial safety net covering a full range of health services.

Raising eligibility standards for Medicaid to 100 percent of the federal poverty level will give an estimated 9.5 million to 11 million uninsured Americans access to Medicaid coverage. (The Medicaid program currently pays for the care of over 21 million people annually.) These reforms would increase Medicaid costs by only about 25 percent while increasing the population served by the program by about 70 percent. This is because three-quarters of Medicaid spending now goes for long-term care and other services for the elderly and disabled. Medicaid coverage for poor uninsured populations is far less expensive on a per capita basis.

Contain Health Care Costs

Efforts to improve access will be thwarted, at least to some extent, if no way is found to curb the escalation of health care costs. As the cost of care continues to rise, employers who are on the margin with respect to decisions to offer coverage will find coverage unaffordable. Solving the cost problem is a prerequisite to solving the access problem.

Although there are no simple solutions to the cost problem, a key component of any effective cost containment strategy is the further development of managed care systems that integrate financing and delivery — HMOs, PPOs, point-of-service plans, and the like. Since physicians make most of the key decisions that determine

the cost of treatment, it is imperative to make sure that patients get care from physicians (and other providers) who use resources efficiently. Managed care systems build on that premise by selecting panels of providers for their networks who meet specified criteria and who agree to be monitored to assure that they continue to provide high-quality cost-effective care. Patients are then given financial incentives to choose these providers as their caregivers. By integrating the financing and delivery of care, managed care improves quality while constraining costs.

A second major element in effective cost containment must be improved knowledge about what constitutes cost-effective care. New technologies that promise better care are introduced into medical practice, often at great cost, before anyone has made a careful assessment of their cost-effectiveness or even appropriateness for certain treatments. Insurers, government, and all who pay for medical services have a stake in developing better mechanisms and procedures for that assessment.

Related to the need for better knowledge about technologies is the need for better information about what constitutes good medical practice. (One symptom of this need is that in many areas of medicine there is broad variation in the treatment of patients with similar conditions.) Increased efforts should be directed to filling the knowledge gap by establishing mechanisms and financing to develop medical practice guidelines and protocols that define the range of acceptable medical practice for particular conditions. This task will require a substantial commitment of resources from both government and the private sector. These kinds of advances in medical knowledge will help to improve utilization review activities by providing standards that are accepted by both physicians and, very likely, the courts as well.

Government has a vital role to play in the

battle against cost escalation, particularly with respect to technology assessment, protocol development, and the collection and analysis of data that can be used to develop more accurate measures of cost, use, and medical outcomes. Also necessary is a legal climate that is hospitable to the growth of managed care. Government should refrain from limiting insurers' ability to employ appropriate utilization review techniques and should not outlaw managed care plans that require patients to pay significantly more when they opt to get care from non-network providers (thus generating significantly higher costs).

Government can help reduce administrative costs by cooperating with industry-wide efforts to utilize common claims forms and expand electronic collection, analysis, and payment of claims. Finally, government has to take the lead in malpractice reform. Such reform includes reducing the incidence of malpractice by encouraging better risk management activities by providers, taking steps to assure that only competent providers treat patients, and making legislative changes in the malpractice system so that awards are appropriate and adjudication does not absorb an excessive percentage of the costs of righting the wrongs done to patients.

HIAA

Health Insurance Association of America
1025 Connecticut Avenue, N.W.
Washington, D.C. 20036-3998

PP191

A REPORT ON
THE ATTITUDES OF
FORTUNE 1000
SENIOR LEVEL EXECUTIVES
TOWARD
THE HEALTH CARE COST CRISIS

CONDUCTED FOR:
THE HEALTH INSURANCE ASSOCIATION OF AMERICA

JANUARY 1990

BY
THE ROPER ORGANIZATION INC.
205 EAST FORTY SECOND STREET
NEW YORK

The Roper Organization Inc.
205 East 42nd Street
New York, NY 10017

January 1990

Respondent:

CEO.....25%
COO.....7%
CFO.....39%
Other senior exec:..29%

Good morning/afternoon. My name is _____ and I'm working on a survey of Chief Executive Officers of America's largest industrial and service companies that is being conducted by The Roper Organization in New York City.

The survey is concerned with cost pressures affecting American business these days. The interview will take only about 10 minutes, and your individual responses will be kept completely confidential.

1a. Which four or five factors would you say are having the most adverse effect on the prosperity of our nation these days?

Respondents answering = 100

Federal budget deficit	57%
U.S. educational system/ no qualified workers/ low quality of staff performance	26%
Health care costs mentioned (net)	25%
Cost of capital/ high interest rates	25%
Foreign competition	22%
Trade deficit	20%
Drugs/crime	17%
Inflation	15%
Slowdown of economy/ growth/industry	12%
Productivity/ low productivity	12%
Competition (general) (not foreign)	9%
Lack of savings/ high consumer debt/ spending	9%
Rising costs/ high operating costs (high overhead)	8%
Health care costs (2nd mention)	8%
Taxes/tax rates	8%
Government incompetence/ out of touch gov't/ inability of gov't to make decisions	7%
Health care costs (4th mention)	6%
Too many government regulations/ high cost of gov't regulation	6%
Health care costs (1st mention)	5%
Short term attitudes/ outlook of business	4%
Health care costs (3rd mention)	4%
Hostile takeovers/ buy outs	3%
High cost of litigation	3%
Quality/quality control	3%
Health care costs (5th mention)	2%
All other mentions	30%

1b. Which four or five factors are having the most adverse effect on the prosperity of American business today?

Respondents answering = 100

Federal budget deficit	49%
Foreign competition	33%
Cost of capital/ high interest rates	27%
U.S. educational system/ no qualified workers/ low quality of staff performance	25%
Health care costs mentioned (net)	24%
Trade deficit	15%
Too many government regulations/ high cost of gov't regulation	14%
Inflation	13%
Rising costs/ high operating costs (high overhead)	12%
Slowdown of economy/ growth/industry	12%
Productivity/ low productivity	10%
Drugs/crime	9%
Health care costs (1st mention)	7%
Health care costs (2nd mention)	7%
Government incompetence/ out of touch gov't/ inability of gov't to make decisions	7%
Lack of savings/ high consumer debt/ spending	6%
Taxes/tax rates	6%
Health care costs (4th mention)	5%
Competition (general) (not foreign)	4%
High cost of litigation	4%
Quality/quality control	4%
Health care costs (5th mention)	3%
Short term attitudes/ outlook of business	2%
Hostile takeovers/ buy outs	2%
Health care costs (3rd mention)	2%
Employee benefit/ entitlement costs	1%
Reduced consumer confidence in products	1%
All other mentions	31%
None	1%

1c. Which four or five factors are having the most adverse effect on your corporation's financial status today?

Respondents answering = 100

Cost of capital/ High interest rates	32%
Rising costs/ high operating costs (high overhead)	31%
Federal budget deficit	23%
Slowdown of economy/ growth/industry	21%
Health care costs mentioned (net)	19%
Too many government regulations/ high cost of gov't regulation	17%
Foreign competition	16%
Competition (general) (not foreign)	15%
U.S. educational system/ no qualified workers/ low quality of staff performance	12%
Trade deficit	12%
Health care costs (1st mention)	8%
Inflation	8%
Government incompetence/ out of touch gov't/ inability of gov't to make decisions	8%
Lack of savings/ high consumer debt/spending	5%
Employee benefit/ entitlement costs	5%
Health care costs (2nd mention)	4%
Productivity/low productivity	4%
High cost of litigation	4%
Health care costs (4th mention)	4%
Health care costs (3rd mention)	3%
Quality/quality control	3%
Taxes/tax rates	3%
Deregulation	2%
Drugs/crime	1%
High cost of injury settlements	1%
All other mentions	28%
None	4%

2. Would you say health care costs are a major problem for your corporation these days, or a minor problem, or not really a problem?

Respondents answering = 100

Major problem.....	65%	(ASK 3)
Minor problem.....	31%	(SKIP TO 4)
Not really a problem....	4%	(SKIP TO 6)
Don't know.....	-%	(SKIP TO 6)

3. Could you please elaborate on why you say health care costs are a major problem for your corporation? PROBE: Anything else?

Asked of and based on respondents for whom health care costs are a major problem
Respondents answering = 100

Health care costs rising faster than other costs/ cost must be controlled	48%
Costs are rising	45%
Problem with retirees	8%
Need a way of assessing cost effectiveness/ worth of services	5%
Rising costs make us less internationally competitive	2%
National competitiveness hurt by difficulty of managing expenses	2%
Lack of patient management/ monitoring of patient care/ no one to oversee/ no centralization	2%
Other mentions	6%
None	2%

4. Where would you rank health care costs among the factors that adversely affect your corporation's financial status? Would you say they are... (READ LIST)

Asked of and based on respondents for whom health care costs are a problem
Respondents answering = 96

The number one problem.....	3%
One of the top three.....	11%
One of the top five.....	33%
A significant, but not critical problem, or.....	51%
Not really a problem.....	1%
(DON'T READ) Don't Know.....	-%

5. Do you view the issue of health care costs as a lot more important to your corporation than two or three years ago, or just about the same now as then?

Asked of and based on respondents for whom health care costs are a problem
Respondents answering = 96

A lot more important.....	71%
Just about the same.....	28%
Don't know.....	1%

6. As employers' difficulties with health benefit programs have grown, has your interest in some sort of universal national health insurance plan increased?

Respondents answering = 100

Yes.....	32%
No.....	64%
Don't know.....	4%

7. Which of these statements comes closest to describing how you feel about the portion of health care costs your employees bear--that is the level of cost sharing between the corporation and the employee?

Respondents answering = 100

- a. The level of cost sharing should be increased substantially to make employees more cost conscious27%
- b. The level of cost sharing should be increased slightly .36%
- c. The level of cost sharing is just about right27%
- d. The level of cost sharing is slightly higher than it ought to be 6%
- e. The level of cost sharing is substantially too high.... 2%
- Don't know 2%

8. In the last 2 or 3 years, have you made any major changes in your corporation's health benefit plan specifically targeted at containing costs, such as raising deductibles, utilization controls, reducing benefits, or switching to HMO's or PPO's?

Respondents answering = 100

- Yes.....89% (ASK 9)
- No.....10% (SKIP TO 10)
- Don't know..... 1% (SKIP TO 10)

9. Please tell me specifically what kinds of changes have you made? PROBE:
Any other changes?

Asked of and based on respondents who made major changes in their health benefit plan targeted at containing costs

Respondents answering = 89

- Increased cost to employee (net) 74%
- Increased employee cost-sharing (including both deductible & co-payments) 60%
- Increased employee cost sharing (nfi) 20%
- Increased employee share of premium/employee pays more or all for dependents 7%
- Moved to managed care care (HMO's, PPO's, provider panels) 62%
- Increased utilization review 30%
- Reduced benefits/eliminated part of benefit plan 27%
- Offered flexible benefits/cafeteria style program 11%
- More effective control of administrative costs/self insurance/hire TPA (third party administrator) 3%
- Employee education 1%
- Reimburse doctors, hospitals, other providers based on negotiated rates/fee and discount rates 1%
- Provide incentives for out-patient care 1%
- Doing a better audit of claim payments 1%
- Other mentions 7%

10. How successful would you rate your efforts to curb wasteful or excessive use of health services by your employees? Have your efforts been ... (READ LIST)

Respondents answering = 100

Very successful..... 7%
Somewhat successful.....66%
Not too successful, or.....20%
Not at all successful?..... 1%

(DON'T READ) Don't know..... 6%

11. Have increases in health care costs had a substantial adverse effect on your employees' finances or standard of living, or a minor effect, or no real effect at all?

Respondents answering = 100

Substantial adverse effect.... 8%
Minor effect.....62%
No real effect.....28%
Don't know..... 2%

12. Now I'm going to ask you a question about HMOs, PPOs, and similar models that use networks of providers to manage care. Do you think HMOs, PPOs and similar models of delivery are effective or not effective in controlling costs?

Respondents answering = 100

Effective.....48% (SKIP TO 15)
Not effective.....34% (ASK 13)
Don't know.....18% (SKIP TO 15)

13. Do you think this provider network approach could be effective if appropriate changes were made, or is there no way for it to be effective in controlling costs?

Asked of and based on respondents who think networks of providers are not effective in controlling costs

Respondents answering = 34

Could be effective59% (ASK 14)
No way for it to be effective ..24% (SKIP TO 15)
Don't know18% (SKIP TO 15)

14. What changes do you think are needed in order for provider networks-- that is HMOs and PPOs--to be effective in controlling costs?

Asked of and based on respondents who think provider network approach could be effective if appropriate changes were made

Respondents answering = 20

Control doctor's costs	10%
Make HMO's and PPO's designed to be more attractive/appeal to more people	10%
Better access to physicians and other providers/need more doctors	10%
Increased employee cost-sharing	5%
Less government regulation	5%
People should be educated on prevention	5%
Better control over utilization/better monitoring over use	5%
Make HMO's and PPO's mandatory for all employees	5%
Other mentions	30%
None	5%
Don't know	20%

15. I'm going to read you three possible solutions to the health care cost problem that involve varying degrees of public and private-sector involvement. Please tell me which one you would choose as the right mix of public and private-sector responsibilities?

Respondents answering = 100

- a. Primary reliance upon improved private-sector efforts to contain health care costs, with only the current level of government regulation, or..... 62%
 - b. Improved private-sector cost control measures along with increased reliance on government for cost control such as regulation of physician and hospital prices, or..... 31%
 - c. State or national health insurance where government is responsible for containing costs through top down budget controls and other measures..... 4%
- Don't know..... 3%

16. I'm now going to read you six possible approaches to reducing health care costs. After I read each one, please tell me if you think it is a good solution or a bad solution? First, (read item). (ASK ABOUT EACH)

Respondents answering = 100

	GOOD SOLU- TION	BAD SOLU- TION	DON'T KNOW
a. Have employees pay a larger share of their health care costs.....	72%	25%	3%
b. Reduce unnecessary use of services through prior approval or other utilization review mechanisms.....	85%	13%	2%
c. Increase physician and hospital efficiency by applying guidelines and standards for good medical practices and the cost effective use of expensive technologies.....	85%	9%	6%
d. Utilize networks of efficient providers, and give patients incentives to use these providers, such as HMOs and PPOs.....	77%	11%	12%
e. Place government limits on all health care providers' prices.....	15%	75%	10%
f. Adopt a national or state health plan with government control of the total health care budget.....	5%	94%	1%

IF GOOD SOLUTION IN ITEM F OF Q.16, ASK Q.17. OTHERWISE SKIP TO Q.18.

17. Is a national or state health plan something that American business should lobby for, or something that American business should not lobby for?

Asked of and based on respondents for think adopting a national or state health plan is a good solution
Respondents answering = 5

Should lobby for.....3 respondents
Should not lobby for....2 respondents
Don't know.....none

18. In percentage terms, how much have your corporation's health care costs risen in the past year--less than 10%, or between 11 and 20%, between 21 and 30%, between 31 and 40%, over 40%, or have they actually gone down?

Respondents answering = 100

Less than 10%.....12%
Between 11 and 20%.....66%
Between 21 and 30%.....17%
Between 31 and 40%..... 3%
Over 40%..... 1%
Actually gone down..... -%
Don't know..... 1%

19. Approximately what percentage of your corporation's operating expenses were health care costs in 1989--less than 4%, or between 4 and 6%, between 7 and 9%, between 10 and 12%, between 13 and 15%, or over 15%?

Respondents answering = 100

Less than 4%.....38%
Between 4 and 6%.....34%
Between 7 and 9%..... 8%
Between 10 and 12%..... 2%
Between 13 and 15%..... 1%
Over 15%..... -%
Don't know.....17%

20. Does the person responsible for overseeing your corporation's health benefits policy report directly to the Chief Executive Officer?

Respondents answering = 100

Yes.....	56%
No.....	44%
Don't know.....	-%

21. Is there anything else you would like to say on the subject of health care costs?

Respondents answering = 100

Need stability on costs/premiums.....	18%
Serious situation/ something must be done.....	12%
No government interference/government should not be involved.....	9%
More efficient networks.....	4%
Employees don't recognize costs.....	2%
Other mentions.....	13%
Nothing else.....	54%

HOLD FOR RELEASE UNTIL:
Monday, March 26, 1990



CONTACT: Don White
202/223-7782

Health Insurance Association of America

NEWS RELEASE

FORTUNE 1000 SENIOR EXECUTIVES OVERWHELMINGLY OPPOSE NATIONAL HEALTH INSURANCE

WASHINGTON, D.C., March 26 -- Ninety-four percent of the nation's leading executives oppose national health insurance as a solution for the country's escalating health care financing crisis, according to a survey released today by the Health Insurance Association of America (HIAA).

The survey -- conducted by the Roper Organization Inc. -- also shows that the nation's senior executives are confident of their ability to control their own health costs. More than two-thirds (68 percent) believe that managing health costs through networks such as health maintenance organizations and preferred provider organizations is -- or could be -- effective.

"Those who contend that a nationalized health system has the support of business and is thus inevitable need to look again," said Carl J. Schramm, president of HIAA.

"This survey shows clearly that the U.S. business community believes national health insurance is bad medicine for our

- more -

nation's health care financing ills," observed Schramm.

"Furthermore, given its sky-high cost, national health insurance would be a big, expensive pill to swallow."

Added Schramm, "These leaders of American commerce are posing the questions government commissions and other policymakers face: does the nation need and can it afford yet another costly entitlement program when deficits seem out of control and we have failed to provide medical care coverage for even our poorest citizens?"

Other survey findings include:

- o Health care costs were cited by the executives polled (in response to an open-ended question) as one of the five leading factors adversely affecting the prosperity of American business.
- o Sixty-six percent of the executives polled said that their corporate health care costs have, in the last year, risen by 11 percent to 20 percent. Seventeen percent said their corporate health care costs have risen by 21 percent to 30 percent.
- o Eighty-five percent of the executives polled believed reducing unnecessary use of services (through prior approval or other utilization review methods and increasing physician and hospital efficiency by applying guidelines and standards for good medical practice) and using technology assessment are good solutions to cutting health care costs.
- o Eighty-nine percent of the executives polled have made changes in their corporate health plans targeted at containing costs.

"Corporate America believes a private sector-public sector approach is the most practical, cost-effective method of providing access to health care and solving our nation's soaring health care costs," said Schramm.

- more -

"More than 60 percent of the executives responding to the survey indicated that the private sector should take responsibility for solving their health care financing crisis, while more than 30 percent support a private sector approach with some government involvement," noted Schramm.

The HIAA survey findings are based upon 100 interviews conducted by the Roper Organization in January 1990 with chief executive officers, chief operating officers, chief financial officers, and other senior executives from Fortune 500 and Service 500 companies. To prevent biasing the sample, the executives were informed only that the survey addressed "cost pressures affecting American business."

HIAA is a trade association of 320 commercial insurance carriers that provide health insurance for approximately 95 million Americans.

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Health Insurance Association of America

SUMMARY OF FINDINGS

The senior executives of major U.S. companies overwhelmingly oppose a national health insurance plan as a solution to the nation's health care cost problem. Ninety-four percent of the senior executives surveyed believe national health insurance would be a bad solution, while only 5 percent view it as a good solution. This is indicative of the general lack of enthusiasm these top level executives show for exclusively government solutions to the health care cost problem, even though they believe health care costs are a serious problem.

These findings are from a survey of senior executives conducted by the Roper Organization in January of this year. One hundred interviews were conducted with chief executive officers (25 percent), chief operating officers (7 percent), chief financial officers (39 percent), and other senior executives (29 percent) from Fortune Industrial 500 and Service 500 companies. In order to get an unbiased sample, the executives were informed only that the survey addressed "cost pressures affecting American business." The survey addressed topics including the importance of health care costs and judgments about the effectiveness of managed care in containing costs, as well as the level of support for a private versus a public solution to the cost problem.

When asked what mix of public and private sector involvement they desire in a solution to the health care cost problem, business leaders clearly want the private sector to take the lead in health care cost containment, though a role for government regulation is not completely ruled out. A majority (62 percent) favor primary reliance on improved private sector efforts to control costs, while nearly one-third (31 percent) advocate improved private sector cost control measures coupled with an increased reliance on government regulation. There is very little support (4 percent) for a solely government solution such as state or national health insurance with government responsibility for containing costs through top down budget controls.

Senior executives are, on the whole, optimistic about managed care as a solution to the cost problem. Forty-eight percent think that HMOs, PPOs, and similar models of networks of providers are effective in containing costs, while 34 percent say they are not effective. Eighteen percent don't know. Among those who feel that provider networks are not currently effective, a majority think they could become effective if appropriate changes were made.

When asked about other approaches to reducing health care costs, strong preferences emerge. Eighty-five percent think that increasing physician and hospital efficiency by applying guidelines and standards for good medical practice and the use of technology assessment is a good solution. Equally popular (85

percent) is the reduction of unnecessary use of services through prior approval or other utilization review mechanisms. A majority (77 percent) favor use of networks of efficient providers with patient incentives to use those providers. Increased employee cost sharing is seen as a good solution by 72 percent.

Solutions involving only a government role are rarely judged a good solution. For example, only 15 percent of senior executives think that government limits on providers' prices is a good solution.

Health care costs are very much on the minds of the top level executives. Health care costs are named by the executives as one of the four or five factors having the most adverse effect on the prosperity of the respondents' corporation, the prosperity of American business, or the prosperity of the nation.

When asked explicitly to rank health care costs among the factors that adversely affect their corporation's financial status, a majority (51 percent) call it a "significant but not critical problem." One-third of the senior executives label it "one of the top five," while 11 percent say it is "one of the top three." Three percent call it their "number one problem."

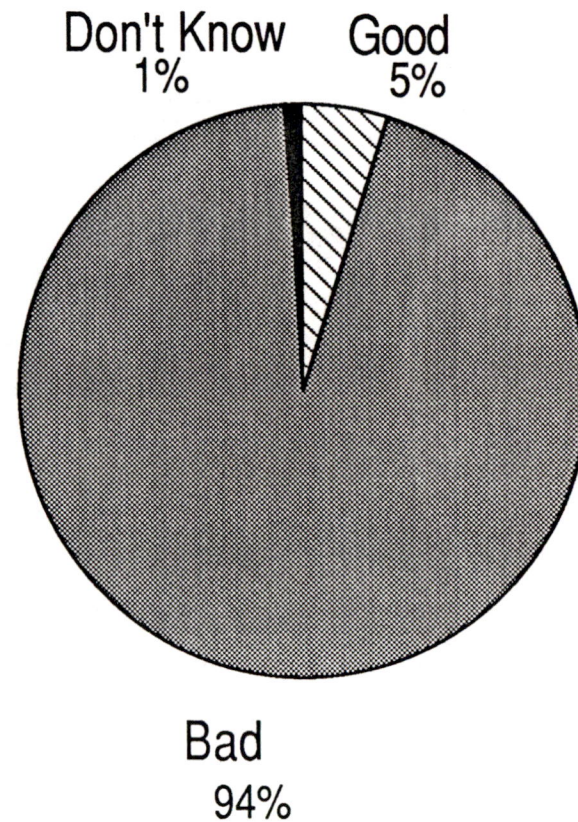
Among senior executives who say health care costs are a problem for their corporation, 7 in 10 say the issue is a lot more important today than two or three years ago.

Nearly nine out of ten of the senior executives interviewed say their company has made major changes in its health benefit plan specifically targeted at containing costs. Primary among these changes is a move to managed care with provider networks and an increase in employee cost sharing.

Roughly three-quarters rate themselves successful at curbing wasteful or excessive use of health services by their employees, while 20 percent say they have been not too or not at all successful. Another 6 percent don't know how to rate their efforts.

March 22, 1990

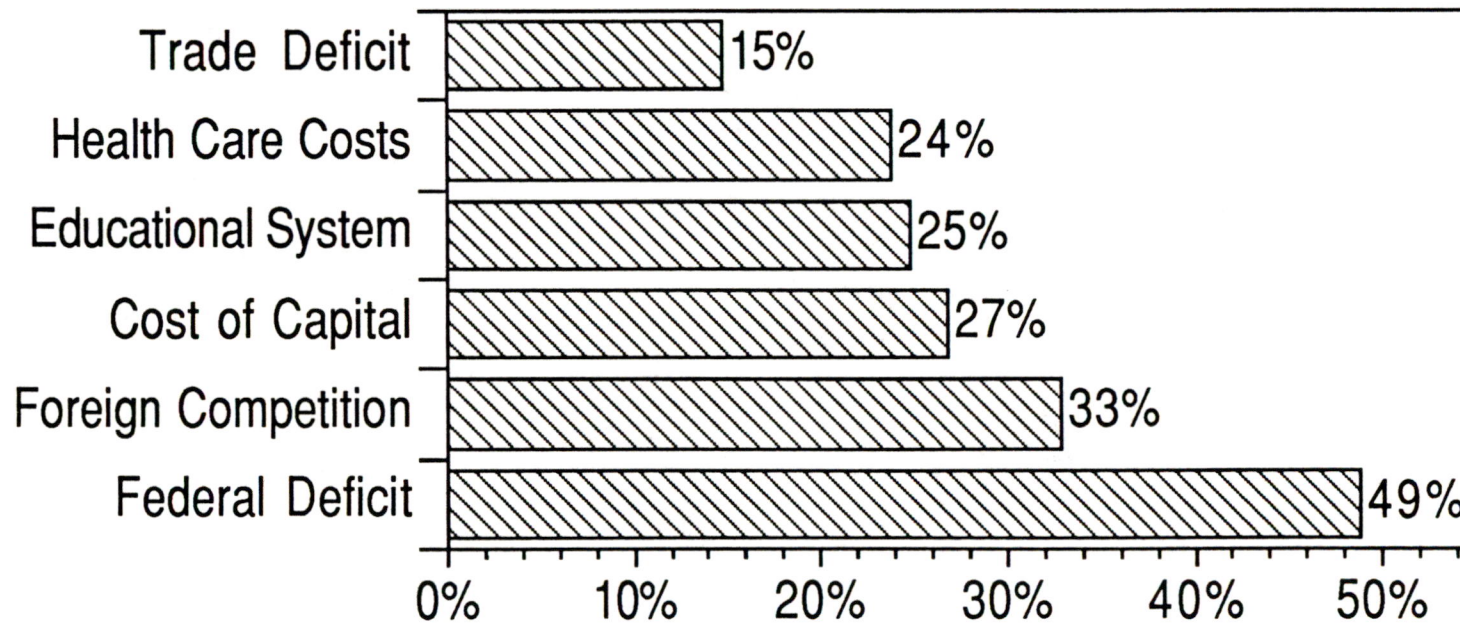
National or state health insurance—good or bad solution?



1990 CEO Survey,
Roper for HIAA

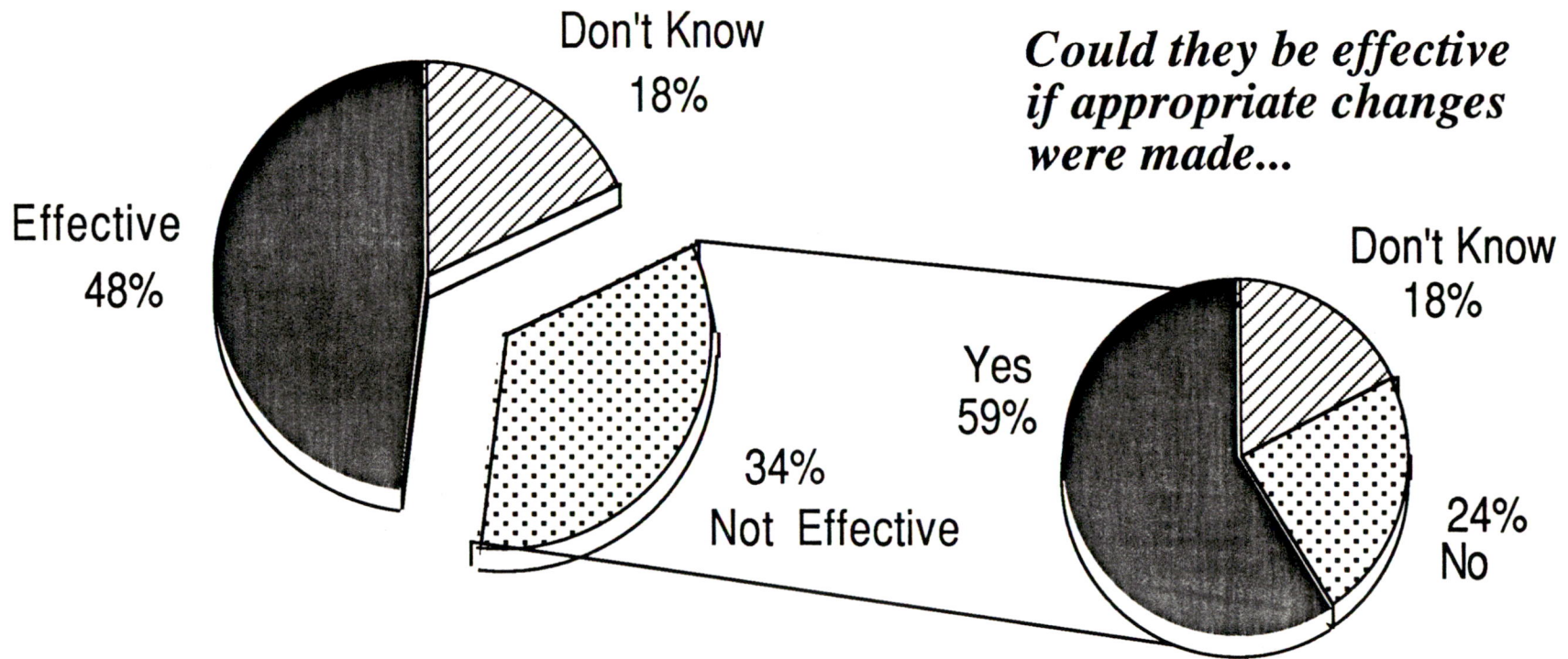


What factors adversely affect American business prosperity?

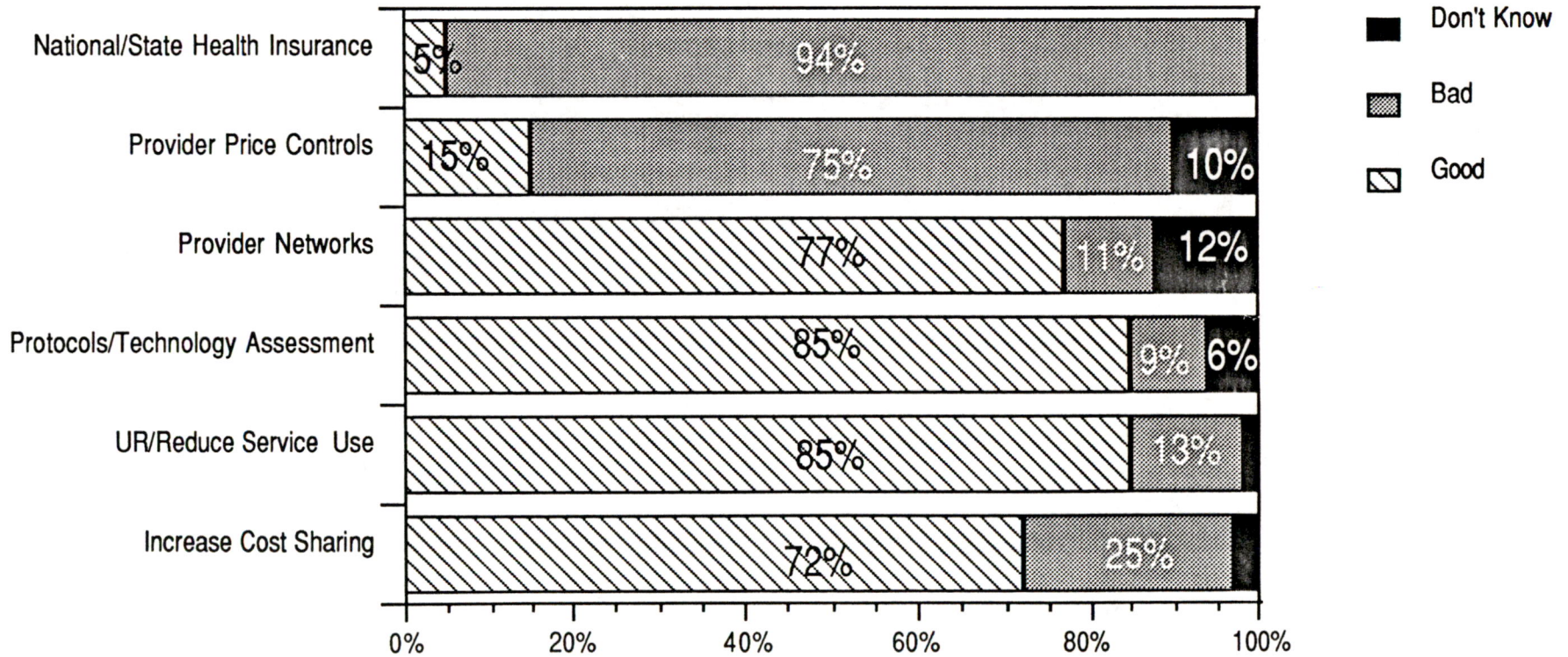


(Responses to Open-ended Question)

Do you think that HMOs, PPOs,
etc. are effective in controlling
costs?



Are these good or bad solutions to the health cost problem?



1990 CEO Survey,
Roper for HIAA



NEWS RELEASE

**HEALTH INSURANCE INDUSTRY PROPOSES
MAJOR REFORM OF SMALL EMPLOYER MARKET**

Washington, D.C., February 26, 1990 -- Leaders of the country's major health insurance companies have approved a plan that would make health care coverage available to all small employers and help contain the cost of that coverage.

The plan, which represents a major reform of the small employer market, was adopted by the Board of Directors of the Health Insurance Association of America (HIAA) at its meeting last week. It is one part of an overall plan proposed by the industry to increase access to health care coverage for those Americans without it.

Dr. Louis W. Sullivan, Secretary of the Department of Health and Human Services, attended the meeting and applauded the Association's efforts to address the problems facing small employers in providing health insurance for their employees.

"The insurance industry has taken the lead in seeking to assure that small employers and their employees have access to health insurance coverage," said Carl J. Schramm, HIAA president. "This plan represents a fundamental change in the way our industry does business," he added.

Under the plan, employers with 25 or fewer employees who seek to purchase health insurance for their employees would not be

- more -

denied coverage even if one or more of their employees might otherwise be a high risk or uninsurable in today's market. Once insured, neither the group nor an individual in the group would be denied continued coverage because the group's or an individual's health deteriorates. Further, when an employer changes insurance companies or an employee changes jobs, individuals would generally not have to meet any new pre-existing condition restrictions. There also would be limits on how much the premium and annual premium increase could vary for similar groups. The plan calls for a system to be funded by the private sector through which high risk individuals could be reinsured.

The reinsurance system also would ensure that if for some reason an employer group was unable to obtain coverage, they could purchase basic coverage for 150 percent of the average premium for similar groups. Losses from the reinsurance system would be borne equitably by the health benefit market.

Legislation at the state and federal levels would be necessary to obtain market-wide compliance with the reforms, to allow the reinsurer to fund its losses, and to preempt state provider and benefit mandates.

Because rising health care costs have a direct impact on the small employer market and all aspects of insurance, the Board also adopted a report on health care cost containment that relies heavily on the increased development of managed care programs. Those programs include channelling patients to efficient providers; improving the productivity and efficiency of providers by identifying and encouraging providers to adopt appropriate and efficient methods for delivering care under specific circumstances; promoting the use of economic incentives for consumers to be cost conscious in making choices to utilize medical services and in selecting providers; and promoting efforts

to improve the general health status of the population through support for wellness programs, illness prevention activities and consumer education efforts.

There also were cost containment recommendations for government actions which include establishing policies that will encourage the development of managed care systems, and that will match supplies of medical resources with needs, changes to reduce the occurrence of malpractice and to reform the malpractice liability system, and activities related to data collection and analysis.

The recommendations on small employer market reform and cost containment will be incorporated into HIAA's four-point plan to increase access to health care coverage through a joint public/private approach.

HIAA is a trade association of 320 commercial insurance carriers who provide health insurance protection for approximately 90 million Americans.

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**HEALTH INSURANCE ASSOCIATION OF AMERICA
PROPOSAL FOR FINANCING HEALTH CARE FOR AMERICANS**

SUMMARY

- I. The problem is complex because of the heterogeneous nature of the population without health insurance.
 - A. Thirty percent are below the federal poverty level; 30 percent are near poor, between 100 percent and 200 percent of the poverty level; and 40 percent are above 200 percent of the poverty level.
 - B. Eleven percent are the self-employed and their families; 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.
- II. HIAA proposes a four point plan:
 - A. Reform and expand Medicaid to cover all those below the federal poverty level, regardless of family structure, age or employment status.
 1. Eliminate categorical restrictions.
 2. Uncouple eligibility for Medicaid from eligibility for welfare cash payment.
 3. Low-income individuals above the poverty level should be able to "buy into" an income-related package of primary and preventive care.
 4. "Spend-down" program should be required in all states for the medically needy.
 5. For those Medicaid-eligible people who are working, optional "buy-out" program should allow state to pay the employee share of employer group insurance and to provide transition coverage for those coming off Medicaid.
 - B. Allow insurers to offer more affordable coverage:
 1. Extend ERISA preemption of state mandated benefits given to self-insured plans to insured employee plans.
 2. Allow insurers to market lower-cost prototype plans.
 - C. Provide tax assistance to make private coverage more affordable.
 1. Help small businesses afford coverage by allowing a 100 percent tax deduction for the self-employed as long as they provide equal coverage for their employees.
 2. New tax subsidies should be targeted to financially vulnerable groups. Subsidies could be directed at: financially fragile employers, low income individuals offered employer sponsored coverage and low income individuals not offered employee sponsored coverage.
 - D. Guarantee availability of private health insurance:

1. For high risk groups, a private reinsurance mechanism should be established, with losses spread equitably through the private sector.
 2. For uninsurable individual, state pools with losses financed by state general revenues or other broad-based funding should be established; if a state does not act, HHS should set up a pool in that state with losses paid with federal funds that HHS would otherwise spend in that state.
- III. HIAA also believes that quality and cost of care are essential components of any health care financing proposal, and we encourage the creation of an environment that promotes low-cost insurance and managed care benefits, not subject to state mandates or other restrictions.



Health Insurance Association of America

PROPOSAL FOR SMALL EMPLOYER MARKET REFORM

The Health Insurance Association of America has developed a fair and equitable proposal to assure that all small employers can avail themselves of relatively affordable health insurance coverage. The HIAA plan would:

1. guarantee that employers with fewer than twenty-five employees who seek to purchase health insurance for their employees will not be denied such health insurance coverage even if one or more employee might otherwise be either uninsurable or a high risk in today's world;
2. provide that once insured, neither the group nor an individual in the group may be denied continued coverage because the group's or the individual's health deteriorates;
3. limit the rate of year-to-year premium increases relative to other groups insured by the same carrier;
4. permit medical underwriting only for the purpose of determining the level of risk, and thus anticipated health claims;
5. not deny coverage or apply new preexisting condition restrictions to an insured individual in a group changing either employers or insurance carriers;
6. establish a privately funded and administered reinsurance mechanism through which insurers could reinsure high risk persons;
7. assure that any group would pay no more than 150 percent of the average cost of similar groups for basic coverage.

HEALTHCARE EQUITY ACTION LEAGUE

EMPLOYERS UNITED FOR REFORM

NEWS RELEASE

Contacts: David Cullen, National Federation of Independent Business, (202) 554-9000
Joan Simmons, Healthcare Leadership Council (202) 347-5731 360

HOLD FOR RELEASE UNTIL 2 PM TUESDAY, OCTOBER 15, 1991

BROAD BUSINESS ALLIANCE PUSHES FOR HEALTH CARE REFORM

WASHINGTON, Oct. 15---Putting the nation's health care system back on the path to solid, long-term reform is the goal of a broad business alliance, the Healthcare Equity Action League (HEAL), announced at the National Press Club here today.

"The basic structure of our health system is sound," National Federation of Independent Business Vice President John Motley said in announcing the group. "Not only can it be repaired, it can be improved and broadened to meet the health needs of all our citizens. The solution we offer will be cost-effective, efficient, and will deliver the greatest and best possible health care to the largest number of people."

HEAL, a coalition of nearly 300 major firms and organizations (see enclosed list), represents hundreds of thousands of large and small businesses, health care providers, insurers and related groups who play a major role in offering health care to millions of employees. Participants are committed to strengthening the U.S. health care system through a series of incremental, apolitical reforms.

The proposed solution, a seven-step, incremental plan, includes repeal of state health insurance mandates, reversal of anti-managed care laws, reform of small employer insurance underwriting and medical malpractice policy, equal tax treatment of employers, and promotion of better informed consumer participation and cost containment.

"HEAL was formed to refute the idea that there are only radical approaches to solving our country's health care problems," said Healthcare Leadership Council President Pamela G. Bailey. "We offer a better way. One that stabilizes the delivery system by getting people covered, keeping them covered and bringing accountability into the system."

Page Two; Healthcare Equity Action League

Bailey called the HEAL plan "a roadmap for how we can all-- government, provider, insurer, employer and consumer--work together to reform our system."

Food Marketing Institute Senior Vice President and General Counsel Harry Sullivan said the nation's employers are being overwhelmed by the increasing cost of providing health benefits to workers. "We can't wait any longer while grandiose and unrealistic proposals to reform our system are proposed, debated and rejected. The HEAL proposals represent a sound, realistic way to address the dual problems of cost and access. They should be adopted as quickly as possible."

National Association of Wholesale-Distributors President Dirk Van Dongen said the alliance is convinced by experience and common sense that the problems of access to health care cannot be solved through any form of national health insurance or government-mandated coverage.

"The main obstacle for employers who want to provide health care benefits is cost," said National Restaurant Association Senior Director of Government Affairs Mark Gorman. "If an employer can't afford it today, a mandate from Washington won't make it affordable tomorrow either. Solving the cost problem is the only way to get at the access problem. That's what HEAL is all about."

Following the announcement, the members of HEAL will undertake a nationwide grass-roots effort to deliver its message before upcoming political campaigns obscure the issue.

The Healthcare Equity Action League is headquartered at 1725 K Street, N.W., Suite 710, Washington, D.C. 20006.

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HEALTHCARE EQUITY ACTION LEAGUE (HEAL)**STEERING COMMITTEE**

Actna Life & Casualty
 American Apparel Manufacturers Association
 American Bakers Association
 American Business Conference
 American Cyanamid Company
 American Farm Bureau
 American Hardware Manufacturers Association
 American Institute of Architects
 American Managed Care & Review Association
 Amway Corporation
 Associated Builders and Contractors
 Association of Health Insurance Agents
 The Beer Institute
 Beneficial Management Corporation
 Burroughs Wellcome Company
 Carl Karcher Enterprises
 Caterair International Corporation
 The CIGNA Corporation
 Council of Smaller Enterprises
 Eli Lilly & Company
 Evanson Hospital Corporation
 Federation of American Health Systems
 Florists' Transworld Delivery Association
 Food Marketing Institute
 Harman Management Corporation
 Harris Methodist Health System
 Health Industry Distributors Association
 Health Industry Manufacturers Association
 Health Insurance Association of America
 Health Midwest
 Health One
 Healthcare Leadership Council
 Hershey Foods Corporation
 Hillcrest Baptist Medical Center
 Humana Inc.
 Industrial Distribution Association
 International Mass Retail Association
 John Hancock Mutual Life Insurance Company
 Kimberly Quality Care
 The Law Offices of Deborah Steelman
 Marlou Corporation
 Morrison Incorporated
 National American Wholesale Grocers' Association
 National Association of Aluminum Distributors
 National Association of Chain Drug Stores
 National Association of Convenience Stores
 National Association of Wholesaler-Distributors
 National Committee for Quality Health Care
 National Council of Chain Restaurants
 National Federation of Independent Business
 National Medical Enterprises, Inc.
 National Restaurant Association
 National Retail Federation
 National Wholesale Druggists' Association
 New York Life Insurance Company
 NMTBA-The Association for Manufacturing Technology
 Pagonis & Donnelly Group, Inc.
 Pennsylvania Hospital
 PepsiCo
 The Principal Financial Group
 The Prudential
 Schering-Plough Corporation
 ServiceMaster Management Services
 Super Valu Stores, Inc.
 The Travelers Companies
 U.S. Federation of Small Businesses, Inc.
 Wendy's International, Inc.
 Wills Eye Hospital

HEALTHCARE EQUITY ACTION LEAGUE (HEAL)**GENERAL MEMBERSHIP**

Advertising Specialty Institute
 Aerospace Industries Association
 Air-conditioning & Refrigeration Wholesalers Association
 Alabama Wholesale Beer & Wine Association
 Albertson's, Inc.
 Allen Park (MI) Chamber of Commerce
 Alliance of American Insurers
 The Aluminum Association
 American Council on Education
 American Electronics Association
 American Federation of Small Business
 American Furniture Manufacturers Association
 American Machine Tool Distributors Association
 American Meat Institute
 American Society of Computer Dealers
 American Supply Association
 American Traffic Safety Services Association
 American Veterinary Distributors Association
 Appliance Parts Distributors Association
 Associated Beer Distributors of Illinois
 Associated Equipment Distributors
 Associated General Contractors
 Association of Ingersoll-Rand Distributors
 Association of Steel Distributors
 ATLAND Management Corporation
 Automotive Service Industry Association
 Aviation Distributors & Manufacturers Association
 Baker Industries, Inc.
 Beauty & Barber Supply Institute
 Barton Dickinson & Company
 Beer & Wine Association of Ohio
 Beer Industry League of Louisiana
 Beer Industry of Florida
 Beer Wholesalers Association of New Jersey
 Benihana National Corporation
 Bicycle Wholesale Distributors Association
 Biscuit & Cracker Distributors Association
 California Association of Tobacco & Candy Distributors
 California Association of Wholesalers-Distributors
 California Beer & Wine Wholesalers Association
 California Trucking Association
 Central Wholesalers Association
 Ceramic Tile Distributors Association
 Chamber of Commerce of Hawaii
 Chamber of Commerce of New Rochelle (NY)
 Charles M. Orsholmer & Associates, Inc.
 Chicago Metropolitan Distributors Association
 Clemson Area (SC) Chamber of Commerce
 Colorado Beer Distributors Association
 Computer Dealers & Lessors Association
 Copper & Brass Servicenter Association
 Dairy and Food Industries Supply Association
 Davenport (IA) Chamber of Commerce
 Digital Dealers Association
 Beker Drug Company
 Electrical-Electronics Material Distributors Association
 Engine Service Association
 Farm Equipment Wholesalers Association
 Fire Suppression Systems Association
 Fluid Power Distributors Association
 Food Industries Suppliers Association
 Food Processing Machinery and Supplies Association
 Foodmaker, Inc.
 Foodservice Equipment Distributors Association
 General Merchandise Distributors Council
 Georgia Beer Wholesalers Association
 Glenwood Springs (CO) Chamber Resort Association
 Grand Rapids Area (MI) Chamber of Commerce
 Greater Detroit Chamber of Commerce Wholesaler-Distributor Association
 Greater North Dakota Association/WAM Council
 Greater Raleigh (NC) Chamber of Commerce
 Greater Washington Food Wholesalers
 HealthTrust, Inc.
 Henderson (NV) Chamber of Commerce
 Hobby Industry Association of America
 Hoffmann-La Roche Inc.
 Independent Electrical Contractors, Inc.
 Independent Laboratory Distributors Association
 Independent Medical Distributors Association
 Independent X-ray Dealers Association
 Indiana Beverage Alliance
 Institutional & Service Textile Distributors Association
 International Dairy Foods Association
 International Truck Parts Association
 International Sanitary Supply Association
 Iowa Grain and Feed Association
 Irrigation Association
 JT&A, Inc.
 Jewelry Industry Distributors Association
 Jobbers Credit Association
 Johnson & Johnson
 The Krystal Company
 Lenoir County (NC) Health Cost Containment Coalition
 Long John Silver's, Inc.
 Los Angeles Fasteners Association
 Machinery Dealers National Association
 Manitowoc-Two Rivers (WI) Chamber of Commerce
 Material Handling Equipment Distributors Association
 MDU Resources Group, Inc.
 Metro East (MI) Chamber of Commerce
 Metropolitan Life Insurance Company

Mid-America Supply Association
 Middle Atlantic Wholesalers Association
 Mississippi Malt Beverage Association
 Missouri Beer Wholesalers Association
 Montgomery County Pharmaceutical Association of Pennsylvania
 Motorcycle Industry Council
 Music Distributors Association
 National Appliance Parts Suppliers Association
 National Appliance Service Association
 National Association of Chemical Distributors
 National Association of Container Distributors
 National Association of Electrical Distributors
 National Association of Fire Equipment Distributors
 National Association of Floor Covering Distributors
 National Association of Flour Distributors
 National Association of Hose and Accessories Distributors
 National Association of Meat Purveyors
 National Association of Realtors
 National Association of Recording Merchandisers
 National Association of Service Merchandising
 National Association of Sign Supply Distributors
 National Association of Sporting Goods Wholesalers
 National Association of Tobacco Distributors
 National Association of Wholesale Independent Distributors
 National Beer Wholesalers Association
 National Building Material Distributors Association
 National Business Forms Association
 National Candy Wholesalers Association
 National Club Association
 National Commercial Refrigeration Sales Association
 National Electronic Distributors Association
 National Fastener Distributors Association
 National Food Distributors Association
 National Frozen Food Association
 National Grocers Association
 National Independent Poultry & Food Distributors Association
 National Industrial Glove Distributors Association
 National Insulation and Abatement Contractors Association
 National Lawn & Garden Distributors Association
 National Locksmith Suppliers Association
 National Marine Distributors Association
 National Office Products Association
 National Paint Distributors
 National Paper Trade Association
 National Printing Equipment & Supply Association
 National Sash & Door Jobbers Association
 National School Supply & Equipment Association
 National Solid Wastes Management Association
 National Spa & Pool Institute
 National Truck Equipment Association
 National Welding Supply Association
 National Wheel & Rim Association
 National Wholesale Furniture Association
 National Wholesale Hardware Association
 New England Paper Merchandising Association
 New England Wholesalers Association
 New York State Beer Wholesalers Association
 New York State Plumbing & Heating Wholesalers
 North American Horticultural Supply Association
 North American Wholesale Lumber Association
 North American Heating & Airconditioning Wholesalers Association
 North Carolina Beer Wholesalers Association
 North Carolina Wholesalers Association
 Northern Rhode Island Chamber of Commerce
 Northwestern Public Service Company
 Optical Laboratories Association
 Orange County (NY) Chamber of Commerce
 Outdoor Power Equipment Distributors Association
 Pacific Southwest Distributors Association
 Pet Industry Distributors Association
 Petroleum Equipment Institute
 Petroleum Marketers Association of America
 Piscataway-Middlesex Area (NJ) Chamber of Commerce
 Pocono Mountains Chamber of Commerce
 Post Card Distributors Association of North America
 Power Transmission Distributors Association
 Reno Sparks Convention and Visitors Authority
 Rhode Island Hospitality Association
 Safety Equipment Distributors Association
 Santa Ana (CA) Chamber of Commerce
 Schiffli Lace & Embroidery Manufacturers Association
 Scripps Memorial Hospitals
 Shoe Service Institute of America
 Small Business of America
 Snack Food Association
 South Carolina Beer Association
 Southern Wholesale Hardware Association
 Southern Wholesalers Association
 Specialty Tools & Fasteners Distributors Association
 St. Lucie County (FL) Chamber of Commerce
 Steel Service Center Institute
 Suspension Specialists Association
 Tennessee Malt Beverage Association
 Textile Care Allied Trades Association
 United Products Formulators & Distributors Association
 Wallcovering Distributors Association
 Waste Management Inc.
 Water & Sewer Distributors of America
 Western Association of Fastener Distributors
 Western Suppliers Association
 Wholesale Beer Distributors of Arkansas
 Wholesale Beer Distributors of Texas
 Wholesale Distributors Association
 Wholesale Florists & Florist Suppliers of America
 Wholesale Stationers' Association
 Wine & Spirits Wholesalers of America
 Wisconsin Wholesale Beer Distributors Association
 Woodworking Machinery Distributors Association
 Woodworking Machinery Importers Association

HEALTHCARE EQUITY ACTION LEAGUE

EMPLOYERS UNITED FOR REFORM

NEWS RELEASE

SOLVING THE HEALTH CARE CRISIS: STATEMENT OF BASIC PRINCIPLES

We support an effective, affordable, free enterprise solution to the health care cost crisis facing the Nation.

Problems of cost and financing have limited access to quality health care for the millions of Americans who do not now have health care coverage; and they jeopardize future access for the additional millions of Americans whose insurance coverage is at risk due to rising costs or expensive personal health problems.

We strongly believe that viable solutions to the health care crisis must address the problems of cost and access in tandem. We also believe that solutions must be immediate, substantive, incremental, and based on market principles, relying on a mixture of incentives and structural and legislative reforms.

Problems of access will not be solved through any form of national health insurance or through federally-mandated coverage. We oppose so-called "play or pay" proposals which would require all employers to provide health insurance to their employees or pay an excise tax. Trigger proposals which would mandate health insurance by a time certain if it were not otherwise generally made available by employers are unacceptable as well.

We oppose proposals to restructure our health care system with government imposed controls. We also oppose proposals that would have government toll patients how much health care they can have, rather than realistically addressing the causes of the cost spiral.

We fully recognize that the health care crisis cannot be solved by maintaining the status quo. More to the point, the problems will only get worse if delay of relief occurs on issues of general consensus for the sake of extended public debate on highly controversial proposals.

In fact, our respective memberships demand change and relief. Therefore, while we firmly oppose certain universal proposals, we recommend that the following specific, positive steps be implemented as expeditiously as possible:

- **Full Federal Preemption of State Health Insurance Mandates.** There are currently over 800 state mandates which impose a myriad of requirements on health insurance policies, thus significantly increasing the cost of premiums for non-self-insured businesses and the cost of health care for all businesses. Freeing all policies from these well-meaning but counterproductive mandates would immediately and significantly lower the cost of health insurance for all firms and increase access for small business and individuals alike.

(continued)

- ***Preemption of State Laws Which Restrict Managed Care and Cost Sharing.*** Managed care systems have proven effective. Yet, a number of states have enacted so-called "freedom-of-choice" laws or other provisions that block the efforts of those who buy health care to implement innovative managed care systems. Further, many states have regulations limiting the amount of cost-sharing by individuals, thereby inhibiting selective contracting arrangements and barring incentives needed to encourage employees to be cost-conscious in their decision-making. Eliminating barriers to managed care could substantially reduce costs due to wasteful or inappropriate care.
- ***Reform of Insurance Underwriting.*** To assure health care access, health insurers, HMO's and third party administrators should guarantee the availability and renewability of health insurance to those who wish to purchase it, regardless of size, status, or geographical location of the purchaser. Risk-sharing should be increased by elimination of rating practices which penalize individuals and small employers. Further, the denial of health insurance to employees and dependents due to pre-existing conditions when an employer changes his insurer or when employees change jobs should be prohibited. Cancellation of insurance when employees or dependents file claims should also be prohibited.
- ***Reform of Medical Malpractice Provisions.*** Prudent malpractice reform will reduce the need for costly defensive testing and other forms of health care delivery used to avert malpractice claims.
- ***Full Deductibility of Health Insurance Premiums for All Businesses.*** While incorporated businesses are allowed to deduct 100 percent of their health insurance premiums, partnerships, sole proprietors and S-corporations only receive a 25 percent deduction. The tax code should be amended to provide equal treatment to all businesses, which would in turn provide an incentive to smaller companies to obtain or expand health insurance.
- ***Consumer Empowerment and Individual Responsibility.*** A competitive health care marketplace will not occur unless patients behave like educated consumers who believe that they have a responsibility to make good health care decisions. Patients must become active and informed participants in their own care and their own well-being. In order that they and their surrogates may have timely and reliable information on fees, treatments, and physician practices, the development and dissemination of data, including outcomes research, and appropriate practice protocols and hospital ratings should be encouraged. Wellness education is another significant key to controlling future health care expenditures.
- ***Health Care Cost Increases Must be Brought Under Control.*** While the recommendations listed above will have salutary effects on escalating costs and on current cost-shifting to the employer-based system, more will need to be done. The development of a market based system can provide affordable health care without compromising quality. Incentives must be provided for government, providers, and private insurers to aggressively pursue innovative purchasing and managed care techniques. Health care providers must become part of the solution to escalating health care costs.

FOR THE HEALTH OF A NATION
Report of
The National Leadership Commission on Health Care

EXECUTIVE SUMMARY

Formed in 1986 by a group of concerned citizens to address the three major problems of cost, quality, and access to health care, the National Leadership Commission on Health Care proposes a major restructuring of the nation's health care system. The Commission's proposal provides universal access to a basic level of health services; it controls escalating costs through wider use of innovative purchasing of care and through greatly expanded research on the quality and appropriateness of health care; it emphasizes expanding the practical application of that research. The Commission believes that reducing redundant health services will both contain costs and improve the quality of health care.

The Commission brought together a distinguished group of leaders from many areas -- health care, business, law, economics, politics, ethics, and labor. The Commission sought to develop a clear sense of the scope of the problems in health care, a vision to reach for, and workable solutions to bring us closer to that vision. It released an interim statement in June, 1987, outlining its view of the seriousness of the problem.

During its deliberations, the Commission agreed on a vision of a healthy society in the 21st century, one which promotes preventive care and healthy lifestyles through vigorous public education, and operates an innovative, efficient health care system that provides universal access to a basic level of appropriate, affordable care. The system would encourage personal responsibility for choosing good health and appropriate treatment, support a strong doctor-patient relationship, and promote a public-private partnership to control costs and constantly improve the quality of care. It would also find a solution to the malpractice crisis.

PROBLEMS WITH THE CURRENT HEALTH CARE SYSTEM

The American health care system has done in many ways a remarkable job in providing health care to the American people. American medicine has long been a leader in the field, making superb contributions in the form of important new technologies to prevent and treat disease. Public and private insurance programs combine to protect most Americans against devastating losses at vulnerable times of ill health and disability. Yet millions of Americans are disenfranchised, encountering barriers of entry to the health care system. Health care costs are escalating so rapidly that many payers have become alarmed at the upward spiral. And fundamental questions are now being asked about the uncertainties in the quality and appropriateness of care being delivered.

Serious strains in the system are raising the frustrations of all who participate in it. Physicians are concerned about outside parties intruding on their clinical decisions and damaging the doctor-patient relationship. Hospitals find it increasingly difficult to cope with pressures for cost containment and with rapidly changing laws and regulations.

Government and major private payers are trying with limited success to control rising costs. Patients are faced with higher costs, but they don't see care improving sufficiently to justify their increasing payments -- and they continue to present the system with ever-increasing demands. Such strains in the health care system will be exacerbated by the rapid aging of the population, the AIDS epidemic, and the continuing technology explosion, which spawns more and more new treatments, that, though often beneficial, are also costly.

These problems grew out of the postwar period, which ushered in wonder drugs, sophisticated medical technology and the expansion of health insurance to cover the majority of the population. With the adoption of the Medicare and Medicaid programs in 1965, 85 percent of the population had some form of health insurance, leaving the consumers of health care shielded from, and thus much less sensitive to, cost increases than consumers in other sectors of the economy.

Cost. These developments have led to increases in health care expenditures that far outstrip general inflation rates. Factors fueling the cost increases include general inflation, accelerated inflation in medical care prices, the aging of the population, patient demand, increasing physician supply, the use of inappropriate care, the practice of defensive medicine, and advances in medical science leading to expensive new technologies -- all compounded by the inherently inflationary ways in which most care is financed and delivered. Americans spent \$550 billion on health care in 1988, over 11 percent of GNP, far more than any other country. If these trends continue, costs will double by 1995 and triple by the turn of the century, hitting \$1.5 trillion in the year 2000. In that year, health care will consume 15% of GNP, and this country will spend \$5,551 on health care for every American man, woman, and child. The National Economic Commission estimates that if present trends continue, by the year 2005 the Medicare program alone will exceed in size either the Social Security or the defense budgets.

As a result, cost containment has become a rallying cry in both the private and public sectors. The federal government has enacted the prospective payment system (PPS) for hospitals, setting payment in advance according to a patient's diagnosis. Some state governments have instituted closely regulated global budgeting for hospitals and tight control on new construction. Private payers have turned to managed care mechanisms, such as health maintenance organizations (HMOs), as a way to hold down costs. Such efforts have successfully reduced hospital use, but they have also shifted costs to the outpatient setting, and these costs have continued to rise rapidly.

Access. Increasing costs are accompanied by another disturbing development: growing numbers of people without health insurance, and therefore without good access to health care. Financial strains on the Medicaid program mean that it now covers only 45 percent of those in need. Today about 37 million Americans lack insurance; a third of them are children. Perhaps an equal number have very inadequate coverage. Thus one out of every four Americans may be either uninsured or seriously underinsured. These people tend not to seek help until they are quite sick, which makes them more of a burden on the health care system than they would otherwise be.

Quality. Quality of care is the third area of major concern. We have insufficient information on the quality and outcomes of medical services and insufficient means of monitoring the quality of care and fostering its improvement. Recent studies have heightened this concern, citing large regional variations in the use of some medical service that do not seem to be based on differences in medical need. Over the past two years, there has been a steady drumbeat of stories detailing the percentage of unnecessary or equivocal care in the use of one procedure after another. It has become clear to many

experts that this is no longer a problem that is isolated in a few specialties but rather is generic to the health care of the nation. The sad fact is that our quality control system is at best rudimentary. Hospitals, for example, have traditionally focused only on how care is delivered; they have just begun to measure the impact of that care on patient outcomes. Patients also have few tools to help them assess the quality and appropriateness of their treatment.

These critical problems in cost, quality, and access to health care in America present a clear and compelling case for change. They are interrelated problems that cry out for interrelated solutions. Piecemeal approaches have not worked in the past, and will not in the future. Each problem can be solved effectively only in relation to the other two. Until we can better define quality and appropriate care, we cannot really know what is worth providing access to and what is worth paying for.

THE COMMISSION'S PROPOSAL

In response to these serious health care problems, the Commission proposes a new public/private partnership that will provide access for all to a health care system which will deliver cost-effective, appropriate care. Under our proposal, all Americans would be required to have health insurance coverage for a package of basic service.

Our model calls for a shared responsibility to finance care for the currently uninsured. It retains a significant role for the states and private insurance companies. It is structured to foster competition and innovation in the quality and efficient management of health care services. The plan calls for a strong education campaign to encourage patients to adopt healthy lifestyles and to inform patients and providers about guidelines for appropriate care to help them make better decisions about treatment.

The Commission's strategy, then, has the following critical, interrelated elements:

- o Provide universal access through a Universal Access (UNAC) program to a basic level of health care, regardless of income.
- o Make individual Americans responsible for having health insurance for at least a basic level of care.
- o Expand the existing insurance system by encouraging all employers to provide health insurance for their employees.
- o Spread the cost of universal access systematically among all individuals and employers who can afford to contribute and make explicit now hidden costs, with everyone paying a small premium for a basic level of care for those who cannot afford to pay.
- o Establish a nationally determined level of basic services of health care available to all, allowing for state variations above that level.
- o Greatly increase research on the appropriateness, effectiveness, and quality of care and publicize the results widely to help patients and providers assess treatment.
- o Control costs by reducing the amount of inappropriate care as a result of the expanded research.

o Encourage the marketplace to work more efficiently by stimulating the development and use of solid information about appropriateness, quality, and cost, thus giving the private sector the tools to develop more efficient organizations of providers and other cost-effective delivery systems.

o Develop a process for a strong public-private partnership to improve quality and control costs by coordinating the expanded research on appropriateness and quality and disseminating the results through the health professional organizations.

o Develop and continually update national guidelines useful to practitioners in making clinical decisions, through the appropriate medical specialties.

o Call on existing state agencies to operate the program to finance care for the currently uninsured, negotiating fair compensation for providers who serve that population.

o Promote nationwide the current, promising state reforms in malpractice.

A realistic strategy must not only deal with all three areas of cost, access, and quality; it must also engage all the parties which provide, pay for and use health care. This means that any effective system-wide solution must be a public-private partnership. The responsibility does not lie with the government alone, which pays for 40 percent of the country's health care bill, but also with private individuals and other private payers, who account for the other 60 percent.

While our systemic approach to reform is important, individual parts of the solution can be modified without endangering the integrity of the overall solution. For example, the source of the funding for improving access could come from general revenues rather than a specific fee. It was with the intention of assuming fiscal responsibility that we decided to specify a source of funding and to sketch out the dimensions of the cost.

Fundamental Principles

The Commission's proposal is based on seven fundamental principles which the Commission developed during its deliberations.

I. Principle of Universal Access:

There should be no financial barrier separating Americans in need of health care from access to available care.

II. Principle of Fair Compensation:

Every provider of health services in America should be adequately compensated for services rendered to patients.

III. Principle of Clinical and Economic Freedom:

To the maximum extent possible, without unduly compromising other important principles, health policy ought to restore clinical freedom in rendering health services and economic freedom in financing these services, within the context of adequate countervailing market power from those who ultimately pay for health-care in America.

IV. Principle of Shared Responsibility:

Financial responsibility for health care for those too poor to afford it should be shared by government, individuals and businesses.

V. Principle of Individual Responsibility:

To help achieve the goal of universal access to health care, the individual has a duty to have adequate health insurance coverage for him-or herself and dependent children.

VI. Principle of Basic Benefits Guarantee:

The design of a basic package of health-service benefits to which all Americans should have reliable access is ultimately a federal responsibility.

VII. Principle of a Strong Doctor-Patient Relationship

Any health care system should include the goal of protecting the integrity of the doctor-patient relationship.

The Commission's proposal builds upon the American tradition of providing private health insurance through the workplace. It is designed to encourage continued extensive reliance on that approach, without mandating that employers provide such coverage. The system thus preserves the pluralistic approach to health-care financing apparently preferred by Americans.

The National Leadership Commission does not consider it appropriate for it to establish the national basic benefits package for all Americans. The initial package would be set by enabling legislation. But the Commission strongly recommends that mental health benefits and preventive services, especially prenatal care, be included in this package.

Access to Care For All Americans

The Commission's proposal, known as the Universal Access or UNAC program, would extend health coverage to the 37 million Americans who now lack health insurance. All Americans would be covered by the national basic package of services. There are several ways they could obtain this coverage. Most Americans would probably continue to obtain privately-financed coverage as an employment benefit, with the employer contributing most or all of the money for the premium. Any American could also choose to purchase this coverage with personal funds or could supplement employer-provided coverage with personal funds. Older Americans would continue to receive Medicare coverage. Everyone else would receive public coverage through the UNAC fund. The Commission proposes that all employers, and all individuals with incomes above 150 percent of the poverty level, pay a premium or a fee to finance health insurance for those not covered by employee plans. The Commission's plan uses strong incentives to encourage employers to offer coverage and to improve coverage under some existing plans. It also has provisions for all individuals who can afford to do so to pay for part of their care.

The Commission has presented a model plan in its report which details how this proposal could work in practice. Estimates of the costs of various provisions of the proposal and how they would be financed are given in the full report.

SEE FINANCING CHART

The Commission's UNAC safety net system would be administered at the state level by a cooperative effort involving all stakeholders in the health care system. The federal government would provide guidelines for the program designed to treat all Americans equally, regardless of location, but the program would not be centrally directed as is, for example, the Medicare program. There would be ample room for regional variations within broad federal guidelines.

In addition to a national package of minimum health care benefits to which every American has access, the Commission's proposal allows the states to determine any additional benefits for their residents. The UNAC program would be administered by state agencies which would have the power to negotiate with providers and practitioners to establish the package and payment policies for UNAC beneficiaries. The Commission explicitly chose to work with existing state agencies rather than create a new level of bureaucracy.

The Commission recommends that states broaden their agencies to include representatives of the major private stakeholders in health care -- payer, practitioners, and consumers -- perhaps appointed by state governors. The Commission recognizes that it will not be easy to generate the cooperation needed to realize its goals, primarily because attitudes will have to change. But the Commission is unanimously convinced that cooperation is both desirable and possible. It is clear to the Commission from its discussions with dozens of physicians and the testimony of leaders of the professions that they are eager to play a role in this process. The Commission regards their role as essential to the success of any proposed change in health care policy.

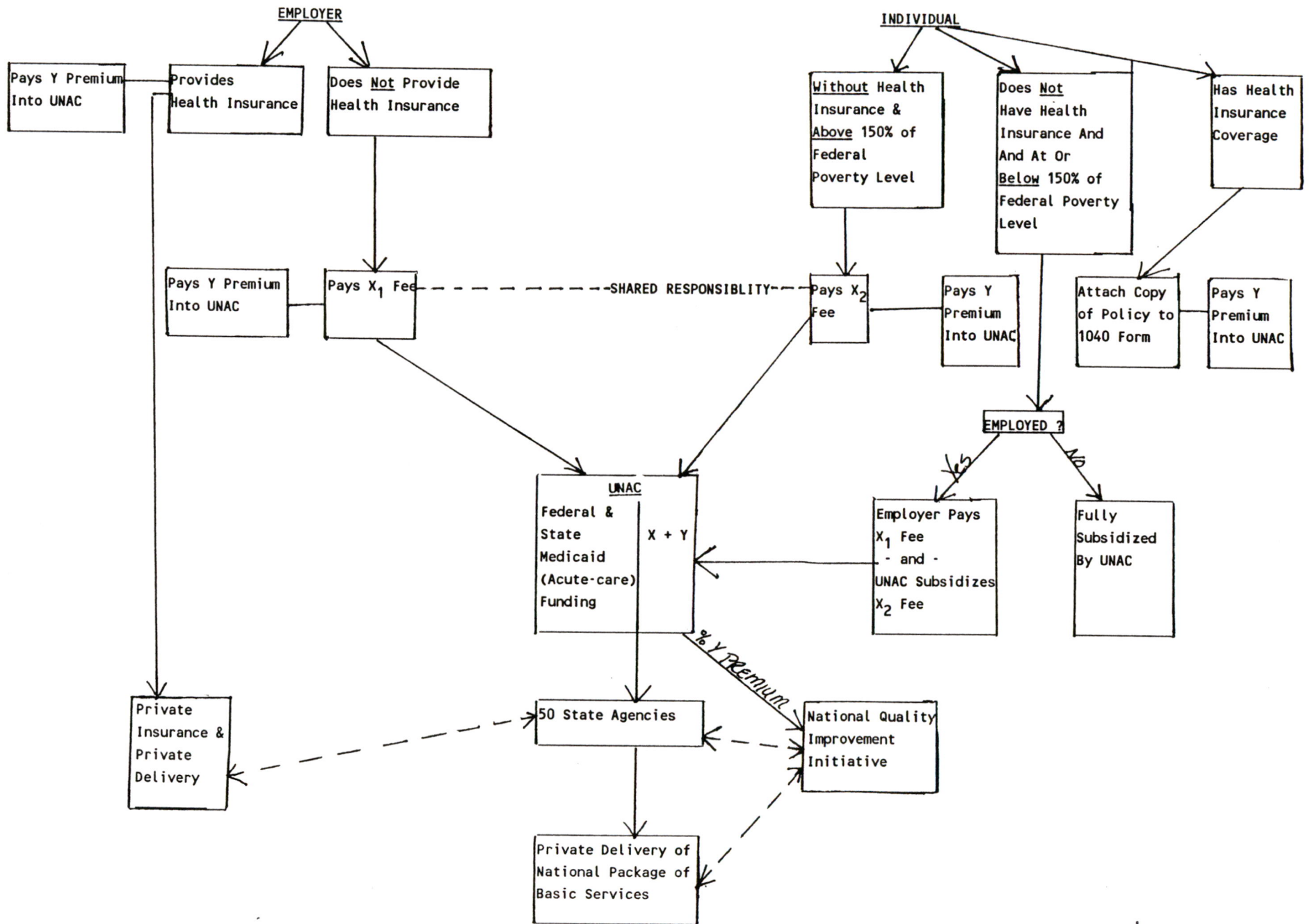
Cost Control and Quality Improvement

The Commission's approach to cost control goes beyond the provisions summarized above. It is also inextricably linked to its proposal for improving the quality and appropriateness of health care. The Commission plan seeks to remove cross-subsidies and make explicit the cost of care for all. At least some of the cost of providing universal access would be made up in savings resulting from improved quality control. The Commission's strategy is designed to improve both the value of care and the efficiency of the systems that provide care. A marketplace approach by definition, the Commission's proposal would greatly increase information available to providers and patients on the quality and appropriateness of health care. Such information, if widely disseminated, would allow the competitive advances of the past few years to play out.

The Commission has concluded that an important level of inappropriate over- and under-use of care has been documented for some time now. The reasons for inappropriate care include the following: an incomplete and continually evolving science base for that care, often creating uncertainty about appropriateness and effectiveness in clinical decision-making; perverse financial incentives; seeking to meet unrealistically high patient expectations; and the malpractice crisis. In addition, systems for assuring that care is provided in the best fashion are too often inadequate.

Health professionals and patients need several types of new knowledge. When a consensus on medical knowledge is possible, they need to learn better which tests and procedures are appropriate for an individual situation. When guidelines exist for particular conditions or treatments, they need to examine the scientific basis of those guidelines to determine its adequacy. They also need more basic scientific information about which medical practices are truly effective and which are not. And they need better ways to measure what

HEALTH CARE FINANCING & DELIVERY: A SHARED RESPONSIBILITY



happens when care is provided and how it can be more effective. This can only occur within a general understanding that each patient presents a unique set of problems.

Improving information on quality and appropriateness will have far-reaching effects. In addition to reducing the level of uncertainty, which in turn reduces unnecessary and inappropriate care, successful improvements in quality and appropriateness information should also help stem the tide of increasing health care costs, increase efficiency, improve the doctor-patient relationship, and reduce malpractice suits. Fortunately, there is solid evidence that health care providers will use relevant, well-presented information to improve the quality and appropriateness of their care. The Commission has found that governmental agencies and private organizations with clinical expertise are actively pursuing:

- (1) Objective analysis of the proper use of existing and emerging approaches to diagnosis and treatment, often known as appropriateness research and technology assessment;
- (2) Clinical trials on the effectiveness of medical practices;
- (3) Research designed to understand and, where appropriate, reduce practice variation, often known as outcomes research and practice pattern monitoring;
- (4) Synthesis of current research and clinical experience into practical clinical practice guidelines; and
- (5) Development and use of clinical and organizational measures to stimulate improvement in the quality and appropriateness of care.

National Quality Improvement Initiative

The Commission has found, however, that this work is woefully underfunded. The Commission has also found lacking a process where participants can develop a nationally coordinated strategy. The Commission proposes a National Quality Improvement Initiative that would fund such work and would ideally involve periodic collective priority setting, coordination, and progress evaluation, while maintaining decentralized activities.

The Commission's plan would raise additional funds for this important research with a supplemental fee applied to the Y premium (see chart) for both employers and individuals. We estimate that the fund should rise gradually to \$500 million in research per year, when the rate applied to both the employer and the employee Y revenue bases would be about one one-hundredth of one percent (0.011 percent).

At the Commission's request, Lewin/ICF prepared a very rough estimate of potential savings that could be generated by reducing inappropriate care. Based on HCFA estimates that as much as two percentage points of the annual hospital intensity index would be influenced by practice pattern changes, the Commission's estimate suggests a potential saving of two percentage points of the currently projected growth rate of health expenditure. This means that over a four-year period, about \$5.9 billion annually for Medicare Parts A and B combined could be influenced by changes in practice pattern. For national health expenditures, the figure is \$84 billion for fiscal year 1990-1993, or an average of \$22 billion annually that could be influenced by practice pattern changes. Using a second method of approximating the potential effects of changing practice patterns on health care costs, the Commission developed a very conservative "bottom up" estimate of potential savings from reducing inappropriate services; assuming a 4 percent growth rate in health expenditures annually, this estimate could approach \$1.5 billion a year by FY 93.

Malpractice Reform

The Commission believes that the current system of malpractice litigation against providers of health care -- hospitals, physicians and nurses -- impedes the delivery of economical, high-quality care to American citizens. The Commission recognizes that patients should be fully compensated for injuries resulting from negligent care, and it supports strengthening procedures to identify and correct below-standard practices, but the present system of medical malpractice litigation does not achieve either goal and has other adverse consequences as well.

Malpractice litigation has driven up the cost of medical care overall and, in some specialties, at a dramatic rate. Providers who can obtain malpractice insurance are forced to pass on its rising cost to patients (or third-party payers) through increased fees. The fear of malpractice suits encourages defensive medicine, in which providers perform additional procedures, especially diagnostic ones, principally to protect themselves against law suits. Such procedures increase both the cost of care and sometimes health risks to patients. The current system of malpractice litigation also corrodes the patient-physician relationship.

We are, therefore, convinced that the malpractice system must be reformed, and we are encouraged by the breadth of interest in reform both within the medical profession and outside it. Some promising proposals have been adopted experimentally on a state or local basis, and we strongly support continued exploration of potential solutions, and the adoption of the most promising reforms at the national level. Such proposals include instituting strict criteria for expert witnesses in malpractice suits, strengthening standards of negligence, limiting punitive damages and contingency fees, encouraging mediation and arbitration as alternatives to lawsuits for resolving disputes.

CONCLUSION

The Commission calls for a solution in three parts to a system undermined by three very serious problems. The problems are unnecessary, because we know how to solve them. They are larger than they ever needed to be because for years we understood them too little, we spent time blaming one party or another, and we did not have the scientific knowledge in some areas to respond to them. In recent years, we have found the will, we have learned that no one is to blame, and we have developed the scientific ability to improve, to begin to close the gap between art and science that has characterized medicine for many years. There will always be some art and some uncertainty, because our science continuously stretches into new areas and because every patient presents a unique set of problems. But today we have some promising methods for reducing uncertainty. It is incumbent on us to use them and to improve them continually to advance the quality of care and control the cost of care.

Above all, we are hopeful. Much has happened in just the two-and-a-half short years of the life of this Commission that indicates to us that all parties involved in analyzing, delivering, paying for, and benefiting from health care in this country are anxious to become involved in a solution that works. We hope that our strategies will suggest a way.

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