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could also still self-insure, but in this case, enhanced insurance state solvency and increased Department of Labor standards would apply to ensure the economic stability of the plans.

Functions -- HINs could contract with insurers to provide coverage to members or could self-insure subject to enhanced state solvency regulation (if state solvency standards are insufficient, Department of Labor solvency standards would operate as a backup oversight system). All federally approved HINs would be required to offer at least one coordinated care/HMO option, and at least one fee-for-service or other alternative option. Managed care and fee-for-service alternatives would include a "basic" package priced at the amount of the refundable health credit.

Organization -- HINs would be structured as non-profit voluntary membership corporations with a board of directors elected by the membership. HINs would have a full-time staff to manage benefits. HINs would be registered and qualified, as applicable, by a state agency or by the Department of Labor. There would be no limit on the number of HINs that could be established in a given area, but HINs would be required to have a "significant" share of the small employment market in the State to assure effective purchasing power in the market. HINs could be established along the lines of professional societies, industry, or trade associations and would be subject to all of the market reforms listed in the preceding sections.

HINS will provide the mechanism for pooling large numbers of individuals, that is now only available to large companies, to small employees and individuals. These plans have not grown in the past because of State laws. To allow for Federal preemption, plans had to "self insure". Small groups have difficulty sharing capital to self insure risk. This system allows "imputed ERISA exemptions" -- small firms can join together without self-insuring, and have insurers carry the risk.

Multi State Pooling -- HINS would allow for the first time, multi state pooling of small firms. Groups like NFIB National Small Business United and The Chamber of Commerce (or any other group) could offer the same basic plans to members nationwide. In the past, State barriers have prevented such plans. This will simplify marketing and administration and sharply reduce costs.

Increasing Flexibility for Health Plans

The following provisions of State law would be preempted for all health plans. These laws unduly limit flexibility for health plans thereby increasing health care costs.

Limiting State Mandated Benefits -- These include state laws that require insurers to cover certain optional or ancillary services. These mandated benefits drive up premium costs up by at least 3 to 5 percent and are enacted primarily because of special interest group lobbying in State legislatures. States could continue to require essential services such as hospital, physician, and diagnostic testing services.

Provisions that Restrict Managed Care -- Many special interest groups, lobby state legislatures to impose restrictions which prevent the development of managed care -- and the competitive pressure it imposes on fee-for-service providers. Anti-managed care laws include --

- Restrictions on reimbursement rates or selective contracting: Laws that restrict the ability of a carrier to negotiate reimbursement rates with providers or contract selectively with a limited number of providers.

- Restrictions on differential financial incentives: Laws that limit the financial incentives that a health benefit plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

- Restrictions on utilization review: Laws that (a) prohibit utilization review of any or all treatments and conditions, (b) require that such review be made by an in-state physician or by a physician in a particular specialty, (c) require the use of specified standards of health care practice in such reviews, or require the disclosure of the specific criteria used in such reviews, or (d) require payment to providers for the expense of responding to utilization review requests.

Federal/State Relationships

Most of the reforms described in the preceding section would be implemented by the states. Thus, the responsibility for regulating health insurance would remain primarily with the states. However, Federal legislation would be amended to provide States with clear incentives to enact laws that will achieve national goals.In many cases, as with HIN certification and

oversight, there would be backup federal certification and oversight procedures.

Under this approach, after an initial period to allow state action, if a state's health insurance laws do not meet prescribed Federal guidelines, then insurance sold in-state would be certified through a Federal back-up mechanism. And, to provide further incentives for state action, without directly preempting states' prerogatives a non-complying state's administrative grant funding for health programs would be frozen at the level of the first year of non-compliance.

Other reforms would be implemented directly by Federal government through amendment of the Federal Employee Retirement Income Security Act (ERISA) or through other appropriate legislation. Certification of HINs would fall into this category.

As stated above, Federally certified HINs would be protected from state mandated benefit laws and state premium taxes in the same manner as an ERISA-qualified self-insured plan. Federally certified HINs would, however, be subject to additional state requirements to assure solvency. States could provide an alternative process for certification of HINs. Federal and state certification processes would coexist in a manner similar to Federal and state charter of banks. If state laws and state premium taxes were excessive, a HIN could apply to the Department of Labor for federal certification -- pre-empting state law. As a result, state would be encouraged to facilitate market pooling and access to coverage for small business -- or risk losing their traditional insurance oversight and regulatory role to a federal backup system.

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throughout: change Tax Credit to Health Insurance credit

Chapter 4

Expanding Access By Helping People Pay For Insurance:

The Health Insurance Tax Credit (Voucher) and Deduction

Current tax law provides substantial benefits to individuals whose employers contribute to their health care insurance costs. Other federal programs -- including Medicare, Medicaid, VA, and CHAMPUS -- provide substantial benefits to certain veterans, elderly, and low-income people. Many unemployed individuals and working uninsured do not receive any federal contribution to their health insurance. Uninsured people often seek medical care in hospital emergency rooms, which is costly and inefficient. The tax credit and deduction plan described below is designed to help many of the Nation's uninsured obtain health insurance. The plan places the highest priority on providing health insurance for low-income individuals, but also would provide benefits to millions of moderate-income individuals who enjoy little or no employer contributions for health insurance and to self-employed individuals.

Health Insurance

~~Tax~~ Credits (Vouchers) and Deductions for Low-Income and Moderate-Income Individuals

Low- and moderate-income persons who are not covered by other federally subsidized health insurance programs will be eligible for a tax credit (voucher) or deduction for the purchase of insurance. Low-income individuals (who have no current income tax liability) would transfer their credits to employers or insurance companies to purchase a "basic" benefits package. States would identify basic plans and ensure that insurance companies would make basic benefit plans available (see Chapter __). Other individuals and families will be eligible to receive a deduction for the purchase of health insurance.

Eligible persons for a tax credit or deduction will include single persons with modified adjusted gross incomes of up to $50,000, persons filing as heads of households with incomes of up to $65,000, and married persons filing jointly with incomes of up to $80,000. The amount of the transferable health credit (voucher) will decline with increasing income levels and will range from $1250 to $125 for single persons, from $2500 to $250 for married couples and other two-person families, and from $3750 to $375 for families of three or more.

The Administration's proposal will also provide a tax incentive for the purchase of health insurance for millions of moderate-income individuals who are currently working but whose

health insurance premiums are not fully paid under an employer plan. Specifically, families may elect to claim a *deduction* instead of the credit applicable to them. The deduction will be available to persons without regard to whether they itemize or claim the standard deduction and will be equal to $1250 for single persons, $2500 for married couples and other two-person families, and $3750 for families of three or more.

Both the transferable health credit and deduction amounts will be increased to account for inflation. Applicable credit and deduction amounts will be reduced by the amount of any contribution made by the employer to the employee's health plan. Individuals with employer contributions exceeding the applicable credit will receive neither the credit nor the deduction.

Beginning July 1, 1993, eligible individuals with modified adjusted gross income (defined as the sum of adjusted gross income, nontaxable Social Security payments, Railroad Retirement payments, and tax-exempt interest) less than or equal to 50 percent of the tax filing threshold (the sum of the standard deduction and taxpayer and dependent exemptions) will receive the maximum credit. The credit will be phased down between 50 and 100 percent of the applicable tax threshold in 1993, 1994, and 1995. Phasedown thresholds will increase to a range from 75 to 125 percent of the tax threshold in 1996 and from 100 to 150 percent of the tax threshold by 1997. Hence, when fully phased in, all eligible individuals or family units with modified adjusted gross income at or below the tax filing threshold -- which approximates the poverty level -- will receive a transferable credit sufficient to purchase a core health insurance benefits package. The credit would not be reduced below a minimum equal to 10 percent of its maximum value, so that a minimum credit would be provided in the amount of $125 ($250 for married couples and $375 for families).

Individuals who receive other federal support (e.g., covered by Medicare Part A, Medicare Part B, Medicaid, CHAMPUS, and other Federal health programs) would not be eligible for the credit. Effective January 1, 1994, the transferable tax credit would replace the supplemental earned income tax credit available under current law for certain low-income taxpayers who contribute toward the purchase of health insurance coverage for their children.

Health credits and deductions could be claimed on the tax return at the end of the year. Alternatively, transferable health credit recipients could receive an advance credit during the year by applying to a state governmental office, or by being randomly assigned to a participating insurer by a qualified provider, in consultation with a registering agency. States may select a state agency, such as the Employment Service human resource department or, with the consent of the Secretary of Health and Human Services,

the Social Security Administration to certify applicants' eligibility and to notify the Internal Revenue Service of the issuance of the advance credit. Advance credit holders will transfer the credit to the employer or insurer who provides health insurance in payment for coverage. The insurance provider will then reconcile the amount of the advance credit on their tax return.

Tax Credits and Deductions for Self-Employed Individuals

Self-employed individuals will generally be entitled to the greater of 100 percent of the applicable credit up to $3750 for a family *or* a 50 percent deduction of their health insurance premiums. The health insurance deduction for high-income self-employed individuals may not exceed the maximum amount of the exclusion for employer-provided health insurance allowed for high-income employees (see Chapter xx).

Achieving the Goal of Expanded Access

The health insurance tax credit and deduction provides assistance to many taxpayers for the purchase of health insurance. When fully phased in, 92 million individuals are projected to use a tax credit or deduction provided by the program to buy health insurance. Virtually all low-income individuals who are currently uninsured would receive the maximum credit.

In 1993, 3.1 million self-employed taxpayers currently buying health insurance would benefit from the extension and increase in the deduction available to the self-employed. Still more self-employed individuals will benefit because they qualify for the health insurance tax credit. The insurance market reforms discussed in Chapter 3 will reduce the cost of health insurance for many self-employed individuals at all income levels.

Chapter 5

Making the System More Cost-Effective

Overview

Over the past several decades, per capita health care costs in the United States have been increasing more than 4 percent per year faster than general inflation. Since 1960, real per capita health spending has grown as a share of GNP from 5.3 percent in 1960 to an estimated 13.1 percent in 1991. If current trends were to continue, total health spending could reach 26.1 percent to 43.7 percent of GNP by 2030 under alternative assumptions (Waldo et al., 1991). Clearly, these trends are unsustainable if the United States is to improve its economic base and standard of living.

This rapid growth reflects a number of ongoing pressures that cannot be easily changed or controlled: the changing demographics of the U.S. population, the labor-intensive nature of health care services, and the introduction of beneficial -- but highly costly -- new technology. Other causes of escalating health care costs -- market failures in health care and health insurance -- accentuate these pressures but can and should be addressed through enhanced competition.

Currently, the mix of services provided is not necessarily that which fully informed consumers would purchase under optimal conditions and services are not produced at minimum cost. A key issue is the role of insurance. While health insurance has important benefits -- it protects individuals and families from unexpected high health care costs and it reduces financial barriers to care -- traditional fee-for-service insurance with low cost-sharing stimulates incentives for over-utilization of services. The reason is straightforward: with insurance paying most of the cost, health care is perceived to be a free good for patients and demand for medical care increases above optimal levels. Moreover, insulated from the cost of care, consumers have little reason to shop for the best price.

More efficient forms of health insurance coverage are available. These include fee for-service coverage with modest cost sharing and coordinated care coverage, where the health plan strives to buy the best package of health care at the lowest cost on behalf of plan enrollees. However, due to distortions in the health insurance market, demand has been relatively weak for these more efficient forms of coverage.

There are three principal distortions in the market for health insurance which support inefficient forms of coverage: (i) open-ended government subsidies which reduce consumer sensitivity

to cost, (ii) opportunities for favorable risk selection -- or "cream-skimming" -- which can give inefficient health plans an unfair cost advantage, and (iii) limited consumer information regarding the quality of care in competing health plans which can lead consumers to mistake higher price (or more intense service delivery) for better care or superior outcomes.

There are other weaknesses in our current system as well. There is substantial consumer and provider uncertainty regarding the effectiveness of a broad range of alternative diagnostic and therapeutic procedures. Moreover, prevention often is neglected resulting in needless illness and greater cost. Finally, our current legal system increases health care costs by fostering "defensive medicine" and excessive litigation costs.

Against this background, the outlines of a comprehensive reform strategy become apparent. The key initiative is to shift health care delivery to a more market-based, competitive system. There must be additional and complementary initiatives as well. Other critical elements include reducing administrative costs, coordinated care initiatives, more prudent purchasing of care (particularly through public programs), prevention, and malpractice reforms.

Each of the elements proposed individually push the system towards greater efficiency. Added together, these elements form building blocks of a more fully integrated market-based system which can spur an ongoing market dynamic.

Strengthening Competition

The Administration's reform proposal has three main elements which will strengthen competition. These elements will lead to greater efficiency and fairer allocation of resources. And, the nature of competition will shift. Providers and the mix of services will be will be chosen based more on price relative to quality and meaningful outcomes.

Changes in Tax Policy. Three proposal contains three changes in tax policy that strengthen competition: (i) a tax credit for low-income individuals and families, (ii) a deduction for self-paid health premiums of up to $1250/$3750 for middle income individuals and families, and (iii) a limit on the exclusion from Federal taxable income for employer-paid health insurance for upper income taxpayers.

The tax credit is a crucial reform. For the first time, government assistance for the low-income will be provided through the credits rather than through a publicly administered health insurance program. Reliance on tax credits will allow increased consumer choice to price and purchase insurance coverage. Low income individuals will be empowered through tax credits to shop among plans and coverage options. Moreover, because the credit

is set as a fixed dollar amount rather than as a percent of premium costs, consumers will be sensitive to cost and will purchase additional coverage only when the benefits of such coverage at the margin outweigh competing goods and services. The capped tax deduction for self-paid premiums will have a similar positive effect on consumer choice and competition.

The cap on tax subsidies for upper-income individuals and families will also enhance equity and efficiency. There is little justification to providing open-ended subsidies to upper-income taxpayers who can afford health insurance without government assistance. Moreover, a number of economists (see, for example, Enthoven, 1980; M. Feldstein, 1971; Feldstein and Friedman, 1977; Greenspan and Vogel, 1980; P. Feldstein, 1988; Ginsburg, 1981; Newhouse, 1978; Pauly, 1980; Pauly, 1986; Wilensky and Taylor, 1982) have pointed to the open-ended nature of current income exclusions as a serious distortion which subsidizes inefficient or excessive coverage and contributes to health care cost inflation.

Consumers affected by the tax credit, capped deduction, and tax cap for high income groups can be expected to be more cost-sensitive. The best study to date indicates that restoring marginal cost sensitivity in this way could result in a 5 percent one-time reduction in health care costs for those affected (Chernick, Holmer, and Weinberg, 1987). This estimate is consistent with other studies which indicate one-time savings of between 2 percent and 13 percent (EBRI, 1989). Moreover, OMB staff estimates indicate a potential for ongoing savings. The rate of health care cost growth could be reduced by 20 percent, though this is more speculative.

While only a percentage of the population will be directly affected by these reforms, a broader spillover effect seems likely. Employers are likely to provide more efficient forms of insurance coverage to all employees -- not just those directly affected by the change in tax policy. Because coverage does not correlate highly with income (Taylor and Wilensky, 1985), this spillover effect is plausible. Thus, strengthening market forces at both ends of the income spectrum could yield savings for all.

There will be spillover benefits into non-medical areas as well. By providing subsidies for health insurance to low-income workers, the tax credit will encourage re-entry into the work force -- particularly for Medicaid recipients who may fear of losing insurance coverage if they resume employment. Broader health insurance should also lead to productivity gains from improved health status for the uninsured unemployed/working poor.

Insurance Market Reforms. The insurance market reforms will help correct serious distortions in market forces, making competition more effective as a means of encouraging greater efficiency. Competition based on "cream skimming" or favorable risk selection will be effectively blocked. This will push

competitors to focus on cost-containment and quality. Group purchasing through Health Insurance Networks ("HINs") will also give small businesses greater market "clout." And, pre-emption of State-mandated and anti-managed care laws will give health plans new flexibility to respond to market pressures for greater efficiency and cost savings.

Improved Information. Comparative cost and quality information would be made available to purchasers through a new series of state and local initiatives. Providing this information is a critical element for a pro-competition reform strategy. Comparative information for individual and institutional purchasers will enable purchasers to shift demand towards high-value health plans and providers. This, in turn, will provide powerful incentives for plans and providers to compete by controlling costs while improving quality. Even a minority of well-informed consumers can influence other consumers and the direction of the market (Pauly, 1978). Plans and providers that demonstrate equivalent or superior outcomes at lower cost would gain a competitive edge. Service utilization and costs could be cut appreciably with no deterioration in outcomes.

Funding also will be increased for outcomes research. This research will better define the safety and effectiveness of key medical and surgical procedures and will facilitate more appropriate use of costly technologies. Funding also will be increased for efforts to develop practice guidelines for practitioners. By specifying a "best practice" approach for specific conditions, guidelines can help prevent unnecessary or potentially harmful care.

Administrative Savings

Over the past year, considerable attention has focused on administrative costs in the U.S. health care system. Several studies suggest that administrative costs are indeed higher in the U.S. when compared with countries such as Canada. However, the story is more complex. Simple administrative cost comparisons can be misleading.

For example, some administrative costs (e.g., spending on utilization review) can result in net savings by identifying and preventing costly, unneeded, and potentially dangerous care. And, the U.S. leads the world in health care quality assurance. Quality assurance increases administrative costs, but adds important value for consumers. Furthermore, most of the comparative studies have failed to note the "hidden" costs of the Canadian system. Waiting times for patients seeking elective surgery and other specialized services are dramatically lower in the U.S. than in other countries. Finally, the U.S. health care system provides greater diversity and choice.

Nonetheless, there are areas where overhead costs in the U.S. are excessive and savings are possible. One area of concern is administrative and marketing costs for health insurance sold to small businesses. Overhead costs can be as high as 40 percent of total premiums for very small businesses compared with less than 6 percent for very large businesses. Another area of concern relates to the high cost of paperwork associated with billings and claims forms.

Under the Administration's proposal, group purchasing arrangements, or Health Insurance Networks, for small business will help reduce administrative and marketing costs. And the market reforms will reduce overhead costs by prohibiting medical underwriting and by discouraging "churning" of accounts.

[Insert Table here with estimated cost savings by firm size]

Other administrative savings will be proposed as well. The Secretary of Health and Human Services is leading a number of initiatives to streamline administrative procedures. These include accelerated development of data standards for electronic claims processing, and encouragement of electronic medical records and/or "smart cards" for insurance enrollees.

Coordinated Care

The Administration's reform proposal would encourage greater use of coordinated care arrangements through increased enrollment in public programs -- Medicare and Medicaid -- and elimination of state laws that hinder development of these arrangements.

"Coordinated care" refers to a diverse -- and still evolving -- set of alternative delivery models introduced over the last two decades. Examples include Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Coordinated care plans offers the potential of: lower cost, improved outcomes through better quality assurance, and expanded consumer choice among health service delivery options. Coordinated care systems closely integrate the financing and delivery of health care. Unlike fee-for-service or "a la carte" medicine, clinical decisions are coordinated across the full continuum of care. Combining organizational and financing components also allows for more efficient management of price and volume.

Studies show direct savings from coordinated care (Luft, 1980; Manning et al., 1987; McCaffree et al., 1976; Luft, 1978; Roemer and Shonick, 1973; Wolinsky, 1980) -- as high as 30 percent (Luft, 1981). Other studies (Dowd, 1986; Robinson, 1991; Rossiter, 1989; Scheffler et al., 1988; Welch, 1991) show significant "spillover" savings: as coordinated care systems gain market share in local markets, fee-for-service costs are reduced as providers are forced to compete more vigorously. And, it is important to stress that the cost containment potential of

coordinated care is dynamic. Further savings are likely as management systems improve and as better techniques for delivering medical care are developed.

Prudent Purchasing in Public Programs

Expenditures for both Medicare and Medicaid programs have continued to grow at double digit rates. Medicare baseline growth for FY 1992 is projected at 11.8 percent; expenditures under Medicaid have increased at nearly 19 percent on average over the last three years, making it the fastest growing domestic program. The Administration's proposal would reduce growth in Medicare costs to xx% a year through prudent purchasing and other measures to improve efficiency. Medicaid cost growth would be slowed to xx% a year by encouraging greater reliance on coordinated care and by providing states with greater flexibility. These savings will be achieved with no reduction in benefits for program recipients.

The Administration also supports measures to stop abuses in the current system. For example, payment for physician self-referrals would be prohibited under the Medicare and Medicaid programs. Physicians and other providers increasingly refer patients for tests or to diagnostic centers in which they hold some financial stake -- a clear conflict of interest. Recent evidence indicates these "self-referral" arrangements can increase costs per episode of care by as much as 400-700 percent (Florida Cost Containment Board, 1991; Hillman et al., 1990).

Prevention

Prevention is a "win-win" investment. Health care costs can be cut while improving well-being and increasing worker productivity. Healthy behaviors can prevent between 40 and 70 percent of all premature deaths, a third of all cases of acute disability, and two-thirds of all chronic disability. Accordingly, the Administration's proposal focuses additional dollars on prevention efforts which have maximum return on investment. Specific initiatives include increased funding for: (i) vaccine research and other research targeted at preventing specific diseases; (ii) screening programs such as blood lead level testing, pap smears, mammograms, and blood cholesterol testing; and (iii) health promotion activities, such as campaigns to reduce smoking, increase seat belt use, or encourage early prenatal care for low-income women.

Medical Professional Liability Reform

Medical malpractice reform is a key element of health system reform. Malpractice premiums more than doubled from approximately $1.9 billion in 1984 to $4.2 billion in 1988. And,

the threat of malpractice forces doctors to practice "defensive medicine" -- ordering unnecessary tests and procedures simply as documentation to protect against litigation. Defensive medicine costs are estimated at about $20 billion a year. The current system also involves lengthy delays and excessive litigation costs.

To address these problems, the Administration is proposing comprehensive reform. States would be encouraged to reform medical malpractice litigation by: (i) capping the amount of allowable non-economic damages; (ii) eliminating joint and several liability for non-economic damages; (iii) eliminating the collateral source rule that allows the double recovery; (iv) requiring structured payments for malpractice awards, as opposed to lump sum payments; (v) promoting pretrial alternative dispute resolution to encourage reasonable settlements; and (vi) implementing procedures to enhance quality of care. These reforms would also be applied to Federal courts, and alternative means of resolving medical malpractice claims would be piloted within the Federal Employees Benefits Program.

In addition,

Overall System Effects

Each of the individual elements will encourage greater efficiencies and fairer allocation of resources across the U.S. health care system. Added together, these elements also can provide an ongoing dynamic within the overall health care delivery system. Strengthening competitive forces plays an important role in this system dynamic.

Tax policy reform, health insurance market reform, and greater availability of comparative value information will together generate increased cost sensitivity and increased consumer shopping across all income and occupational groups. Suppliers can be expected to respond with more affordable benefit packages and more efficient mix of services. For example, use of cost-sharing and coordinated care plans could increase. As coordinated care achieve greater premium cost advantage, more individuals would switch to these plans from fee-for-service coverage. And, coordinated care plans would have incentives to increase savings by making provider networks more selective and by reducing marginally useful care, including cost-increasing technologies.

Increased use of coordinated care by Medicare and Medicaid would reinforce these market shifts. Public and private activity combined could make coordinated care plans the dominant system. The market power enjoyed by coordinated care approaches would further mean that norms of care (and consumer and physician expectations) would increasingly be established by this sector. A so-called "norms effect" could have spillover effects into the remaining fee-for-service sector, increasing both efficiency and quality in the provision of care.

Additional elements of the reform will lessen overall excess demand for medical services. For example, coordinated care plans and other medical providers have little control over costly behaviors such as smoking and not using a seat belt. The prevention initiatives will help in this area. Similarly, malpractice reforms will discourage costly practices related to defensive medicine. Administrative savings will be achieved through use of standardized claims format and electronic claims processing. The overall impact on individual and market behaviors will be greater than the sum of its individual parts.

Savings Estimates

OMB/Bill Curtis estimates and discussion here

Implications for Future Research and Development

While the next steps for health system reform are clear, further research and development is inevitably needed if our market based health care system is to evolve and strengthen over the next several decades. Three areas of research warrant special priority: (i) factors that affect the demand for health insurance and demand for traditional vs. coordinated care coverage, (ii) development and refinement of risk adjustors for insurance market reforms, and (iii) better approaches to develop and package information on outcomes and cost of care.

Further research on the demand for health insurance is crucial for a more complete understanding of the dynamics of a market-based system and for more accurate predictions regarding the response to policy interventions in terms of cost and coverage. It also will be extremely important to understand relative preferences for different types of coverage -- catastrophic, medical savings account type approaches, coordinated care plans, and so on. Implementation of the tax credit proposal offers researchers an opportunity to better measure demand elasticities of price and income for health insurance. Research could also be initiated to gain a better understanding of the factors that affect demand by Medicare beneficiaries for coordinated care versus traditional fee-for-service coverage.

Development of improved health risk adjusters also is critical if competition among health plans is to be focused on efficiency and quality. At least two approaches exist currently for adjusting for risk selection: Ambulatory Care Groups and Diagnostic Cost Groups. A short-term strategy would be to further refine and validate these systems as well as re-examine previous research using health status measures and other measures. A longer-term effort could involve development of second-generation risk adjusters.

Research also is needed to develop better measures of efficiency and quality. And this information needs to be packaged in ways that will be most useful for health care purchasers whether individual consumers or institutional purchasers. For example, individuals and employers are likely to find plan-level cost and quality information most useful, while health plans need comparative data on individual providers for purposes of selective contracting and negotiating discounts. Over the next several months, the Administration will refine research priorities in these and related areas as it moves forward in support of system reform.

Section 5.A

Malpractice Reform: Changing Incentives for Provider Behavior

Distortions in the current health care delivery system derive in part from perverse incentives created by the current climate for malpractice and litigation. Symptomatic of these distortions are the increasing levels of unnecessary and costly defensive medical practices resulting from the perceptions of providers such as physicians and hospitals. Fear of antitrust liability also increases costs by producing often inefficient and duplicative distribution of sophisticated services and equipment. Finally, the quality of health care can be diminished because of reluctance by professional review boards and hospitals to deny or restrict a physician's privileges because of potential antitrust liability.

In May 1991, the President proposed the "Health Care Liability Reform and Quality of Care Improvement Act," to address the costs of malpractice insurance, the transaction costs of malpractice litigation, the length of malpractice dispute resolution proceedings, and to reduce the incidence of malpractice through increasing the quality of care. The provisions of the health care initiative outlined here supplement that proposal, addressing the increasingly common practice of engaging in unnecessary defensive medicine and the effects of antitrust laws on costs and the quality of care activities.

Principles for Malpractice Reform

The Health Care Liability Reform and Quality of Care Improvement Act is based on three principles:

- o medical malpractice reform should seek both improved quality of care for patients and lower litigation costs;
- o legal reforms should reduce the incentives for physicians to practice unnecessary defensive medicine or to abandon practice in inner city and rural areas;
- o incentives for States to act are preferable to Federal preemption of current State law. Federal preemption should be used only selectively and narrowly.

Unnecessary Defensive Medicine

Malpractice costs play a significant role in the rapid growth of health care spending. These costs include the direct costs of insurance, litigation, and settlements. Perhaps most importantly, however, the current malpractice system creates incentives for physicians to engage in defensive medicine -- excessive tests, failure to delegate certain tasks to other qualified professionals, and in general a more elaborate style of care than is necessary for the provision of sound medical care.

Often, unnecessary defensive medicine may be the result of a misperception on the part of providers. A recent study of physicians in New York (**Hans, need cite**) found that physicians tend to overestimate the risk of being sued by a factor of three. As a result, efforts should be made to communicate the true level of liability risk to providers. And not all unnecessary defensive medicine is attributable to fear of liability. In some cases, as in fee-for-service medicine, there may be a strong economic incentive to engage in such activity. The fear of liability, however, does result in an increase in the degree and kind of diagnostic testing, the reluctance to delegate certain basic functions, and the abandonment of care for some high risk patients or in high risk specialties such as obstetrics (**Todd/AMA, 1989 -- Hans, do you have this reference?**).

Beyond the provisions in the Health Care Liability Reform and Quality of Care Improvement Act, the President's plan endorses approaches to reduce the amount of unnecessary defensive medicine and to clarify the application of antitrust laws in the health care area; these include: (i) establishment of standards of care, (ii) offers of settlement, (iii) encouragement of out-of-court dispute resolution, and (iv) offer to use alternative dispute resolution (ADR). Each is discussed below.

Establishment of Standards of Care. Researchers, medical associations, and others have attempted to provide guidance to physicians on the proper standard of medical care for individual clinical indications. For the most part, however, it is the tort system, through the judgments of lay juries, that defines the standards of care physicians must meet. Although not regulatory, the precedential value of the jury's determination and clinical uncertainty generally can effect profoundly the actions of those in the medical sector. There is also a perceived lack of predictability in the U.S. medical malpractice litigation system because of the variety of results that can be generated by case-by-case determination by different juries. This uncertainty and the role of non-medical persons in determining what is adequate medical care often has reinforced overly cautious behavior -- and resentment -- of the litigation system in the medical community.

The perceived problems of the medical liability system extend beyond the

uncertainty of outcomes. Many physicians are as troubled by the process of litigation as its results. The cloud of a lawsuit, the delay, and subjecting the physician's behavior to the review of others, particularly lay persons, is as daunting as the notion of an insurance payout.

To avoid the judgment of lay juries and the delay inherent in the current civil justice system, some have called for taking medical malpractice cases out of the courts entirely. Other forms of dispute resolution have a significant role to play in reforming malpractice litigation, and the President's plan proposes the use of such procedures as discussed below. Nevertheless, the courts will continue to be the focal point of alleged malpractice disputes. Accordingly, this initiative includes an element to bring more predictability to jury determinations of whether certain behavior by health care providers meets the standard of due care.

Standards of care offer the added benefit of enhancing the value of alternative dispute mechanisms. Where voluntary non-binding alternative dispute resolution is invoked, as proposed in this initiative, standards of care will bring heightened confidence that the determination of the mediator or arbitrator will reflect accurately the behavior of a jury if the case proceeds to trial. Thus, parties will be better positioned to judge the consequences of rejecting the proposed determination.

In recent years, there has been increased interest in the development of standards of care as references for physicians by medical groups, insurers, and legislators. The debate has centered on who would develop such standards, the degree of specificity required to make the standard useful, the degree of flexibility necessary to reflect the individuality of patients and circumstances, and the proper use of such standards. The Omnibus Budget Reconciliation Act of 1989 (PL 101-239) established the Agency for Health Care Policy and Research within the Public Health Service to promulgate guidelines and standards of quality and other "performance measures." No provision was made for giving any legal effect to such standards in litigation, however.

Moreover, since 1972, the organizations overseeing quality in Medicare, Peer Review Organizations, (PROs, previously PSROs) have had the ability to adopt standards of care; a physician adhering to those standards is given immunity from liability. No such immunity producing standards have been promulgated, however. This has been attributed to the use of internally inconsistent language in the statute and the tendency of PROs to judge actions retroactively rather than to guide future actions,

The President's plan proposes an expansion of the efforts of the Department of Health and Human Services to develop standards of care. Properly established standards can be given a rebuttable presumptive legal effect when introduced by the

defense in State or Federal court. But because the Administration does not like to resort to wholesale preemption, and because some States, such as Maine, may undertake to develop their own standards of care, Federal standards would preempt state law only where a State had not adopted its own standard for use by providers.

S. 314, introduced by Senator Cohen, is a thoughtful approach to the adoption and use of Federal standards of care. This approach contains three significant answers to the troubling questions that have been raised in the debate over standards of care in the past.

First, the bill places the responsibility for the promulgation of the standards of care with the Department of Health and Human Services. The bill avoids bureaucratic dominance of the process by providing ample opportunity for input and comment by private physicians and other interested parties. This process will assure that standards do not inadvertently endorse too high a standard or one that does not take into account geographic variation. It also requires ongoing review of the standards developed. Moreover, because the standards can be introduced at trial only to create a rebuttable presumption of the standard of care, HHS will not be creating a new regulatory burden.

Second, the bill recognizes that few, if any, standards will be uniformly appropriate to all circumstances, either because of the nature of the practice, geographical variations, and, implicitly, because no two patients are the same.

Finally, the bill allows the introduction in evidence of the standard of care by the provider only. Once introduced, the standard is presumed to be an appropriate standard of medical care. Because the use of the standard is controlled by the defendant, it cannot be used to force a physician to comply with a standard with which he or she does not agree.

Many commentators have opposed standards because they believe the use of standards cannot be limited only to the defense. However, no legislative action will ever make medicine an exact science. To identify certain behavior as falling within the set of behaviors that meet the legal standard of due care does not compel the conclusion that all other behavior falls outside the set of behaviors that meet that legal standard. There may be alternative methods of treatment that will also meet the legal standard of due care that are not reflected in the standard promulgated.

There are also concerns that government sanctioned standards may result in standards of care above the usual clinical practice in some areas -- and therefore increase costs. Standards are intended to define one course of conduct that meets the definition of adequate medical care; they are not intended to define the only appropriate course of conduct. Moreover, standards are not intended to result in a

"gold standard" of treatment. The purpose is to reduce the level of unnecessary defensive medicine while increasing the quality of care. Moreover, if a State determines that the standard has been set too high and will have an adverse effect on the delivery of care in the state, it may adopt its own standard.

Promulgating standards of care and providing some limited legal force to those standards should bring increased predictability to the medical malpractice system. Physicians knowledgeable about the standards will also have guidance in determining the adequacy of care provided. This predictability and guidance will, over time, reduce the amount of unnecessary defensive medicine practice. To the degree fear of liability is a motivating factor for defensive medicine, standards of care should reduce the cost of health care.

Dispute Resolution

In addition to standards of care, the President's plan seeks to reduce the delay and adversarial nature of medical malpractice litigation. In this regard, three provisions to preempt state law would be proposed: (i) offers of settlement, (ii) offers to engage in alternative dispute resolution, and (iii) state contract law.

Offers of Settlement. The President's plan would permit either party to a malpractice action to make a formal offer of settlement. This provision has been discussed for application in other areas of civil justice in need of reform, such as product liability. In effect, the provision makes Rule 68 of the Rules of Civil Procedure available to plaintiffs as well as defendants. S. 1936, introduced by Senator Chafee, contains such a provision.

The provision requires that, notwithstanding State rules of civil procedure, any plaintiff or defendant may make an offer of settlement within a designated period prior to trial. If an offeree rejects the offer of settlement and does not do at least as well as the offer at trial, that party must pay the other's attorney's fees.

Offers to Engage in Alternative Dispute Resolution. Senator Chafee's bill also permits any party to a malpractice action to offer to use a state-approved ADR procedure. If the court finds that the other party's refusal to use ADR was not in good faith, the party refusing ADR must pay attorney's fees. A rebuttable presumption is created that a refusal to participate in ADR is not in good faith.

Although the Administration supports permitting either party to litigation to make an offer to use ADR, the question of attorney's fees should be simplified. The President's plan would propose that if the party refusing to engage in alternative dispute resolution loses at trial, that party should pay the others attorney's fees.

State Contract Law. Finally, the Administration seeks to encourage agreements between patients and providers, made prior to the delivery of health care services, to use out-of-court dispute resolution mechanisms if a dispute arises. It is unclear, however, whether such contracts are valid in all States. Contracts between patients and providers would be permitted to require non-binding arbitration before a lawsuit can be filed notwithstanding conflicting state law.

Antitrust Law

In addition to the issues of medical liability and dispute resolution, antitrust issues bring law and medicine together. For instance, professional peer review has always reflected a tension between the necessity to "weed out" those who do not meet the standards of the profession, and the possibility that such review could be used unfairly and illegally to limit competition in the profession. With the emergence of new methods of health care delivery, like HMOs and PPOs, and increasingly sophisticated and costly technology, confusion about the proper application of the antitrust laws in the health care field has increased.

As part of a comprehensive health initiative, the President's Plan proposes a series of steps to assure that the new emphasis on the quality of care is not undermined by concerns of allegations of collusion, that concerns of antitrust liability do not discourage the evolution of a more organized and efficient health care delivery system, and that the cost of health care is not increased unnecessarily because of duplication of costly technology and services.

The President's initiative includes legislation to address (i) the issue of the unnecessary duplication of technology, and the provision of guidance by the Federal government on the issue of the application of the Federal antitrust laws to (ii) peer review and (iii) coordinated care issues.

Medical Technology. Often expensive equipment is duplicated by competing health care organizations because of concern over the application of the antitrust laws to the sharing of equipment and services. As a result, the supply of this expensive technology may unnecessarily exceed demand.

To reduce the costs of high technology equipment and services, the Administration will again urge Congress to pass the joint production venture legislation, S. ___, transmitted by the President on _____. Alternatively, the Administration urges passage of legislation like that in S. 314, specifically providing a waiver for hospitals jointly purchasing, contracting for, or sharing high technology equipment and services.

Peer Review Activities. State disciplinary boards and hospital medical staffs often review physicians' qualifications to determine whether a license or hospital privileges for the physician should be limited, denied, or revoked. Presumably, the goal is to ensure an appropriate quality of care. Often, however, the physician whose privileges are curtailed will sue the reviewing physicians and witnesses on the grounds that the review is really a veiled attempt to limit competition. As hospitals try to become more competitive, they will want the most efficient physicians on their staffs.

Some observers suggest that the creation of certain "safe harbors" for actions limiting physician privileges can avoid litigation costs and the chilling effect of potential litigation without unduly limiting competition. Changes in substantive law are not necessary. Rather, the Department of Justice will provide enhanced guidance for State peer review boards and hospitals with respect to actions to deny, revoke, or suspend the license of privileges of any physician.

PPOs, HMOs and Other Pooling Arrangements of Providers. The emergence of coordinated care is creating new legal issues in health care. For instance, if physicians in an area ban together to form a PPO, thus fostering price reductions and promoting higher quality care, it may be alleged that they are nonetheless reducing the number of competitors for physician services. In rural areas, physicians banding together to form a PPO could appear to reduce competition even though they were fostering efficiency.

At the same time, diligent enforcement of the antitrust laws is necessary to prevent price fixing and illegal tie-ins in the provision of health care. Reducing the fear of liability for certain beneficial activities while maintaining the deterrent effect of the antitrust laws for traditional anticompetitive endeavors is the challenge for antitrust enforcement agencies, particularly the Department of Justice and the Federal Trade Commission.

The President's Plan would clarify the antitrust standards that apply to provider pooling arrangements such as PPOs and HMOs. Additionally, the Department of Justice will increase its enforcement efforts against those in the health care industry who would boycott such provider organizations. Together with the efforts of the Federal Trade Commission, the actions of the Department of Justice should provide the guidance that these evolving entities need to prosper.

Models of Care

An array of coordinated care plans currently exist. One well-known example is the health maintenance organization (HMO), in which a defined, comprehensive set of health services is provided to an enrolled group of individuals. The organization assumes financial risk for part or all of the group's health care. In the "group model" HMO, a physician group contracts with the entity at financial risk. Under the "staff model" HMO, physicians are employees of the HMO.

In recent years, the major growth in coordinated care arrangements has been in organizations in which consumers retain greater choice about the care they receive within the coordinated structure. A popular model has been the independent practitioner association (IPA) HMO in which the HMO contracts with two or more independent group practices or with an association of independent physicians. Consumers are able to select their provider from the panel of participating practitioners.

A second popular example is the preferred provider organization (PPO), in which a network or panel of providers contracts with the entity. Many consumers have favored PPOs because they allow greater freedom of choice in selecting providers. Typically, providers are reimbursed for services based on a negotiated fee schedule. Providers generally accept lower fees in exchange for directed access to increased numbers of patients. Utilization review programs ensure that physicians do not offset lower fees with inappropriately increased volume. Consumers may choose a provider outside the PPO network, but face additional out-of-pocket payments.

Other plans exist, including the point-of-service (POS) plan, essentially an HMO-PPO hybrid. POS plans utilize a network of participating practitioners. Beneficiaries select a primary care physician, who makes all referrals for specialty care. If individuals seek care from a participating provider, they incur little or no additional costs. Individuals opting to seek care outside the plan face higher deductibles and copayments.

Perhaps not surprisingly, other countries such as Canada and England are now emulating the characteristics of coordinated care arrangements:

- England has recently implemented the most thorough reform of its system since its founding, by installing elements of market responsiveness by providers, especially by HMO-like private physician groups;

- Canadians are experimenting with "Health Service Organizations" which are similar to HMOs in concept but which do not always have the prepaid, locked-in enrollment features that can increase efficiency.

Evidence: Cost and Quality

Evidence indicates that coordinated care plans offer health care to enrollees that is as good as, and in many cases, superior to care that of fee-for-service medicine. Studies have generally shown comparable quality based on assessments of medical records between fee-for-service medicine and HMOs (Cunningham and Williamson, 1980; Luft, 1981). In addition, studies have shown that beneficiary satisfaction is very high in Medicare HMOs and equal to that found in Medicare as a whole (Rossiter, 1989). Moreover, Medicare HMOs offered more supplemental benefits, including preventative services, for a lower premium than that of traditional Medigap policies. In general, HMOs have been able to reduce hospitalization and increase the use of primary care. A lower number of hospital patient days for coordinated care plans versus traditional fee-for-service results in substantial savings while ensuring quality care.

A number of studies indicate cost savings associated with the use of coordinated care (Luft, 1980; Luft, 1981; Manning et al., 1987; McCaffree et al., 1976; Luft, 1978; Roemer and Shonick, 1973; Wolinsky, 1980) -- as high as 30 percent (Luft, 1981). Other studies (Dowd, 1986; Robinson, 1991; Rossiter, 1989; Scheffler et al., 1988; Welch, 1991) have shown "spillover" cost-saving into the fee-for-service sector as coordinated care plans increase their market share in an area and stimulate competition among a variety of plans, thereby driving down costs.

Evidence regarding cost savings from coordinated care is ongoing, in part because of the newness of plans and their changing organizational nature. **(Gail, are you going to provide information on Allied Signal study???)** Further savings are likely as management systems improve and as better techniques for delivering medical care are developed.

While there has been debate about whether some of the savings associated with HMOs can be attributed to favorable selection (i.e., healthier people enrolling in HMOs), the Rand Health Insurance Experiment (Manning et al., 1987) demonstrated that HMOs provide significant potential savings over fee-for-service medicine. Assessment of health outcomes between the HMO group and the traditional fee-for-service group showed no difference. In this multi-year demonstration in which individuals were randomly-selected into an HMO, reported savings over 5 years were as high as 25 percent, compared to patients randomly selected into fee-for-service arrangements.

Trends in Enrollment

The shift toward coordinated care over the past decade has been clear. As

Figure xx illustrates, in 1984 over 85 percent of all individuals with insurance received their care through fee-for-service providers. The most significant growth has occurred in those coordinated care plans that offer consumers substantial flexibility to choose their own physicians. In 1990, managed fee-for-service, PPOs, IPAs, and POS plans accounted for over 60 percent of the private insurance market.

Enrollment in public programs has been less robust. Medicare, under the TEFRA risk contract HMO option, has promoted alternative delivery systems since the mid-1980s. However, HMO enrollment has stalled since 1986, with risk enrollees only increasing from 1.0 to 1.3 million beneficiaries. Only 3 percent of Medicare beneficiaries currently are enrolled in alternative plans, in striking contrast with the under 65 population.

Perhaps the most serious problem is that HMOs compete with a large, government program that has near monopsony power. Medicare purchases fee-for-service (FFS) care for most of its beneficiaries and obtains deep price discounts due to its large market share. These price discounts may overwhelm potential savings that HMOs can obtain from discounts and better control over utilization.

A second problem has been that HMOs are paid only 95 percent of comparable FFS costs (because of presumed efficiencies). Nevertheless, HMOs face marketing and enrollment costs unlike government. They further face greater financial risk on average due to full prospectivity, relatively small numbers of enrollees, and an AAPCC payment methodology which currently fails to predict resource use and can fluctuate substantially year-to-year.

A third problem is that HMOs have a limited ability to offer seniors a more attractive benefit package than what is offered by FFS Medicare. This is especially true for seniors (about 40 percent) who have employer-based supplemental benefits. These supplemental benefits can overlap with HMO-based benefits under Medicare coverage. Moreover, HMOs cannot offer cash rebates to seniors because they are prohibited from doing so by anti-kickback provisions. Nor can they lower Part B premiums.

For Medicaid, HMOs have had legislative authority to enter into contracts with State agencies since 1967. However, only in the early 1980s did congressional regulations inhibiting HMO contracting with Medicaid begin to better balance with needs to maintain adequate oversight of quality, allowing greater enrollment.

In addition, legislation authorized use of new forms of alternative delivery arrangements, such as primary-care case management (with an appointed physician or other primary care provider serving as a gatekeeper to specialist and inpatient services) and health insuring organizations (a fiscal intermediary that functions much like the

insurance portion of an HMO by providing strong utilization controls). This meant States had a variety of alternatives for testing the cost-effectiveness of Medicaid recipients into coordinated care plans.

By 1991, nearly two and one-half million Medicaid recipients across 28 States received care under coordinated care arrangements (Hadley and Langwell, 1991; Wilensky and Rossiter, 1991). Nevertheless, these gains in enrollment still account for less than 10 percent of Medicaid recipients nationally.

Increasing Incentives

The President's reform proposal emphasizes greater use of coordinated care arrangements through increased enrollment in the private sector and through public programs.

In the private sector, millions of Americans eligible for the tax credit would have the choice of enrolling in coordinated care plans offered within their State. Because of efficiencies of care provided by HMOs and other alternative delivery arrangements, premiums offered by these plans would be expected to be very competitive relative to traditional fee-for-service plans. From a quality and continuity of care perspective, plans could provide more primary/preventive and comprehensive benefits relative to fee-for-service plans.

Medicare and Medicaid. Through the public programs, incentives for coordinated care will be pursued more aggressively. Medicaid intiatives will be encouraged through increased State flexibility and Federal matching rates that are based on a per capita basis -- discussed in greater length in section xx of this chapter.

Medicare is discussed in more detail here. HCFA will initiate a two-pronged approach because the only coordinated care alternative currently is the HMO option. Medicare will:

- o create new options, as alternatives to the most structured form of coordinated care (HMOs), that would provide beneficiaries with greater provider choice while introducing them to the benefits of coordinated care; and

- o take steps to strengthen the existing HMO option.

New options, such as Point of Service (POS) and Employer POS would be created. Under current law, a beneficiary who wants to receive benefits through an HMO must enroll with that plan. Beneficiaries enrolling in HMOs with risk contracts are required to receive all of the Medicare covered services through the HMO.

In recent years, employers have been moving toward health plans where individuals make a choice at the point of service of whether or not to receive care through the plan's network of providers or outside of that network. These plans have both been popular with employees and have achieved the desired results of moving a significant percentage of services into the preferred provider network.

Under POS, HCFA would enter into multi-year contracts with entities (POS contractors) to create comprehensive preferred provider networks (primary care physicians, specialists, hospitals, labs, etc) for beneficiaries not enrolled in risk plans. POS contractors would negotiate discounts for bundled Part A and Part B payments for high cost/high volume surgical procedures. They would also negotiate other discounts from providers and suppliers. POS physicians would have incentives to make referrals only within the POS network.

For employer POS, HCFA would contract with employer or union-sponsored plans to provide medical review/utilization review (MR/UR) for Medicare covered services for retirees. This would enable employers and Taft-Hartley trusts to coordinate benefits to retirees through the same administrative structure used to coordinate care for active employees and/or under-65 retirees.

For the longer run, the more significant initiative will be to strengthen the existing coordinated care program. The President's plan will initiate several actions to that will increase investment in the current program.

One approach will increase payments to HMOs with risk contracts. This could either be done by (i) increasing payments from 95 to 100 percent of the AAPCC or by (ii) increasing payments to 100 percent through outlier payments and beneficiary rebates.

If through the AAPCC, the additional 5 percent could encourage the entry into the Medicare market of HMOs who currently are not participating. Existing plans could use the additional 5 percent to improve their competitive edge against Medigap plans by offering additional benefits or providing rebates to beneficiaries.

If through an outlier pool, Medicare would make additional payments to HMOs for a portion of the costs of high cost cases above a predetermined threshold. For example, if Medicare paid for 60 percent of the costs for cases that exceeded $61,000 in 1993, payments to HMOs would increase on average by 2.5 percent.

In addition to outlier payments, Medicare could provide rebates to beneficiaries enrolled in HMOs as a concrete sign of the support of the risk contract program. The rebate could equal 30 percent of the Part B premium.

A second general approach to strengthen the current program will be through reform of the current AAPCC payment methodology. Although the AAPCC methodology is accurate in predicting the costs for an HMO's total enrollment, its predictive power in regard to individual enrollees is extremely low.

Even though enrollment in risk plans as a percent of total Medicare enrollment is low, in some counties enrollment is greater than 25 percent. Over the past few years the increases in the AAPCCs for these counties has lagged behind the national average increase (USPCC). For example, while the national average increase in rates for the past three years was 22.6 percent, in one county with 34 percent enrollment the increase was 15.5 percent. In another county with 27 percent enrollment the AAPCC actually decreased over the past three years. Several options are available, such as

- Break the Link with Fee-for-Service in High Penetration Areas -- Recompute rates for high penetration areas based on the growth in the USPCC rather than changes in the geographic factor. Use the change in the USPCC to update rates in subsequent years. This change would provide a somewhat higher rate for the approximately dozen high penetration counties.

- Experiment with Competitive Bidding To Establish Payment Rates -- The premium contribution for beneficiaries in a defined market area could be set equal to the lowest price for the Medicare benefit package submitted by a qualified plan. The contribution could be adjusted by risk-specific categories.

  Under one variation, a negotiated price, in the first year of a multi-year contract, could be above AAPCC level as long as the rate moves toward the AAPCC rate over the course of the contract through reduced updates.

A third general approach will be to increase flexibility of HMO option. HMOs with risk contracts currently cannot deal exclusively with employer groups but must be open to all enrollees in their services area. HMOs cannot currently enter into multi-year contracts with Medicare with fixed rates for the term of the contract. Instead, they are limited to contracting on a year-to-year basis. Under this approach:

- Establish a new risk contracting option that allows for provision of coordinated care services to Medicare group retirees only. If a group is 1,000 or more, payment to the plan could be either the current HMO payment rate, or an experience rate based on the projected health care utilization of the specific Medicare group retirees enrolled. The proposal would eliminate problems under current law which deter employers from offering an HMO option to their Medicare-eligible retirees.

- Establish a multi-year based contracting option, for up to three years. Each year

AAPCC projections would be developed for the subsequent two years. Plans exercising the multi-year option could lock-in these rates rather than the AAPCCs applicable for one-year contracts. A long-term contract with stable rates would constitute a commitment on the part of Medicare and the HMO to the risk contract program.

- Permit HMOs/CMPs to conduct continuous open enrollment exclusively for new beneficiaries. As a result of this proposal, more newly entitled beneficiaries would have a coordinated care option available to them upon enrollment.

- Develop Market Specific Comparative Material on HMOs and Medigap. Each year HCFA would produce a comparative guide, by MSA, of coordinated care options available to beneficiaries. Such a guide would show additional benefits provided and premiums charged, by plan. To make beneficiaries aware of the price value of the coordinated care options, premiums for Medigap plans with comparable benefits would also be displayed.

A fourth general approach to strengthen the existing HMO program would be to refine the current AAPCC payment methodology. Plans argue that the payment rates are slightly depressed because of the treatment of Medicare beneficiaries for whom Medicare is the secondary payor -- working aged. Another payment issue is the lack of a health status adjustor. Experience with what was believed to be the most promising adjustor (DCGs) indicated that it further exacerbated the current problems with favorable selection rather than improving the accuracy of payment. Research and analysis is already underway to address both of these issues within the next 2-3 years.

A fifth general approach is to reform cost contract options. In addition to the risk contract option, coordinated care plans currently have two cost-based options under Medicare. There is a cost contract option for which plans have to meet many of the same requirements as for a risk contract. Under a second cost option, plans can enter into agreements to become Health Care Prepayment Plans (HCPPs). Neither of these cost options provide incentives for the efficient delivery of care, however, and would be phased out over the next 5 to 10 years. Currently, these plans do contribute to the program as additional choice to alternative delivery organizations for Medicare beneficiaries.

A sixth and final approach to strengthen the existing HMO program is to strengthen oversight of the HMO program. The President's Plan will expand sanction authority against plans that (i) engage in prohibited marketing practices, (ii) distribute marketing material without obtaining the required prior approval, or (iii) do not cooperate with quality review.

Anti-Coordinated Care Laws

Currently, many State-based laws and regulations discourage greater use of coordinated care arrangements. Examples of these barriers include restrictions on reimbursement rates, restrictions on selective contracting for providers and services, restrictions against certain financial incentives arrangements, and utilization review activity. The President's plan would eliminate anti-coordinated care laws and regulations.

Second, Federal waivers are currently applied to demonstrating and evaluating new coordinated care approaches, in effect designating them as exceptions to mainstream health care policies and practices. Under the President's Plan, these waivers of exception would be "flipped." States would have to apply for exceptions to coordinated care policies instead.

Chapter 5.C

Effects of Consumer Information

(Suggested Alternative Title:
Providing Comparative Value Information for Health Purchasing)

Background

Providing useful information for purchasing health care is a critical element for a pro-competition health reform strategy. Informed consumer choices should guide the delivery of medical care. In a market of coordinated care organizations, consumer choice could be exercised through selection of a health plan in which to enroll. With traditional fee-for-service coverage, consumer choice would be exercised through decisions about providers and procedures.

People now routinely make many decisions about insurance coverage and medical care. Strengthening competition through the tax credit and through health market reforms will encourage more direct comparisons with costs and outcomes -- that is, assessing the value of their health care dollar.

Currently, meaningful information about comparative costs and outcomes is not routinely available to consumers. Consequently, consumers are unable to assess the value of their health care dollars by making comparisons of costs and outcomes across health care providers and health plans. This lack of consumer information has potentially harmful effects on consumers and the Nation. Anecdotal information is unreliable. Even surgical mortality rates can be misleading without adjustments to reflect differences in the severity of illness.

As a result, consumers and purchasers of care do not know what they are buying. In the absence of information, consumers are apt to rely on higher price or more intensive service delivery as proxies for quality. Thus, limited consumer information can insulate providers from competition and can lead to excessive prices and inefficient delivery of care.

Wider availability of cost and outcomes information will strengthen incentives for efficiency, especially coupled with changes in government subsidies for insurance. Health plans that demonstrate equivalent (or superior outcomes) at lower premium cost would gain a competitive edge. Similarly, people want to know, for example, if Hospital A provides better care than Hospital B and would choose accordingly, if they could. Because consumers tend to mistake higher cost or more intensive service delivery as proxies for better quality, service utilization -- and costs -- could be cut appreciably with no deterioration if consumer choices were guided by valid cost and quality information.

Through concerted public/private sector action, it should be possible to

implement information systems that would enable health care purchasers to make meaningful comparisons of cost and quality between health plans and health providers. The long-run potential to control costs while improving quality is substantial. Even a minority of well-informed consumers can influence other consumers and the direction of the market (Pauly, 1978). With better information, health plans that limit cost-increasing technologies could pass the savings on to purchasers. Cost-increasing technologies would be adopted only if consumers believe that the resulting improvement in health outweighs the added cost.

Comparative value information can change consumer decision making. For example, *Washington Consumers' Checkbook*, a magazine published by a nonprofit organization, illustrates that consumer's use of information changes market behavior. Since 1979, *Washington Consumers' Checkbook* has prepared an annual guide to Federal plans in the Washington, D.C. area. The guide compares plan benefits, special features such as dental coverage or customer service, eligibility, premiums, and out-of-pocket costs, and draws conclusions. The results of the comparisons have influenced market share each open season. For example, during the 1980 enrollment period, a plan that was ranked highly in terms of benefits relative to costs increased its Washington D.C. enrollment by 120 percent, compared with less than 20 percent nationally.

More sophisticated prototype systems for comparing costs and quality are available as well. To encourage greater employee support for selective contracting and to provide hospitals with stronger incentives to improve quality while controlling costs, a group of major employers in Cleveland, Ohio is sponsoring the Cleveland Health Quality Choice (CHQC) project. CHQC is developing a state-of-the-art system for measuring and comparing the quality of care in Cleveland-area hospitals. The system will include a survey to measure perceptions of quality from the patient's standpoint and a system for measuring quality from a clinical standpoint. Patient outcomes (e.g., death and complications) in hospital intensive care units and for selected medical and surgical admissions will be monitored with detailed clinical adjustments to account for differences in severity of illness.

CHQC hopes to be producing quality reports on a routine basis starting in 1992. CHQC expects that participating employers would use this information to guide their health purchasing decisions. Employers would share this information with their employees to encourage use of the selected providers. While it will be several years before the full impact of the program can be assessed and the Cleveland group must overcome many hurdles, use of outcomes data to compare quality appears to be just a matter of time.

Other systems for measuring outcomes have been developed as well. A consortium of HMOs is working with leading researchers from RAND corporation to develop indicators of quality that could guide consumers in selecting between competing HMOs. The MedisGroups system is routinely used by over 500 hospitals nationwide to monitor quality. And, the Health Care Financing Administration will

begin to implement the Uniform Clinical Data Set (UCDS) system to monitor the quality of hospital care provided to Medicare patients in the Nation's hospitals.

Proposal

Under the Administration's proposal, each State would implement programs to help make comparative value information more readily available for health care purchasers. This initiative would be included as part of the health insurance market reform proposal.

States could develop information systems directly or could delegate this responsibility to private sector groups. States could give preference to local health care purchasing coalitions, such as the Cleveland Quality Health Choice coalition.

Within one year of enactment, states would develop and make broadly available "blue book"-type information with information regarding average prices and costs for common health care services. Information could include mean and median price and a measure of the variability across and within market areas. This information could be especially useful for large purchasers of care for preferred provider arrangements and negotiated discounts. Sufficiently discrete definitions (e.g., CPT-4 codes) of a broad range of representative services could be developed to permit meaningful comparisons.

Within five years, states would develop systems to provide comparative quality and outcomes data for health care purchasers and for consumers choosing health plans and hospitals.

The Federal government would implement these information systems directly in the case of inaction by the state and would charge a user fee to defray the cost.

The Secretary of the Department of Health and Human Services would develop prototype systems, such as Medicare's Uniform Clinical Data Set (UCDS), to facilitate data gathering and comparisons of outcomes. There would be an emphasis on experimentation to test different methods for gathering and analyzing outcomes and quality information. HHS would fund evaluations to determine the most cost effective methods (e.g., those methods that yield the greatest useful information at lowest cost).

When appropriate, national standards could be established to facilitate uniform data gathering that would facilitate analysis and comparisons across the Nation.

Section 5.D

Personal Responsibility and Prevention

Personal Responsibility

Effective reform of the U.S. health care system can neither be sufficient nor complete until there are basic changes in how Americans view responsibility for their own lives. Individuals must choose, for example, to improve eating habits and increase exercise; to reduce consumption of alcohol and tobacco; to end substance abuse; avoid the high risk behavior that spreads HIV; seek the necessary medical examinations and vaccinations; seek early prenatal care; wear seat belts and take other necessary precautions; and learn to resolve conflicts without resort to violence. Personal decisions about how to live may have the most important effect on the Nation's health and the cost of caring.

About half of the 2.2 million deaths which occur in the U.S. every year are potentially preventable, as are many of the illnesses that afflict millions of Americans. Many of these factors involve freely-made individual choices. Better control of fewer than 10 factors -- such as diet, prenatal care, exercise, the use of tobacco, alcohol and illegal drugs, and the use of seat belts -- could prevent between 40 and 70 percent of all premature deaths, a third of all cases of acute disability, and two-thirds of all cases of chronic disability. Since the preservation of individual choice is a cornerstone of American democracy, disease and injury prevention must become individual as well as national priorities. In this, the Nation will have created a "culture of character," which actively promotes responsible behavior and the adoption of lifestyles that are conducive to good health.

Benefits of Taking Responsibility for Health. Personal behavior can have a dramatic effect on quality and length of life.

JAMA Chart

Public and private efforts to promote healthy behavior have already achieved fairly dramatic results:

Smoking. The Nation has witnessed the effects of changes in behavior across society as the incidence of one of the leading contributors to preventable deaths, smoking, has declined from 40 percent in adults in 1965 to 28 percent in 1990. This dramatic behavior change was brought about through a combination of actions by individuals, private industry, health providers, and all levels of government.

Traffic Accidents. Increased use of safety belts, declines in drunk driving, and better vehicle crashworthiness have cut the traffic fatality rate by 50 percent since 1973. If the traffic fatality rate had remained at the 1973 level, an additional 40,000 lives would have been lost in 1991 alone.

One of the most important factors in reducing the traffic fatality rate has been the growing use of seat belts and child safety seats. As shown in the accompanying chart, simply accepting the personal responsibility for using these safety devices has saved many lives. As people increase their use of seat belts, child safety seats, and air bags, the Nation will see more lives saved every year. Air bags will be installed in an estimated 90 percent of all new cars sold in the United States by 1995.

Heart Disease and Stroke. During the 1980s, death rates declined for two of the leading causes of death among Americans: heart disease and stroke. Much of this progress is attributable to changes in behavior. The more than 40 percent decline in heart disease mortality since 1970 reflects dramatic increases in high blood pressure detection and control, the decline in cigarette smoking, and increasing awareness of the role of blood cholesterol and dietary fat. Stroke death rates, which have dropped by more than 50 percent in the same period, also reflect gains in hypertension control and reductions in smoking.

Investing in Prevention

Prevention is an important addition to increased emphasis on personal responsibility. Preventive practices are, by and large, simple, inexpensive and effective. Prevention makes sense for a number of reasons. Many preventive interventions are proven to be cost effective. And prevention is a good investment for the market place, resulting in fewer productive days lost and in reduced morbidity and cost to the health care system.

Costs of Preventable Health Problems. There is ample research estimating the costs of illness and disability, in terms of diminished life, productivity foregone, and money spent treating illness and disability. These costs are particularly sobering when the illness or condition could have been prevented.

Health Problem	Years of life lost	Costs (millions of dollars)
cardiovascular disease	15,000,000	135,000 (1985 $)

alcohol abuse	3,140,178	7,672 (1980 $)
smoking	534,870	4,509 (1980 $)
high blood pressure	319,499	6,289 (1980 $)
cholesterol	159,333	7,655 (1980 $)
glucose intolerance (diabetes mellitus)	133,627	5,239 (1980 $)
cancer	18,000,000	72,000 (1985 $)
injury	2,300,000	180,000 (1988 $)

Prevention is Cost Effective. In 1987, primary prevention and health promotion accounted for less than 5 percent of overall health care spending, yet there is mounting evidence that prevention is cost-effective.

Preventive activity	Savings per dollar spent	Total savings per year (in millions)
immunization		
measles,mumps,rubella	14.40	- -
polio	10.00	400 (1990 $)
Hib	-	
prenatal care	3.40	
breast cancer screening (30% women age 65-74)	-	3,538 (2020 $)
hypertension screening	-	80,000 (1986 $)

Note: "-" means not available

Investing in Our Economic Future. Disease prevention presents the opportunity to dramatically cut health care costs, prevent the premature onset of disease and disability, and help all Americans achieve healthier, more productive lives. Although the emphasis on prevention has led to overall health improvements, the U.S. is still burdened by preventable illness, injury, and disability. Injury now costs the U.S. well over $100 billion annually; cancer, over $70 billion; and cardiovascular disease, $135 billion.

Prevention presents the opportunity to dramatically cut health care costs, prevent the premature onset of disease and disability, and help all Americans achieve healthier, more productive lives.

Disease or condition	Preventable Risk Factors	Lives Lost (1988)
heart disease	tobacco use, obesity, elevated blood pressure, elevated cholesterol, sedentary lifestyle	765,156
cancer	tobacco use, improper diet, alcohol abuse, environmental exposures	485,048
cerebrovascular disease	tobacco use, elevated blood pressure, elevated cholesterol, sedentary lifestyle	150,517
unintentional injuries	safety belt nonuse, alcohol abuse, home hazards	97,100
chronic lung disease	tobacco use, environmental exposures	82,853

Directions for Prevention. In recognition of the clear advantages of aggressive prevention activities, the government is supporting and enhancing prevention programs with known benefit, and, through demonstrations, testing interventions for their efficacy and efficiency. The Federal government spent over $8 billion for prevention in FY 1992. This will rise to nearly $9 billion in FY 1993. These programs fall into the following basic categories:

- Childhood Immunizations. Childhood immunizations are among the most cost-effective prevention activities. A $1 investment in Measles-Mumps-Rubella (MMR) vaccine may return $14 in averted medical care costs. Other routinely administered vaccines such as Diphtheria-Tetanus-Pertussis (DTP) and Oral Polio are reported to have similarly high rates of return. Through coordinated efforts at all levels of government and the private sector, the Nation has achieved a 98 percent immunization rate for children entering school.

  The President's initiative will increase Federal support for Centers for Disease Control (CDC) childhood immunization activities by $52 million. CDC will use this increased investment to target more of its efforts toward raising

immunization levels in inner cities and other areas where the expected health returns on these activities are certain to be high.

- Healthy Start/Infant Mortality Prevention. The Nation's infant mortality rate continues to decline, having reached its lowest level ever (9.1 deaths per 1,000 live births) in 1990. But while the overall infant mortality rate continues to decline, mortality for African-American infants remains twice that for white infants -- demonstrating the need for more intensely targeted assistance.

  However, additional investment in prenatal care and nutritional assistance targeted to low-income women continues to yield high returns. Overall, nearly 25 percent of all women and nearly 40 percent of African-American and Hispanic women do not begin prenatal care during their first trimester of pregnancy, the most crucial time for prenatal care. One study has indicated that investment in prenatal care can yield significant returns: each dollar invested in prenatal care for high-risk women might save $3 in treatment costs.

  The President's initiative proposes over $9.3 billion for all Federal activities to reduce infant mortality, including $143 million for Healthy Start, an important program that targets Federal resources to 15 areas with exceptionally high rates of infant mortality.

- Women, Infants, and Children Nutrition Assistance (WIC). The proposal continues the President's strong commitment to WIC with the largest one-year increase ever proposed for the program, $240 million (9 percent), for a total of $2.84 billion -- sufficient funds for full participation by eligible pregnant women and infants. A recent evaluation of the Special Supplemental Food Program for Women, Infants, and Children (WIC) found that for each dollar spent on nutritionally at-risk pregnant women and infants, Medicaid spending fell by between $1.92 and $4.21 during the first 60 days after birth.

- Head Start/Early Childhood Development. Additional investment in early childhood education programs such as Head Start continues to produce significant returns. Head Start provides a range of comprehensive early childhood development services, including education, nutrition, health and other social services. Several studies indicate that children who enroll in Head Start experience immediate gains in cognitive growth, social development, and health status. One study even suggests that for every dollar invested, Head Start may

eventually save $6 in averted costs associated with special education, crime, and income support.

The President's initiative contains the largest single-year funding increase in the history of Head Start, proposing an additional $600 million for a total of $2.8 billion. With the Administration's proposal, Head Start will serve an estimated 157,206 more children in 1993. This unprecedented increase in Head Start supports participation of all eligible and interested disadvantaged children for one year, complementing the 36 States (plus the District of Columbia) which also support pre-school programs.

The President's initiative also proposes $850 million for the child care and development block grant, which was part of the child care legislation that the President proposed and subsequently signed in 1990. Funds from this block grant provide low-income families with vouchers they can use with the child care provider of their choice, and provide additional early childhood development services for pre-school age children.

The proposal further includes $6 million for a new initiative in HHS to use local schools as a way to bring primary health care services to children from low-income families who might not already have access to these services. These "Ready to Learn" grants will enable community health centers and local schools in selected low-income communities to provide health outreach services through local schools.

- Access to Primary Health Care/Expanding Community Health Centers. Comprehensive primary health care services include diagnosis and treatment as well as education designed to encourage healthy behavior. Continued investment in improving access to primary health care is important to many communities and can yield sizable returns. There is evidence that increased access in low-income communities can improve overall health status and reduce the use of emergency services.

To put primary health care services within the reach of people who do not currently have adequate access, the 1993 initiative includes an additional $1.3 billion for programs supporting primary and preventive health care.

The initiative also contains $120 million for the National Health Service Corps (NHSC). This 19 percent increase will enable the NHSC to expand the program and train additional physicians to provide health services in low income and

underserved areas, increasing the availability of primary case -- particularly in low-income underserved areas. NHSC will augment over a 100 health professions training programs administered by the States and non-profit organizations.

- Breast and Cervical Cancer. Despite increasing Federal investment in breast and cervical cancer screening, NIH predicts that over 45,000 women are expected to die from these two diseases in 1993. Unless medical research can produce a treatment to prevent these conditions, the key to successful treatment of breast and cervical cancer remains early detection. The earlier these diseases are discovered, the sooner treatment can begin and the greater the chance of survival.

  Screening for breast and cervical cancer has been increasingly effective at preventing mortality, and the Federal investment has risen to enable more women to benefit from such preventive measures. Over the past 15 years, the incidence of invasive cervical cancer among women age 65 and older has dropped at an estimated annual rate of about 4 percent, due largely to the increased use of pap smears. While breast cancer remains a leading cause of death, the use of mammography for early detection is the best current hope for preventing breast cancer deaths.

  The President's initiative will invest $515 million for screening through the Medicare program and through the Public Health Service. This investment will focus resources on screening low-income, high-risk women in age groups for which screening is recommended.

- HIV/AIDS Funding. Under the President's initiative, total Federal HIV/AIDS funding increases by 13 percent to $4.9 billion.

- Smoking Cessation. According to a report of the Surgeon General, continued investment in smoking cessation, particularly if targeted towards pregnant women, is likely to yield beneficial returns. Smoking during pregnancy retards fetal growth, reduces birthweight, and doubles the risk of having a low-birthweight baby. Studies have shown a 25-50 percent higher rate of fetal and infant deaths among women who smoke during pregnancy compared with those who do not. One study even suggests that each dollar invested in smoking cessation for pregnant women may yield about $6 in averted costs for

neonatal intensive care and extended care for low-birthweight infants. Beyond the damage tobacco use during pregnancy may cause, smoking is also a factor in the deaths of over 400,000 Americans every single year.

The President's initiative increases support of smoking cessation by 5 percent over 1992 levels. Included in this increase is an additional $3 million for the CDC Office on Smoking and Health, enabling CDC to expand its smoking cessation education activities for specific at-risk populations, including minority and low-income pregnant women.

- Lead Poisoning Prevention. Lead poisoning is the most common environmental disease of young children, disproportionately affecting poor, minority children in the inner cities. Yet childhood lead poisoning may be preventable through detection and abatement. This initiative includes $40 million for CDC Lead Poisoning Prevention Grants which support about 30 state-wide lead poisoning screening programs. CDC grants allow States to identify low-income children at risk of lead poisoning and refer those with high blood lead levels for medical treatment.

  In addition to the CDC grant program, the Department of Housing and Urban Development (HUD) will continue assisting low- and moderate-income private residential property owners abate lead-based paint by providing grants to States and localities. HUD's public housing modernization program will continue to be the main source of funding for lead-based paint testing and abatement activity in public housing. It is estimated that approximately $50 million will be spent on these activities in 1993.

- Injury Prevention. Preventing injury through encouraging increased personal responsibility can also save lives. For example, every one percent increase in seat belt use saves more than 160 lives per year. If the U.S. were to increase the national average of seat belt use from the 1990 rate of 48 percent to the Administration's goal of 70 percent by the end of 1992, 3,800 lives could be saved annually and 100,000 injuries could be prevented -- yielding potential economic benefits of $2.5 billion.

  The initiative increases funding for injury prevention to almost $2 billion, a 9 percent increase over 1992. These funds will be used primarily within the Department of Transportation (DOT) for aviation, rail, highway, marine, and pipeline and hazardous material transportation safety. An estimated 50,000 lives

are lost annually in incidents in the transportation sector. DOT will use these funds for safety inspection and enforcement, research and development, and education programs -- all aimed at reducing accidents in the transportation sector. The initiative also includes increased emphasis on reducing drunk driving and increasing occupant protection.

- Family Planning. Studies suggest that investments in family planning may also yield high returns. Some studies attribute reductions in infant mortality achieved over the last 20 years in part to effective family planning. Recognizing the importance of these services, the President's initiative contains an additional $37 million for HHS family planning grants and Federal Medicaid payments, an increase of 8 percent.

- Physical Fitness and Diet. Studies show that regular physical activity can help prevent or manage coronary heart disease, hypertension, non-insulin dependent diabetes, osteoporosis, and obesity. People who are active have lower rates of colon cancer and stroke, as well as fewer back injuries. Moreover, changes in diet have been shown to reduce the risk of cardiovascular disease and stroke.

  The initiative increases funding for health education, disease prevention, and physical fitness activities. It also focuses on bringing health promotion and disease prevention activities to older Americans. The Administration on Aging will provide more health risk assessments, nutritional counseling, group exercise programs and other health promotion activities. These activities might improve the health and quality of life of older Americans and allow many older people to receive these services regularly.

- Tuberculosis Control. For years, the Nation has been making great strides toward eliminating tuberculosis (TB). The disease has been curable and preventable for almost four decades. The long-term decline in TB morbidity enjoyed by the United States ended in 1984. TB cases in the U.S. have been increasing since 1985.

  TB diagnosis and treatment could be an effective health intervention and the Administration is determined to stem the recent growth of TB levels by attacking the recent outbreak of this preventable disease head on. Therefore, the initiative includes a 106 percent increase over 1992 for CDC Tuberculosis Control Grants.

In summary, to confront the problems of access to health care and the continued escalation in health care costs, efforts are underway to address the problems of the uninsured and the underinsured and to tackle the country's growing health care expenditures. No matter what path is ultimately chosen, it is clear that prevention will play a critical role in the future health of Americans. It is also apparent that prevention can only be accomplished in partnership among individuals, the business community, and government.

5.D: REFORMING THE MEDICAID PROGRAM

Overview

The President's reform proposal would dramatically modernize the twenty-six year old Medicaid program.

- **Medicaid recipients will benefit from enhanced access and improved quality through coordinated care plans.**

- **States will have new flexibility to take advantage of innovation, program efficiencies, and better methods for cost control.**

- **Significant savings will be achieved that will help fund expanded insurance coverage for an additional xx million low and modest income Americans through the new health tax credit (HTC) system (see chapter xx).**

Medicaid currently provides health insurance coverage for xx million low-income Americans. Recently, Medicaid also has become a vehicle for funding "uncompensated care" provided by disproportionate share hospitals (DSH) -- hospitals that have high charity care caseloads.

Medicaid has been widely criticized as providing fragmented, episodic, and often substandard care. Moreover the program is viewed as wasteful and inefficient. These problems stem primarily from continued reliance on an outdated fee-for-service delivery system. In addition, the program is overly rigid and bureaucratic.

Under the proposal, Medicaid would be restructured to rely primarily on delivery of health care through coordinated care systems. Moroever, states would have new flexibilty to respond to local needs and concerns. States would have the option of choosing between two broad approaches.

- A state could maintain existing Medicaid eligibility and benefit levels while shifting enrollment into coordinated care programs. Under this approach, the new tax credit system would operate seperately from the existing Medicaid program, though states would play an important role in administering the tax credit system.

- Alternatively, a state could combine its existing Medicaid programs with the new health tax credit (HTC) system to develop a new universal access program covering all state residents with incomes below poverty. Under this approach, a state could operate a single public insurance program or could provide credits for purchase of private coverage.

Coincident with these reforms, Federal funding for acute care for the non-elderly (excluding DSH payments) would shifted from an open-ended draw on the Treasury to a flat per capita grant to the states. This would provide states with new incentives to maximize program efficiencies. Overall, the reforms would improve quality and access for program recipients while freeing up funds to expand access for other low income individuals and families through the new tax credit system.

Summary of Current Law Versus Administration's Proposal

Current Law							
($ in billions, Federal Share)	1992	1993	1994	1995	1996	1997	93-97
Total Medicaid	72.5	84.5	98.3	113.8	131.2	150.9	578.7
Percent Increase	–	16.6%	16.3%	15.8%	15.3%	15.0%	15.8%
Acute Care (including DSH)	31.0	36.5	42.9	50.2	58.5	67.9	255.9
Percent Increase	–	17.7%	17.5%	17.0%	16.5%	16.1%	17.0%
Long-Term Care & Dual-Eligibles	38.9	45.0	52.0	59.8	68.5	78.2	303.7
Administration	2.6	3.0	3.4	3.8	4.2	4.8	19.1

Impact of Reform Proposal							
($ in billions, Federal Share)	1992	1993	1994	1995	1996	1997	93-97
Total Medicaid	72.5	83.3	94.9	107.1	120.3	134.5	540.0
Percent Increase	–	14.9%	13.9%	12.9%	12.3%	11.8%	13.2%
Acute Care	31.0	35.3	39.5	43.6	47.7	51.7	217.7
Percent Increase	–	14.5%	11.9%	10.4%	9.4%	8.4%	10.8%
Long-Term Care & Dual-Eligibles	38.9	45.0	52.0	59.8	68.5	78.2	303.7
Administration	2.6	3.0	3.4	3.7	4.1	4.6	18.6

As these charts show, there are three main components to Medicaid program costs: (1) acute care for the non-elderly, (2) long-term care and services to "dual eligibles" (those eligible for both Medicare and Medicaid), and (3) program administration. The President's reform proposal is directed at the acute care portion only, excluding DSH. Currently, the projected annual rate of growth for acute care is 17.0 percent compared with 10.8 percent under the proposal.

Background

Medicaid is a joint Federal/State program designed to meet the health insurance needs of certain low-income individuals. States set most program rules within broad Federal guidelines, determine beneficiary eligibility, and pay provider claims.

In general, Medicaid eligibility is linked to other cash assistance programs such as Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). In recent years, mandatory eligibility has been extended to certain groups with incomes above the cash welfare program standards (for example, poor and near poor pregnant women and children). Optional coverage extends to certain other groups, such as the "medically needy," whose illnesses force them to "spend-down" to meet Medicaid eligibility criteria.

Current Medicaid eligibility requirements leave many poor without coverage. Certain categories of persons cannot qualify for Medicaid under current rules, no matter how poor or how sick they are (non-disabled single adults and childless couples, for example). Only about 50 percent of the poor are covered by Medicaid. Another 20 percent have other insurance. Thirty percent, therefore, are without insurance.

Most Medicaid recipients receive health care through traditional fee-for-service arrangements. Physicians, hospitals, and other providers are paid on the basis of itemized bills for the services they render. As a result, they have strong incentives to provide additional services regardless of benefit. Moreover, providers are not paid on the basis of outcomes: no is paid to keep patients in good health. Nor is there anyone responsible for coordinating services to avoid duplication and to improve quality. As a result of this mismatch of incentives and responsibilities:

- The care many Medicaid patients receive is often fragmented -- too little, too much, inappropriate, or too late;

- Too many recipients use hospital emergency rooms as their primary entry point to the medical care system, often for non-emergency conditions; and

- Too many people are deterred from seeking treatment in the early stages of a medical condition. Receiving treatment in the later stages often leads to hospitalization that could have been avoided.

The Medicaid program also has been under stress due to recently enacted service and eligibility mandates, increased caseloads, court mandated payment levesl, and overall health care inflation. As a result of these forces, Medicaid is the fastest rising portion of both Federal and State budgets.

In 1992, combined Federal/State spending on Medicaid will surpass $127 billion, up from $62.5 billion in 1989 -- a 103 percent increase. The Federal contribution, based on State per capita income ranging from 50-83 percent of program expenses, will exceed $72.5 billion, or a 114 percent increase since 1989.

[insert graph showing Medicaid program cost growth]

While the current program clearly is in crisis, successful experience with coordinated care programs show that responsible reforms can improve the health care available to the disadvantaged while moderating cost growth. Two examples underscore this point:

- A Detroit-based health maintenance organization (HMO), Comprehensive Health Services, provides care for the 60,000 Medicaid recipients and has saved the Medicaid program at least $6.9 million in 1990. These savings are due to a reduction in unnecessary hospitalizations and increased attention to preventative care, particularly for high risk pregnant women and infants.

- Under Kentucky's Primary Care Case Management (PCCM) program, each Medicaid recipient has a primary care physician responsible for providing or authorizing all non-emergency care care. By emphasizing primary and preventative care through a single physician, cost and quality problems associated with overuse of emergency rooms and duplication of medications or tests have been avoided. As a result, the Kentucky program has reduced infant mortality rates and has achieved savings of $25 million a year, or approximately 10 percent of program costs.

While programs of this type holds promise, only xx million Medicaid recipeients receive care through coordinated care programs: 1.4 million receive care through HMOs and other prepaid health plans, while an additional 1 million receive care through PCCM programs. The remaining xx million (xx%) continue to receive care through fee-for-service systems. In contrast, xx% of workers and dependents with employment-based private insurance are covered through coordinated care plans, and this percentage continues to grow rapidly (see chart xx, chapter xx).

The comparatively small share of Medicaid recipients covered under coordinated care plans reflects a number of factors. Most importantly, under current law, states must go through a complex waiver process to secure Federal approval to establish coordinated care programs. Waiver requirements are overly rigid and block a number of initiatives that would be routine in the private sector. Moreover, state Medicaid programs are subject to political resistance from entrenched interests has, a factor that is not significant in the private sector.

It is important to note that Medicaid also has become a vehicle for funding "uncompensated" or "charity" care provided by hospitals to individuals without Medicaid or other insurance coverage. Under recently enacted legislation, states will be able to provide higher Medicaid payments to "disproportionate share hospitals" (DSH) that provide care to a disproportionate amount of uncompensated care to uninsured patients. Over the next five years, the Federal government will provide $75.5 billion in DSH payments.

While this is a reasonable stop-gap approach, it has two disadvantages when compared with a direct expansion of insurance coverage. First, there is no assurance that DSH payments are used exclusively for patient care. More importantly, DSH payments for inpatient hospital care fails to provide access to ambulatory care and primary and preventative services that could avert the need for a disabling illness and costly hospital care.

Proposal

Scope.– The proposal focuses reform on acute care Medicaid for the non-elderly. Long-term care and acute care programs under Medicaid for seniors, including Medicare/Medicaid dual eligibles and qualified Medicare beneficiaries, would remain unchanged. Disproportionate share hospital (DSH) payments also would remain unchanged.

Financing.– Federal financial participation for acute care (excluding DSH) would be shifted from open-ended cost-based reimbursement to a prospectively determined per capita payment. This change would provide important incentives for program efficiency. The resulting savings reflect the potential for significant improvements in efficiency through either of the two major reform options that the states would have under the proposal.

The per capita payment would be state-specific, based on total per capita costs for the acute care portion of Medicaid in a state in 1992. Acute care costs related to Medicare recipients would be excluded from this calculation as would DSH payments. The state's 1992 per capita cost would then be indexed for general inflation, using the percent increase in the consumer price index for urban areas (CPI-U) plus 6 percent for 1993, 5 percent for 1994, 4 percent for 1995, 3 percent for 1996 and 2 percent for 1997 and future years. This add-on to the CPI-U accounts for additional amount for medical cost inflation.

From 1960 to 1990, per capita health care costs in the United States increased by about 4 percent a year faster than the CPI-U. Thus, the add-on of 2 percent for 1997 and future years assumes that the reforms could moderate the historical rate of health care cost growth by about a half. Savings of this magnitude should be possible through coordinated care and increased flexibility for state programs. The phase-in from CPI-U plus 6 percent in 1993 to CPI-U plus 2 percent in 1997 provides time for states to take advantage of the new programmatic flexibility provided.

Actual Federal payments to a state would equal the product of the total number of Medicaid recipients in the state times the inflation indexed state per capita acute care costs times the Federal Matching Assistance Percentage (FMAP). The FMAP formula would remain unchanged from current law and is intended to reflect a state's relative need for Federal assistance.[1] Different per capita payment amounts could be used for different age-sex or other groupings to adjust for changes in the population covered by a state program over the years.

Although the proposal does not affect DSH payments directly, the need for DSH payments could decrease dramatically. With a projected increase in insurance coverage of xx million Americans resulting from tax credits and other reforms, there would be fewer uninsured patients, hence less need to assist hospitals with "charity" care costs. Thus, additional funds could be available to further expand the credits. Alternatively, the payment formula could be revised to include DSH payments within the Federal per capita payment while still yielding the same aggregate savings as those proposed.

State Option 1 - Separate Medicaid and Tax Credit Programs.-- As noted above, states would have two broad options regarding reform of their Medicaid programs for acute care services provided to the non-elderly. Under the first option, states would be required to shift all non-elderly Medicaid recipients into coordinated care programs, over a five year period. Otherwise, program rules would remain substantially unchanged.

Coordinated care programs would include health maintenance organizations (HMOs), preferred provider organizations (PPOs), primary care case manager (PCCM) programs and other cost effective alternative delivery systems. Current restrictions that impede access to coordinated care plans under Medicaid would be relaxed. Because enrollment in coordinated care would be the norm, a state would need to apply for a Federal waiver to continue significant fee-for-service enrollment.

Eligibility rules would remain the same as under the current Medicaid program. States would be required to continue to cover all current mandatory

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[1] The Federal matching assistance percentage (FMAP) = 1.00 - .45 x [(state per capita income)/ (U.S. per capita income)]^2

eligibility groups under Medicaid, as well as any optional groups they covered as of January 1, 1992.

States would continue to provide mandatory Medicaid benefits. States currently provide optional Medicaid benefits would be able to adjust these benefits, but would be required to maintain the actuarial value of the total benefit package (e.g., an optional benefit could be dropped if another benefit of equivalent value is added). States also could modify the amount, duration, and scope of mandatory or optional benefits subject to a requirement that the actuarial value of the benefits be maintained. As under current law, providers would be required to accept Medicaid rates as payment-in-full with no signficant cost sharing or balance billing.

Under this option, states would be responsible for coordinating the certain aspects of the HTC program. As described more fully in chapter xx, the tax credit would be used for the purchase of private insurance coverage. States would certify eligibility for and the amount of the HTC for those who wish to obtain their tax credit prospectively.

States also would be required to define a "basic" benefit package with an actuarial value equal to the tax credit amount. And, states would be required to assure that at least two private health plans offer this basic plan to credit recipients within the state. Federal quality assurance programs would continue to assure proper program administration, e.g, proper eligibility determination for Medicaid and tax credit recipients and prevention of fraud and abuse.

State Option 2 - Unified Program.-- Under this option, states could establish a unified program that combines Medicaid with the new Federal HTC to provide health insurance coverage for all state residents with incomes below poverty. Coverage would be phased-in in tandem with the phase-in for the HTC.

States would have broad flexibility in establishing these programs. They could operate a unified public insurance program or establish a state health credit program to supplement Federal HTC payments. Any eligible individual or family could opt-out of the state's public insurance program to purchase private insurance. Those who opt out would receive the full amount of the Federal HTC that they would otherwise be eligible to receive plus a supplementary state credit equal to the value of any additional benefits the state might provide under the program.

States that operate a unified public insurance program for Medicaid and credit eligibles would provide uniform benefits for both groups. States that provide supplementary state health credits would provide uniform credits to all individuals and families varying only by income.

States that provide insurance directly would cover all Medicaid mandatory benefits and as well as prescription drugs. States would have flexibility to modify the amount, scope, and duration of benefits and could add or drop optional benefits

provided that the actuarial value of the benefit package is maintained when spread over all individuals who are eligible to participate in the program.

States that operate a unified health insurance credit program would be subject to a maintenance of effort requirement. The state's financial contribution would be set to equal the amount the state would have paid had it maintained a seperate Medicaid program, as under option 1.

To help finance these programs, states would receive a lump sum payment from the Federal government. This payment would equal the sum of Federal per capita payments for those who meet Medicaid eligibility requirements and HTC payments for those who are eligible for them. Payments would be based on estimates of the Medicaid and HTC eligible populations within the state. Estimates would be reflect base year eligibility rates updated to reflect changes in population and changes in unemployment and other factors likely to influence the size of the eligible population.

To the extent practical, states would no longer apply complex Medicaid eligiblity standards for the under 65 population. Eligibility would be based simply on individual or family income in relation to poverty. States would help to administer the Federal HTC and would assure availability of "basic" benefit coverage from at least two private health plans, as under option 1.

Chapter 5.H

ADMINISTRATIVE SAVINGS

Overview

Recent studies suggest that paperwork savings of $67 to $100 billion a year would be possible if the United States shifted to a Canadian-style national health insurance program. (GAO, 1991; Woolhandler and Himmelstein, 19xx) A critical review of available information by OMB indicates that potential savings are much lower, at most $31 to $49 billion. The OMB analysis also shows that these savings would be more than offset by an increase in benefit costs. (Darman, October, 1991)

Moreover, simple administrative cost comparisons are misleading because they fail to capture the value added by effective administrative measures. The United States spends over $xxx million a year on various quality assurance programs, measures that improve health care and reduce costly and potentially dangerous inappropriate care. And, as a recent study points out, delays in treatment under the Canadian system lead to "hidden" costs of up to 0.6 percent of GDP -- or more than $xx billion dollars a year if translated to the United States. (Danzon, 1991)

Nonetheless, significant administrative savings are possible while maintaining choice and diversity for our citizens. Moreover, paperwork burdens, hassles, and confusion associated with obtaining health care can be reduced. The reform proposal contains five initiatives to accomplish these goals:

- **Electronic billing using standardized formats will drastically reduce paperwork and reduce administrative costs by xx%, or $-- billion a year.**
- **Shifting from costly case-by-case medical review to pattern of care review will reduce the "hassle" factor for physicians, focus review efforts on problem areas, and improve quality.**
- **Use of electronic "smart" for billing and eligibility determinations will reduce paperwork and confusion for consumers at the point of service.**
- **Development of user-friendly computerized medical record systems will reduce paperwork burdens for providers while improving quality.**
- **Market reform will reduce administrative costs by xx%, or $-- billion a year by providing efficiencies of scale through group purchasing for small businesses and by eliminating medical underwriting costs.**

These reforms will bring the billing and record-keeping in our health care system into the twenty-first century, through a system-wide movement to automated and more

standardized billing, claims adjudication, eligibility determination, and clinical information.

Background

Health care overhead is a diverse category that embraces a wide range of activities including: claims processing costs for insurers, billing costs for providers, utilization review, quality assurance, maintenance of enrollment and eligibility records, premium collection, marketing costs, and profit. Public and private insurance and billing costs totalled almost $80 billion in 1991, or about 12.2% of total personal health spending. Insurance administration accounts for $43.6 while provider billing costs account for the remaining $36.2 billion.

Insurance Administration and Provider Billing Costs in the U.S., 1991 (Source: HCFA, OMB staff estimates)

	Cost in Billions of $	As % of Total Administration	As % of Total Personal Health Spending
Insurance Administration	$43.6	54.6%	6.7%
Hospital Billing Costs	$17.1	21.5%	2.6%
Physician Billing Costs	$10.4	13.0%	1.6%
Billing Costs for Other Providers	$8.7	10.9%	1.3%
Total Insurance and Billing Costs	$79.8	100.0%	12.2%

Of the total of $43.6 billion for insurance administration in 1991, $32.8 billion is for private insurance, $5.7 in Federal costs, and $5.0 billion in state and local costs. The bulk of this spending (77.5%) is for claims processing, quality assurance, and general administration. Marketing costs and profits total $6.0 billion while taxes paid by private insurers account for the remaining $3.7 billion.

Administrative Costs for Public and Private Insurance in the U.S., 1991 (Source: HCFA, HIAA, BCBS, OMB staff estimates; excludes billing costs for providers)

	Cost in Billions of $	As % of Total Insurance Administration	As % of Total Personal Health Spending
Total Public and Private Insurance Administrative Cost	43.62	100.00%	6.70%

Claims Processing , Quality Assurance and General Administration,(private and public)	33.82	77.54%	5.19%
Taxes Paid by Private Insurers	3.76	8.61%	0.58%
Marketing and Commissions	3.83	8.77%	0.59%
Profit	2.21	5.07%	0.34%

Insurance administration costs have increased from 5.3 percent of total personal health spending in 1965 to 6.7 percent in 1991. This change primarily reflects an increase in insurance coverage during the interval. Out-of-pocket spending, as a percent of total personal health spending, decreased from xx% in 1965 to xx% in 1991. With this decrease, administrative costs were bound to increase.

Private insurance administrative costs vary substantially with firm size as a percentage of benefit payments, ranging from up to 40% of benefit costs for very small firms to under 6% for very large firms. This disparity in costs reflects the fact that large businesses enjoy efficiencies of scale in the purchase and administration of insurance benefits. Risk premiums are lower for large groups coverage because benefit costs are much more predictable. Commissions for brokers also are higher for very small firms due to the retail nature of this segment of the market.

Health Insurance Overhead Cost as Percent of Benefit Payments(Source: CRS, 1989)

Firm Size	Claims Admin.	Gen. Admin.	Interest Credit	Risk & Profit	Commissions	Premium Taxes	Total
1 to 4	9.3	12.5	-1.5	8.5	8.4	2.8	40
5 to 9	8.6	11.2	-1.5	8.0	6.0	2.7	35
10 to 19	7.2	9.2	-1.5	7.5	5.0	2.6	30
20 to 49	6.3	7.6	-1.5	6.8	3.3	2.5	25
50 to 99	4.3	4.8	-1.5	6.0	2.0	2.4	18
100 to 499	4.1	4.0	-1.5	5.5	1.6	2.3	16
500 to 2,499	3.9	3.2	-1.5	3.5	0.7	2.2	12
2,500 to 9,999	3.8	1.4	-1.5	1.8	0.3	2.2	8
10,000 or more	3.0	0.7	-1.5	1.1	0.1	2.1	5.5

Proposal

Administrative costs could be cut by as much as xx% under four major reform initiatives. Three of the initiatives would streamline paperwork. The first three of these initiatives are already underway under the leadership of Secretary Louis Sullivan of the Department of Health and Human Services. These three paperwork reduction initiatives could reduce administrative costs by as much as xx% saving up to $xx billion a year. These initiatives would be complemented by reform of the small group market. As described more fully in Chapter xx, health insurance market reform could reduce administrative costs for small group coverage by as much as xx%, saving up to $xx billion a year.

Reducing Claims Processing and Billing Costs Through Standardization and Automation.– Voluntary standardization of claims forms can reduce billing costs and reduce provider billing costs to levels comparable to those that can be achieved under single payer systems. In December, 1990, the Health Care Financing Administration's HCFA-1500 claims form was finalized. This form -- which is used for physician and outpatient services -- was developed by the Uniform Claim Form Task Force, co-chaired by the American Medical Association and HCFA. Task Force participants included representatives of every major third payer. While use of the HCFA-1500 is voluntary, wide acceptance is expected. Similar efforts have led to near universal acceptance of the UB-82, as the standard form for inpatient hospital bills.

Substantial savings could also be achieved through electronic billing. HCFA is actively working with the private sector to develop technical standards to promote greater use of electronic billing. Currently, 75 percent of Medicare Part A and 42 percent of Part B claims are submitted electronically. Medicare costs are reduced by about $0.50 per claim with electronic submission. Electronic billing also reduces costs for providers and helps reduce clerical errors. Comparable savings can be achieved for private sector claims. HCFA has set 100 percent electronic submission for hospitals and 75 percent for others within three years.

The combination of electronic claims submission and standardization of the data elements required for claims will reduce provider cost and frustration. Providers submitting claims electronically will benefit from clearer adjudication of claims. Moreover, electronic systems will help avoid technical mistakes, such as missing one line on a form, that often delay payment.

Over the next several months, the Administration will study options for encouraging electronic claims submission. Secretary Sullivan has already initiated a public/private task force chaired by **[insert name and position]** to **[describe mission of task force]**. The task force is scheduled to make recommendations to the Secretary by **[insert date]**. One possible reform to encourage widespread use of electronic billing involves incentives for physicians and other providers to submit Medicare claims electronically (see chapter xx).

Streamlining Medical Review.-- A third area -- improving medical review -- can reduce the "hassle factor" for physicians while reducing costs for unnecessary care. The goal would be to shift away from claim-by-claim denials toward monitoring and encouragement of cost-effective practice patterns. Claim-by-claim review is burdensome and costly -- sometimes the cost of the review can exceed the potential savings.

HCFA has developed and is now testing the Uniform Clinical Data Set (UCDS) a new system that would permit a shift to pattern review for inpatient hospital care. The UCDS is a state-of-the-art system for abstracting critical medical information for hospital records. Once this information is abstracted and entered into a computerized system, "expert" system programs can identify patterns of care that suggest a systematic problem that might warrant further review and corrective action.

If the UCDS system proves to be successful in practice, it could serve as a model for use by private insurers. In a complementary effort, the Public Health Service is devoting $130 million in 1991-2 to outcomes research to increase information about what patterns of care are most effective in improving health outcomes and at what cost.

Developing Electronic "Smart" Cards.-- Secretary Sullivan has launched an initiative to accelerate development of electronic "smart" cards for use by consumers. **[Insert information on task force -- who is the chairman, what charge has been given, when is the report date]**

Electronic "smart" cards would be used by patients at the point of service to provide insurance information to providers. This would eliminate the need for patients to repeatedly fill out confusing forms. Smart cards also would streamline billing procedures for doctors and hospitals by immediate information regarding eligibility, coverage, benefits, copayments and deductibles.

Dollar savings will accrue directly to insurers and providers through more efficient administrative procedures, and be passed on to consumers through lower premiums and out of pocket costs. Eventually, "smart" cards could be used for electronic storage of the card holder's medical records. This would help prevent duplication of tests, medication errors, and other quality of care problems.

Developing Computerized Medical Record Systems.-- Secretary Sullivan also has initiated a task force to accelerate development of computerized medical record systems.

[Insert information regarding this task force, who is chairman, what is the charge, what is the date for report to the Secretary. Also insert one or two sentences on AHCPR efforts, if any, to assist in development]

Computerization will facilitate rapid access to critical information regarding an individual's past medical record. Once computerized patient records and related information networks are in widespread use, providers will have access to state-of-the-art information on the effectiveness of various care paths as well as more complete, accurate patient medical records.

"Expert" systems can be built-in as part of these systems to alert physicians to potential problems, such as the need to follow-up on an abnormal test result. Computerized records will also strengthen quality assurance by providing hospitals and health plans with reliable statistical information regarding outcomes and complication rates.

Health costs could be reduced as well. Up to 20 percent of all medical care performed in the United States may be unnecessary or harmful. Computerized patient records will capture clinical data for effectiveness research. This research will help physicians better understanding of when certain costly therapies should be used.

Early reports are encouraging. The General Accounting Office has reported that an automated medical record system reduced hospital costs by $600 per patient in a Veterans Affairs hospital. Other studies have demonstrated reduced lengths of stay associated with computerized patient records. If broadly implemented, computerized patient records could reduce unnecessary care by about 5 to 10 percent, saving $20 billion a year by the end of the decade. More significant savings are likely in later years.

Reducing Overhead Costs Through Health Insurance Market Reform.--Finally, health insurance market reform will reduce administrative costs for small group coverage by an average of xx percent. Savings will be even higher for groups with 10 or fewer workers. The bulk of this savings will be achieved through health insurance networks (HINs) – group purchasing associations for small business and individual coverage. HINs will help reduce overhead costs to xx% of benefit costs. It is projected that xx% of coverage sold to firms with fewer than 100 workers will be provided through HINs.

Even outside of HINs, substantial savings will be achieved through elimination of costs associated with medical underwriting. Moreover, by refocusing competition on costs, the reforms will also help to reduce marketing costs. The overall effect will be to reduce administrative costs by an estimated xx% for small group coverage purchased outside of HINs, with savings of xx% for firms with fewer than 10 workers.

[NOTE: EDITING IN PROGRESS]

CHAPTER 6

PROBLEMS WITH ALTERNATIVE APPROACHES

Many of the proposals for health system reform are patterned after one of two basic models: a centralized Canadian-style national health insurance system or an employer "play-or-pay" mandate. While widely discussed, these proposals are often designed in relatively cursory fashion, with little or no assessment or analysis of impacts for implementation in this Nation. This chapter presents a rigorous analysis of these models.

A. CANADIAN MODEL

Overview

While apparently successful in many respects and highly popular with the Canadian people, the Canadian system -- like all other universal public insurance systems -- suffers from two basic structural flaws -- flaws that are bound to lead to serious long term problems with cost, access, and quality.

- **There are no demand side incentives for efficiency.** Because medical care is free to consumers, consumers do not play the same role they play in normal markets.

  Market forces that normally drive economic systems to greater efficiency simply do not exist. Moreover, consumers are unable to express their preferences through market choices.

- **Second, all major resource allocations are made centrally through the political process, but health care is too complex, too sensitive to micro-level conditions, for centralized management to be effective.**

  The Canadian system relies on blunt, macro-level, supply-side constraints such as global budgets, limits on high-tech equipment, and limits on physician supply.

  But, efficiency -- high quality care at the lowest possible cost -- requires that optimal decisions be made at the hospital bed-side and in the physician's office.

  This cannot result from central planning, so resources are bound to be wasted and quality is at risk.

These flaws are are already beginning to be manifest in the actual experience of the Canadian system:

- **Costs have not been controlled effectively despite the enormous power that a single payer has under a universal public insurance program. Indeed, Canadian costs have been rising slightly faster than U.S. costs.**

  Costs growth can be moderated through non-market means, but with significant inefficiency. Resources are wasted on low-priority care while blunt cost containment measures limit spending where added resources could make a real difference in outcomes.

- **Supply-side constraints has led to artificial shortages of critical personnel and equipment.**

  Canadians have significantly less access to state-of-the-art technologies and often have to wait weeks or months for effective treatments that are readily available for Americans from all walks of life.

  While waiting, many Canadians are at an increased risk of death or must indure painful or disabling symptoms that could have been corrected. And, certain procedures, such as coronary bypass surgery, appear to be rationed, especially for senior citizens.

  Lost productivity and other costs associated with delays in surgery are estimated at 0.6% of Canadian GDP. These losses could be even higher if delays for other medical services are taken into account.

- **Incentives for Canadian physicians and hospitals reward additional care regardless of appropriateness or quality. As a result, utilization rates are have increased rapidly and resources have been wasted.**

- **Reliance on crude global budgets as a means of controlling costs has forced Canadian hospitals to cut back on staffing in critical areas. As a result, post-operative death rates in Canada are are 40 percent higher than in U.S. hopsitals, for certain high-tech, life saving surgical operations.**

Even if the Canadian system were an unqualified success, its success, if imported into the United States would be less than assured. Each nation has its own unique political, cultural, and economic environment. Experience with the Medicare and Medicaid programs in the United States suggests that a Canadian-style universal public insurance program could not be imported successfully.

- Over the past decade and a half, effective management of Medicare and Medicaid has been stymied by increasing politicization. Today, an Act of Congress is needed to change the amount that Medicare pays for a wheel chair.

- As a result, Medicare and Medicaid per capita costs continue to grow more rapidly than per capita costs for the remainder of the population.

  If the U. S. political process has been unable to control xx% of health spending, there is little reason for optimism that it could be more successful in controlling costs for the entire health system.

Indeed, the thought that as much as xx% of the GNP by the year 2000 could be subject to direct political control should be enough to give most Americans pause for serious concern.

Basic Features of the Canadian Model

For the past two decades, the ten Canadian provinces have operated government-based health insurance plans that cover hospital and physician care. The Canadian system was not implemented all at once, but gradually evolved over many years following World War II. The Canadian system itself, and American proposals to implement a Canadian-style approach, share a number of basic structural features:

- Health insurance is provided to all citizens through a centralized, publicly administered program. Health care services are provided by private-sector hospitals, physicians, and other providers. Private insurance is prohibited, except for services not covered by the public program.

- Covered benefits include hospital, physician, mental health, and preventative care. (Some Canadian provinces also cover prescription drugs and long-term care.) Care is free with no cost-sharing at the point of service

- Hospitals and other institutional providers are paid on the basis of global budgets that cover all patient care costs during a year. Global budgets are set annually by government authorities, through a process that involves some element of negotiation.

- Physicians, and other non-institutional practitioners and providers are paid on a fee-for-service basis according to a government-established fee schedule. Overall payment for physician services are limited by a a global budget or "expenditure target."

- To control costs, the supply of facilities, equipment, and providers is strictly regulated. Hospitals are limited to government-set budgets for capital expenses. Construction projects and high-cost equipment purchases require special approval. Physician supply is limited and the specialty distribution is regulated to encourage general practice.

- Financing is primarily through broad based taxes (including a payroll tax). Some Canadian provinces also require small premium payments. Others place a special tax on employers.

- The Canadian system is administered through the provinces with supplemental Federal financing. A Canadian-style system in the U. S. could be jointly administered by Federal and state governments (as proposed by Senator Kerrey) or primarily by the national government (as proposed by Congressman Russo).

Basic Structural Flaws in the Canadian Model

Lack of Demand-Side Incentives.-- At a fundamental level, the Canadian system lacks effective incentives for efficiency. Because medical care is free to consumers, market forces that normally drive economic systems to greater efficiency simply do not exist.

This flaw could be partly remedied by requiring some cost-sharing at the point of service. The RAND health insurance experiment has conclusively shown that modest levels of cost-sharing reduce demand with little or no measurable impact on health status. (references to follow) But, the flaw in the Canadian system is deeper than a simple lack of cost-sharing.

Because consumers do not have a choice of alternative health plans and do not pay any portion of the premium cost, there is no dynamic that could lead to the development of more efficient systems for delivering high quality care at low cost. It is no accident that innovative health care delivery systems, such as Kaiser Permanente or Group Health of Puget Sound, have emerged in the United States, but not in Canada.

In the U.S., employers and individuals, concerned about getting good value for their health care dollars, have incentives to demand better forms of health care delivery. This, in turn, creates a market for such systems, and organized health plans then compete with one an other for market share, leading to progressive improvements in cost-effectiveness and quality. This consumer-driven process of progressive simply improvement cannot occur in a Canadian-style system.

As a result, the Canadian health care system is curously frozen in time, resembling the U.S. health care system as it existed in the mid-1960s. Medical care

continues to be an unorganized cottage industry. Physicians are subject to little oversight to assure efficiency and quality of care. And physicians continue to be paid exclusively on a fee-for-service basis despite clear evidence that this approach is inherently inflation. None of the improvements in health systems delivery or innovative payment arrangements that have developed in the United States over the past decades have been able to take root in Canada.

Overall, Canadian citizens as individuals are relegated to a diminished role in decision making in the health care system. Because they cannot make their own choices in the market, they are forced to rely on the vagaries of the political process.

Supply-Side Controls.-- Because incentives for needed, appropriate care only are so poorly structured, the government is left with controlling costs through crude supply side controls implemented through a central planning measures. There are at least problems with this approach.

Arbitrariness of Measures. An initial problem is the relative crudeness of the measures used for budgeting; technical details tend to be highly arcane. Hospital budgets have historically not accounted for case-mix differences or efficiencies in care across settings. Only recently have some provinces begin to experiment with Diagnosis-Related Groups (developed and used in the United States for over a decade) for assessing severity of its caseload. Overall, centrally planned budgets and spending caps may or may not be developed with adequate information about patient population needs or appropriate funding for cost-effective care. Frequently, there is no correct decision and policies tend to be arbitrary.

Loss of Flexibility. A second problem is that use of central controls necessarily curtails local flexibility and needs. Decisions for new facilities and the purchase of new technology can take months or even years to complete; the application process can be cumbersome, expensive and politicized, without necessarily resulting in an efficient allocation of resources (NEJM cite). Lowered quality of care can result from lags in the decision process.

The Veterans Affairs (VA) system in the U.S. is an analogous example of using supply controls to determine resource distribution. The VA has been a recognized leader in such areas as cardiac care and radioisotopes, but not all facilities have been adequately utilized. At the same time, even as late as the mid 1980s, fewer than one-third of VA centers had CT scans. An earlier, extensive study by the National Academy of Sciences (1979) found widespread evidence of maldistribution in terms of equipment, basic and specialized services, staffing, and number of beds.

Weak Political Incentives to Contain Costs. The third general problem is that the centralized process may be too removed or too politicized to effectively contain costs. The link between health costs and the consumer preference for benefits relative to costs may be too attenuated. Broad-based political support for cost-

containment may be unrealistic. Lobbying by providers and special interest groups, partisan disputes, and a host of other complications make success in containing costs erratic, at best.

At the other extreme, centralized systems are often vulnerable to swings in economic cycles. Because revenues are raised through the tax system, budgets must adjust to revenue flows. This means that Federal contributions are cut back during recession or economic downturn. Federal contributions in Canada in fact have been frozen starting in 1991; the freeze will be extended through 1995 (Barer and Evans, 1991). During this recent downturn, the Canadian health system has made-up for declining federal revenues by both adding user fees and cost-shifting to provincial budgets.

Canada: The Evidence to Date

The preceding discussion suggests that the design inherent in any centralized, government-controlled health insurance scheme will have adverse impacts on costs, access, appropriate use of resources, and quality. In fact, a growing body of evidence strongly suggests ive of these impacts in the current Canadian system.

Failure to Control Cost Growth.-- Even with strict global budgeting and some rationing of care, Canadian health costs continue to grow faster than U.S. costs. Between 1970 and 1980, Canada's annual compound rate of growth for per capita health expenditures was 12.4 percent, compared with 11.9 percent in the U.S. Between 1970 and 1990, Canada's expenditures grew annually 10.8 percent, compared with 10.5 percent in the U.S. (OECD, 1990; Schieber et al., 1991).

[Bar Chart or Growth]

Cost-containment also has become more difficult in Canada in recent years. Rising demands on the system resulting from free universal access have placed increased financial burdens on the government -- burdens which are increasingly difficult to bear.

Declining national contributions and cost-containment measures have initiated a recent round of hospital staff layoffs and bed closings. In Ontario, for example, the richest and most populous province, where more than a third of the Canadians live, has lost nearly 5,000 hospital jobs and 3,500 beds over the last two years. In Toronto, the provincial capital, 2,900 of 15,000 acute-care beds have been taken out of service (Media Digest, November 25, 1991).

To contain costs, Canada has cut payments to providers, making the yearly price negotiations more and more difficult. The rising Canadian costs, kept

artificially under control by government price and spending caps, has been described as "a pressure cooker that is building steam on a hot stove" (Iglehart, 1986).

Limited Access to High-Tech Services.-- Reliance on crude supply side constraints to control costs will inevitably lead to shortages and delays in treatment. This has occurred in practice.

Treatment Delays -- Canadians must often wait to receive treatment. For example, Canadians can wait (on average) 4.9 months for open heart surgery, and 5.5 months for bypass surgery (Globerman, 1990).

Chart 1: Bar Chart: Waiting Times

These waiting times for medical treatment can have potentially adverse effects on patients' health. Patients not receiving timely access to diagnostic procedures -- such as MRIs, CT scans and mammograms -- and can suffer setbacks due to delayed treatment. Those waiting for acute procedures -- such as open heart surgery -- can risk death waiting for care.

Waiting for treatment also results in a direct economic loss. (Danzon, 1991). If unable to work while waiting for care, individuals may face financial setbacks. Some may even lose their jobs. There is the additional social loss of productivity. The overall cost of delays in surgery has been estimated at 0.6 percent of Canadian GDP. (reference -- see Danzon for primary cite)

Technology. The most advanced medical technology is limited to Canadian citizens. Government control of hospital capital and operating budgets limits the penetration of medical technology in the Canadian market. For example, U.S. citizens have access to more open heart surgery, cardiac catheterization, organ transplants, radiation therapy, extracorporeal shock and lithotripsy, and magnetic resonance imaging.

[Bar Chart, Medical Technologies, U.S.vs Canada
Dale Rublee, Health Affairs]

Data from Anderson et al. (NEJM, 1990?) also suggest rationing of selected expensive procedures for older age groups. Heart valve surgery and bypass surgery for patients ages 65-74 and 75+ were consistently performed less often in Canada. For patients age 75 and above, a full 4 times as many bypass procedures were performed in the U.S. as in Canada for the same age group of patients.

Limited availability of medical technology has prompted the Canadian government to even send some patients to the U.S. to seek advanced medical care. For example, the British Columbia Health Association has contracted with Seattle

hospitals for coronary bypass surgeries (Washington State Hospital Association, 1990), and Ontario and Alberta have similarly contracted with U.S. hospitals for high technology care (Goodwin, 1990; Sherlock, 1990).

While these instances may be rationalized as temporary problems, the Canadian system generally is able to use U.S. access to technology as a "safety valve." Since the U.S. provides an available supply of medical technology just across the boarder, Canada may have an incentive not to invest in sufficient supply. If the U.S. were to adopt a Canadian system, this safety valve would no longer exist for Canada, nor would one exist for Americans (HIAA, 1990).

Innovation. There are several areas of evidence of the Canadian system lagging in organizational and managerial innovations. For example, coordinated care arrangements have just recently taken hold in a few of the Canadian provinces. As mentioned in Chapter xx, these Health Service Organizations use similar approaches for more cost-effective care.

Limited hospital budgets for capital improvements has meant that the physical plants and equipment in many hospitals is nearing obsolescence (Iglehart, 1986). This lessens Canadian hospitals' ability to provide the best structural attributes for high quality care.

Ineffective Use of Resources Resulting from Inappropriate Incentives.-- Because Canada continues to rely primarily on fee for service payment, physicians are rewarded for additional care regardless of need or quality. As a result, utilization per physician increased by 25.1 percent in Canada between 1971 and 1985, compare with only 7.0 percent in the United States (Barer et al., 1988). Overall, Canadian physicians provide a much higher volume of services than U.S. physicians. While no data are available on rates of appropriateness, these substantially higher levels of medical utilization raise concerns about the amount of inappropriate and unnecessary care being delivered and paid for by the Canadian taxpayer.

Relative Use of Physician Services in the Canada and the United States (services per capita)

Source: Fuchs, 1990.

Service Type	Canadian Rate as percent of U.S. Rate
Diagnostic and Therapeutic Procedures	120%
Office Visit and Consultations	156%
All Physician Services	139%

Hospitals also face perverse incentives. Because hospitals are paid on a fixed global budget, the financial incentive is to use available beds for patients with the lowest cost. As a result, Canadian hospitals are filled with chronically ill, but low cost, patients, termed "bed blockers." These incentives affect quality as well for hospitals spill-over to staffing decisions. There are lower staff-to-patient ratios in Canada (1.87) versus the United States (3.47) (Newhouse et al., 1988). The mix of staff is less specialized reflecting lower case severity; quality and intensity of care for high-risk patients, however, can suffer as a result of these staffing patterns (see below).

Comparison of Hospital Care in Canada and the United States
(use rates for people aged 65 and older)
(Source: Newhouse, 1988)

	Unites States	Canada	Canadian Rate as % of U.S. Rate
Admissions Per Capita	0.33	0.35	106%
Length of Hospital Stay (in days)	7.96	13.32	167%
Hospital Days Per Capita	2.63	4.66	177%
Hospital Staff Per Occupied Bed	3.47	1.87	54%

Generally, service production is poorly integrated in the current system across the continuum of care. Because settings and sets of providers are paid on a fee-for-service basis, efficiencies across settings lag behind the U.S. experience. Fully integrated health plans such as Kaiser are able to achieve production efficiencies that are difficult to achieve in fee-for-service settings. Same-day, ambulatory surgery and substitution of outpatient for inpatient care has lagged behind its U.S. counterparts.

Pressures on Quality.-- While compartive studies are scant, Roos et al. (1989) recently reported a comparison of Canadian and U.S. post-operative mortality rates. Interestingly, Canadian hospitals did as well as U.S. hospitals on low risk surgical procedures. However, relative risk of post-operative survival was much poorer in Canada than in the U.S. for high risk procedures. These outcomes may be due to (again) incentives of hospital budgeting practices which encourages lower staff-to-bed ratios, which in turn mean that needed intensive care support following surgeries is far less available and effective in the Canadian system.

Quality assurance activities such as peer review, second opinion, utilization management and outcomes information are also relatively undeveloped in Canada compared with the United States. Historically, Canada has not attempted to question physicians' judgements about the medical necessity of the treatments they

recommend. This professional sovereignty and freedom from outside interference is an aspect of their health care system that Canadian physicians value highly. One observer has characterized it as the price they extract for their participation in an otherwise highly regulated system (HIAA, 1990).

Similarly, Canadian hospitals have few incentives to compete based on increased quality of care, and because of tight budgets, do not invest to any significant level in data collection and quality review.

Could a Canadian-Style System Be Successfully Implemented in the United States?

Critical Differences Between the United States and Canada.-- The notion of simply copying the Canadian system is simplistic. Each nation has its own unique political, cultural, and economic environment and history. Even if the Canadian system were an unqualified success in Canada, its success, if imported into the United States would be less than assured.

One major difference between the United States and Canada is our form of government. We rely on a system of checks and balances, with independent executive, legislative, and judicial branches. Canadians, in contrast, have a parliamentary form of government, which effectively combines legislative and executive functions. The result is, that there is little potential in Canada for the political deadlock that has characterized health policy in the United States over the past decade.

Experience with the Medicare and Medicaid Programs.-- Experience with the Medicare and Medicaid programs suggests that a Canadian-style universal public insurance program could not be translated successfully into the United States. While these programs have succeeded in expanding access to the elderly, the disabled and many low income Americans, these programs has become increasingly politicized over the past 10 years with the result that effective program management has been stymied.

When enacted in 1965, Congress delegated broad responsibility for management of Medicare and Medicaid to the Executive branch and to the States. Congress legislated only the broad outlines of the programs and limited its role to oversight. Today, virtually every detail of operation of Medicare and Medicaid is dictated in hundred of pages of dense legislative language that are comprehensible only to a handful of Congressional staff and executive branch experts.

With the increasing complexity of the legislation, few Members of Congress even have an opportunity to vote on the issues involves. Over the past decade, the full House and Senate have only had a handful of opportunities to debate and vote on critical programmatic issues. Generally, these issues are decided in Committee or

Subcommittee, with other members being limited to an up or down vote on the whole package.

Micromanagement of program details by legislators may be inevitable because it extends political power and influence of key Committee members.. The technical details of payment policy often are highly arcane but of great monetary significance. Often there is no "correct" decision. Thus, many payment policies are somewhat arbitrary. Yet, once the policy is set, it tends to be rigid and is stoutly defended by the interested party that benefits.

This process of politicization has progressed to the point where it now virtually requires an Act of Congress to change how much Medicare pays for a wheel chair. As a result, per capita health care costs for Medicare and Medicaid recipients have grown consistently faster than per capita health care costs for the remaining population.

If the politcal process has been unable to control xx% of health spending, there is little reason for optimism that it could be more successful in controlling costs for the entire health system. Indeed, the thought that as much as xx% of the GNP by the year 2000 could be subject to direct political control should be enough to give pause for serious concern for most Americans.

Potential for Massive Transition Costs and Disruptions.–

[discussion of budget and transition costs association with shift to national health insurance system]

References

Steven Globerman, Waiting Your Turn: Hospital Waiting Lists in Canada (Vancouver: Fraser Institute, May 1990).

Carol Goodwin, "U.S. Miracle Workers Take Pay Cuts the Help Canadians," The Kirchner-Waterloo (Ontario) Record, February 15, 1990.

John K. Igelhart, "Canada's Health Care System," New England Journal of Medicine 315 (3): July 17, 1986, p. 203.

Howard Kim, "Canada Tabs Washington Hospital, Modern Health Care, March 26, 1990.

Ed Neuschler, Canadian Health Care: The Implications of Public Health Insurance, HIAA Research Bulletin, June 1990.

Karen Sherlock, "Detroit Offers Short Wait for Health Surgery," The Edmonton Journal, January 6, 1990.

Washington State Hospital Association Weekly Report 15:8 (February 23, 1989).

6. B. THE PROBLEMS WITH "PLAY-OR-PAY"

Overview

"Play-or-pay" is a widely discussed approach for expanding health insurance access. Employers would be required to play, e.g., provide private insurance for workers and dependents or pay a payroll tax to fund public insurance for their workers and dependents. Variants of this approach have been proposed by Senators Mitchell and Kennedy and by Representative Rostenkowski, among others.

While "play-or-pay" would expand insurance coverage, it suffers from four serious drawbacks. "Play-or-pay" would:

- **Hurt workers by increasing unemployment and by forcing employers to cuts wages to offset mandate costs.** While "play-or-pay" seems to put the burden on employers, this is largely an illusion. Employers will inevitably shift the burden to employees. Between 400,000 and 700,000 jobs could be lost in the short-run, with a long-term potential as high as one and a half million. Moreover, cash wages for the "beneficiaries" of the mandate would decrease by 7 to 9 percent depending on the payroll tax rate.

- **Be a back door to national health insurance.** "Play or pay" is inherently unstable and would rapidly degenerate into national health insurance. According the Urban Institute, xx million workers and dependents with private coverage would be shifted into the public plan. Overall, xx% of Americans would be insured publicly. At this point, the public plan would undoubtedly use its near-monopsony position to gain deep discounts from providers resulting in a massive cost-shift that would rapidly price the remaining private coverage out of the market.

- **Increase inflation and hurt small business.** While the $30 billion cost of the mandate will be shifted to workers, in the near-term, employers will bear the burden. Some employers may try to pass this added cost on to consumers in the form of higher prices. But, many businesses that do not currently provide coverage have low profitability and are engaged in intense competition. Of particular concern, small business will be disproportionately impacted.

- **Increase costs for government by $xx billion $37 billion over and above the new payroll tax receipts.** "Play or pay" is not self-financing. A Federal subsidy of $37 billion would be needed to fund the gap between payroll tax receipts and actual costs, and this gap is likely to grow rapidly. Although premium costs average 7 percent of payroll, actual costs vary widely. Low-wage firms incur costs well in excess of 7 percent. These firms will disproportionately opt to "pay," but the tax will be grossly inadequate for health coverage for these firms. This problem will be compounded by the fact that premium costs also vary widely. Firms with higher premiums due to an

older or sicker workforce would have strong incentive to opt into the public plan, further undermining the solvency of the plan.

How Play or Pay Plans Operate

"Play or pay" employer mandates are designed to provide coverage for workers and their dependents with little direct cost to government. Employers are required to provide coverage directly or pay a payroll tax. Mandates typically apply for all workers employed more than 17.5 hours a week.

- To "play," employers would be required to provide "basic" health coverage. Typically, employers could require workers to pay up to 20 percent of premium costs and could require workers to pay modest cost sharing on benefits.

- Employers not providing health benefits directly would be required to pay a payroll tax to cover a portion of the cost of benefits provided through a public insurance program. Typical payroll tax rates are in the range of 7 to 9 percent. Generally, there is no cap on taxable wage base.

"Play or pay" mandates usually are complemented with an expanded public insurance program to replace Medicaid and provide subsidized coverage on a sliding-scale basis for those without employer-paid coverage or Medicare. Some form of price regulation also generally accompanies "play or pay" proposals as a means of restraining costs. The regulation may involve some form of payer/ provider negotiations or may be administered directly by a regulatory agency.

Characteristics of the Working Uninsured

The working uninsured are the intended beneficiaries of "play or pay" mandates. Thus, it is important to understand who they are.

[insert table from Monheit & Short article showing health insurance status and characteristics of employed persons: age, sex, race, size of establishment, hourly wage, and occupation]

[summary of pertinent features from table: uninsured workers tend be predominantly low wage, low skilled occupations, therefore highly vulnerable to a shift in burden of mandate from employers]

Consequences of "Play or Pay"

Effects on Insurance Coverage.-- From this standpoint, "play or pay" appears to be a success. According to a simulation of this policy conduced by analysts at the Urban Institute, an estimated xx million Americans and their dependents would receive insurance coverage as a result of the mandate. An additional xx million Americans would be covered through a public plan for unemployed and self-employed individuals and dependents.

[insert summary table 2 and 3 on changes in coverage from Urban Institute study; tables need to be consolidated and clarified]

Assuming a 7 percent "play or pay" tax, insurance costs would increase by $29.7 billion for employers, in 1989 dollars, and by $36.8 billion for employers. Premiums paid by individuals would increase by $0.8 billion, while uncompensated hospital care would decrease by $15 billion.

[insert summary table 7 from Urban study]

The Effects on Wages and Employment .-- "Play or pay" mandates appear to put the burden on employers, but in the long-run, the burden will fall primarily on workers . As a result, workers will inevitably be hurt more than they are helped. For primary breadwinners who will need to hold a job under all circumstances, the main effect of the expanded health insurance coverage is likely to be a drop in real take-home pay. For workers who are able to move in or out of the labor force, the effect is likely to be a combination of lower take-home pay and reduced jobs.

The reason is a straight forward matter of economics. At the margin, the total compensation an employer is willing to pay (including wages and fringe benefits) will equal the marginal value to the employer of the labor that is provided. As a result, if employers are forced by government mandate to increase benefits, employer will reduce employment or reduce cash wages. A mandate simply cannot force an employer to pay more in compensation than the value of the labor to the employer. This conclusion has been supported by a number of empirical studies that have analyzed other mandates. (See, e.g, Gruber and Krueger, 1990; **insert other references)**

For workers who are not free to leave the labor market, the cost of keeping their jobs with a 7 percent "play-or-pay" payroll tax would be a 7 percent reduction in cash wages. The burden would be particularly great because most of the working uninsured are low-wage workers who are already struggling just to make ends meet. For example, the mandate would result in --

- A pay cut of $xxx a year for the average 34 year old male high-school graduate, currently earning $xx,xxx a year; and

- A pay cut of $xxx a year for the average 34 year old male high-school dropout, currently earning $xx,xxx a year.

For other workers, 400,000 to 700,000 jobs would be lost. Moreover, if the "play-or-pay" mandate evolves into a universal public insurance program, as seems likely, available to all regardless of employment, job losses could exceed one and one half million.

A review of the characteristics of the uninsured workers makes these predictions seem even more realistic. (See table xx). Most of uninsured workers are low-wage, low-skilled workers. To be blunt, these workers simply do not have the "clout" in the market place to command costly fringe benefits. While unfortunate, this is a fact that cannot be overlooked.

A far better approach is to provide direct assistance for low-income workers through tax credits, as the President has proposed. This approach is much more "progressive" in terms of income distribution. Income is actually transferred directly to assist low-income workers, without the risk of job loss or reduction in wages that a mandate inevitably involves.

"Play or pay" health mandates have other disadvantages for workers as well.

- XX million currently insured workers would be forced to change coverage. XX million would be forced to give up their private insurance and would be forced into a "one size fits all" public insurance plan that may not meet their needs. These shifts in coverage are illustrated in table xx.

  [Be sure that tables are provided to illustrate these shifts.]

- Families that depend on supplemental income from part-time employment of a spouse could be hurt. If the mandate applies to part-time work. Employers will cut back on part-time jobs because of the added cost. On the other hand, if the mandate does not apply, it would fail to close an important gap in coverage and government would be forced to pick up the costs through the back-up public plan.

- Finally, "play or pay" may be lead to frequent changes in coverage that would be confusing for workers and increase adminstrative costs. Only 32 percent of currently uninsured workers end the year in the same job. In contrast, 72 percent of people who start a year employed and insured end the year in the same job. (Klerman and Buchanan, 1990) Job turnover will force often a changes in coverage because different employers tend to contract with different insurers.

A Backdoor to National Health Insurance

Pay-or-play is often presented as an alternative to universal public health insurance like that in Canada or Britain. Such plans remove choices from patients and limit doctors' flexibility as described in more detail elsewhere in this document. Recognizing these shortcomings, proponents of pay-or-play have generally presented their proposals as simple extensions of the existing system of employer provided health insurance in which the public component is downplayed.

This overlooks the strong temptation that employers, who now offer health insurance to their workers, will have to choose the shift to the public pay option, if the new payroll tax rate is as low as 7 or even 9 percent. A recent study conducted for the Labor Department by independent policy analysts at the Urban Institute reaches some startling conclusions on the potential size of such a shift.

PIE CHART -- HEALTH INSURANCE COVERAGE PUBLIC VERSUS PRIVATE: 3 WEDGES: PRIVATE, NEW PUBLIC(INCLUDING MEDICAID), AND MEDICARE. ASSUME A 7 PERCENT TAX RATE.

- A pay-or-play plan with a 7 percent payroll tax would cause a shift of 52 million Americans from employer provided health insurance to the newly created public plan. Even if the tax were as high as 9 percent, there would still be a shift of 32 million.

- At the 7 percent tax rate, 26 million of the 33 million who are currently uninsured would end up in the public plan. Only 7 million would actually receive health insurance through their employers. At the higher 9 percent rate, 22 million of the uninsured would join the public plan.

- When the Medicare population is included, the enrollment in public health insurance is 144 million or 58 percent of the total population, when the payroll tax is 7 percent; it is 117 million, or 47 percent, of total population at a payroll tax of 9 percent.

- For workers in small firms, private health insurance would quickly become a thing of the past under pay-or-play. At a 7 percent tax, 81 percent of the workers in firms with 25 workers or less would be enrolled in the public plan.

The Urban Institute study only considers the static effects of a pay-or-play mandate. It analyzed the initial shifting that would take place as employers selected the least-cost option. Once a pay-or-play system is in effect, however, dynamic forces will be set in motion that drive the system further toward univeral public coverage.

- As long as some private employers continue to offer coverage, a pay-or-play mandate does not require Congress to raise taxes to "improve" that coverage. It will be difficult for lawmakers to resist pressures from provider groups to

include extra services in the mandated benefit package. Over time this will induce more employers to shift to the pay option.

- Unless Congress is willing to let the payroll tax rise to whatever level is needed to fund the public plan entirely out of its revenues, there will be a marked cost advantage to employers from paying rather than playing. This competitive advantage is likely to widen over time as Congress adds benefits to the mandate.

Effects on Employers

The initial harmful economic effects of a pay-or-play mandate will fall mainly on employers. Small firms would be especially hard hit.

- Employers would have to come up with $30 billion in extra health insurance premiums or higher taxes under a pay-or-play mandate with a 7 percent payroll tax, a 23 percent increase in their current health insurance costs; if the tax is 9 percent, the added payments from employers are larger, $44 billion, a 34 percent increase.

- The largest proportional increases are for small employers. For firms employing less than 25 workers, employer payments for health insurance would rise by 71 percent with a 7 percent payroll tax rate, and by 100 percent if the tax rate were 9 percent.

- Many employers would be forced to pay a higher share of premium costs under a pay-or-play mandate, since most proposals limit sharply the amount of employee cost-sharing.

  Some employers would also be required to provide broader benefits, the estimated cost of the required upgrades for a typical pay-or-play mandate is $15 billion.

- Health insurance coverage varies widely by sector ranging from a low of 24 percent in agriculture to a high of 80 percent in local and state government. Sectors with low rates of coverage will be hard hit by the mandate.

- Coverage also varies widely by firm size, ranging from 40 percent for small firms with less than 25 workers to 73 percent for firms with 500 or more employees. A sharp increase in costs for small firms relative to large firms would threaten the most dynamic sector of the U.S. economy.

- In the short run, a pay-or-play mandate will lead to somewhat higher prices and increase in the inflation rate. For firms, that cannot pass on increases in costs through higher prices, there would be a fall in profits. Assuming the

monetary authorities maintain their existing targets for inflation, the effect of the mandate would be to raise unemployment and lower real GNP.

The Cost to the Government of Pay-or-Play

A pay-or-play mandate would give rise to a vast new Federal health insurance program, four times as large as Medicare and inadequately funded.

BAR CHARTS -- COST TO GOVERNMENT UNDER PAY-OR-PLAY WITH 7 PERCENT AND 9 PERCENT PAYROLL TAXES COMPARED WITH CURRENT

- The Urban Institute estimates that a pay-or-play mandate with a 7 percent payroll tax would not be adequately funded. The new payroll tax would not cover the full cost of the new public plan. A subsidy of $37 billion would be needed from general revenue. A 9 percent payroll tax would lower the subsidy to $25 billion, but not eliminate it. The subsidy is likely to grow over time.

Pay-or-Play Fails to Address Cost-Control Effectively

Play-or-pay proposals are often coupled with proposals to control rising medical costs through price regulation schemes. Price controls of this sort are doomed to fail, since pay-or-play does nothing to address the dynamic factors that are driving up health care costs. In the absence of meaningful reforms, imposing price controls is like putting lid on a pressure cooker. If the heat remains on the lid evenutally blows off and the pot boils over.

- The flawed incentives present in the existing system that lead consumers to use more and physicians to provide more are left in place.

- Some features of pay-or-play could drive up costs. Coverage will be duplicated for families with multiple employers. That could lead to more inefficient "first dollar" coverage in which employees do not face any out-of-pocket health costs.

1/27/92

Case Studies

The President's plan will allow all Americans to have access to affordable health insurance. The following are illustrative examples of how the President's plan would work.[1]

Case #1

A family of three with one working parent, and a total family income of $10,000 (just below the poverty level):

[Full Credit of $3750]

- Under the current system, this family is not eligible for Medicaid and cannot afford private health insurance.
- Under the President's plan, this family would qualify for a $3750 transferable credit to buy basic health insurance through the State designed group health plan (or another of their choice).

Case #2

A mother with two children who was on welfare (AFDC) in the past, and has returned to a job earning $8500 per year. No employer health insurance is provided:

[Full Credit of $3750]

- Under the current system, a mother receiving AFDC who returns to work continues to receive Medicaid for 6 months; after the 6 month period, the family is charged 3 percent of the family income as a Medicaid premium. After 1 year, the family is no longer eligible for Medicaid.
- Under the President's plan, the family would qualify for a $3750 transferable credit to buy basic health insurance through the State group health plan (or another private plan) when they no longer qualify for Medicaid.
- The President's plan removes the current disincentive for AFDC families to remain on welfare because they fear losing Medicaid coverage -- the President's plan will ensure continued coverage for welfare recipients who return to work.

Case #3

A family of 4 with a household income of $35,000, and no employer sponsored health insurance:

[Full Health Care Deduction of $3750 and Access to Group Coverage]

- **Under the current system, they often cannot find affordable coverage.**
- **Under the President's plan they would receive a $3750 tax deduction (a benefit of approximately $1050) to help with the purchase of insurance.**
- **In addition, their employer(s) would provide information and arrange access (but not be required to contribute) to group coverage. For example, the employer could arrange coverage through a Health Insurance Network (HIN), so that the family can buy more affordable coverage through a large employer group -- with larger risk pools rather than costly individual coverage.**

Case #4

A single individual below the poverty level not eligible for Medicaid (e.g. woman with no children and most males):

[Individual Credit of $1250]

- **Under the current system, this individual has no access to health insurance, and usually receives "unreimbursed care" through hospital emergency rooms.**
- **Under the President's plan, this person would receive a $1250 transferable credit for the purchase of group health insurance through the basic State health plan, or some other private plan.**

Case #5

A homeless person who currently relies on emergency room treatment for serious illnesses:

[Individual Credit of $1250]

- **Under the current system, hospitals and other providers give uncompensated care, shifting the costs and higher charges to government and individuals with insurance.**

- Under the President's plan, this person would use the $1250 credit to choose a basic health insurance package. If the individual did not choose a plan, the State and/or hospital could assign them to a "basic plan" insurer -- with the premium paid by the transferable credit. Hospitals would receive reimbursement for most costs that they formerly had to provide for free.

Case #6

A family of 4 with household earnings of $50,000, and a $1000 employer contribution to health insurance:

[Health Care Deduction]

- Under the President's plan, this family would receive a health care tax deduction of $2750 ($3750 minus employer contribution of $1000), making their health insurance much more affordable.

Case #7

An individual with a serious health problem is considering changing jobs, but is afraid of giving up current employer coverage:

[Portability and Security of Health Care]

- Under the current system, a person changing jobs may not be covered under a new employer's policy because of health status. Pre-existing conditions exclusions may also apply, interrupting coverage.

- Under the President's plan, regardless of health status, the new insurer would be required to offer unrestricted access to the new employer's group coverage.

- In addition, insurers would not be permitted to deny coverage due to health status, and persons with previous health benefits could be not denied coverage of preexisting conditions. [So long as no insurer can avoid pre-existing conditions, and all must accept new risks, no insurer will be disadvantaged].

Case #8

An employer of a small firm of 20 workers would like to offer employees health insurance, but cannot find affordable coverage:

[Small Market Reforms]

- Under the current system, small employers have difficulty finding affordable coverage. The problem becomes worse when one member of a small group has a poor medical history or current high medical costs.

- Under the President's plan, small employers would have access to larger group coverage through Health Insurance Networks (HINs) spurred by major insurance and ERISA reform. Large group coverage is less expensive and more efficient, since insurance administrative costs are much lower and risk is more effectively distributed.

- In addition, the plan would set limits on the variation of premiums insurers can charge to different groups. Insurers would not be able to deny coverage to any individual, or drastically increase premiums when one member of a group becomes ill. Additionally, a long term "risk adjustment" between insurance pools would remove the incentive for insurers to compete by "cherry picking" low risks and encourage competition on service and cost effectiveness.

Case #9

An individual just diagnosed with a serious health problem applies for health insurance for the first time:

[Guaranteed Issue]

- Under the current system, uninsured persons with serious health problems are often denied health insurance -- for any price.

- Under the President's plan, insurers would be required to offer coverage to any individual, regardless of health status. Premium levels would be limited so that costs would not be prohibitive.

Case #10

A family earning $17,000 has no employer coverage and currently cannot afford health insurance:

[Partial Health Credit]

- Under the President's plan, this family would receive a partial health tax credit of $XX towards the purchase of health insurance (or a $3750 deduction -- whichever provides the greater benefit).

- Affordable group coverage would be made available through a State coordinated "basic plan" pool that would guarantee access to basic health insurance coverage.

Case #11

An individual with an income of $200,000 and an employer contribution of $1940 towards health insurance:

[Limit on Deductibility of Rich Plans for High Income People]

- **Under the President's plan, nothing would change for this individual.**
- **However, if the employer contribution increased above $1940 (the projected 70th percentile level of average national employer contributions for 1993) to, for example, $2140, the individual would realize $200 of imputed taxable benefits.**
- **This is intended to address the prevalent problem of high income people overconsuming health care because of excessive employer-purchased insurance coverage that is a tax free benefit to the individual. This will encourage high income individuals and their employers to buy more reasonable insurance plans.**

Case #12

An individual is planning on choosing a health plan, and wants to get the best quality plan for the most competitive price. But he is unsure of which plan to choose:

[Consumer Information]

- **Under the current system, consumers have limited objective knowledge of the relative prices of insurers, providers. Nor are they aware of the hospitals and doctors included in the plan -- or of the relative quality of local hospitals and doctors.**
- **Under the President's plan, comparative information on quality and price of health care will be available to consumers. Area provider groups will collect and disseminate information on insurers, physician, hospitals, labs and other facilities -- both on price and quality. This local health care "blue book" will allow consumers to identify the best health plans, and providers. As a result, consumers will be better equipped to choose the health plan that is best suited to their needs.**

1. The examples presented assume the fully-phased in program.

– Melinda Kitchel
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