

**THE DIRECTORY OF TRANSITION OUTREACH:
GOVERNMENTAL ENTITIES AND INTEREST GROUPS**

FEBRUARY 1, 1993

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STATE AND LOCAL INTERESTS

1. Governors

National Governors' Association

**Alicia Pelrine 202-624-5340,

**Carl Volpe 202-624-7729

Governor Carrol Campbell

Nikki McNamee 202-624-7784

Governor Lawton Chiles (Dem. - Florida)

Bob Rogan 904--488-1295

Governor Howard Dean (Dem. - Vermont)

Anya Rader 802-828-3333

Governor Jim Florio (Dem. - New Jersey)

Brenda Bacon 609-777-2207

Governor Roy Roemer (Dem. - Colorado)

Alan Weil 303-866-2155

Governor John Waihee (Dem. - Hawaii)

Peter Sybinsky 808-586-4433

Governor David Walters (Dem. - Oklahoma)

Garth Splinter 405-271-4224

2. Other State and Local Officials

Association of Attorneys General

Barbara Zelner (Medicaid Fraud Counsel) 434-8000 (8020)

American Public Welfare Association

Jane Horvath 202-682-0100

International City Managers Association

William Hansell, Elizabeth Kellar, 289-4262

National Association of Counties

Tom Joseph, Larry Jones, 393-6226

National Association of State Treasurers

Christopher Brown, 624-5460, 624-8595

National Association of Towns and Townships

Tom Halicki, Jeff Schiff, 737-5200

National Black Caucus of State Legislators

Diane Bush, 387-8259

National Conference of State Legislatures

Joy Johnson Wilson 202-624-5400

National League of Cities

Janet Qurst, 626-3000

U.S. Conference of Mayors

Richard L. Johnson, 293-7330

State Senator Robert Connor (Rep. - Delaware)

Joy Johnson Wilson 202-624-5400

State Representative Art Hamilton (Dem. - Arizona)

Joy Johnson Wilson 202-624-5400

State Representative Tom Mason (Dem. - Oregon)

Joy Johnson Wilson 202-624-5400

State Representative Karen McCarthy (Dem. - Missouri)

Joy Johnson Wilson 202-624-5400

State Senator Cindy Resnick (Dem. - Arizona)

Joy Johnson Wilson 202-624-5400

State Representative David Richardson (Dem. - Pennsylvania)
Joy Johnson Wilson 202-624-5400
CONGRESSIONAL OUTREACH:

1. Congressional Leadership

Senate

Senator George Mitchell, Majority Leader
**John Hilley 202-224-5556, **Christine Williams 202-224-5344
**Bob Rosen 202-224-5344
Senator Bob Dole, Minority Leader
Sheila Burke 202-224-5311
Senator Moynihan, Finance Committee Chairman
Faye Drummond, Paul Offner 202-224-4515
Senator Bob Packwood, Finance Ranking Republican Member
Ed Mihalski 202-224-5315
Senator Kennedy, Labor and Human Resources Chairman
**David Nexon 202-224-7675
Nick Littlefield 202-224-5465
Senator Nancy Kassebaum, Labor Ranking Republican
Andy Patzman 202-224-4774
Senator Jay Rockefeller, Finance Medicare Subcommittee Chairman
**Mary Ella Payne 202-224-6472
Senator Dave Durenberger, Finance Medicare Subc. Ranking Republican.
Susan Foote 202-224-3244
Senator John Chafee, Finance Medicare Subc. Ranking Republican
Christine Ferguson 202-224-2921
Senator Tom Harkins
**Peter Reinecke
Senator David Pryor, Aging Comm. Chair, Secretary of the Senate
**Chris Jennings 202-224-5364

House

Speaker Tom Foley
Bonnie Lowrey, 202-225-5604
Congressman Richard Gephardt, Majority Leader
**Andi King 202-225-0100
Congressman Bob Michels, Minority Leader
David Kehl 202-225-0600
Congressman Newt Gingrich, Minority Whip
Ed Cutler 202-225-4501
Congressman Dan Rostenkowski, Ways and Means Chairman
**Brian Biles 202-225-7785
Congressman Bill Archer, Ways and Means Ranking Republican
Chip Kahn 202-225-4021
Congressman John Dingell, Energy and Commerce Chairman
**Donald Shriber 202-225-3147
Congressman Norman Lent, Energy and Commerce Ranking Republican
Howard Cohen 202-226-3718
Congressman Bill Ford, Labor and Education Chair (through staff)
Karen Vagley 202-225-4527
Congressman Pete Stark, Ways and Means Health Subcomm. Chairman
**Brian Biles 202-225-7785

Congressman Henry Waxman, Energy and Commerce Health Subc. Chair
**Karen Nelson 202-225-0130
Congressman Pat Williams, Labor and Education Subcommittee Chair
Phyllis Borzi 202-225-5768

2. Outreach to Rest of the Congress

Senator Max Baucus (Dem. - Montana)
Maureen Testoni, Tom Finigan 202-224-2651
Senator Jeff Bingaman, (Dem. - New Mexico)
Carrie Bille, Bob Frank 202-224-5521
Senator David Boren, (Dem. - Oklahoma)
Eric Liu 202-224-4721
Senator John Breaux (Dem. - Louisiana)
Laird Burnett 202-224-4623
Senator Tom Daschle (Dem. - South Dakota)
**Rima Cohen, Laura Petrou 202-224-2321
Senator Bob Kerrey (Dem. - Nebraska)
Shiela Nix, Shiela Murphy 202-224-6551
Senator Howard Metzenbaum, (Dem.- Ohio)
Michell Barnhagan, 202-224-5546
Senator Donald Reigle (Dem. - Michigan)
Debbie Chang 202-224-4822
Senator Paul Wellstone, (Dem. - Minnesota)
Ellen Shaffer 202-224-5641
Senator Harris Wofford (Dem. - Pennsylvania)
John Gomperts, Kevin Eckert 202-224-6324

Congressman Mike Andrews (Dem. - Texas)
**Dave Kendall 202-225-7508
Congressman Xavier Becera (Dem. - California)
David Kim 202-225-6235
Congresswoman Cardiss Collins (Dem. - Illinois)
John Gray, 202-225-5006
Congressman John Conyers (Dem. - Michigan)
Frank Clemente 202-225-5051
Congressman Jim Cooper (Dem. - Tennessee)
**Caroline Chambers 202-225-6831
Congressman Kika de la Garza (Dem. - Texas)
Anton Papich 202-225-2531
Congressman Harry Johnston (Dem. - Florida)
Roger Berry 202-225-3001
Congressman Jim McDermott (Dem. - Washington)
Barbara Smith 202-225-3106
Congressman Robert Menendez (Dem. - New Jersey)
Mike Hutton 202-225-7917
Congressman Solomon Ortiz (Dem. - Texas)
Leti Defena 202-225-7741
Congressman Bill Orton (Dem. - Utah)
John Lewis 202-225-7751
Congressman Bill Richardson (Dem. - New Mexico)
Scott Wiener 202-225-6190
Delegate Carlos Romero-Barcelo (Dem. - Puerto Rico)

Luis Baco 202-225-2615
Congresswoman Lucille Roybal-Allard (Dem. - California)
Henry Conterasa 202-225-1766
Congresswoman Louise Slaughter (Dem. - New York)
Felicia Bloom 202-225-3615
Congressman Charles Stenholm (Dem. - Texas)
Colleen Kepner 202-225-6605
Congressman Louis Stokes (Dem. - Ohio)
**Leslie Atkinson 202-225-7032
Congressman Mike Synar (Dem. - Oklahoma)
**Vivek Varma 202-225-2701
Congresswoman Nydia Velasquez (Dem. - New York)
Ed Cazlell 202-225-2361
Congressman Ron Wyden (Dem. - Oregon)
**David Schulke 202-225-4811

Congressional Black Caucus
Amelia Parker 202-226-7790
Congressional Hispanic Caucus
Rick Lopez 202-226-3430
Senate Rural Health Caucus
Peter Reinecke 202-224-6265

3. Response to Congressional Outreach Survey

**Democrat
Health Assistants**

Last	First	State	Phone	Fax	Health Care	Assistant
Bacchus	James	FL	202/225-3671	202/225-9039	Stephanie	Nelson
Berman	Howard	CA	202/225-4695	202/225-2790	Bob	Blumenfield
Boucher	Rick	VA	202/225-3861	202/225-0442	Mary	Swetnam
Cardin	Benjamin	MD	202/225-4016	202/225-9219	Sean	Cavanaugh
de Lugo	Ron	VI	202/225-1790	202/225-9392	Jeffrey	Farrow
DeLauro	Rosa	CT	202/225-3661	202/225-1988	Greg	Levine
Dellums	Ronald	CA	202/225-2661	202/225-9817	Deanna Milligan	Kirtman
Durbin	Richard	IL	202/225-5271	202/225-0170	Tom	Faletti
Foglietta	Thomas	PA	202/225-4731	202/225-0088	Barbara	Zylinski
Frost	Martin	TX	202/225-3605	202/225-4951	Ronnie	Carleton
Gibbons	Sam	FL	202/225-3376	202/225-8027	Barbara	Toffling
Glickman	Dan	KS	202/225-6216	202/225-5398	Mary	Frasche
Hall	Tony	OH	202/225-6465	202/225-9272	Gail	Amidzich
Kanjorski	Paul	PA	202/225-6511	202/225-9024	Michael	Burton
Klecza	Gerald	WI	202/225-4572	202/225-0719	Laura Saul	Edwards
Kopetski	Michael	OR	202/225-5711	202/225-9477	Scott	Barstow
Lancaster	Martin	NC	202/225-3415	202/225-0666	Susan Carr	Gossman
LaRocco	Lawrence	ID	202/225-6611	202/225-1213	Mark	Brownell
Levin	Sander	MI	202/225-4961	202/226-1033	Dr. Michael D.	Miller
Long	Jill	IN	202/225-4436	202/225-8810	Jennifer	Boehm
Manton	Thomas	NY	202/225-3965	202/225-9497	Elaine	Simek
Markey	Edward	MA	202/225-2836	202/225-8689	Joanne	Cunningham
McCloskey	Frank	IN	202/225-4636	202/225-4688	Chet	Speed
McCurdy	Dave	OK	202/225-6165	202/225-9746	Laura	Brodbeck
Mollohan	Alan	WV	202/225-4172	202/225-7564	Elizabeth	Whyte
Murtha	John	PA	202/225-2065	202/225-5709	Ray	Landis
Oliver	John	MA	202/225-5335	202/226-1224	Sylvia	Gaudette
Pastor	Ed	AZ	202/225-4065	202/225-1655	Terri	Schroeder
Payne	Lewis	VA	202/225-4711	202/226-1147	Andrea	Price
Pelosi	Nancy	CA	202/225-4965	202/225-8259	Steve	Morin
Peterson	Collin	MN	202/225-2165	202/225-1586	David	Rinebolt
Peterson	Peter	FL	202/225-5235	202/225-1586	Jason	Altmire
Poshard	Glenn	IL	202/225-5201	202/225-1541	Bernadette	Laniak
Rahall, II	Nick Joe	WV	202/225-3452	202/225-9061	Birdie	Kyle
Rangel	Charles	NY	202/225-4365	202/225-0816	Jon	Sheiner
Rose	Charles	NC	202/225-2731	202/225-2470	Bob	Henshaw
Sabo	Martin Olav	MN	202/225-4755	202/225-4886	Ellen	Samuelson
Sarpalius	Bill	TX	202/225-3706	202/225-6142	Elizabeth	Garrett
Schumer	Charles	NY	202/225-6616	202/225-4183	Randolph	Harrison
Slattery	Jim	KS	202/225-6601	202/225-1445	Janet	Murguia
Stenholm	Charles	TX	202/225-6605	202/225-2234	Rebecca	Tice
Stokes	Louis	OH	202/225-7032	202/225-1339	Leslie	Atkinson
Swett	Richard	NH	202/225-5206	202/225-0704	Andrew	Sperling
Wheat	Alan	MO	202/225-4535	202/225-5990	Hector	Delatorre
Williams	Pat	MT	202/225-3211	202/225-1257	Phyllis	Borzi
Wilson	Charles	TX	202/225-2401	202/225-1764	Laura	Miller
Wyden	Ron	OR	202/225-4811	202/225-8941	David	Schulke
Yates	Sidney	IL	202/225-2111	202/225-3493	Edna	Nadlin

**Republican
Health Assistants**

Last	First	State	Health Care	Assistant	Phone	Fax
Baker	Richard	LA	Jamie	Baskerville		
Boehlert	Sherwood	NY	Victoria	Blatter		
Clinger, Jr.	William	PA	Ed	Amorosi		
Cunningham	Randy	CA	Camille	Conway		
Emerson	Bill	MO	Kelly	Hughes		
Fawell	Harris	IL	Alan	Mertz		
Gekas	George	PA	Charles	Frohman	225-4314	225-8440
Gillmor	Paul	OH	Jennifer	Baxendell		
Goss	Porter	FL	Carolyn	Rey		
Grandy	Fred	IA	Shawn	Coughlin		
Gunderson	Steve	WI	Sherry	Kaiman		
Hunter	Duncan	CA	Mark	Epley		
Johnson	Nancy	CT	Molly	Frantz		
Johnson	Sam	TX	Jim	Glottfelty		
Kyl	Jon	AZ	Cynthia	Berry		
Lewis	Tom	FL	Andrew	Cherry		
Machtley	Ronald	RI	Kristen	Stewart		
McCrery	Jim	LA	Scott V.	Nystrom		
McMillan	J. Alex	NC	JoAnn	Willis		
Myers	John	IN	Susan	Sturman		
Petri	Thomas	WI	Joseph	Flader		
Porter	John	IL	Mike	Myers		
Skeen	Joe	NM	Cherie	Harder		
Sundquist	Don	TN	Kimberley Bes	Lorden		
Taylor	Charles	NC	Caroline	Choi		
Walker	Robert	PA	Gail	Giedzinski		
Walsh	James	NY	Martha	Carmen		
Zeliff, Jr.	William	NH	Taylor	Caswell		

**Senators
Health Assistants**

First	Last	Party	State	Health Care	Assistant	PHONE	FAX
Bill	Bradley	D	NJ	Kenneth	Apfel	224-3224	
Richard	Bryan	D	NV	Opal	Winebrenner	224-6244	
Dale	Bumpers	D	AR	Elizabeth	Goss	224-4843	
William	Cohen	R	ME	Priscilla/Mary	Hanley/Gerwi	224-2523	
John	Danforth	R	MO	Laura	Steeves	224-6154	
Pete	Domenici	R	AZ	Mike	Knapp	224-6621	
Dave	Durenberger	R	MN	Susan Bartlett	Foote	224-3244	
J.	Exon	D	NE	Mary	Peterson	224-4224	
Bob	Graham	D	FL	Susan	Emmer	224-3041	
James	Jeffords	R	VT	Mark	Powden	224-5141	
J.	Johnston	D	LA	Laura	Hudson	224-5824	
Nancy	Kassebaum	R	KS	Andrew	Patzman	224-4774	
Mitch	McConnell	R	KY	Paul	Grove	224-2541	
Sam	Nunn	D	GA	Brent	Orrell	224-3521	
Charles	Robb	D	VA	Susan	Albert	224-4024	
John	Rockefeller IV	D	WV	MaryElla	Payne	224-6472	
Paul	Sarbanes	D	MD	Julie	Kehrli	224-4524	
Malcolm	Wallop	R	WY	Michael	Hoon	224-6441	

LABOR

AFL-CIO

****Karen Ignagni 202-637-5000**

AFSCME

Gerald McEntee, Rob McGarrah 202-429-1000

American Federation of Teachers

John Abraham, Katherine Kany 202-879-4400

Building Trades Department, AFL-CIO

Bob Georgine 202-347-1461

Communications Workers of America

Louise Novotny 202-434-1100

International Ladies Garment Workers Union

Evy Dubrow 202-347-7417

Retail, Wholesale and Department Store Union

Lenore Miller 212-684-5300

Service Employees International Union

****John Sweeney, Gerry Shea 202-898-3380**

Teamsters

Angie Hunter 202-624-8741

United Auto Workers

Owen Bieber, Alan Reuther 202-828-8500

United Mine Workers of America

Bill Samuel 202-842-7280

United Steel Workers of America

John Sheehan 202-638-6929

DISABILITY GROUPS

AIDS Action Council

Karen Ringem 202-986-1300

Dan Bross 202-986-1300

American Congress of Rehabilitation Medicine

Peter Thomas 202-659-2900

American Speech-Language-Hearing Association

Steve White, Mary Fox-Grimm 301-897-5700

American Psychological Association

Janet O'Keefe 202-955-7618

The Arc

Kathy McGinley 202-785-3388

Epilepsy Foundation of America

Bill Schmidt 301-459-3700

National Association of Developmental Disabilities Councils

Christine Metzler 202-347-1234

United Cerebral Palsy Association

Bob Griss 202-842-1266

HEALTH CARE ADVOCATES

****Families USA**

Ron Pollack 202-737-6340

Health Care for America

Harvey Sloane, Phil Johnson 202-546-3507

Healthcare Leadership Council

Jeff Trummell, Pam Bailey 202-333-7400

National Health Law Program

Gregg Haifley 202-887-5310

****National Leadership Coalition for Health Care Reform**

Henry Simmons, Peggy Rhodes 202-647-6830

National Senior Citizens Law Center

Patricia Nemore, Burt Fretz 202-887-5280

SINGLE-PAYOR ADVOCATES

American Public Health Association

Katherine McCarter 202-789-5645

Church Women United

Nancy Chupp 202-544-8747

Citizen Action

Bob Brandon, Cathy Hurwit 202-775-1580

Consumers Union

Gail Shearer 202-462-6262

Graphic Artists Union

Tim Williams 202-775-1796

International Brotherhood of Teamsters

Angela Hunter 202-624-6890

National Association of Social Workers

Madeline Golde 202-336-8237

National Council of Senior Citizens

Larry Smedley, Dan Schulder 202-347-8800

National Farmers Union

Nancy Danielson 202-554-1600

National Hispanic Council on Aging

Marta Sotomayor 202-265-1288

Neighbor to Neighbor

Glen Schneider 415-824-3355

NETWORK:A National Catholic Social Justice Lobby

Katherine Pinkerton 202-526-4070

Oil, Chemical, and Atomic Worker Union

Nolan Hancock 703-876-9300

Physicians for a National Health Program

Carolyn Clancy 301-227-8357

Public Citizen

Sara Nichols 202-546-4996

United Cerebral Palsy Associations

Bob Griss 202-842-1266

United Church of Christ, Office of Church in Society

Patrick Conover 202-543-1517

United Electrical Workers

Bob Kingsley 703-684-3123

RELIGIOUS

Church Women United

Nancy Chupp 202-544-8747

Evangelical Lutheran Church in America

Sarah Naylor 202-783-7501

Interreligious Health Care Access Campaign

Donna Mandel 202-543-5878

National Council of Churches

Mary Cooper 202-544-2350

United Church of Christ

Patrick Conover 202-543-1517

United Methodist Church

Jane Hull Harvey 202-488-5600

US Catholic Conference

John Carr, Nancy Wisdo, Patricia King 202-541-3140

CHILDREN'S HEALTH ADVOCATES

The Alan Guttmacher Institute

Rachel Gold 202-296-4012

American Academy of Pediatrics

Jackie Noyes, Graham Newsome 202-662-7460

American Association of University Affiliated Programs

Katie Neas 202-588-8252

American College of Obstetricians and Gynecologists

Susan Lightfoot 202-863-2510

American Nurses Association

Daniel O'Neal 202-544-4444

American Public Health Association

Katherine McCarter, Rich Gilbert 202-789-5650

American Speech-Language-Hearing Association

Steve White, Mary Fox-Grimm 301-897-5700

Association for Retarded Citizens

Kathy McGinley 202-785-3388

Association for Care of Children's Health

William Sciarillo 301-654-6549

Association of Maternal and Child Health Programs

Susan Campbell 202-775-0436

Children's Defense Fund

Carol Regan 202-628-8787

Child Welfare League

David Liederman, Mary Bourdette 202-638-2952

Health and Medicine Council of Washington

Dale Dirks 202-544-7499

March of Dimes Birth Defects Foundation

Kay Johnson 202-659-1800

National Association of Children's Hospitals and Related Institutions

Peter Wilson 703-684-1355

National Association of Community Health Centers

Freda Mitchem 202-659-8008

National Center for Clinical Infant Programs

Beverly Jackson 703-528-4300

National Commission to Prevent Infant Mortality

Mary Capenter 202-205-8364

National Council of Community Hospitals

Marty McGeein 202-728-0830

U. S. Catholic Conference -- Department of Social Development

Patricia King 202-541-3188

Virginia Perinatal Association

Carola Bruflat 703-255-9820

Women's Legal Defense Fund

Joanne Mustead 202-986-2600

MINORITIES

Cherokee Nation

Pamela Iron 918-456-0671, x202

NAACP

Ed Mailes 202-638-2269

Urban League

Robert McAlpine, Lisa Bland Malone 202-898-1604

National Council of La Raza

Christina Lopez 202-289-1380

National Congress of American Indians

Michael Anderson 202-546-9404

National Indian Health Board

Gordon Belcourt, Julia Davis 303-759-3075

RURAL INTERESTS

Communicating for Agriculture

Jeffrey Smedsrud 612-854-9005

National Association of Rural Electric Cooperatives

Bob Bergland, Carolyn Watts 202-857-9559

National Rural Health Association

Bruce Behringer 615-929-6423

MENTAL HEALTH INTERESTS

American Academy of Pediatrics

Jackie Noyes 202-662-7460

American Psychiatric Association

Melvin Sabshin 202-682-6000

American Psychological Association

Bryant Welch, Donna Daley, Daniel Zingale 202-955-7618

Child Welfare League of America

Mary Bourdette 202-638-2952

Mental Health Law Project

Joe Manes 202-467-5730

Mental Health Policy Resource Center

Leslie Scallet 202-775-8826

National Alliance for the Mentally Ill

Laurie Flynn 703-524-7600

National Association of Community Health Centers

Dan Hawkins 202-659-8008

National Association Psychiatric Treatment Centers for Children

Joy Midman 202-638-1604

National Association Social Workers

Sue Hoechstetter 202-408-8600

National Council of Community Mental Health Centers
James Finley 202-624-5835 or 301-984-6200
National Mental Health Association
Chris Koyanagi, John Ambrose 703-838-7502

ALCOHOL AND DRUG ABUSE

American Academy of Family Physicians
Susan Hildebrandt 202-232-9033
Center for Science in the Public Interest
Patricia Taylor 202-332-9110
Coalition for the Prevention of Alcohol Problems
Patricia Taylor 202-332-9110
National Ass. of Alcoholism and Drug Abuse Counselors
Patrice O'Toole 703-920-4644
National Coalition to Prevent Impaired Driving
George Macker 202-639-0054

EMPLOYERS

1. Large

Acme Steel
Richard Stefan 708-841-6010
American Iron and Steel Institute
Peter Hernandez 202-452-7212
Association of Private Pension and Welfare Plans
Ellen Goldstein, John Blount 202-289-4582
Bethlehem Steel
Benjamin Boylston 215-694-4044
Erisa Industry Committee
Mark Ugoretz 202-789-1400
General Motors
Freddie Lucas 202-775-5027
IBM
Gerri Colombaro 202-515-5000
Inland Steel
William P. Boehler 219-399-5513
Johnson & Johnson
Ralph Larson, Jack Hall, Shannon Salmon 202-408-9482
LTV
Barbara Kostuk 202-625-3373
National Association of Manufacturers
Sharon Canner 202-637-6000
National Retail Federation (both large & small employers)
Tracy Mullin, Steven Pfister 202-783-7971
National Steel
Richard Coffee 219-273-7857
Pepsico
David Wright 914-243-3600
Washington Business Group on Health
Mary Jane England 202-408-9320
Wheeling-Pittsburg Steel
Dan Keaton 304-234-2474

2. Small

National Association of Life Underwriters (Insurance Agents)
Dave Hebert 202-331-6023
Jeff Trinca 202-638-1950
National Federation of Independent Businesses
John Motley 202-554-9000
National Small Business Legislative Council
John Satagaj 202-639-8888
National Small Business United
Tom Cantor 202-887-5599
John Galles 202-293-8830
U.S. Chamber of Commerce
Kristin Bass 202-463-5514

INSURERS

1. Large Insurers

Aetna
Laurie Sullivan 202-223-2821
Cigna
Michael Shiffer 202-296-7174
Metropolitan Life Insurance Company
Carol Kelly 202-659-3575
Prudential
Tom O'Hara 202-463-0060
Travelers
Roger Levy 202-789-1380

2. Mid Range Insurers

General American Life
Michael Hogan 314-525-3662
Massachusetts Mutual
Barry Gottehrer 202-737-0440
Mutual of Omaha
Cecil Bykerk 402-978-2534
New York Life
Jessie Colgate 202-783-4484
Phoenix Home Life
Donna Davis, Maura Melley 203-275-5025

3. Insurance Interest Groups

American Family Life Assurance Company (AFLAC)--Supplemental Insurers
David Pringle, Joey Laudermilk 202-887-1423
BlueCross BlueShield Association
Barney Tresnowski, Mary Nell Leonard 202-626-4780
Delta Dental Plans (Dental Insurers)
Don Ruscio 202-546-4732
Health Insurance Association of America
Willis Gradison 202-223-7780
Independent Insurance Agents of America
Paul Equale 202-863-7000
Self Insurance Institute
Jim Kinder 202-828-5015

PROVIDERS

1. Physicians

****American Academy of Family Physicians**
Charles Huntington 202-232-9033
American Academy of Opthomology
Cynthia Moran 202-737-6662
American Academy of Pediatrics
Jackie Noyes, Graham Newsome 202-662-7460
American College of Obstetricians and Gynecologists
Kathy Bryant 202-863-2511
****American College of Physicians**
John Ball, Peter Bouxsein, Elizabeth Prewitt 202-783-9033
American College of Preventive Medicine
Donna Grossman 202-789-0003
American College of Surgeons
Paul Ebert 312-664-4050
****American Medical Association**
Jim Todd, John Zapp, Dorothy Moss 202-789-7400
American Psychiatric Association
Jay Cutler, Phylis Greenberger, Mel Subshin 202-682-6000
American Society for Internal Medicine
Alan Nelson, Susan Short 202-289-1700
College of American Pathologists
Jane Hart 202-371-6617
National Medical Association
Rich Butcher 619-263-6101
Physicians Who Care
Ron Bronnow 202-547-7177
Society on General Internal Medicine
Valerie Fedio 202-857-1107
Society of Thoracic Surgeons
Robert Wilbur 202-857-1100

2. Non- MD Professionals

American Academy of Physician Assistants
Nicole Gara 703-836-2272
American Association of Nurse Anethetists
Sue Ellen Hopkinson 202-682-1267
American Association for Marriage and Family Therapy
Kathryn Pontzer 202-452-0109
American Chiropractic Association
Michael Hogan 202-276-8800
American College of Nurse Midwives
Karen Fennell 202-289-0171
American Dental Association
Skip Wheat 202-898-2400
****American Nurses Association**
Virginia Betts, Donna Richardson 202-544-4444
American Occupational Therapy Association
Fred Somers 301-948-9626
American Optometric Association
Nancy Garland 301-718-6514
American Podiatric Medical Association
John Carson 301-571-9200

American Physical Therapy Association
Bob Asztalos 703-706-3165
American Psychological Association
Janet O'Keefe 202-336-5934
American Speech-Language-Hearing Association
Steve White 301-897-5700
Employee Assistance Professionals Association
Maureen Kerrigan 703-522-6272

3. Hospitals

American Association of Osteopathic Hospitals
Brian Hypes 202-686-1700
American Healthcare Systems Institute
Jim Scott 202-393-0860
**American Hospital Association
Dick Davidson, Rick Pollack, Jim Bentley 202-638-1100
American Protestant Health Association
Jerry Dykman 202-783-7507
Catholic Health Association
Bill Cox, Jack Bresch 202-296-3993
Columbia Hospital Corporation
Richard Scott 817-870-5900
Federation of American Health Systems (for-profit hospitals)
Michael Bromberg 202-833-3090
InterHealth
Ben Aune 612-646-5574
Lutheran General Health Systems
Leighton Smith, Kevin Wardell, Michael McCarthy 708-823-3548
Methodist Health Systems
Nancy Schlichting 614-566-5099
Miami Baptist Hospital
Brian Keeley 305-596-6503
National Association of Children's Hospitals and Related Institutions
Anne Langley 202-452-8811
Riverside Methodist Hospitals
Nancy Schlichting 614-566-5099
St. Joseph's Hospital (on Ethics)
Joe DeSilva 602-285-3101
Voluntary Hospitals of America
Daniel Bourque 202-822-9750

4. Managed Care Providers

American Association of Preferred Provider Organizations
Tom Gilligan 312-245-1555
American Managed Care and Review Association
Charles Stellar 202-728-0506
FHP, Inc.
Janet Newport 202-223-5718
Foundation Health
Chris Drake 916-631-5281
Group Health Association of American
Jim Dougherty, Erling Hanson, Linda Rose 202-778-3210
Healthcare Compare
Dan Bruener 916-925-7800

Kaiser Permanente

Jim Lane 501-271-6306

Managed Health Care Association

Carol Cronin 202-371-8232

United Healthcare

Ted Mondale 612-936-1620

US Health Care

Jim Stocker 215-628-4800

5. Others Providers

Ad Hoc Hispanic Health Care Providers and Policy Experts

Elena Rios 916-646-3770

COSSMHO-- Coalition of Hispanic Health and Human Services Provider

Jane Delgado 202-387-5000

Wellness Councils of America

Harold S. Kahler 402-572-3590

LONG TERM CARE

1. Consumer Groups

Alzheimer's Association

Steve McConnell 202-393-7737

****American Association of Retired Persons**

John Rother 202-343-3700

Consumers Union

Gail Shearer 202-462-6262

Families USA

Ron Pollack 202-737-6340

National Association of Area Agencies on Aging

John Linkous 202-296-8130

National Committee to Preserve Social Security and Medicare

Martha McSteen 202-822-9459

National Council of Senior Citizens

Lawrence Smedley 202-347-8800

National Council on the Aging

Daniel Thurz 202-479-1200

The Leadership Council of Aging Organizations (32 national aging organizations)

Horace Deets, AARP 202-343-2300

The Long Term Care Campaign (representing 137 cooperating Organizations)

Deborah Briceland-Betts 202-393-2092

Save Our Security (representing over 100 organizations)

Arthur Flemming 202-822-7708

Generations United (representing numerous aging and children's advocates)

Tess Scannell 202-638-2952

2. Provider Groups

National Association for Home Care

Dayle Berke 202-547-7424

American Health Care Association (Nursing Homes)

Paul Willging 202-842-4444

American Association of Homes for the Aging
Mike Rodgers 202-782-2242
National Institute on Adult Daycare
Betty Ransom 202-479-6682
Tori Wagman 202-479-6613
American Association for Respiratory Care
Cheryl Brown 703-351-5282
American Federation of Home Health Agencies
Ann Howard 301-588-1454
Health Industry Distributors Association
Craig Jeffries 703-549-4432
The Oley Foundation
Bruce Grefrath 202-546-2545

PHARMACEUTICAL INTERESTS

1. Drug Manufacturers

Merck

Teel Oliver 202-833-8205

Johnson and Johnson

Shannon Salmon 202-408-9482

Pfizer

Ken Bowler 202-783-7070

Schering Plough

Rob Lively 202-463-7372

SmithKlineBeecham

Dave Jenkins 202-452-8490

Syntex

Richard Schwartz 415-855-5601

Eli Lilly

Bill Tureene 202-955-5350

Searle

Kurt Furst 202-842-0706

Marion Merrel Dow

Ronald Docksai 202-429-3423

2. Generics

Generic Pharmaceutical Industry Association

Dee Fensterer, Bill Haddad 212-683-1881

National Association of Pharmaceutical Manufacturers

Robert Milangese, George Barrett 212-838-3720

National Pharmaceutical Alliance

Chris Sizemore, Cerie McDonald 703-836-8816

3. Biotech Interests

Industrial Biotechnology Association

Richard Godown, Lisa Raines 202-857-0244

Roche Pharmaceuticals

Herbert Conrad 201-235-2421

T Cell Sciences, Inc.

James Grant 212-734-7490

Novo Nordisk

Harry Penner 212-867-0123

Genetech, Inc.
Kirk Raab 415-266-1210
Synergen, Inc.
John Saxe 303-938-6200

4. Pharmacists

American Pharmaceutical Association
John Gans, Bill Hermelin 202-628-4410
American Society of Consultant Pharmacists
Timothy Webster 703-920-8492
National Association of Chain Drug Stores
Ronald Ziegler, Dave Lambert 703-549-3001
National Association of Retail Druggists
Charles West, John Rector 703-683-8200

5. Purchasers

Group Health Association of America
Jim Dougherty, Earling Hanson, Linda Rhodes 202-778-3210
American Society of Hospital Pharmacists
Joseph Oddis, Tom Bruderle 301-652-8278

REHABILITATION

National Association of Rehabilitation Facilities
Carolyn Zollar 703-648-9300
National Rehabilitation Coalition
Alan Parver 202-624-7225

LABORATORIES

MetPath
Kim McCarthy 202-347-2270

SUPPLIERS

Health Industry Manufacturers Association
Alan Magazine 202-783-8700
National Association for Infusion Therapy
Alan Parver 202-624-7225
National Association of Medical Equipment Suppliers
Corrine Parver 703-836-6263

RESEARCH/ACADEMIA

(Research meeting coordinated by Terry Lehrman--202-544-1880)
AIDS Action Council
Derek Hodel 202-986-1300
Alliance for Aging
Dan Perry 202-293-2856
American Society of Microbiology
Janet Shumker 202-737-3600
American Society of Tropical Medicine and Hygiene
George Mill 615-327-6212
Arthritis Foundation
Arthur Grayzel 703-276-7555
Association of Independent Research Institutes
April Burke 202-393-5250

Association of American Medical Colleges
Dick Knapp 202-828-0400
American Federation for Clinical Research
Lynn Morrison 202-628-3954
Association of Minority Health Professions Schools
Dale Dirks 202-544-7499
Association of Academic Health Centers
Roger Bulger 202-265-9600
Association of Schools of Allied Health Professions
Jarrett Wise 202-994-3725
Cystic Fibrosis
Bob Dresing 301-951-4422
Federation of American Societies for Experimental Biology
Shu Chien 301-530-7000
Hereditary Disease Foundation
Nancy Wexler 212-960-5650
Howard University
Claude Cowan 202-806-6100
Johns Hopkins University
Bill Richardson 301-516-8068
Merck
Teel Oliver 202-833-8205
National Coalition for Cancer Research
Marguerite Donoghue 202-544-1880

Miscellaneous

American Heart Association
Sarah Kayson 202-822-9380

ADMINISTRATION/ELECTRONIC DATA PROCESSING/FINANCING

American Health Information Management Association
Kathleen Frawley 202-736-2155
GMIS, Inc.
Thomas Owen, Robert Dolan, James Walsh 215-296-3838
Health Care Financial Management Association
Tom Gray 202-296-2920
Joint Commission for the Accreditation of Healthcare Organizations
Dennis O'Leary 708-916-5600

POSITIONS OF LEADING ORGANIZATIONS

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POSITIONS OF LEADING ORGANIZATIONS

A multitude of national associations, coalitions, groups and individuals have come forward with proposals for health system reform. These proposals range in scope, approach and specificity.

A few groups advocate scrapping the present health care delivery and financing system altogether and replacing it with a single-payer, Canadian-style system operated by the federal government.

Most groups advocate building on the strengths of the current system but making significant changes. These plans typically incorporate employment-based coverage with a "play-or-pay" scheme to ensure minimum coverage, and new or strengthened public programs to serve the poor and unemployed. Access to a minimum level of benefits is assured. Many of these plans use tax deductions and vouchers, tax reforms, and various incentives to encourage the development and use of managed care systems. Insurance reforms, state benefit mandate repeals, and state anti-managed care law preemptions also are recommended.

Finally, some groups advocate hybrid approaches, including plans based on small group insurance reforms. Some of these rely on market forces, consumer incentives and other mechanisms including a mix of those cited above to improve access and control costs.

It is worth noting that the various plans differ greatly in terms of their specificity. Many plans address in detail the core issues of access, financing, cost-containment and market reforms. Some present only broad principles upon which reforms should be based.

If any one principle unites these proposals, however, it is the almost universal call for delivering health services through managed care systems. While some plans recommend major changes in the way health care is delivered and financed, almost every plan, including those recommending that the delivery system should remain unchanged, proposes incentives to promote the development and use of innovative managed care networks and systems.

The following discussion contains the key points of many of these proposals, organized in terms of:

- How access to care is assured (Coverage).
- How costs would be contained (Controlling Costs).
- How the current health care delivery system would be modified (Delivering Health Services).
- How the health insurance system would be changed (Health Insurance System Reform).

AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association (AHA) plan includes universal access through a mix of public and private sector financing mechanisms. Employer-based health coverage remains the principal source of coverage. A new public program consolidates and expands the Medicare and Medicaid programs and expands coverage. Cost controls are achieved through a restructuring of both the health care delivery and financing system. Practice parameters play a key role in standardizing care and managing costs. Tort reform and antitrust reform also are highlighted. The AHA initially had advocated a play-or-pay formula, but backed off that approach and now supports an incentive-to-play plan with a safety net for those who cannot play.

COVERAGE

The employment-based private insurance system is enhanced with phased-in, mandated coverage in conjunction with tax credits and other incentives to make insurance more affordable for business. Employers

retain the ability to self-fund, but must assume responsibilities and obligations for coverage equal to those of insured businesses. Coverage must meet minimum specifications of a federally-defined basic benefits package. A national commission is created to define the package.

Employers contribute at least 50 percent of premium costs for full-time employees and dependents. Businesses not covering employees are required to pay taxes to finance government-run plan(s). Part-time employees must be covered.

Small employers with small group plans for less than 25 employees will purchase community-rated plans from public programs or privately convened groups.

Self-employed individuals are allowed to deduct 100 percent of health insurance premium costs on their federal income taxes.

Consumers pay deductibles and copayments for all services in the basic plan, except for preventive services.

Individuals without employer-based coverage are enrolled in government-sponsored programs. Full government subsidies are provided for those falling 150 percent below the poverty level, with a sliding scale used for those above 150 percent.

CONTROLLING COSTS

Payments by purchasers (consumers and insurers) are based on capitated fees to so-called "community care networks." An independent board sets capitated rates and cost-sharing formulas. Risk-adjusted capitation rates serve as the budget for delivering care to communities. Provider incentives are aligned through risk-adjusted capitated payments to the community care networks.

The Medicare and Medicaid programs are consolidated and expanded in scope through creation of a new public program. The benefits package for the new program is matched to budget targets set by Congress biannually.

Cost-effectiveness guidelines are created for the development and use of new and existing medical technology and specialized services.

DELIVERING HEALTH SERVICES

The health care delivery system is restructured through creation of "community care networks," which provide integrated care at the community level and are paid on a capitated basis. Payer and purchaser use of networks is encouraged by financial incentives for beneficiaries. Hospitals and physicians remain key partners in the formation and operation of networks. Hospitals coordinate the networks and provide those systems needed to achieve managed care objectives. Networks use the risk-adjusted capitation rates as their budgets.

HEALTH INSURANCE SYSTEM REFORM

AHA's plan will eliminate risk avoidance underwriting practices and encourage risk management. An amendment to the Employee Retirement Income Security Act (ERISA) will require self-funded plans to contain the same contribution obligations as insured employers. A reinsurance mechanism is proposed. Pre-existing condition exclusions are eliminated and mechanisms allow for the portability of health benefits.

*A more detailed summary of the AHA proposals appears at pages AHA 1-7,
which follow this Executive Summary.*

AMERICAN MEDICAL ASSOCIATION

The American Medical Association (AMA) "Health Access America Plan" provides for a uniform floor of essential benefits through required employment-based private insurance and government programs for those outside the employment setting who are unable to provide insurance for themselves. The plan calls for tax incentives and credits, as well as state risk pools, to make private coverage available to new and small

businesses. The plan relies on managed competition and strengthened market forces. It preserves the patient's right to choose a personal physician and insurance plan.

COVERAGE

Employers contribute an unspecified percentage of premiums for all full-time workers and dependents. Group plans must include a comprehensive list of services, with minimum benefits including "reasonable" annual limits on premiums, co-payments and deductibles. Employers must offer benefits packages to employees in three different financing options.

Employers must provide part-time employees with individual private-sector insurance vouchers, equal to a designated percentage of each employee's wages. Vouchers are used to cover a portion of premiums for a minimum benefits insurance policy.

State risk pools are used to cover the uninsurable and uninsured, or those employed in small businesses.

Self-employed individuals deduct 100 percent of premium costs. If private insurance is unaffordable, self-employed individuals may obtain coverage from state risk pools.

CONTROLLING COSTS

The AMA plan relies heavily on tort reform, tax caps on health care benefits and insurance reforms to control costs. Practice guidelines are used to standardize care and control costs. Medicaid reimbursement levels match Medicare levels. Tax rebates are given to employees who enroll in benefit plans where premiums are less than the employer's contribution rate. Limits are placed on federal tax exclusions for employer-provided benefits.

DELIVERING HEALTH SERVICES

No significant modifications are proposed to the current delivery system. The plan calls for greater use of managed care.

HEALTH INSURANCE SYSTEM REFORM

Health insurance benefits are fully portable and pre-existing condition exclusions are eliminated. Employer plans are required to hold open enrollment for employees who lost coverage due to a change in their spouse's coverage.

Federal incentives are given to help states create private, not-for-profit health risk pools to make private sector coverage available at standard group rates for the medically uninsurable and others for whom premiums are too expensive and/or group coverage is not available, including small businesses.

The Medicaid program is expanded and reformed on a phased-in basis to provide coverage for all who are below the poverty line.

A more detailed summary of the AMA proposals appears at pages AMA 1-14, which follow this Executive Summary.

BLUE CROSS/BLEU SHIELD ASSOCIATION

Under the proposal of the Blue Cross/Blue Shield Association, private plan coverage for basic benefits is guaranteed. Tax subsidies are provided for individuals and employers. Insurers must meet new federal criteria and services are delivered through new cooperative service delivery arrangements. The Blues plan calls for insurance system and Medicaid reforms.

COVERAGE

Full government subsidies are provided for basic benefit packages for those at the poverty level, with a sliding scale used for those at near-poverty levels. Large employers contribute at least 80 percent of premium costs for basic employee benefit packages and 50 percent of costs for dependents. Tax subsidies are provided on a sliding scale for low-income employees.

Small employers must either offer private coverage or contribute to the cost of a basic benefits package; employees of non-contributing firms receive tax subsidies. Tax subsidies are provided for contributing employers with marginal profitability.

Health insurance premiums for the self-employed are fully deductible.

CONTROLLING COSTS

All persons eventually receive care through so-called community care partnerships (CCP), which are created by any provider or payer entity. CCPs, certified by states, must meet standards for managing costs. CCPs get full tax deductions for providing services. Insurers must make commitments to managing costs and must enroll an increasing share of enrollees in CCPs until all are enrolled. Outcome measures evaluate care and control costs. A system is created to evaluate and regulate distribution of capital-intensive medical technologies. There are limits on federal tax exclusions for employer-provided benefits.

DELIVERING HEALTH SERVICES

State-certified CCPs deliver health care services. CCPs represent a partnership between insurers, providers and consumers. Through contracting arrangements with CCPs, insurers (or Accountable Health Plans) both finance and manage patient care.

HEALTH INSURANCE SYSTEM REFORM

The Blues plan endorses a joint public-private sector malpractice reform effort. Only insurers meeting new federal criteria are licensed by states as Accountable Health Plans to offer coverage. All benefits are portable, and no one can be denied coverage. Limits and exclusions for pre-existing conditions are eliminated under universal coverage for basic benefits.

A more detailed summary of the Blue Cross and Blue Shield proposals appears at pages BC/BS 1-10, which follow this Executive Summary.

HERITAGE FOUNDATION

The Heritage Foundation's proposal uses a tax reform strategy to provide access for the uninsured. The proposal calls for replacing the current tax exclusion for company-provided plans with a system of refundable tax credits for purchasing health insurance and medical services. The proposal mandates coverage for all individuals, although under this plan the strict employer-based system of health coverage is eliminated. Tax incentives are used to encourage consumer purchase of low-cost plans, including catastrophic coverage.

COVERAGE

Employment status is not a factor in health coverage. Benefits provided by employers are fully taxable for employees. Tax credits enable individuals to purchase coverage and use for out-of-pocket expenses. Low income individuals and the uninsurable are covered by Medicaid. Medicaid eligibility is based only on poverty status.

CONTROLLING COSTS

Costs are controlled primarily by relying on a restructuring of existing tax incentives. Tax incentives for families encourage use of low-cost plans.

DELIVERING HEALTH SERVICES

No restructuring of the current system is recommended.

HEALTH INSURANCE SYSTEM REFORM

No major reform is proposed. Changes in the federal tax system achieve the needed incentives. Benefits are portable, since coverage is not tied to employment.

A more detailed summary of the Heritage Foundation proposals appears at pages HERITAGE 1-4, which follow this Executive Summary.

NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

The National Leadership Coalition for Health Care Reform uses an employer-mandated play-or-pay approach that guarantees universal access to a standard benefits package called "Pro-Health." Anyone not covered by private insurance is eligible for a state Pro-Health plan. Pro-Health helps individuals buy insurance only through the private health insurance market. The program is administered by private insurers and a health review board.

COVERAGE

Employers provide a standard benefits package to employees and non-working dependents through private insurance, or they enroll employees in Pro-Health and pay a 7 percent payroll tax matched by an employee contribution of 1.75 percent.

All employers are required to contribute .5 percent of payroll (up to a maximum Medicare taxable base per employee) to help finance Pro-Health. Pro-Health enrollees pay premiums based on income level. Employers choose different approaches for full-time and part-time employees.

A subsidy is provided to small businesses to help make the cost of insurance more affordable. The self-employed can purchase coverage through Pro-Health. Those not employed purchase coverage through state Pro-Health plans. Subsidies are provided for those falling below the poverty line, with a sliding scale for up to 200 percent above the poverty level.

CONTROLLING COSTS

To control costs, a national Health Review Board sets national annual expenditure targets, which are submitted to Congress for approval. The goal is to reduce the rate of growth in health spending 2 percent per year until it matches the GNP growth rate. Uniform provider payment rates for all payers and capital spending targets are set by the government. Practice guidelines are used to standardize care and control costs.

DELIVERING HEALTH SERVICES

"Organized Delivery Systems" (ODS) are responsible for delivering services. ODSs compete on their ability to deliver and manage care within a uniform rate schedule.

HEALTH INSURANCE SYSTEM REFORM

Insurance system reforms eliminate exclusions for pre-existing conditions, guarantee portability of benefits and renewability, and implement community rating. State mandated benefit laws are preempted. Pro-Health is available to those experiencing gaps in private coverage. Pro-Health replaces Medicaid-covered acute care services. Malpractice reforms are proposed.

A more detailed summary of the Coalition's proposals appears at pages NLCHCR 1-4, which follow this Executive Summary.

AFL-CIO

The AFL-CIO plan proposes universal coverage delivered through a government-administered program. Medicare eligibility is reduced to age 60. The national social insurance program covers comprehensive long-term care services.

COVERAGE

Congress establishes a core benefits package and a federal program for the unemployed and current Medicaid population. Employers, regardless of size, share the cost of premiums for covering employees and dependents, including part-time employees. Supplements to the basic benefits package can be negotiated. The national program covers long-term care, including inpatient care, community-based treatment, and home care.

CONTROLLING COSTS

A national commission administers a national cost containment program. The commission negotiates uniform all-payer rates, sets an annual rate increase target for total health spending, and creates a capital budgeting system.

DELIVERING HEALTH SERVICES

No restructuring of the current system is recommended.

HEALTH INSURANCE SYSTEM REFORM

Included are malpractice reforms, risk pooling, mechanisms for reducing administrative costs, preemption of state-mandated benefits, and managed care standards. The health insurance system is reformed to achieve guaranteed portability and renewal of coverage. Restrictions on pre-existing conditions are dropped.

A more detailed summary of the AFL-CIO proposals appears at pages AFL-CIO 1-2, which follow this Executive Summary.

HEALTH INSURANCE ASSOCIATION OF AMERICA

The plan proposed by the Health Insurance Association of America focuses on ensuring access for those who currently are uninsured or risk losing their insurance because of job loss or other events. The plan is voluntary and uses managed care and insurance reforms that promote competition to control costs. Financial incentives are used to encourage the purchase of private insurance. Medicaid is expanded to cover all poor and, through buy-in options, the near-poor.

COVERAGE

Financial incentives encourage the purchase of private plan benefits. Coverage is available to all employers, including small businesses. The self-employed may deduct 100 percent of premium costs. Industry-backed legislation makes insurance available to employees of smaller businesses as well as larger groups.

Private coverage is more widely available to "high risk" individuals and those not part of employer groups through the creation of not-for-profit reinsurance organizations and state risk pools. Medicaid is expanded to cover all below the poverty level. The near-poor receive tax subsidies to buy into income-related packages of care. A national risk pool catches those not covered when states fail to create their own pools.

CONTROLLING COSTS

The government and insurance industry encourage expanded use of managed care programs. Electronic claims management and processing are used to cut overhead costs.

DELIVERING HEALTH SERVICES

No major restructuring is proposed. The plan advocates greater reliance on managed care.

HEALTH INSURANCE SYSTEM REFORM

Reforms require carriers to accept all small-employer applications. Portability and renewability are ensured. Carrier premiums cannot vary widely among similar groups. Limits are placed on how much carriers can raise rates of employer groups before basic increases for all small-employer groups. State laws mandating benefits are repealed.

A more detailed summary of the HLAA proposals appears at pages HLAA 1-2, which follow this Executive Summary.

THE JACKSON HOLE GROUP

The Jackson Hole Group plan represents a managed competition approach to health system reform. It ties tax policy, competition among providers and outcomes measurement to increase access and contain costs. Consumer choice plays an important role, based on the premise that individuals from plans screened by employers and other intermediaries will comparison shop for the most cost-efficient plans. The Jackson Hole Group's proposal contains a modified play-or-pay provision. The plan is implemented in two steps.

COVERAGE

Phase One, which takes five years, emphasizes cost-containment. Insurers and health providers create so-called Accountable Health Partnerships (AHPs) to offer uniform effective health benefits. Health Insurance Purchasing Corporations (HIPCs) are designated to buy health care on behalf of small employers. AHPs submit bids to HIPCs for the right to serve the region. The lowest bids serve as the base price for tax exemptions on premiums paid by all purchasers.

Phase Two thereafter mandates universal coverage. HIPCs purchase health care for small employers collectively.

Employers must provide full-time employees with coverage through an AHP and contribute 50 percent to 100 percent of the cost of the lowest-priced AHP offered by a local HIPC. The employer purchases coverage for part-time employees or pays a payroll tax. Small employers with up to 50 employees must purchase coverage through HIPCs.

Non-employed individuals with incomes are taxed to help cover the purchase of insurance through an HIPC. Public programs contract with HIPCs for acute care coverage. Medicare is gradually shifted into HIPCs and AHPs.

CONTROLLING COSTS

The federal tax exclusion for health benefits is limited to AHP enrollees and capped at the lowest cost AHP in the region. A combination of public and private sector boards regulate health services and benefits.

HIPCs are used to increase the size of risk pools, limit opportunistic carrier-switching by enrollees, and provide incentives for more prudent purchasing of coverage.

DELIVERING HEALTH SERVICES

The delivery system is restructured through the creation of Accountable Health Partnerships, managed care-like organizations publicly accountable for health outcomes.

HEALTH INSURANCE SYSTEM REFORM

A mix of government and private sector boards set and monitor standards for benefit plans, insurance and health care delivery. AHPs must meet health insurance standards, including prohibitions against medical underwriting, waiting periods or exclusions for pre-existing conditions.

A more detailed summary of the Jackson Hole Group's proposals appears at pages JACKSON 1-4, which follow this Executive Summary.

THE ENTHOVEN/KRONICK PLAN

The Enthoven/Kronick plan proposes universal health insurance coverage based on managed competition with mixed public and private sponsorship. It uses a play-or-pay mechanism. Those not covered by Medicare, Medicaid or other public programs purchase affordable coverage either through their employer or through a "public sponsor." The plan calls for competition among health plans and informed consumer choice, which rewards providers who deliver cost-efficient care. All plans must provide a basic benefits package.

COVERAGE

Federal legislation gives states incentives to create public sponsor plans, which provide coverage at moderate prices for individuals not covered by other plans. States are guarantors of coverage.

Employers contribute the average cost of a basic benefits package for all full-time employees and dependents. Employers either cover part-time, temporary or other uncovered employees or pay an 8 percent payroll tax on the first \$22,500 in wages to fund public sponsored plans. Small employers can purchase coverage from the public sponsors, with contributions capped at 8 percent of payroll. The self-employed obtain coverage through public sponsors, with contributions made through income taxes.

Low income persons are covered by current public programs, with additional 100 percent government subsidies for those falling at or below the poverty level, and a sliding scale used for those up to 150 percent of the poverty level. No initial changes are made to Medicare or Medicaid.

CONTROLLING COSTS

Public sponsors contract with so-called "Qualified Health Plans" (QHPs) based upon cost-effectiveness factors. QHPs incorporate managed care. Incentives are provided for enrolling in QHPs, with an emphasis on capitation arrangements. Also, the plan limits tax-favored employer contributions, with consumers paying anything over the average cost of the basic benefits plan.

DELIVERING HEALTH SERVICES

The proposal fosters increased market competition among managed care plans. Sponsors manage the process of informed, cost-conscious consumer choice that rewards the most cost-efficient providers with more subscribers, and drives costly, low-quality providers from the market.

HEALTH INSURANCE SYSTEM REFORM

The proposal eliminates pre-existing condition exclusions and provides for some portability of benefits. QHPs cannot use medical underwriting. A risk rating system with cross subsidies through public sponsors avoids biased risk selection. The market for private individual coverage is eliminated. State-mandated benefits are preempted.

A more detailed summary of the Enthoven/Kronick proposals appears at pages ENTHOVEN 1-17, which follow this Executive Summary.

CATHOLIC HEALTH ASSOCIATION

The Catholic Health Association (CHA) plan combines universal insurance with elements of managed care and market competition to ensure access and contain costs. It blends regulatory and competitive mechanisms rather than focusing on employer mandates or single-payor approaches. The plan focuses on reforming the system to meet patient needs rather than financing pressures. It is presented as an alternative to what the CHA calls budget-driven decision making.

COVERAGE

All individuals choose coverage from so-called "Integrated Delivery Networks" (IDNs) during open season. No denial of enrollment is permitted. Premiums are not collected. Client cost sharing is income-based. Cost sharing does not apply to those below the poverty level, but a sliding fee scale is used for those between 100 percent and 150 percent of poverty level. Annual cost sharing amounts are limited. Supplemental benefits and services can be purchased outside the system, but without tax benefits.

Employers and employees are asked to contribute to the system at a rate sufficient to cover the cost of all workers and dependents: a 6.9 percent payroll tax on employers and 1.7 percent payroll tax on employees.

CONTROLLING COSTS

A National Health Board recommends national expenditure levels and allocates funds to State Health Organizations (SHOs). SHOs determine community needs, authorize Integrated Delivery Networks (IDNs) within the state, and provide IDNs with capitated payments.

IDNs, the sole providers of services, receive risk-adjusted capitated payments to provide the full range of patient care services. All IDN providers are linked through contractual arrangements. Risks are born by all participants. Capitated payments are adjusted to reflect the particular health care needs of enrolled populations.

Most major public financing sources, including Medicaid, CHAMPUS and the VA, are consolidated into a single dedicated health care trust fund.

DELIVERING HEALTH SERVICES

The service delivery system is reformed. Several IDNs are developed in each community, with each IDN serving between 50,000 and 100,000 individuals. All providers must join at least one IDN to participate in the health care system. IDNs compete on the basis of service and quality, not price. IDNs assume the financial risk for the basic comprehensive benefit package and full continuum of services.

HEALTH INSURANCE SYSTEM REFORM

The role of insurers changes. Aside from providing supplemental insurance, indemnity insurers no longer exist. Current insurance companies manage IDN risk, process claims data, and develop contractual arrangements with IDN providers.

A more detailed summary of the CHA proposals appears at pages CHA 1-7, which follow this Executive Summary.

HEALTHCARE EQUITY ACTION LEAGUE

The Healthcare Equity Action League (HEAL) proposes a bipartisan health reform plan based on insurance underwriting and malpractice reforms and other measures to control costs. The current financing and delivery system would be improved rather than altered. Government-imposed controls are not recommended.

COVERAGE

Universal coverage is achieved by lowering the cost of health care and removing current barriers to employer-based coverage. State mandated benefits are eliminated. State laws restricting managed care plans are preempted. The tax code is changed to allow full deductibility for employer premiums regardless of business size.

Consumers are empowered by information and an emphasis on wellness.

CONTROLLING COSTS

Costs are controlled through incentives that encourage providers and insurers to use innovative purchasing and managed care systems.

DELIVERING HEALTH SERVICES

No significant change is recommended.

HEALTH INSURANCE SYSTEM REFORM

HEAL seeks full portability of benefits, malpractice reforms to reduce the practice of defensive medicine, and insurance underwriting reforms to prohibit denial of claims for pre-existing conditions.

A more detailed summary of the HEAL proposals appears at pages HEAL 1-2, which follow this Executive Summary.

NATIONAL COMMITTEE FOR QUALITY HEALTH CARE

The National Committee for Quality Health Care plan advocates incremental improvements in the current market-based system. The plan retains employment-based coverage, with universal access to a basic level of benefits, and uses tax code changes and a mix of employer and consumer incentives. The plan stresses the use of practice guidelines and outcomes research. Consumer education also is emphasized to create higher levels of cost awareness.

COVERAGE

Tax code changes allow equal tax treatment for employers regardless of size, including the self-employed. Tax incentives are provided for small employers and low-income employees. State mandated benefit laws are repealed. The Medicaid program is retained. A basic minimum benefit plan for the poor but Medicaid-ineligible is provided, with income subsidies for the near-poor and low-income workers. A mix of employer and consumer incentives is used to expand access.

CONTROLLING COSTS

Reliance on managed care, outcome measures, practice guidelines, malpractice reforms is intended to control costs. Incentives for healthy life-styles and enrollment in cost-effective health plans are provided. Incentives for employee participation in premium cost sharing are given. The Committee proposes repeal of state mandated benefits, certificate-of-need regulations, restrictions on utilization review and other anti-managed care laws. Incentives are provided to encourage the development of integrated health delivery systems. Adequate payments in all government-sponsored programs are required to avoid cost shifting. Protocols for evaluating new technology are set, with technology and resource allocation decisions based on market needs.

DELIVERING HEALTH SERVICES

Integrated health delivery and financing systems are urged, with greater emphasis on managed care.

HEALTH INSURANCE SYSTEM REFORM

Small market insurance reforms will make coverage affordable and portable. New reinsurance mechanisms are set up for insurers.

A more detailed summary of the Committee's proposals appears at pages NCQHC 1-8, which follow this Executive Summary.

AMERICAN ASSOCIATION OF RETIRED PERSONS

The "Health Care America" proposal of the American Association of Retired Persons (AARP) blends employer play-or-pay, a government-sponsored single payer mechanism, and private market changes, including small group insurance reform and tax credits. The current private insurance market is retained. The plan guarantees universal access to comprehensive health care through a new Medicare program and private employment-based coverage. The Medicaid program is abolished. Coverage is available regardless of age, income or employment status. A single health insurance access card (MEDICARD) is used to access all services. Long-term and preventive care are covered. Physician and hospital payment rates are standardized and spending targets are set at the federal and state levels.

COVERAGE

All are covered regardless of age, income level or employment status through MEDICARD. Tax credits are provided for low-income persons; the poor pay no premiums, deductibles or coinsurance. Employers must purchase private coverage or pay an 8 percent payroll tax to enroll employees in the new Medicare program. Non-low-income persons are subject to deductibles and coinsurance for selected services. Annual out-of-pocket expenses are limited to \$1,500 for individuals and \$3,000 for families. Medicare enrollment is set at \$50 per adult plus \$25 for family members. MEDICARD is used to access all services. Long-term care coverage includes deductibles for home and community services and copays for nursing home stays up to an income-related limit.

CONTROLLING COSTS

The plan is funded by premiums, deductibles and copayments, plus a payroll tax (if applicable) and either a special 3 percent national income tax or 5 percent value-added tax. A "sin" tax, 5 percent surtax on existing corporate income taxes and higher estate taxes are also possible. Spending targets are set at national and state levels; the spending growth rate is limited; physician, hospital and nursing home rates are standardized; and prescription drug prices are limited. Standardization and electronic billing are used to reduce administrative costs.

DELIVERING HEALTH SERVICES

No restructuring is proposed.

HEALTH INSURANCE SYSTEM REFORM

The plan proposes small group insurance reforms.

A more detailed summary of the AARP proposals appears at pages AARP 1-13, which follow this Executive Summary.

COMMITTEE FOR NATIONAL HEALTH INSURANCE/ HEALTH SECURITY ACTION COUNCIL

The Health Security Partnership Program of the Committee for National Health Insurance/Health Security Action Council proposes universal access to core benefits through employment-based coverage or a state-based Health Security Partnership Program. Basic benefits and standards are set by the federal government, while the plan is organized, administered and financed through state participation. The states negotiate advanced budgets with providers. The elderly are covered through the existing Medicare program, with Medicaid folded into a new state-based partnership program. Long-term care coverage is phased-in. A national fund is used to enhance services in underdeveloped areas and to sponsor service delivery research.

COVERAGE

Individuals enroll in health insurance delivery plans approved by the Health Security Partnership Program in their state. Plans include state programs or employment-based private plans; all individuals receive a Partnership card guaranteeing access to a package of core benefits, including all "medically-necessary" services. Access to long-term care is phased in, beginning with qualified Medicare beneficiaries.

CONTROLLING COSTS

The plan is funded by federal and state revenues, private insurers and the Medicare Trust Fund, with states deciding how to fund their programs. Increases in state health budgets are tied to GNP growth. States negotiate advanced spending budgets with health care providers. A new relative value scale is used for physician fees. States negotiate budgets and fee caps biannually. Drug manufacturers are subject to pre-budgeted levels. A single state organization is used to administer and fund the program. States certify insurers and develop guidelines for service delivery.

DELIVERING HEALTH SERVICES

No restructuring is recommended. Unspecified incentives are used to promote more efficient service delivery mechanisms.

HEALTH INSURANCE SYSTEM REFORM

Federal/state standards require community rather than small group rating. Duplicative insurance offerings are eliminated. Insurers can offer supplemental medical programs.

A more detailed summary of the Council's proposals appears at pages HSAC 1-3, which follow this Executive Summary.

FEDERATION OF AMERICAN HEALTH SYSTEMS

The Federation of American Health Systems (FAHS) plan combines employer play-or-pay with Medicaid and Medicare reforms to guarantee universal access to a minimum benefits package. Employee tax deduction levels for employer-financed health benefits are limited to fund an expanded Medicaid program. Tax credits are used to help small businesses purchase insurance. Retirees and the self-employed are subject to a modified play-or-pay scheme. The Medicare program is expanded and gradually converted to include private insurance options. Medicaid also is gradually converted to a program providing income-based subsidies for private health insurance plans.

COVERAGE

Employers are required to provide full-time employees with basic public or private health insurance coverage (with an 80 percent minimum employer contribution) or pay a payroll tax to support expanded and modified Medicare and Medicaid programs. Early retirees without employer coverage, the self-employed and those under 65 not covered by an employer's plan are required to enroll in a private plan or pay a tax (with a specified ceiling) to enroll in the public plans. Those purchasing coverage receive a tax credit. A national minimum benefits package is created for Medicaid, and state funding is replaced by national funding. Medicaid is expanded to include paying for private coverage, while current eligibility is replaced with a sliding scale income test. Medicare is converted to a voucher (private health plan) system with incentives for encouraging the use of PPO options. The actuarial value of the Medicare voucher is taxed, with exemptions for the poor.

CONTROLLING COSTS

The FAHS plan states that when a certain amount of employer-paid health insurance becomes taxable, employees will become cost-sensitive consumers. A ceiling for exclusion encourages employers to voluntarily offer multiple health plans, including low-cost options. Eliminating open-ended employer contributions while encouraging equal contributions to all employee plans stimulates competition and gives consumers an economic stake through cost sharing and copayments.

DELIVERING HEALTH SERVICES

No restructuring is recommended.

HEALTH INSURANCE SYSTEM REFORM

The FAHS plan recommends malpractice reforms to reduce defensive medicine; suggests study of the need for a federal re-insurance (catastrophic stop loss) program to protect consumers facing high cost medical care (including nursing home care). It calls for federal preemption of state mandated benefits with substitution of a national minimum benefits standard; also, the plan favors repeal of state laws banning limitations on patient freedom in selecting providers.

A more detailed summary of the FAHS proposals appears at pages FAHS 1-21, which follow this Executive Summary.

AMERICAN NURSES ASSOCIATION

The American Nurses Association's "Nursing's Agenda for Health Care Reform" combines employment-based coverage under a play-or-pay scheme with a new public program administered by the states. Universal access is guaranteed to a federally defined package of essential services. Eventually, all government-sponsored health programs would be merged into a new public plan. Deductibles and copayments are used to provide for a cost-conscious use of resources by consumers, with exclusions and limitations for the

poor and for certain services. Special programs would be created to provide services to vulnerable groups (i.e., infants and children). States are given latitude to modify health service delivery systems to meet local needs. State and local review boards determine budgets, cost-reduction mechanisms and allowable insurance premiums.

COVERAGE

A public plan administered by the states provides coverage for those below 200 percent of the poverty level, high-risk populations and the potentially medically indigent. Employers and individuals can buy into this plan. Employers must offer coverage or pay to support public programs. The plan includes financial relief for small businesses that is not specified. Premiums will be made affordable (with the manner unspecified) to ensure universal access to insurance. Private plans must meet new federal coverage standards. Deductibles and copayments are used, but are waived or subsidized for the poor (those with income below 200 percent of poverty); deductibles are held to a minimum for certain kinds of programs and services (e.g., well-child care, immunizations, managed care plans).

CONTROLLING COSTS

State and local review boards are created to determine resource allocation, cost reduction approaches, allowable insurance premiums and provider reimbursement levels, although mechanisms are not specified. Boards use federally set guidelines. Managed care is required for public plans and managed care incentives are provided for private plans. A preventive care emphasis produces a future "health dividend." Standardized billing, utilization review, improved administrative procedures, regulatory reforms and plan consolidation contribute to cost containment. There is greater use of practice guidelines and outcome measures.

DELIVERING HEALTH SERVICES

States are allowed to plan for, administer and modify delivery systems to reflect "geographical diversity." The plan encourages delivery of services in "convenient familiar sites," maximizing the use of local settings (including schools, etc.) and using a range of qualified health professionals.

HEALTH INSURANCE SYSTEM REFORM

The plan envisions private insurance market reforms, including community rating and a cap on out-of-pocket expenses for catastrophic care. All providers contribute to state reinsurance pools.

A more detailed summary of the ANA proposals appears at pages ANA 1-20, which follow this Executive Summary.

NATIONAL ASSOCIATION OF SOCIAL WORKERS

The National Association of Social Workers (NASW) plan calls for a federally administered single-payer system financed through a progressive federal dedicated tax on personal income coupled with an employer payroll tax. Universal access to comprehensive health care services, including long-term care, is guaranteed. The plan abolishes employment-based and private insurance coverage. Individuals enroll in the national plan within their states and receive care through participating public and private providers, including Integrated Health Service Plans. The program is administered by a new National Health Board, to which all current Health Care Financing Administration responsibilities would be transferred. Medicare, Medicaid, CHAMPUS and VA programs are phased out. States are given substantial responsibilities under the plan.

COVERAGE

All persons are automatically enrolled in the national health program. Access to services is guaranteed. Comprehensive coverage includes mental health and long-term care. No deductible is used, although

copayments are required if needed to control utilization. (Copayments are modest and not means-tested.) Nursing home and residential facilities residents are required to pay "modest" room and board fees, which are waived for the poor. Community-based and mental health services are promoted. State screening and care coordination systems are created for long-term care delivery. The program is financed through a federal dedicated tax on personal income, an employer payroll tax and state contributions based on a formula. Also, the plan favors dedicated estate taxes and an increase in "sin" taxes, plus federal taxes on businesses "which have been proven to expose workers to substances that cause chronic and fatal diseases, illnesses and disabilities." Small businesses are protected by a cap on contributions.

CONTROLLING COSTS

A federal National Health Board (NHB) is created to administer the program. NHB provides states with annual global budgets based on a formula. Budgets include state health block grant funding. The states, following federal guidelines, ensure implementation of all health services and determine funding distribution. Hospitals receive prospective global budgets for operating expenses developed through annual negotiations; separate funds for capital expansion and the purchase of advanced equipment are subject to state approval. States determine whether to pay other facilities (clinics, etc.) using prospective global budgets or capitation. Individual practitioners and group practices are reimbursed on a fee-for-service basis. (Groups may select capitation). Reimbursement rates are based on a negotiated national (adjusted) fee schedule using a resource-based relative value scale. Peer Review Organizations are extended to cover all health providers and services.

DELIVERING HEALTH SERVICES

No restructuring is recommended. Integrated Health Service Plans become comprehensive, integrated plans through which enrollees obtain services from providers.

HEALTH INSURANCE SYSTEM REFORM

A special commission is created to study malpractice reform.

A more detailed summary of the NASW proposals appears at pages NASW 1-5, which follow this Executive Summary.

AMERICAN HEALTHCARE SYSTEMS

"Patients First," the American Healthcare Systems plan, proposes a series of immediate reform measures and steps leading to long-term reform. The immediate measures include a restructuring of the Medicaid program to expand coverage and transfer responsibility for mandatory acute care services to the federal government. Various changes in Medicare are proposed, including eliminating distinctions between Parts A and B. A series of small group insurance reforms are recommended to enhance affordability and access to coverage, and a new standard for the tax deductibility of health insurance premiums is recommended. Also, the plan calls for the creation of a complementary public delivery system to provide services for the medically indigent. A Congressionally-created National Health Care Reform Commission would develop national goals for access, quality and cost. The plan also calls for a series of large-scale demonstration programs to test alternative delivery and financing schemes.

COVERAGE

The plan retains employment-based health coverage, with small group reforms to ensure acceptance of all groups by insurers and acceptance of all employees and dependents without regard to pre-existing conditions. Benefits are priced according to minimum benefits and additional benefits, giving employers/employees freedom of choice among different insurance products at different rates. Minimum benefits packages are

created, with the premium cost 100 percent tax deductible by whomever pays the premium. Copays and deductibles are used, including \$500 per individual and \$1,000 per family per year. There is 20 percent coinsurance on covered services above deductible amounts (up to limits). Under Medicaid, the federal government assumes responsibility for mandatory acute care services, with states responsible for long-term care and related coverage; categorically based eligibility for Medicaid is eliminated. Medicaid rates are increased to match Medicare rates. Medicare Part A and B distinctions are eliminated, with individual premiums adjusted by income levels. A public delivery system is created for the medically indigent where necessary.

CONTROLLING COSTS

Cost containment is achieved during the long-term reform phase by implementing the results of recommended experiments and demonstration projects, including research on effectiveness of services or per-capita basis for paying providers, mandatory managed care for public programs, and various cost-containment strategies, including rationing.

DELIVERING HEALTH SERVICES

No restructuring is recommended.

HEALTH INSURANCE SYSTEM REFORM

States cannot mandate coverage for additional services beyond a Minimum Benefits Package. Malpractice reforms are suggested, including preemption of state tort law and implementation of national tort reforms.

A more detailed summary of the Systems' proposals appears at pages AmHS 1-8, which follow this Executive Summary.

PEPPER COMMISSION

The U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Commission) issued its final report—"A Call for Action"—in September 1990. Senate Bill 1177, introduced by Senator Jay Rockefeller (D-WV), incorporates the major recommendations of the Commission's plan, which recommends strengthening the existing employment-based health coverage system with tax credits and subsidies for small businesses. Large employers are required to provide coverage for their employees. The unemployed and poor are covered through a new federal program that replaces the Medicaid program. All individuals are required to obtain health coverage from their employers or from the public program. A federally specified minimum benefit package is created.

COVERAGE

The plan calls for universal access to services through employer-based coverage or a public program. Except for preventive health services, significant consumer cost-sharing (subject to income and an out-of-pocket minimum) applies to create cost-sensitive consumers. Employers can select coverage through a public health insurance program. Medicaid is replaced by the new federal program, which adopts and extends Medicare's payment mechanisms. Medicare (or the new public program) provides financial help with premiums, deductibles and cost sharing for low income individuals. Public coverage reinforces but does not replace primary care delivery systems already subsidized to serve particular population segments. An insurance strategy (public, private or both) is used for long-term care.

CONTROLLING COSTS

Efficiencies of the new program, including changes in Medicaid and Medicare programs, will help achieve cost containment goals. Managed care is recommended for both private and public programs. Insurers offering managed care plans to large employers are also required to open options to small employers.

DELIVERING HEALTH SERVICES

No restructuring is recommended.

HEALTH INSURANCE SYSTEM REFORM

The Commission recommends that the Physician Payment Review Commission and Congressional committees explore malpractice reform and legislative remedies. Also, various requirements would end current private insurance underwriting, rating and marketing practices.

A more detailed summary of the Commission's proposals appears at pages PEPPER 1-17, which follow this Executive Summary. See also pages ROCKEFELLER 1-13 for a summary of the Senate bill introduced on behalf of the Commission.

A number of organizations have proposals that contain broad principles and set forth general directions for health system reform. Their major principles and recommendations are summarized below.

ADVISORY COUNCIL ON SOCIAL SECURITY

The 1991 report by the Advisory Council on Social Security, entitled "Commitment to Change: Foundations for Reform," proposes a series of insurance reforms and tax law changes, coupled with measures to spur economic growth as a first-step process toward health reform.

The Council also recommends an evolutionary approach to reform. It proposes that research initiatives be used to identify and support comprehensive community or state experiments that, in turn, would serve as precursors to systemic reform at the national level. A Federal Oversight Commission would identify and support these initiatives, including studies of restructuring Medicare and Medicaid, the use of employer mandates, and creating public health insurance models for acute care.

The Council's report places special emphasis on improving access to care for children and underserved populations.

Among the Advisory Council's recommendations for immediate reform:

- Insurance reforms to improve benefits portability, enact small group market reforms, disallow state-mandated benefits for small employer core benefit plans, and preempt state laws limiting the use of managed care.
- Build a stronger economy by reducing the federal deficit and undertaking other initiatives.
- Undertake malpractice reforms, including use of alternative dispute resolution mechanisms.
- Medicare Selective Contracting to identify and certify high-quality, cost-efficient providers for specific high-cost procedures.
- Create Medicare Centers of Excellence for major surgical procedures.

- Develop uniform claims system.
- Merge Medicare Parts A and B.

A more detailed summary of the Advisory Council's proposals appears at pages ACSS 1-8, which follow this Executive Summary.

NATIONAL ASSOCIATION OF MANUFACTURERS

The National Association of Manufacturers (NAM) resolution on health care reform supports major reform that is based on a continuation of a public/private health care delivery and financing system. NAM recommends short-term incremental changes consistent with the principles listed in its resolution, which include:

- Individuals should be responsible for obtaining either private or public coverage; all employers and employees should share the cost of coverage.
- Financing mechanisms should not disproportionately impact any one segment of the economy.
- Medicare, Medicaid and other publicly supported health programs should be adequately funded; Medicare should remain the primary payor for the elderly and disabled.
- Federal tort reform should be pursued to reduce defensive medicine costs and improve access to managed care and group purchasing.

A more detailed summary of the NAM proposals appears at pages NAM 1-4, which follow this Executive Summary.

THE BUSINESS ROUNDTABLE

The "Health Care Policy Principles" issued by The Business Roundtable support an employment-based system of coverage coupled with Medicare and Medicaid reforms, including the use of managed care by public programs. No new government programs should be created. While the Roundtable does not favor expanding entitlement programs, it does call for entitlement based on an ability to pay. Tax policy should be used to create incentives for individuals to purchase coverage.

Among the Roundtable's principles:

- Build on the current employment-based system of coverage; create no new government programs; allow employers to increase the employee's stake in cost containment by relating employee contributions to life-style choices, rewarding selection of lower cost plans, and greater cost sharing through deductibles, premium contributions and copayments.
- Use tax credits to increase the availability of private health coverage.
- Preempt federal and state laws mandating benefits.
- Undertake small group insurance market reforms.
- Create a reinsurance pool for the uninsurable.
- Incrementally expand Medicaid to the poverty level.
- Allow working low-income individuals and families to buy into Medicaid.

- Through policies, drive the rate of increase in age-adjusted per capita cost of health care toward the rate of general inflation.
- Use managed care to improve delivery and financing.

A more detailed summary of the Roundtable's proposals appears at pages ROUNDTABLE 1-10, which follow this Executive Summary.

NATIONAL GOVERNORS' ASSOCIATION

The National Governors' Association position on health care reform, contained in a report entitled "A Healthy America: The Challenge to States," supports comprehensive, state-wide health care reforms that maximize preventive and public health programs and experiment with medical care payment strategies. The NGA supports state-based reform, since states already play major roles in health care delivery through their purchasing, regulating, allocating and licensing roles. Also, the NGA argues that reforms must be based on state administration to ensure appropriate service delivery systems sensitive to local needs. The NGA sees states as incubators for experimentation and innovation while national consensus on reform is being created.

Among the principles supported by the NGA:

- Enable states to reorient health care delivery toward preventive and primary care, with preventive and primary care coverage a mandated part of benefit packages.
- States should require employers to offer health coverage; reduce insurance costs by targeting benefits, using tax credits to directly subsidize premium costs, and using mechanisms (that are unspecified) to indirectly subsidize the cost of insurance.
- States should identify the unique needs of disparate populations among the nonworking uninsured and develop systems of care to meet their needs. Suggested approaches include: build on the existing Medicaid program; use insurance subsidies, create universal coverage schemes, provide public catastrophic insurance, and directly fund health services.
- Make better use of incremental cost control strategies currently available to the states, including managed care, use of provider taxes and revenue pooling to reduce cost shifting, and use of regulatory cost containment tools like CONs and hospital rate setting.
- Experiment with financing and service delivery systems that enhance access to care at affordable costs: single private systems; using alternative grouping and financing arrangements rather than employer-based coverage; mixing public financing for basic health care with private insurance for catastrophic coverage.

A more detailed summary of the NGA proposals appears at pages NGA 1-6, which follow this Executive Summary.

LEAGUE OF WOMEN VOTERS OF THE UNITED STATES

The League of Women Voters of the U.S. released in April 1992 its position statement on health care reform, which is based on Phase 1 of the League's study of the health care system. Phase 2, focusing on financing and administration, will be concluded in April 1993.

The League's April 1992 statement addresses four issues: minimum basic level of quality care; equity issues; cost control; and allocation of resources to individuals. The League supports both the single payor and play-or-pay approaches. However, it does not endorse any currently introduced legislation and will not do so until 1993. The League supports universal access to a basic minimum level of care (including long-term care)

regardless of ability to pay. It also supports various cost containment strategies, including regional planning for allocating personnel, facilities and equipment; malpractice reforms; managed care; utilization review; and consumer accountability through deductibles and copayments.

A more detailed summary of the League's proposals appears at pages LWVUS 1-4, which follow this Executive Summary.

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

The Healthcare Financial Management Association (HFMA) statement on health care reform contains nine principles, including:

- Universal access to a defined set of basic services should not be contingent on employment with a specific company.
- There should be fair payment for providers delivering efficient and appropriate services.
- Cost-effective care should be identified and defined through the use of practice guidelines, protocols, geographic standards or benchmarks for procedures.
- Legal and regulatory obstacles to cost reductions should be reduced through Medicaid reforms, antitrust and antifraud reforms, tort reforms and reforms of state insurance laws.

A more detailed summary of the HFMA proposals appears at pages HFMA 1-4, which follow this Executive Summary.

HEALTHCARE LEADERSHIP COUNCIL

The Healthcare Leadership Council's "Health Care Policy Package" advocates building on the strengths of the current pluralistic system, mixing small group insurance reforms, income-related subsidies, Medicaid reforms, managed care, malpractice reform and changes in state laws to enhance access and control costs.

Among the Council's major points:

- Encourage employer-based coverage for all employees on a voluntary basis; reexamine this issue if voluntary efforts are ineffective.
- Assure availability and affordability of coverage through small group market reforms and income-related subsidies for the poor and small employers.
- Exempt small employers from state mandates.
- Standardize Medicaid eligibility at the federal poverty level; create minimum basic benefit and payment plans.
- Mandate state risk pools for the uninsurable.
- Preempt state-mandated benefit requirements and other state restrictions on plan offerings.
- Enact malpractice reform measures.
- Encourage use of managed care by both public and private providers.
- Encourage equitable reimbursement in government-sponsored programs to avoid cost-shifting.

A more detailed summary of the Council's proposals appears at pages HLC 1-3, which follow this Executive Summary.

Advisory Council on Social Security

The following information is excerpted from a book entitled "Commitment to Change: Foundations for Reform," which was published in December 1991 by the Advisory Council on Social Security (ACSS). For further information, contact ACSS, 200 Independence Ave., SW, Room 638-G, Washington, D.C. 20201, (202) 245-0217.

Health Recommendations

The Council articulated four urgent needs of the Nation's health care system and prepared detailed recommendations to meet these needs:

- The need to improve access to health care for millions of Americans;
- The need to significantly reduce the rate of growth in health care costs and increase the rate of growth in the general economy;
- The need to fundamentally reform many of the basic institutions involved in the delivery and financing of health care; and
- The need to fully involve the American people in the commitment to change by the beginning of the 21st Century.

Two types of recommendations emerge:

First, the Council believes certain changes can and must be acted upon immediately. These are directed at the weakest part of our current system and will not conflict with, but will rather support and strengthen, the foundation for future broad-scale systemic change.

Second, the Council recommends an activist Federal leadership role with a financial investment in our future by supporting and nurturing local and regional solutions for change. The process of developing and implementing

change at community and State levels represents the will of the people. When consensus for reform is achieved, the reform will be perceived as more acceptable and compatible with American expectations for solutions than one that is imposed by the Federal Government.

The Council expects local successes to be evaluated against national criteria that take into consideration not only the needs of today but also the effects on the future. Such an evaluation will yield information about the real implications of reform; it will point to real winners and losers in the system; but, most importantly, it will yield the information we most desperately need to know: What effect will reform have on slowing the rate of growth that seems destined to cripple our economy while at the same time reducing the barriers to access that now confront millions of Americans.

Recommendations to Improve Access to Care are directed at our Nation's children and other underserved populations, and are entitled:

- Assist State Departments of Health to establish School Based Clinics for primary care services for children.
- Assist States in offering School Based Major Medical Insurance to complement and supplement care provided through school based clinics.
- Expansion of the Community and Migrant Health Center Program directed at millions of Americans without primary care services.
- Commitment to Reduce Infant Mortality through consolidated and concentrated efforts at all levels of government.

- Correct Flaws in Private Health Insurance through four separate legislative proposals directed at the most egregious processes now in effect, such as unreasonable premium variations and cancellations due to claims experience or health status.
 - Improve the Portability of Private Health Insurance;
 - Federal legislation to establish new rules for insurance sold to small employers;
 - Disallowance of State-Mandated Benefits for Small Employer Core Benefit Plans; and
 - Preemption of State Laws Limiting the Use of Managed Care in Health Benefit Plans.
- Increase access to Health Insurance for the Self Employed by changing tax laws to make tax treatment of self-employed equivalent to that of employees.

Recommendations to **Reduce the Rate of Growth of Health Care** through cost-reducing measures and **Build a Stronger Economy** through investing in our human resources and increasing growth in GNP are directed at providing a strong economic system so that we can maintain our standard of living, including a good, affordable health care system.

- Reduce the Federal Deficit to Improve the Productive Capacity of the Economy strongly encourages investment in education, training, human resource development, and capital investment in plant and equipment. Commitment to deficit reduction is critical.

- Cabinet level Task Force on Investment in Human Resources, to focus attention on and direct action toward altering counterproductive domestic trends.
- Actions to accelerate promotion of Healthy Lifestyles are presented.
- Establish a President's Council on Fitness for the Second 50 Years to promote health throughout life in an aging society.
- Research to Foster Independent Living directed toward facilitating impaired persons to independently perform daily activities.
- A program to educate, prevent, and treat Preschool and Elementary School Children about Drug and Alcohol Abuse to be developed and implemented by the U.S. Surgeon General.
- Conduct a massive public education campaign directed at Prevention of Disease.
- A model secondary school course for Family Financial Management and Financial Planning would be developed to prepare young adults about managing resources for major expenses, including health care.
- Information on Medical Treatment Outcomes would be required on local and regional health care markets to facilitate assessment and correct weaknesses in manpower and facility resource allocation, use trends, and financing allocations.

- Alternative Procedure to Adjudicate Malpractice Claims involves a proposal for national administrative tribunal for Federal claims, and a companion proposal applicable to States.
- Medicare Selective Contracting would establish a process for identifying and certifying high-quality, cost-efficient providers for specific high-cost procedures. Only certified providers would be reimbursed.
- Medicare Centers of Excellence, which meet rigorous criteria for quality and efficiency, would be established for major surgical procedures. Only designated facilities would be reimbursed.

Reform of Health Care Institutions is directed at reform within the health care system to make it more efficient and effective.

- Establish an Advisory Council on Health Claim Standardization to develop a uniform claim with the intent of reducing paperwork and costs associated with health claims.
- The Attorney General is directed to revise existing rules limiting Hospital Mergers and Joint Ventures for cases where increased efficiencies could be gained.
- Merge Medicare Parts A and B, which now are only artificial distinctions and contribute to inefficiencies within the Program.
- Facilitate Technology Assessment and Data Pooling through an Advisory Group on Technology Assessment Data directed at better understanding and managing technology.

- Effectiveness Research and Medical Practice Guidelines are to be given broader exposure through development of a medical school curriculum and programs to better inform physicians in their personal practice.
- Basic Research to Improve Health Outcomes while reducing costs, proposed in the research agenda by the Institute of Medicine, is strongly advocated.
- To assist individuals facing terminal illnesses, The Medical Directive and Proxy Act would foster reforms and establish a registry containing individual's instructions regarding specified life-prolonging medical procedures.

Specific recommendations for a strategic evolution to reform our health care system follow:

Recommendations to Fully Involve the American People in the development of America's 21st century health care system. Community and regional efforts to address the problems of our health care system are proliferating across the country. These recommendations would strategically support a number of these efforts and other prototype systems identified by the Council.

- Immediately designate a Federal Oversight Commission to identify and support appropriate comprehensive community or State initiatives which would serve as precursors to systemic reform at the national level. A broad range of prototype plans are suggested for consideration:

Comprehensive prototype reforms

- insurance market reform
- all payer model
- employer mandate
- consumer choice
- public/private partnership
- individual tax credit
- universal medical expense
- public health insurance model for acute care

Medicare prototype reforms

- combined acute and long-term care coverage
- Medicare voucher plan

Medicaid prototype reform

- improved access to Medicaid services
 - improved Medicaid enrollment
 - improving Medicaid coverage of the uninsured
- Appropriate and allocate sufficient Federal funds to test and evaluate the prototypes.
 - Evaluate prototypes against common criteria. The Council endorsed criteria developed by the Expert Panel which identify five major objectives and include numerous specific criteria against which proposals for reform should be evaluated. The major evaluation categories are:

- Effect on Opportunities for Underserved People to Receive Needed and Appropriate Health Services;
 - Distributional Effects of Who Pays in the Near Term and in the Future;
 - Effect on Short-Term and Long-Term Economic Growth for the Nation;
 - Effects of Reform Implementation; and
 - Relationship between Reform and American Culture and Values.
- Report the results of testing and evaluation of the prototypes to the Congress and the President in a timeframe to allow reform to be in place by the end of this century.

Only through nationwide commitment to this process will we focus and gain the consensus on changes necessary for health care reform. Investment in exploring for the best alternatives is the only way to ensure that resources will be available for a future American health care system that can serve our residents.

American Association of Retired Persons

The following information is reprinted from a pamphlet entitled "Health Care America—Meeting America's Health Care Needs: AARP's Draft Proposal For Health Care Reform," which was published in early 1992 by the American Association of Retired Persons (AARP). It is reprinted here with their permission. To obtain a copy of the pamphlet, or for further information, contact AARP, 601 E Street, NW, Washington, D.C. 20049, (202) 434-2277.

Health Care America Proposal Highlights

Health Care America is AARP's draft proposal for a comprehensive health care system that provides health and long-term care coverage for all individuals. The cornerstone of the plan is MEDICARD, a single health insurance access card. The card guarantees each user — regardless of age, income or job status — high-quality health coverage through a strengthened, improved and expanded Medicare program or through private employer-based coverage that meets the same standards for coverage, benefits, quality and cost-containment. Long-term care coverage is available to all individuals through the new Medicare program.

Health Care America - An Overview

- The new program is easy to use and understand. All one needs to obtain health services is his or her MEDICARD. The card assures access to a full range of benefits, including hospital and doctor care, preventive care, outpatient prescription drugs and long-term care.
- It controls costs. It also standardizes doctor and hospital payment rates, and limits prescription drug prices. The proposal establishes spending targets at both the national and state levels. Its streamlined billing system cuts down on administrative expenses.
- It includes what most people don't have — long-term care coverage in the home, in the community and in the nursing home. It places limits on long-term care costs to the individual. People with disabilities can get help with their daily

activities if they live at home or in the community. If they need nursing home care, that's also covered. Out-of-pocket payments for these services are limited so that long-term care is affordable.

- It preserves our freedom of choice. We can select our own doctors — just as we do today.
- It promotes preventive care. There is no charge for such preventive measures as physical check-ups, prenatal and well-baby care, pap smears, immunizations and other services that help ensure good health.
- It provides comprehensive benefits for all. Everyone automatically is covered, regardless of age, employment status or income. No individual can be denied coverage on the basis of a pre-existing condition.

Why We Need To Take Action

America's health care system is in deep trouble. While some of us enjoy the highest standard of medical technology and life-saving procedures in the world, many of us can't afford basic health services. The system is unfair and grossly inefficient. National spending on health care continues to soar even as millions go without health coverage. Millions more are unable to afford needed long-term care. It is a crisis we can no longer ignore.

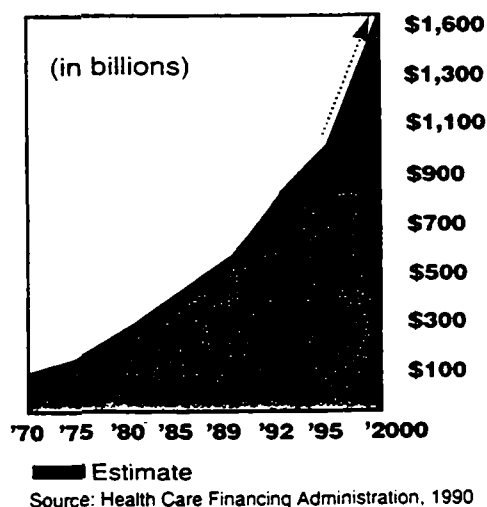
Consider these facts:

- Our annual health care spending is expected to rise from \$800 billion in 1992 to \$1 trillion by 1995, according to government projections.

Unless we reform our health care system, that figure will nearly double — to \$1.6 trillion — by the year 2000. The average per person spending on health care will soar from \$2,566 in 1990 to more than \$5,700 in the year 2000.

- The cost of health care is rising two to three times faster than general inflation. In other words, two to three times faster than most people's incomes. Our incomes are rapidly losing ground to our health care bills. Employers are being forced to cut back on hiring and pensions and other benefits. The high cost of health care is placing America at a competitive disadvantage in the world marketplace.
- An estimated 36 million Americans do not have health care coverage. Two-thirds of these are workers and their dependents. Almost 10 million children under age 18 have no coverage.
- On average, nursing home care costs \$30,000 per year, much of which is paid by the nursing home resident or his or her family. Residents often use up their savings to pay for their care. Long-term care services in the home and the community are frequently unavailable or unaffordable for those who need them.

National Health Care Expenditures



Reforming our health care system has become a national priority. The truth is, we can't afford not to. AARP has responded to this challenge by developing Health Care America, a draft proposal that controls cost, guarantees quality of care, and provides comprehensive benefits for all.

Where AARP Stands

For more than three decades, AARP has taken a leadership role on issues of health and long-term care. AARP stands firmly for a health care system that provides high-quality, affordable health and long-term care for all. Health Care America achieves that goal. We recognize that no matter which approach to health care reform our nation adopts we will all face difficult decisions on how to pay for a new system and how our care is provided.

Health Care America reflects the Association's strong commitment to improving the quality of life for all generations. The need for a better system of health and long-term care is so great that it overrides what some may view as AARP's organizational self-interest. Although AARP derives considerable revenue from providing health insurance to members, the Association will gladly forego every penny of it in exchange for a national health care system that guarantees universal access to quality care, real cost containment, and a way to pay for care that is broad-based and fair.

Health Care America: A "Blended" Plan

We call this a "blended" plan. That's because it takes the best elements from several different approaches to health care reform along with our best ideas and "blends" them into one highly efficient plan. Our planning was guided by the following goals. The new system must:

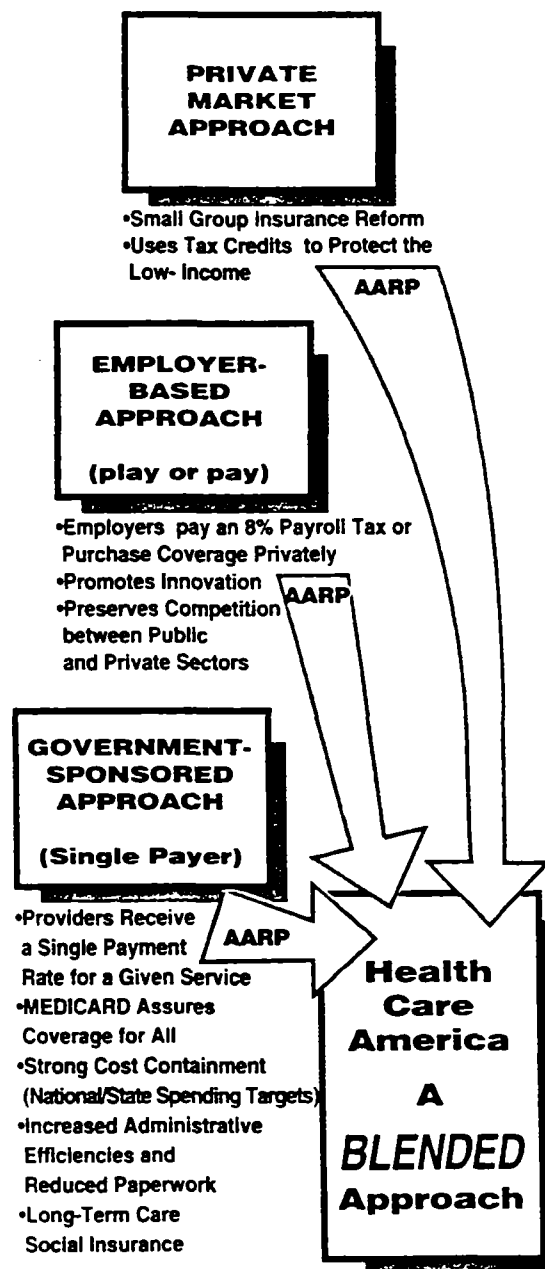
- control costs
- cover everyone
- ensure quality
- provide a comprehensive set of benefits, including long-term care
- ensure fair and equitable financing

The proposal's cornerstone is MEDICARD, a single health insurance card that guarantees access to the full range of coverage, from hospitalization, physician services, and nursing home care to preventive health services and outpatient prescription drugs.

Coverage is available to everyone through the new expanded and strengthened Medicare program. The program is built on the strengths of the existing Medicare program but makes improvements in its benefits, cost containment and administration. Employers can enroll their workers in Medicare or instead pay privately for their medical benefits, that is for their hospital, doctor, lab, X-ray, preventive services, etc. However, benefits provided privately must be as good as or better than those provided through the new Medicare program.

Either way, you can no longer be denied coverage on the basis of a condition you already have, such

How Health Care America "Blends" Approaches



as diabetes or heart disease. Everyone automatically is eligible for coverage of health and long-term care services.

The proposal's benefits fall into two categories:

1) doctor, hospital and other medical and preventive care services; and 2) long-term care.

Doctor, Hospital, and Other Medical and Preventive Care

This includes health services that help prevent disease; medical care given for short-term or temporary illnesses; emergency care; accidents or hospitalizations; and prescription drugs. For most families, direct out-of-pocket expenses for health care will be less than they pay today.

What the Plan Covers:

- Hospital and other inpatient services
- Physician and surgical outpatient services
- X-ray and laboratory services
- Both inpatient and outpatient mental health care
- Preventive care such as periodic check-ups, mammography, pap smears, colorectal tests, prostate cancer screening, prenatal and well-baby care, dental/vision/hearing screening services
- Dental/vision/hearing treatment for all children and low-income adults
- Outpatient prescription drugs

HEALTH CARE AMERICA'S MEDICAL CARE COVERAGE At-A-Glance

KEY POINTS	HOW MUCH YOU WOULD PAY
Annual Deductible Single/Family	\$200/\$400
Annual Out-of-Pocket Limit Single/Family	\$1500/\$3000
Hospital Services Inpatient	0% coinsurance
Physician & Surgical Outpatient Services	10% coinsurance
X-ray and Laboratory	10% coinsurance
Mental Health •Inpatient •Outpatient	0% coinsurance 10% coinsurance
Preventive (e.g., Check-ups Immunizations, Mammography, Pap Smears, Colorectal and Prostate Cancer Screening)	No deductible 0% coinsurance
Prenatal and Well-Baby Care	No deductible 0% coinsurance
Prescription Drugs	10% coinsurance
Premiums: •For those in the new Medicare	\$50 mo. / \$600 year
•For those with employer-based coverage	Up to 20% of total premium

What You Pay for Medical and Preventive Care:

- **Deductibles.** A single person would pay the first \$200 of medical costs per year before the insurance kicks in; a family would pay the first \$400.
- **Coinsurance (or copayments).** The plan pays 100 percent of preventive care such as checkups and immunizations. You pay 10 percent of most other services, including prescription drugs, X-ray and laboratory services, and outpatient mental health care. There is no coinsurance for inpatient hospital care and hospice care.
- **Prescription medication is provided.** The plan covers all but 10 percent of the cost of outpatient prescription drugs.
- **Your risk is limited.** Yearly, no one would pay more out of their own pocket than \$1,500 per person or \$3,000 per family in deductible and coinsurance amounts.
- **Premiums.** Individuals and families enrolled in the new Medicare program would pay a monthly premium of \$50 per adult and \$25 for family coverage, regardless of how many children are in a family. So, a family of four (2 adults and 2 children) would pay \$125 per month under the plan. Individuals receiving medical coverage through an employer could be asked to pay up to 20 percent of the private premium costs.
- **Low-income people would be protected.** The poor would pay no premiums, deductibles or coinsurance. Other low-income individuals or families would be eligible for assistance with their out-of-pocket health costs.
- **Taxes.** (See "How We Pay For The Proposal," page 16.)

Long-Term Care

Long-term care services would be covered for people with chronic conditions or disabilities (both physical and mental, e.g., Alzheimer's Disease) who need assistance in their daily lives.

Millions of Americans — in fact, almost all Americans — now have virtually no protection from the financial costs of long-term care. This will become an increasing problem as our population ages. By the year 2000, nearly 9 million Americans will need long-term care, up from about 7 million in 1988.

This is a particularly critical issue for those who will need nursing home care and their family caregivers. On average, nursing home care currently costs \$30,000 per year. Nationally, about half of nursing home costs are paid by the nursing home resident or his or her family. People currently have to use up their savings and become poor before getting help with their nursing home costs through the Medicaid program.

Health Care America offers what other plans don't — a comprehensive and affordable set of long-term care protections. The goal is to help people remain independent and at home for as long as possible. The same MEDICARD that ensures access to physicians' services, clinics and hospitals also guarantees coverage of long-term care services for everyone through the new Medicare program.

The plan covers care provided in the home, in the community and in the nursing home. It supports

AARP'S LONG-TERM CARE COVERAGE At-a-Glance

Coverage through the new Medicare Program	Persons of all ages with serious disabilities or impairments.
Benefits	Home and community-based services, including respite and adult day care. Nursing home care.
Cost-Sharing •Deductible •Coinsurance	None 20% for home and community-based services. Room and board co-payment for nursing home care (not to exceed \$962 per month in 1993).
Financial Protection	Income-related caps on out-of-pocket costs. No asset test.
Administration	National public program administered as part of Medicare. States contract with care coordinating agencies which determine a person's need for services.

the efforts of families to care for their own. Again, everyone — regardless of age, income or employment status — will be eligible for long-term care services if they need them. In all settings, services are made available at a reduced cost to those persons with lower incomes.

What the Plan Covers:

- The plan provides long-term care in the most appropriate setting. A “care” coordinator, such as a nurse or social worker, works with you, your doctor, and your family to determine if you need long-term care and, if so, which setting would be best for your needs.
- Home and community services. If you are able to stay at home, the plan will cover services to support the informal help you receive from family and friends. These services might include personal or nursing care, homemaker services, adult day care, respite care for family members, transportation or minor home adaptations.
- Nursing home care. If you or a loved one needs to be in a nursing home, this will be arranged by your care coordinator, such as a nurse or social worker.
- Quality long-term care. Quality will be assured through extensive monitoring. For example, your care coordinator will help make sure that the services you receive are of the highest quality. All providers of long-term care services will be certified and licensed. An expanded advocate service for residents will also monitor the quality of care in nursing homes or in your home or community.

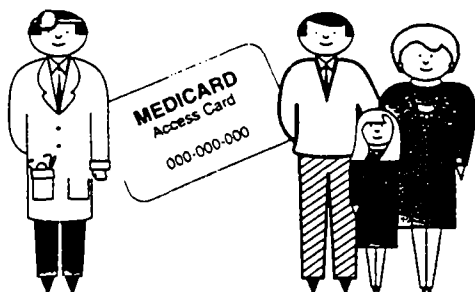
What You Pay for Long-Term Care:**Home and Community Services**

- The plan will pay for 80 percent of the cost of home and community services with no deductible. You or your family will pay the remaining 20 percent up to an annual limit of \$1,500 per person or \$3,000 per family. Studies show that more than three out of four older persons who receive such long-term care services under Health Care America will pay \$460 a year or less.
- Annual out-of-pocket spending caps for those with both medical and home or community long-term care expenses will be limited to \$1,800 per individual or no more than \$3,600 per family.
- Persons with incomes below the poverty level will pay nothing for their care. Others with low incomes will receive assistance in paying providers for their share of care. Out-of-pocket spending for home- and community-based care is capped for all individuals.
- States will determine the prices for home and community services through a competitive bidding process.
- People would not have to "spend down" or use up their savings and become poor in order to qualify for care, as is the case under Medicaid today.
- You will need to pay a certain amount for room and board. The amount you pay is related to your income up to a specified limit. For example, a resident with an annual income of \$12,000 will pay \$150 a month in 1993. A single resident with an annual income of \$24,000 will pay \$550 a month. No one will pay more than \$962 a month (an amount representing about 35 percent of the average cost of nursing home care in 1993).
- All nursing home residents will be able to keep a monthly \$100 personal needs allowance, regardless of income.
- Married nursing home residents will be able to protect \$1,790 per month of their own income to support their spouses. Additional income could be protected to support other dependents or to pay high housing costs.
- Your care is covered based on a plan worked out in consultation with a nurse, social worker or other care coordinator. States will set the rates paid by your care coordinator for nursing home care.

Nursing Home Services

- If you need to be in a nursing home, the plan will provide coverage for your entire stay. You will not have to use up your savings before receiving coverage, nor will you need to pay a deductible.

Use of the System by the *Patient* and the *Provider* under Health Care America



1. You will receive a MEDICARD to use when visiting your doctor or other health care professional. The card enables you to receive the full range of covered health care services.
2. With MEDICARD, your health provider gains access to a computerized system that bills either Medicare or your private insurer for the health services you received.
3. Your doctor or other health provider receives full payment from either the new Medicare or from your private insurer. Medicare or the insurer bills you for your share, if any, on a monthly basis.
4. If you need long-term care, your card enables you to contact a care coordinator, such as a nurse or social worker. This person will help you determine the type of care required. He or she will then authorize the services you need to maintain your independence at home or help obtain admission to a nursing home, if that becomes necessary.

What The Plan Costs

Many people believe that the \$800 billion spent on health care in 1992 is more than enough to pay for a new health care system. While we can drastically reduce the waste in our current system and save money, the savings won't pay for everything we need to add.

AARP estimates that it will take \$112 billion in new taxes to provide comprehensive health and long-term care to all individuals. However, increased taxes will be offset significantly by reductions in how much we pay for insurance premiums, deductibles, coinsurance and other out-of-pocket costs for health care. Taking these factors into consideration, the true added cost of Health Care America is closer to \$22 billion in the first year, with savings achieved in following years.

What do we get in return? Everyone — children, the employed, retired, and unemployed — will have full access to high-quality health and long-term care services. The 36 million Americans who have no insurance today will be covered.

As a nation and as individuals, we will have far greater control over our health spending. Workers will no longer have to worry about losing their health coverage if they lose or change their jobs. Chronically ill or disabled persons won't have to spend all their hard-earned savings to pay for long-term care or worry about paying for the medicine their doctors prescribe.

If we do nothing, we will still end up spending more and more for a fragmented system that leaves millions of people without access to health and long-term care.

How We Pay For The Proposal

Health care costs today are covered by three general sources:

- Taxes on individuals and businesses (federal, state and local)
- Premiums paid by employers
- Premiums and out-of-pocket payments by individuals

Health Care America attempts to make the way in which we pay for our total health care system more fair and efficient.

Health Care America provides much more health care coverage and reduces out-of-pocket expenses for most people. For many, it also lowers premiums. On a national scale, the plan provides the first real means to limit increases in our yearly health care costs, producing billions in savings over the next few years and beyond.

However, like any plan that provides comprehensive care for all, Health Care America will require funding tradeoffs. Existing revenues dedicated to health care, as well as an increase in taxes, will be necessary to pay for the increased services, benefits and expanded coverage in the new Medicare program. A number of sources would be used to pay for the new Medicare program:

- Existing state and federal funding for health care programs would continue.
- An 8 percent payroll tax would be paid by employers who enroll their workers in the new Medicare program. This would be waived for

employers who provide equivalent or better health care coverage to their workers and workers' dependents. Special provisions would protect new and low-wage businesses from the transitional burden of this tax.

- Premiums of \$50 per month would be paid by adults enrolled in the new Medicare program. Families would pay an additional \$25 per month for children. The maximum family premium would be \$125 per month.

The remaining money would come from new tax revenues, mostly from one of the following:

- A special 3 percent national income tax.

Under the national income tax, income includes: adjusted gross income, total Social Security benefits, tax exempt interest and contributions to IRA/Keogh/401K plans.

The first \$15,000 of yearly income per person or \$20,000 per couple is exempt from the tax. A couple with \$30,000 in income would pay a tax of \$300 per year.

OR

- A 5 percent tax on consumption called a "value added tax."

This tax is like a sales tax. It is commonly used by democracies throughout the world to help pay for health care. It would be added to the price of all goods and services, except food, housing, and medical care. The tax would be refunded for

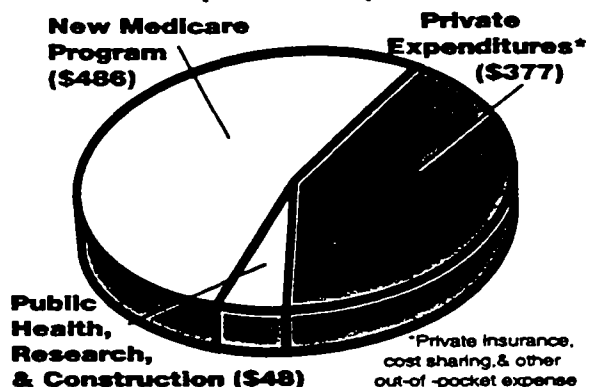
those with low incomes who file for a tax credit on their income tax return. A couple with \$30,000 in income that spends \$10,000 on covered goods and services would pay \$500.

Additional Tax Revenue Sources

The balance of the necessary funding would come from the following sources:

- Increased "sin" taxes on alcohol and tobacco. These would be doubled, reflecting the health costs to society associated with tobacco and alcohol use.
- A 5 percent surtax on existing corporate income tax. This compensates for the plan's substantial savings to many employers who would have greatly reduced costs for retiree health benefits and other health care services.
- Higher estate taxes on estates over \$2.5 million. Estate tax rates would be brought back to pre-1981 levels to help finance the estate protection features of the long-term care protections.

SYSTEM COSTS UNDER HEALTH CARE AMERICA (1993) (In Billions)



**Total Health Care Spending
(\$911)**

Source: Lewin/ICF HBSM

Proposal Advantages: A Summary

- It's easy to use and understand. Each of us receives a MEDICARD to present to health care providers. Benefits cover hospitalization, physician services and mental health care, as well as outpatient prescription drugs and preventive and long-term care. All services are itemized on a single, easily understood monthly statement.
- It controls cost. For the first time, our national health care system would operate on a spending plan. Spending targets are set at the national and state levels, and rates of growth in health care spending are limited. The proposal standardizes fees charged by doctors, hospitals and nursing homes. It strictly limits prescription drug prices, and it reforms our medical malpractice insurance so that physicians no longer would feel they need to order unnecessary medical procedures to protect themselves.
- It is far more efficient. Streamlined administration, the use of standardized forms, and electronic billing eliminate much of the nightmarish complexity and paperwork of today's health care system. They also reduce costs.
- It provides comprehensive benefits for all. Everyone is eligible for coverage regardless of age, employment status or income. The welfare-based Medicaid program is abolished and low-income protections are provided without stigmatizing recipients.
- It preserves our freedom of choice. We can continue to select our own doctors, hospitals and other health providers.
- It provides comprehensive long-term care. Services can be provided in the home, in the community, and in the nursing home. It also places limits on out-of-pocket, long-term-care expenses so that no one need go broke as they do under the current Medicaid program.
- It covers outpatient prescription drugs. You pay only 10 percent out of pocket for your prescriptions.
- It protects the already-sick. No one can be excluded from coverage on the basis of a "pre-existing" medical condition such as diabetes or heart disease.
- It greatly reduces out-of-pocket spending. It covers 100 percent of preventive care costs. It eliminates coinsurance payments for inpatient hospital care and hospice care. The proposal also sets annual limits on out-of-pocket spending for medical care services. Supplemental insurance for medical care is no longer necessary because the benefits are so comprehensive.
- It places new emphasis on preventive care. By diagnosing and treating small problems early, we can prevent costly illnesses, and even unnecessary deaths.
- It provides children with total health services. The plan includes dental, vision, and hearing screening *and* treatment for *all* children.
- It strengthens vital health research and quality assurance programs. The plan provides for continued improvements in our technology and in the quality of our health services by increasing funding for research in biomedical treatment and outcomes of care.
- It gives employers a choice. Rather than enroll employees and their dependents in the new

Medicare program, employers can choose to provide private coverage, just as long as it is as good as or better than Medicare coverage. This promotes innovation and maintains an important standard of comparison for Medicare. (Note: Employers are not required to contribute toward the cost of long-term care coverage for their employees and the dependents of employees. Long-term care services are covered through the new Medicare program.)

How The Proposal Was Drafted

Health Care America was drafted in response to requests from members that the Association play a vital role in reforming our nation's fragmented system of health and long-term care. It was built on the principles for health care reform already adopted by AARP's Board of Directors. Health Care America is a draft proposal only, and will not be finalized until we fully review it with our members and hear back from them.

Prior to drafting Health Care America, AARP conducted more than 25 public hearings. At those sessions, thousands of AARP members and the general public heard the testimony of health experts and voiced their own views on health care reform. The Association gathered feedback from hundreds of AARP community forums, focus groups and opinion polls and fielded thousands of letters from concerned citizens. AARP also studied other national health care proposals, the health care systems of other countries, and innovative health programs across America.

As a result, AARP's volunteer leadership asked the all-volunteer National Legislative Council to develop a plan for health care reform that meets the needs of its members and the general public.

Health Care America reflects the Association's current best thinking on how to address the crisis in our health care system. The draft proposal is meant to inform our members about potential solutions while providing an opportunity for discussion, debate, and plan modifications. We recognize that this is not the only way to reform our nation's health care system, but it is a specific detailed attempt to spell out a comprehensive and effective proposal. AARP seeks your active participation in this process.

Where We Go From Here

Health Care America is a draft proposal *only*. AARP will take no action on it until we fully hear from our members. In coming months, there will be many opportunities for members to let us know what they think about the proposal through hearings, community forums, surveys and more. AARP's volunteer National Legislative Council will take this member feedback and incorporate it into a revised plan in early 1993. The Board of Directors then has the final authority and responsibility to decide whether or not to formally propose the revised plan to the President and Congress.

We also will continue to evaluate other plans and proposals using our health care reform principles. We realize that there may be several ways to achieve the goals set forth in the principles. Health

Care America blends the best ideas of several plans. Because many members expressed interest in a single-payer plan, AARP studied ways to convert its proposal to a single-payer plan. A description of Health Care America as a single payer plan is included in the Appendix at the end of this brochure.

AARP recognizes that any comprehensive health care reform proposal will be controversial. Debate is fundamental to our society's democratic process. By providing this draft plan, AARP is hopeful that it will move the difficult debate about health care reform closer to resolution.

What You Can Do

- Become informed. Read articles on health and long-term care issues in your local newspaper, in national magazines, and in AARP publications. Watch TV programs on the issues. Learn about specific problems with health and long-term care that affect people in your community.
- Get involved. Attend local programs on health care reform — and on Health Care America in particular. Call your local AARP chapter or unit to find out when a program is scheduled. Write your legislative representatives and candidates for public office to learn their position on health care reform.

Reforming America's health care system is *every-one's* concern.

If you are interested in more information on AARP's Health Care Campaign or have comments on Health Care America, write to:

Bob Sell, Chairman
AARP National Legislative Council
601 E Street, NW
Washington, DC 20049

American Federation of Labor / Congress of Industrial Organizations

The following position statement was adopted in November 1991 by the American Federation of Labor / Congress of Industrial Organizations (AFL-CIO). It is reprinted here with their permission. For further information, contact AFL-CIO, 815 16th Street, NW, Washington, D.C. 20006, (202) 637-5027.

Health Care

The nation faces a crisis in health care. We spend more than any other country, have 37 million people without protection and there are mounting threats to the quality of care. If current trends continue at the bargaining table, by the end of the decade one-third of total compensation will go to pay for health care at the expense of wages and other benefit improvements.

In comparison with other industrial nations, the U.S. health care system fails the tests of fairness and equity. Even those who support the current system can no longer defend the excessive overhead and administrative costs associated with our fragmented system.

We continue to believe, as we have advocated for many years, that a unified national health care system with a single payer should be the ultimate goal. We also believe that the urgency of the current crisis demands action now.

As the Executive Council, in a unanimous action, declared last February: "The urgency of the health care crisis for the consumers and purchasers of care and for those who have fallen through the cracks in the current system requires us to seek relief now, without compromising our principles, and to support measures that can be enacted."

That February 1991 council statement also called on Congress to enact federal legislation that will: "Continue the labor movement's long-held goal of a social insurance national health care program, while recognizing that reform may come about in stages. Accordingly, we will support measures that would move the nation toward our goals."

We, therefore, urge Congress to establish a national commission of consumers, labor, management, government and providers to administer a single national cost containment program by negotiating uniform payment rates to be used by all payers, establishing a target for the annual rate of increase in total health care spending and establishing a capital budgeting system to encourage the efficient distribution of capital. In pursuing an effective cost containment program, the federation also will work to ensure fairness for health care workers.

We urge Congress to establish a core benefit package to which all Americans are entitled and to require all employers - including the federal government - to contribute fairly to the cost of care. Any benefit package supported by the federation must include preventive care. Congress also must establish a federal program for those not in the work force. We believe that any program must contain progressive and equitable financing.

Recently, there has been a growing interest in reforming insurance practices in the small group market. While we support such long-overdue reform, the AFL-CIO believes that far more needs to be done and that reforms should be developed by Congress - not the states - to assure uniformity across the country.

The new regulations from the Financial Accounting Standards Board (FASB) that go into effect in 1993 have led a number of employers to cut back coverage for future retirees or eliminate protection altogether. Such actions already have drastically increased the number of retirees without coverage, and the problem is growing. Trade unionists believe that the most effective way of responding to this crisis is to reduce the age of eligibility for Medicare to age 60. This would spread the cost of retiree health care over the entire population and would no longer unfairly penalize employers who have attempted to protect their retirees against the high cost of getting sick. We also support the development of a national social insurance program to cover long-term care services, including inpatient, community-based treatment and home care. Trade unionists believe that all individuals providing health care services, including those providing long-term care, should be provided adequate compensation and training.

In broadening its grass-roots campaign for national health care reform, the AFL-CIO calls upon national and international union affiliates and state and local bodies to organize support for our health care principles among union members, employers, providers and community leaders.

The AFL-CIO believes that nothing short of full-scale restructuring of the system will solve our problems. We have reached the stage where quick fixes are no longer possible and where "voluntary efforts" no longer offer promise.

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American Healthcare Systems

The following information is excerpted from a report entitled "Patients First: A Report and Recommendations," which was published in December 1991 by American Healthcare Systems. It is reprinted here with their permission. To obtain a copy of the full report, contact American Healthcare Systems, 12730 High Bluff Drive, Suite 300, San Diego, CA 92130-2099, (619) 793-9393.

Patients First is the result of long deliberations by American Healthcare Systems (AmHS) on the issue of health care system reform.

It is at once a credo and a slate of recommendations. Moreover, because of the sensitive issues with which it deals, the report begins with an identification of the values espoused by AmHS and includes relevant summaries of key discussions and the rationale for resulting recommendations.

AmHS recommends that the report be read in its entirety, particularly because of its scope, but also because its proposed studies and demonstrations can be best judged in a broad context. AmHS welcomes comments on its report from all responsible parties.

VALUE STATEMENTS ON HEALTH CARE

AmHS has developed 25 value statements on access to health care; the roles and responsibilities of government, employers, individuals, and providers in the health care system; and the costs and financing of health care. The following are the basic values from which the other values in the report have been derived:

All Americans should have access to a defined, basic minimum set of

health care services. Wellness services and long-term care should be available to all, and no individual or family should be financially devastated by personal health care expenditures.

The federal government should provide leadership in health care strategy; mandate minimum benefit standards for all health financing plans; allow individual purchases of benefits beyond the minimum; set quality standards; and assure funding of basic biomedical, clinical, and health services research, inclusive of outcome studies.

Federal, state, and local governments should be responsible for adequate financing of health care services for the poor and indigent and directly provide a defined, basic minimum set of health care services when the private sector is unable to offer them.

Employers should play a major role in the health insurance and financing system, making health insurance coverage available to their employees and their employees' dependents.

Individuals should be responsible for their own health status, appropriate utilization of services, and lifestyle choices. They should share in the responsibility for their own health insurance coverage. When individuals are enrolled in public health programs,

their choice of providers should be subject to contractual or governmental constraints.

Providers should have primary responsibility for meeting and responding to the health care needs of individuals and communities; working with government, employers, and others in developing effective delivery and financing systems; and striving for delivering appropriate care and continuous quality improvement in that care.

Financing for new health care needs should come from the redistribution of existing resources. New resources should be provided for long-term care.

The health care system should foster strong incentives to control costs and promote effective and efficient health service delivery.

Health care services should be financed through a public/private pluralistic system.

Providers should be compensated appropriately for services rendered.

Major tort reform and alternative dispute resolution systems should be essential components of health system reform.

PROBLEMS AND TRENDS IN THE HEALTH CARE SYSTEM

While the United States excels in many aspects of health care delivery, many problems exist with the present structure of the system. AmHS' report cites an extensive array of data from numerous sources that identify underlying causes of rising health care costs.

Included in the report are reviews of societal issues; access to health care; rural and urban problems; roles and responsibilities of key players in health care (government, employers, citizens, hospitals and hospital systems, and physicians); excess

capacity and inefficiency in the system; and costs and financing of health care.

The following are brief examples of health care system problems documented in this section of the report:

- Total health care spending in the United States today is 12 percent of the Gross National Product, a figure that is expected to climb to 17 percent by the year 2000 and 37 percent by 2030.

- In 1988, health care represented the nation's third largest domestic trade and services industry. With 8.8 million employees, the industry consumes 11 percent of the GNP.

- Employer health costs continue to increase 20 percent to 30 percent per year, significantly affecting labor costs and international competition.

- Annual government spending on Medicare and Medicaid may exceed Social Security outlays by the year 2000. The government expects to spend \$156 billion on Medicare and Medicaid in the current fiscal year and \$269 billion for Social Security. Public and private health spending now exceeds \$660 billion a year, or \$1.7 billion a day.

- State Medicaid programs insure about 23 million Americans. In 1989, Medicaid expenditures reached \$54.5 billion and continue to rise. In 1989, states spent over \$21 billion of their own budgets on Medicaid. Low reimbursement rates, high provider administrative costs, and strict eligibility limits mean that growing numbers of both Medicaid and non-Medicaid eligible poor are receiving inadequate health care.

- According to one estimate, unnecessary, defensive medical tests cost \$15 billion a year. Major tort

reform and alternative dispute resolution systems could reduce much inappropriate use of health care resources. The direct cost of medical professional liability insurance rose from \$1.7 billion in 1983 to \$5.9 billion in 1988 for physicians and from \$800 million in 1983 to \$1.3 billion in 1985 for hospitals.

- An estimated 31 million Americans lack health insurance; about 15-to-18 million uninsured are employed or are in families of employed people who do not have health insurance. Only 46 percent of businesses with fewer than ten workers offer health insurance coverage to their employees.

- The health insurance industry avoids covering groups with high-risk members. Three-to-five million individuals are not sufficiently covered by health insurance because they are chronically or seriously ill and cannot afford coverage. Community rating to spread risk and keep insurance affordable for all has virtually disappeared.

- Substantial waste occurs in the insurance industry. A comparison with Canada's system showed that in 1987 administration costs in the U.S. were between \$96.8 billion and \$120.4 billion or 19.3 to 24.1 percent of total health care spending. In Canada, comparable administrative costs were between 8.4 percent and 11.1 percent.

- Because of small risk pools, insurance premiums for businesses with fewer than 25 workers increased 33 percent in 1989, but only 20 percent for businesses with more than 200 employees. In very small firms, a single catastrophic illness can cause premiums to double.

- There are approximately 194,000 excess beds, primarily in hospitals that are small, rural, and non-teaching. The

total annual capital cost associated with excess beds is \$3.1 billion.

- Many hospitals unnecessarily duplicate expensive equipment and programs to retain patients and physicians. In 1990, hospital spending for equipment increased an average of 16 percent and is projected to increase 10 percent in 1991.

- In 1988, 65 percent of all hospitals experienced negative patient revenue margins. Between 1985 and 1988, about 60 percent of all hospitals had declining margins, for which Medicare reimbursement policies and managed care contracting were in large part responsible.

- In 1988, hospitals provided \$11 billion of uncompensated care, the volume of which is increasing.

- Uninformed personal decisions concerning costly life-sustaining medical treatment add substantially to the nation's health care bill. About 30 percent of Medicare costs are incurred during the last year of a beneficiary's life, and the greatest expense is incurred in the last 30 days.

- Lifestyles have a direct impact on health care costs, as evident in the use of tobacco, drug and alcohol abuse, and in violent injury. Smoking alone costs more than \$52 billion a year in health expenses and lost productivity. Diagnosis, treatment, and research related to drug abuse cost over \$2 billion in 1983, the most recent estimate. Over 2.2 million people are victims of violent injury each year.

- AIDS cases totalled an estimated 300,000 to 480,000 in 1991, not including an estimated 1.5 million HIV-infected individuals and an estimated 100,000 to 1 million AIDS Related Complex (ARC) patients. Healthcare providers must manage the cost of AIDS care, estimated to range from \$25,000 to \$50,000 per patient.

- Infant mortality is rising as more communities experience sustained poverty. Low-birthweight babies are increasing, each such birth costing between \$14,000 and \$30,000.

- An estimated 1-to-2 million people are homeless, are illegal aliens, or are hard to enroll in health care programs. When these people become ill, they present themselves for care but usually are unable to pay for services.

- The population over 65, presently 31.3 million, will increase to 50.3 million by 2020; those 85 and over will increase from 3.5 million to 7.2 million, creating heavier demands on health care.

IMMEDIATE REFORM MEASURES

Specific recommendations for immediate reform—changes in the system to improve access to care through expanded eligibility, enhanced coverage, and greater provider participation—were made separately by AmHS from its recommendations for cost containment requiring experimentation and demonstration, which follow in the next section. Major recommendations for immediate change include:

Medicaid and Medicare

Federal and state responsibilities must be restructured under MEDICAID, with the federal government assuming complete responsibility for mandatory acute care services and states assuming complete responsibility for long-term care and related coverage.

- General Medicaid eligibility requirements should be expanded to cover all persons with family incomes of less than 100 percent of the poverty level; categorical eligibility should be eliminated.

- A special Medicaid eligibility standard should be set for pregnant women and children at 185 percent of the federal poverty level.

- Medicaid provider payment rates should be raised to Medicare levels, to be phased in over five years.

- Medicare and Medicaid administration should be combined to reduce administrative costs.

- Increased costs to the federal government for Medicaid reforms should be financed through increases in excise taxes on alcohol, tobacco products, firearms and ammunition, and federal licensing fees for motorcycles.

Recommended changes in Medicare include elimination of the distinction between Parts A and B of the program in order to reduce administrative complexity and costs.

- The Medicare Part B premium should be renamed "the Medicare premium." Total premium collections should remain the same, but individual premium levels should be adjusted according to income levels.

- Medicare provider payment reforms should be aimed at eliminating inconsistent incentives between current hospital and physician payment systems.

Small Group Business Insurance Reform

It is recommended that the small business group market (for businesses with fewer than 100 employees) be reformed. Insurers should be required to:

- Accept all groups seeking coverage, including the self-employed;

- Accept all employees and dependents without regard to pre-existing conditions;

- Adopt community rating, with demographic and geographic adjustments, regardless of employee health status or prior use of services; and

- Price the Minimum Benefit Package (see Tax Policy) separately from add-on benefits.

Tax Policy

A Minimum Benefit Package should be defined so that a standard for the tax deductibility of health insurance costs can be established. The cost of the Minimum Benefit Package should be 100 percent federal income tax deductible to whoever pays the premium.

The Minimum Benefit Package should not be mandated for all private health insurance plans until comprehensive demonstrations that identify the effect of mandates on both employers and employees are conducted and evaluated. It should provide coverage for:

- Preventive care
- Emergency care
- Inpatient and outpatient hospital services, with a 140-day limit on hospital inpatient days per calendar year
- Physician services
- Limited mental health and substance abuse services
- Hospice care
- Catastrophic health expenses

Cost-sharing for the Minimum Benefit Package should be:

- \$500 deductible per person per calendar year
- \$1000 deductible per family per calendar year
- 20 percent coinsurance on all covered services above the deductible amount, with \$3,000 annual coinsurance limit per person and \$5,000 annual coinsurance limit per family, with no lifetime maximum.

Deductibles and coinsurance should not apply to preventive services.

States should not be permitted to mandate coverage for additional services beyond the Minimum Benefit Package.

- Employer contributions for benefits beyond the Minimum Benefit Package should be tax-deductible expenses for the employer and counted as employee income for income tax purposes.

Public Delivery System

To provide services for the medically indigent, a complementary public delivery system should be developed, to include the following steps:

- The Public Health Service should develop national standards to identify medically underserved populations.
- States should develop comprehensive plans for addressing the health care needs of underserved areas and/or populations that utilize the resources of current federal, state, and local public health clinics.
- At least one publicly funded public health center should be located in each medically underserved area, and federal funding for the existing Migrant Health Centers (MHC) and Community Health Centers (CHC) programs should be increased to support that commitment.

Medical Malpractice Reform

Major reform of the current system for dealing with malpractice litigation, requiring federal legislation, should include:

- Preemption of state tort law and implementation of national tort reforms, including: limits on noneconomic damage awards to \$250,000; structured settlements for

future damage awards over \$100,000; consideration of collateral sources of recovery; limits on legal contingency fees; and unified statutes of limitation.

- Strengthening of state licensing boards by increasing their resources and regulatory authority.
- Funding of demonstrations to test alternative dispute resolution systems for addressing malpractice claims.
- Improved quality assurance efforts by professional organizations and federal and state governments through grant programs and education.
- Malpractice coverage, through the Federal Tort Claims Act, in publicly funded and operated health care facilities serving the medically indigent.

Medical Education

Major reform is recommended to resolve problems related to medical specialty and physician geographic maldistribution. With changes but no increases in financial incentives, reform should assure:

- That federal support from the Public Health Service and the Health Care Financing Administration (through both direct and indirect Medicare payments) for graduate medical education for non-primary care physicians be limited to an amount equal to support for primary care physicians.
- That states develop comprehensive plans to identify health personnel needs (specialty mixes and shortages) and direct health professions' educational funds to implement them.

Clinical Practice Guidelines

It is recommended that the following steps be taken to promote

appropriate use of health care resources and greater consistency in the practice of clinical medicine:

- Support should be assured for ongoing development of clinical practice guidelines and outcomes research through the Agency for Health Care Policy and Research.
- Rapid dissemination of guidelines should be promoted, incorporating them in hospital-based quality improvement education efforts.

Public Disclosure

AmHS recommends that health care cost and quality information be made widely available to purchasers and patients in order to facilitate informed decisions concerning their choices of health care providers and services.

To this end, health care organizations should correct and refine data systems so that the release of information will be of value. In addition, they should work toward explaining the use of such information so that public interpretations are constructive and realistic.

National Health Care Reform Commission

Congress should establish a National Health Care Reform Commission comprised of representatives of federal, state, and local governments; health care providers and practitioners; health insurance companies; manufacturers and distributors of health care equipment, supplies, and pharmaceuticals; and citizen representatives.

- Among its major duties, the Commission would develop national goals for access, quality, and cost of

health care services, provide guidance to states on comprehensive demonstrations and experiments, and analyze results.

- The Commission would recommend to both the Congress and the President additional specific legislative reform proposals based on analysis of successful demonstrations.

Long-Term Structural Reforms, Experiments, and Demonstrations to Achieve Cost Control

It is recommended that underlying assumptions on which the current health care system is based be re-examined.

To assure that any changes in the system are demonstrably workable rather than merely theoretical, AmHS proposes that a series of large-scale, comprehensive demonstrations and experiments be conducted to test alternative methods of delivering and financing medical care services and controlling costs.

Experiments and demonstrations have proved invaluable in the past, as in the development and implementation of Medicare's prospective payment system (PPS) and the Medicare HMO program, for example. Conversely, the absence of adequate advance testing and experience resulted in repeal of Medicare's Catastrophic Coverage Act and has seriously hampered Medicare physician payment reform.

- Experiments could re-evaluate such issues as the following: relationships between hospitals and their staff physicians; whether or not provider payments should be based on services provided or on a per capita basis; whether mandatory managed care for public programs can work effectively; and what degree of

restriction on provider choice would be acceptable in public programs.

- Models must be developed for delivery system reforms that improve access, achieve cost containment, and assure value to patients, purchasers, and communities, and approaches to cost containment must be developed that achieve these same objectives.

- Experiments are needed to determine whether different service delivery arrangements could result in more efficient delivery of health services through such public entities as the Department of Veterans' Affairs, Department of Defense, and the Indian Health Service. This is particularly true of veterans' hospitals. It is possible that care can be as effectively provided for veterans in private facilities, a concept that would need to be tested thoroughly on a geographically limited basis, as would any changes in the services of these public entities.

- Federal policy leaders should identify areas for study that they deem to be of high priority; states should be granted flexibility to develop study models suited to their special needs.

- In addition to study areas already identified, AmHS proposes other possible experiments and demonstrations in such areas as the regionalization of health services; mandating of employer health plans versus proposals to offer employers an option to either offer insurance or pay a tax that would enable their employees to be covered under a governmental program; technology management; reduction of excess capacity and waste in the system; alternative cost control mechanisms such as commissions to set provider rates; health care rationing; and analysis of state initiatives to implement reform.

Societal Reform Measures

AmHS concludes that too little attention has been paid to the responsibilities for health care by society in general and by individuals in terms of their own health and use of the health care system.

Society must address such issues as aging, poverty, the environment, and its own expectations of health care. Society must respond to such difficult ethical questions as providing costly technical support systems when there is no hope for a patient's recovery. Such questions are even more crucial in a time of limited fiscal resources.

Individual responsibility for personal health and the use of valuable health resources must be strengthened if the nation is to provide access to basic health care services for all Americans at an affordable price.

■ The cost of preventable disease is staggering, and many expenses associated with preventable disease could be eliminated if individuals would practice positive lifestyle management.

■ Premature death and disability must be reduced; a physical environment supportive of human life must be maintained; and family and community support for healthy lifestyles must be cultivated.

AmHS recommends that the demonstration approach be utilized regarding the initiatives set forth in *Healthy People 2000*, published by the U.S. Public Health Service in 1990.

Those initiatives defined health promotion strategies related to individual lifestyle; health protection strategies related to environmental and regulatory measures that confer protection on large population groups; and preventive services, including counseling, screening, immunizations, and chemoprophylactic interventions. Unless such initiatives—aimed at reducing needless demand on the nation's health care resources—are put in place and made to succeed, no efforts to contain costs can possibly be effective.

American Hospital Association

The following information is reprinted from a document entitled "A Healthier America Through Community Care Networks: The American Hospital Association's Vision for National Health Care Reform," which was published in May 1992 by the American Hospital Association (AHA). It is reprinted here with their permission. To obtain a copy of the full document, or for further information, contact AHA, 840 Lake Shore Drive, Chicago, IL 60611, (312) 280-6349.

This document was approved by the AHA Board of Trustees in May 1992. It is the Association's most current policy on health care reform. The AHA will continue to develop and improve its vision for change.

Executive Summary

Hospitals and their leaders have a professional responsibility to their patients and their communities to provide leadership in solving the problems of our health care system and making this nation the healthiest in the world. Toward that end, our nation must come together on strategies to promote health and well-being and to assure judicious use of a health care system reshaped to put patients first.

The challenge of health care reform is to simultaneously expand access to health care and contain costs while at the same time promoting improvement in the quality of care. The AHA's vision for reform, described below, provides for universal access, economic self-discipline for the delivery system, and quality care.

Universal access to health care coverage would be provided through:

- ❑ A pluralistic system of financing, combining private coverage and a new single public program consolidating and expanding Medicare and Medicaid.
- ❑ An emphasis on private coverage through the workplace, where employers ultimately would be required to provide and help pay for health coverage for their employees and dependents, with employees ultimately required to accept and pay their share of the cost of coverage. A significant phase-in period, with tax breaks for employers and low-wage earners and other types of assistance, would protect against economic dislocations.
- ❑ A basic benefit package in the public program that would serve as the floor for coverage offered in the private sector. Benefits should cover the full continuum of care, from preventive through long-term care. Issues of affordability should be addressed first by reducing unnecessary or marginal care and by adjusting cost sharing, before consideration of limitations on the scope of services. Following an opportunity for public comment, an inde-

pendent commission would select the most beneficial combination of coverage and cost sharing, given the funds made available for the public program by the Congress.

- ❑ A plan to ensure the availability of physicians and other health professionals needed to provide adequate access to health care services for everyone.
- ❑ Insurance reforms that prohibit practices such as the use of pre-existing condition clauses, which result in avoiding rather than managing risk, diminishing the value of private health insurance.

Economic self-discipline in the health care system would be provided through:

- ❑ Fundamentally restructuring health care delivery through the establishment of community care networks that would provide patients with integrated care organized at the community level.
- ❑ Restructuring financial incentives using risk-adjusted capitated payments to networks to encourage providers within the network to promote the health of patients through primary and preventive care, collaborate with other providers to avoid unnecessary duplication of services, and conserve health care resources.
- ❑ Other complementary efforts, such as development and dissemination of medical practice parameters, medical liability system reform, reform of antitrust and other laws that impede efficient use of resources, and strategies for reducing administrative costs in the system.

The quality of care would be improved through:

- ❑ Reorienting the system to focus on improving the health status of communities and on coordinating and better managing patient care.
- ❑ Focusing attention on continuous quality improvement, which will further facilitate the integration of care and referral of patients within networks.
- ❑ A sustained level of governmental and private support for innovation and the evaluation of new clinical approaches.

The Need for Change

The U.S. health care system is unique, both in its strengths and weaknesses. In the aggregate, the United States has a wealth of health care facilities and highly trained personnel. We have long been recognized as a leader in the high quality of care provided. Our health care system has encouraged clinical innovation and is known for state-of-the-art treatments and technologies.

Despite these strengths, many problems remain. Chief among these is inadequate access to health care coverage in this country. There are currently 36 million uninsured individuals in the U.S., 10 million of whom are children. Half of the uninsured live in families with incomes below the poverty threshold. Medicaid, a program originally designed to provide health insurance for the poor, now provides care for only about 40 percent of the poverty population. Because of strained federal and state finances, even those who qualify for Medicaid face limitations on the services they receive. Many state Medicaid programs, for example, do not pay for screening and preventive services. Even for the privately insured, coverage limitations are more commonplace today as many employers and insurers resort to benefit cutbacks to limit their rising costs.

A compounding problem is the continuing rapid growth in health care spending. National health expenditures in 1992 are expected to exceed \$800 billion, rising at an annual rate of over 10 percent. We currently devote more than 13 percent of our Gross National Product to health care spending, more than any other nation in the world. Despite this level of spending, the U.S. still suffers significant deficits in health status. For instance, among the western industrialized democratic nations, the U.S. ranks first in spending per capita, but 21st in infant mortality.

Faced with growth in health care costs, federal and state lawmakers have frequently opted to reduce payments to hospitals and physicians over the last 10 years. In the aggregate, the Medicare program now pays hospitals for only 90 percent of the cost of treating Medicare patients. State Medicaid programs frequently pay even less. While payment varies from state to state, in the aggregate Medicaid now pays hospitals for only 80 percent of the cost of treating Medicaid patients. In addition to these payment short-

tals, hospitals in 1990 provided over \$9 billion in unsponsored care to the medically indigent for which no payment was received.

To cope with payment shortfalls and unsponsored care, health care providers have often shifted these unfunded costs to privately insured patients by raising their prices. For these and other reasons, private insurance premiums have increased even faster than hospital costs. These rising insurance costs which affect so many Americans, including middle-class Americans, have brought the issue of health care to the political forefront.

As costs rise, policy makers are increasingly dissatisfied with the health care system. While we have considerable capacity for providing care, our capacity is excessive in some areas and inadequate in others. The proliferation of freestanding health care facilities has added to the problem of excess capacity and encouraged further fragmentation of care.

Most importantly, rising costs, fragmentation of care, and coverage limitations and complexities have led to patient dissatisfaction with the health care system. In the current system, individuals generally receive health care from a changing array of providers, and only after they become ill. Patients are often left to patch together services in a variety of settings from unconnected providers. Adding to patients' frustrations are the paperwork and billing associated with an episode of care. After a hospital stay, for example, patients may receive one bill from the hospital, several more from attending and consulting physicians, and a notification of payment from an insurance company. All of this has begun to raise questions for all Americans as to the value they receive for the health care dollars spent.

AHA's Vision for Health Reform

Hospitals and their leaders have a professional responsibility to their patients and their communities to provide leadership in solving the problems of our health care system and making this nation the healthiest in the world. Toward that end, our focus is on affordable access to needed health care, including preventive services. This nation must come together on strategies to promote health and well-being and to assure judicious use of a health care system reshaped to put patients first. Leadership is required to forge partnerships among hospitals, physicians, other health professional groups, business, government, labor, insurers, the educational system and, above all, the American public.

AHA supports 10 goals for improving our health care system that everyone — citizens, providers, insurers, purchasers, and governments — must work toward. Our health care system should provide:

1. **Basic health services coverage for all.** All individuals, at a minimum, must have access to a benefit package of basic health care services.
2. **High-quality care.** Medical conditions must be effectively managed and coordinated and continuous improvement in the quality of care must be promoted.
3. **Community-focused, patient-centered care.** Care delivery and financing must be managed at the local level to recognize appropriate community variations in health care needs, available resources, and medical practice patterns consistent with national standards.
4. **Timely access.** Individuals must be encouraged to obtain care when and where it is most likely to change the course of a disease or prevent avoidable illness, loss or impairment of function, or death.
5. **Affordable care.** Patients must be able to obtain needed care for what they are willing and able to pay.
6. **Efficiently delivered care.** Financial and other incentives for participants in the health care system must be aligned to eliminate conflicting interests, discourage unnecessary duplication of services, and promote continuous improvement in the efficient use of resources to restore or preserve health.
7. **Adequately and fairly financed care.** To mitigate cost-shifting, any public or private financing program must itself bear the full cost of the services provided to its enrollees or beneficiaries.
8. **User-friendly care.** All participants in the health care system must be able to obtain, deliver, and pay for care with minimum confusion and paperwork.
9. **Adequate and appropriate supply of health care professionals.** We must ensure the availability of the number and types of physicians and health care professionals needed to provide access to health care services for everyone.
10. **Innovation.** We must encourage the continued development of new and more effective methods of treating and preventing illness and delivering services.

There are currently over 100 proposals being considered for reforming the U.S. health care system. But most do not address all of the goals we consider critical to improving the health care system. The current health reform debate centers on two priority, but competing, needs: expanding access and containing costs. The challenge of health care reform is to find an

acceptable balance between expanded access and cost containment while at the same time promoting continued improvement in the quality of health care we provide. We believe that the AHA's vision for reform, described below, strikes an appropriate balance, providing universal access to coverage, cost containment, and quality care.

Universal Access

Universal access is the first priority. The AHA's proposal provides universal access to coverage for basic care through a pluralistic system of financing — a combination of private coverage and a new single public program consolidating and expanding Medicare and Medicaid.

Private Coverage

As in our current health care system, employer-sponsored private coverage would be the principal source of health care coverage for individuals under the AHA vision. This is the most practical road to universal access. It builds on the strength of current employer, employee, and insurer relations. Employer-based groups currently cover 88 percent of the nonelderly, privately insured population and more than 85 percent of the uninsured are connected to the workforce — either as workers or living in a family headed by a worker. Required employment-based coverage encourages employers to treat health care coverage like Social Security or workers' compensation — as a cost of doing business. It also provides the best means of maintaining a local relationship between providers, consumers, and payers.

AHA's approach would strengthen employer-sponsored coverage. Required employment-based coverage would be phased in and preceded by insurance reforms, tax breaks, and hardship funds for small and new employers to allow time to put in place more affordable coverage. Underwriting practices, such as pre-existing conditions clauses, designed to avoid rather than manage risk, would be precluded. Reinsurance mechanisms and insurance pools would be developed where necessary to spread risk so that more affordable insurance is available to small businesses and to self-employed and medically uninsurable individuals.

Ultimately, employers would be required to sponsor group health coverage and pay at least 50 percent of the cost of doing so for full-time permanent employees and their dependents and a prorated amount for part-time permanent workers and their

families. Employers would retain the ability to self-fund coverage, but they would assume responsibilities and obligations for health care coverage that are equal to those of insured businesses, such as participating in state risk pools.

The employment-based coverage provided would have to meet minimum specifications of a federally-defined basic benefit package, described below, thereby pre-empting state mandated benefit laws. Employers would be free to offer more than basic health benefits if they and their employees so desire. Employees would be required to accept employer-sponsored coverage (unless they were otherwise covered) and pay their share of the cost of coverage. Low-income employees would be assisted by tax incentives (e.g., tax credits) to help cover their share of premiums.

In the area of taxes, Congress would grant the same tax advantages to self-employed individuals and unincorporated businesses for the purchase of health benefits (100 percent, rather than 25 percent, deductibility of premiums as a business expense) that large employers and their employees currently enjoy.

Incentives such as these can be used to maintain a pluralistic financing system with heavy reliance on employer-sponsored private coverage. The key is to design incentives that make private coverage economically feasible and desirable for employers and employees.

A New Public Program

On the public side, a new program would consolidate and expand upon Medicaid and Medicare, providing basic health benefits to these individuals as well as to all others unable to obtain private coverage. Government's first priority in subsidizing coverage under the public program should be targeted at those least able to afford coverage.

Enrollees in the public program with income less than 150 percent of the federal poverty level would receive fully subsidized basic benefits, with the possible exception of nominal cost sharing. Those with income greater than 150 percent of the federal poverty level would make contributions to premiums scaled to their ability to pay, in addition to copayments and deductibles. The public program would pay for all Medicaid recipients in full and would pay all or part of the premiums and cost-sharing for most Medicare beneficiaries.

The public program would be financed by a combination of broadly based federal tax revenues

and premium contributions from those covered who can afford them. These monies would be dedicated to an off-budget trust fund that would pay for covered health care costs for public program enrollees. With a single public program, states' financial responsibility for Medicaid could gradually be phased out, but they

consumer's decision making role, has the added advantage of providing the incentive of reduced exposure to out-of-pocket costs for those consumers who enroll in networks where utilization could be better managed.

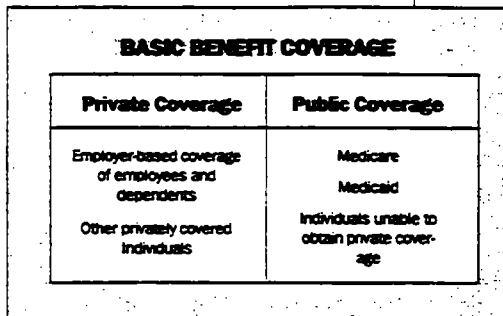
To maintain incentives for families to continue their role as caregivers, long-term care (other than post-acute recuperative care) would carry a \$10,000 deductible. These deductibles and copayments would be waived for low-income individuals to assure that they do not serve as barriers to access.

Determining the basic set of benefits is perhaps the most difficult and critical element of this proposal — difficult because it means reconciling benefits with available funding; critical because it

determines the core of health care coverage. An independent commission, established outside the federal political and budgetary process, would be responsible for defining the basic benefits package. On a biannual basis, Congress would determine the aggregate funding level for the new public program. The independent commission would then determine the specific benefits that could be provided by the public program within that budget. This set of benefits also would serve as the benefit floor for coverage offered in the private sector, thereby pre-empting state mandated benefit laws. Coverage under the benefit package would be defined by health care needs and services, not specific provider settings, leaving latitude to assure that care is delivered in the most appropriate, cost-effective setting.

The primary objective of establishing an independent commission is to stimulate a public debate on the proper balance between the health care benefits to be promised and the funds available. The independent commission would first provide Congress the information and advice it needs to set a budget target for the public program. This might include information on benefit levels and cost sharing, the adequacy of public program funding, and the adequacy of provider payments under the public program. Given the funds made available for the public program by Congress, the independent commission would select the most beneficial combination of coverage following an opportunity for public comment. If the funding level is inadequate to cover some services that the public wants, Congress and the President would be pressured by voters to increase health care funding levels.

Several approaches are available for balancing health care benefits with available funding. The first step would be to identify and eliminate inappropriate



could continue to subsidize those unable to pay the long-term care deductible proposed as part of basic benefits coverage. Federal and state financial responsibilities for other domestic programs could be realigned to maintain current levels of state health funding support.

Basic Benefits

AHA believes that coverage of the full continuum of care is a necessary first step in refocusing on efficient clinical decision making. AHA calls for a broad basic benefit package covering the full continuum of care from preventive care through long-term care. Historically, public and private benefit packages have addressed the affordability issue by excluding or severely limiting coverage of certain types of services. This approach has had several practical but unfortunate effects: discrimination against certain types of illnesses (such as Alzheimer's disease) and creation of incentives for health care practitioners and providers to deliver whatever services are covered, rather than the most efficient service to meet a patient's need.

In order to provide incentives for the responsible use of health care services by consumers, some cost sharing would be required. To create the right incentives, cost sharing would not be applied to preventive services, but would be focused on those points where consumer judgment on whether, when, and where to seek services plays a significant role in appropriate utilization. For example, if enrolled in a network where a primary caregiver oversees access to specialty care, cost sharing might focus on primary care visits, emergency room visits, and outpatient prescriptions. If not enrolled in such an arrangement, cost sharing might apply to all but preventive services. This approach, in addition to being sensitive to the

and unnecessary care from the health care system. This can be facilitated by promoting effectiveness and outcomes research to identify where care currently provided to patients yields marginal benefit to their health or quality of life. Equally essential is the development and use of medical practice parameters, which operationalize what we learn from such research by improving our understanding of what types of care are appropriate under specific clinical circumstances. Reforming our medical liability system can also be helpful by obviating the need to practice defensive medicine, as well as reducing the excessive costs currently associated with the tort system. Promoting the widespread use of living wills and other advance directives would make it easier for patients and their families or guardians to reject non-beneficial final care.

If savings from reducing inappropriate and unnecessary care are not enough to bring benefits and costs into balance, the independent commission, through a public process, would develop and apply criteria for determining which services and clinical conditions would be covered in the basic benefits package. Once the commission has included coverage for a particular clinical condition, it would be expected to cover all services necessary to treat the clinical condition including long-term or rehabilitation care. The intention is that no type of service would be excluded arbitrarily from coverage in all cases. Rather, criteria would be developed to include services for specific clinical conditions. Health care practitioners and providers would not be required to provide services excluded from the basic benefit defined by the commission.

Another avenue available to the commission in reconciling the definition of basic benefits with available funding would be the adjustment of cost-sharing and premium levels. The implications of the commission's decisions would be significant. Coverage and cost-sharing variations can have two primary effects: shifting expenditures from premium costs to patient out-of-pocket costs or vice versa, and stimulating or curbing utilization of services which would affect total health care expenditure levels.

For example, if the commission chooses to augment capitated premium payments with high consumer cost sharing (e.g., a deductible of \$500 for inpatient and outpatient care, a \$10,000 deductible for institutional long-term care, and coinsurance of 20 percent except for preventive care) the average annual premium would be about \$2,630, at least half of which (\$1,315) would be paid by the employer. By comparison, the average premium in existing employer plans is about \$3,440, of which the average employer pays about 75 percent (\$2,580). An approach that incorporates high consumer cost sharing, however, would need to be coupled with some sort of limit on out-of-

pocket expenses based on income to assure that no one would be impoverished as a result of these cost-sharing requirements.

Alternatively, the commission could select an intermediate approach, with capitated premium payments and fixed dollar copayments for just those services where the consumer has significant influence over utilization (e.g., routine care). Under this scenario, the average annual premium would be about \$3,940. The higher annual premium amount reflects lower consumer out-of-pocket spending. Because this type of approach means that networks are more reliant on capitated payments and must bear the associated financial risk, networks might be required to carry stop-loss insurance coverage to guard against unpredictably large expenses.

The commission also could choose to finance benefits entirely through capitated premium payments, imposing no cost-sharing on consumers except for long-term care services. The average annual premium in this case would be highest — about \$4,305 — reflecting no additional spending required on the part of consumers. However, an approach that requires no consumer cost-sharing is likely to result in increased utilization of services since consumers would not be asked to bear any additional cost of care.

Economic Discipline

In this environment of limited financial resources and competing public priorities, our nation must seriously address the issue of cost containment beyond the question of benefit coverage. Because our current health care system encourages further fragmentation of care as well as unnecessary use and duplication of services, the AHA believes that simply increasing access to the current system will deepen frustrations with health care costs and invite more intrusive regulation by government and insurers without corresponding benefit to patients.

Competing incentives for health care providers and consumers have led to a system that is costly and fragmented. Physicians are paid for each service rendered, giving them an incentive to provide more services. Hospitals, on the other hand, are often paid a fixed amount per patient for each admission, particularly for Medicare patients. Once a patient is admitted, hospitals are encouraged to conserve health care resources by providing medically necessary services, but no more. There is no incentive, however, to keep people out of the hospital in the first place. In the absence of such incentives, insurers use external utiliza-

tion review to constrain access to hospital care. Consequently, more tests and more surgeries are being provided outside hospitals in physicians' offices or in freestanding facilities where financial incentives to conserve are generally absent and quality assurance mechanisms seldom are in place.

The result is that patients must navigate a fragmented health care system, going from provider to provider in order to seek the full spectrum of care they need. Because most consumers have insurance and do not pay directly for the cost of much of the health care they use, consumers have little incentive to conserve their use of health care resources, to weigh potential benefit compared to cost, or to shop for the most cost-effective providers.

Responsible and effective cost containment begins by restructuring the health care delivery and financing systems to realign incentives and encourage the efficient use of resources by everyone.

Restructuring Health Care Delivery

Health care delivery should be fundamentally restructured by establishing community care networks that would provide patients with integrated care organized at the community level. Networks would be responsible for providing all of the services covered for their enrolled population and would coordinate patient care over time and across various provider settings. Patients would turn to their network for everything covered — from preventive care to acute care to long-term care services.

Where possible, consumers would have a choice of networks as they became available in each community. Required annual open enrollment would ensure that no one was "locked in" to an unsatisfactory network. In smaller communities where only one network may be available, other safeguards would be needed to ensure that the network is held publicly accountable for patient satisfaction and the quality of care it provides to the community.

Community care networks are the keystone to universal access. They are designed to:

Focus on community health status. Networks would be responsible for maintaining and improving the health status of their enrollees, giving them an incentive to reach out into their communities and to work with public health, social service or other organizations that can help to measure and improve health status.

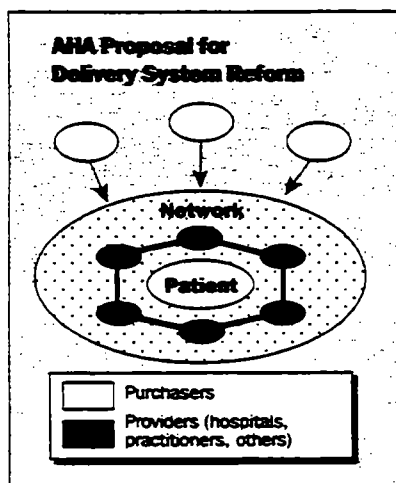
Focus on patients. Networks would minimize patient hassles by truly managing and coordinating care, by making available a broad spectrum of care, and by giving patients a consistent point of access to the health care system.

Focus on prevention and primary care. Networks would emphasize wellness in addition to the treatment of illness.

Focus on community-level solutions to community problems. Networks would match local health care resources and strategies to local community needs and circumstances.

Community care networks represent a self-disciplining system with coherent and consistent incentives that encourage providers to do what they do best — manage the health care of their patients.

Community care networks hold the promise for



true management of patient care. Many of the current "managed care" arrangements are simply insurer programs that contract with a selected group of providers who agree to discounted prices. The providers participating in the plan often change each year as the insurers use their leverage to seek deeper discounts from providers. The insurer then controls access to those providers through a complex system of authorizations that must be obtained from the insurer before anyone can receive non-emergency care. While this approach emphasizes managing costs, it does not manage care.

True managed care requires assessing patient health risks and needs. It means planning and organizing care so that problems are averted or treated early and all needed services are efficiently provided without unnecessary duplication of capacity. Within community care networks, patient needs would be returned to the focus of the delivery system and the management of care responsibility would be returned to the caregivers.

To meet these goals, as well as to create a more user-friendly system, each network enrollee would choose a primary caregiver to assure a consistent

specified point of entry into the network. The primary caregiver would act as the care manager for that individual. It would be the primary caregiver's responsibility to ensure that an initial evaluation of health status is conducted, that appropriate primary care and preventive services are provided, and that services throughout the system are coordinated for the patient, particularly when specialty services are needed.

Restructuring Financial Incentives

The key to successful community care networks is creating strong incentives for Americans to choose them and aligning provider incentives through risk-adjusted capitated payments to the networks. Capitation — a set fee paid to the network per enrollee — provides the network with its budget for delivering care to the enrolled community. It allows the public program, employers, and employees to manage their outlays, but leaves the allocation of resources to local decision making. Most important, it provides the stimulus for re-orienting our health care focus from sickness to wellness. This type of approach encourages providers to:

Promote the health of patients and prevent future, more costly illnesses. If the network's enrolled population is relatively stable, then the network has an incentive to provide its enrollees with low-cost preventive care now in order to avoid the use of more costly acute care in the future.

Collaborate with other providers to avoid unnecessary duplication of services. Once providers are linked within a network, the financial incentive will be to avoid duplicative facilities and services that were encouraged previously by the competitive system.

Conserve health care resources by providing only appropriate and necessary care. The collective challenge to providers within networks will be to provide needed health care services within the fixed capitation amount through better patient care management by practitioners and institutions.

The independent commission responsible for determining the basic benefit package would also be responsible for setting actuarially sound capitated rates under the public program to be paid to networks. This commission would balance the public need for cost containment with hospitals', practitioners', and other providers' need for fair payment.

The independent commission also would adjust those rates to reflect the underlying risk of the popula-

tion covered and the geographic conditions under which services are delivered. By broadly adjusting the capitation payments to networks, the payments would better reflect the expected costs of serving each network's enrolled population. This gives networks the incentive to treat everyone in their community; young or old, sick or well.

Placing capitation rate-setting for the public program in the hands of an independent commission does not guarantee elimination of government cost-shifting to the private sector. The AHA believes it can go a long way, however, toward minimizing it. In the private sector, network payment rates would be negotiated between networks and employers. It would be left to individual states to decide whether to regulate those decisions in any way.

Because capitated payments require the network to take on some financial risk, networks might be required to carry stop-loss insurance coverage to protect against unpredictably large expenses.

Network Characteristics

Networks are designed to foster new relationships among physicians, other health professionals, hospitals, community health centers, and nursing homes as well as private insurers. As the major sources of care in most communities, hospitals and physicians would need to be key partners in the formation of networks.

Hospitals often provide services beyond inpatient acute care, and are the locus of most specialized technology. Moreover, as generally the largest health delivery organizations in their communities, hospitals can provide many of the management and service coordination skills and systems necessary to integrate and manage the delivery of high-quality services.

Physicians and other health professionals are essential to successful formation and operation of networks. Patients build strong relationships with their physicians. For many people, their primary care physician is the first point of entry into the health care system. Networks must actively involve local physicians in order to coordinate and manage patient care.

Networks also offer a range of opportunities for private insurers. Insurers may choose to partner in a network, with providers and the insurer underwriting the risk of the enrolled population. Alternatively, insurers may participate in networks by providing reinsurance to networks, marketing and promoting networks to prospective enrollees, assisting networks in evaluating their cost and quality performance to support marketing, helping with regulatory compliance and insurability decisions, processing provider payments within the network, etc.

Hospitals, physicians, insurers, and other partici-

parts may choose from a variety of roles in the network. They may assume a leadership role as a network owner, a partnership role, or more traditional roles. Networks may form between selected providers and major employers, local government, or insurers. Even where hospitals and physicians are not network owners or partners, some may wish to negotiate a payment arrangement to share in the overall operating results of their network. Ownership and governance of networks could take a not-for-profit, investor-owned, or public form, depending on local values, interests, and practical realities.

Larger communities may be served by several networks while smaller communities might be served by only one. The number of networks would be determined in part by the number of parties willing to organize into partnerships in an area. The number of networks in an area also would be affected by each network's need to pool health costs and risks over a sizeable enrolled population.

Broad government parameters would guide network formation. Some of these guidelines would provide assurances to the public as to the financial stability of networks. Other guidelines might address networking with hospitals that have special missions such as teaching, research, or care to the indigent, to encourage the participation of these institutions. Similar guidelines might address the inclusion of physicians offering specialized services. No requirement would be made to include all area providers in a network.

Above all, the network concept is flexible and must remain so. Because networks are designed to reflect the individual needs and preferences of each community, no two networks will look exactly alike. Network arrangements will vary by geographic location in order to recognize appropriate community differences, preserve latitude for local decision making, and provide for appropriate involvement of state and local governments. A uniform approach to the organization and operation of networks would defeat the goal of community-tailored health care.

Flexibility also means open arrangements for the payment of providers within the network. While most networks would operate on a budget determined by the fixed annual payments per enrollee, the network could choose to pay its providers in a variety of ways. Hospitals might be paid based on costs, prospective rates, per admission or other unit of service, a capitated rate, or a global budget. Similarly, physicians might be paid based on costs, a fee schedule, a salary, or a capitated rate. Hospitals, physicians, and others might share in the operating results of their network.

In looking to the future, collaboration among providers within networks, with constructive competition across networks where two or more are formed, seems to hold the best promise for expanding access to health care while controlling costs. But to reassure the public of the value that can be achieved under this approach, public accountability is essential. Networks would be structured to give providers greater freedom to make decisions without the micro-management by government payers and insurers. In exchange, networks of providers must be willing to be accountable to government, employers, and the public for their financial and quality performance.

Public accountability might be demonstrated in various ways. Networks might provide regular reports to their communities on health status improvement, patient satisfaction, and provider satisfaction with network relationships. Public accountability might be achieved by reporting on selected indicators related to network costs, quality, and overall efficiency. This information could be compared across networks if adjusted to reflect population risk and use factors such as age, sex, or socioeconomic status. In communities served by only one network, a greater measure of public oversight might be needed. Public accountability in this case might be demonstrated through more direct public oversight of network operations and capitated rates or through public representation on the network's governing body. The goal is for networks to strengthen, not diminish, accountability to patients and the public.

Community care networks hold the promise for improving the health of our nation in a cost-efficient way. But how much society can save on its health care bill depends in large part on what society is willing to do. Saving money will depend on the extent to which community care networks are established throughout the country and used by consumers as their health care source. The formation of networks and consumer selection of networks would be encouraged by tax and other incentives, moving at a pace determined not only by the strength of the incentives but also by how fast the advantages of networks are realized.

If strong incentives are provided to encourage the formation and use of networks, 80 to 85 percent of the population is expected to enroll in networks. If society requires participation in networks and everyone enrolls, system efficiencies and administrative savings would be about 20 percent greater. If, however, no changes are made in incentives to form or use networks, only 20 to 25 percent of the population would be expected to enroll. In this case only about one-quarter of potential system efficiencies and administrative savings would be achieved.

Human Resources

The United States must adopt a more coherent and comprehensive approach to ensuring the availability of physicians and other health professionals needed to provide adequate access to health care services for everyone, particularly access to primary care as universal access to health care coverage becomes a reality. The human resource policy goals are adequate supply, efficient use of health care professionals, and appropriate geographic distribution of needed human resources. Steps to achieve these goals must be based on sound assessments of human resource needs and should focus on both the near and long term.

To accomplish this, a second public/private commission would be established to provide a regular and comprehensive assessment of future human resource needs. Advice from this commission could be used to develop both national and state strategies. The commission also would provide advice on national health care training policies and federal funding priorities for educational program and student support. The direction and organization of graduate medical education should be a collaborative effort by hospitals, medical schools, affiliated programs in alternative settings, appropriate national standard setting agencies, and the commission.

Community care networks, through their providers, should be responsible for conducting or supporting educational programs in the health professions and allied fields to ensure a continuing supply of trained professionals for their community. Further study is needed, however, on the appropriate methods for paying providers for the cost of educating physicians and other health professionals within the framework of community care networks paid on a capitation basis.

Initiatives would be designed to stabilize training programs, promote new programs where needed, reorient training programs to future needs, and attract qualified students to the health professions. For example, efficient use of health care professionals would be promoted by enhancing career mobility within professions and eliminating barriers that unnecessarily limit flexibility and discretion in the use of personnel. Appropriate geographic distribution of health care professionals would be achieved by attracting and retaining personnel in poor, remote, or underserved areas so that everyone has reasonable access to needed services.

Research

Health system reform must include a sustained level of governmental and private support for innovation and the evaluation of new approaches. Biomedical research enhances our capacity to diagnose and treat illness; health services research is essential for more complete information on such critical issues as assessing the efficacy of diagnostic and therapeutic regimens and establishing the relationship between treatments and outcomes. Our future ability to improve the value of health care services will depend in significant part on rigorous evaluation of today's and tomorrow's delivery and payment system innovations.

From Vision to Reality

AHA's vision for reform could be implemented incrementally in order to minimize disruption in current coverage patterns and facilitate the broadening of benefits. For example, access could be expanded in stages. Starting with mothers and children, coverage of the poor and near poor who are not currently covered by Medicaid should be provided by the public program over a pre-established period of time. Next, individuals with incomes exceeding 150 percent of the poverty level could be phased in, making premium contributions according to ability to pay.

Similarly, community care networks could be developed in stages, growing in concert with community values and needs. Listed below are some of the changes needed to make the health reform vision a reality.

Changing the Health Care Environment

- ❑ In hospital strategic planning and operations, shift emphasis from provider competition to collaboration and integration. Focus on both hospital/physician relationships and hospital-to-hospital relationships
- ❑ Seek antitrust reform to allow for greater provider collaboration
- ❑ Seek tort reform to reduce the cost of the malpractice system and its effect of stimulating defensive medicine
- ❑ Seek insurance reform to make health insurance more available and affordable for employers and individuals
- ❑ Equalize tax incentives for all employers to provide health insurance for employees and their dependents
- ❑ Seek new programs or waiver authority that offer options for reorienting care delivery in government programs
- ❑ Improve funding for Medicare and Medicaid

Developing Resources and Skills

- ❑ Develop provider skills in accepting and managing financial risk
- ❑ Expand emphasis in medical education programs on primary care careers
- ❑ Invest in medical practice parameters, clinical guidelines, and outcome measures with rapid implementation
- ❑ Develop community health status and needs assessment tools
- ❑ Encourage community reports on population health status
- ❑ Establish uniform data requirements and implement electronic methods to collect, store, and share community and patient data across providers

Encouraging the Formation and Use of Networks

- ❑ Work with physicians and other providers in transitional network arrangements such as IPAs and PPOs
- ❑ Develop networks consistent with existing waiver authority under Medicaid and Medicare HMO/CMP options, and employer opportunities at the local level
- ❑ Require employment-based coverage for basic benefits package
- ❑ Strengthen financial incentives for public program beneficiaries to use networks, including required network enrollment where there are at least two networks from which to choose
- ❑ Offer tax or other incentives aimed at employers, employees, insurers, and providers to offer and use networks

American Medical Association

The following information is excerpted from a report entitled "Health Access America," which was published by the American Medical Association (AMA). It is reprinted here with their permission. To obtain a copy of the full report, or for further information, contact AMA, 515 State Street, Chicago, IL 60610, (312) 464-5000.

Health Access America Highlights

The American Medical Association believes our nation's health care system must be reformed. The status quo is not acceptable. Better methods must be developed to control rising health care costs. Health insurance must be extended to the millions who now lack coverage. Specifically, Health Access America recommends legislative initiatives to:

- ✓ Ensure defined health care coverage for all Americans.
- ✓ Provide for a uniform floor of essential benefits for all Americans — through required employment-based private insurance and through government programs for those outside the employment setting who are unable to provide insurance for themselves and their families.
- ✓ Control rising health care expenditures through market forces — not counterproductive regulations — that encourage fair, equal competition in the health care sector and preserve the patient's right to choose his or her physician or health insurance plan.
- ✓ Create a more competitive health care marketplace by empowering patients with price information, financial incentives to make economical health care decisions, and the freedom to choose the method of provider payment in their insurance coverage — benefit payment schedule (listed payment amounts for covered services); "usual, customary, or reasonable" (UCR); or prepaid. The medical profession should be empowered to enforce ethical and clinical standards that continue to place patients' interests first.
- ✓ Establish a level playing field where all competitors play by the same rules — insured and self-insured alike. It is time to reestablish the principle that insurance should spread the risk, not avoid it. It is time to eliminate the competitive pressure to refuse to cover preexisting medical conditions. It is time to overcome "job-lock" that prevents workers from changing jobs for fear of losing health insurance.
- ✓ Defend the patient's right to decide, with his or her physician, about treatment options without outside interference or burdensome administrative costs.
- ✓ Reform the professional liability system.

These essential reform initiatives build upon — rather than relinquish — the strengths of our nation's health care system. These initiatives also recognize that neither pure competition nor overregulation benefits patients. Pure competition forces physicians to behave more like entrepreneurs and less like medical professionals. Overregulation erodes the privacy and autonomy that are at the heart of the physician-patient relationship.

Our Health Access America initiatives *would not* establish a nationalized health care system — which would jeopardize the access to quality care that most Americans have and would foster government price regulation, inefficiencies, and rationing of health care services.

In March of 1990, the American Medical Association (AMA) announced a plan of action, called Health Access America, to improve our nation's health care system. At the plan's foundation is a set of fundamental principles, outlined in Appendix A, that emphasize a comprehensive, private/public approach to expand access and control rising health care costs.

To expand access, employers must be required to provide health care coverage to employees and their dependents, just as employers are required to contribute to Social Security and unemployment compensation. Government programs of assistance must be expanded and properly targeted. To control costs, market-based reforms must be introduced that provide individuals with price information and financial incentives to choose the type of health insurance and method of paying for care that best meet their needs. The AMA believes that this market-based approach preserves a hallmark of our health care system — individual freedom of choice — and is far preferable to centrally-controlled, regulatory mechanisms that are certain to foster government price regulation, inefficiencies, and the inevitable rationing of health care services.

Since announcing Health Access America, we have actively discussed our plan with the government, other health care organizations and interested groups, and representatives of labor, business, and the insurance industry. In response to the national dialogue, we have modified our plan to incorporate important refinements. This second edition of Health Access America incorporates changes based on attentive listening to all sides of the health reform debate.

As pledged in the first edition of Health Access America, the AMA will continue to pursue a collaborative process and to refine and improve our plan. This approach provides the best hope for finding a comprehensive solution to the problems that do exist, without jeopardizing the strengths of our current system. But the physicians of America who are represented by the AMA also believe that the time for action — to expand access and control costs — is now.

The AMA Plan

The AMA plan, Health Access America, is based on the fundamental principle that reform of our nation's health care system must preserve its current strengths. Today, approximately 213 million or 87% of all Americans have private or public insurance providing access to high quality health care. Most Americans receive health coverage through the work place. Employment-related insurance covers 60% of all Americans, with an additional 27% covered by government programs and private, individual policies.

Our system has a number of other strengths, including:

- The ability of most patients to choose the physician, hospital, and type of health care plan they want.
- The widespread availability of new technologies.
- The freedom to conduct scientific research and to individualize treatment according to the best interests of each patient.

- A superior medical education system which attracts the best and brightest and provides a rigorous and comprehensive learning process to assure the public of well-trained physicians.
- An independent medical profession where physicians are able to act as patient advocates rather than as agents of the government.

Despite these strengths, major problems remain. Access to health care is limited for many people and costs are rising rapidly. Some 35 million Americans, or about 13% of our population, are without health insurance. These individuals often delay medical care until they are very sick and have no alternative but to seek treatment in hospital emergency rooms. This, of course, is not the most desirable or cost-effective way to deliver care.

Through Health Access America, the physicians represented by the AMA have developed a comprehensive plan to bring about needed reforms while preserving and fostering the high level of care that has saved and improved so many lives. Our plan combines strong market-based strategies with specific government activities to promote a fair and competitive health care marketplace.

Health Access America has four basic goals:

- Expand health care coverage to all Americans.
- Control rising health care expenditures.
- Foster a continued level of excellence in the quality of health care services.
- Ensure individual freedom of choice to select the type of insurance coverage and health care received.

We recognize that in today's fiscal environment, universal coverage cannot occur without effective cost containment. Therefore, we have chosen to describe the cost containment measures included in Health Access America first, followed by the specific provisions to expand access, promote quality, and assure freedom of choice.

I. Cost Containment

Rising health care expenditures are driven by many factors: inflation; population growth; new and expensive technology; broad-based insurance coverage which insulates individuals from the full price of their health care decisions; and health conditions associated with increasing societal problems such as violence, drug abuse, poverty, and HIV infections. The inappropriate costs associated with "defensive medicine," excessive administration (including unnecessarily complicated hurdles for patients to receive benefits), and medical care delivered outside of professionally developed practice parameters and which is not justified after peer review further contribute to rising health expenditures.

The AMA believes that all Americans should be assured of high quality care delivered at appropriate costs. Health Access America would achieve this goal by promoting true market forces and by restoring insurance principles to the health care marketplace. Our specific cost containment measures encourage competition and individual choice — and would put patients back in charge of decisions about their health care and insurance coverage. This element of choice, emphasized in our plan, is a crucial prerequisite to ensuring consumer value and continued health care quality.

Cost Containment: Key Points

- Institute true market forces and restore true insurance principles to ensure value for services.
- Foster competition in the health care marketplace and empower patients to directly impact provider payments through selection and use of the financing method of their choice.
 - Require providers to release price information to patients before treatment.
 - Require insurers to release, on a prospective basis, information on the amount they will pay for medical services included in the minimum benefits package.
 - Require employers and insurers to offer individuals a choice of insurance financing plans — a benefit payment schedule, a UCR version, or a prepaid version.
 - Encourage tax-deductible contributions to health IRAs.
 - Enact legislation to allow medical societies to review patient complaints about physicians' fees and to mediate fee disputes.
- Repeal or override state-mandated health benefit laws.
- Implement professional liability reform to reduce malpractice insurance premiums and the costs of defensive medicine.
- Curb administrative costs through uniform claim forms, electronic bill processing, and reductions in review requirements.
- Limit the amount of employer-provided health insurance that is tax-exempt and provide tax-free rebates to employees who select less costly insurance plans.
- Develop practice parameters to help ensure that only appropriate health care services are delivered.
- Eliminate "balance billing" for all insured patients below 200% of poverty.

Point 1: Encourage cost-conscious patient decision-making by requiring release of health care fees, by emphasizing insurance rather than prepayment in the health care marketplace, and by empowering patients with the right to choose the method of insurance payment.

Insurance coverage for predictable, often routine, relatively low-cost medical services has been a major cause of escalating health care costs. Such coverage diminishes individual incentives to be concerned about the price of care (because insurance will pay) and adds to the administrative costs associated with claim submission, review, and third party payment.

To remedy this problem, patients must be put back in charge of interacting with physicians and other health care providers regarding routine, predictable, and relatively low-cost services. Patients should be given both incentives to spend wisely and protection against out-

of-pocket expenses. Information on the price of health care should be widely disseminated to encourage a more truly competitive market for health care services and products. Specifically, the following actions are needed:

- Require health care providers (including physicians, hospitals, pharmacies, durable medical equipment suppliers, and others), to make fees for frequently provided services and products readily available to consumers before the service or product is provided.
- Require insurers to release, in a standard, easy-to-understand format, information to enrollees and prospective enrollees on the amount of payment provided for any covered service included in a minimum benefits health insurance package.*
- Allow individuals the freedom to choose how they want their health insurance to cover fees — either benefit payment schedule, UCR, or prepaid.
- Encourage tax-deductible contributions to health IRAs or similar tax-preferenced plans. Such savings could be cashed out for medical expenses, during retirement, or during periods of disability. Tax incentives should be provided when employers and employees voluntarily agree to deductible amounts above that included in the AMA minimum benefits package.
- Enact federal and/or state legislation to allow medical societies to review patient complaints about physicians' fees or services, arbitrate fees, and mediate voluntary agreements about fees between patients and physicians.

Congressional enactment of the resource-based relative value system (RBRVS) for physician payment under Medicare ultimately will also help provide patients with advance information as to what Medicare will pay for a service. This system will also create a more rational basis for paying physicians who treat Medicare patients.

Point 2: Repeal or override state-mandated benefit laws to help reduce the cost of health insurance, while also assuring through legislation that minimum benefits are provided in all insurance and self-insurance programs.

Health insurance policies must comply with a myriad of mandated benefit laws in the various states — over 800 such mandates nationwide, according to the Health Insurance Association of America. The HIAA estimates that such mandates prevent 16% of small firms from offering health insurance. HIAA also estimates that 51% of the firms that converted to self-insurance between 1981 and 1984 did so to avoid state mandates. Repealing or overriding current mandated benefit laws would improve both the affordability and availability of private insurance.

Point 3: Effect major professional liability reform to reduce the inappropriate cost of defensive medicine and liability insurance premiums.

Defensive medicine, the ordering of tests and procedures which might not be ordered were it not for liability concerns, drives up health care costs. Liability insurance premiums and defensive medicine activities add significantly to the average physician's bill for services. Major liability reforms must be enacted to control these costs.

* The AMA has developed a minimum benefits insurance package designed to do the most good for those who currently do not have coverage, while balancing cost considerations. Please see the "Universal Coverage" section of this report and Appendix B for a complete description of the AMA minimum benefits package.

Elements of a legislative reform package that would also preserve the rights of injured patients include:

- Federal funding to states to develop alternative dispute resolution systems for medical professional liability cases.
- Federal legislation to establish selected tort reforms, such as:
 - Limitations of \$250,000 or less on recovery of noneconomic damages.
 - A mandatory offset of collateral sources, such as health insurance and disability benefits, when computing plaintiff compensation.
 - A decreasing sliding-scale formula for paying attorney contingency fees.
 - Periodic payment for future awards of damages.
 - Limiting the period for suspending statutes of limitations in cases involving injuries to minors.
 - Requiring a certificate of merit as a prelude to filing medical liability cases and adopting basic criteria for medical expert witnesses.

This legislation should override any conflicting state laws.

Point 4: Reduce the administrative costs of health care delivery and the excessive and complicated paperwork nightmare faced by patients and their families.

A multitude of complex insurance regulations and paperwork requirements have developed under the current insurance system. This administrative labyrinth, faced by patients and physicians alike, can hinder prompt delivery of needed health care and contributes to national health spending.

Elements of a legislative reform package to streamline our insurance system include:

- Require all private insurers and self-insured firms to use a single, uniform claim form, such as the HCFA 1500 form used by Medicare. A standardized format for electronic claims processing should also be required.
- Provide tax incentives to encourage health insurers to switch to a standard electronic billing format.
- Amend federal and/or state laws to regulate third party utilization review and managed care programs to reduce the "hassle factor" and the costs of various and conflicting managed care requirements, claims procedures, review practices, and disclosure policies.

Point 5: Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans that apply to state-regulated health insurance policies.

Effective competition in the health care market requires a level playing field for insurers and the self-insured alike. However, employers who currently self-insure their workers' health care costs are exempt from most state requirements that apply to commercial and Blue Cross/Blue Shield insurance policies. This exemption removes self-insured employers from equitable participation in state risk pools and creates an "unequal playing field" that leaves many people without access to health insurance. Amending ERISA would remove this inequity

and guarantee that all insurers are subject to the same standards and requirements. It would also help reestablish the true insurance principle of spreading risk across the broadest possible population.

Point 6: Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices.

The current tax treatment of employer-provided health benefits encourages individuals to overinsure — obtaining coverage for an excessive number of ordinary, routine, and highly predictable health services. This can result in greater health care utilization and expenditures (compared to what would occur without such “rich” coverage). Such “overinsurance” also is contrary to the basic insurance principle of protecting individuals from relatively high-cost, unpredictable, medical expenses where personal budgeting is often impractical or impossible.

To encourage individuals to make more economical decisions about health care, the following tax reforms are essential:

- Limit tax exemptions for employer coverage provided beyond that specified in the minimum benefits package. Such tax limitations should:
 - Cap employers’ tax deduction for health benefit premiums at an appropriate ceiling (eg, 133% to 150% of the geographically-adjusted costs of the minimum benefits package).
 - Make employer-paid insurance premiums that exceed the cap taxable income to the employee. However, employees would be able to deduct, for income tax purposes, any amounts paid out-of-pocket. (The Congressional Budget Office has estimated that a tax cap on insurance deductibility of \$250 per month for family coverage and \$100 per month for individual coverage would raise revenue an average \$12 billion per year over a five year period. Such new revenue could be used to fund expanded access for the uninsured.)
- Provide tax-exempt rebates to employees who select health insurance plans with premiums less than their employer’s contribution to more expensive plans. Such plans would still be required to contain coverage for the minimum benefits insurance package.

II. Universal Coverage

Who are the uninsured today? Working Americans and their families make up the large majority (81%) of the uninsured. Most of the uninsured (61%) are poor or near poor; almost one-third live below the federally-established poverty level but are not covered by Medicaid. (Medicaid covers only about 40% of those in poverty.) An additional category of the uninsured includes people at various income levels, some employed and some not, who are considered by insurance companies as “medically uninsurable” because of medical conditions. Some estimates indicate that there are about three million Americans in this category.

Why do the uninsured lack coverage? Access to employment-based coverage is the most important factor that determines whether a person has insurance. For many of the working poor, however, insurance often is not available through their employer. For many other low-income people, eligibility restrictions block effective access to public insurance programs such as Medicaid.

The AMA believes that all Americans, regardless of income, should be assured of affordable coverage of their health care costs. Health Access America would achieve this goal through employer-required insurance, Medicaid expansion, and reform of the health insurance market.

The AMA examined other mechanisms to provide health care coverage for all Americans, such as "play-or-pay" mandates (which give employers the "option" of providing coverage or paying into public programs) and national health insurance systems. However, we believe that the disadvantages of these approaches — which include inefficiencies, potential health care rationing, and near total government domination of the health care marketplace — far outweigh any perceived advantages.

Universal Coverage: Key Points

- Require employers to insure all employees and their families.
 - The mandate would be phased-in over several years, based on the size of employer.
 - Tax modifications and benefits would be offered to employers.
- Expand Medicaid to cover everyone below the poverty level.
- Reform the health insurance market to make private coverage more affordable and predictable.
- Create state risk pools to make private coverage available to small businesses and those who remain uninsured.
- Restructure Medicare to a prefunded, actuarially sound program with enhanced catastrophic coverage.

Point 1: Require employers to provide health insurance for all employees and their families, with tax help to employers.

Employers would be required to insure all full-time workers and their dependents, extending access to many working American families who now lack such coverage. The employer plan must include, at a minimum, coverage for basic hospital, physician, diagnostic, pre-natal, post-natal and well-baby care services (see Appendix B). To help limit patient liability for out-of-pocket expenses, reasonable annual limits for premiums, co-payments, and deductibles should be included in the minimum benefits package. In addition, the benefit package must be offered in three different financing versions, where available: a benefit payment schedule version, a UCR version, and a prepaid version.

Employers would also be required to provide part-time workers with individual private-sector insurance vouchers, equal to a designated percentage of each worker's wages. The vouchers would be redeemable to cover at least a portion of the premium for a minimum benefits insurance policy for a worker and his or her family.

To make the transition manageable for all businesses, employer-required coverage should be phased-in over several years, with larger businesses subject first to the requirement. Tax incentives must be provided and state risk pools created so that new and small businesses can afford the cost of private coverage. Such tax incentives include amending the Internal Revenue Code to:

- Provide a federal sliding-scale tax credit for small businesses whose insurance premiums for the minimum benefit package exceed a designated percentage of payroll/wages and a designated percentage of before-tax income.
- Extend an additional tax benefit to all new businesses. During the first year of operations, businesses would be entitled to a 150% deduction for insurance premium costs. During the second year, businesses would be allowed a 125% deduction for these same costs.

Additional elements in a legislative program to bring about employer-required coverage include:

- Establish a federal incentive program for states to enact legislation to set up private, not-for-profit health benefit pools to provide coverage to the uninsurable, to the uninsured, and to small business. Require such pools to offer to small businesses (less than 25 employees) access to the minimum benefits insurance policy at standard group rates.
- Make permanent the temporary 25% income tax-deduction for insurance premiums paid by the self-employed. Expand this deduction to 100% for the self-employed and others who must pay 100% of their insurance premium.
- Expand COBRA continuation coverage for individuals who lose their job. Employers should be required to continue to pay their same share of the employee health premium for up to four months after employee termination.
- Require employers to offer an enrollment period for employees covered under a dependent plan who lose coverage when their spouse or other family member changes employment.

Expanding coverage through the work place will help promote continuity of benefits so that individuals and their families are not faced with the possibility of losing insurance when changing jobs. Mandated health benefit laws should also be repealed to lower the cost of basic employee health care benefits for small businesses, as discussed earlier in this report.

Point 2: Effect major Medicaid reform to provide uniform health benefits to all persons below the poverty level.

The AMA believes that federal and state governments must ensure access to and funding for medical care for persons below the poverty level. Medicaid must be expanded and new national standards established so that all persons below poverty are eligible for and receive a uniform set of health benefits.

Income should be the only eligibility criterion for Medicaid; all other existing categorical requirements should be repealed. A single national formula should be used to determine eligibility; state discretion in setting the economic level of eligibility should be eliminated. This will end the widespread inequities existing across state boundaries in the Medicaid program today. The federal poverty level should also be adjusted by a state cost-of-living modifier to ensure that Medicaid eligibility reflects the economic realities in the various states.

Medicaid benefits should cover all medically necessary physician and hospital services and should not differ across state lines. Because of the impoverished status of Medicaid beneficiaries, added coverage for prescription drugs, rehabilitative services, and emergency services must be provided. Medicaid reimbursement levels should be increased to prevent access problems caused by unrealistically low reimbursement levels.

Medicaid reforms will require that society provide adequate resources so that no individual is deprived of necessary care because of an inability to pay for that care. Recognizing the substantial costs of Medicaid expansion, the AMA encourages a phased-in approach that would expand Medicaid coverage for pregnant women and children below the poverty level and create a basic national level of Medicaid benefits. This national benefit level would cover necessary inpatient and outpatient hospital and emergency services; rural health clinic and other laboratory and x-ray services; home health services; early and periodic screening, diagnosis, and treatment (EPSDT) for individuals under 21; family planning; physician services; prescription drugs; and rehabilitative services.

This national level of Medicaid benefits consists of the presently required services plus prescription drugs, rehabilitative services, and emergency services. States, at their own expense, could cover additional benefits beyond the basic national level.

Point 3: Seek innovation in insurance underwriting, including new approaches to creating larger, risk-spreading groups and reinsurance.

To improve both the affordability and availability of private insurance, especially for small businesses, the following insurance market reforms are essential:

- Implement community rating to limit insurance premium costs and annual increases. Open enrollment periods and guaranteed renewability of coverage should also be required.
- Eliminate preexisting condition limitations so individuals with chronic or other medical problems, like cancer, heart disease, or diabetes, can obtain private insurance.
- Establish "reinsurance" pools to cover individual carrier/self-insurance costs beyond a certain amount of health care expenses (eg, \$25,000 or greater).
- Require private insurers to offer the minimum benefits coverage policy in three different versions: a benefit payment schedule version, a UCR version, and a prepaid version. This requirement, of course, would not restrict insurers from marketing other types of policies.

Point 4: Create state-level risk pools in all states to make private sector coverage available at standard group rates for the medically uninsurable and for others for whom individual health insurance policies are too expensive and group coverage is not available.

In our approach, a state risk pool is a legislatively created program that would act as a conduit for the provision of private insurance and would provide a mechanism for funding, across a broad population, any excess costs beyond premium revenue. These risk pools would help ensure that all Americans can obtain affordable private health insurance. Small employers should also have access to the risk pools, if affordable coverage is not available in the private market. Premiums should be set at standard group rates, with premium assistance from the state for those not covered through employment and who have annual incomes between 100% and 150% of the federal poverty level.

As a condition of federal tax deduction, all payors of employee health benefits, including self-insured employers, must help underwrite the excess costs of the risk pool established by state law, if the state selects this method rather than general revenues to fund excess costs. A 100% tax deduction should be given for premiums paid by individuals who purchase coverage through the pool.

Point 5: Enact Medicare reform, creating an actuarially sound prefunded program to assure senior citizens continued access to quality health care and to avoid the future financial bankruptcy of the program.

Special reform efforts must be pursued to assure the elderly's continued access to the health care system. Today, four workers' tax contributions support a single Medicare beneficiary. As our population ages, there will be only two workers paying taxes to support each beneficiary by the middle of the next century. A shrinking base of workers means substantially higher premiums in the years to come. Without reform, the system will collapse.

Our Medicare reform measures include a new approach to catastrophic benefits. An enhanced Medicare Trust Fund would be established and funded through individual and employer tax contributions during the working years. The tax rates to fund the trust fund would reflect several variables including: demographic factors, inflation, technological advancements, adequate access, geographic cost of practice differences, return on equity, capital development, labor and other practice costs, and professional liability costs. Senior citizens would not be taxed for this program. All persons reaching eligibility age would be entitled to a voucher for purchase in the private sector of a comprehensive health insurance policy meeting federal standards. Senior citizens would retain the freedom to choose their type of insurance coverage and method of paying for care (eg, benefit payment schedule, UCR, or prepaid).

The Medicare program would be removed from the federal budget process and its continuing Congressional budgetary pressures. Medicare trust funds would be administered by an independent, federal reserve-board type agency. This agency would be required to negotiate Medicare payment rates for physician services with the AMA, the national organization with the largest physician membership.

Point 6: Expand long-term care financing through private sector coverage encouraged by tax incentives and an asset protection program, and through Medicaid coverage for individuals below poverty.

Special reform efforts are needed to ensure the elderly's access to long-term care. Under the "asset protection" program, individuals could purchase private, long-term care insurance that would protect their assets (up to the dollar value of the insurance benefits) from being included in any determination for Medicaid eligibility for long-term care.

Sliding-scale subsidies should be provided for the purchase of long-term care insurance for individuals with incomes between 100% and 200% of the federal poverty level. Employer-provided long-term care insurance should be taxed in the same way as all other health benefit plans. A federal tax deduction or credit should be created to encourage care giving by family members.

A phased-in legislative approach to accomplish the above elements would include:

- Amend Medicaid to allow for an "asset protection" program that would adjust resource eligibility requirements to allow an individual to retain assets up to the amount that private insurance pays on his or her behalf for long-term care.

- Amend the Internal Revenue Code to allow businesses and individuals to treat payment for long-term care insurance in the same manner as health insurance premiums are now treated.
- Allow individuals to deduct, for income tax purposes, 100% of the cost of long-term care insurance premiums without meeting the 7% floor for health costs or the 2% floor for miscellaneous deductions.
- Amend the tax code to allow for penalty-free and tax-free withdrawals from individual retirement accounts (IRAs) for the purchase of long-term care insurance.

III. Quality of Health Care

The high quality of health care services is one of the greatest strengths of the American health care system. Specific recommendations in Health Access America to foster this continued level of excellence include:

Point 1: Develop practice parameters to help ensure that only appropriate medical services are provided, thus impacting favorably on the quality and cost of medical care.

Practice parameters include guidelines, standards, and other patient care strategies that assist physicians in planning individual treatment regimens. Guidelines are recommendations for patient care that may identify a particular care strategy or a range of care strategies. Standards are generally accepted principles for patient care. Practice parameters may outline a range of appropriate tests and procedures for management of a given clinical condition or may identify a range of clinical conditions for which a given procedure or treatment may be appropriate. It remains the physician's responsibility to choose what is more appropriate for the individual patient. The primary benefit of parameters is appropriate patient care. Secondary advantages include the improved use of resources, reduced liability, and better review criteria. The AMA, in conjunction with national specialty societies, is working diligently to facilitate the development of practice parameters.

The AMA urges public and private quality assurance programs and utilization review systems to adopt parameters developed by professional organizations. To encourage appropriate utilization of health care services and resources, properly developed practice parameters should be widely disseminated and implemented as a foundation for review criteria in quality assurance programs, utilization review systems, and physician payment. However, only when variations from practice parameters are deemed, by the preponderance of medical opinion, to be inappropriate in any clinical situation may they be used as per se indicators of quality problems. Otherwise, variations from parameters should constitute only a signal for further peer-to-peer considerations relative to quality or payment issues, with payment delay (not denial), pending such peer-to-peer discussions.

Legislation is also needed to ensure continued, adequate appropriations for health care assessment research and development of professional practice parameters.

Point 2: Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care.

In these times of strain upon the health care system, where physicians face multiple and sometimes competing pressures from insurance carriers and the government, the AMA urges all physicians to:

- Treat each patient as an individual.
- Use their best professional judgment in every case.
- Inform their patients of the benefits, risks, and estimated costs of treatment.
- Treat their patients with courtesy, dignity, respect, compassion, and timely attention to their medical needs.

The AMA also encourages physicians to provide care without charge or at reduced rates for the uninsured and others who cannot afford such care. Many medical societies sponsor efforts to provide free or reduced-fee care to the needy and these commendable efforts should continue.

In addition, physicians should accept the insurance amount (either the benefit payment schedule amount or the UCR amount, whichever is applicable) as full payment when treating privately-insured persons below 200% of the poverty level. Physicians should not charge any amount beyond the negotiated payment level when treating Medicare patients below 200% of the poverty level.

Point 3: Urge expanded federal support for medical education, research, and the National Institutes of Health to help bring about continuing medical breakthroughs which historically have resulted in many life-saving discoveries.

The American people have benefitted greatly from scientific discoveries and technological developments derived from our nation's past support for medical research. Cost-saving as well as life-saving medical advances developed in our country have improved the quality and duration of life for millions, in our nation and around the globe. We must continue to strongly support such medical research to remain on the leading edge of advancing the state of medical knowledge and technology.

Point 4: Encourage health promotion and disease prevention.

Physicians and patients should become more active participants in health promotion and disease prevention. Such activities can improve the extent and quality of life and reduce national health spending. For example, one recent estimate indicates that 35% of all hospitalized patients are there due to an alcohol or drug abuse problem. Health-related problems due to other life-style choices, such as smoking, have also been widely documented. Estimates by the Centers for Disease Control's Office of Smoking and Health indicate that 390,000 Americans die each year from tobacco-related illness and that the direct health care costs related to these illnesses are about \$22 billion per year.

For its part, the AMA continues to promote programs to eliminate smoking, discourage alcohol and drug abuse, reduce cholesterol, encourage better adolescent health, and other similar measures to improve health status and to reduce health care costs.

IV. Freedom of Choice

The individual's freedom of choice to pursue services which meet his or her health care needs, combined with a free and independent medical profession, are firmly based on the American recognition of the importance of the individual and are the cornerstones for our strong American health care system. All of this is not to say that there is no proper role for government in the health care marketplace. Government's role should be to: (1) encourage the private sector to deliver the highest quality of care for the most people possible; (2) assist the private sector to deliver the highest quality of care at the most reasonable cost; and (3) provide financial assistance for Americans who cannot afford health insurance.

The reform initiatives in Health Access America balance these private and public responsibilities and preserve the freedom of individuals to select the physician, hospital, and type of health care plan they want. Specific initiatives that require employers and insurers to offer the minimum benefits insurance package in three different versions — a benefit payment schedule version, a UCR version, and a prepaid version — also ensure that individuals are able to select their preferred method of *paying* for health care.

In all three required versions of the minimum benefits package, employers must offer optional coverage for unlimited physician office visits and hospital days, at an added cost to the employee selecting this coverage. No policy may contain a provision excluding coverage on the basis of a preexisting medical condition.

In the benefit payment schedule version, payment may be adjusted by carriers or employers as long as: (1) some payment is scheduled for each of the required benefits; and (2) out-of-pocket expenses for the minimum benefits are limited to \$1500 per individual and \$3000 per family. Any expenses beyond the scope or intensity of the required minimum benefits would not count toward this out-of-pocket maximum. The prepaid version must provide for at least the scope and intensity of services included in the minimum benefit package. The same out-of-pocket limits and optional benefits noted for the benefit schedule would apply for the prepaid version.

The concept of managed care, when it is part of a pluralistic system of choices, also is an acceptable approach to health benefits management. Such managed care programs should compete openly and equally in the health care market with other delivery systems and should comply with the basic principles on managed care outlined in Appendix C of this report.

Conclusion

Reform of our nation's health care system through the provisions contained in Health Access America presents an enormous challenge to all concerned. For its part, the AMA intends to move forward vigorously on legislative and other fronts. We welcome and encourage the support and participation of others to bring about a strengthened American health care system.

American Nurses Association

The following document is a report entitled "Nursing's Agenda For Health Care Reform," which was published by the American Nurses Association. It is reprinted here with their permission. For further information, contact the American Nurses Association, 1101 14th Street, NW, Suite 200, Washington, D.C. 20005, (202) 789-1800.

The American Nurses Association (ANA) and the National League for Nursing (NLN) and more than 65 other national nursing organizations, representing approximately 1,000,000 nurses, have endorsed Nursing's Agenda for Health Care Reform. The Agenda has been distributed to Congress, business, labor and allied health care organizations.

Elements of the plan include:

- * Universal access to a federally defined standard package of essential health services.
- * A better balance between treatment of disease, health promotion and illness prevention.
- * Provision of primary health care in convenient, familiar settings such as schools and workplaces.
- * Use of a full range of qualified health professionals.
- * Greater use of case management and managed care.

To implement the plan, nursing organizations will:

- * Develop a grassroots lobbying and public education campaign.
- * Analyze state and federal legislation and support proposals that are consistent with nursing's agenda.
- * Work with members of Congress to incorporate the agenda into federal law.
- * Develop publications and white papers that address the plan in greater detail.
- * Hold public hearings to focus debate on the recommendations included in the agenda.
- * Spearhead a program to provide immunizations to children.

EXECUTIVE SUMMARY

America's nurses have long supported our nation's efforts to create a health care system that assures access, quality, and services at affordable costs. This document presents nursing's agenda for immediate health care reform. We call for a basic "core" of essential health care services to be available to everyone. We call for a restructured health care system that will focus on the consumers and their health, with services to be delivered in familiar, convenient sites, such as schools, workplaces, and homes. We call for a shift from the predominant focus on illness and cure to an orientation toward wellness and care.

The basic components of nursing's "core of care" include:

- ▶ A restructured health care system which:
 - Enhances consumer access to services by delivering primary health care in community-based settings.
 - Fosters consumer responsibility for personal health, self care, and informed decision making in selecting health care services.
 - Facilitates utilization of the most cost-effective providers and therapeutic options in the most appropriate settings.
- ▶ A federally-defined standard package of essential health care services available to all citizens and residents of the United States, provided and financed through an integration of public and private plans and sources:
 - A public plan, based on federal guidelines and eligibility requirements, will provide coverage for the poor and create the opportunity for small businesses and individuals, particularly those at risk because of preexisting conditions and those potentially medically indigent, to buy into the plan.
 - A private plan will offer, at a minimum, the nationally standardized package of essential services. This standard package could be enriched as a benefit of employment or individuals could purchase additional

services if they so choose. If employers do not offer private coverage, they must pay into the public plan for their employees.

- ▶ A phase-in of essential services, in order to be fiscally responsible:
 - Coverage of pregnant women and children is critical. This first step represents a cost-effective investment in the future health and prosperity of the nation.
 - One early step will be to design services specifically to assist vulnerable populations who have had limited access to our nation's health care system. A "Healthstart Plan" is proposed to improve the health status of these individuals.
- ▶ Planned change to anticipate health service needs that correlate with changing national demographics.
- ▶ Steps to reduce health care costs include:
 - Required usage of managed care in the public plan and encouraged in private plans.
 - Incentives for consumers and providers to utilize managed care arrangements.
 - Controlled growth of the health care system through planning and prudent resource allocation.
 - Incentives for consumers and providers to be more cost efficient in exercising health care options.
 - Development of health care policies based on effectiveness and outcomes research.
 - Assurance of direct access to a full range of qualified providers.
 - Elimination of unnecessary bureaucratic controls and administrative procedures.
- ▶ Case management will be required for those with continuing health care needs. Case management will reduce the fragmentation of the present system, promote consumers' active participation in decisions about their health, and create an advocate on their behalf.

- ▶ Provisions for long-term care, which include:
 - Public and private funding for services of short duration to prevent personal impoverishment.
 - Public funding for extended care if consumer resources are exhausted.
 - Emphasis on the consumers' responsibility to financially plan for their long-term care needs, including new personal financial alternatives and strengthened private insurance arrangements.
- ▶ Insurance reforms to assure improved access to coverage, including affordable premiums, reinsurance pools for catastrophic coverage, and other steps to protect both insurers and individuals against excessive costs.
- ▶ Access to services assured by no payment at the point of service and elimination of balance billing in both public and private plans.
- ▶ Establishment of public/private sector review — operating under federal guidelines and including payers, providers, and consumers — to determine resource allocation, cost reduction approaches, allowable insurance premiums, and fair and consistent reimbursement levels for providers. This review would progress in a climate sensitive to ethical issues.

Additional resources will be required to accomplish this plan. While significant dollars can be obtained through restructuring and other strategies, responsibility for any new funds must be shared by individuals, employers, and government, phased in over several years to minimize the impact.

NURSING'S AGENDA FOR HEALTH CARE REFORM

Nurses provide a unique perspective on the health care system. Our constant presence in a variety of settings places us in contact with individuals who reap the benefits of the system's most sophisticated services, as well as those individuals seriously compromised by the system's inefficiencies.

More and more, nurses observe the effects of inadequate services and of the declining quality of care on the nation's health. Firsthand experience tells us that the time has come for change. Patchwork approaches to health care reform have not worked. While preserving the best elements of the existing system, we must build a new foundation for health care in America. It is this realization that drives *Nursing's Agenda For Health Care Reform*.

Nursing's plan for reform converts a system that focuses on the costly treatment of illness to a system that emphasizes primary health care services and the promotion, restoration, and maintenance of health. It increases the consumer's responsibility and role in health care decision making and focuses on partnerships between consumers and providers. It sets forth new delivery arrangements that make health care a more vital part of individual and community life. And it ensures that health services are appropriate, effective, cost efficient, and focused on consumer needs.

A HEALTH CARE SYSTEM IN CRISIS

The strengths and weaknesses of our nation's health care system are well documented. Every day, many Americans profit from the system's technological excellence, extensive medical research, well-educated health professionals, diverse range of providers, and myriad of facilities. Millions of people live longer lives because of the care they receive.

But America's health care system is also very costly, its quality inconsistent, and its benefits unequally distributed. Although the system provides highly sophisticated care to many, millions of Americans must overcome enormous obstacles to get even the most elementary services. In short, health care is neither fairly nor equitably delivered to all segments of the population.

As caregivers in a diversity of settings, responsible for providing care and coordinating health care services 24 hours-a-day, nurses clearly understand the implications of the system's failings. The more than two million nurses in America are at the front lines — in hospitals, nursing homes, schools, home health agencies, workplaces, community clinics, and managed care programs. And what nurses see are the alarming effects of a system that has lost touch with the communities it is supposed to serve:

- ▶ More and more people must overcome major barriers to gain access to even the most elementary services.
- ▶ Too many Americans receive treatment too late because they live in inner cities or in urban or rural areas where service levels are inadequate.
- ▶ People enter hospitals daily in advanced stages of illness, suffering from problems that could have been treated in less costly settings or avoided altogether with adequate disease prevention and health promotion services.
- ▶ The lack of access to prenatal care contributes to an alarming number of infant deaths and low birth weights each year.
- ▶ Obstacles to obtaining fundamental services, such as childhood immunizations, are largely responsible for a resurgence in preventable diseases.
- ▶ Disproportionate amounts of resources are used for expensive medical interventions, which all too often provide neither comfort nor cure.
- ▶ Every year, expensive nursing home care impoverishes an alarming number of residents and their families.

Major changes in the health care system can no longer be put on hold. Further analysis and investigation will neither change the facts nor diminish the problems.

Today, more than 60 million Americans are either uninsured or underinsured. This fact alone cries out for health care reform. Now, the system's inability to contain costs is placing more and more Americans with "adequate" insurance coverage at risk of hardship when major illnesses do occur. Employers and employees alike are desperately seeking solutions to the dual problems of rising health care costs and increased premium rates that threaten basic coverage for most American workers and their dependents.

Americans cannot afford to sit idly and do nothing. Health care costs are approaching 12 percent of the gross national product (GNP). Health care is expected to cost over \$756 billion in 1991.¹ If nothing is done to control expenditures, health care spending is expected to reach \$1.2 to \$1.3 trillion by 1995 — an increase of some \$500 billion in less than five years. At this rate, if the system remains unchanged, spending will reach between \$2.1 and \$2.7 trillion by the year 2000.²

THE FRAMEWORK FOR CHANGE

Nurses strongly believe that the health care system must be restructured, reoriented, and decentralized in order to guarantee access to services, contain costs, and ensure quality care. Our plan — the product of consensus building within organized nursing — is designed to achieve this goal. It provides central control in the form of federal minimum standards for essential services and federally defined eligibility requirements. At the same time, it makes allowances for decentralized decision making which will permit local areas to develop specific programs and arrangements best suited to consumer needs.

Nursing's plan is built around several basic premises, including the following:

- ▶ All citizens and residents of the United States must have equitable access to essential health care services (a core of care).
- ▶ Primary health care services must play a very basic and prominent role in service delivery.
- ▶ Consumers must be the central focus of the health care system. Assessment of health care needs must be the determining factor in the ultimate structuring and delivery of programs and services.
- ▶ Consumers must be guaranteed direct access to a full range of qualified health care providers who offer their services in a variety of delivery arrangements at sites which are accessible, convenient, and familiar to the consumer.
- ▶ Consumers must assume more responsibility for their own care and become better informed about the range of providers and the potential options for services. Working in partnership with providers, consumers must actively participate in choices that best meet their needs.
- ▶ Health care services must be restructured to create a better balance between the prevailing orientation toward illness and cure and a new commitment to wellness and care.
- ▶ The health care system must assure that appropriate, effective care is delivered through the efficient use of resources.
- ▶ A standardized package of essential health care services must be provided and financed through an integration of public and private plans and sources.

- Mechanisms must be implemented to protect against catastrophic costs and impoverishment.

The cornerstone of nursing's plan for reform is the delivery of primary health care services to households and individuals in convenient, familiar places. If health is to be a true national priority, it is logical to provide services in the places where people work and live. Maximizing the use of these sites can help eliminate the fragmentation and lack of coordination which have come to characterize the existing health care system. It can also promote a more "consumer friendly" system where services such as health education, screening, immunizations, well-child care, and prenatal care would be readily accessible.

At the same time, consumers must be the focus of the health care system. Individuals must be given incentives to assume more responsibility for their health. They must develop both the motivation and capability to be more prudent buyers of health services. Promotion of healthy lifestyles and better informed consumer decisions can contribute to effective and economical health care delivery.

Finally, in implementing reforms, attention must be directed to the unique needs of special population groups whose health care needs have been neglected. These individuals include children, pregnant women, and vulnerable groups such as the poor, minorities, AIDS victims, and those who have difficulty securing insurance because of preexisting conditions. Lack of preventive and primary care for this sector has cost the nation enormously — both in terms of lives lost or impaired and dollars spent to treat problems that could have been avoided or treated less expensively through appropriate intervention.

Access to care alone may not be sufficient to resolve the problems of these vulnerable groups. For those individuals whose health has been seriously compromised, a "catch up" program characterized by enriched services is justified. Coverage of pregnant women and children is critical. This first step represents a cost effective investment in the future health and prosperity of the nation.

It is this set of values that distinguishes nursing's plan from other proposals and offers a realistic approach to health care reform.

A PLAN FOR REFORM

Nursing's plan for health care reform builds a new foundation for health care in America. It shifts the emphasis of the health care system from illness and cure to wellness and care. While preserving key components of the existing system, it sets forth new strategies for guaranteeing universal coverage; making health care a more vital part of community life; and ensuring that the health care services provided are appropriate, effective, and cost efficient.

The following pages provide a general overview of nursing's vision for a better health care system.

UNIVERSAL ACCESS TO A STANDARD PACKAGE OF ESSENTIAL SERVICES

Nursing's plan envisions a new and bold approach to universal access to a standard package of essential health care services and the manner in which these services are delivered.

The federal government will delineate the essential services (core of care) which must be provided to all U.S. citizens and residents. This standard package will include defined levels of:

- ▶ Primary health care services, hospital care, emergency treatment, inpatient and outpatient professional services, and home care services.
- ▶ Prevention services, including prenatal and perinatal care; infant and well-child care; school-based disease prevention programs; speech therapy, hearing, dental, and eye care for children up to age 18; screening procedures; and other preventive services with proven effectiveness.
- ▶ Prescription drugs, medical supplies and equipment, and laboratory and radiology services.
- ▶ Mental health services and substance abuse treatment and rehabilitation.
- ▶ Hospice care.
- ▶ Long-term care services of relatively short duration.

- Restorative services determined to be essential to the prevention of long-term institutionalization.

By taking this approach, traditional illness services are balanced with provisions for health maintenance services which prevent illness, reduce cost, and avoid institutionalization. Thus, hospital coverage and emergency care are covered, as are such services as immunizations, physical examinations, and prenatal and perinatal care.

The creation of federal minimum standards for essential services will necessitate modifications in existing public programs. The ultimate goal will be, over time, to merge all government-sponsored health programs into a single public program.

Coverage Options

Universal coverage for the federally defined package of essential services will be provided through an integration of public and private plans and resources.

- A public plan, administered by the states, will provide coverage for the poor (those below 200% of the federal poverty level), high-risk populations, and the potentially medically indigent. Any employer or individual will also have the option of buying into this plan as their source of coverage.
- Private plans (employment-based health benefit programs and commercial health insurance) will be required to offer, at a minimum, the nationally standardized package of essential services. This package could be enriched as a benefit of employment or individuals could purchase additional services from commercial insurers if they so choose.

All citizens and residents will be required to be covered by one of these options. Under both the public plan and private plans, no one will be denied insurance because of preexisting conditions. If employers do not offer private coverage, they will be required to pay into the public plan for their employees. Employer payments will be actuarially equivalent to the costs of employee and dependent coverage. Financial relief will be made available to small businesses (25 employees or less) for whom this provision would not be feasible. Individuals with no source of private coverage could also buy into the public plan. To assure universal coverage for essential services, systems

will be developed to identify the insurance option through which each individual's needs are met.

Premiums and Payment Rates

Access to health care services will be enhanced by offering insurance premiums that the public can afford and payment rates to providers that are equitable and inclusive.

Both the public and private plans will utilize deductibles and copayments to ensure that beneficiaries continue to pay for a portion of their own care and, therefore, have financial incentives to be economical in their use of services. Deductible amounts and copayment rates, however, will never serve as barriers to care. Provisions will be made to waive or subsidize deductions and copayments for households with incomes below 200% of the federal poverty level. Deductibles for certain types of programs and services (e.g., health promotion, such as well-child care, immunizations, and mammograms; and managed care plans) will be held to a minimum to encourage wider use of cost-efficient, wellness-oriented options.

Public and private payers will be required to offer fair and consistent rates of payment to providers. To protect access to care, providers will not seek payment at the point of service; nor will they be permitted to engage in balance billing. Because providers will be reimbursed fairly through insurance and the problems of uncompensated care will be largely eliminated, there will be no need for providers to charge consumers amounts above the established rate. Consequently, the consumer's financial responsibility for health care services will be more predictable.

To make insurance more affordable to individuals and to reduce costs to insurers and employers, nursing's plan calls for reforms in the private insurance market. These reforms may encompass a variety of strategies, including:

- ▶ Community rating for all insurers.
- ▶ A cap on the out-of-pocket expenses individuals must pay for catastrophic care, including nursing home and other long-term care.
- ▶ State reinsurance pools to protect insurers and consumers against the high costs of insuring a broader range of patients.

Special Programs for Vulnerable Groups

Countless individuals suffer from long-term health problems associated with inadequate access to basic health services over time. Often, the poor and many members of minority groups are in this category. Special programs will provide services and outreach to vulnerable populations in order to compensate for formerly inadequate care and its consequences.

For infants and children (e.g., low birthweight babies, battered and neglected children, pregnant teenagers, children who abuse drugs, and young victims of violence and homelessness), such programming could be viewed as a health service ("Healthstart") equivalent to the Headstart Program for those who are educationally disadvantaged. An expanded version of the Women's, Infants and Children (WIC) Program may be needed to produce quality outcomes in maternal-child health for poor and minority populations. Other special population groups also may warrant compensatory health programs beyond the scope of essential health benefits and services.

It is important to note that the ultimate goal of improved health is not achievable exclusively within the confines of the health sector. Social failures also have serious health consequences. Improvements in the broader environment have a major impact on health status and health care costs. While the focus of this plan is on the health care system, nursing's long-term policy agenda for the nation is much broader. National health reform must also consider the interrelationships between health and such factors as education, behavior, income, housing and sanitation, social support networks, and attitudes about health. Better health cannot be the nation's only goal when hunger, crime, drugs, and other social problems remain. Consequently, nursing is committed to pursuing reform in other areas affecting health. Discussion of such reform, however, is beyond the scope of this paper.

Long-Term Care

The high costs of long-term care often threaten to impoverish patients and their families. Nursing's plan seeks to prevent impoverishment and the potential loss of dignity by recognizing both public responsibility for long-term care and continued personal commitment to planning for such care. Financing arrangements will provide "front-end" coverage for chronic care and long-term care services of short duration through a variety of public and private options.

Beyond addressing short-term needs, individuals will be expected to assume personal responsibility for long-term care

through strengthened private insurance programs and a variety of innovative financing arrangements. Such strategies will include privately purchased long-term care insurance, new savings and tax incentives, and home equity conversion opportunities. Such steps are essential to prevent individuals and their families from becoming impoverished by necessary care that can be anticipated and planned for. Emphasis on personal responsibility, however, does not ignore the fact that there will always be some individuals who will be left without resources and who must reach out for public assistance.

Catastrophic Expenses

Length and/or intensity of illness may generate catastrophic costs. Given this fact, limits will be placed on individuals' out-of-pocket payments for catastrophic health care expenses. Costs to insurers or individuals that exceed preset limits will be covered through a state reinsurance pool, to which all insurers must contribute. Under nursing's plan, insurers will tap into the pool when the cost of the insured exceeds preset limits. When costs decline, they will resume normal financing.

Decentralized Delivery System

Although standards for essential health services and eligibility requirements are to be mandated at the federal level, delivery mechanisms for health services will be decentralized in terms of planning and administration to foster greater consumer orientation. Because local needs differ, states will have the authority to modify implementation in order to reflect geographical diversity.

To promote greater use of disease prevention and primary health care, services will be delivered, whenever possible, in convenient, familiar sites readily accessible to households and individuals. Maximizing the use of local settings, including schools, homes, places of work, and other community facilities, will help reduce the fragmentation of primary health care delivery and promote a more consumer-friendly system.

COST EFFECTIVE, QUALITY CARE

By properly balancing individual health needs and self care responsibilities with provider capabilities, care can be provided in a more efficient and coordinated manner. It can be more effectively directed at health promotion activities that will ultimately improve outcomes and reduce costs. Nursing's plan for reform is designed to achieve such a balance.

Provider Availability

Financial and regulatory obstacles, as well as institutional barriers, that deny consumer access to all qualified health professionals will be removed. The wider use of a range of qualified health professionals will increase access to care, particularly in understaffed specialties, such as primary health care, and in underserved urban and rural geographical areas. It will also facilitate selection of the most cost-effective option for care.

Under this arrangement, health providers must be reasonably and fairly compensated for their services. Where fee-for-service payment arrangements continue, payments for patient services must be made directly to providers.

Consumer Involvement

Consumers will be encouraged to assume more responsibility for their own health. Health professionals will work in partnership with consumers to evaluate the full range of their needs and available services. Together, the consumer and the health professional will determine a course of action that is based on an understanding of the effectiveness of treatment.

Outcome and Effectiveness Measures

Development of multidisciplinary clinical practice guidelines is essential to the proper functioning of the health care system. These guidelines will be used to sensitize providers and others to the proven effectiveness of practices and technologies. With clear-cut information on the value of various procedures, payers, providers, and consumers can work together to eliminate wasteful and unnecessary services. Moreover, increased dissemination of research findings regarding health care outcomes will enhance provider and consumer involvement in making the most effective choices about care and treatment. By taking this approach, the likelihood of serious disputes or litigation over appropriateness of care will be minimized. Likewise, the need for defensive practices designed to protect providers against malpractice suits will be greatly reduced.

Practice guidelines and directives derived from research, while providing an element of control, will be supportive of innovation. Coverage will be extended to procedures shown to be significantly more effective and less costly than existing approaches, and/or useful in improving patient outcomes and quality of life. At the same time, an effort will be made to carefully weigh new therapeutic approaches with high start-up costs that may ultimately be less expensive than present methods.

Use of advancements in clinical practice and technology will be conditioned on satisfying criteria related to cost efficiency and therapeutic effectiveness. Such an approach will not deny people essential services. It will, however, carefully assess the appropriateness of providing high-tech curative medical care to those who simply require comfort, relief from pain, supportive care, or a peaceful death.

Review Mechanisms

State and local review bodies — representative of the public and private sectors and composed of payers, providers, and consumers — will be established. These groups, operating under federal guidelines, will determine resource allocation, cost reduction approaches, allowable insurance premiums, and fair and consistent reimbursement levels for providers. Such review will be sensitive to ethical issues.

Managed Care

Managed care will be instituted both to reduce costs and to assure consumer access to the most effective treatments. Nursing's plan envisions managed care as organized delivery systems which link the financing of health care to the delivery of services — serving to maximize the quality of care while minimizing costs. To promote the use of managed care, enrollment in approved provider networks will be a requirement for those covered by the public plan. Managed care will also be encouraged for recipients of private coverage through reductions in deductibles and copayments.

In the ~~past~~^{past}, managed care has been used, in many instances, to protect the pocketbooks of insurers rather than the rights of consumers. Managed care must be restructured to retain the maximum possible consumer choice and to place a premium on services that address the health of consumers.

Case Management

In contrast to managed care systems, case management is rooted in the client-provider relationship. Case management services will be used to integrate, coordinate, and advocate for people requiring extensive services. The aim of case management is to make health care less fragmented and more holistic for those individuals with complex health care needs. A variety of health care professionals are qualified to provide this service. The first allegiance of these providers will be to their clients. Acting as advocates, they will provide both direct care and negotiate with systems on behalf of their clients. They will be authorized to access services for a given client.

Both case management (provider) and managed care (delivery systems) models are important to the smooth functioning of the health care system.

A REALISTIC PLAN OF ACTION

Under nursing's plan, universal coverage will be achieved through implementation of both the public and private plan options. Employers will be motivated to collaborate with employees in shaping private plans which best satisfy their needs. At the same time, as larger numbers of more diverse groups participate in the public plan, the attractiveness of this option in terms of cost, quality, and image will be enhanced.

While the public and private sector plans can move forward simultaneously, it may be necessary to expand coverage to segments of the population in sequential steps. These steps would be introduced at an acceptable and financially reasonable rate until the ultimate goal of universal coverage is achieved. This approach would avoid excessive shocks to the health care system and allow the public to adjust to changing patterns of service.

Given this perspective, the first targeted population would include all pregnant women, children under age six, and those individuals who demonstrate a health status seriously compromised by a history of inadequate care. Improvements in coverage and benefits for these groups will have the greatest impact on the nation's future health and productivity.

As expeditiously as possible, other segments of the population would be covered. These groups might be targeted as outlined below; this sequence, however, is not necessarily intended as a rigid order:

- ▶ All children and young people, ages 6-18.
- ▶ All those above age 18 with incomes below 100% of the federal poverty level.
- ▶ All employees and dependents.
- ▶ All those with incomes below 200% of the federal poverty level.

The process will culminate with the merger of all entitlement plans into a single public program to provide coverage to all

citizens and residents who do not have or cannot obtain coverage through a private plan.

THE FISCAL IMPLICATIONS OF REFORM

It is impossible to predict the dollar amount which will be associated with the expansion of services or the efficiencies in nursing's plan. It is predictable that additional funding will be necessary to support start-up costs and transition. It is also possible that such expenditures will be recaptured over time.

A number of proposals for reform have been introduced. Among those proposals with cost estimates, additional health care costs range from \$60-\$90 billion.^{3, 4} While nursing's plan for expanded coverage is similar in a number of ways to some of these proposals, offsetting proposed efficiencies integral to the plan will create significant dollars for reallocation. These resources will be directed to areas currently underfunded or excluded, including long-term care and primary care services.

While precise financial estimates are not possible at this time, several general observations can be made.

Cost Impact

Extension of coverage for essential services to the uninsured and underinsured will result in the dedication of more dollars. One source estimated that such coverage, if provided in 1990, would have added approximately \$12 billion to health spending.⁵

It will also be necessary to dedicate more dollars to the expansion of long-term care services. Cost estimates for improved long-term care coverage vary. One 1990 study suggests that provision of comprehensive long-term care services, if implemented in 1990, would have cost \$45 billion — \$34 billion of which would have been new costs.⁶ Nursing's plan, however, calls for more limited coverage supported through a combination of public dollars and enhanced personal responsibility.

In the initial phases of nursing's health care reform, the emphasis on preventive services will require dollars. Over time, however, improved health resulting from the availability of comprehensive primary health care services will produce a cost-reducing "health dividend." By placing greater emphasis on health promotion and disease prevention in community-based settings, the system will reach out aggressively to individuals and households to foster an increased commitment to healthy lifestyles, prevention of disease, periodic screening for early detection of illness and earlier treatment, and promote

informed decision making by the consumer. All of this will contribute to cost-effective, early interventions which, over time, will reduce the need for more costly care.

Cost Savings

New costs associated with nursing's plan will be offset to a considerable degree by the following cost-saving initiatives:

- ▶ Required usage of managed care in the public plan and encouraged use in private plans.
- ▶ Incentives for consumers and providers to utilize managed care arrangements.
- ▶ Controlled growth of the health care system through planning and prudent resource allocation.
- ▶ Assurance of direct access to a full range of qualified providers.
- ▶ Development of health care policies based on effectiveness and outcomes research.
- ▶ Incentives for consumers and providers to be more cost efficient in selecting health care options.
- ▶ Elimination of unnecessary bureaucratic controls and administrative procedures, through such measures as standardized billing, simplified utilization review, streamlined administrative procedures, regulatory reforms, and consolidation of plans.

Sources of Revenue

To the extent that any additional dollars are needed, sources can be found. Responsibility for financing health care reform must be distributed equitably among individuals, employers, and government.

Individuals will continue to pay a portion of health costs through copayments by households and individuals with incomes above 200% of the poverty level, and through reduced copayments for those whose incomes are 100-200% of the poverty level.

Employers will provide private health insurance that meets or exceeds minimum federal standards for their employees and dependents, or will provide coverage through the public plan. Accommodations will be made to provide small businesses with the necessary financial relief to meet this obligation.

State governments currently pay a portion of health care expenses for the poor and fund certain other health programs. Nursing's health care reform plan calls for consolidation of existing government health plans into a single public program. When this occurs, all states will contribute revenues to the program through maintenance-of-effort arrangements.

Revenues to pay for any increased costs could be derived from some combination of higher tobacco and alcohol taxes, additional payroll taxes, higher marginal income tax rates, and the increase or elimination of the income ceiling for FICA tax collection. A value-added tax (similar to a national sales tax) could also be considered.

A LOOK TOWARD THE FUTURE

The existing health care system stands as evidence of the futility of patchwork approaches to health care reform. America's nurses say it is time to frame a new vision for reform — time for a bold departure from the present. Reform of any single component of the system will not do the job. Insurance reform alone will not guarantee access to care if the health care delivery system is not restructured. Conversely, many people will remain unserved or underserved if health care services are so costly that millions of Americans cannot afford to purchase care.

To be most effective, a health care system must do more than provide equipment, supplies, facilities, and manpower. It must guarantee universal access to an assured standard of care. It must use health resources effectively and efficiently — balancing efforts to promote health with the capacity to cure disease. It must provide care in convenient, familiar locations. And it must make full use of the range of qualified health professionals and diverse settings for care. It is this insight that underlies nursing's plan for reform — making it the most viable solution to the nation's health care crisis.

SOURCES

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4. Mark G. Battle, January 8, 1991, National Association of Social Workers, remarks during NASW's National Health Care Press Conference.
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6. *Pepper Commission*, p. 151.

Blue Cross and Blue Shield Association

The following information appeared in a packet entitled "Community Partnerships for a Healthy America," which was published by the Blue Cross and Blue Shield Association (BC/BS). It is reprinted here with their permission. To obtain a copy of the full packet, or for further information, contact BC/BS, 676 North St. Clair Street, Chicago, IL 60611, (312) 440-6000.

The Blue Cross and Blue Shield Association has developed a comprehensive proposal for health care reform that would work better than any of the proposals suggested so far. We would reform the system from the ground up. Our proposal has the essential ingredients of cost control and universal coverage. And it results in a private insurance system more responsible and more responsive to the public. Our proposal—Community Partnerships for a Healthy America—embodies four principles.

1 The Health Care Industry Should Be Reformed to Make Private Insurance More Responsive to Public Needs

To make health insurance a better consumer value, we envision dramatic change in the way insurers do business. Our "partnerships" approach would assure accountability in the health insurance marketplace by imposing government requirements for responsible behavior on companies that sell health benefits. Only insurers that meet these federal criteria would be licensed by states to offer coverage as Accountable Health Plans.

Not surprisingly, health insurance worked better when the marketplace was less complex and health care costs were lower. Insurance companies accepted all comers, regardless of their health needs or problems. Because costs were lower, insurers could charge everyone the same rate without causing hardship for any single individual or group, effectively spreading the costs of care for the very ill across the entire population.

Over the years, enterprising businesses recognized health insurance could be highly profitable, especially if only healthy groups and individuals were insured. There now are more than 1,500 health insurance companies in the marketplace, and many compete for business primarily by avoiding those who need health care services.

Community Partnerships for a Healthy America would make the insurance system fairer, more responsible, more responsive to consumers and simpler for everyone from doctor to patient. Government and the private sector would work side-by-side to craft tough new guidelines for insurers and create financial incentives to boost cost-effectiveness. Insurers would have to meet these federal guidelines for responsible market behavior to be licensed by their states as community-based Accountable Health Plans.

These standards for insurers' marketplace behavior would specify a basic set of benefits that all Accountable Health Plans would have to offer as a minimum. An important component of this basic benefit package would be preventive care, including such services as prenatal care, well-baby care and other effective preventive and screening procedures.

The basic set of benefits would be "portable." No one could be denied coverage if he or she lost or changed a job or joined another employer group policy. And because everyone would be covered for at least the basic set of benefits, there would be no need for limits or exclusions for pre-existing conditions.

Every small group and individual would be assured access to private coverage regardless of health problems. Rates would be set equitably. Groups and individuals couldn't be dropped because of health problems.

Accountable Health Plans also would have to implement uniform electronic billing and data collection systems. This not only would free consumers from insurance claim forms and reduce paperwork burdens on hospitals and physicians, it also would cut overhead and administrative expense.

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2 To Control Costs, New Incentives are Needed
to Change the Way Medicine is Practiced

If health care costs are to be controlled, Accountable Health Plans must do more than meet standards for marketplace behavior. They must make a major commitment to managing costs.

The Blue Cross and Blue Shield Association believes that the strategy of controlling health care costs either by imposing arbitrary limits on total spending or depending on government regulation of prices for physicians and hospitals won't effectively address cost problems. Price controls alone haven't slowed health care cost increases. Government-imposed caps at best are a blunt instrument to force less spending. But they don't eliminate inappropriate or poor-quality care or ensure the right services are available to meet community health care needs. Instead, an unreformed health care delivery system simply learns to live within a government-imposed budget, which means that patients have less timely access to needed care and that health care delivery inefficiencies continue.

We think controlling costs starts with reforming the way health care is delivered, and that that can best be done community by community. Rather than rely on price controls that bear no relation to the type or amount of treatment required, we need a private health care financing system where competition is based on balancing cost containment, quality and patient satisfaction.

Our strategy will put incentives in place to change the way medicine is practiced, helping eliminate the nearly 30 percent of certain medical procedures estimated to be unnecessary and emphasizing lower-cost, early intervention.

Our ideas are based on the strategy of keeping people healthy. To accomplish this, we envision a restructuring of relationships among Accountable Health Plans, hospitals, physicians and other health care providers. Our program will require Accountable Health Plans to be responsible for bringing together all those involved in patient care to make decisions in the best interest of the patient.

We call these cooperative arrangements Community Care Partnerships. These partnerships are based on the following:

- Accountable Health Plans would contract with the Community Care Partnerships composed of hospitals, physicians and other health care providers that have a record of providing high-quality, cost-effective services. These arrangements would enable Accountable Health Plans to provide the full range of covered benefits, emphasizing not only the financing of care but also management of patients' total health care needs.
- Any qualified entity could establish a Community Care Partnership. Groups of physicians currently in a comprehensive group practice could decide to qualify. Hospitals could set up hospital-based Community Care Partnerships. And employers might want to establish these networks for their employees. Accountable Health Plans, to be licensed to do business, will have to make a deep commitment to managing costs and will be required to move an increasing share of their enrollees into Community Care Partnerships.

- Everyone in the Community Care Partnership would participate in a continual education process, assuring that patients receive the best possible care, while keeping care affordable. After they select providers that deliver care cost-effectively, Accountable Health Plans would monitor closely the hospitals and physicians in their network, constantly providing them information on their performance. The focus of care would shift to patient outcomes rather than the intensive case-by-case review that characterizes today's managed care.
- Drawing on Accountable Health Plans for information on the effectiveness of their medical interventions, Community Care Partnerships would inform physicians on clinical outcomes and practice patterns to improve their decision making. With the overwhelming increase in the complexity and number of possible medical treatments available, the way physicians treat medical problems varies widely, many times with no difference in medical outcome. Not only does this mean our current system uses scarce resources unwisely, it also may be subjecting patients to treatment that, at best, causes discomfort and, at worst, exposes them to unnecessary risks. Under this new arrangement, caregivers would know more about how the care they provide is affecting their patients' health.
- Community Care Partnerships would keep enrollees better informed. With the increasing sophistication of procedures and options for treatment, individuals often face choices about what's best for their own circumstances. Better-informed consumers will make healthier, more satisfied consumers, assured that they're getting the most appropriate care.

To truly change incentives for how we deliver and use medical care, Community Care Partnerships must become the rule, not the exception. To achieve this, we would have government apply the carrot-and-stick approach to employers through the tax system.

Employers now can fully deduct the cost of their contribution to employees' health coverage. Under our proposal this deduction would depend increasingly on employers enrolling their employees in Community Care Partnerships. Eventually the deduction would be available only to employers whose workers enroll in such partnerships.

To ensure the success of Community Care Partnerships, government also must reform medical malpractice laws to eliminate incentives for doctors and hospitals to over-treat and over-prescribe. Many services are performed only to protect against malpractice suits. If we're holding physicians and hospitals accountable for the procedures they select and the outcome of those decisions, incentives for excessive treatment must be eliminated.

We also would ask the government — in partnership with insurers, physicians and hospitals — to make a greater commitment to developing information on the effectiveness of specific medical procedures, medical technology and equipment, and drug therapy. Clinical studies would be used to improve standards for determining how best to treat and cost-effectively apply expensive technology and drugs to specific illnesses.

We believe the result of these restructured incentives will be a health care marketplace where competition no longer drives insurance companies to gravitate toward the healthiest, lowest-cost groups and individuals.

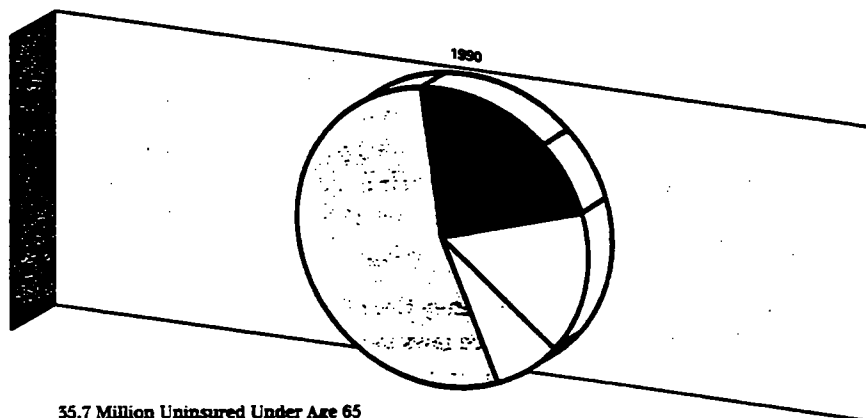
With our changes, there will be an overwhelming incentive on the part of Accountable Health Plans, physicians and hospitals, and all other health care providers to compete by balancing cost containment, quality assurance and patient satisfaction.

3 All Americans Under Age 65 Should Be Guaranteed Private Insurance for Basic Benefits

Our proposal would assure private health insurance coverage for everyone except those covered under the government's Medicare and Medicaid programs.

Our proposal for universal coverage begins in the workplace, where the vast majority of Americans receive health insurance protection. Employer-based coverage is the logical vehicle to extend private health insurance to as many Americans as possible. An estimated 85 percent of the 160 million people with private health insurance are covered by their employers, while nearly 80 percent of the more than 35 million Americans lacking insurance coverage are full- or part-time workers or their dependents (see Exhibit 5 a & b).

3 (a) Non-elderly Population Without Health Insurance, by Work Status of the Family Head.



35.7 Million Uninsured Under Age 65

54% - 19.3 million - Full year, full time

14.5% - 5.2 million - Non-worker

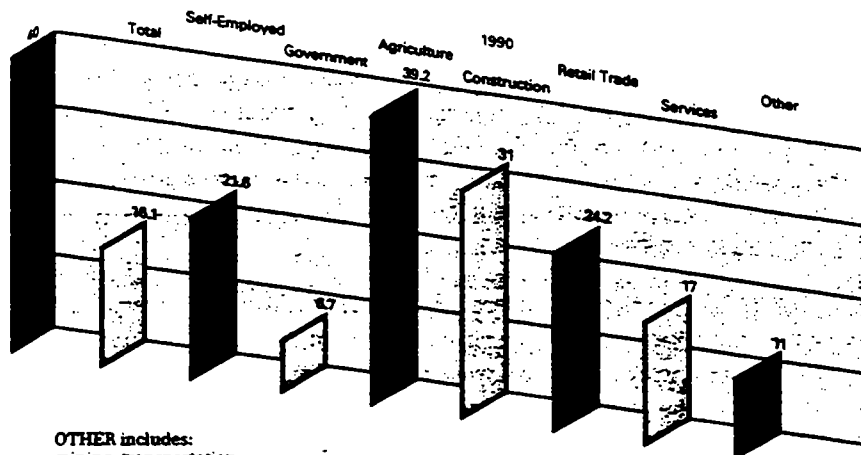
8% - 2.8 million - Part year

15.8% - 5.7 million - Full year, some unemployment

7.7% - 2.8 million - Full year, part time

Source: Employee Benefit Research Institute

(b) Rate of Uninsured by Industry (percentage).



OTHER includes: mining, transportation, communications, utilities, finance, insurance, real estate, manufacturing and wholesale trade.

Another important reason for building on private insurance provided through the workplace is that most people like their employer-based insurance. However, many are worried about losing those benefits in the future.

Under our plan, large employers, most of whom provide health care coverage for their workers, would have to contribute most of the cost of the basic set of benefits for their employees and part of the cost for their dependents.

Unlike their larger counterparts, many small employers don't contribute to the cost of their employees' coverage (see Exhibit 4). We don't believe it's realistic to ask small businesses to contribute on a par with large employers. So we would require small employers to offer the basic benefit package to their employees without requiring them to contribute to the cost of that coverage. They would be encouraged to contribute, and federal subsidies for marginally profitable employers would be available.

4 Insurance by Company Size

Size of Firm (Number of Employees)	Under 10	10-24	25-99	100-499	500-999	1000 & Over
Percent of Firms Offering Insurance	33	72	94	99	100	100
Percent of Employees in Firms Offering Insurance	42	70	94	97	100	100

Source: Congressional Budget Office

Small employers that couldn't afford to contribute to the cost of coverage, even with federal subsidies, would be asked at least to contract with an Accountable Health Plan and handle administrative responsibilities of their employees' coverage, such as payroll deductions. Small employers that offered coverage without subsidizing it also would be required to pay an assessment equal to approximately 40 percent of the basic benefit package's cost. These funds would help pay for tax subsidies for all employees — also equal to about 40 percent of the cost of the basic benefit package — which would help all employees pay for the coverage their employer selects.

To help assure universal coverage, our plan would require everyone who's employed to accept the coverage offered by his or her employer. Government would subsidize working Americans with family incomes at or below the poverty level to offset fully the cost of their contribution to insurance premiums. Those with incomes near poverty would be subsidized on a sliding scale.

Non-workers also would be eligible for government subsidies to encourage them to buy private insurance policies. Regardless of income, they would be eligible for a subsidy equal to approximately 40 percent of the cost of the basic benefit package. Again, individuals at or below the poverty level would receive subsidies that would cover the entire cost of their insurance. And those with incomes near poverty would be subsidized on a sliding scale.

This approach retains the best aspects of our current system, including its links to the workplace, as the traditional source of health insurance coverage. It also creates incentives to fill gaps in the current system and extend coverage to the unemployed.

4 Government Should Regulate, Not Operate, America's Health Care Coverage System

There's talk about scrapping the private insurance system and trying to cure the nation's health care ills with a single national health program run by the federal government. Others support creation of large, new, government-run pools to cover many Americans.

The Blue Cross and Blue Shield Plans believe there's much worth saving in the current private-public health insurance system, especially if private insurers and the federal government become full partners in a new reform effort. Although most of the responsibility for operating America's health care coverage system would remain with the private sector, the federal government would have the essential job of establishing guidelines to make sure health insurance companies behave in a more accountable, dependable way.

The federal government can assure that preventive care has its rightful place in the front line of health care services. The federal government can use tax laws to encourage development and use of Community Care Partnerships that will give Americans high-quality, cost-effective and coordinated care. And the federal government can put in place incentives to assure that every citizen is covered under a basic set of benefits.

The federal government also must continue its historic role of protecting the elderly, the poor who cannot purchase private insurance and other groups that otherwise might have difficulty getting the health care they need. Government programs should be accountable for paying their fair share of the cost of covered services. Services under the Medicaid program — for those who decide not to or can't buy private coverage — should be expanded, and eligibility for benefits broadened to include all those with family incomes at or below the poverty level. These obligations can't be shirked if a true safety net of insurance protection is to be available for all Americans.

Summary

For more than 60 years, Blue Cross and Blue Shield Plans have been there for America in communities across the nation. Babies have been born, grown up and had babies of their own under the protection of our Plans. We believe everyone — regardless of age, income or job status — deserves the same protection. Community Partnerships for a Healthy America will achieve this goal.

If we're going to control costs, we must do more than require Accountable Health Plans to meet standards for marketplace behavior. We must change the way medical care is delivered, making the delivery system more accountable. We can do this through cost-management incentives for deciding what type of care is prescribed and what method of treatment is selected. But for those incentives to work, it will take a new level of cooperation among all stakeholders in reform. And it will demand vastly better information on medical care and outcomes to facilitate sound decision-making.

- 1 The health insurance industry undergoes reform to make private insurance more available and affordable. Private insurers are licensed as Accountable Health Plans (AHPs) to assure that:
 - All Americans are covered under a set of benefits that includes primary and preventive care.
 - All groups or individuals have access to private coverage for health care.
 - Coverage continues even if an individual loses or changes a job, or joins another group policy.
 - Paperwork for enrollees and health care providers is substantially reduced.
- 2 To control costs, strong cost-management incentives change the way medical care is provided and consumed.
 - AHPs are required, over time, to move an increasing share of their enrollees into Community Care Partnerships (CCPs) of hospitals, physicians and other health care providers that compete based on cost, quality and patient satisfaction.
 - Employers have tax incentives to enroll employees in CCPs, which assure high-quality care, provide only necessary services and monitor enrollees' health outcomes.
 - Hospitals, physicians and other providers work cooperatively with the private sector and government to establish medical care guidelines.
 - The federal government reforms malpractice laws to eliminate incentives for hospitals, physicians and others to provide unnecessary services.
- 3 All Americans under age 65 are guaranteed private insurance coverage for basic benefits.
 - All working Americans have private insurance through their employer, regardless of company size.
 - It is recognized that many small employers cannot contribute to the full cost of a basic benefit package for their employees.
 - Non-working Americans and the working poor receive government subsidies to make sure private insurance is affordable.
- 4 The federal government regulates, but does not operate, America's health care coverage system.
 - Government assures that everyone not covered under Medicare and Medicaid is covered under private insurance that guarantees cost-effective, high-quality care.
 - An improved Medicaid program remains as a safety net for those with incomes at or below the poverty level.

The Business Roundtable

The following position statement was issued in January 1992 by The Business Roundtable. It is reprinted here with their permission. For further information, contact The Business Roundtable, 200 Park Avenue, New York, NY 10166-0097, (212) 682-6370.

Introduction

The attached principles point the way for bringing about needed improvements in the accessibility, cost, and quality of health care services. These changes should build upon the existing health care system in incremental steps.

The following beliefs underlie these principles:

1. The Roundtable *supports* the goal of access to needed health care services for all Americans.
2. The Roundtable *supports* an employer-based system which would allow employers to use their role as purchasers and managers to reform the delivery of health care.
3. The Roundtable *supports* the responsible reform of government programs to allow government to fulfill its responsibility to those in need through programs based on individual ability to pay.
4. The Roundtable *supports* policies that promote improved measurement and assurance of quality for health care purchasers.
5. The Roundtable *supports* policies to achieve control of health care costs.
 - These policies should be directed at the goal of reducing the rate of per capita health care cost inflation.
 - These policies should promote wellness and prevention activities as well as increased individual responsibility for decisions which affect health care costs.
 - These policies should include the application of managed care principles in both public and private programs.
 - These policies should not include government price controls.

These principles are a working document to guide The Business Roundtable's policy decisions in the legislative process. Changing circumstances may require that specific principles be reconsidered from time to time. The Business Roundtable's decisions on health care policy should advance the goals and beliefs stated above.

Roundtable Health, Welfare and Retirement Income Task Force Health Care Policy Principles

I. General

- A. We support the policy goal that all Americans have access to needed health care services.*

Achieving this goal will include making affordable, basic coverage available to those able to pay for it and broad-based government-financed coverage for those who do not have the means to pay. It may also include continued support for public health programs that are currently provided by various levels of government with special emphasis on the most cost-effective care. Mandating universal coverage should not be a part of achieving this goal. Rather, improvements in access should be achieved in incremental steps through policies consistent with these principles.

- B. Access, cost and quality of health care are interrelated problems that must be addressed concurrently.*

The degree to which access to health care services can be expanded depends on our ability to achieve greater stability and affordability of health care costs. Health care costs cannot be contained if there is a large amount of inappropriate care. Quality care and innovation should not and need not be sacrificed to control costs. These interrelationships must be considered if we are to adopt an effective, workable health care policy.

- C. Government should focus on more effective management of existing programs (Medicare, Medicaid), and should not make changes which shift costs to the private sector.*

Medicare continues to be one of the fastest growing domestic programs. Some of the growth can be attributed to rising health care costs. Some of it is due to the way that the program is managed. There has not been enough emphasis on the use of managed care for Medicare recipients, nor have there been clear standards set for appropriate care.

Medicaid also has not kept its original promise. In an effort to reduce costs, the federal government and the states have reduced the income threshold for Medicaid eligibility. This has resulted in the situation that we face today where only 40 percent of those below the federal poverty level qualify for this program. Part of the problem is that Medicaid has become the primary source of payment for nursing home care, drawing resources away from basic health care services. Also contributing to the problem is the need to improve the delivery of health care to this population. Demonstration programs have shown good results in both cost and enrollee satisfaction for recipients enrolled in managed care plans.

D. We should build on the present employment-based system of coverage, rather than creating new government programs. We support public sector incentives for private health care coverage.

Our present system of private health care coverage provides benefits to over 80 percent of Americans. We do not believe that it would be wise to move away from this and to create an entirely new system. We recognize that there are aspects of the current system that need reform and we support a number of changes, as discussed in Sections II., III. and IV. of this document. We believe that the public sector can contribute best to these improvements through tax incentives to support private health coverage.

E. We support entitlement programs based on an individual's ability to pay as the vehicle for meeting the needs of the poor, near-poor and medically indigent. We do not favor the expansion of entitlement programs that are not based on an individual's ability to pay.

Entitlement programs based on an individual's ability to pay are essential if our health care system is to meet the basic needs of the poor. We believe that the Medicaid program needs to be improved toward the long-term goal of covering all of the poor and assisting in some fashion on a sliding scale based on ability to pay, the population on the margin between unemployment and steady participation in the workforce.

We oppose expanding benefits under programs that are not based on an individual's ability to pay. Providing benefits at taxpayers expense to individuals who can afford to pay for them is an unacceptable use of limited tax dollars.

- F. We favor the use of tax incentives to encourage individuals to provide for their health care needs and to encourage employers to prefund retiree health benefits.*

We believe that the government should use tax policy to encourage individuals to provide for their own health care needs. By providing tax incentives that would enable additional individuals to purchase coverage, we can reduce the burden on public programs. Tax policy should encourage companies to prefund retiree health benefits.

- G. We oppose federal or state requirements which would mandate that employers provide any particular levels or types of health care benefits.*

Employers need to have the flexibility to create benefit plans that most appropriately take into account their economic position and the particular needs of their workforce. Mandated benefits or coverage is at odds with such economic realities and could significantly add to employment costs at a time when U.S. industry is facing intense worldwide competition. Mandated benefits enable legislative bodies to expand coverage without accountability for the cost. In the extreme, mandated benefits could lead to the demise of the private coverage system.

II. Access

- A. Tax credits should be provided to increase the availability of private health care coverage.*

We believe that refundable tax credits are one desirable way to address the problem of affordability. This incentive should be targeted to those genuinely unable to afford the cost of providing coverage. Credits could be given to employers meeting certain criteria, or to low-income individuals directly.

- B. We support reform of the small group insurance market to achieve greater availability of coverage and stability in pricing.*

We support making insurance costs more affordable and more predictable for small employers. The insurance industry is working with a number of states to achieve reforms in this market.

C. Reinsurance pools should be established for uninsurable individuals and groups.

The establishment of reinsurance pools would allow insurers to write coverage for groups and individuals who currently find it impossible to purchase insurance at any price because one of their employees or dependents is uninsurable.

D. We oppose state laws that mandate coverage of particular health care services or types of providers.

State laws mandating specific health care benefits impede the expansion of private coverage by increasing the cost. Research indicates that 16 percent of the firms that do not offer coverage (these firms employ approximately 15 million full-time employees) would do so in an environment that was free of mandated benefits.

E. Medicaid should be expanded incrementally up to the poverty level in all states.

Medicaid currently covers only about 40 percent of those below the poverty level. We support the recently enacted incremental expansions for children and pregnant women. The ultimate goal should be that of covering all the poor under Medicaid, recognizing that adequate provision for the cost must be made under state and federal budgets.

F. Low-income (e.g., between one and one and one-half times poverty) individuals and families should be allowed to "buy-in" to Medicaid.

Working people with incomes above the poverty level should be allowed to "buy-in" to a low-cost benefit package including cost-effective preventive and ambulatory services. Any such arrangement must be carefully crafted to continue to encourage employer plans. Ways should be explored to encourage coverage under employer plans for those in transition from poverty status to participation in the work force.

III. Cost

A. In both the public and private sectors, the U.S. should seek reductions in the cost of health care services. The Business Roundtable should support the development of policies which drive the rate of increase in the age-adjusted per capita cost of health care toward the rate of general inflation. These policies should be developed with the participation of business, government, providers, and labor.

Policies to accomplish the above objectives should address all elements that determine the cost of care, including standards for appropriateness. These policies may include targets for health care cost, but should not include government price controls or government-enforced limits on total health care spending. Cost reduction efforts should also include ways to reduce administrative costs in the health care system.

B. The budgeting process for publicly financed health care programs should create incentives for public agencies and legislative bodies to effectively manage and adequately fund the cost of services under new as well as existing programs.

The 1990 Budget Enforcement Act provides for automatic increases in the deficit limits for increases in the cost of existing entitlement programs due to inflation or demographic changes. Since inflation and demographic changes have been major causes of cost increase, we are concerned that too little attention will be paid to growth in the cost of existing programs.

C. We support managed care as a means to improve health care delivery and financing. We favor the expansion of managed care through the private market and the elimination of barriers (both state and federal laws) to the operation of managed care plans.

"Managed care" means a set of activities to promote the provision of appropriate care in the most cost-effective manner, including all or most of the following:

1. Selective contracting with providers;
2. Direct negotiation of reimbursement with providers;
3. Management and review processes to apply medical practice guidelines for cost and quality performance;
4. Significant benefit incentives for patients and consumers to use participating providers;
5. Assumption of some financial risk by providers.

It is anticipated that these plans could be sponsored by employers, hospitals, groups of physicians, insurance carriers, units of government, or other entities. Appropriate management of health care delivery focuses on quality as well as cost. As emerging research continues to define clinical efficacy and appropriateness, managed care organizations stand to play a key role as a vehicle for implementing medical practice guidelines. Appropriate managed care activities should not reduce cost at the expense of quality.

D. We strongly encourage the further application of managed care principles under publicly-financed health care programs.

The private sector is increasingly adopting programs that manage the provision of care under employer-sponsored programs. As purchasers of 40 per cent of the health services provided in the U.S., state and federal governments should be equally aggressive in looking to managed care as a vehicle for assuring the cost-effective provision of appropriate services.

E. Cost sharing by employees including deductibles, co-insurance and co-payments is a legitimate strategy for helping contain health care costs and should be a part of good benefit plan design.

Since 1950 the share of disposable personal income that consumers devote to out-of-pocket health care purchases has remained roughly constant, ranging between 3.0 and 3.9 percent. Though insurance deductibles and other cost sharing increased during the 1980s, the increases have not been sufficient to transfer purchasing responsibility to the consumer. The average deductible actually increased less than medical prices during the 1980s.

Cost sharing is an appropriate strategy for enhancing consumer cost-consciousness to reduce utilization of medically ineffective or marginally effective services, however it should not impose financial hardship or inhibit timely use of necessary health care services.

F. Tax-exempt financing for health care facilities and equipment should be restricted to needed modernization and conversion of existing services.

Non-profit community hospitals have needs for such projects as converting acute inpatient beds to other needed services and complying with life and safety codes. Subsidies such as tax-exemption for bond interest are not appropriate, however, for financing unneeded increases in service capacity. Authorities that approve projects for tax-exempt funding should have rigorous processes to validate the need for capital projects.

G. We support policies to reduce the level of fraud and abuse under public and private health care benefit programs.

Fraud and abuse add to the cost of benefits with no corresponding value. Incentives should exist for managers of both public and private sector programs to detect and eliminate fraudulent claims by beneficiaries. Abusive billing practices by providers, such as inappropriate "unbundling" and "upcoding" also need to be reduced.

H. We support tort reform to address medical liability problems; this would also reduce the cost of defensive medicine.

Although increases in medical malpractice premiums have leveled off, defensive medicine remains a costly phenomenon. Liability problems affect every part of the health care system, from manufacturers of pharmaceutical and medical devices through health care institutions and practitioners.

Reforms needed include limits on general and punitive damages, elimination of double recoveries, elimination of joint and several liability, and alternative dispute resolution mechanisms. The use by physicians of accepted medical practice guidelines should constitute an acceptable defense against negligence actions.

I. Health benefit plans should be designed to reinforce individual accountability for the factors under their control that influence health care cost.

Reducing the rate of cost increases will require the active cooperation of individuals, as well as employers, providers and government. To increase the employee's stake in controlling cost, employers should consider at least the following:

- Relating employee contributions to lifestyle choices (e.g., higher health plan contributions for smokers, lower contributions for those who exercise regularly).
- Designing contribution schedules to reward selection of lower cost plans by employees.
- Greater cost-sharing through premium contributions, deductibles and co-payments to reflect the rate of increase in costs to employers. Retaining some level of cost-sharing in instances of multiple coverage should also be considered.

IV. Quality

A. We support the development of wellness and prevention programs.

Keeping people healthy reduces the base level of demand for health care services. Personal behavior choices have great influence in determining individual health status. Though encouraging wellness and prevention is not a sufficient solution on its own to the cost problem, it is good public policy.

B. We believe that managed care has the potential to improve the quality of care by assuring that the most appropriate care is provided.

Medical practice guidelines will have a positive effect on quality only if they influence the day-to-day behavior of clinicians. Organized managed care programs represent a key strategy for introducing the most up-to-date clinical guidelines into day-to-day medical practice, as long as the delivery systems also provide the proper economic incentives for appropriate care.

C. We favor continued refinement and dissemination of health care quality indicators to purchasers.

Purchasers of health care include employers, welfare funds, government, and consumers. All of these groups have relatively little knowledge for evaluating the quality of services or bases for comparison among providers. To the extent that purchasing decisions are driven by meaningful indicators of quality, health care purchasing will become increasingly based on value – a change we strongly support.

D. We support efforts to expand and coordinate technology assessment, health care outcomes research and the development of medical practice guidelines.

Many health care experts assert that many commonly performed medical procedures lack clinical trials to determine their efficacy or appropriateness. The Institute of Medicine has identified the need to better define “what works in the practice of medicine”. We support the role of the new Agency for Health Care Policy and Research. We also support efforts in the private sector to perform and coordinate clinical trials of new technologies and procedures. Research is needed to develop models which measure quality in terms of desired outcomes.

As they are developed, medical practice guidelines should be broadly disseminated to physicians and other health care providers. The results of technology assessment and health care outcomes research should also receive broad distribution among those who provide, manage and purchase health care services. In addition to supporting medical practice, improved clinical guidelines can help clarify what should be the standard of negligence for determining medical malpractice.

E. We support continued research and innovation in medical care.

Support for continued research and development in health care should be an objective of our health care system. We must continue to develop new and advanced treatments that enhance the quality of medical care and that address changing health needs. Any changes in financing, delivery or management of health services should provide incentives to promote innovation.

Catholic Health Association

The following information is excerpted from a report entitled "Setting Relationships Right: A Working Proposal for Systemic Healthcare Reform," which was published in February 1992 by The Catholic Health Association of the United States. It is reprinted here with their permission. To obtain a copy of the full report, contact The Catholic Health Association of the United States, 4455 Woodson Road, St. Louis, MO 63134-3797, (314) 427-2500.

Today, millions of working Americans, their families, and others cannot afford or otherwise obtain health insurance, and are often excluded from the benefits of our nation's healthcare system. Hundreds of thousands go without needed care or become impoverished when they have to pay their medical bills. And large numbers die prematurely for lack of care. Paradoxically, all of this is happening at a time when national healthcare expenditures are escalating rapidly, seemingly without control, and are consuming increasing portions of the nation's wealth. These problems have been exacerbated by the abandonment of community rating in private health insurance and employers' growing resistance to cost-shifting. Together these developments are undermining our nation's voluntary social safety net in healthcare and are making it much more difficult for many of our not-for-profit healthcare institutions to meet their historic missions of community service.

Meanwhile, the healthcare delivery system is fragmented and lacks economic discipline. It is increasingly burdened by a broad range of private and public rules on prices, volume, and methods of treatment that make American healthcare providers among the most regulated in the world (Exhibit 1, p. 10).

The Catholic Health Association of the United States is responding to this crisis by proposing¹ a value-driven reform proposal that provides comprehensive, high quality care—including long-term care—for all. The CHA working proposal (Exhibit 4, p.18) combines unitary financing with multiple payors and a pluralistic delivery system. To assure equity there is universal coverage for a comprehensive package of services. To assure efficiency and innovation there is competition. To assure quality, there is informed consumer choice and state chartering of private provider networks. To assure overall expenditure control there is a national budgeting process and extensive use of managed competition.

This is not a proposal to adopt the Canadian system, nor the British, German, or Japanese. This is a proposal designed to enhance the demonstrable strengths of American healthcare while addressing its weaknesses at the opening of the 21st century. It represents a unique public/private partnership to assure high quality, innovative, and affordable healthcare to all.

I. Values in the Reform Proposal

Healthcare reform is essentially a debate about values. Defense of the status quo in healthcare and every proposal for reform are based on a set of implied or explicit values. Catholic healthcare providers have a distinctive value tradition, and much of that tradition makes

1. Adopted by the CHA Board of Trustees, February 20, 1992, as one model for systemic reform that reshapes the U.S. healthcare system in a manner consistent with the values articulated in this document.

an important appeal to a broad cross-section of contemporary Americans. Six such values are embodied in this reform proposal.

- **Healthcare Is a Service**

Care of the ill and dying is an important measure of the moral character of any society. This conviction has an important implication relevant across American healthcare: Healthcare must always be more than a business. It is an essential social good, a service to persons in need and should never be reduced to a mere commodity exchanged for profit.

- **Healthcare and Human Dignity**

Every person is the subject of human dignity. The most important secular consequence of this view is commitment to individual human rights. Many Americans have a right to healthcare through various public programs, but the importance of healthcare to human dignity insists on universality, that is, all persons have a right to basic and comprehensive healthcare.

- **Healthcare and the Common Good**

Dignity is realized only in association with others. The human person is inherently social and this entails an obligation to serve the common good. Few messages are more important in light of the excessive individualism of contemporary culture. That is, we cannot look only at the self-interest of a few. We must also look at what is in the best interest of our communities and nation. Service to the common good is not foreign to America; it is an important part of our Biblical and other national traditions that must be recovered. Rediscovery of the common good is critical to the future of healthcare if not all other American social systems.

- **Healthcare and the Poor**

The wealthy and the well should care for the poor and the sick. This conviction, the original moral premise of community-rated health insurance, is strongly reflected in many American movements that have been driven by concern for those who are less well-off. Since programs for the poor too often become poor programs, a reformed healthcare system should tie the fate of the poor to that of the average American.

- **Healthcare and Stewardship**

Each of us is required to exercise responsible stewardship over creation. This belief has a secular parallel in the widespread recognition that natural and other resources are not unlimited and must be managed wisely. Responsible healthcare reform requires the introduction of economic discipline into the healthcare delivery system and the creation of credible expenditure controls to hold overall spending within realistic financial and political limits.

- **Healthcare and Government**

Respect for the dignity of persons should be balanced with support for institutions that serve the common good. This wisdom is reflected in American political traditions and suggests that a politically prudent reform must use federal authority to create a national healthcare community, respond to local diversity through state involvement, preserve pluralism in delivery, and protect a range of choice by clients and patients.

II. The CHA Working Proposal for Reforming the Healthcare System

The CHA working proposal begins with delivery reform, in contrast to other proposals that focus primarily on financing issues. The current delivery system is deficient primarily because it is fragmented and too costly. Financial incentives too often encourage providers to function in isolation from one another with little integration among primary care, acute care, and long-term care settings. Some important services are excluded while others are duplicated. Health promotion and preventive care are often uncovered. The current system also lacks internal economic discipline, forcing purchasers to use costly and demoralizing external controls on physicians and healthcare facilities. Finally, access to the current delivery system is often restricted. This is especially true for the millions of individuals who have no insurance but also for many persons with insurance.

Most existing reform proposals would impose new financing and external cost controls on this inefficient delivery system. This approach is certain to fail. The CHA working proposal recognizes that effective cost and quality control can occur only in concert with a reformed delivery system.

Elements of a Reformed System

Funding for the proposed system derives from multiple sources—some presently in place, some newly gathered into a healthcare trust fund managed by a new national agency, the National Health Board (NHB) (Exhibit 2, p. 13). The NHB administers the trust, establishes annual expenditure levels, and determines a comprehensive benefits package for all. A new entity at the state level, the State Health Organization (SHO), receives NHB dollars, charters local networks of providers, assures competition among them, and allocates funding to them on a risk-adjusted, capitated basis. New private entities, Integrated Delivery Networks (IDNs) (Exhibit 3, p. 14), compete to provide a continuum of care to their enrollees and bear the financial risk of capitated payment. Clients choose their doctors and hospitals by selecting one of several locally competing IDNs during periodic open enrollment periods.

- **Clients**

All individuals select among IDNs during an open season process. No one can be refused enrollment regardless of health status. Risk-adjusted capitation helps assure that sick and

high-risk individuals are not avoided by providers. Premiums are eliminated. Client cost sharing is income-based. Persons below poverty have no cost sharing, while those between 100 and 200 percent of poverty pay on a sliding fee scale. Annual cost sharing amounts are limited to \$2,000 for individuals and \$3,000² for families. No balance billing is allowed. Supplemental benefits and care can be purchased outside the IDN system but without tax benefits.

Clients are represented at every level of the system: on the IDNs, the SHOs, and the NHB.

- **Comprehensive Benefits**

The specifics of coverage are determined by the NHB, tailored by the SHOs, and delivered by the IDNs. Categories of benefits include: preventive care, acute care, and long-term care (Exhibits 5 & 6, pp. 21 & 22).

- **Integrated Delivery Networks (IDNs)**

An IDN is a set of providers—institutions and professionals—privately organized by contract (or ownership) and publicly chartered by the SHO. IDNs assume financial risk for providing a continuum of healthcare services: preventive, primary, acute, and long-term care. Most providers will be in or contract with one or more IDNs to participate in the healthcare system. Each IDN receives a risk-adjusted capitated payment to provide care to an enrolled population. Communities will be served by several IDNs, competing for enrollees on the basis of quality and service.

Clients select from among IDNs in their community during a periodic open season and participate in network decision making.

The IDN concept is designed to create new relationships among providers in order to improve coordination, efficiency, and quality of care. IDNs ensure that patients receive appropriate levels of care in optimal settings by offering a care coordination function to all enrollees. IDNs are accountable for healthcare quality and effectiveness. Open seasons that allow individuals to change IDNs, risk adjusted capitated payments, and periodic charter review by the SHO guarantee that IDNs provide high-quality, innovative, client-centered care. In other words, they will produce good value for the healthcare dollar.

2. See note p. xv.

State Health Organizations (SHOs)

SHOs determine community needs, authorize or "charter" IDNs within the state, assure competition among them (wherever competition is feasible), provide IDNs with their capitated payments, and empower consumers by providing comparative information on IDN service and quality. SHOs grant charters to IDNs only when they demonstrate their responsiveness to community needs. Clients are represented on the SHO.

Each state has at least one SHO while some large states are likely to have a number of regional SHOs. The SHO administers open season for IDN enrollment and pays each IDN a risk-adjusted, capitated payment for each of its enrollees from funds allocated by the NHB. The SHO applies for targeted funding from the NHB for special state needs, determines ground rules for IDN development and competition, and ensures that IDNs remain responsive to community needs.

National Health Board (NHB)

The NHB is an independent, public agency modeled on the Federal Reserve Board. It is charged with overseeing the system, managing the national trust fund, recommending healthcare expenditure levels to Congress, allocating funds to the SHOs, and determining a uniform, comprehensive benefits package for all individuals.

The NHB has an autonomous board insulated from undue influence by the President or Congress. The board is comprised of 10 to 15 members appointed by the President and confirmed by the Senate.

The NHB has three critical features: First, the *independent* character of the NHB allows it to challenge purely budget-driven decisions regarding healthcare. Second, the NHB has "Boren Amendment" judicial recourse if underfunding occurs. Third, through the NHB citizens have a direct voice in the system, for the first time gauging the appropriateness of healthcare appropriations and thereby holding politicians accountable for their action or inaction on healthcare budgets and benefits. The link between healthcare and its cost is public and explicit.

Financing

Major public financing sources are maintained. Employers and employees pay their health insurance premiums through a new 6.9 percent payroll tax on all employers and a 1.7³ percent payroll tax on all employees. New excise taxes on alcohol and tobacco are added and federal income tax is increased. These various financing sources are combined into a *dedicated* national trust fund for healthcare (Exhibit 9, p. 34).

3. See note, p. xv.

In the short run, many employers save money under the reformed system, and the average household spends less out-of-pocket. In the long run, everyone saves money as costs are controlled even as quality and universal coverage are assured.

III. Strategic Goals Met

The proposed system assures comprehensive care for all. It also meets three additional strategic goals: 1) the system produces value for each additional dollar spent on healthcare; 2) the system provides an adequate flow of dollars to sustain the healthcare infrastructure; and 3) the system makes providers and clients primarily responsible for cost and quality control.

1. Good value requires striking a balance between economic discipline and society's desire for effective and comprehensive healthcare services. Annual healthcare budgeting allows the nation to deal explicitly with healthcare spending. Capitated IDNs competing on service assure efficiency, quality, and innovation. Additional administrative savings result from consolidation of multiple public programs, elimination of indemnity insurance, and uniform procedures and billing forms.

2. Adequate flow of dollars is assured in three ways. First, the NHB is an *independent* agency. Second, there is judicial recourse if the system is underfunded. Finally, providers and clients are joined as healthcare system advocates and are able to react to any financial gap between NHB recommendations and federal funding.

3. Cost control and quality are primarily assured by providers and clients. Providers help set the rules for reimbursement, internal cost containment, and quality control by managing the IDN or serving on its board. Clients participate in decision making and help contain costs through wellness efforts and by exercising informed choice in their selection of an IDN. Funding is set by the NHB and apportioned by the SHO as it oversees quality. The reformed system eliminates today's private and public regulatory controls on prices, volume, and methods of treatment by making providers and clients primarily responsible for cost and quality control.

The proposal retains the best of our pluralistic healthcare system while introducing essential incentives for economic efficiency. Maximum flexibility is retained at the local level to allow for creative arrangements among providers, efficient methods of payment and delivery, and choice for individuals. Yet unitary funding assures universal coverage and a level of financial stability that is simply not achievable in our present system.

IV. Estimated Costs and Financial Impact ⁴

Estimated First Year Spending

During the first year of operation the proposed system results in an increase in spending estimated at \$31 billion, or about 4.2 percent of current healthcare spending (Exhibit 7, p. 30).

Distribution of First Year Costs

Households, on average, spend less on healthcare. Private employers pay more as a group, but many employers who currently offer comprehensive insurance to their employees pay less. State and local governments pay less for healthcare. The federal government "breaks even" because the proposal is budget neutral at the national level (Exhibit 8, p. 32).

Potential Savings

The CHA working proposal will save the economy large amounts of money annually, how much cannot be predicted accurately. If the reformed system reduces the rate of spending by only two percent each year, \$580 billion will be saved over the next decade.

4. These estimated costs and savings are preliminary, and presented for illustrative purposes only. They will change as CHA continues to examine and refine them based on such factors as CHA's reform objectives, the range and types of benefits included, the relationship between copayments/deductibles to the overall cost of the reform proposal, and levels and types of taxation.

The Enthoven Proposal

The following health care reform proposal was written by Professor Alain Enthoven and Professor Richard Kronick of the Graduate School of Business at Stanford University. It appeared in the January 5, and January 12, 1989, issues of the New England Journal of Medicine. It is reprinted here with their permission. For further information, contact Professor Enthoven, Graduate School of Business, Stanford University, Stanford, CA 94305, (415) 723-0641.

A CONSUMER-CHOICE HEALTH PLAN FOR THE 1990s

Universal Health Insurance in a System Designed to Promote Quality and Economy

(First of Two Parts)

ALAIN ENTHOVEN AND RICHARD KRONICK

Abstract America's health care economy is a paradox of excess and deprivation. We spend more than 11 percent of the gross national product on health care, yet roughly 35 million Americans have no financial protection from medical expenses. To an increasing degree, the present financing system is inflationary, unfair, and wasteful. In its place we need a strategy that addresses the whole system, offers financial protection from health care expenses to all, and promotes the development of economical financing and delivery arrangements. Such a strategy must be designed to be broadly acceptable in our society.

WHY UNIVERSAL HEALTH INSURANCE?

The Paradox of Excess and Deprivation

The health care economy of the United States is a paradox of excess and deprivation. We spend about 11.5 percent of the gross national product (GNP) on health care, much more than any other country.^{1,2} And whereas other countries have stabilized the share of their GNP that is spent on health, ours has accelerated in recent years. Inflation-adjusted per capita spending for health care grew by 4 percent per year from 1970 to 1980, and by 4.6 percent per year from 1980 to 1986.¹ The Health Care Financing Administration (HCFA) recently projected that according to present trends, health care spending would reach 15 percent of the GNP by 2000.¹ These growing expenditures are adding greatly to deficits in the public sector, threatening the solvency of some industrial companies, and creating heavy burdens for many people.

At the same time, roughly 35 million Americans have no financial protection from the expenses of medical care — no insurance or other coverage, public or private.³⁻⁶ This number is substantially higher than it was 10 years ago, as increasing numbers of employers find ways to avoid supplying coverage for employees and their dependents. Millions more have inadequate coverage that leaves them vulnerable to large financial risks.⁷ And uncounted millions have coverage that excludes preexisting medical conditions. Our present system of financing health care systematically denies coverage to many who need it most. Health insurers want to insure those who are the least likely to need medical care and to protect themselves and their

To remedy the deprivation, we propose that everyone not covered by Medicare, Medicaid, or some other public program be enabled to buy affordable coverage, either through their employers or through a "public sponsor." To attack the excess, we propose a strategy of managed competition in which collective agents, called sponsors, such as the Health Care Financing Administration and large employers, contract with competing health plans and manage a process of informed cost-conscious consumer choice that rewards providers who deliver high-quality care economically. (N Engl J Med 1989; 320:29-37.)

policy holders from the costs associated with the care of the very sick.

The U.S. health care economy is inflationary. It is still dominated by fee-for-service payment of doctors and hospitals by third-party intermediaries with open-ended sources of finance. There is no total budget set in advance within which providers must manage the care of their patients. For the most part, there is no incentive to find and use medical practices that produce the same health outcome at less cost. And this method of payment leaves insured consumers largely unaware of the costs of the services they receive.

Health maintenance organizations (HMOs) and preferred-provider insurance (PPI), called "managed care plans," now cover more than 60 million Americans.^{8,9} Such plans have the potential to create serious cost consciousness among consumers and providers. But they will not achieve it as long as potential subscribers do not have to pay the full extra cost themselves when they choose a more costly plan. (PPI contracts selectively with providers about price and use controls, and it reimburses patients at a higher rate when they see contracting providers, as a way of motivating patients to use such providers. In turn, access to patients is the incentive for providers to accept negotiated fees and controls.)

The employers of most insured people offer their employees a traditional insurance scheme by which all or most of their medical expenses are reimbursed after the payment of a deductible. If employers offer a less costly managed care plan, they often offer to pay its premium in full, as long as it does not exceed that of the traditional plan. Thus, the managed care plan has little or no incentive to reduce its price or improve its efficiency, because the employee making the choice sees little or no financial reward for choosing it. Some employers offer a fixed-dollar contribution and a cost-conscious choice of plan. In such cases, the managed care plan is motivated to

From the Graduate School of Business, Stanford University, Stanford, CA 94305, where reprint requests should be addressed to Dr. Enthoven.

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reduce its price to attract subscribers. But even then, the Internal Revenue Code permits employees to characterize their premium contributions as nontaxable employer contributions and thus make the payment with pretax dollars. The effect is that if an employee chooses a health plan that is more rather than less costly, the government is likely to be paying about one third of the difference in cost in the form of tax relief.^{10,11} As a result, the employee's cost consciousness is attenuated, and the health plan has less need to cut its price to attract subscribers. In any case, health plans have little or no incentive to improve their efficiency in order to serve a few cost-conscious customers if most of their customers are not cost conscious; such plans need only shift costs from the former to the latter.

Moreover, most such "managed care" plans are really little more than traditional insurance arrangements that deal with physicians on an arms-length basis. It is unlikely that they will be able to achieve economical organization and delivery of care without obtaining the support of physicians and their commitment to that goal.

This inflationary financial environment reinforces other powerful cost-increasing factors: a growing supply of doctors looking for ways to make themselves useful; a professional culture that esteems the aggressive use of the most advanced technology without recognizing cost effectiveness as a virtue; the explosive growth of costly new forms of technology; the rising expectations of patients and malpractice litigation when expectations are not met; and an aging population. Little in this system promotes the cost-conscious use of resources or the efficient organization of the delivery system.

In addition, the present system of financing health care in the United States is unfair. It provides most people — those who are regularly employed by a medium-sized or large employer — with coverage either at no cost or at prices subsidized by the employer and the tax system. But the system denies the opportunity of coverage to millions of others for no good reason — to seasonal and part-time employees, self-employed persons, widows, divorcees, early retirees, the unemployed, and others whose employers choose not to provide health care coverage. Not all uninsured people are poor or unemployed. In fact, nearly two thirds of them are members of families with incomes above the poverty level; more than two thirds of uninsured adults belong to the labor force.³ Viewed another way, when the uninsured are seriously ill (and most expenses are for seriously ill patients), taxpayers, insured persons, or both end up paying for most of their care. Voluntarily or involuntarily, some people are taking a free ride. Those who can do so ought to contribute their fair share to their coverage and be insured.

In the past, our open-ended financing system provided a ready source of financing for those who could not pay, even if it did not ensure equitable access to care. Hospitals simply raised their charges to those

who could pay in order to cover the costs of those who could not. In recent years, efforts by employers and the government to contain costs have attacked this means of support for "uncompensated care." Hospitals have come under increased financial pressure to develop strategies to avoid caring for those who cannot pay — even to the point of closing their emergency rooms. Many who cannot pay turn to public providers of last resort, such as county hospitals. But these institutions are also under increasing financial pressure as public finances are strained and the numbers of the uninsured increase.

The present system is wasteful in many respects. We have spent little on evaluating medical technology, and there is much uncertainty about its efficacy.^{12,13} Much care appears to be of unproved value.^{14,15} There is considerable duplication and excess capacity in our medical facilities. The association between jobs and health insurance complicates and interferes with job mobility, because most people must change health plans when they change jobs. The presence of large numbers of uninsured persons imposes large costs on providers when they perform determinations of eligibility and coverage. The uninsured obtain much of their primary care in the outpatient departments and emergency rooms of public hospitals, instead of in the much less costly setting of a primary care physician's office. The deferment of care for conditions such as hypertension and diabetes adds to health risks and can cause much more expensive emergencies later. The lack of prenatal care can lead to very costly premature delivery and the birth of children with handicaps. The unavailability of insurance imposes heavy penalties on the uninsured: the postponement or denial of treatment, causing avoidable sickness and suffering, and the depletion of personal savings.

For all these reasons, our present system of health care does not reflect American values. We cherish efficiency and fairness, but we have a system that is neither efficient nor fair. Very few Americans believe that other Americans should be deprived of needed care or subjected to extreme financial hardship because of an inability to pay. There is widespread public outrage when a hospital turns away a delivering mother or an injured person for this reason. Congress has passed laws to punish hospitals that do this. But we have failed as a society to create institutions that assure all persons of the opportunity to obtain needed care, when they need it and without an excessive financial burden.

The Need for a Comprehensive Strategy to Promote Efficiency and Equity

To improve the health care system, we need a strategy that is comprehensive. Partial interventions can produce negative consequences or be rendered ineffective by developments elsewhere. Attempts to contain costs by the cost-conscious choice of managed care systems will be fruitless if, somewhere else, open-ended demand is bidding up the prices and standards of

care that the managed care systems must meet. Why should doctors and hospitals accept serious cost containment by HMOs if there is plenty of open-ended demand for their services elsewhere? Partial "categorical" approaches leave people out and create enormous complexities as people change categories. And they can treat unequally people who appear similar but who actually fall into different categories.

The problems of achieving equity and efficiency are intimately related. Attempting to promote efficiency by making everyone conscious of costs conflicts with providing cross-subsidies for uncompensated care. On the other hand, we cannot afford to provide coverage for those who lack it without making the system efficient for all. The accelerating spiral of growth in expenditures has necessitated cutbacks in employer-provided coverage and Medicaid eligibility, and it is one of the main arguments used against universal coverage.

Thus, a satisfactory strategy for the health care economy in the United States must simultaneously address both sides of the paradox of excess and deprivation. We have designed our proposal with two main goals in mind. The first goal is to provide financial protection from health care expenses for all, either through enrollment in comprehensive health care financing and delivery plans or, for the irreducible minimum of people, through public providers of last resort. There will always be some — the homeless, undocumented aliens, and others whose life style does not include enrollment in a health plan, carrying a membership card, and making regular payments — whose needs will have to be addressed by public providers of last resort. But we can drastically reduce their numbers and so ease the financial burden on these institutions.

Our second goal is to promote the development of economical financing and delivery arrangements, by requiring consumers to be conscious of costs in choosing among health care organizations. There is ample evidence that efficient prepaid group practices can reduce the cost of care by 10 to 40 percent, as compared with open-ended fee-for-service practices, even without competition from other HMOs to serve cost-conscious purchasers.^{16,17} There is good reason to believe that competition to serve cost-conscious purchasers could motivate cost-reducing innovation and slow the growth of health care spending. Our strategy would be to encourage the spread of HMOs and other efficient delivery arrangements by giving all consumers a choice of plans that requires a consideration of costs. Those who prefer to keep traditional "free choice of provider" arrangements and are willing to pay the extra costs associated with them would be free to do so.

The Need for a Broadly Acceptable Plan

Universal health insurance has not attracted overwhelming support in this country. Those who favor it should consider carefully the sources of opposition and seek to avoid designing a plan with features so

objectionable to large numbers of American people or key interest groups that the plan would not be considered seriously in the political process. The idea of universal health insurance raises fears of socialized medicine or total dependence on the government for payment, of radical change or the disruption of satisfactory existing arrangements, of large-scale redistribution of income, or of excessive regulatory coercion. The causes of such fears can be avoided. We have designed a proposal for incremental change that is compatible with American cultural preferences and that should find broad acceptance. We will discuss these issues in the second part of this article.

A UNIVERSAL HEALTH INSURANCE PLAN BASED ON MANAGED COMPETITION WITH MIXED PUBLIC AND PRIVATE SPONSORSHIP

Under this proposal, everyone not covered by an existing public program would be enabled to buy affordable subsidized coverage, either through their employers, in the case of full-time employees, or through "public sponsors," in the case of the self-employed and all others. We illustrate the general concepts with specific examples of tax rates, employer contributions, benefit packages, and other detailed features of the proposal. These should be understood as illustrative and, within limits, as "tunable dials" that can be adjusted in the political process. A supporting document provides more detail.¹⁸

State-Level Public Sponsors

Under this proposal, the federal government would enact legislation giving each state powerful incentives to create a "public sponsor" agency to act as sponsor for people otherwise unsponsored. A sponsor is an institution that ensures each member of its sponsored group financial coverage of health care expenses at a moderate price. In the competitive model we recommend, the sponsor serves as the broker, selecting the coverages to be offered, contracting with health plans and beneficiaries about rules of participation, managing the enrollment process, collecting premium contributions from beneficiaries, paying premiums to health plans, and administering both cross-subsidies among beneficiaries and subsidies available to the whole group. The main sponsors in this country are employers, Taft-Hartley trusts, and the HCFA. Public sponsors would aggregate the buying power of small employers and individuals. In a manner similar to that of very large employers such as the federal government, public sponsors would contract for a wide variety of managed care plans to be offered to the participating population in a competitive annual enrollment. (Whether to offer traditional indemnity insurance would be a management decision made by public sponsors.)

Public sponsors would offer to contract with any person or family not covered through employment who wished to abide by the conditions of participation, including enrollment during the annual open-enrollment period and a "lock in" for the full year.

Such purchases of coverage would be subsidized: the public sponsor would pay 80 percent of the cost of the average qualified health plan, and the person or family covered would pay the rest.

Public sponsors would offer to act as brokers for employers who wished to obtain coverage through these agencies. Small employers and even many medium-sized employers are not large enough to manage competition among health plans effectively.¹⁹ Moreover, small employers that buy insurance on their own are forced to pay higher rates, reflecting greater variability in small groups. A public sponsor could combine these risks and achieve economies of scale. States could achieve such economies in administration as well as greater bargaining power with the health plans by assigning this responsibility to the agencies that already buy coverage for public employees.

Obligations of Employers

Under this proposal, employers would be required to cover all full-time employees (and their dependents not otherwise covered) and to pay an 8 percent payroll tax on the first \$22,500 (i.e., half the Social Security wage base) of the wages and salaries of all employees not covered. In addition, employers would be required to offer all full-time employees (those working at least 25 hours per week) a choice of qualified plans, possibly including traditional insurance, and to contribute at least 80 percent of the average cost of the basic coverage, which would include the employees' dependents unless they were covered under a spouse's policy. (Some benefit plans would be more elaborate than others. For each health plan offered, the employer would obtain a quotation for the price of basic coverage, as defined below. The employer's required contribution would then be 80 percent of the weighted average of those prices.) The employees would be required to pay the difference between the employer's contribution and the cost of the health plan they chose.

Before the annual enrollment period, employers would designate each worker as full time, and thus covered automatically, or part time. (Part-time workers could also be designated as covered.) Detailed rules would be developed to specify which workers would have to be designated as full time and covered. Employers could choose to pay the 8 percent tax rather than cover seasonal or temporary workers.

Self-employed persons, early retirees, and everyone else not covered through full-time employment would be required to contribute through the income tax system. An 8 percent tax would apply to adjusted gross income up to an income ceiling related to the size of the household. The ceiling would be calculated to ensure that households with sufficient income paid for approximately the total subsidy that was available to them. The proceeds of the 8 percent tax would be used by public sponsors to subsidize the purchase of coverage by people not covered by an employer.

Why require employers to cover full-time employees

and pay a tax on the earnings of workers not covered? Most health coverage in our country is based on employment, and there is no realistic prospect of changing that in the short run. We propose to spread the cost more evenly over all employment, and to fill in with publicly sponsored coverage where employment-based coverage cannot reasonably be expected to work. Publicly sponsored coverage for individuals has to be subsidized to create a strong incentive for even the healthy to subscribe. In the absence of a subsidy, consumers in apparently good health would seek to avoid paying for coverage until they got sick, or would rely on charity care or public providers because they know that our society is unwilling to let people suffer and die without care. Premiums would soar. The market would break down in a spiral of adverse risk selection, as the market for individual coverage in this country has in fact done.²⁰

If publicly sponsored and subsidized coverage were available without the mandate or tax, employers would have a powerful incentive to stop providing coverage and send their employees to the public sponsor. People without coverage would demand it from the public sponsor, which would have to provide it without a source of revenue. Therefore, we propose to use the mandate to keep most coverage employment based. (An alternative model, publicly financed and sponsored, will be discussed in Part Two.) The tax on the earnings of workers not covered by employers would raise much of the funds needed for the public sponsor from those who would benefit. This approach would help avoid a large-scale redistribution of income. Also, it would minimize the otherwise strong incentives for employers to reduce the hours of workers to a level below 25 hours per week, to avoid providing health benefits. Viewed in another way, the 8 percent tax would be a means of aggregating premium contributions on behalf of the part-time, seasonal, and other workers whose attachment to a single employer is not strong enough to justify requiring the employer to provide full insurance coverage. Taft-Hartley trusts do this for unionized workers in specific industries; the proposed mechanism would generalize the Taft-Hartley trust idea to everyone who was not employed full time by a single employer.

We recognize that there are good arguments against the employer mandate and the tax. Any tax distorts economic decision making. This issue will be discussed in Part Two.

Subsidies to Premiums for the Poor

To encourage nearly universal coverage, individuals and families would be eligible for an additional federal subsidy toward the portion of the health insurance premium that they would have to pay if their adjusted gross income was below 150 percent of the poverty level for their family size. Without a subsidy, a family's share of an average premium would be approximately \$500. For many families of four with an income equal to 100 percent of the poverty

level — approximately \$11,000 — this would be a substantial expenditure that many would feel they could not afford.

For families with an income below 100 percent of the poverty line, the subsidy would equal the amount of the family's premium contribution (assuming the health plan chosen was no more expensive than the average cost of a basic health plan). For families whose income was between 100 and 150 percent of the poverty level, the subsidy would decrease to zero on a sliding scale as income approached 150 percent. This subsidy would be available both to full-time employees covered by their employers and to those buying coverage through the public sponsor, provided their income was low enough to qualify. The administration of the subsidies would be handled by the agency chosen by each state. We would prefer to see the public sponsors kept out of the process of income testing, because they are not meant to be welfare agencies. One possible approach would be for such testing to be carried out by public welfare agencies that would certify the eligibility of persons and families for subsidies.

Subsidies for Small Businesses

Small businesses are an important source of new jobs. We would suggest easing the burden of providing coverage for them in two ways. First, as noted earlier, they would be able to buy coverage through the public sponsor, thus realizing the benefits of the public sponsor's economies of scale. Second, small businesses (those with fewer than 25 full-time employees) that arranged coverage through the public sponsor would be required to pay no more than 8 percent of their total payroll for basic benefits for their employees. If the employer's 80 percent contribution for health insurance exceeded 8 percent of the payroll, the sponsor would subsidize the excess amount.

Creating an Environment with Cost-Conscious Choice

Employers would be required to make a fixed contribution that would be independent of the health plan chosen. (As discussed below, this contribution would vary with the health-risk categories of the enrollees in each plan.) The amount of an employer's contribution that could be excluded from the employee's taxable income would be limited to 80 percent of the average cost of a qualified health plan in the employer's geographic area. The HCFA would offer employers a variety of approved risk-rating systems to translate this into individual tax-free amounts. Additional tax-free contributions under Section 125 of the Internal Revenue Code, which authorizes tax-favored "cafeteria benefit plans," would not be allowed.

The defined-contribution approach and the limitation on the amount of tax-free employer contributions are intended to promote both efficiency and equity. With these limitations, employees who chose more costly plans would have to pay the extra costs with their own net-after-tax dollars. This requirement should promote the choice of less costly plans. In ad-

dition, the limit on tax-free contributions would help make funds available to lower-income people not currently covered.

Qualified Health Plans

Qualified health plans would have to include the basic benefits package specified in the HMO Act, possibly with tighter definitions and restrictions to reduce costs. This package would be updated periodically through legislation and regulation. Deductibles could be no higher than \$250 per person in 1988, adjusted for inflation; health plans would pay at least 80 percent of the fees of contracting providers. We would prefer to allow only a small copayment or deductible for inpatient hospital services, because patients have relatively little influence over decisions about the use of such services. However, if more substantial cost sharing among patients were allowed, the premiums could be reduced and, with them, the overall cost of the scheme to taxpayers. Total out-of-pocket expenditures for deductibles and coinsurance for contracting providers' services covered by the health plan could not exceed 100 percent of the annual premium. Qualified plans could not exclude coverage for preexisting conditions for members who enrolled during an annual open-enrollment period. Our intent is to encourage the development of cost-effective managed care plans. Thus, health plans would be free to limit or exclude coverage of the services of nonparticipating providers, except in emergencies when participating providers were not available.

Continuity of Coverage

One goal of the proposal is to have everyone join a health plan during the annual enrollment period and stay in that plan for the subsequent year, unless a "qualifying event" occurred (such as divorce or a move to a new home). This provision would reduce administrative costs and new beginnings on annual deductibles, and would improve the ability of health plans to manage care. Everyone would start the year either covered by his or her employer in a health plan of the employer's arranging or covered by a health plan arranged by the public sponsor. The subsidy of 80 percent of the average cost of qualified health plans contracting with a public sponsor would come either from an employer or from the public sponsor (in the case of part-time employees or other uncovered workers).

People who moved from one part-time job to another would simply keep paying the public sponsor the difference between 80 percent of the average premium and the cost of the coverage they had chosen. Similarly, people who moved between part-time jobs (or unemployment) and full-time jobs with employers that arranged coverage through the public sponsor would feel no discontinuity. When a person was hired, the employer would simply pay 80 percent of the average premium to the public sponsor (as the employer would do for each of its other full-time employees). The sub-

scribers would pay their shares either through the employer or through the sponsor.

When a person took or left a job with an employer that acted as an independent sponsor, there might be some discontinuity. In the detailed design of the program, a choice would have to be made between permitting changes in the health plan when they are caused by a job change and preventing them by complex rules.

Federal-State Cost Sharing and Administration

The federal government would collect revenues from three sources — the payroll tax paid by employers, taxes from self-employed persons and others eligible to buy subsidized insurance from the public sponsor, and additional revenues derived from a limitation on the amount of an employer's contribution that employees could exclude from their taxable income. The federal government would make these monies available to any state that created a public sponsor agency operating in accordance with federal guidelines.

Using the prices charged by health plans contracting with the public sponsors, the HCFA would determine the average cost nationally of a qualified health plan. After adjusting this cost to regional market areas (probably Metropolitan Statistical Areas) to account for regional variation in input prices (primarily wages), the HCFA would agree to pay each public sponsor half of the regionally adjusted cost for each enrollee to whom the sponsor sold a health plan. The public sponsor would be required to subsidize the enrollees to the amount of 80 percent of the average premiums of the health plans with which it had contracted. In states with high bills for medical care, relative to wages and other input prices, the average premiums would be likely to be higher than the regionally adjusted national average cost. These states would be required to contribute more than 30 percent of the cost to fund the state's share of the program. Conversely, states with relatively low medical care costs would pay less than 30 percent for their share.

A scheme of the general type outlined here could be financed and managed by the federal government, by the states, or by the states with federal guidelines and financial support. The federal government is likely to be able to develop and apply superior competence, and its taxing power is needed to make universal health insurance a reality. Otherwise, states competing to attract jobs would be reluctant to place such burdens on their employers. But the federal government could raise the money and turn it over to the states, as it does with Medicaid.

In this model, each state would be the guarantor of coverage for its citizens. There are several reasons to prefer the plan that involves state responsibility with federal support and guidelines. First, there is considerable diversity among states' health care systems and policies. Second, a substantial part of the money required to care for the uninsured now comes from more or less broadly based state and local sources, including

employers' payments to private hospitals for bad debts or free care, and direct appropriations from state and local governments to short-term hospitals and medical programs for care for the recipients of general assistance. The states now rely on various mixes of these sources. The requirement for partial state funding is intended to keep this proposal from being regressive in relation to the status quo, by ensuring that this broadly based funding would be retained in the health care system. Third, there is wide variation among market areas in the cost and use of services. The responsibility for costs should be decentralized to the state level in order to motivate states, local governments, and employers to support cost-reducing policies.

Relation to Medicare and Medicaid

We propose no initial change in Medicare and Medicaid. The public sponsors would have enough work to accomplish the objectives set out thus far. However, once this program was operating successfully, there would be opportunities to use the capabilities of the public sponsors to assist the Medicare and Medicaid programs. For example, Medicaid programs should consider contracting with the public sponsors to provide coverage for families on welfare, in order to ease the transition from welfare to work. The existence of the public sponsor would mitigate the work disincentive associated with losing eligibility for Medicaid because of an extra dollar earned, and a Medicaid-public sponsor agreement might mitigate this disincentive further. The existence of nearly universal coverage through the public sponsor should greatly reduce the number of people who "spend down" into Medicaid. As for Medicare, it might find an advantage in using the public sponsors as brokers for HMO enrollment.

Managed Competition, Technology Assessment, and Management of Outcomes

Here we address the institutional framework within which consumers and providers decide about their participation in plans for health care financing and delivery and the incentives and constraints within which physicians and managers make their decisions about care and resource allocation.

The market for health plans is not inherently competitive. Market forces do not automatically lead it to produce an efficient, much less a fair, outcome.¹⁹⁻²² In a free market, health plans could pursue profits or survival by using numerous competitive strategies that would destroy efficiency and fairness and that individual consumers would be powerless to counteract: risk selection, market segmentation, product differentiation, discontinuities in coverage, refusals of insurance for some people, biased information, and anticompetitive behavior. Consumers avoid buying coverage until they get sick, and health plans protect themselves with elaborate strategies, including medical review (e.g., testing for the human immunodeficiency virus) and the exclusion of coverage for preex-

isting conditions. For 35 million Americans to lack coverage is the sort of thing that happens when people are left to a free market.

The type of market structure that we believe can produce reasonable efficiency and fairness is one of managed competition in which intelligent collective agents, called sponsors, contract with competing health plans and continuously monitor and adjust the market to overcome its tendencies to failure. Managed competition has been discussed extensively elsewhere.¹⁹⁻²² The key idea is that sponsors would manage a process of informed, cost-conscious consumer choice that would offer the reward of more subscribers to health plans whose providers delivered high-quality care economically.

The sponsors could employ various tools and strategies to counteract the causes of market failure. For example, when consumers had a choice of plan, the medical costs expected per person might be distributed unevenly among the different plans in what is called biased risk selection. If all patients had to be insured for the same price, achieving a favorable selection might be very advantageous to a health plan. The techniques of attracting good risks and repelling bad ones are many and subtle. If the incentives were not structured properly, a health plan might be led to underserve sick patients in order to encourage them to switch to another plan at the next enrollment period.²³ Or if the health plans were free to vary the premiums or decide whether to renew an enrollment, they would find it advantageous to charge high premiums to high-risk enrollees, or to offer them poor coverage or none at all.

The sponsor could attenuate these incentives by "risk rating" — the process of identifying and grouping persons according to the characteristics that help predict medical expense, with a different price quoted to cover the people in each group. Then the incentive to discriminate against the sick could be reduced by allowing the health plans to charge higher prices for the care of people in high-cost groups. Unfairness to these people could be avoided by tying the sponsor's contributions to the costs in each category, thus protecting the sick from higher costs. For example, the sponsor should pay each health plan an amount equal to the expected cost of efficient care for each of its enrolled patients with the acquired immunodeficiency syndrome, in order to avoid a disincentive to the enrollment and care of such patients. Medicare uses a rudimentary risk-rating system in contracting with HMOs.²⁴ In addition, the sponsor might contract for standardized coverage in order to prevent the manipulation of the terms of coverage to select patients in particular risk groups. And the sponsor could manage the enrollment process, including contacts between beneficiaries and health plans that might be designed to select for risks. Finally, the sponsor could monitor performance with regard to risk selection and take corrective action as needed. In this way, sponsors could control economic in-

centives so that the health plans would produce efficient and fair service.

For managed competition to yield efficient, high-quality care, providers, sponsors, and consumers must all be well informed about the constituents of such care. Thus, it is essential that the institutional framework include effective, broad-based programs in technology assessment, the risk-adjusted monitoring of outcomes, and outcomes management. Bunker et al. have proposed the creation of an "institute for health care evaluation" that would establish a uniform data base, identify technologies for assessment, and carry out and disseminate the results of evaluations.^{25,26} Blumberg has defined "risk-adjusted monitors of outcomes" as statistical systems that measure outcomes continuously and enable comparisons to be made that take into account appropriately the differences in patient mix of the populations being compared.²⁷ This approach can be used, among other things, to identify specific providers whose outcomes are better or worse than expected. Ellwood has recently proposed "outcomes management . . . a common patient-understood language of health outcomes; a national data base containing information and analysis on clinical, financial, and health outcomes that estimates . . . the relation between medical interventions and health outcomes . . . and an opportunity for each decision-maker to have access to the analyses that are relevant to the choices they must make."²⁸

Such information strategies are complementary to the process of managed competition; neither can have its intended effect without the other. The information enables sponsors and consumers to choose health plans wisely and to be informed about cost-quality tradeoffs. It enables physicians to avoid using their resources on treatments that do not improve outcomes and to save them for treatments that do. Managed competition rewards them for acting on such information.

In addition, such information is a public good. The profit incentive does not motivate the production of such information in socially optimal amounts. Substantial support by government is both necessary and a wise investment for taxpayers in the long run. All providers must participate in uniform systems of data reporting, because selective reporting on a voluntary basis will not produce credible data. Thus, action is required on the part of the states, the federal government, or both. Although large employers and government agencies (e.g., the HCFA) can gather, analyze, and publish much of this information, it will not have credibility with physicians until they participate actively in its development.

COVERAGE, COSTS, AND BUDGETS

The Congressional Budget Office, which makes such estimates for the Congress, has estimated the effects of our proposal on coverage, costs, and public-sector budgets.²⁹ Here we report their estimates, which are similar to our own.¹⁸

Of the 35 million people who are currently uninsured, according to Congressional Budget Office estimates, approximately 22 million would be covered by their employers under the proposed program, and the remaining 13 million would be eligible to purchase subsidized coverage from a public sponsor (Table 1). In addition to the 13 million currently uninsured people who would be eligible to buy coverage from the public sponsor, 6 million people currently purchasing nongroup insurance would be able to do so. Employers would purchase coverage for 43 million people in addition to those now covered by employer-sponsored insurance (this includes many self-employed people who currently purchase coverage).

Government needs money for five purposes under this proposal: (1) to subsidize 80 percent (50 percent from the federal government) of the cost of an average health plan for households in which no member is a full-time worker; (2) to subsidize small businesses arranging coverage through the public sponsor, whose unsubsidized costs exceed 8 percent of payroll; (3) to subsidize the individual's share of the premiums when family income is less than 150 percent of the poverty level; (4) to cover the increased cost to the federal employee's health benefits program; and (5) to cover the revenue lost from the reduction in taxable wages when employers contribute to the health insurance of previously uninsured employees.

This money would be raised in three ways. First, there would be an 8 percent tax on the first \$22,500 of the wages of noncovered workers and a similar tax on self-employed persons and others. Second, there would be a limit on the amount of an employer's contribution to health insurance that could be excluded from an employee's taxable income. Third, the states would be required to fund part of the program, using monies saved because of the large reduction in the costs of hospital care that is publicly sponsored or uncompensated.

Table 1. Health Insurance Status of the American Population at Present and as Projected under the Proposal.*

PROJECTED TYPES OF COVERAGE	TOTALS (PROJECTED)	CURRENT TYPES OF COVERAGE			
		EMPLOYMENT- BASED GROUP†	OTHER PRIVATE	MEDICARE, MEDICAID, OR CHAMPUS‡	NONE
		millions of people§			
Totals (current)	241.2	135.1	19.7	51.1	35.3
Employment-based group†	178.3	135.1	13.6	7.1	22.5
Medicare, Medicaid, or CHAMPUS‡	44.0	—	—	44.0	—
Public sponsor	18.9	—	6.1	—	12.8

*Source: Preliminary Congressional Budget Office simulations based on the March 1988 Current Population Survey.²⁹

†Includes all people with employment-based coverage, regardless of other insurance, except those covered by Medicare.

‡CHAMPUS denotes the Civilian Health and Medical Program of the Uniformed Services. Figures include veterans covered by the Department of Veterans' Affairs.

§People are classified according to their own insurance and work status or that of the family member whose plan covers them.

Table 2. Probable Effects of Full Implementation of the Proposal on the Federal Budget.*

	COST OR SAVINGS (BILLIONS OF 1988 DOLLARS)
Outlays	
Matching contributions to public sponsors	8.7
Subsidies to small businesses	3.9
Subsidies to low-income individuals and families	3.9
Cost added to health-benefit plan for federal employees	0.2
Savings to Medicare, Medicaid, and CHAMPUS†	-3.9
Total	12.8
Revenues	
Payroll tax on part-time workers‡	4.4
Income tax on others eligible to buy from public sponsors	2.5
Cap on exclusion of employer contributions from individual income-tax and payroll-tax bases	11.2
Savings from elimination of all health care benefits from Section 125 of Internal Revenue Code	5
Revenue loss from mandated employer contributions — individual income and payroll taxes	-5.7
Total	12.4
Net effect on federal budget deficit	0.39

*Source: Preliminary Congressional Budget Office estimates based on 1983 Current Population Survey and August 1983 base line.²⁹

†CHAMPUS denotes the Civilian Health and Medical Program of the Uniformed Services.

‡Net of income-tax and payroll-tax effects due to lower wages.

§Not yet estimated, but expected to be small.

¶Value shown is approximate because of rounding off.

We think that the cost of the benefit package we have described would be approximately \$2,400 per family per year.¹⁸ The Congressional Budget Office estimates that with a \$2,400 annual family premium our proposal would not have a significant effect on the federal deficit (Table 2). New federal expenditures (after accounting for offsets) would be approximately \$12.8 billion; this would be balanced by approximately \$12.4 billion in additional tax revenue. There is some uncertainty associated with all such estimates, but we believe that these are accurate enough to demonstrate that a proposal such as ours can be crafted that has no effect on the deficit. As we have shown, the proposal has been designed with a number of "tunable dials." Some marginal adjustments may be necessary to achieve deficit neutrality (or may be desirable for other reasons), but the proposal as currently formulated is close to "budget neutral."

State-government expenditures required to provide the 30 percent subsidy for people who would buy health insurance directly from the public sponsor are estimated at \$5.2 billion. Some states would be able to fund these expenditures in large part by redirecting current state and local government expenditures in support of care for the uninsured poor. In 1983, state and local governments spent more than \$2 billion for general-assistance medical programs.³⁰ and in 1986 they spent \$1.4 billion in direct appropriations to short-term care hospitals (Fraser I, American Hospital Association: personal communication). The need for such expenditures would diminish greatly

when almost everyone had insurance, and most such funds could be used to support the states' 30 percent subsidy of the regionally adjusted national cost of a health plan.

In some states, care for the uninsured poor is delivered largely by private hospitals and paid for through cost shifting to private payers. In such states new revenues would be required to provide the state's share of the subsidy to be used by the public sponsor. However, raising these new revenues would not harm the productive capacity of the states' economies. They would not be diverting funds from other sectors to the health care sector but simply shifting the source of the subsidy from a private-sector cross-subsidy to a direct public subsidy. Nationally, the private-sector cross-subsidy was approximately \$7 billion in 1986 (Fraser I, American Hospital Association: personal communication). We expect the subsidy to increase to \$8.3 billion in 1988.

In its first full year of implementation, we expect that our proposal would increase total health care expenditures by approximately \$15 billion—3 percent of current health care expenditures and 0.3 percent of the gross national product. This would be a one-time increase. As Medicare and Medicaid have taught us, the important effects of a new health care program are not seen in the static, first-year effects, but rather in the long-term effects. It is ambitious but reasonable to set it as a goal for a program such as the one we propose—given cost-conscious demand and managed competition among health plans—to restrain health care costs to a rate of growth close to that of the GNP. If this favorable result were to occur, we would reduce health care costs by \$15 billion per year (that is, \$15 billion in the first year, \$30 billion in the second year, \$45 billion in the third year, and so forth), as compared with the current path of expenditures. These savings, which would be shared by the government and private employers (and ultimately by wage earners), would soon dwarf the one-time cost increase that our proposal would create.

In the second part of this article, we will discuss the general characteristics and expected effects of our proposal and compare it with alternative systems. We pay particular attention to effects on the organization of medical practice and the delivery of medical care.

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A CONSUMER-CHOICE HEALTH PLAN FOR THE 1990s*

Universal Health Insurance in a System Designed to Promote Quality and Economy

(Second of Two Parts)

ALAIN ENTHOVEN AND RICHARD KRONICK

Abstract We describe the characteristics necessary for a plan for universal health insurance to find broad acceptance. Such a plan must represent incremental, not radical, change; must respect the preferences of voters, patients, and providers; must avoid major disruption in satisfactory existing arrangements; must avoid creating major windfall gains or losses; must avoid large-scale income redistribution; and must not be inflationary.

Our proposal would create a framework that would encourage the efficient organization of care. Successful organizations would probably be those that attracted the

loyalty and commitment of physicians, integrated insurance and the provision of care, and aligned the interests of doctors and patients toward high-quality, cost-effective care. The proposal's chief potential disadvantage would be its effect on the employment opportunities of low-wage workers, but this effect could be minimized.

In addition, we discuss a proposal to mandate coverage by employers of full-time employees, legislation enacted recently in Massachusetts, high-risk pools, and the system followed in Canada, comparing each of these alternatives with our proposal. (N Engl J Med 1989; 320:94-101.)

GUIDELINES FOR A BROADLY ACCEPTABLE PLAN

Universal health insurance has not attracted overwhelming support in this country. Indeed, its enactment in any form would be a remarkable achievement. To be politically viable, a proposal for universal health insurance must respect American cultural preferences for pluralism, diversity, local solutions, and individual responsibility. It must consider the preferences of providers and consumers for a variety of systems and styles of care. It must not provoke the strong opposition of large or important groups. What are the fears and concerns of the opponents of universal health insurance, and how does our proposal seek to dispel them?

Socialized Medicine

Universal health insurance in the United States would not have to resemble "socialized medicine" as it exists in the United Kingdom or Scandinavia. Many Americans instinctively reject any system they think would be bureaucratic, inconvenient, impersonal, or unresponsive to patients' needs and preferences — traits sometimes associated with the British and Swedish systems.¹⁻³ Many fear a framework that would be inefficient and by which care would therefore be rationed in queues or in which advanced technology would be unavailable. American physicians fear a system in which their professional judgments about patients' needs would be subordinated to political considerations. Most would resist having their incomes and working conditions circumscribed by political factors that bore no relation to the quality and

value of their services. The national experience with Medicare and Medicaid suggests that physicians resist depending totally on government as the source of payment.

As we showed in the first part of this article, coverage that is nearly universal could be achieved in large part through a diversity of health plans (nonprofit and for profit) in the private sector such as now exists in the United States. We call our proposal "A Consumer-Choice Health Plan for the 1990s" because it would present consumers with a choice among such health plans and an opportunity to exercise cost-quality judgments that reflected the consumers' own preferences. The health plans would be responsive to patients because they would need to compete for subscribers. The plans would have to give value for money, because consumers would be conscious of costs in their choices. Health plans would also have to compete for the participation of physicians and thus would have to respect their professional judgments and aspirations. Payment to the physicians would be made through the health plans in which they participated, thus coming ultimately from satisfied enrollees. Such a model would be inherently much more adaptable than a public-sector monopoly.

Radical Change and Large Windfall Gains or Losses

A universal health insurance plan would not necessarily mean radical discontinuity with the present, nor would it necessarily create large windfall gains or losses. Nor would it have to mean major disruption in the current arrangements by which most employed people are satisfactorily covered. Incremental change is one of the most consistent themes of American politics. If we were making a fresh start in health insurance, we would not recommend an employment-based system, because of the many problems associated with

From the Graduate School of Business, Stanford University, Stanford, CA 94305, where reprint requests should be addressed to Dr. Enthoven.

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it. But the present system involves large vested interests and liabilities that cannot simply be ignored. For example, many employers have obtained the services of employees in part by promising them health benefits after retirement. The present value of such liabilities exceeds \$200 billion.⁴ An acceptable policy could not suddenly transfer such a responsibility from employers to the taxpayers in general. Most Americans obtain good coverage through their employers and consider their arrangements satisfactory.⁵ To disrupt these arrangements would provoke opposition needlessly. So we have designed a proposal for nearly universal coverage, one that would neither cause large windfall gains and losses nor disrupt satisfactory arrangements. The only immediate change for most people who are covered through employment would be an end to "cost unconsciousness" in their choice of health plan.

Redistribution of Income.

Our society appears to have little taste for income redistribution, and a universal health insurance plan does not have to involve extensive redistribution. Inevitably, in the case of the poorest people, who cannot be expected to pay the cost of their care, others with higher incomes must help them, just as they do today. But our proposal would raise a large part of the needed funds from nonpoor working people who are uninsured today.

Health care financing in the United States today is regressive. Lower-income families that are insured (or their employers) pay premiums similar to those paid by higher-income families, hence spending a higher percentage of their income. Financing a universal insurance scheme could be similarly regressive. Our point is not to advocate regressive financing, but to separate universal health insurance conceptually from income redistribution.

Some may consider it harsh to require low-wage workers to pay the equivalent of an 8 percent tax toward their health insurance. If taxpayers of more ample means were willing to take on the burden of covering the poor, we would consider it to be all to the good. But it is important for low-income people to have health care coverage, even if they must pay a substantial part of the cost themselves.

Inflation

Universal health insurance does not have to be inflationary. On the contrary, reform of the total system is needed to cure the present lack of awareness of costs that contributes so much to inflation. Overinsuring the well-to-do without considering costs is much more inflationary than being conscious of costs and covering the poor. Medicare and Medicaid exacerbated inflation because they locked in the fee-for-service cost-reimbursement modes of provider payment and effectively blocked reform of the system. There is now

an adequate supply of doctors and hospital beds, so increasing the numbers of the insured need not bid up prices substantially.

Small Business

We recognize that our proposal is likely to incur strong opposition from small businesses that do not now offer their employees coverage. Such businesses would see it as a tax increase that would damage their competitive position. In Part One we described methods to soften the blow. More could be done if other sources of financing could be identified. The uninsured are no healthier than the rest of us; some of them will be seriously ill, will need care, and will be unable to pay. We view employers and employees who do not participate in health insurance, but who receive care, as taking a "free ride" at the expense of other employers and taxpayers.

EFFECTS ON MEDICAL PRACTICE, COVERAGE, AND EMPLOYMENT

Medical Practice

If our proposal were enacted and successful, how would it affect the organization and delivery of medical care? What would be the characteristics of the organizations that would be likely to succeed in the framework we have designed?

First, there would be room for much variety in the systems and styles of care, reflecting the circumstances and preferences of patients and providers. Our proposal need not lead physicians to fear being engulfed by one monolithic salaried practice for all. Second, successful organizations would have to attract the loyalty and commitment of physicians. Successful health plans could not be seen by participating physicians as "just another insurance company" in an adversarial relation. Controls on the use of health services cannot produce economical care in the face of opposition by physicians. Increasingly, physicians would select one health plan and form a loyal and relatively exclusive relation with it, seeing themselves as responsible participants in its management, perhaps with some equity interest, not just as "hired hands." Physicians would take part responsibly in all important decisions, working in partnership with managers skilled in the nonmedical aspects of program operation. Physicians would see their personal success as related to that of their chosen health plan; they would be willing to adapt and sacrifice in order for the plan to succeed. Insurance companies have important roles in marketing, finance, management of facilities, data collection and analysis, and other business functions. In the long run, the most successful such companies would be the partners of physicians, not their employers.

Third, successful organizations would integrate insurance and the provision of care, as health maintenance organizations (HMOs) do today. Provider or-

ganizations would be motivated to organize the delivery of care for maximal efficiency. Because the size of premiums would depend primarily on the efficiency of the provider, the provider's income and the volume of patients would both depend on the provider's ability to restrain costs while providing good care. Thus, physicians would evaluate the benefits and costs of specific practices, curtailing practices that did not produce better outcomes for patients in order to free resources for those that did.

Fourth, in the long run, the most successful organizations would probably be large prepaid group practices and other multispecialty group practices, because they appear to foster economical practice styles.⁶⁻⁸ One key to economy and quality is the presence of busy, proficient doctors, which requires matching the numbers and types of physicians to the needs of the population served. Prepaid group practices and other systems with a similar organization can also match other resources, such as beds and equipment, to the needs of the population served. And they can organize care in the least costly settings, with an emphasis on outpatient care and home care. Other factors that favor large multispecialty group practices are those of mutual professional support and stimulation, group support for continuing medical education, a group size large enough for resources and risks to be shared, peer-group participation in decisions about clinical policies, and greater opportunities for physicians to choose their life styles.

Fifth, in successful organizations the interests of doctors would be aligned with those of patients in providing economical care of high quality and avoiding incentives to provide care that was not in the patients' best interests, considering both quality and cost. Physicians would avoid the powerful incentives for short-term maximization of profits that are inherent in some forms of public stock ownership.

Through a combination of democratic social choice and market forces, society would signal what it was willing to pay for care. Then physicians would do their best to provide the highest standard of care achievable within those limits.

How would physicians be paid? Neither a straight salary unrelated to individual performance nor an uncontrolled fee-for-service system based on "usual, customary, and reasonable" charges would align doctors' interests with those of patients. The workings of market forces on health plans that were free to adapt and innovate would probably lead to the development of performance-based systems of pay somewhere between fee-for-service, with "resource-based relative-value scales," and salaries, using peer judgment and various indicators of performance.

What about traditional fee-for-service individual and single-specialty group practices? We doubt that they would generally be compatible with economic efficiency. We would expect this type of practice to continue, but to decline gradually in importance. Fee-

for-service solo practitioners would continue to be found in individual practice association HMOs and preferred-provider insurance plans, but under contracts with regard to fees, controls on the use of services, and risk sharing. Some physicians would work independently. Some would survive in private solo practice without health plan contracts, serving the well-to-do, much as private practice survives in the United Kingdom. For best results, however, physicians ought to organize themselves in cohesive units that could take responsibility for managing the quality and economy of care.

What we have proposed is a strategy for reforming the delivery of health care by reforming the system of payment. Its effectiveness would be enhanced if there were also a supply-side strategy that assisted in the formation of a greater number of efficiently organized systems of care.

Coverage

There is no precise basis for predicting the rates of participation by people now uninsured. Experience with large-scale programs in which the size of the employees' contribution exceeds that of the one we propose suggests that participation rates would be high. Public sponsors would have to market their services actively. Our proposal would give the states incentives to market coverage effectively, since each person enrolled through the public sponsor would bring into the state a federal contribution equal to half the adjusted average cost of the premium. And each enrollee would represent one less potential burden on the taxpayers for uncompensated care. Providers could make free rides unattractive by instituting relatively tough collection policies with regard to uninsured persons who could pay for care. The availability of subsidized insurance would make such policies more acceptable.

Employers, Employment, and Real Wages

Our proposal would affect wages, employers, and employment. In a perfectly competitive market, the total payments for each worker's services — wages, fringe benefits, and payroll taxes — should equal the value of his or her contribution to the output of the firm. After a period of adjustment, any increase in health insurance costs or payroll taxes would be offset approximately by a decline in real wages. In real labor markets, however, various factors might prevent wages from declining by as much as the employer's increase in costs for health benefits. Thus, increases in such costs might result in higher prices or lower profits.

Even so, in the case of part-time workers who are currently uninsured or those in firms with fewer than 25 employees but with wages above 108 percent of the minimum wage, we would expect the long-term effect to be a reduction in wages of approximately 8 percent. On the other hand, part-time workers and those in small firms who are now insured at a cost in excess of

8 percent of their pay would see an increase in wages, employment opportunities, or both. Currently uninsured full-time workers in firms with more than 25 employees whose wages exceed the minimum wage by the amount of the employer's cost to insure them would also see a reduction in wages roughly equal to the employer's cost for health insurance. But in exchange, such workers would receive access to health care coverage and mainstream care at competitive subsidized rates.

Employers that now provide coverage would be relieved of the expense of coverage for spouses whose employers do not provide coverage, as well as the hidden tax of charges that help cover bad debt and free care, which average about 10 percent of hospital bills. Also, they would face a reduced disadvantage in relation to employers that do not now insure their employees. Small employers that now pay more than 8 percent of payroll for health insurance would find their costs reduced. For employers who do not currently provide insurance, this proposal would close down a free ride by deliberately taking away a competitive advantage vis-à-vis employers that do cover their employees. However, for small employers, it would do so at a cost limited to about 8 percent of payroll. The proposal would also offer them a way of buying coverage at competitive group rates.

Employers that now provide coverage for their employees are burdened by three types of mandate whose valid social purposes would be served more effectively by our proposal and that therefore could and should be repealed or preempted by federal law. These are, first, the many state insurance laws that mandate coverage in specific amounts and for specific types of services; second, the so-called COBRA continuity law, which requires employers to sell coverage to former employees and their dependents for 18 or 36 months after the termination of employment; and third, Section 89 of the Internal Revenue Code, which imposes complex rules against discrimination in favor of highly paid employees. Under our proposal, the federal government would set a minimal benefit package as a national standard, continuity of coverage for employees who left firms would be provided through the public sponsors, and coverage would be universal, with limits on the tax break for the highly paid. These would be important steps in the simplification of employers' obligations. In appraising their total effect, one should bear in mind that a major element of our proposal is the creation of incentives for efficiency as a means of containing the growth of health care costs.

The most important potential negative effect of our proposal, as compared with the status quo, would be a reduction in opportunities for employment among people with few job skills by, in effect, raising the minimum wage. To part-time workers and employees of small firms, our proposal would mean an implicit 8 percent increase in the minimum wage. Requiring

employers to cover full-time employees could add a cost of 11 percent of pay in the case of individual coverage for a worker receiving the minimum wage (\$3.35 per hour), and 27 percent in the unusual case of such a worker who covered his or her family. In the drafting of legislation to implement this proposal, further provisions should be designed to reduce this burden, especially the extra burden of family coverage.

Any tax or regulatory mandate distorts economic decision making. If this proposal were enacted, there would be negative effects on employment, as there are now in our employment-based system of coverage. But the achievement of widespread health insurance inevitably entails some taxes and regulations. Our present method of providing health insurance through employment groups is subsidized by taxes to a great degree. We must look for a realistic compromise — what economists call a “second best” — because universal health insurance without some regulation and tax support is impossible.

Young people are the group whose employment would be most likely to be affected, because a comparatively high percentage of them work at the minimum wage.⁹ Strong evidence suggests that a 10 percent increase in the minimum wage would reduce the employment of 16- to 19-year-olds by about 1 percent, although some studies have found the effect to be as much as 3 percent.⁹⁻¹¹ The effect would be much smaller among older workers because fewer of them work at the minimum wage. Mitigating actions are possible. The minimum wage could be adjusted to allow employers to pass along part or all of the increase in the cost of health benefits. The employment of people under 18 could be exempted from the mandate and tax. Thus, the negative effects on employment need not be large.

STRATEGIC ALTERNATIVES BASED ON MANAGED COMPETITION

The mixture of public and private financing and administration in the model we have described is not the only way to achieve universal health insurance that is based on managed competition. Indeed, the employment-based model has many important disadvantages, such as gaps in coverage, cost, inequity, and complexity. The presence of a large number of private sponsors creates great complexity as each tries to deal with health plans on the basis of its own preferred system of pricing or of rating risks. We have proposed this approach because we believe it represents politically feasible incremental change and meets our guidelines for a broadly acceptable plan. It does have important advantages, such as keeping the function of sponsorship decentralized and largely in the private sector, and keeping employers together as a focused political group interested in cost. Thus, we consider this proposal the most plausible starting point for incremental reform. There is, however, another serious possibility.

In many respects, the simplest model would be one that is financed and administered publicly. One of us proposed such a model 10 years ago,¹² according to which government would raise all the revenue, except for individual premium contributions, with taxes such as those on payroll, income, and consumption. This approach would spread out the costs of health care and avoid placing an extra burden on those who employ sicker workers. Acting as a sponsor on behalf of all persons covered, a government agency (federal or state) would contract with the participating health plans, design and operate a single risk-rating system, and manage the enrollment process. All health plans would have to play by a single set of rules. The system could be managed either by the Health Care Financing Administration (HCFA), currently the best-qualified sponsor, or even better, by a newly constituted agency somewhat independent of political pressures, whose design would resemble that of the Federal Reserve System. Such a model would be less open to innovation than one with substantial private-sector sponsorship, since the decentralization of the sponsorship role entailed by private-sector involvement would make it easier to test new ideas.

What would happen if the competition to serve cost-conscious buyers were ineffective in constraining the growth of expenditures to a rate considered satisfactory by society in general? Such a scenario could emerge if the public sponsors were ineffective in pursuing policies to encourage competition and if relatively noncompetitive market structures persisted. In response, one action that a publicly financed and administered model could take would be to institute a system of administered prices analogous to that used in hospitals under the Medicare prospective-payment system. The health plans would then receive fixed, periodic prospective payments based on the composition of their memberships according to diagnostic cost groups, and they would have to accept such payments as payment in full.¹³ They would compete with regard to quality and service but not with regard to price.

The immediate adoption of a publicly financed and administered model would represent radical change, create large windfalls, and disrupt satisfactory existing arrangements. Providers would probably feel threatened by such a concentration of power on the demand side. However, a system that was publicly administered in large part might evolve from our mixed proposal if the public sponsors could work effectively, causing large numbers of employers to choose to arrange coverage for their employees through them. Thus, those who would prefer to see a model that was financed and administered publicly might view our incremental proposal as one step in an evolutionary process toward public sponsorship on behalf of those who would not be better served by private-sector sponsors. If all but the largest employers chose to contract for coverage through a public spon-

sor, many disadvantages of the employment-based system would be alleviated. Thus, with the enactment of our proposal, some of the main benefits of public financing and administration would be realized without the threat of a government takeover of the whole system.

COMPARISONS WITH SOME PROMINENT ALTERNATIVES

Mandated Coverage of Full-Time Employees by Employers

President Richard Nixon in 1974 and Senator Edward Kennedy in 1987 proposed requiring employers to provide coverage for all full-time employees and their dependents.^{14,15} Senator Kennedy would require employers to cover all employees working 17.5 hours a week or more, and their dependents, with a health plan that met certain standards. Employers would be required to pay 80 percent of the premium, and in the case of low-wage workers, 100 percent. The secretary of health and human services would be required to select and certify regional insurers in each of six to eight regions, which would offer indemnity plans and managed care plans at low and high options on a community-rated basis. The secretary would encourage the regional insurers to contract with groups of small businesses for administrative services.

As explained earlier, requiring employers to cover their full-time employees is a necessary part of a larger strategy that subsidizes the coverage of those not covered through employment but tries to keep the sponsorship of most health insurance in the private sector. Senator Kennedy has performed a valuable service in helping to place universal health insurance on the national agenda. But his proposal does not pretend to achieve universal health insurance or cost containment by itself. It would leave gaps: the self-employed, part-timers working less than 17.5 hours at any given job, employees during their first 30 days on the job, the unemployed, those outside the labor force, workers in firms not covered by the Fair Labor Standards Act or with fewer than six employees (for the first five years), and dependents of workers in these categories. In the short run, the Kennedy proposal would leave out at least 10 to 12 million people, and eventually more, as employers responded to its incentives. By not taxing all employment that was not covered by health insurance, it would give employers a powerful incentive to find ways to meet their needs with 17-hour-per-week employees. And it would provide no mechanism for aggregating premium contributions from these people. At the same time, it would create a disincentive to hiring part-timers who worked more than 17.5 hours per week. It lacks a built-in strategy for cost containment. The community-rated regional insurers do not appear likely to promote effective competition in organizing local health systems for efficiency. In leaving intact the current tax treatment of employer-provided health insurance, the proposal

would not promote cost-conscious consumer choice and would be unlikely to lead to cost containment.

Massachusetts

Massachusetts recently enacted a law "to make health security available to all citizens of the Commonwealth and to improve hospital financing,"¹⁶ with two main features. First, the act creates a public sponsor, the Department of Medical Security. The department will contract with health plans to make affordable coverage available to small businesses and, subject to the availability of funds, will provide subsidized coverage for individuals who are otherwise unsponsored. Second, starting in 1992, the act will impose a "play-or-pay" tax on all employers of six or more workers, which would be equal to 12 percent of the first \$14,000 of each employee's wages. Employers will be able to deduct the costs of their health benefits from this amount. Thus, employers who spend at least this much on health benefits will not pay the tax. Employers of five or fewer employees, temporary or seasonal employees, part-time employees who work less than 20 hours a week, and employees covered elsewhere (e.g., on a spouse's plan) will all be excluded. The Department of Medical Security will use the revenues generated by this tax to provide subsidized coverage. Various small incremental steps over the next four years are intended to prepare for the extensive change in 1992.

Philosophically, this act resembles our proposal in its use of incentives to motivate the private sector to provide coverage and in the use of a public sponsor to fill the gaps left by the private sector. In appraising the concept, one must bear in mind that several powerful factors seriously inhibit an individual state in the design of a universal health insurance program. First, by the enactment of the Employee Retirement Income Security Act of 1974, Congress preempted state regulation of employee benefit plans.¹⁷ States may not require employers to provide health benefits. Second, the federal income-tax treatment of employer-provided health benefits amounts to a key subsidy for private health insurance, the limitation of which would be an important way of creating cost-conscious choice. Third, the states compete for taxpaying residents and businesses. A state government contemplating an increased tax on business has reason to fear that it may cause established businesses to migrate and new businesses to choose to start elsewhere.

In our view, the exemption of many employees from the play-or-pay payroll tax is regrettable. The combination of a public sponsor that will sell subsidized insurance to those not covered through employment, with exemptions for employers from mandates and play-or-pay taxes, invites insolvency for the program. Not only will the public sponsor be required to provide coverage for the employees of small businesses that currently do not provide health benefits, but we would expect many small businesses that currently do pro-

vide coverage to stop. The public sponsor would then be required to cover the newly uninsured employees of such small businesses without a source of funds for the subsidy. Better methods of cushioning small business from the costs of employment-based universal health insurance are available, which retain the financial base to support it.

The Massachusetts law is not incompatible with a strategy of managed competition, but it does not require it. Without the authority to limit the extent of employers' contributions that are tax-free under federal income and payroll taxes, Massachusetts cannot create a key feature of managed competition — namely, cost consciousness among consumers in the choice of plan. For most of the 1980s, Massachusetts has relied on a regulatory approach to cost containment. We believe managed competition would be more effective in the long run because of its focus on the reorganization of the delivery system into efficient units. And we believe managed competition would be more acceptable in the great majority of states that have chosen not to regulate hospital revenues. Finally, the Massachusetts legislature has not identified all the sources of funding necessary to carry out its intentions. We believe the superior taxing power of the federal government is needed.

High-Risk Pools

Six states have enacted legislation creating health insurance pools to serve people who are not eligible for group insurance and who, because they are at high medical risk, cannot buy individual insurance.¹⁸ Typically, these pools offer to sell insurance to such people at 150 percent of the price of a standard-risk policy. The pools are supported by subsidies from all the health insurance companies in the state. Enrollments are low, even in relation to the target populations.

This strategy has been ineffective, for several reasons. First, most of the uninsured are not "medically uninsurable." Bovbjerg and Koller, who have studied high-risk pools, report a consensus guess that only about 1 percent of the general population is medically uninsurable.¹⁹ Second, the price is too high. Without a subsidy, few people can afford such insurance or will choose to purchase it. There is no good reason why they should not be granted tax subsidies equal to those available to the employed. Third, insurers have objected that the expansion of this program, which they and their policyholders must subsidize, puts them at a competitive disadvantage in relation to employers who have the option to insure themselves and escape the burden of subsidizing the pool. Thus, they lack an incentive to market it effectively. Fourth, this approach includes no incentives for efficiency in the care of high-risk patients.

Canada

What about the Canadian system as a model for the United States? In Canada's federal-provincial system,

the federal government makes a substantial per capita payment to each province's health insurance plan, provided the province publicly administers universal, comprehensive coverage for hospital and physicians' services and meets certain other conditions. The provinces finance hospital care through prospective global budgets, determined on a historical basis, with annual increases for inflation, increases in workload, and approved new programs. Physicians are paid on a fee-for-service basis, according to a fee schedule negotiated between each province and its medical association. About 76 percent of the expenditures for health care are included in the provincial budgets, with the provinces remaining "at risk" for the cost of care and therefore interested in containing its growth.¹⁹

It is hard to imagine a process of incremental change by which the Canadian model would be recreated in the United States. But any fair appraisal of the Canadian model would have to acknowledge some major strengths and achievements. Canada has universal coverage at a 1985 cost of 8.6 percent of the gross national product, as compared with 10.6 percent in the United States. Its share of the gross national product has apparently stabilized, whereas ours is accelerating. Canadians have much less paperwork because there is a single insurer for everyone — the provincial government — to whom the physicians send their bills. Fee-for-service payment gives the doctors an incentive to deliver services, whereas hospital expenditures are capped by global prospective budgets. Thus, Canadian doctors have a financial interest in hospital productivity, because their receipts for services to inpatients are directly related to the number of patients hospitals can serve within their limited budgets.

Would the Canadian system be a good model for the United States? The answer is very uncertain. The Canadian system is locked into the fee-for-service model, with no built-in forces of the market or other forces to lead its providers to organize the system for optimal quality and efficiency. It does not make considerations of quality assurance and use control in the physicians' interest, as the managed-competition model might do here. Nor does it motivate doctors to avoid providing services of little or no marginal benefit to the patient. We do not know how much of Canada's lower rate of expense is the result of greater efficiency and how much the result of the denial of access to technology that would be beneficial.

Serious questions can be raised about the capability of the American federal and state governments to manage the whole health care system with a tolerable level of competence. The Canadians have a parliamentary system that is less vulnerable than our own to the pressures of special-interest groups. They have a stronger tradition of civil service. And the provinces operate on a smaller scale and with much more cultural homogeneity than many of our larger states.

But the key problem is that an attempt to enact a system like the Canadian one, involving a virtually

complete government takeover of health care financing, would represent far too radical a change to be politically feasible in this country. The achievement would be impressive enough if someone could muster a winning coalition to support the incremental changes we have proposed. But any serious attempt to reproduce the Canadian model would provoke the intense and concerted opposition of powerful groups. Providers would resist the notion of government as the sole source of payment. Health insurance companies, HMOs, other intermediaries, and administrators would resist the threat to put them out of business. Millions of relatively well-to-do Americans would fear that "socialized medicine" would deprive them of access to high-quality care and advanced technology. Although some might support it (big business, eager to unload its heavy liabilities, or the millions badly served by the present system), we would expect a firestorm of opposition. We see no evidence that the American people are sufficiently fed up to consider taking such a leap. And as we have shown, it is not necessary to fight such battles to achieve universal health insurance.

CONCLUSION

Critics will point out that there is no certainty that a strategy of managed competition would in fact restrain the growth of health care expenditures to tolerable levels. They can point to the negative experience of the 1980s, when an apparently competitive system emerged that was accompanied by accelerated growth in expenditures. This experience is not directly relevant, however, because key elements of managed competition were missing: widespread cost-conscious demand, an effective sponsor to manage the competition for a large part of the population, relevant information about cost and quality, and an understanding of the necessary ingredients of managed competition. In short, fragments of "competition" were present, but not a comprehensive and concerted strategy. As with any bold public-policy initiative, there can be no guarantee that this one would succeed. The vision of managed competition as a national strategy represents a complex extrapolation from some successful experiences, using generally accepted economic theory.

What is clear is that continuing on the present path will produce results that are increasingly unsatisfactory: more and more people lacking coverage, expenditures rising to intolerable levels (15 percent of the gross national product and beyond), and little confidence that the money is being well spent. In comparison, the uncertainties of universal coverage under managed competition are surely to be preferred.

The only proved method for bringing the growth in total expenditures into line with the gross national product is for government to take over most of health care financing and place it under firm global budgets. This is what many industrialized democracies have done, at least in the case of hospital care. Even in that

case, however, there is no assurance that stability in the growth of reported financial expenditures would not be achieved at the cost of many delays or denials of care — thus, by a shifting of the costs of illness back to patients and other sectors of the economy. None of the countries that have adopted global budgets in the public sector have solved the problem of creating incentives for the efficient organization and delivery of care.

In view of our historic preferences for limited government and decentralization, our reliance on incentives in the private sector, and our at least partial success with relatively efficiently organized systems of health care, it seems reasonable to give comprehensive reform of incentives a serious try before something more alien and drastic is considered.

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Federation of American Health Systems

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National Health Policy

The American health care system needs to provide universal access to quality care at a reasonable cost. The Federation of American Health Systems believes that progress toward these goals requires the following:

- 1) A cap on the amount of employer paid health insurance that is tax free to the employee; these revenues should be used to finance the increased costs of an expanded Medicaid program.
Purpose: To restrain demand and establish incentives for lower cost health insurance plans.
- 2) Expansion of employment-based private insurance coverage. Employers should offer a minimum benefit package to their employees, or in the alternative, pay a tax on wages paid. Early retirees, self-employed, and all others under age 65 not covered by insurance would be subject to a "buy insurance or be taxed" requirement with tax credits for small employers.
- 3) Medicaid reform: federal minimum standards for Medicaid eligibility, benefits, and payment for services; gradual conversion of Medicaid to a program that subsidizes private health insurance plans with subsidies related to income, and a buy-in option for the unemployed and uninsurable regardless of income.
- 4) Federal pre-emption of state mandatory benefits laws, and the substitution of a national minimum benefits package.
- 5) Repeal of state laws banning limitations on patient freedom of doctor or hospital choice.
- 6) Gradual conversion of Medicare to a program with private insurance options, and immediate expansion of Medicare demonstration projects to test preferred provider (PPO) and other insurance options. To ease the burden on private payers, Medicare payment rates should be derived not by government fiat, but by competition among health plans.
- 7) Taxation of the actuarial value of the Medicare benefit, with an exemption for low income beneficiaries.
- 8) Research, development, and dissemination of data for developing medical practice protocols, to increase quality and reduce unnecessary services.
- 9) Study of the desirability of federal government re-insurance (catastrophic stop loss) for all Americans.
- 10) Federal malpractice reform such as limits on contingent fees for plaintiff attorneys and limits on punitive damages and awards for pain and suffering.

- 1) A cap on the amount of employer-paid health insurance that is tax free to the employee

The reasons for supporting a tax cap were well stated by the President's Commission for the Study of Ethical Problems in Medicine:

"The employer-exclusion provision gives a larger subsidy to those with a smaller need for financial protection...and exacerbates the tendency of lower income people to be less well insured than those with higher incomes..."¹

"This pattern of care is difficult to justify from an ethical standpoint. There seems to be little reason for such government assistance to middle and upper income individuals, most of whom could take financial responsibility for their own care...without undue hardship."²

The tax subsidy, estimated at \$32.6 billion for fiscal 1991, represents substantially more than the federal government spends on Medicaid.

¹President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Securing Access to Health Care, Volume One: Report, U.S. Government Printing Office, March 1983, p. 163.

²Ibid, p. 167.

Presently, under Section 106 of the Internal Revenue Code, amounts contributed by employers for employees' health insurance are not included in the employee's income. This amount also is not included in the amount of the employee's pay which is subject to Social Security taxes. Consequently, employees have a great financial incentive to bargain for more costly, broad, employer-financed health benefit packages. Since there is no limit on the amount of the exclusion, neither labor nor management has any great financial incentive to reduce health benefits, participate in preferred provider arrangements, or provide less than first-dollar coverage. Employees are not encouraged to seek benefit packages more specifically tailored to meet their health care needs, especially in light of the prevalence of group health coverage. Such broad coverage stimulates more frequent utilization of health care services and drives up health care expenditures. It effectively eliminates any cost consciousness on the part of consumers of health care.

Enactment of a ceiling on the employer exclusion would cause many employers to voluntarily offer multiple health plans including a low-cost option.

Eliminating the open-ended employer contribution while encouraging equal contributions to all employee health insurance plans will stimulate competition among health plans and

providers. Also, consumers of health care must have some financial stake in the system through some cost sharing of premiums and copayment of incurred costs in order to bring some market-oriented restraint into decisions about utilization and choice of plans. Higher premium and delivery costs should be borne by the party selecting the plan or provider.

2) Expansion of employment based private insurance coverage and mandatory health insurance for individuals under 65 not covered by their employer

Employers would be required to provide all their full time employees (as specified by regulation) with a basic health insurance package as specified by the federal government. The minimum required employer contribution to a health plan would be some set percent, e.g. 80%, of the cost of obtaining the minimum required coverage; employees would pay the difference between actual cost and the employer requirement.

Employers could choose not to cover part-time employees (as specified by regulation), but in that event, they would have to pay a payroll tax based on the temporary or seasonal workers' compensation. These workers - unless they chose to buy coverage with their own money - would be automatically enrolled in a publicly sponsored program, which would contract with private health plans to provide specified coverages for a set price per enrollee.

Employers could choose to enroll their employees in a health plan sponsored by a public agency created to do the following:

- contract with selected health plans (insurers, HMOs) as to price, scope of services, conditions of participation;
- enroll individuals and families willing to abide by the

conditions of participation (e.g., enrollment during an annual sign-up period for a minimum of one year);

- collect and disburse premiums;
- monitor performance.

Early retirees without employer coverage, self-employed people, and anyone else under 65 not covered by an employer would be required to pay a specified tax on adjusted gross income up to a specified ceiling. In return, they could enroll in one of the health plans offered by a public agency specifically established to arrange health insurance coverage for people not otherwise covered. The tax could be avoided by showing proof of a health insurance policy that met minimum coverage requirements. People under 65 who bought their own insurance would receive a tax credit equal to the amount of tax they would have paid or the cost of the premium, whichever was less.

3) Medicaid Reform

a) Establishment of a national minimum benefits package for Medicaid, and national rather than state-based funding

It is not fair that the availability of necessary services depends on an accident of geography. The same level of coverage - a decent minimum - should be equally available to all. This can be done only with a nationally uniform Medicaid benefits package.

Similarly, wealthier Americans should subsidize poor Americans regardless of where they are, and the amount of the contribution should be based on income, not on state of residence.

b) Gradual conversion of Medicaid from a program that pays for services to one that pays for private coverage

There is minimal patient price shopping and provider or patient concern for total cost unless annual payment for health services is fixed in advance and includes all covered services. Fixed payment for all services has the further important advantage of focussing provider attention and accountability on the full range of a patient's needs, not just discrete parts. Medicaid cannot realize these benefits for enrollees until it switches from payment a la carte to fixed price payment where the

recipient (a health plan) is accountable for all the costs of covered services for beneficiaries as well as the quality of those services. Such a switch requires that Medicaid pay an organization to provide comprehensive care rather than pay individual providers on a service-by-service basis.

An added advantage of converting Medicaid to a public sponsor and overseer of health plans is that it would provide a mechanism for pooling and focussing the market power of millions of individuals and thousands of small businesses that otherwise would have to buy health coverage on their own. The large time and administrative cost savings - to both insurers and insureds - resulting from the public pooling process, combined with the bargaining power inherent in the concentration of purchasing power, should enable individuals and small businesses to obtain coverage at much better rates than they could get by themselves.

c) An income test to determine Medicaid eligibility and/or eligibility for a subsidy to purchase a publicly sponsored plan

The crazy quilt of Medicaid eligibility rules should be replaced by a sliding scale income test whereby payment for coverage of the services specified in a minimum benefits package would be subsidized to a varying degree, depending on income.

Care for people whose health status makes them uninsurable should be financed by the public sponsor, who would pay a single

price to a health plan in return for the plan's commitment to meet the uninsurable's needs for a specified period. The uninsurable person would still be required to pay the tax plus some additional specified amount based on income.

4) Federal pre-emption of state mandatory benefits laws, and the substitution of a national minimum benefits package

Mandated benefits increase the costs of health insurance, therefore reducing its affordability. State benefit mandates also violate the principle of national uniform coverage. Also, national financing of subsidies for health coverage would not be acceptable if some people were to benefit disproportionately by virtue of where they lived. For these reasons, state mandates should be preempted by a national minimum benefits package designed to strike a nationally acceptable balance between costs and adequacy of coverage. Specifically, state mandated benefits should be limited to a package of basic coverage for acute care, mental health services, and protection against catastrophic illness costs.

5) Repeal of state laws banning limitations of patient freedom of doctor or hospital choice

Competition will not produce its desired effects unless suppliers (doctors and hospitals) have a reasonable expectation of increasing market share if they offer a lower price or better value for the dollar. If third party payers cannot lawfully direct their beneficiaries to selected providers, then providers reap no benefit from offering discounts, and payers are unable to use their buying power to drive the best possible bargain. With repeal, patients would retain the right to use a provider of their choice, but they would have to pay extra if the provider is not under contract to the payer - an insurance company or self-insuring employer - to deliver specified services for a set price.

6) Gradual conversion of Medicare to a voucher (private health plan) system, and expansion of Medicare demonstration projects to test preferred provider (PPO) options

The voucher concept involves giving Medicare beneficiaries the choice of enrolling in a private health plan of their choice with the federal government paying the plan a fixed amount. Medicare's payment would be equivalent to its average expected per capita cost for all Medicare enrollees in a particular actuarial category. A health plan would be eligible to receive a voucher only if it met stringent federal qualification standards.

The potential advantages of a well designed expanded choice program for Medicare beneficiaries are compelling. First, instead of a single benefits package, Medicare enrollees would have available a variety of benefits plans. Thus, they would be better able to find the health plan that best fits their particular circumstances and preferences. Second, Medicare enrollees would benefit from greater provider flexibility in fitting treatment to each patient's particular medical needs. Questions of whether a service is covered by Medicare would be less likely to get in the way of providing what was necessary. The result should be better quality per dollar spent and greater beneficiary satisfaction.

Some of the advantages of greater Medicare beneficiary choice of providers are already apparent. For example, a recent study of Medicare patients enrolled in health maintenance organizations showed that they are just as satisfied with their medical care as those who choose their own physicians and pay on a fee-for-service basis; and they were more satisfied with claims processing. The study was performed by the Williamson Institute for Health Studies at the Medical College of Virginia, Louis F. Rossiter, Director and principal author, and was funded by the Health Care Financing Administration.

The advantages to taxpayers are also compelling. Medicare outlays would be more predictable. Cost containment and quality monitoring would be simpler, cheaper, and more effective.

Progress toward realizing these advantages requires the following steps:

a) The Secretary of HHS and the Democratic health subcommittee chairmen and ranking Republican members should meet to discuss the development and implementation of major pilot programs to refine the concept. Examples include: preferred provider options (PPOs) for specific services, e.g., coronary artery bypass grafts (CABGs); PPOs for populations with specified high cost disabilities; and PPOs where Medicare contributes a fixed amount to a private employer who assumes full

responsibility for a retiree's health care.

b) A special quality control mechanism for risk contracts should be negotiated, including a more intensive PRO or contracted review and a built-in, ombudsman-type mechanism for hearing and settling subscriber complaints.

c) Much improvement is needed in the Health Care Financing Administration's (HCFA) ability to predict enrollee costs by identifying measurable characteristics which better correlate with expected costs.

d) To assure quality, eligible risk contractors should be restricted to those already approved for federal employees by the FEHBP and those recommended by HHS and approved by the appropriate congressional committees.

e) While risk contracts with employers, insurers, and other corporate entities should be pursued, it should be made clear that the option belongs to individual Medicare beneficiaries. The political support for the PHP option will only surface when Congress realizes that some elderly want this option and that elected politicians should not deprive them of an added option -- the same choice of insurance that most under age 65 Americans enjoy.

f) It is essential that HCFA have the flexibility to alter major pilot programs in response to feedback from beneficiaries and providers. The primary goal is to develop programs that give Medicare beneficiaries the best possible value for the dollar. Consequently, if a choice has to be made between correcting a pricing or benefits design problem and doing nothing in order to assure the scientific integrity of a comparison of different pilot plans, scientific integrity should be sacrificed, and HCFA, within guidelines set by Congress, should be free to make necessary adjustments.

g) The pilot programs should be national in scope. Three approaches deserve an especially careful look.

First, Medicare could offer the PHP option to all new Medicare eligibles at the beginning of each fiscal year. This is the group most likely to select a private option and most knowledgeable about insurance options since most have current work force coverage.

Second, all present Medicare enrollees could be given the chance to enroll in a federally qualified private health plan of their choice. Specifically, Medicare enrollees could be given the choice of enrolling in health plans made available to federal employees by the federal government under the Federal Employees Health Benefits Program

(FEHBP). Each of these plans would have to meet detailed federal standards before they could be offered to employees. Through this option, the federal government could use its expertise and control over access to a very large market to assure that Medicare patients, regardless of their choices, were choosing a plan that at minimum met standards established by experts responsible for assuring that Medicare beneficiaries receive the best possible coverage per dollar available.

Third, as proposed by Harvard economist Joseph Newhouse³, Medicare could pay a federally approved health plan a blend of capitation with fee-for-service. For example, a plan might receive for each enrollee an amount equal to one-half of the average annual expected per capita cost for enrollees in a particular actuarial category with the remaining half paid on the basis of fee-for-service. The right capitation/fee-for-service mix, e.g., 50-50, 30-70, 70-30, would have to be established empirically; it could be abandoned gradually as Medicare became more adept at setting prices so that doctors and hospitals neither won nor lost by clever selection of healthier patients. An interim blended approach would split the financial risk between providers and government rather than putting it entirely on one or the other.

³Newhouse, Joseph P., "Rate Adjusters for Medicare under Capitation," Health Care Financing Review, 1986 Annual Supplement, U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, Baltimore, Maryland, December 1986, pp. 45-55.

In brief, there are available today Medicare beneficiary choice options that are well enough thought through to try on a big scale basis.

Like any health care payment system, the private health plan option will require tradeoffs and the working out of significant problems before it can live up to its potential. The major problem is to develop a pricing system which minimizes insurer incentives to make themselves attractive to healthy Medicare beneficiaries but to shun those who are sick and therefore high cost. This so-called "selection" problem where health plans encourage only the healthy to select them is difficult but by no means insurmountable. Researchers have already identified a bevy of remedial measures such as: experience rating (Medicare capitation rates set on the basis of the experience with enrollees with similar characteristics), HCFA quality monitoring, standardized minimum benefits packages to minimize screening out high cost enrollees through benefit plan design, e.g., limiting drug coverage to exclude chronic patients, etc.⁴

Research is currently underway to overcome the various technical problems but the pace of work is much too slow and the scope of effort much too small. At the current rate and level of

⁴Enthoven, Alain C., "Managed Competition in Health Care and the Unfinished Agenda," Health Care Financing Review, 1986 Annual Supplement, U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, Baltimore, Maryland, December 1986, pp. 105-119.

capitation testing, the beneficiary choice idea will die before it gets a full and fair hearing in the court of public opinion. We believe each of the reservations about PHPO can be addressed in national pilot projects drafted with bi-partisan support with strong safeguards. But, nothing less than a high priority, big scale, high visibility series of demonstrations will create the necessary information to develop a high value added program. Like successful businesses, there should be less theorizing and more of a "try it, fix it, try it again" mentality.

One of the major reasons this has not already happened is that proponents of the idea have done a poor job of marketing the concept to the elderly. The beneficiaries and those soon to become beneficiaries should be leading the fight for the PHP option, but they have to be convinced that it is not another budget cutting scheme designed by government officials obsessed with the notion we can deliver care to more elderly for less money. The elderly also need to have clear answers to questions about quality protection and convenient access to services.

7) Taxation of the actuarial value of the Medicare voucher with an exemption for low income individuals

Under current law, poor people under age 65 are subsidizing wealthy people 65 and over. There is no ethical or pragmatic justification for this state of affairs. Government

re-distribution of income should be from the wealthier to the poorer regardless of age. By including the actuarial value of a voucher in adjusted gross income, the affluent will be contributing proportionately more to the financing of Medicare, and the poor will be largely spared. In effect, taxation of the actuarial value of a Medicare voucher is a simple way of instituting a Medicare means test, but does not bar any individual from being eligible for Medicare benefits.

Even with a means test, the lifetime contributions to the Medicare Part A trust fund made by people becoming eligible for Medicare will not come close to covering the average per enrollee cost of expected benefits. The current ratio of benefits to contributions is 7 to 1.

To avoid double taxation, the actuarial value of the voucher subject to tax would not include the additional benefits provided with passage of the Medicare Catastrophic Protection Act of 1988.

8) Research, development, and dissemination of data for developing medical practice protocols to improve quality and reduce unnecessary services.

All Americans want their physicians to provide care that offers the best chance for the best possible outcome. Unfortunately, for many procedures, little is known as to whether they in fact yield the benefits they are purported to have (i.e., are they effective?), and how their effectiveness compares with that of other procedures. Furthermore, even when some physicians know what works best, that information sometimes is slow to spread throughout the physician community as a whole. Research on effectiveness, development of treatment protocols based on the findings from effectiveness research, and dissemination of this information are essential both to advance the state of the art of medical care and to improve the performance of the average physician.

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9) Study of the desirability of federal government re-insurance (catastrophic stop loss) for all Americans

Even with universal coverage for specified benefits, some Americans will still face the prospect of financial ruin as the result of heavy, continuing costs for uncovered services, especially nursing home care. To protect all Americans from financial devastation, there may be merit to a federal re-insurance (catastrophic stop loss) program. The basic concept is that once a certain percent of income had been paid out-of-pocket for uncovered services, the federal government would pay a reasonable amount for subsequent needed services. Since there is an inherent conflict between the goal of cost containment and the socialization of payment for an individual's health care (the cost is spread throughout society rather than borne by the patient or his family), the stop loss program would have to be designed very carefully.

10) Federal malpractice reform

Fear of being the defendant in a malpractice suit encourages physicians to practice defensive medicine which translates into aggressive use of diagnostic tests and procedures even if the extra cost far exceeds potential extra medical insight except in a vanishingly small percent of cases. Furthermore, when malpractice is found to have occurred, the plaintiff attorneys often reap disproportionate rewards, and the plaintiffs themselves have to endure years of delay and uncertainty as to what if any compensation they will receive.

Many reforms have been proposed and there has been considerable experimentation in the states. The federal government should examine the evidence as to what works and incorporate effective measures into federal legislation. Key criteria for including various reform measures are fair, swift compensation to people who have been injured as the result of health care, minimization of legal and administrative costs, and greater physician understanding as to what constitutes appropriate care.

Healthcare Equity Action League

The following document is entitled "Solving the Health Care Crisis: Statement of Basic Principles," and was published by the Healthcare Equity Action League (HEAL). It is reprinted here with their permission. For further information, contact HEAL, 1725 K Street, NW, Suite 710, Washington, D.C. 20006, (202) 872-0885.

SOLVING THE HEALTH CARE CRISIS: STATEMENT OF BASIC PRINCIPLES

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

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

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

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

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

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

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

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

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

Health Insurance Association of America

The following document is entitled "Health Care Financing For All Americans: A Blueprint for a Stronger Health Care Financing System," and was published in June 1992 by the Health Insurance Association of America (HIAA). It is reprinted here with their permission. For further information, contact HIAA, 1025 Connecticut Ave., NW, Washington, D.C. 20036-3998, (202) 223-7780.

HEALTH CARE FINANCING FOR ALL AMERICANS

A Blueprint for a Stronger Health Care Financing System

Eighty-seven percent of all Americans are covered by health insurance. We now must close the gap—provide coverage for the 13 percent who are uninsured—and assure those already covered that they will not lose their access to health care because of job loss or other events.

To accomplish this, the same public-private partnership that brought health insurance to the vast majority of Americans must move in new directions. Providing health care access to all Americans will require the combined efforts of the health insurance industry and state and federal governments.

THE HEALTH INSURANCE INDUSTRY MUST:

Make insurance coverage available to small businesses.

Industry-backed legislation, already approved in some states, would make insurance available to all working Americans, through:

- Guaranteed availability and renewability. Reforms would require a broad range of insurance carriers in each state to accept all small-employer applicants, guaranteeing insurance to small businesses. No employee could be excluded due to high risk, and coverage could not be cancelled because an employee's health deteriorates.
- Continuity of coverage. When small employers change insurance carriers or workers change jobs, workers would not face new restrictions based on preexisting conditions.
- Premium pricing limits. A carrier's premiums could not vary widely among similar groups. There also would be a limit on how much carriers could raise the rates of an employer group beyond the basic increases for all small-employer groups.

Continue to expand managed care programs. Already covering more than one in three Americans, HMOs, PPOs, and other managed care options are delivering health care of a high quality while helping to restrain the spiraling costs of medical care.

Cut administrative costs. "Paperless claims" and other streamlining initiatives will cut the overhead involved in claims processing and help create a "user-friendly" system.

STATE GOVERNMENTS MUST:

Help high-risk people get private insurance coverage. Two major steps proposed by HIAA are:

- Establish not-for-profit reinsurance organizations. These entities would help private insurers issue coverage to high-risk individuals in small-employer groups by spreading losses more broadly.
- Create more state risk pools to cover medically uninsurable people who are not part of an employer group. More than half of the states already have established these pools.

Repeal state mandated benefits that push up insurance costs. State laws that mandate specific benefits hinder insurers' abilities to offer more basic and affordable benefit plans to small employers.

Reject and repeal obstacles to managed care programs. These obstacles include requiring utilization review entities to be domiciled in the state and mandating the use of numerous medical specialists to perform the reviews. Requirements that force insurers to accept any provider into the network regardless of the provider's ability to provide cost-effective care that meets basic criteria should be eliminated.

THE FEDERAL GOVERNMENT MUST:

Expand Medicaid to cover all those below the federal poverty level. Extend to all states the Medicaid "spend-down" program, which makes Medicaid available to persons whose health care expenses bring their income down to the eligibility threshold, so that no one is impoverished by medical expenses.

Give needed help to the "near poor" by providing tax subsidies to low-income individuals and families, and by allowing low-income families above the poverty level to "buy into" an income-related package of primary and preventive care services.

Give tax relief to small businesses by extending to the self-employed the 100 percent tax deduction for health insurance premiums that already is available to larger businesses.

Assure coverage to the medically uninsurable by establishing a national risk pool for uninsurable individuals in any state that fails to do so, administered by the Secretary of Health and Human Services.

Promote the growth of managed care by exempting such programs from state impediments to managed care.

6/19/92

Health Security Action Council

The following information is reprinted from a pamphlet entitled "The Health Security Partnership: An Equitable and Universal National Health Plan—Where Reform Meets Reality," which was published by The Health Security Action Council (HSAC). It is reprinted here with their permission. To obtain a copy of the pamphlet, or for further information, contact HSAC, 1757 N Street, NW, Washington, D.C. 20036, (202) 223-9685.

The Health Security Partnership is a national health care program with strong cost containment developed by the Committee for National Health Insurance (CNHI) over the past four years. It is a true federal/state partnership to provide universal access to quality, affordable health care. CNHI represents major business, labor, education, professional, senior citizen, and youth organizations. The principal features of the program are listed below.

1. Universal eligibility would be assured by individual enrollment in the program, either through his/her employer's insurer or through the state Health Security Partnership program.

2. Core benefits required of every qualified plan would include all medically necessary services, excluding routine dental and vision procedures. Mental health care would be included on a limited basis at the outset, and longterm care would be phased in. Consumer choice of health care providers would be guaranteed.

3. Cost containment would be effected by requiring all health care providers to negotiate advance budgets with the state. Payments to physicians would be made under the relative value schedule, negotiated on a state by state basis every two years. Drug manufacturers could not charge more than prebudgeted amounts. The flow of funds would be controlled by a single state organization. Providers could not charge patients more than preapproved fees. Managed care plans would be encouraged. There would be continuous monitoring of treatment effectiveness. States would certify insurers under standards of cost, efficiency, and quality of service. State guidelines would apply to length of hospital stay, preadmission testing, laboratory, X-ray, and other services. Administration and claims procedures would be simplified.

4. The role of private insurance would continue as at present, but under federal/state standards that would require community rather than small group rating, prevent duplicative insurance offerings, and provide opportunities for insurers to offer supplemental medical programs.

5. Quality protection would be assured by monitoring conducted by federal and state advisory commissions with representation of insurers, providers, and consumers, which would evaluate treatment effectiveness and appropriateness, assess new technological approaches, and make recommendations to the federal and state governments. Enforceable consumer grievance procedures would be guaranteed.

6. Restructuring health care delivery, an evolutionary process, would evolve through new federal/state incentives for better, more efficient services and use of more effective clinical procedures.

7. Longterm care would be phased in under a new federal/state subsidy program, starting with eligibility for those currently qualified for Medicare. Benefits would be financed by a trust fund with new federal revenues, under a matching formula.

8. Funding would come from federal and state government sources, private insurance, the Medicare trust funds, and consumer payments. An estimated \$35 billion would be required annually during the initial phases of the program, but long-run savings through advance budgeting and other cost controls would soon begin to offset new costs.

9. A National Resources Development Fund would provide for new services and resources, for encouraging states to try different ways of delivering care, and to help medically underdeveloped areas to improve access to quality care.

COST CONTAINMENT FEATURES OF THE HEALTH SECURITY PARTNERSHIP

The U.S. Bureau of the Census reports that almost 63 million Americans – some 28 percent of the entire population – were without health service protection during a recent 24 month period. About two-thirds of this group had no protection at all for at least seven months. And three-quarters of the group were in families of workers employed during the period studied.

The magnitude of this problem is due in large part to sharply escalating costs of health services and health insurance coverage. In fact, for the past fifteen years, the cost of health care in America has by far surpassed the general rate of inflation.

This is due to several factors, including administrative costs of health insurance claims processing, cost-shifting from the medically indigent to those able to pay, and the absence of any meaningful governmental restraint on pricing of services, equipment, and pharmaceuticals. Notwithstanding the fact that American health care at its best is probably the best in the world, health care in America is – in effect – rationed according to the ability of patients to pay for care. Cost-shifting adds to the rationing phenomenon because there are limits to the availability of uncompensated care; many public facilities have been forced to close as a result of this, and increasing numbers of hospitals are in financial difficulty.

The Health Security Partnership, as proposed by the Committee for National Health Insurance, is designed as an equitable, pragmatic, and politically acceptable way of resolving the health care cost dilemma. Following are the major cost constraint features of this comprehensive program.

Consolidation of Existing Programs

The Health Security Partnership would be established as a single medical care system. Medicaid would be integrated into the program and Medicare would be incorporated into the unified plan over a period of time.

Initially, most states could provide basic protection through mandatory employment-based insurance. Part time employees and persons outside the labor force would participate in a program of state-supplied coverage. Subsidies to small business would be available in cases where provision of coverage is burdensome.

Administrative Savings

The program would be administered under a joint national/state partnership with national standards and state patterns of organization for delivery of services. The experience of health services in other countries with national plans indicates the potential for enormous savings in administration, as a result of regional operation.

Insurers who wish to participate in the national/state program would be required to base all payments on community ratings (instead of the current experience rating system). They would also be required to make all payments on a capitation basis. Prepaid group practice plans would make separate contracts with the state administrative agency.

Budgeting in Advance

A major cost inflator in health care has been the unpredictability of rate increases for services, followed by steep rises in insurance premiums. The Health Security Partnership would require biennial state and national budgets approved in advance. Special Congressional action would be required for

any increases in federal support beyond growth of the national economy. It is estimated that this would immediately cut in half the annual increases in the costs of physicians' services.

Here is how budgeting would deal with three major health care cost inflators.

1. Payments to hospitals and nursing homes would be negotiated on a prospective basis as part of the state biennial health care budget process. Advance budgeting for hospitals would remove much of the problem of uncompensated care, which accounts for approximately \$10 billion in unpaid (and/or cost-shifted) hospital bills.

2. Payments for increasingly expensive prescription drugs would be constrained under a new method. Manufacturers would be allowed to charge state agencies only 85 percent of current drug prices, indexed annually to general inflation rates. In any case, the state could be charged no more than the lowest amount paid by any purchaser within the state. The program would also require the use of generic drugs, approved for equivalency by the Food and Drug Administration.

3. Payments to physicians would also be negotiated biennially between representatives of the doctors and the state agency. Instead of paying doctors in private practice on a fee-for-service basis, a new relative value fee schedule, approved for Medicare for 1992, would be used and applied on a statewide basis.

A Single Payer System

The Health Security Partnership would achieve additional savings by being a single payer (i.e., buyer) program. Although the interrelationships of the state agency and insurance carriers would be necessarily complex, the experience of states like Maryland and New York provides clear evidence that major economies in cost of

administration -- including elimination of waste and duplication -- can be achieved. The planned budget approach underlying this method reflects an important new concept: that the single buyer is concerned not only with paying the bill, but that the medical intervention had merit and was justified.

Restructuring of Health Care Delivery

The program will begin reorganizing and restructuring the delivery of health care. Organization and control of the flow of funds is expected to provide incentives to organize services more efficiently, reduce waste, and encourage more effective application of new knowledge and technology in medical practice.

Key to the reorganization and restructuring process will be consumer participation in national and state policy development, particularly in the area of grievance procedures. Through information broadly circulated, consumers would come to know and understand these procedures as they are needed. They will become a part of program accountability.

Financing

The restructuring of health care delivery, as enhanced by prospective budgeting and program accountability, will involve a new financing mechanism. The Health Security Partnership would be funded one-third from the national sector, one-third from the states, and one-third from the insurance industry, patient payments, and the like. Cost estimates by independent actuaries and consultants indicate a substantial reduction in the rate of increases in the first year of the plan, with greater savings likely as the program is developed and refined.

Healthcare Financial Management Association

The following document is entitled "HFMA Healthcare Reform Framework," and was published by the Healthcare Financial Management Association (HFMA). It is reprinted here with their permission. For further information, contact HFMA, 1050 17th Street, N.W., Suite 700, Washington, D.C. 20036, (202) 296-2920.

HFMA HEALTHCARE REFORM FRAMEWORK

Purpose of framework

The Healthcare Financial Management Association (HFMA) recognizes that reform of the nation's healthcare system will be a major topic of debate across the nation in 1992 and in future years. Healthcare financial managers can make an important contribution to the debate because of their understanding of the healthcare delivery system and their expertise on financial issues, a central issue in the current debate.

To enable HFMA to evaluate the many healthcare reform proposals that are being introduced, and to provide helpful information and analysis to legislators and other policymakers, HFMA's Chairman's Task Force on Healthcare Reform has identified the following nine elements that should be included in whichever healthcare reform plan ultimately is enacted.

Any healthcare reform proposal that is enacted into law should:

1. **Balance benefits with resources available:** The reform plan's covered benefits must be balanced against the resources that society is willing to allocate to health care. The benefit structure should be flexible to allow for changes in economic conditions that may increase or decrease available resources. The benefit package should place a major emphasis on preventive/primary care.
2. **Provide universal access to a defined set of basic services:** The reform plan should provide access to basic services for all legal residents of the U.S. This access should not be contingent on employment with a specific company.
3. **Provide consistent, appropriate incentives to all parties:** The reform plan should provide incentives for healthy behavior, and effective use of needed healthcare services. The plan should provide incentives for the following groups:
 - a. **Consumers:**
 - o Consumers should participate in the selection of and payment for healthcare services.
 - o Consumers should be held accountable for the results of their lifestyle decisions.

- o Consumers should have the right to decline life-sustaining services in terminal care situations and to die with dignity.
- b. Providers:
 - o All providers of care should receive consistent incentives to provide efficient and effective care within a continuum of care.
 - o Risk- and reward-sharing among providers should be encouraged.
 - o Cooperation among providers should be encouraged.
- c. Payers/Employers/Government:
 - o Payers should pay adequate rates, thus eliminating the need to shift payment shortfalls from one group to another.
 - o The plan should reduce healthcare system costs by providing for coordination of payments and benefits.
 - o The plan should reduce redundancy, administrative duplication, and paper flow.
 - o The plan should increase the predictability and stability of healthcare costs.
- 4. **Provide fair payment for services rendered:** The reform plan should provide fair payment to providers who furnish efficient and appropriate services to patients. Fair payment is defined as meeting providers' full financial requirements (including replacement reserves and uncompensated care) with annual increases that are predictable, determined through a consistent method, tied to real cost increases, adjusted for demographic, economic, and appropriate technological changes, and not artificially capped due to budget constraints.
- 5. **Reduce administrative burden and clearly define roles for both the public and private sectors:** The reform plan should seek to minimize administrative burden. The plan should encourage the use of

electronic data interface (EDI), uniformity of billing forms and procedures, electronic medical records, and the use of sampling instead of data collection from the universe of providers. To reduce overall administrative costs and provide greater coordination, the plan should balance and clearly define the appropriate roles of the private sector and government at all levels.

6. **Encourage development and use of appropriate technology, medical research, and medical education:** The plan should have the flexibility to incorporate access to technologies that are demonstrated to be effective. The plan should define how new technologies will be evaluated and included in the benefit package. The plan should encourage research to ensure progress in the treatment of illness and disease and should provide for medical education of healthcare professionals.
7. **Define appropriate, cost effective care:** The plan should define appropriate, cost effective care and specify how that definition will be enforced and how it will be revised in light of changing conditions. Tools that may be used to identify appropriate, cost effective care include the use of practice parameters, protocols, geographic standards, or benchmarks for medical procedures. The definition also should identify appropriate conditions for care at various treatment levels or sites.
8. **Reduce legal and regulatory obstacles to achieve cost reductions and/or improved care:** Areas that should be addressed include:
 - o Reform of Medicaid funding, eligibility, and payment systems.
 - o Reform of antitrust and antifraud and abuse regulations that prevent consumers, payers, or providers from cooperative efforts that increase access to high quality, cost effective care within communities.
 - o Reform of tort laws to discourage frivolous suits and excessive settlements.
 - o Reform of state insurance laws that mandate benefits or prohibit appropriate networks of insurers and risk-pooling.

- o Reform of licensure laws for health professionals that inappropriately restrict the provision of services to certain credentialed specialties.
9. Provide an appropriate transition period: The reform plan should include a detailed implementation schedule, allowing sufficient time and funding for consumers, payers, employers, and providers to convert to the new healthcare system.

Healthcare Leadership Council

The following document, "The American Acute Care Health System, Its Chief Problems, With Proposed Solutions," was issued on January 15, 1991, by the Healthcare Leadership Council (HLC). It is reprinted here with their permission. For further information, contact HLC, 1500 K Street, NW, Suite 360, Washington, D.C. 20005, (202) 347-5731.

The American Acute Care Health System, Its Chief Problems, With Proposed Solutions

January 15, 1991

The United States has a superb acute care system for the 87 percent of the population covered by health care plans.

- There are no waiting lists.
- We have the best trained health care providers in the world.
- We lead the world in the research, development, and diffusion of medical technology.
- Every large American city has a hospital equal to the best in the world outside America.

These strengths must be nurtured and protected from those who would suggest that a centrally planned and operated system, like the U.S. Post Office or the East European economies, is preferable to our pluralistic, consumer-driven market economy.

The quality of our system is high for those fully covered by a health care plan. But there are problems of access for the uncovered, and of affordability for both the covered and uncovered. These problems were created in large part by well-intended public policy choices and economic incentives.

These problems are highly interrelated and lie in the broad areas of access and affordability. The U.S. public policy goal should be to seek the best mechanism for balancing quality, access, and affordability.

Access

In 1991, 31 million people are not covered by health care plans.

- (1) An estimated ten to 12 million of those uncovered fall below the poverty line but are not covered by Medicaid.

Solution - Standardize eligibility for Medicaid at the federal poverty level and establish a minimum basic benefit and payment plan.

Funds to finance this modest humanitarian expansion should come from specific taxes. Members of the Healthcare Leadership Council will support such financing.

- (2) An estimated 14 to 16 million of those uncovered are employed or members of employed households.

Solutions -

- a. Level the playing field by extending the exemption from costly state mandates to small employers. It is estimated this would reduce coverage costs significantly.
 - b. Assure the availability and affordability of coverage for individuals and small employers by enacting appropriate market reforms and providing income-related subsidies for individuals near the federal poverty line and for small employers.
 - c. Encourage employer-provided coverage for all employees on a voluntary basis. However, this issue should be re-examined after a reasonable period of time if voluntary efforts are ineffective.
- (3) An estimated two to three million of those uncovered have medical conditions that make coverage too expensive.

Solution - Twenty-six states now have uninsurable risk pools, some with a state subsidy. The remaining states should create similar pools.

Affordability

- (1) Encourage consumer participation in health care costs and choices by:
- a. encouraging enrollment in cost-effective health care plans;
 - b. encouraging appropriate cost sharing;
 - c. expanding employee participation in premium costs;
 - d. instituting lifestyle incentives/penalties; and
 - e. developing useful information, including clinical outcomes research, for use by consumers and providers in making health care decisions.

- (2) Reverse or override legislation that inhibits innovation, creativity, or affordability of medical plan offerings, such as:
 - a. state-mandated benefits;
 - b. restrictions on selective contracting with providers;
 - c. certificate of need requirements; and
 - d. restrictions on appropriate utilization review procedures.
- (3) Enact medical malpractice tort reform measures.
- (4) Encourage the use in both public and private sectors of innovative managed care health programs, which have proven successful in slowing the rate of cost increases.
- (5) Encourage equitable reimbursement in all government-sponsored programs, to avoid cost-shifting.

Summary

The most important task for the American health care industry is to preserve the essence of our remarkably effective pluralistic health care system.

Centrally planned economic and health care systems throughout the world are crumbling. It is foolish to believe that a centrally planned quick fix is available for the American health care system.

Rather, the U.S. policy goal should be to summon the political will to reverse policy choices, economic incentives, and legislation which have contributed to our present problems of access and affordability.

The Heritage Foundation

The following article is entitled "A Tax Reform Strategy to Deal With the Uninsured," and was written by Dr. Stuart Butler of The Heritage Foundation. It appeared at pages 2541-2544 of the May 15, 1991 issue (Vol. 265, No. 19) of the Journal of the American Medical Association. It is reprinted here with both Heritage Foundation and AMA permission. For further information, contact The Heritage Foundation, 214 Massachusetts Ave., NE, Washington, D.C. 20002, (202) 546-4400.

Stuart M. Butler, PhD

The high level of uninsurance in the United States is due in large measure to the tax treatment of health care, which is based on the tax exclusion for company-provided plans. Correcting the perverse incentives for providers and patients resulting from this tax treatment is the crucial step to creating a national health care system that is affordable and efficient. The Heritage Foundation proposal calls for the elimination of the current tax exclusion and its replacement with a system of refundable tax credits for the purchase of health insurance and medical services.

(JAMA 1991;265:2541-2544)

ALMOST 90% of Americans say that fundamental changes are needed in the nation's health care system. Dissatisfaction centers on the shortcomings of health insurance.¹ One of the most pronounced deficiencies of this system, of course, is that as many as 37 million Americans lack health insurance.

Policymakers tend to assume that the only way to correct the problem is to construct a national health care system in which tighter regulation is used both to control providers and to constrain the appetites of consumers. Whether such policymakers favor a government-run Canadian-style system, or one requiring employers to provide universal access to health insurance, the assumption is that normal consumer choice within free and open markets can have no major role. This assumption is erroneous. Policymakers should recognize that the deficiencies in today's US health care system are due in large part to powerful and perverse incentives resulting from the current tax treatment of health care. By correcting those incentives it would be possible to construct a system based on consumer-driven markets, in which the problem of uninsurance is solved and resources are used more efficiently with little or no increase in government expenditures.

HOW THE TAX SYSTEM LEADS TO UNINSURANCE

The vast majority of American families receive medical insurance through their employer. The tax code strongly encourages such employer-provided

coverage as a fringe benefit because such plans are excludable without limit from the employee's taxable income. While limited tax relief is also available to the self-employed and those incurring unusually heavy medical costs, for most Americans the company plan is the only way of receiving a tax break for medical costs.

The tax exclusion for company-based plans undoubtedly has encouraged the spread of health insurance and eased the financial worries of millions of families. But it is also a major cause of uninsurance and rapidly escalating health costs. There are three reasons for this:

1. *Inequity in tax assistance.*—A tax exclusion provides the employee with tax relief from all taxes (including payroll tax) at his or her marginal tax bracket. Thus, the tax benefit is highest for employees in the highest bracket with the most expensive health plans. A highly paid executive can easily receive a tax subsidy worth over 40% of the cost of a generous package, when state and local tax relief is considered. Meanwhile, an employee in the same firm, with children, making \$10 000, may be below the tax threshold and receive no income tax break at all. Worse still is the individual who has no company plan, or a plan not covering his or her family. This person normally must pay in after-tax dollars for his or her family's insurance or out-of-pocket medical expenses.

Thus, the tax code gives virtually no help to Americans at the bottom of the income ladder who are not covered by company plans, while it can mean thousands of dollars in tax subsidies for higher-paid individuals. It is little wonder that approximately three quarters of

the uninsured (those lacking private insurance or eligibility for public programs) are workers or the dependents of workers, concentrated heavily among lower-paid employees.² Moreover, a company-provided plan does not have to contain any specific features, such as preventive medical care, family coverage, or catastrophic protection, to be eligible for the tax exclusion. So it is not unusual to find workers with a very expensive plan paying for all routine dental care, and yet lacking catastrophic protection.

2. *Job mobility disincentives.*—A job change of any kind, whether voluntary or forced, usually requires a family to change its insurer because coverage is employer-based. This often means waiting periods and preexisting condition clauses in the new plan, and possibly some change in benefits that the family would not have freely chosen. For families with severe health problems this can mean that moving to a better job is impossible, and a layoff can be a disaster.

3. *Inflationary pressure.*—With health care largely paid for by the employer (completely so in the case of first dollar coverage, which covers all costs), an employee has little or no incentive to be economical when seeking services. If the employee does try to economize, it is the employer who normally will gain the vast bulk of the savings (assuming the annual deductible has been exceeded). Knowing that the patient has little incentive to economize, physicians and hospitals also have little incentive to hold down costs. Providing the perceived value of a service is greater than the copayment—if any—faced by the patient, the patient will have no cause to challenge the price charged the insurer and ultimately the employer.

This lack of concern for price is, of course, a recipe for inflation. This in turn adds to the number and plight of the uninsured. Rising costs force more companies to reduce coverage or drop dependents from plans. The annual survey of corporate health insurance conducted by the New York City benefits

From The Heritage Foundation, Washington, DC.
Reprint requests to The Heritage Foundation, 214
Massachusetts Ave NE, Washington, DC 20002 (Dr
Butler).

consulting firm of A. Foster Higgins & Co, for instance, found employees facing an average increase of \$20 per month in 1990 for their share of family health plan costs, and more firms encouraging employees to accept restrictions on their choices of medical care (*Wall Street Journal*, January 29, 1991:B1). Higher insurance rates cause more families without company plans to forgo insurance while facing higher out-of-pocket costs.

HOW A MARKET-BASED NATIONAL HEALTH CARE SYSTEM WOULD WORK

Proposals that would mandate employers to provide insurance for employees and their families or pay a payroll tax for public insurance (so-called play-or-pay proposals) simply would force all employers into today's flawed system. The result would be higher labor costs and fewer employment opportunities for workers whose low skills and whose insurance or health payroll tax costs would be high compared with their output. In addition, if employers were prohibited from reducing benefits or coverage, they would resort to even tighter controls over the most basic health care decisions of American families. A Canadian-style system similarly would use regulation rather than markets to determine access and to allocate resources. As we now see in the Canadian system, just as with its forerunner the British National Health Service, removing market prices as the primary regulator of demand leads to chronic overdemand when compared with supply and to waiting lines and shortages.¹⁴

The alternative to such systems based on curbing consumer choice and expanding regulation, which implicitly remove consumer-driven markets from health care, is to address the perverse incentives that lead to today's shortcomings, and to construct a system based on an active consumer-driven market. Such a system has been developed by The Heritage Foundation.⁵

The Heritage Foundation proposal is based on a reform of the tax treatment of health care, designed to achieve two goals. First, by changing the structure of existing tax relief, it would provide more help to the uninsured to obtain health care and insurance, and less to those who do not need generous tax subsidies. The available pool of forgone tax revenues at the federal level alone is estimated by the Congressional Budget Office to be worth \$48 billion in 1991.⁶ Second, the new structure of tax relief would provide stronger incentives for consumers to challenge provider costs and to seek the best insurance value for

their money.

The Heritage Foundation proposal calls for two principal steps:

1. *Replace today's tax exclusion with a new system of refundable tax credits for health expenses.*—The current tax exclusion for company-provided health benefits would be phased out over several years. Any health package received by a worker would be included as taxable income on the employee's W2 tax form. If a company were to discontinue or scale back its health plan, it would have to add the cash value of the reduced benefits to employee paychecks. Over the same period, however, a new system of tax credits in the personal tax code would be introduced for family health care costs (out-of-pocket costs, insurance premiums, and prepaid plans). These credits would be "above-the-line," meaning they would be available to those who do not itemize deductions on their tax returns. They would also be "refundable." This means that if the total credit exceeded the family's tax liability, the Internal Revenue Service would remit the difference.

The size of the credit (in percentage terms) would depend on the family's total annual health care spending compared with its income; the higher that ratio, the higher the percentage credit. Thus, a typical family incurring insurance and direct medical costs (including any employer-paid benefits) equal to 10% of its annual income, might be eligible for a 20% credit. If that same family faced unusually high costs, eg, 30% of income, the credit might rise to 50%. Higher costs would mean a still larger percentage credit, such that the actual costs to the family, net of the tax credit, would be manageable. Similarly, if the family's annual costs were low compared with its income, the percentage credit would be lower than 20%, and perhaps phased out entirely above a certain income. The credit would be designed to ensure that these net costs would not normally exceed 10% of family income. By comparison, the most comprehensive analysis of family health expenditures currently available, based on the National Medical Care Expenditure Survey of 1977, showed that out-of-pocket premium and direct service expenses averaged 10.1% of family income for families earning less than \$12,000 per annum, falling to 2.5% for families earning more than \$20,000.⁷

2. *Establish a "Health Care Social Contract."*—Under this "social contract," each head of household would be required, by law, to enroll all family members in a health plan containing at least a federally prescribed basic package of features. These would include

catastrophic stop-loss insurance (which limits out-of-pocket costs to a fixed dollar amount), hospital and physician coverage for all family members, and routine preventive care. The out-of-pocket deductible and copayment in the health plan could not normally exceed 10% of adjusted gross income. Health plans would be required to offer a series of premiums, based on different out-of-pocket costs, and consumers would be required to choose a plan meeting at least the 10% requirements. While this would mean lower-income families typically would face higher premiums, reflecting the out-of-pocket limit, this in turn would be offset by the larger tax credit available to them.

The federal government would in turn guarantee to make it financially possible for each household to discharge this legal responsibility in one of the following two ways: through the system of refundable tax credits or by granting access to Medicaid or Medicare. Thus under The Heritage Foundation proposal, all Americans would have at least a basic package of medical care, paid for by themselves or by the federal government.

This two-pronged market strategy would have significant effects on the American health care system. First, it would guarantee basic health coverage to all Americans, irrespective of their place of employment—or whether they were employed at all.

Second, government help to offset medical costs would be based on medical expenses as a proportion of income, not on the family's marginal tax rate. Thus a part-time employee of Joe's Bar and Grill would be eligible for exactly the same structure of tax help as a senior executive with Megacorp Inc, but the part-time employee—or the chronically sick individual—would receive more cash help by virtue of his or her income and likely medical expenses.

Third, the credit system would introduce a powerful tool to curb rising health care costs, since families would have a strong incentive to seek the best value for their money in their health care decisions and to avoid overutilization. One reason for this is that the individual purchaser of insurance or services would keep any savings (net of the credit) gained through prudent buying, rather than these savings going to the employer. This incentive would be strongest for those eligible for only a small credit (generally the more healthy and affluent buyers), and weakest for those eligible for a large credit. Another reason is that an employee no longer would effectively be locked into the plan provided through the employer. Thus,

the employee could "shop around" for a plan with the necessary services at the best price. That in turn would intensify competition among insurers and service providers. A family might choose more services that their company plan used to offer. Or it might mean fewer extra services, if a healthy employee had been overinsured, leaving the family with extra cash income.

Fourth, the consumer-driven model would drastically reduce the need for expensive administrative regulation by insurers and employers. Most critics of the current US health care system point out, correctly, that it is probably the most bureaucratized and administratively top-heavy of systems.⁴ This did not just "happen." In the rest of the US economy, consumer choices based on real prices spur efficiency and force providers to compete by streamlining overhead costs. But in health care provision, the actual cost of services is largely irrelevant to consumer decisions. Thus, the immediate payers of medical bills—insurers and employers—have been forced to install a system of administrative controls and paperwork in an effort to allocate resources reasonably efficiently in spite of consumer demands. Consumer choice is a far more effective method of regulating prices and encouraging efficiency. It does not require a vast superstructure of resource planners trying to manage consumers. It is the individual decisions of consumers themselves that achieve an efficient system.

Fifth, a tax system allowing Americans to select from a full range of competing plans would end most of the employment mobility problems plaguing today's system (and inherent in employer-mandated proposals) because a family would not change plans merely because the head of the household changed jobs. Moreover, because the employer would not be responsible for providing health coverage under The Heritage Foundation proposal, there would not be an incentive for firms to avoid hiring individuals who would pose high insurance costs—another major drawback of mandated-benefits schemes.

Sixth, reforming the tax code would allow the uninsured to be protected at a far lower cost to the government than other approaches. Indeed, it might well be accomplished without any net increase in the federal deficit. The Congressional Budget Office estimates that if the current tax exclusion for company-based plans were ended and replaced with a flat 20% income tax credit for insurance costs up to \$250 per month for families (\$100 for individuals), the federal government would collect an ad-

Revenue Estimates of Options for Limiting the Tax Exclusion for Company-Based Health Plans and Introducing a Credit in the Personal Code*

	1991	1992	1993	1994	1995
Monthly limit on exclusion†					
\$400 for families/\$160 for individuals					
Total receipts, \$ in billions	1.5	3.1	4.5	6.7	9.6
Affected recipients, %	15	16	19	22	26
\$300 for families/\$120 for individuals					
Total receipts, \$ in billions	5.4	10.1	13.6	18.4	23.6
Affected recipients, %	32	35	39	40	42
Annual refundable credit‡					
\$200 per individual, up to \$600 per household					
Total cost, \$ in billions	-0.4	-6.1	-6.6	-7.3	-7.8
Permanent 25% deduction for self-employed, \$ in billions	-0.2	-0.4	-0.5	-0.5	-0.6

*Estimates assume that contributions to cafeteria plans for health care will be included in the computation of employer contributions. Data from Department of the Treasury, Office of Tax Analysis.

†The monthly exclusion limit and the value of the refundable credit for 1991 and beyond are indexed by the consumer price index for all items.

‡The refundable credit is available to persons who do not have employer-provided insurance or public health insurance.

ditional \$89.4 billion in net additional income and payroll taxes over 5 years.⁴ This means that the basic 20% credit considered by the Congressional Budget Office could be expanded by additional credits in the amount of nearly \$18 billion per year and still remain budget neutral. The US Treasury has analyzed a limited version of a plan similar to The Heritage Foundation proposal. If the monthly exclusion for company-provided plans were capped at \$400 per family (\$160 per individual), the treasury estimates that the extra revenue would, by 1995, finance an annual refundable credit of \$200 per individual (up to \$600 per family) for families lacking company plans. If the monthly cap were placed at \$300 per family (\$120 per individual), the credit would still leave the treasury with a net annual surplus of \$15.8 billion by 1995. This financial cushion would permit more generous credits to needy families and finance the refundable credits envisioned in The Heritage Foundation proposal. A summary of the treasury's estimates is provided in the Table.⁵

Seventh, the tax credit system would reduce Medicaid and welfare costs. Since The Heritage Foundation proposal includes a system of refundable tax credits for lower-income individuals, it would eliminate the current disincentive for many welfare recipients receiving Medicaid to take a job with few or no medical benefits. The Medicaid program would be retained under The Heritage Foundation proposal as an integral part of the welfare system. Subsidized risk pools and similar state-based innovative strategies would also be encouraged as a safety net to deal with unusual situations,⁶ although the number of uninsurable Americans would decline under the proposal (see below).

Eighth, the strong consumer incen-

tives in The Heritage Foundation proposal would reduce pressure for medically unnecessary state mandates on insurers. Such mandates are a significant factor in rising insurance costs. Moreover, according to a statistical study by Goodman and Musgrave,⁷ as many as 9.3 million Americans lack health insurance specifically because of the additional costs due to mandates. With families paying directly for insurance, rather than these costs being "hidden" in company plans, there would be far less voter acceptance of pressure from provider groups to add new services to state mandates. The same political dynamic would help offset providers' lobbying at the federal level to expand the legally required basic package.

There are a number of understandable concerns about such a consumer-driven system based on individual choice of a medical plan, including the following:

1. *Can average Americans really make informed choices about health care?*—The more informed and technically sophisticated a consumer is, the more likely he or she is to make sound decisions regarding a medical plan. But there are two reasons why individuals with little medical knowledge can be confident buyers in the system envisioned under The Heritage Foundation proposal.

The first is that any comprehensive plan would, under federal law, have to include at least the basic set of services. The second reason is that a system based on individual buyers does not in any way rule out the formation of group buyers. Indeed, most individuals probably would join groups, both to gain bargaining power as organized buyers, and to delegate detailed purchasing decisions to an organization they trusted. Such groups would negotiate plans with

providers and insurers on behalf of their members, much as companies do today. The important difference is that consumers would be able to choose a buyer group they really trusted and still obtain tax benefits; today they are effectively restricted to a group organized by their employer.

Various groups can be imagined participating in a system like The Heritage Foundation proposal. A trade union, a professional organization, or a state farm bureau might manage a plan on behalf of its members. Churches, university alumni groups, and school associations also might act as brokers. Other groups might comprise those who suffer from particular ailments, such as diabetics, who would be seeking the most economical plans supplying additional specialized services. The Heritage Foundation proposal, unlike the mandated benefits approach, would make it very easy for these specialized plans to develop.

2. *Wouldn't adverse selection undermine The Heritage Foundation proposal?*—Active consumer choice is considered the key to the workings of other segments of the economy. In the health sector it is usually deemed adverse. The reason for this is that the principal method we use to subsidize working Americans facing high medical costs is equal premiums for company-based group plans. In this way the healthy subsidize the unhealthy. Naturally, a problem immediately arises if healthy consumers are permitted to opt out of the group and choose a lower-cost plan reflecting their better health risk. Hence, elaborate steps are included in managed care proposals to restrict or guide consumer choices.²

The Heritage Foundation proposal avoids this problem by cross-subsidizing through the tax code, rather than through premium setting. Under The Heritage Foundation proposal there would indeed be a tendency for healthy individuals to purchase lower-priced plans, leaving higher-risk individuals to face steeper premiums. But the higher-risk consumers would receive large credits to offset the higher costs, financed by US Treasury savings achieved from lower revenue losses on the leaner plans chosen by healthy individuals. This method of cross-subsidy is not just more precise and consistent, and less expensive to the taxpayer, than the necessarily wide variations in subsidy levels with company groups. It would also reduce the problem of uninsurable individuals. Today such individuals cannot be insured except at rates they or their employer cannot afford. With the sliding scale credit in The Her-

itage Foundation proposal, however, realistic premiums could in many instances be charged and paid.

3. *Would a tax credit system be difficult for the consumer to operate?*—Employees would instruct the payroll department of their employer to adjust their withholding to reflect their anticipated credit. If the employee was eligible for a refundable credit, that credit would be added to the paycheck each pay period. At the end of the year the total credit would be adjusted when the family filed its tax return.

Variants of this basic mechanism would deal with most potential difficulties. If anticipated costs were to rise unexpectedly, the employee could change the number of exemptions claimed (as an individual would do if he or she were to take on a larger mortgage for a home). If the individual became unemployed, or a sudden outlay exceeded the family's immediate ability to pay, despite catastrophic protection, federal regulations could require providers to wait for payment until the appropriate refundable credit was processed by the Internal Revenue Service. In addition, to ensure regular premium payments, a requirement could be placed on larger employers to make a payroll deduction on behalf of their employees and to remit it to the insurance company chosen by the employee, as many firms currently do for 401K savings plans.

The primary tool to assure compliance with the mandate for families would be to require proof of basic insurance to be attached to the annual tax return. Insurance companies or health plans providing the basic comprehensive package would be required to send enrollees a statement indicating the period of coverage (if an employee switched companies, the statement would indicate the change). There would be fines for families failing to include proof of insurance with their tax return. While some families would still evade the requirement, just as some evade taxes, this system would reduce the problem to an acceptable level.

CONCLUSION

A structural change of this kind might seem politically unrealistic, but there are several reasons to believe otherwise. It is certainly less radical than replacing the entire system with a Canadian-style system. It can also be introduced gradually. A specific credit to cover one segment of the uninsured, for instance, could be paid for with a modest cap on the current exclusion. When consumers and insurers had grown accustomed to that change, the credit could be expanded and the cap reduced.

Moreover, the idea of individual tax credits to help certain categories of Americans to purchase medical insurance or services is not new or unique to The Heritage Foundation proposal. The 1991 budget passed by Congress in October 1990, for instance, contains a new program granting a 50% refundable tax credit for low-income families purchasing insurance to cover children not covered under company plans.

Capping or limiting the exclusion of company plans also is not a new idea. It was routinely proposed as a deficit reduction measure during the Reagan administration. It made little headway then because workers saw no advantage in supporting such a measure. Blending a phaseout of the exclusion with a very different political equation, however, since millions of employees would gain from such an exchange, including many workers currently with generous plans. In today's climate of deficit reduction and concern about rising unemployment, a "balanced budget" proposal that does not mean huge new federal outlays or additional payroll costs for business has a distinct attraction.

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The Jackson Hole Group

The following report is entitled "A Proposal For Reform From the Jackson Hole Group: The 21st Century American Health System/Managed Competition," which was published by The Jackson Hole Group. It is reprinted here with their permission. For further information, contact The Jackson Hole Group, P.O. Box 350, Teton Village, WY 83025, (307) 739-1176.

A PROPOSAL FOR REFORM FROM THE JACKSON HOLE GROUP The 21st Century American Health System/Managed Competition

The Jackson Hole Concept:

A competitive health system where health insurance and health care competition is motivated, structured and regulated to reward with the most customers those health organizations who get the best health results at the lowest costs. By inference, those consumers who choose a healthy life style and the most cost-effective health organizations are rewarded with the best health at lower expense. Coverage is universal. Quality is uniformly and objectively measured on the basis of Health Outcomes.

- Most health care service is delivered through Accountable Health Partnerships - AHPs (managed care-like organizations that are publicly accountable for their health outcomes);
- Small employers must purchase coverage from competing Health Insurance Purchasing Cooperatives (HIPC); HIPC arrange for consumers to obtain coverage from competing AHPs;
- Employers are mandated to provide full-time workers with coverage through an AHP or HIPC. Insurance is purchased or a payroll tax is paid for all noncovered employees (e.g., part-timers). No public pool — all coverage through Accountable Health Partnerships (AHPs) and Health Insurance Purchasing Cooperatives (HIPC);
- Three private-sector boards propose standards, and an SEC-like independent, quasi-nongovernmental agency, the National Health Board (NHB), administers them;
- The federal tax exclusion for health benefits is limited to AHP enrollees and capped at the price of the lowest cost AHP in the region.

Specific recommendations on each major component of the proposal are outlined below.

I. Financing and Delivery of Health Benefits

A. Accountable Health Partnerships (AHPs)

Description

- Arrangements for financing and delivery of health care services.
- Established by either a single, vertically integrated organization or an affiliation between a carrier and a provider(s).

- AHP Requirements:

- Provide and finance the full array of Uniform Effective Health Benefits
- Be accountable for the health of beneficiaries, through outcomes management, etc.
- Meet health insurance standards including prohibitions of medical underwriting, waiting periods or exclusions for preexisting conditions.

The combination of uniform benefits and a uniform health accounting system will facilitate consumer choices. The same information system should improve medical decision-making.

B. Health Insurance Purchasing Cooperatives (HIPC's)

Description

- Purchasing agents and health benefits offices for small employers
- Nonprofit entities with boards made up of individuals elected by participating employers
- One per geographic area
- Individuals or small employers (up to 50 workers) required to purchase health coverage through HIPC
- Adverse selection issues addressed through reinsurance or risk adjusters.
- Process:
 - HIPC contracts with registered AHPs in the region
 - Each individual or eligible employee of participating small businesses selects an AHP during HIPC's annual open enrollment period
 - Each AHP offering coverage through the HIPC establishes a single community rate for its enrollment. Carriers can make demographic adjustments to their rates.
 - Employer contributes a specified amount based on the lowest-priced product to each employee's coverage, collects the remainder through payroll deductions and makes premium payments to the HIPC. Only contributions toward the AHP are tax deductible for the individual.

- HIPC distributes premiums to the AHPs; coordinates COBRA, medicaid buy-ins and other required benefits; manages relationships between consumers and AHPs; and makes coverage information available.

HIPCs would reduce competition based on risk and improve consumer information. In addition, HIPCs would increase the size of risk pools, limit opportunistic carrier-switching by enrollees, and provide incentives for more prudent purchasing of coverage by individuals.

C. Uniform Effective Health Benefits

Description

- The basic package of acute care benefits offered by all AHPs (Medicare, Medicaid, and self-insured employer plans)
- Overrides State benefits mandates
- Established and revised on a periodic basis by the Health Standards Board (HealSB) and approved by NHB
- Serves as the baseline for determining the required employer contribution and tax deductibility.

II. Access to Health Benefits

Description

Employed Individuals:

- Employers of all sizes would be required to contribute 50% to 100% of the lowest-priced AHP offered by the local HIPC.
- Employees would be required to accept the coverage offered to them and would be allowed to opt for additional coverage at their own post-tax expense.
- Employers of all sizes would be subject to provide insurance for part-timers or meet payroll deduction requirements. Employers not providing benefits directly would contribute to a payroll tax that would subsidize coverage through the HIPC (purchased from AHPs).

Nonemployed individuals (under 65):

- Non-employed individuals with incomes would be taxed, with proceeds used to cover purchase of insurance through a HIPC (effectively a mandate).
- Public programs could contract with HIPCs for acute care coverage of their beneficiaries.
- Existing arrangements for long-term care coverage would remain in place.

Individuals over age 65:

- Medicare coverage gradually would be shifted into HIPCs and AHPs.

III. Regulation of Health Services and Benefits

A. Public-private partnership and National Health Board

Description

- "SEC model" for implementation and oversight of health reform
- Central federal agency advised by three private sector, standard-setting boards sponsored by insurer, provider, employer and consumer groups
 - National Health Board (NHB) – an independent federal agency charged with overall implementation and oversight (e.g., recommending uniform benefits and tax exclusion amount to the President and Congress, establishing registration requirements for AHPs and HIPCs)
 - Health Standards Board (HealSB) – a private sector board responsible for developing the uniform benefits package and assessing medical technologies, practice effectiveness and consumer concerns
 - Health Insurance Standards Board (HISB) – a private sector board responsible for advising on the implementation of reforms; setting standards for AHPs and HIPCs and working with NAIC to develop model state laws and regulations
 - Outcomes Management Standards Board (OMSB) – a private sector board responsible for establishing and maintaining data systems and uniform outcomes accounting standards.

League of Women Voters of the United States

The following document is the health care position statement of The League of Women Voters of the United States (LWVUS). It is reprinted here with their permission. For further information, contact LWVUS, 1730 M Street, NW, Washington, D.C. 20036, (202) 429-1965.

POSITION STATEMENT OF THE LWVUS

Announced by the national board April 1992

Goals: The League of Women Voters of the United States believes that a minimum basic level of quality health care at an affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology and a reasonable total national expenditure level for health care.

Minimum Basic Level of Quality Care: Every U.S. resident should have access to a minimum basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care and mental health care. Dental, vision and hearing care also are important but lower in priority.

Equity Issues: The League believes that health care services could be more equitably distributed by:

- allocating medical resources to underserved areas,
- providing for training health care professionals in needed fields of care,
- standardizing basic levels of service for publicly funded health care programs,
- requiring insurance plans to use community rating instead of experience rating,
- establishing insurance pools for small businesses and organizations.

Cost Control: The League believes that efficient and economical delivery of care can be enhanced by such cost control methods as:

- the reduction of administrative costs,
- regional planning for the allocation of personnel, facilities and equipment,
- the establishment of maximum levels of public reimbursement to providers,
- malpractice reform,
- the use of managed care,
- utilization reviews of treatment,
- mandatory second opinions before surgery or extensive treatment,
- consumer accountability through deductibles and copayments.

Allocation of Resources to Individuals: The League believes that the ability of a patient to pay for services should not be a consideration in the allocation of health care resources. Limited resources should be allocated based on the following criteria considered together: the urgency of the medical condition, the life expectancy of the patient, the expected outcome of the treatment, the cost of the procedure, the duration of care, the quality of life of the patient after treatment, and the wishes of the patient and the family.

This position is based on Phase 1 of the League's study of the U.S. health care system. Phase 2 of the health care study, which will conclude in April 1993, will address issues of financing and administration.

FOR BACKGROUND PURPOSES ONLYQuestions & Answers about the LWVUS Health Care Position

How is the LWVUS health care position unique?

Unlike most other organizations, the League's position was formulated by directly asking League members what they think about health care delivery in the United States. With 30,000 members participating, the health care position reflects the concerns of thoughtful Americans who have carefully examined the problem and considered the possible solutions. As a result, the League's position is both economically responsible and humane. Difficult financial choices have been made, but with a keen awareness that human lives will be affected.

Does the LWVUS support fundamental reform of the health care system?

Yes. The current system of health care is deeply flawed. Although we are fortunate to have the very best medical technology, millions of Americans are unable to receive even basic care. Moreover, the costs of acquiring health care are skyrocketing. Many American families feel uncertain about their ability to afford adequate health care. The League supports fundamental change that will provide universal access and contain costs.

Does the LWVUS support specific legislation to reform the health care system?

Yes. The League supports provisions of Representative Russo's (HR 1300) and Senator Wellstone's (S 2320) "Single Payer" approach as well as Senator Mitchell's "Play or Pay" approach (S 1227). These provisions meet the League's criteria for fundamental health care reform by providing universal access to a minimum basic level of quality care for all U.S. residents and addressing the problem of high health care costs. The League does not support either President Bush's or Senator Bentsen's intermediate efforts at health care reform because they do not address issues of cost control and universal access to a minimum basic level of care.

The League has not endorsed any currently introduced bill in Congress and will not until 1993 when we have a position on financing mechanisms for health care reform.

What are the most important features of the LWVUS's health care position?

The League supports a health care system that provides universal access to care for all U.S. residents and curtails escalating health care costs.

What does the LWVUS mean by universal access?

All U.S. residents should receive a basic minimum level of quality health care regardless of their ability to pay. This includes primary care, acute care, long-term care and mental health care, the prevention of disease and health promotion and education.

Why is universal access important?

The League believes that access to health care is a basic human need that must be available for all U.S. residents. Moreover, universal access is an important tool in containing health care costs. Under the current system, the cost of uncompensated care for the uninsured is passed along to the insured in the form of higher prices. Providing compensated care to all U.S. residents would reduce this "cost-shifting" and help control health care costs.

Why is long-term care important?

The fastest growing segment of the elderly population is people over age 85. As Americans live longer, the need for long-term care is a reality for every U.S. family. The League supports long-term care as part of a minimum basic level of care for all U.S. residents. The League favors the use of home care over institutionalization as an option for long-term care.

What primary care does the LWVUS think all U.S. residents should receive?

Primary care is the general "wellness" care received by a patient. In particular, the League's definition of primary care includes preventive services, prenatal care, reproductive health care and treatment for chronic illnesses. Noncosmetic dental, vision and hearing care are also included and are especially important for children.

What cost control methods does the LWVUS support to promote the efficient and economical delivery of care?

The League supports methods such as the use of managed care, regional planning for the allocation of resources, utilization review and the reduction of administrative costs.

Why is cost control so important?

U.S. health care costs are spiraling out of control. Families are scared they will be unable to afford the cost of a serious illness. In 1980, the total amount spent on health care per family was \$2,600. This figure grew to \$6,500 in 1991, and if nothing is done to control costs, by the year 2000 it will be \$14,000 per family.

Health care costs are also threatening our economy. Every year, a growing proportion of our gross national product is spent on health care. Health care expenditures for 1992 are projected to account for 13.4 percent of the United States' GNP. Forecasters predict that this number could grow to 16.4 percent by the year 2000 — that's \$1,616 billion spent on health care. Something must be done to address these escalating costs.

What does the LWVUS mean when it calls for "equitable distribution of services?"

The League believes that all U.S. residents should have access to appropriate and quality care regardless of factors such as age, sex, race, socioeconomic status or geographical location. Currently, these factors influence the availability of health care services. The League has identified a number of specific reforms that would promote the equitable distribution of services such as insurance reform, the allocation of resources to underserved areas, training health professionals in needed fields of care and standardizing the level of services in publicly funded health programs.

National Association of Manufacturers

The following information is entitled "Resolution on Health System Reform," and was published by the National Association of Manufacturers (NAM) in October 1991. It is reprinted here with their permission. For further information, contact NAM, 1331 Pennsylvania Ave., NW, Suite 1500-N, Washington, D.C. 20004-1703, (202) 637-3000.

NATIONAL ASSOCIATION OF MANUFACTURERS
RESOLUTION ON HEALTH SYSTEM REFORM
APPROVED BY THE NAM BOARD OF DIRECTORS
OCTOBER 19, 1991

The National Association of Manufacturers supports the development of a national health policy through continuation of a public/private system of health care delivery and financing, but recognizes that major reforms are necessary to address a host of problems including yearly double-digit cost increases; quality deficiencies estimated to add 10 to 30 percent (\$75 -\$200 billion) annually to the cost of health care; a financing/delivery system that rewards providers for quantity rather than quality of services provided; an inefficient medical liability system and related defensive medicine costs; approximately 33 million Americans without health care coverage; and excessive administrative costs.

Cost-shifting resulting from inadequate reimbursement of Medicare and Medicaid providers, and from some firms choosing not to provide coverage for their workers and families, places an unfair financial burden on manufacturing and other industry sectors. It is estimated that cost-shifting adds an additional \$11.5 billion to manufacturers' annual health costs.

While there is widespread agreement on the problems of the U.S. health care system, there is inadequate consensus on a comprehensive solution which is likely to take some time to achieve. In the meantime, there is growing consensus for certain incremental and immediate actions:

- reform of the small group market to assist small employers to obtain health care coverage;
- federal tort reform of the medical liability system;
- practice guidelines and research on outcomes management to improve health care quality and help control costs;
- encouraging the self-employed to purchase health benefits by raising the deductibility to 100 percent and permanently codifying this provision; and
- encouraging effective and efficient health care delivery by eliminating state benefit mandates and reducing state barriers to managed care and group purchasing of health services.

NAM supports these significant reforms and applauds the efforts of Senate and House leaders and key Administration officials who are advocating proposals of this nature. We pledge to work with them on these critical issues because excessive spending on health care impairs U.S. manufacturing competitiveness and erodes our standard of living. Ultimately, we must fashion a system that reduces the high rate of cost increases for American manufacturing and thus preserve our future economic viability and capacity to support other essential national priorities.

BACKGROUND AND PRINCIPLES
APPROVED BY THE NAM BOARD OF DIRECTORS
OCTOBER 19, 1991

Background. The U.S. health care system is financed by a combination of public and private funds with the government assuming 41 percent, business 33 percent and individual payors 26 percent of total annual costs. Government, historically, has been committed to providing health care to the elderly and poor, a commitment which has been seriously eroded in recent years with respect to the poor. At the same time, many businesses provide health benefits coverage to their employees and dependents to encourage a healthy and productive workforce secure from major catastrophic illness expense. Health benefits coverage also acts as a recruiting tool in attracting and retaining workers. The U.S. voluntary health care system is the envy of other nations, producing the latest in technological advances, yet it falls short in certain critical areas.

The United States devotes a much larger proportion of GNP to health expenditures than do other industrialized nations. Government, business and individuals are experiencing great difficulty in sustaining current spending levels, which is reflected in the growing number of persons who are uninsured or medically underserved. Both the government and the business community have reacted to this financial burden by reducing benefits and shifting costs—actions that have exacerbated the problem.

Recent cost increases have forced many employers to give up offering health benefits thereby increasing the number of the uninsured. Some employers are still unable to obtain coverage in the first place, while individuals seeking coverage for themselves and their families face even greater cost and access barriers. Adding to the employer bill for health care is the cost-shifting resulting from inadequate reimbursement of Medicare and Medicaid providers and from some firms, for whatever reason, choosing not to provide coverage for their workers and families. Uncompensated care delivered by hospitals and physicians, estimated at \$12 billion annually, and uncollectible hospital debt are similarly passed on to employers providing coverage.

Quality problems, such as unnecessary and inappropriate care, are estimated by the Rand Corporation to add 10 to 30 percent annually to health costs. Historically, the U.S. health care

system has provided the wrong reimbursement incentives by paying for the quantity rather than the quality of care delivered.

Other concerns—an inefficient medical liability system and related defensive medicine costs, high administrative costs associated with government and private programs, the "hassle" factor impacting the practice of medicine and the patient-physician relationship, and the inadequacies of some health plans requiring enrollees to purchase a second plan to assure sufficient coverage—add to the cost problem.

Excessive spending on health care diverts resources from other societal needs, undermining America's economic strength and competitiveness in the global marketplace and eroding our standard of living. Reform of the health care system must address the fundamental areas of quality, cost and access in a coordinated fashion.

Attempting to solve one problem without attention to the others is likely to perpetuate the inadequacies and inefficiencies of our current system. For example, a cost control strategy must include universal coverage to spread the responsibility more equitably over society as a whole and not disproportionately impact one group over another. Universal coverage is also essential to assure that America's citizens are able to meet tomorrow's physical, intellectual, economic and social challenges.

Re-allocation of funds alone will not solve the problem nor will savings through more appropriate utilization. Additional public funding may be needed to expand access for those without health care coverage, and to assure fair reimbursement and deter cost-shifting to employers. One funding source or a combination of sources may be required. As consensus develops on improving quality, controlling costs and increasing access, NAM stands ready to discuss any necessary financing measures to accomplish these objectives. Ultimately, we must fashion a system that reduces the high rate of cost increases for American manufacturing and thus preserve our future economic viability and our capacity to support other essential national priorities.

Principles

1. The NAM supports development of a national pluralistic health policy through continuation of a public/private system of health care delivery and financing, but recognizes major reforms are necessary.
2. Everyone should have access to appropriate and necessary health care.
3. Each person should be responsible for obtaining either private or public health care coverage. While NAM continues to oppose mandating health care benefits, all employers and employees should share in the financing of such benefits. A critical objective should be to eliminate cost-shifting

to the private sector, and within the private sector from employers who do not provide benefits to those who do.

4. Health care spending should be brought in line with our nation's resources and reasonable expectations for improvement in health status.
5. Access to health care is a concern and responsibility for all of society and thus, in both the private and public sectors, any financing mechanism should not disproportionately impact any one segment of the economy.
6. Providers should continuously improve the value of health care by delivering quality for health care dollars expended, supporting outcomes research and practice guidelines, making data available to assist purchasing decisions and actively participating in managed systems of care; purchasers must work in tandem with providers to achieve this quality-based system.
7. Medicare and Medicaid and other publicly-supported health programs should have adequate budgets, pay providers properly and fairly to eliminate cost-shifting to the private sector, and adopt efficient cost management and quality goals that emphasize managed care.
8. Medicare should continue to be the primary payor for the elderly and disabled.
9. Improve the legal environment for more effective and efficient health care delivery by enacting federal tort reform to help reduce defensive medicine costs and improve access, providing protection for sponsors of employer health plans, amending laws and eliminating barriers to the use of managed care and group purchasing of health coverage and services.
10. All parties—purchasers/employers, providers, federal and state governments, insurers, labor and consumers—must work together to solve the critical problem of access to care, which cannot be solved without concurrently addressing problems of cost and quality.

The NAM supports comprehensive reform of the health care system. Recognizing that it may not be possible to obtain major reforms to the health care system immediately, NAM supports efforts to make incremental changes in the short-term which are consistent with the principles recommended above.

National Association of Social Workers

The following information is the Executive Summary of a report entitled "National Health Care Proposal," which was published in January 1991 by the National Association of Social Workers (NASW). It is reprinted here with their permission. To obtain a copy of the full report, or for further information, contact NASW, 7981 Eastern Avenue, Silver Spring, MD 20910, (301) 565-0333.

EXECUTIVE SUMMARY

The NASW national health care proposal fundamentally restructures the current health care system. The program offers full coverage for high quality, cost-efficient, and equitably-financed health and mental health care to all Americans. The national health plan proposes a federally-administered, single-payer system with state responsibility to ensure delivery of health services, payment to all providers, and planning in accordance with federal guidelines. The plan provides coverage of comprehensive benefits, including long-term care. Enrollees have the freedom to choose among a full range of public and private providers, including alternative delivery plans.

The national health care plan is financed primarily through a progressive federal dedicated tax on personal income and an employer-paid payroll tax with reduced rates for small businesses and for new firms facing economic hardship. States are expected to contribute their fair share, and are permitted to supplement their state global budgets. Limited copayments on certain services could be implemented if needed to control utilization of services.

While it's anticipated that the plan's costs may initially come close to the current level of health care expenditures, approximately \$600 billion a year (11.7% of the gross national product), the unique delivery improvements and the cost containment features built into the proposal are expected to decrease health care expenditures over time. The national health plan expands coverage to the 37 million people previously uninsured, as well as the millions more who are underinsured, and eliminates the inequities in paying for health care that characterize our current system.

PRINCIPAL FEATURES

COVERAGE AND ENROLLMENT

All persons residing in the United States are covered through the national health plan. Each person has the freedom to choose from among any of the participating public and private providers, facilities or care delivery options, including Integrated Health Service Plans (IHSPs). IHSPs are nonprofit, consumer-controlled plans which provide comprehensive health care services in their own facilities to an enrolled population. Individuals will enroll in the national health plan in the state in which they reside.

Coverage through employers or other privately purchased health insurance is discontinued, although private insurance plans may provide coverage for services not covered under the national health plan.

BENEFITS

- Care coordination services, to be used primarily for clients who require multiple services over a period of time or where such services are potentially costly.

- Primary prevention and health promotion services, including comprehensive well-child care for everyone 0-21; perinatal and infant health care; routine, age-appropriate, clinical health maintenance examinations for everyone over 21; family planning services; and school-based primary prevention programs.
- Outpatient primary care services.
- Mental health services.
- Substance abuse treatment and rehabilitation programs.
- Inpatient and outpatient hospital services, including emergency and trauma services.
- Inpatient and outpatient professional services.
- Laboratory and radiology services.
- Long-term care, including home and community-based services.
- Hospice care.
- Prescription drugs, medical supplies, and durable medical equipment.
- Dental care.
- Hearing and speech services.
- Vision care.

EXCLUSIONS

Health services excluded from coverage include cosmetic surgery, except medically necessary reconstructive surgery; and certain amenities in inpatient facilities, such as private rooms, unless medically necessary.

COST-SHARING

There are no deductibles. The National Health Board (NHB) may require copayments if necessary to control utilization, with the following limitations: copayments must not impede access to health care; copayments must be modest in amount; the mechanism for charging and collecting copayments must be administratively efficient; and copayments must not implement means-testing.

Residents of nursing homes and other residential facilities are required to pay a modest room and board fee. These fees may be waived for those below the poverty line.

IMPROVED SERVICE DELIVERY PROVISIONS

The NASW national health plan provides unique and improved prevention and health promotion services; promotes comprehensive, coordinated, and continuous care that addresses the total health needs of every person through the use of primary care providers, care coordination services, and the promotion of IHSPs as comprehensive, integrated health delivery plans; provides access to health services to underserved populations; promotes the expansion of community-based health and mental health services; and establishes state screening and care coordination systems for the delivery of long-term care.

ADMINISTRATION

A new federal National Health Board (NHB) is established as an independent agency to administer the national health care plan. All responsibilities of the Health Care Financing Administration are transferred to the NHB. Medicare, Medicaid, CHAMPUS, and the Department of Veterans Affairs' health programs are phased out under the national health care plan.

The NHB provides the states with an annual global budget for all covered health care expenditures. The global budget for each state is based on a formula that considers size of population, age distribution, the cost of delivering care, socio-economic factors, and a number of key health status indicators. State global budgets will include all state health block grant funds.

The states, in accordance with federal guidelines, will ensure the implementation of all state health services, determine the distribution of health care funding, develop and administer a mechanism to pay and reimburse health care providers, work with localities and the NHB regional offices in undertaking health planning and coordination with appropriate social and human services, implement a quality assurance program, administer a consumer advocacy and information program, and license and regulate all health care providers and facilities.

PAYMENT TO PROVIDERS

- Hospitals will receive a prospective global budget, to be developed through annual negotiations between the designated state agency and the hospital. Global budgets will only be used for operating expenses. Separate funds for capital expansion and purchase of expensive, highly-specialized equipment will be subject to approval by the state.
- Other health care facilities, e.g., community clinics, migrant health centers, nursing homes, rehabilitation facilities, and Integrated Health Service Plans will be paid either on the basis of a prospective global budget or capitation as determined by the state.
- Autonomous health care practitioners and group practices will be reimbursed on the basis of fee-for-service, although group practices may choose capitation. The reimbursement rate will be based on a national fee schedule, adjusted for regional variations, and negotiated by the NHB and a representative organization for each category of health care practitioner. The fee schedule will be a resource-based relative value scale similar to that being implemented for physicians under Medicare.

QUALITY ASSURANCE AND CONSUMER PROTECTION

The NHB will establish a National Council on Quality Assurance and Consumer Protection that is responsible for determining guidelines and overseeing the quality assurance system as it is carried out by the NHB, the Peer Review Organizations, and the Consumer Boards. The NHB will establish quality assurance standards and certification and licensing criteria for all health care providers.

Peer Review Organizations (PROs) as provided for in Title XI of the Social Security Act will be extended to cover all types of health care providers and services. The PROs will be responsible for utilization review and quality control. The composition of PROs must be multidisciplinary to reflect the types of services reviewed. Each PRO is required to have a Consumer Board to oversee the PROs, make recommendations on PRO contracts and carry out educational programs.

The NHB will develop a national health care data base to study quality, effectiveness, utilization and cost of care with respect to all types of health and mental health services.

Federal and state consumer advocacy programs will be established to administer ombudsman programs, hotlines for complaints, consumer information and education programs.

The national health plan will contain a consumer bill of rights.

PLANNING

The national health plan requires local, state and regional planning. At each level, the health planning function will include collecting and evaluating data to determine the supply of and demand for health resources, the distribution of such resources, and the health needs of the population in a given jurisdiction. Goals and priorities will be formulated to serve as guides to the development of health policy and programs at each level of government.

FINANCING

The national health care plan is financed primarily from a federal dedicated tax on personal income and an employer-paid payroll tax. Additional sources of revenue include a state contribution based on a formula that ensures that each state pays its fair share, a dedicated estate tax, an increase in the cigarette and alcohol tax, a federal tax on types of businesses which have been proven to expose workers to substances that cause chronic and fatal diseases, illnesses and disabilities.

All revenues are placed in a National Health Care Trust Fund. All current federal appropriations for health programs are folded into the national health program and transferred to the Trust Fund.

Small businesses are protected by a cap on the amount they must contribute, and new firms facing financial hardships are protected by a reduced payroll tax rate for the first 3 years of operation.

TRAINING AND EDUCATION

The NHB will collect and compile data for publication related to the supply, composition and distribution of trained health care personnel.

The health plan provides for increased federal funding for a number of existing and new programs to: increase the supply of needed health care personnel; encourage more health practitioners to work in underserved areas; support programs that help disadvantaged students successfully complete health training programs; provide retraining programs for those who are displaced as a result of the program; support new approaches to continuing education programs in rural areas; and enable educational institutions to hire qualified staff to teach the importance of mental and psychosocial health in prevention, treatment and health promotion.

RESEARCH

The plan provides funds for research efforts to: continue basic biomedical and comprehensive mental health research; eliminate or control the major diseases affecting the greatest number of people; develop alternative models of health delivery for special populations; study the impact of psychosocial well-being on illness and disease; develop approaches to encouraging healthy life-

styles; and study effective intervention models for the mentally impaired.

The plan also directs research efforts to examine the impact of care coordination on treatment effectiveness and efficiency.

Additionally, funds would be available to continue to develop quality indicators for measuring treatment effectiveness in all types of health care settings, and to develop practice guidelines physicians and other health care practitioners. Research will also be directed at reducing the number of unnecessary medical and diagnostic procedures.

MEDICAL MALPRACTICE REFORMS

The plan directs the NHB to establish a special commission to develop recommendations for medical malpractice reform. The goals of such reforms are to reduce the costs associated with malpractice insurance, reduce the basis for malpractice claims, target physicians and other health care providers who are incompetent, and develop mechanisms that will protect consumers who are victims of malpractice.

National Committee for Quality Health Care

The following document is entitled "Policy Statement for Health Care Reform," and was published in January 1992 by the National Committee for Quality Health Care (NCQHC). It is reprinted here with their permission. For further information, contact NCQHC, 1500 K Street, NW, Suite 360, Washington, D.C. 20005, (202) 347-5731.

National Committee for Quality Health Care

POLICY STATEMENT FOR HEALTHCARE REFORM

PREAMBLE

Medical care in the United States is regarded as the best in the world. In recent years, we have made great strides in diagnosing and treating disease, thus prolonging life and improving its quality. Indeed, according to performance indices developed by the National Committee for Quality Health Care (NCQHC), our health care delivery system has kept pace with the increasingly complex and growing demands made upon it during the past decade—despite the toll exacted by social problems and personal lifestyles beyond the system's control. And these demands have been met without significantly expanding such physical resources as the numbers of doctors and hospitals.

Yet persistent problems related to high cost and financing methods are limiting access to quality health care for millions of Americans who lack health care coverage. These problems are also jeopardizing future access for millions more who are insured, but whose care is at risk due to rising costs or significant health problems. Further, they are stressing the health care system's ability to cope with accelerating demand and greater pressure to constrain costs.

The NCQHC recognizes that maintaining the status quo in American health care is no longer an option. In fact, the problems plaguing the current system will only worsen if we postpone action on significant reforms for which a consensus already exists while we indulge in a prolonged public debate on other, highly controversial proposals.

Through thoughtful reform, begun now, we can develop a market-based system that provides affordable health care without compromising quality. The cornerstone of this reform must be a true public/private partnership to ensure that we preserve the best of the current system and to guarantee responsible participation of everyone: all levels of government; consumers, including employers and employees; and the health industry itself.

The NCQHC has developed the following principles it believes should form the basis of a new American health care policy.

TOUGH CHOICES ARE INEVITABLE

The American health care system falls short of the goal of integrating reasonable cost, high quality, and full access in several important ways. To achieve this goal, providers, governments, consumers and the health care industry must cooperate to effect systemic change in the delivery and financing of care. The success of this effort depends on all parties making a number of tough choices—individually and collectively—about the kind of health care system they want and need, and the trade-offs they are prepared to make.

The NCQHC believes that reform of the American health care system must be incremental. It must be market-based. And it must contribute to the overall, long-term viability of the system by building on its many current strengths. In carrying out this reform, we need a national health policy with specific goals. Although we do not need an arbitrary timetable, the NCQHC is committed to having these reforms in place by the end of the century. Assessment of the effects of incremental change is critical to the shaping of future directions.

Incremental reform implies a flexible process that reflects developing needs, rather than one that simply duplicates other nations' systems or adopts preconceived notions about how our own is structured. Such reform also allows for geographic diversity, giving states and localities a certain degree of latitude to work out individual solutions. Short-term "fixes" and radical reforms that fail to recognize the pluralistic nature of our system—that it is not a unified whole but an amalgam of many local systems—are inconsistent with the needs and interests of the American people.

All Americans need access to basic, high-quality health care. All segments of society, government, and those in the health care system itself have a shared responsibility to ensure that basic care is available to everyone, regardless of the ability to pay.

Intrinsic to the American health care system is the element of choice. On the one hand, we need to ensure access to basic benefits as a floor below which no one should be allowed to fall. On the other, the ceiling should be limited only by what the system can deliver and individuals can obtain.

That our system's resources are finite is obvious. To the extent that individual needs and choices are incompatible with this, the allocation of resources should be determined on a regional basis, by marketplace forces, or through the electoral process.

A significant strength of the American health care system lies in the fact that it is a public/private partnership.

As producers, providers, and care givers, members of the health care industry have a professional responsibility to assume a leadership role in the health care reform process. They must recognize that they need to significantly change the way the components of the system function. And they must change their orientation from a system that emphasizes illness to one that underscores public health, where success is measured by the health status of the population served.

Individuals have a responsibility for their own personal lifestyles, and must make choices that lead to health and well-being. Employers have an obligation to consider fully the needs of employees and their dependents for health care coverage.

And, finally, policy makers have a responsibility to acknowledge that government's role extends beyond the budgetary function. Government has a social obligation to ensure the availability of basic care for the poor or for those otherwise excluded from the system.

Like all health care systems, ours is characterized by limited resources. So there is a need to achieve a balance among access, cost, and quality. Given the basic level of services that should be available to everyone—and considering the pluralistic nature of American health care—cost and access are the factors that determine the distribution of care. Quality health care is doing what is in the best interest of the individual patient at all times, in view of the resources available.

Quality care is the goal in every interaction with the health care system. To achieve that quality, we must understand what it is and be able to measure it. To this end, government and the health care system must continue to cooperate in outcomes research and the development of practice guidelines. Providers, manufacturers, and suppliers must take a more active role in educating consumers about all aspects of health care. Consumers must understand the possibilities inherent in pursuing their own well-being and in making optimal use of the delivery system; they will need to accept that their use will, ultimately, be limited to some extent.

Inherent in preserving consumer choice is the fact that a certain amount of oversupply within the health care delivery system and its attendant cost are the trade-offs for providing service on demand for everyone. Disparity in levels of care is the trade-off for allowing individual choice.

ACCESS MUST BE ENSURED

A significant portion of the American people do not have adequate health care coverage. More than 30 million Americans lack coverage of any kind. Even more have coverage that does not meet their basic needs. Still others are at risk if they lose their jobs or develop costly health problems.

For all employees to have coverage through their employers, we need to take some positive steps. We must encourage employer-provided coverage for all employees, leveling the playing field by providing equal tax treatment for all employers, including the self-employed. Tax incentives for small employers of low-income workers should be considered, along with exempting small employers from costly state mandates to reduce their coverage costs. In addition, appropriate small market insurance reforms should be enacted to ensure that coverage is available and affordable. And, finally, people with potentially costly medical conditions should be brought into the system by promoting the development of appropriate reinsurance mechanisms.

For those who fall below the poverty line but are not covered by Medicaid or other government programs, we must standardize eligibility and establish a basic minimum benefit plan. Income-related subsidies should be provided for the near-poor and low-income workers. Funds to finance this government expansion could come from specific taxes. Admittedly, this expansion will increase government spending on health. But it would not necessarily entail an overall increase in total health expenditures if we successfully contain costs through other measures like managed care, outcomes research, and medical malpractice reform to reduce the costs associated with "defensive medicine."

HEALTH CARE MUST BE AFFORDABLE

Controlling costs is critical to solving the pressing problems of our health care system. The most effective way to do this is by emphasizing quality of care and its beneficial effects on productivity. We must create an environment in which providers can offer, and consumers can purchase, value in every encounter with the health care system.

It is essential to promote consumer participation in containing health care costs and determining choices. There are many ways to do this. Among them are instituting incentives for healthy lifestyles and encouraging enrollment in cost-effective health care plans. We can also support appropriate employee participation in premium costs and cost sharing. Further, we can develop useful information, including clinical effectiveness outcomes research, for consumers and providers to use in making health care decisions.

Overcoming barriers to innovative, affordable health plan offerings will bolster our ability to provide more cost-effective care. One of the measures available is repealing legislation that inhibits innovation, creativity, or affordability of these plans. Such inhibitors include state-mandated benefits, restrictions on selective contracting with providers, inappropriate certificate of need requirements, and restrictions on utilization review procedures. Other initiatives are enacting medical malpractice reform and promoting adequate payment in all government-sponsored programs to avoid the ill effects of cost shifting.

PREVENTION IS A KEY TO GOOD HEALTH

The nation continues to be burdened by preventable illness, injury, and disability. Health promotion and disease prevention offer the opportunity to contain health care costs, to prevent the premature onset of disease and disability, and to help all Americans achieve healthier, more productive lives. The NCQHC supports the nationwide health promotion and disease prevention objectives called for in *Healthy People 2000*; a comprehensive report of the U.S. Department and Health and Human Services.

To achieve the nation's health care goals, all Americans need access to basic preventive services. These range from prenatal care, maternal care, and women's health to basic monitoring of child development. They include immunization for childhood diseases and for vulnerable adults; demonstrably effective basic screening to detect health problems, tailored to age and risk factors; and education and counseling on nutrition, exercise, smoking, drugs and alcohol, and injury prevention.

Implicit in increasing access to necessary preventive services is defining health care coverage for all Americans, expanding preventive services in benefit plans, rejuvenating the public health system, and increasing both the number and distribution of primary care physicians and the availability of preventive services.

To complement expanded access to preventive services, people must be made more aware that the key to good health is developing and maintaining a healthful lifestyle. Individuals must have incentives not only to seek preventive treatment, but to choose healthier lifestyles in the first place. Everyone has a role to play here.

Employers should recognize that offering preventive services to employees is a cost-effective investment in managing health care expenditures and improving productivity. Providers have a dual responsibility to practice preventive medicine and to educate consumers about prevention as an effective alternative to avoidable acute care. Insurers should include prevention benefits as part of their product offering. Academic centers should incorporate prevention programs in the education of health care professionals.

The correlation between poor health and lower socioeconomic status has been well documented. Good health should not be seen as a benefit only for those who can afford it. Prevention programs require up-front costs without fully documented assurance of the payback. Nevertheless, such investments in the future of America are not only necessary but also demonstrated, cost-effective alternatives to acute care.

MANAGED CARE HOLDS GREAT PROMISE

Managed care—a process and structure for delivering, insuring, and financing high-quality care in a competitive environment—is a readily available means to provide affordable health care and achieve quality in both private and public sector health care programs.

If used by all purchasers, including governments, managed care could foster a performance-based health care system that delivers value and is driven by continuous quality improvement.

Managed care implies the use of integrated health delivery systems that emphasize prevention and wellness. It incorporates incentives for consumers to seek timely, appropriate care at the proper site. And it encourages providers to supply this care at an appropriate level of service, and at a reasonable and competitive cost per episode.

With its emphasis on quality, value, and appropriateness, managed care seeks to change the U.S. health care system from within by identifying and rewarding providers on the basis of performance.

If the promise of managed care is to be realized, all providers and purchasers must rely on the following managed care principles as the primary basis for the purchase and delivery of health care in the United States.

We must measure and compare provider performance to establish standards based on quality outcomes and to identify physicians and hospitals that produce the best results. We must purchase care on the basis of value, using data and standards developed to contract with providers who deliver the highest quality in relation to cost. The delivery of services must be managed to guide patients to appropriate providers, services, and settings, and move them back on the continuum of care toward preventive rather than acute services.

Through the use of various financial incentives, consumers should be encouraged to use high-quality providers; providers should be encouraged to deliver high-quality care at reasonable cost. Last, prevention and wellness deserve emphasis to avert the often unnecessary need for acute care services.

The development of this performance-based managed care will require major changes, including:

- **Changes in the behavior of major purchasers.** Purchasers must establish methods of contracting for service based on performance expectations, and evaluate and hold providers accountable for achieving these performance goals.

- **Changes in the expectations and behavior of individual consumers.** Consumers must be encouraged by provider and supplier education efforts to understand the role of personal responsibility in ensuring healthy behavior and to understand and accept a delivery and financing system with fewer choices.
- **Changes in the organization of institutional and individual providers to create and operate integrated health delivery and financing systems.**
- **Changes in the payment and administrative infrastructures of the health care system** designed to reduce the existing administrative requirements and billing complexities that lead to excessive costs.
- **Changes in policies of health care financing to provide incentives for the development of integrated health delivery systems.** Such policies should encourage the development of health care services designed to improve health status, maintain or improve patient function, and achieve efficiency on a cost per capita basis.
- **Changes in government laws and regulations that inhibit or prevent the development and use of effective managed care systems and practices.**
- **Changes within the managed care industry to develop and enforce the self-policing mechanisms necessary to ensure providers and consumers of the full benefits of managed care programs.**
- **Changes in the role of providers in maintaining or improving the health status of the covered population, using clearly defined and agreed upon measurements and staying within contractually set costs per capita.** Achieving an improved status will require a rejuvenated, coordinated effort between strong preventive public health programs and the delivery of acute care.

TECHNOLOGY SHOULD BE USED WISELY

Health care technology is essential to medical progress, and maintaining incentives for innovation is essential if the promise of technology is to be realized. Recognizing that public policy can affect technological development either positively or negatively, all policy choices and financing decisions must be carefully weighed for their impact on innovation and access to quality care, as well as on cost.

Access to technology by all segments of the population is an important element of quality health care. The appropriate diffusion of new and effective medical technologies should be maintained and encouraged. The costs and benefits of diffusion should be proportionate. Limitations based on demonstrated value can be placed on new technology without compromising the quality of care or the strength of the overall system.

The NCQHC proposes the following guidelines for the future use of technology in the health care marketplace.

Protocols that evaluate new technology should be created, with strong provider input. These should be used in making decisions related to the adoption of the technology as well as in those used for reimbursement.

To the maximum extent possible, technology development and resource allocation decisions should be based on market needs rather than regulated by the government. In addition, technology decision makers in the medical marketplace should consider the potential for quality of care and quality of life, along with cost-effectiveness.

Providers should use the most cost-effective technology appropriate to the needs of the individual patient. Information on benefits, including long-term advantages and total in-use costs, rather than purchase price alone, should be obtained and widely disseminated to patients, their families, and any other interested parties.

Technology assessment has an important role in ensuring that technologies are safe and cost-effective. Unnecessary delay and multilevel review should be avoided in technology assessment and in approval for third-party coverage because they add needlessly to research costs and can postpone access to the technology's benefits.

Outcomes research promises to provide a broader context for understanding the appropriate use of technologies and the comparative benefits of various interventions. More outcomes research should be encouraged by all parties and its results incorporated in managed care practices.

Current incentives that encourage inappropriate use of technology should be identified and reforms implemented. This includes reducing medical practices that attempt to limit theoretical malpractice risks as well as eliminating true conflicts of interest associated with patient referrals.

Finally, better communication among all parties in health care delivery will create better informed decisions and more rational use of new technology.

WE NEED TO ACT NOW

Although the current health care system delivers high-quality care for 85 percent of the American people, the NCQHC recognizes that we can no longer abide the status quo. All Americans need ready access to basic care. And they need to know that coverage of their basic health care needs will be available when they need it.

To redress the problems currently undermining the availability and security of health care coverage for all Americans, the NCQHC advocates initiating action now by providers, consumers, business, insurers, and governmental bodies to bring about effective reform of the system.

Legislation can be enacted in 1992 on those reforms for which broad consensus already exists:

- Restructuring the way insurance is marketed to small employers, making it affordable and portable for all employees;
- Reforming the malpractice tort system to reduce unnecessary costs and treatments;
- Making health insurance premiums equally deductible for all employers;
- Pre-empting state legislation that mandates coverage for costly benefit packages or inhibits innovation, creativity, or affordability in health plan offerings.

Action can be initiated now to build toward intermediate reforms:

- Expand government programs, using new tax dollars, to ensure the availability of coverage for the near poor and for low income workers;
- Increase the availability of basic prevention services for all Americans;
- Promote the widespread development and use of managed care as the most effective means to achieve affordable health care in both the public and private sectors.

The groundwork must be laid now for long-term changes in how we achieve and maintain sound health status:

- Developing and disseminating outcomes research and protocol guidelines to promote more effective use health care services;
- Devising the mechanisms necessary to achieve an appropriate diffusion of new and effective technologies so that the costs and the benefits are proportionate;
- Developing personal responsibility for the maintenance of healthful lifestyles as the key to individual good health.

A basic strength of the American delivery system lies in its public/private partnership. Through reforms like those advocated here, this partnership can evolve into the high-quality, cost-effective health care system to which we aspire. Rather than abdicate responsibility to the government, as some would propose, the NCQHC believes that a primary federal role should be to reverse or minimize the hurdles to effective reform, allowing communities to work more successfully to solve problems on a local basis. Governments have the responsibility to ensure the availability of a basic health care safety net for the poor and the medically disenfranchised. The private sector has the responsibility to ensure continued coverage for working Americans and to make certain that the care delivered is of the highest quality and lowest cost appropriate to the situation. Individuals have the responsibility to use their health and their health care system wisely.

National Governors' Association

The following information is the Executive Summary of a report entitled "A Healthy America: The Challenge for States," which was published in 1991 by the National Governors' Association (NGA). It is reprinted here with their permission. To obtain a copy of the full report, or for further information, contact NGA, 444 North Capitol Street, Washington, D.C. 20001-1572, (202) 624-5300.

The health of a nation depends on the health of its people. The Governors share a vision of an America in which all people can attain a level of health that will permit them to lead socially and economically productive lives. But for that vision to become reality, purposeful change must occur, and Governors can do much to pave the way.

Clearly, the nation's health care system is in trouble. The system costs too much and provides too little. Moreover, there are increasing questions about the value of what is purchased.

The cost statistics are familiar. Total health spending has grown from less than 6 percent of the gross national product (GNP) in 1960 to about 12 percent in 1990. It is projected to reach 17 percent of GNP by the year 2000, and 37 percent of GNP by the year 2030. Similarly, state spending has increased at exponential rates. States currently spend more than 20 percent of their budgets on health. Medicaid spending alone has grown by 18 percent in 1990, far outpacing the growth of state economies.

Despite the extraordinary amount spent on health care, access to health insurance and health care is uneven. Roughly 34 million nonelderly Americans have no health coverage at all. Human potential is being wasted needlessly as an increasing number of citizens find even routine preventive and primary care beyond their reach.

Governors realize that while the cost and access statistics are grim, attention to the financing and delivery of medical care alone will not achieve the goal of a healthy America. For health is also a consequence of environment, lifestyle, education, and income.

Governors have taken and will continue to assume significant responsibility for the policies, programs, and resources to address these factors. Yet precious resources that Governors want to invest in education, housing, nutrition, and family support are being consumed by the spiraling costs of medical care.

WHAT CAN GOVERNORS DO?

While there is growing consensus on the nature and extent of the health care problems confronting the nation, there is little consensus on the solutions. That consensus can be forged based on the results of aggressive and creative state-based reforms of the system.

The Governors believe a way to achieve national consensus is to develop comprehensive, statewide health care reforms that maximize preventive and public health programs and experiment with medical care payment programs to reduce overall medical costs.

Why states? First, because Governors have a significant number of important policy levers at their command. They not only are major purchasers of care, but also regulate insurance, license health care professionals and institutions, allocate capital resources, and deliver services.

Further, states are at once both large enough to leverage the development of an effective health care market and small enough to organize a health care delivery system that is close to the people and meets the unique needs of different populations.

Finally, any national consensus on health care reform that emerges will need to be based on state administration of the system to ensure an appropriate service delivery system sensitive to local needs.

HOW CAN THIS REPORT HELP?

This report is premised on the belief that it will be some years before national consensus is reached about how best to reform the nation's health care system. It further assumes that no Governor can afford to wait for national consensus before taking action.

The report, therefore, not only raises and explores the significant problems in the health care system, but also provides both incremental, concrete options and bold, alternative strategies that states can employ to:

Reorient the Health Care System Toward Preventive and Primary Care Services.

A health care system that focuses on promoting and maintaining health rather than treating sickness rests on a foundation of providing systematic and routine preventive and primary care services to everyone. Positive changes in health status are possible if effective preventive and primary care services are adopted at the community and provider level. States can be active catalysts for a reorientation of the health system toward preventive and primary care services. Examples of state strategies include:

- ♦ Fostering community-based services;
- ♦ Employing creative ways to use current resources such as local public health departments and schools to ensure access to basic services;

- ◆ Focusing the state investment in the education of health professionals on preventive and primary care through expanded training opportunities, and extending the use of mid-level practitioners;

- ◆ Mandating preventive and primary coverage in health insurance benefit packages; and

- ◆ Improving current preventive and primary care practices in state programs such as the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Develop Ways to Both Encourage and Assist Businesses in Finding Affordable Health Insurance for Their Employees, and to Stabilize Coverage for Employees Already Receiving Health Insurance.

Of the estimated 34.4 million nonelderly Americans without health insurance, more than 80 percent are either workers or their dependents. Access to the health care system in the United States generally is through employer-based health insurance coverage, but the significant number of working uninsured attests to the problems employers face in finding affordable insurance. This is especially true for small businesses that are less likely to offer coverage to their employees.

There are a number of strategies states can initiate to address this problem of the working uninsured. These include:

- ◆ Requiring employers to offer health coverage under the employer-based health insurance system;

- ◆ Implementing mechanisms to reduce health insurance costs, including targeting benefits, reducing the cost of health insurance premiums, directly subsidizing premium costs (employer tax credits, for example) and indirectly subsidizing the cost of insurance;

- ◆ Directly financing the cost of care by leveraging public funds like Medicaid on behalf of uninsured workers; and

- ◆ Ensuring that the insurance market functions effectively.

Identify the Unique Needs of the Disparate Populations Who Comprise the Nonworking Uninsured and Develop Systems of Care to Address These Needs.

Medicaid was created to respond to the problems of specific vulnerable populations. However, it has become a complex program that does not always meet the needs of those for whom it was intended. Medicaid also currently cannot be deemed a comprehensive approach to provide health coverage to the nonworking population. The states have an enormous investment in Medicaid and other state programs to assist vulnerable populations and must use these resources wisely to improve access for large numbers of individuals who are without any coverage at all.

Options available to the states include:

- ◆ Building on the existing Medicaid program (through Medicaid buy-ins, for example);

- ◆ Using insurance subsidies to assist selected populations to secure health coverage (for example, through high-risk pools);

- ♦ Establishing universal coverage for selected populations (children, for example);
- ♦ Providing public catastrophic insurance for high-expense illnesses;
- ♦ Directly funding health services rather than making changes in health insurance coverage; and
- ♦ Enhancing voluntary efforts by providers to provide care for those in need.

Make Better Use of Incremental Cost Control Strategies That Currently Are Available to Every Governor.

While ensuring access to health services is critical, it cannot be done in the absence of cost control strategies. Because states are the nation's second largest purchaser of health services, they have a vested interest in exercising all means at their command to control costs. There are several generic strategies states can employ to control the cost of health care incrementally. These include:

- ♦ Using managed care strategies aggressively;
- ♦ Leveraging the state's buying power in the health care system to garner substantial discounts;
- ♦ Reducing the impact of cost shifting through such means as provider taxes and revenue pooling arrangements; and
- ♦ Making better use of existing regulatory cost containment tools, including certificate of need, hospital rate setting, and malpractice reforms.

Take Bold Steps to Implement Major Structural Changes in the Health Care System at the State Level to Significantly Check the Rise in Health Care Costs.

Incremental cost control strategies hold some promise for controlling costs in the short run, but major structural changes are needed if costs are to be controlled in the long run. In essence, there are two polar positions regarding health care resource allocation—a market-oriented approach or a public allocation approach.

Regardless of which approach is adopted, each constitutes major structural change in the way health care is financed and each promises to reduce the cost of health care.

To move toward a more market-oriented strategy, there are a series of actions a state would need to take. These actions address the major causes of failure in the health care market—lack of information, the role of insurance in generating unnecessary demand for health care and decreasing price consciousness, barriers to entry for providers, and health insurance industry practices.

The public allocation approach generally eschews the market as the way to allocate health care resources. It requires greater intervention on the part of state government. Basically two alternatives are possible—an all-payor approach and a single-payor approach. The all-payor approach centralizes health care payment decisions in a single quasi-public agency that negotiates payments between providers and purchasers. This approach

retains financing from multiple payors. The single-payor approach, which funnels all financing and payments through a single source, has not been implemented in the United States, though there are several models of both tax-based and social insurance-based systems in Europe.

**Seize the Opportunity to Move
Beyond the Current System to
Develop a Financing and Service
Delivery System That Provides Access
to All at Affordable Prices.**

Gaps in access to coverage and escalating costs require fundamental change in the current health care system in the United States. The basic decision about structural reform is in essence a decision about the respective roles and responsibilities of the private and public sectors. The direction a Governor takes will depend on his or her beliefs about the nature of health care and how resources are to be allocated. Three possible approaches that might be taken are:

- ♦ Creating a single private system using public funds as a source of subsidies and reinsurance;
- ♦ Moving away from the employer-based health insurance system by using other means to group people and collect funds; and
- ♦ Publicly financing basic health care and using private insurance for catastrophic coverage.

This report is not intended to be a statistical status report of the health care system or a textbook for health policymakers. It is intended to encourage consideration of the fundamental questions that must be

addressed in any successful health care reform strategy. It provides both information based on successful state experience and a conceptual framework for moving beyond what has already been tried.

The report asks Governors and other state policymakers to think about the ways they currently "do business" in health care and suggests changes that could be implemented to provide wider coverage to more people at affordable prices.

Several key points, which need to be considered by all states interested in significant reform, emerged in the report.

- ♦ There is a real need to systematically provide the public with information about health care. States must do a better job of ensuring that citizens have access to information about the availability, cost, and quality of medical care.
- ♦ There clearly is too much administrative waste in the system. Whether it is in the marketing of insurance, the multiplicity of overlapping utilization controls, or the complexity of billing and payment procedures, states must look for ways to reduce administrative overhead.
- ♦ Health care services need to be evaluated against appropriate standards to ensure that people are receiving effective health care services.
- ♦ The dysfunctional state of the small business health insurance market must be addressed.
- ♦ Effective and efficient community-based services must be integrated into a state's health care financing and administrative structure.

- ♦ Malpractice must be addressed through tort reform, alternative dispute resolution, and/or the application of practice guidelines as a defensible standard.
- ♦ Careful consideration must be given to the needs of the poor, the working uninsured, and people with special needs to ensure that basic health care services are available to them. This probably will require rethinking the financing, benefits, and coverage of public programs.
- ♦ While a number of the incremental cost control strategies available to states will make some marginal differences in costs, real cost containment will require more dramatic, structural changes in the financing of care.
- ♦ There must be a shared commitment among states, the federal government, businesses, health care providers, insurers, and consumers to work together to achieve an equitable system for financing and delivering health care services.

WHY SHOULD GOVERNORS SEIZE THE OPPORTUNITY?

Reforming the health care system is the most complex, divisive, and politically explosive domestic challenge confronting the nation.

Effecting change, even at the state level, will require extraordinary political will, vigorous leadership, risk taking, and the ability to marshal unlikely coalitions of powerful interested parties.

It will require time, concerted effort, and a willingness to invest resources up front in the expectation of a future reward.

So why try? Because the nation simply cannot continue to spend vast sums of money

shoring up a system that leaves out increasing numbers of people. America cannot afford either the human or the economic waste.

Governors must solicit the active participation of their communities—businesses, labor groups, providers, insurers, and people throughout the state—to create change.

Fear of change must not impede the effort. A more efficient system may be able to provide universal access without added costs and with less microregulation. Reform should not be feared. In fact, the challenges represent an exciting opportunity for all those in the system.

The costs of inaction are high. The nation cannot afford to leave the current health care system as it is. Without significant change at the state level, Governors increasingly will be faced with spiraling costs that rob them of the freedom and flexibility to invest in other issues that are vital for a healthy citizenry and a productive economy. If steps are not taken now to build a real health care system, too many children will continue to come to school unprepared to learn, too many adolescents will continue to face serious but preventable health problems, and too many adults will be prevented from leading full and productive lives.

If health care systems are a reflection of societal values, it is time to make the U.S. system reflect the generosity and caring that are so intrinsic to the nation's history and values. Through innovation and experimentation, Governors can seize the opportunity to develop a health care financing and service delivery system that provides access to all at affordable prices.

National Leadership Coalition for Health Care Reform

The following information is the Executive Summary of "Excellent Health Care For All Americans at a Reasonable Cost," which was published by the National Leadership Coalition for Health Care Reform (NLCHCR). It is reprinted here with their permission. To obtain a copy of the full report, or for further information, contact NLCHCR, 555 13th Street, NW, Washington, D.C. 20004, (202) 637-6830.

The National Leadership Coalition for Health Care Reform proposes a plan to bring *higher-quality health care* to *all Americans* at a *much lower cost*—more than \$600 billion a year lower by the end of this decade—than the present system.

The Coalition's plan has eight elements:

INITIATIVES TO IMPROVE THE QUALITY OF HEALTH CARE

The Coalition calls for the development, under the auspices of a new National Board on Health Care Quality, of national practice guidelines. These guidelines would be used in decisions regarding payments to health care professionals and as standards in malpractice cases.

The Board would fund new research, in order to develop more and better information about the effects of alternative technologies and procedures, and it would disseminate its practice guidelines to those who deliver care. In addition, the Board would work to upgrade the skill and efficiency with which health care is provided—by, for example, helping health care organizations institute continuous quality improvement programs.

UNIVERSAL COVERAGE

The Coalition proposes that every American be guaranteed access to a comprehensive package of health benefits; those who are not privately insured would be able to receive their coverage through a new program, Pro-Health, that would also incorporate the acute care portion of Medicaid.

Coverage would pivot, for those who are employed, around employing firms. Each company would have two options: (1) provide the standard package of benefits to its employees and their non-working dependents

through private health insurance or (2) offer them enrollment in Pro-Health and pay a payroll tax of 7 percent, matched by an employee contribution of 1.75 percent, to cover most of the cost of that coverage. These requirements would be phased in for part-time workers and for start-up firms and small businesses. *All* firms would contribute 0.5 percent of payroll, up to the maximum taxable base under Medicare for each employee, toward the cost of Pro-Health; individuals would contribute 0.5 percent of payroll up to the Medicare cap.

COST CONTROL

The Coalition proposes a tough, no-loopholes strategy to bring health care costs, system-wide, under control. That strategy has three main links:

1. The setting of an annual target for health care expenditures—in the private sector as well as the public sector. This target would be specified, and its federal component submitted to Congress for approval, by a new National Health Review Board. The Board would aim to reduce the rate of growth in health care spending—which has been higher than the rate of growth in the overall economy—2 percentage points each year until it matches the rate of growth in the GNP; from then on, growth in health care spending could be held to levels equal to or less than GNP growth.
2. The establishment of payment rates for the providers of health care services. The National Health Review Board would set these rates at levels calculated to yield overall health care spending no higher than the annual expenditure target. All payers of health care bills—all private insurance companies as well as Pro-Health and Medicare—would be bound by the rates.
3. The establishment each year of a target for capital spending, which would be factored into the setting of rates for payments to providers.

ORGANIZED DELIVERY SYSTEMS

One of the forces working against the improvement of quality and the moderation of cost is organizational fragmentation. The Coalition recommends a major effort to encourage the emergence of organized delivery systems (ODSs), one-stop health care providers that would be responsible, under a

single organizational aegis, for a wide range of services—including inpatient, outpatient, and long-term care. ODSs would compete on their ability to manage the quality and quantity of care provided to those they serve—and, as a result, would have strong incentives to develop and enforce practice protocols, institute programs of continuous quality improvement, and avoid waste.

MANAGEMENT AND OVERSIGHT

The Coalition's plan involves the creation of a public-private partnership for the improvement of the American health care system. An independent National Health Review Board—with members representing health care providers, payers, and consumers, as well as government—would be responsible for overseeing that effort. Its responsibilities would include developing the annual health care expenditure target, updating payment rates, and recommending modifications in the standard benefit package. State Health Review Boards—similarly representative in their composition—would administer state budgets, certify ODSs, manage the Pro-Health program, and administer payment methods and rates.

INSURANCE REFORM

Current insurance practices make it difficult for many small businesses to obtain health insurance for their employees at reasonable rates. To encourage more small businesses to provide health coverage for their employees directly, the Coalition proposes that each insurer be required to: (1) offer small groups the standard benefit package and accept all groups that seek health insurance in the geographic area served by the insurer; (2) set premiums on the same terms, with a return to community ratings, for all groups in an area; and (3) renew all policies with premiums adjusted on an area-wide, not firm-by-firm, basis.

MALPRACTICE REFORM

National practice guidelines will help to protect health care professionals from frivolous lawsuits. The Coalition proposes four other steps to change

the law and policy governing malpractice: (1) in malpractice suits involving care provided under the auspices of an ODS, holding the ODS itself—rather than the care-givers—responsible; (2) conducting demonstration projects to test the impact of alternative methods of resolving malpractice cases; (3) adopting a new recredentialing system for health care professionals—involving periodic reexamination of their patterns of practice; and (4) considering a variety of tort law reforms, including caps on legal fees and constraints on awards.

ADMINISTRATIVE SIMPLIFICATION

The Coalition's proposal—in particular, the establishment of a standard benefit package, uniform rates, and universal coverage—would result in a health care system that is less complicated and less frustrating for all those involved. The simplicity of coverage and billing in the reformed system would facilitate the use of uniform claims forms and electronic billing—which would further reduce both the cost of health care and the complexity of obtaining, and providing, it.



The Pepper Commission

The following information is excerpted from a report entitled "A Call for Action," which was published in September 1990 by The Pepper Commission. To obtain a copy of the full report, contact U.S. Government Printing Office, Washington, D.C. 20402.

Our health care system still inspires awe—and rightly so. Americans should be proud of a system that can provide the best care in the world.

But our system also creates fear—among the millions already excluded from it and the increasing numbers at risk of exclusion:

- Uninsured pregnant women, without the resources to seek prenatal care;
- Workers who are ill, with preexisting conditions that may cost them their health insurance if they change jobs;
- Workers in small businesses, for whom a sudden illness can put insurance premiums out of reach for the entire firm;
- Workers with good coverage, who see their benefits threatened each time they go to the bargaining table;
- Families whose emotional and financial resources are exhausted from providing long-term care to frail parents or disabled children.

Finally, our system breeds frustration—among the many who seek ways to reform it and resolve its problems.

Most reformers agree that our health care system should cover all Americans. But to do so, some would replace the system. Others would reshape it, often in dramatically different ways. People and institutions criticize and ultimately reject initiatives that differ from their ideal or that—in their view—move too fast or too slowly. If their first choice is unattainable, the second choice for many is to do nothing.

Public policy is paralyzed. The fear and the flaws continue.

The Pepper Commission calls for action to end that paralysis with recommendations for legislation that would guarantee all Americans coverage for health and long-term care within a system that both ensures quality and contains costs.

To develop these recommendations, the Commission intensively investigated the problems and alternative actions to address them. It listened to numerous witnesses in public hearings held in the nation's capital and around the country. It heard from experts in health and long-term care. In the process the Commission gathered a wide range of views from consumers, employers, workers, providers, insurers, and numerous organizations and groups. Then its members met in a series of working sessions to consider all these views, clarify their own objectives, and develop recommendations to achieve them.

Based on a shared view that current conditions are unconscionable and that public action is urgent, the Commission unanimously agreed that all Americans should have access to affordable health and long-term care coverage in an efficient and effective system.

"Allowing these health and long-term care problems to persist not only deprives millions of Americans of what they ought to be able to have . . . it diminishes our economy. . . . [and] . . . the United States of America. I don't think it's possible to say . . . that we are a civilized nation when so many of our people . . . do not have long-term care, do not have health insurance."

— Senator John D. Rockefeller IV

After further intense debate, the majority of the Commission adopted specific recommendations to achieve this goal. These recommendations reflect the view that we must begin to build universal health care coverage now. We must pursue the workable rather than the ideal. We must secure and improve the health care system for all Americans, including those currently left out. And we must create a long-term care system that serves our nation's severely disabled and addresses the deepest fears of Americans—elderly and nonelderly—about their future should they become disabled and need long-term care.

This report lays out the problems the Commission believes the nation must solve and the Commission's blueprint to guarantee all Americans affordable, high-quality health care and long-term care when they need it. With this blueprint before us, we can build universal coverage a step at a time.

Because today's system works differently for health care (primarily physician and hospital services) than for long-term care, the discussion and the recommendations address each separately. Although health problems cannot be so neatly segmented, this is simply the most pragmatic way to discuss building a system based on what we now have.

WHY DO WE NEED HEALTH CARE REFORM?

The American health care system is approaching a breaking point. Rapidly rising medical costs are increasing the numbers of people without health coverage and straining the system's capacity to provide care for those who cannot pay. The gap is widening between the majority of Americans, who can take advantage of the best medical services in the world, and the rest, who find it hard to get even basic needed care. As the gap increases, the weight of financing care for those without adequate coverage is undermining the stability of our health institutions. Even for the majority, the explosive growth in health care costs is steadily eroding the private insurance system—the bulwark they count on as their defense against financial risk in case of illness.

"[The] American health care system . . . [is] a paradox of plenty and of want, a system where some receive the benefit of the most advanced medical technologies in the world, yet many poor women can't get decent prenatal care and families can't get help to keep a frail parent from having to go into a nursing home."

— Senator Dave Durenberger

Who Is Uninsured and Why?

Most Americans of working age get insurance for themselves and their dependents through their jobs. But not all of us work—and not all employers provide insurance. People who fail to obtain job-based coverage may also be excluded from Medicaid and other public programs because of restrictive eligibility rules.

Consequently, almost 32 million Americans under 65 lack health care coverage of any kind. That's nearly 15 percent of our nonelderly population. Another 20 million have inadequate coverage. And the proportion who are uninsured was 20 percent greater in the 1980s than in the 1970s.

Anyone can become uninsured—regardless of age, income, or employment status. A close look at the problem shows what kinds of people are falling through the cracks (see Figures 1 and 2):

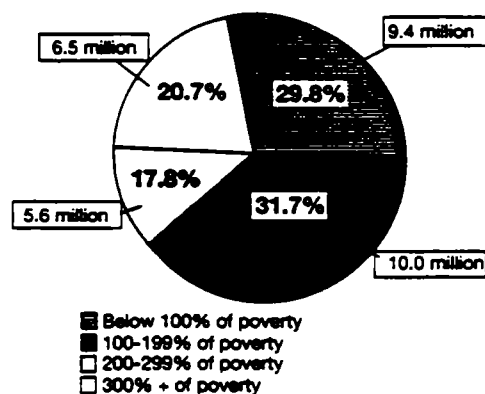
- Many of the uninsured are young. In 1987, nearly half were under 25, and more than 28 percent were under 18.
- Most of the uninsured are poor or near-poor. In 1987, one-third were in families with incomes below the federal poverty level (\$11,611 for a family of four). Two-thirds were in families with incomes below twice the poverty level.
- Most of the uninsured are directly or indirectly attached to the work force. Three-quarters of the uninsured are workers or their dependents.

These characteristics of the uninsured raise two key questions about our country's health care coverage.

- Why doesn't job-based health insurance reach all workers and their families?
- Why does the public safety net fail to protect the poor?

Uninsured Workers—Firms of all sizes have uninsured workers, but workers in smaller firms are much less likely to get insurance through their jobs (see Figure 3). In 1987, just over half of uninsured

Figure 1 Distribution of Nonelderly Uninsured, by Family Income as a Percentage of Poverty, 1987



SOURCE: Lewin/ICF analysis of Current Population Survey data, March 1988.



MIKE MCGARVIN/HOLY CROSS CLINIC AT POVERELLO HOUSE

Almost 9 million children are uninsured—more than one-quarter of all those without public or private protection.

workers were in firms with fewer than 25 employees. Even though most small firms provide insurance to their workers, large numbers do not—increasingly because they are disadvantaged in the insurance market.

Small firms must pay more for insurance than large firms because they have fewer employees among whom to spread administrative costs and any losses for extremely costly enrollees. Small firms thought to present high risks pay even higher rates, and are often forced to exclude certain employees or certain conditions. They are sometimes unable to obtain coverage at any price.

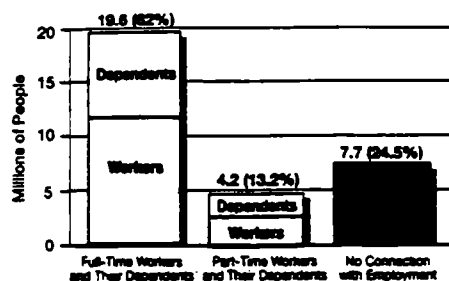
Insurance practices that make it hard for small employers to obtain coverage are the byproduct of today's competitive market. So long as any insurer engages in assessing the risks of each individual in a group (medical underwriting) and group-specific

rating, others must follow suit or risk losing all but the highest-cost groups. Without reform of the insurance market, the problem will only get worse.

Coverage of the Poor—Coverage for the nation's poor is largely the responsibility of the Medicaid program, a federal/state entitlement program administered by the states under broad federal guidelines. Medicaid has accomplished a great deal. But Medicaid does not reach more than a fraction of the low-income population. In 1987, the program assisted only 42 percent of those with incomes below the poverty line. Even among the extremely poor (family incomes below 25 percent of poverty) nearly a quarter are not covered by Medicaid or any other program.

The poor must meet two kinds of tests to receive Medicaid assistance. First, they must fall into one of the categories of persons traditionally eligible for cash

Figure 2 Work Force Connections of the Uninsured and Their Dependents, 1987*



*Under 65 Population

SOURCE: Lewin/ICF analysis of Current Population Survey data, March 1988.

assistance or welfare: the aged, disabled, or members of families with children. Completely omitted from the program, even if they are literally penniless, are single people and childless couples under 65 who do not meet disability tests. Second, applicants must meet financial standards imposed by the states. For many covered groups there are no federal requirements to prevent states from setting shockingly low standards. In Alabama, for example, a family of three qualified for Medicaid in 1990 only if its income was less than 13 percent of the federal poverty guidelines.

Moreover, because states have failed to increase their income eligibility levels to keep pace with inflation, Medicaid programs are covering smaller proportions of the poor. Even recent congressional efforts to expand coverage for pregnant women and young children—severing eligibility for Medicaid from eligibility for cash welfare—appear to have been largely offset by declining coverage among older children and other groups. Finally, in an effort to control costs, states frequently limit both the services covered and the payments made to providers for covered services. The result: inadequate access to service.

Some states have tried to fill in with programs of their own. But funding limitations and other problems have prevented these programs from reaching more than a few of the millions of poor people lacking health coverage.

Without major changes in public policy, Medicaid and supplemental programs will never reach all the poor. Protection will vary considerably from state to state. And many low-income Americans will go without health care coverage even in the more generous states.

4

Who Cares for the Uninsured?

Care for the uninsured poses two fundamental problems. First, people lacking insurance may go without care when they need it. Second, the costs for the care they do receive are unfairly distributed among other groups, straining critical elements of the nation's health care system.

Barriers to Care—The Commission heard heart-breaking testimony about care foregone or delayed; a substantial body of evidence demonstrates that the witnesses were not presenting isolated or unique cases. A 1986 nationwide survey found that uninsured people with serious symptoms saw physicians only half as often as similarly ill people who had insurance. Other studies show comparable results.



Faced with costs they cannot pay, the uninsured delay or do not get medical care.

Often the uninsured delay care for minor or chronic problems until those problems become serious or acute. To the human costs of being uninsured, then, must be added the economic costs of the patterns of care that result.

Financing Care for the Uninsured—Who pays for this care? Although government programs provide some help for people who cannot afford to pay, the insured population foots much of the bill. Providers of care cover their losses on uninsured patients from their charges to those who can pay—primarily the privately insured. For hospitals this cost shifting totaled \$8.3 billion in 1988.

Cost shifting has long been regarded as a hidden tax on those with insurance, much of which is paid by the employers who offer insurance, in effect, to pay for the workers of employers who do not.

Increasingly, employers and insurers are finding ways to avoid this hidden tax at the same time as the need for care is rising. Along with a greater number of uninsured people, the nation is experiencing a rise in costly social problems like drug abuse, AIDS, violent crime, and low birthweight babies—problems that require expensive care. Some hospitals are responding to squeezed resources by eliminating trauma centers and emergency rooms, which are most likely to attract those who cannot pay. These services are then lost to the entire community, causing everyone to travel farther for urgent care.

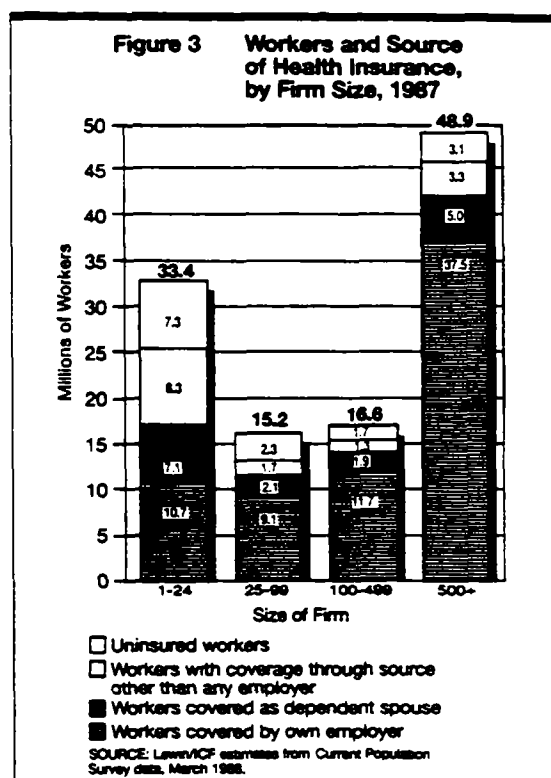
Is Health Care for the Insured In Jeopardy?

For the majority of Americans with health insurance, the problem of care for the uninsured may seem remote. This is a shortsighted view. As the strains on the system grow, those who depend on job-based coverage face an increasing risk of joining the ranks of the uninsured.

"Health insurance is supposed to be a bridge to security . . . [but] we have a system that's falling apart. The 'on-ramp' has collapsed and a lot of children are having difficulty, uninsured because of the income level of who they're born to. The [Medicare catastrophic] 'off-ramp' has collapsed. . . . The long-term care off ramp has never been open. And the group insurance concept is beginning to break apart, which has been sort of the main body of the bridge. . . . [This Commission] has the responsibility to be the safety engineers and architects and we need a review of the entire system."

—J. Robert Hunter, president,
National Insurance Consumers Organization

Especially threatened are workers in smaller firms. Almost half of the smallest firms still offer insurance



to their workers. But their ability to do so is jeopardized by the growing competition among insurers to avoid poor risks. A whole company may lose coverage or see its premiums skyrocket because of the experience of a single individual. Some of these workers may be able to find coverage on their own. But those in poor health may not find coverage at any price, or may only find coverage that excludes the precise condition for which they need care. It makes little sense that hard-working Americans, able and willing to pay, cannot find an insurer that will cover them.

While poor Americans typically face the greatest barriers to insurance coverage, the specter of inadequate insurance and catastrophic medical expenses threatens middle-income Americans as well.

Larger firms do not face problems in the insurance market. Yet their workers, too, are not entirely secure. Their coverage is jeopardized by continuously escalating health care costs. For the country as a whole, health care spending now absorbs 11 percent of the gross national product (GNP) and is projected to absorb 15 percent by the year 2000. For employers, health benefits are equivalent to more than 90 percent of after-tax profits, compared with 74 percent in 1984 and only 14 percent in 1965. Such dramatic increases

not only impede efforts to improve access to health care; they are bound to erode the access we now have as employers cut back on coverage. Employees increasingly are paying more of the premium for themselves and their dependents, causing growing numbers to drop coverage.

And as costs continue to rise, Americans are questioning whether we are getting our money's worth. Concerns about the appropriateness and effectiveness of medical procedures, the quality of health care providers, and the problems related to our approach to medical malpractice add to the crisis caused by the burden of unfinanced care. Unless these concerns are addressed, even those who are now well-insured may find their health coverage in jeopardy.

"I view health care finance in this country as a house of cards. You can add cards at the bottom: Medicaid expansions. You can add cards at the top: Medicare catastrophic. It is still a house of cards. A house of cards can stand in a quiet room, but it cannot stand when there is wind. [And] we have the wind of unmet need. . . the wind of public dissatisfaction. . . the wind of demographic change. . . the wind of cost. . . . This house of cards cannot stand in this wind."

—Deborah Steelman, chairman,
Advisory Council on Social Security

BLUEPRINT FOR HEALTH CARE REFORM

The Commission concludes that, in the absence of systemwide reform, the proportion of Americans without adequate health care coverage will grow. The burden of caring for those who cannot pay will overwhelm the system, putting us all at risk of inadequate access to care. As costs continue to rise, more and more dollars will go to services of uncertain value, while millions of people will go without basic and necessary care.

To prevent such a disaster, the Commission unanimously adopted the following goal:

The Commission is committed to the development of recommendations for public policies that will assure all Americans access to affordable health care coverage that allows them to obtain necessary care and assures them adequate financial protection; that will promote quality

care and address the problem of health care costs; and that will provide the financing required to assure access.

Before selecting its preferred course of action, the Commission explored two major alternative strategies to achieve this goal. The first was an expansion of the Medicaid program to cover all the poor plus subsidies to help the near-poor purchase private health insurance. The Commission believes that such an approach would be an inadequate response to the crisis. Even the substantial expansion of public support the Commission considered would leave some 14 million Americans—almost half the uninsured population—without access to affordable coverage. Further, it would fail to provide help to additional millions whose coverage is inadequate. With so many remaining uninsured, cost shifting and the burden of uncompensated care would still mean inequity and instability in the system as a whole. Finally, broadening the public program for the poor but making no requirements on employers would allow employers who do not now provide coverage to continue to shift responsibilities to others. This approach could also reduce employers' willingness to cover low-income employees who are now protected—shifting substantial costs from employers to taxpayers.

The second major alternative the Commission considered was replacing of the current combined job-based and public approach with national health insurance. The Commission is convinced, however, that such a drastic departure from our current system would be controversial and disruptive to the majority of Americans—for whom insurance still works. It would also totally shift fiscal responsibility from employers to taxpayers. Furthermore, movement to a single federal system would eliminate the diversity and choice that many believe, appropriately guided, can increase the strength and flexibility of our health care system.

In order to act now, as we must, the Commission recommends that we build upon and strengthen the existing system of job-based and public coverage to create universal health care coverage. This is, in the Commission's judgment, the most pragmatic strategy for securing adequate health coverage for all Americans.

Combining universal coverage with other federal initiatives to strengthen the health care system can ensure the value for the health dollar and access to quality service, efficiently delivered, that the nation so sorely needs.

Building Universal Coverage

The Commission's blueprint for building a universal job-based/public system of health care coverage has five parts.

1. The Commission believes that employers and the government together should provide a minimum level of health care coverage for workers and nonworkers who, in turn, should be expected to accept that coverage.

Small employers face considerable and increasing obstacles to purchasing affordable health insurance policies for their employees. Other Commission recommendations address the problems of the insurance market (see below). Because of these obstacles, and because it would take time for the insurance market recommendations to take effect, *the Commission recommends that small employers be encouraged through tax credits/subsidies to provide coverage for their employees.*

Large employers do not face such obstacles. *The Commission recommends that, after a period for adjustment, they be required to provide coverage for their employees.*

The subsidies and the insurance market reform should allow small employers to purchase affordable insurance for their workers. If sufficient progress has not been made after several years, *the Commission recommends that small employers become subject to the same requirements as large employers.*

Even if job-based insurance becomes much more widely available, it will never be enough. The unemployed and the poor will need public protection. *The Commission recommends that the federal government provide coverage for these groups by replacing and expanding the role currently performed by states through the Medicaid program.*

When job-based coverage and the federal program are fully implemented and in place, *the Commission recommends that all individuals be required to obtain health care coverage from their employer or from the public program.*

2. The Commission believes that all parties—employers, individuals, and government—should share in financing health care coverage. Requirements for financial participation should not impose excessive burdens on individuals or employers. It is the federal government's responsibility to establish a ceiling on obligations related to ability to pay, and to provide

the additional necessary financing. Therefore, *the Commission recommends that the small employers encouraged to provide coverage receive tax credits/subsidies to reduce the costs of private insurance; that employers required to provide coverage be able to obtain it from a federal program for a contribution set at a fixed share of their payroll expenses; and that low-income workers and nonworkers receive subsidies to keep their contributions within reasonable bounds.*

3. The Commission believes that private insurers and government should each play a role in administering health care coverage. But there is a critical need for reforms to strengthen both private and public performance, making coverage not only available but also adequate to ensure access to care. In order to preserve and expand private insurance as the primary source of job-based coverage, *the Commission recommends requirements that would bring an end to the underwriting, rating, and marketing practices that are unraveling private insurance protection for small employers. At the same time, the Commission recommends that responsibility for providing public coverage be shifted from states to the federal government, be severed from the welfare system, be uniform across the country, and pay providers at rates determined by Medicare rules.*

4. The Commission believes that universal health care coverage that ensures people access to necessary care must meet an adequate minimum standard. That standard should establish basic protection for the currently uninsured and underinsured and preserve protection for the currently insured into the future. For public and private coverage, *the Commission recommends a federally specified minimum benefit package that includes preventive and primary care as well as other physician and hospital care. Individuals would be responsible for a share of premiums and service costs—on all but preventive services—up to a maximum and subject to their ability to pay.*

5. The Commission believes that action cannot come too soon for the millions without coverage and millions more who see their coverage threatened. However, an effective system cannot be put into place overnight. It will take time to develop and implement.

To balance these concerns, the Commission recommends that the system be put in place a step at a time. The first and most critical step in expanding coverage is to ensure protection for pregnant women and children who are now uninsured and to initiate reforms that reverse the disintegration of the private insurance market for small employers. This would create an environment in which employers would have an op-

portunity to provide the coverage the Commission expects. The second step, to take place in years two through five of implementation, is to effect a series of incentives and requirements for employer coverage, giving employers time to adjust to their new obligations. The final step, to occur in year five, is to extend the federal government's coverage for all nonworkers.

The Commission believes this sequence of steps allows immediate action to address the most urgent problems and provides an orderly transition to universal health coverage.

Strengthening the Health Care System

The Commission recognizes that universal health care coverage can only be as sound as the health care system itself. Coverage that buys unnecessary or inappropriate care, that pays for poor quality, that fails to promote efficient delivery, or that shifts costs from some purchasers to others, wastes private and public dollars that could be used elsewhere.

The Commission disagrees strongly with the view that we cannot extend coverage to the uninsured until we control health care costs and reform the health care system.

The Commission believes, on the contrary, that expanding access to quality care and containing costs through increased efficiency are equally urgent and fundamentally intertwined goals. Ultimate success in reaching either goal can be achieved only through an integrated strategy of system reform. The Commission's recommended strategy has six parts.

1. The Commission believes that the nation needs a national system of quality assurance aimed at defining appropriate or necessary services and ensuring that patients receive these services.

The Commission recommends that national practice guidelines and standards of care be developed and implemented; that a uniform data system on all health care services, regardless of payment source or setting, be developed and implemented to support research on treatment outcomes and assessment of provider performance; that new methods of quality assessment and assurance be developed and tested; and that local organizations be developed and held accountable for effective quality assurance.

It is also imperative that we find a better way to deal with the problem of malpractice. Because there is, at present, insufficient evidence to support specific reforms, the Commission recommends that the Physician

Payment Review Commission and congressional committees study and explore the issue of malpractice and propose legislative remedies.

The Commission believes that universal coverage should be designed in a way that promotes efficiency in service use and delivery of care. Several of its recommendations pursue this goal.

2. *The Commission recommends a minimum benefit package that, except for preventive services, includes significant consumer cost sharing (subject to ability to pay and an out-of-pocket maximum), so that consumers recognize and are sensitive to costs as they consume services.*

3. The Commission recognizes the efforts of employers and their private insurers to manage their health care expenses by encouraging appropriate use of services and negotiating appropriate payment rates with providers. Accordingly, its recommendations include managed care as an appropriate means of service delivery for employers as well as the federal government. Insurers offering managed care to large employers would be required to extend that option to small employers as well. The Commission's recommendations for insurance reform, if implemented, would further encourage managed care and other cost management innovations because insurers could no longer profit simply by avoiding the "poor" risks. Competition would have to be based on efficient service and health care expenditures management.

4. *The Commission recommends also that the newly established federal program adopt and extend Medicare's increasingly effective payment mechanisms.* Initially for hospitals and more recently for physicians, Medicare's payment rules have been refined to reward providers for delivering services efficiently. Applying these rules in the new federal program would extend their scope for publicly financed patients as well as provide a model for private insurers seeking new ways to control their costs.

5. The Commission recognizes that universal coverage in an efficient health care system is necessary but not sufficient to ensure all persons access to the care they need. People in isolated rural areas and inner cities, and particular segments of the population—minorities and the poor, pregnant teenagers, the physically or mentally disabled—would still face difficulties finding and getting the care they need.

The Commission recommends that expanded public coverage reinforce but not replace primary care delivery systems that are subsidized to serve these populations. It also recommends federal support to promote and extend systems that provide and coordinate a broad array of

social and health services. Moreover, it recommends provider payment methods and other mechanisms to ensure the general availability of health providers adequate to serve these most vulnerable citizens.

6. The Commission's commitment to universal coverage in an efficient and effective health care system goes beyond ensuring access to treatment. Preventing the need for treatment ensures Americans the most secure and productive lives, and uses the nation's resources most efficiently.

The Commission therefore recommends federal support for programs of health promotion, disease prevention, risk reduction, and health education toward the reduction of excess morbidity and mortality, and toward the increase of healthy lifestyles.

Beneficiaries and Costs of the Commission's Health Care Recommendations

Building universal coverage in the way the Commission recommends would extend coverage to almost 32 million Americans under 65 who are now uninsured. It would also ensure adequate health insurance coverage for the 20 million under 65 who have some insurance, but are still exposed to catastrophic costs if major illness strikes. All Americans would be guaranteed affordable protection that ensures access to care when they need it.

"I think these are the two words that [characterize what's going on in our country in health care]. The first one is 'wrong.' And the second one is 'stupid'. . . . [People] say South African apartheid [is] . . . wrong. . . . It's immoral. . . . The kind of suffering we have heard about here today is just wrong. . . . On the stupid side, we have already heard about the death, the suffering, the expense, the loss of productivity."

—Luanne Nyberg, director,
Children's Defense Fund—Minnesota

The Commission's strategy for ensuring adequate access to health care for everyone is achievable for less than 2 percent more than the nation spends for health care under current law. If the recommendations were implemented in 1990, the projected increase in total health care expenditures would amount to \$12 billion, raising total current health care expenditures from \$647 billion to \$659 billion in 1990. (All cost estimates are for 1990.)

Table 1 Impact of Commission Plan on Health Care Spending, by Source

(In Billions, 1990)

Federal spending	\$24.0
State and local spending	(7.4)
Employer spending (after taxes)	14.7
Employers who now insure	(12.8)
Employers who do not now insure	27.5
Household expenditures	(19.3)
Net new spending	\$12.0

SOURCE: Lamm/ICF estimates using the Health Benefits Simulation Model.

Not all sectors of society would be required to pay more, however (see Table 1). Employers who now offer health insurance to workers and their dependents are projected to save almost \$13 billion because they would no longer bear the cost shift by insuring (as dependents) individuals who work for other firms or by paying for uncompensated care. Individuals and families are projected to save over \$19 billion, as employers and government share their insurance and health care costs. State and local governments are projected to save more than \$7 billion in payments now made for the uninsured, over and above Medicaid. Because states' contributions to expenditures under the recommendations would be limited in real terms to their current Medicaid contribution, they would also get some relief from the growing burden of financing care for the medically indigent.

Those employers who do not now provide health insurance for their workers and the federal government would share the new costs. Newly insuring employers would face a total of about \$27.5 billion in increased payroll costs, less than 4 percent of payroll after taxes, on average. For a single employer, the increase could not exceed a specified percentage of payroll. This is because the Commission's recommendation allowing employers to choose a public health insurance program would effectively cap an employer's risk. The new federal costs of guaranteeing universal coverage would be \$24 billion—to support adequate coverage for nonworkers and affordable coverage for workers and employers.

Some say we cannot afford universal coverage. The Commission believes that a decision *not* to make this investment would cost the country incomparably more: the disintegration of our health care system and

the waste of our most precious resource, the health and human potential of our people.

Improving Protection for People 65 and Over

The above recommendations apply primarily to Americans under age 65. Nearly all elderly Americans receive their basic health insurance protection from Medicare. Nonetheless, gaps in Medicare protection expose the elderly to considerable financial risk. To address these gaps, the Commission recommends three actions, consistent with recommendations for younger Americans.

1. The Commission is concerned about protecting the elderly against excessive financial burdens in obtaining health coverage or health care. *The Commission therefore recommends that Medicare, or the public plan that replaces Medicaid at the federal level, provide assistance with the Medicare premium, deductibles, and cost sharing to all elderly people with incomes below 200 percent of poverty and undertake strong outreach efforts to ensure participation.*

2. Consistent with the insurance benefits provided to the under-65 population, *the Commission recommends that Medicare be expanded to provide selected preventive services. Preventive services to be added include mammography and colorectal and prostate screening services. As with the under-65 population, other preventive services should be added when they are determined to be effective relative to costs.*

3. Private insurance (usually termed Medigap) supplements Medicare for four out of five nonpoor elderly people. However, continued congressional oversight has documented that the Medigap market has historically been subject to considerable abuse and inadequacy.

The Commission recommends federal action to ensure the nonpoor elderly access to adequate coverage through insurance reforms that are generally consistent with reforms the Commission recommends for other health insurance plans. Recommended action includes support for state or local counseling efforts and legislation to extend federal Medigap standards. Proposed standards would ensure policies of adequate value; allow consumers to compare policies and prices; and prevent sales abuses, duplication of coverage, and discrimination on the basis of health status.

These recommendations would, in combination, benefit 30 million Americans over the age of 65 at a total new federal cost of \$2.8 billion.

WHY DO WE NEED LONG-TERM CARE REFORM?

Between 9 million and 11 million Americans of all ages are chronically disabled, dependent on others for help in the basic tasks of daily living that we call long-term care. As many as 4 million people are so severely disabled they cannot survive without substantial help from others. Millions more know the physical, emotional, and financial burdens of caring for relatives or friends who need such care—a mother with Alzheimer's disease, a child with cerebral palsy, a husband paralyzed from an automobile accident.

Yet in contrast to health care—for which most Americans have insurance, even if inadequate—there is almost no public or private insurance for in-home or nursing home care. Public support, primarily through the welfare-based Medicaid program, comes only after people have exhausted their own resources. Consequently, most Americans face the risk of impoverishment should they need long-term care.



EARL DOTIER

Without adequate public or private insurance, Americans who need long-term care are at risk of impoverishment.

At more than \$2,500 a month, on average, the cost for even a short stay in a nursing home exceeds most Americans' incomes. At a national average cost exceeding \$60 per visit, extensive home care is not far behind. Families exhaust themselves and their resources to provide care at home; long stays in a nursing home consume the savings of a lifetime. As the population ages and technology extends life for young and old disabled Americans alike, these burdens will only increase.

Who Needs Long-Term Care?

Two-thirds of the long-term care population are elderly; the rest are under 65.

The vast majority of people of all ages who need long-term care live in the community (see Figure 4). More than 5 million disabled elderly and over 3 million disabled younger people live at home (or in non-nursing residences). Nearly 2 million people live in nursing homes—1.5 million elderly and 0.2 million people under 65.

During their lifetimes, 36 percent to 45 percent of persons reaching age 65 in 1990 are expected to spend time in a nursing home before they die. A minority of 65-year-olds (about one in five) can expect to receive a year or more of nursing home care. But many nursing home users do not end their days in nursing homes after long stays. Between 26 percent and 45 percent of nursing home stays last fewer than three months, and half these "short stayers" are able to return to their homes.

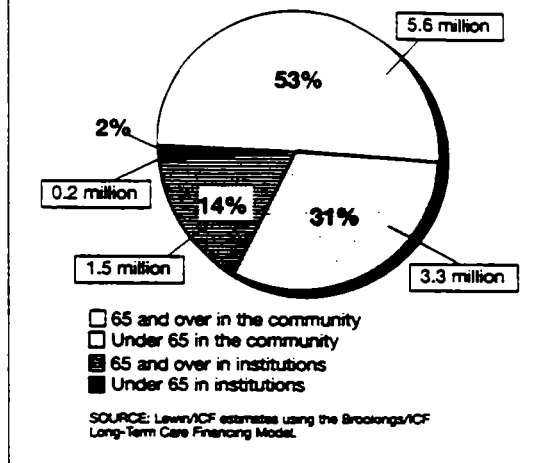
How People Get and Pay for Care

In 1988, the nation spent \$53 billion on long-term care. Only 18 percent of these expenditures went to home care—despite that fact that four out of five disabled and almost three out of five severely disabled live at home. Most home care is provided by relatives and friends. And when people do buy home care, they get little help from public programs.

Public spending on nursing home care, by contrast, is substantial. Almost all of the private share is paid for, without the benefit of insurance, by the individuals and families who need the care. Public support for nursing home care is largely available only *after* people experience financial catastrophe. Consequently, most people who need nursing home care face enormous financial risk.

Caring for People at Home—Almost three-quarters of severely disabled elderly—and two-thirds of the

Figure 4 Residence of People Needing Long-Term Care



most severely disabled elderly—in 1989 relied solely on family members or other unpaid help.

More than 7 million spouses, adult children, other relatives, friends, and neighbors provided unpaid assistance to disabled elderly in 1984. Most of these caregivers are women. Four out of five caregivers average four hours a day, seven days a week. Many caregivers who make this extraordinary effort are vulnerable themselves. One-third are older people, have incomes below or near the poverty level, or are in poor health. More than one in 10 of all caregivers report leaving their jobs to provide care.

That families devote such effort to caring for disabled relatives is moving testimony to the strength of the human spirit. But the scale of their sacrifice suggests there may be objective barriers to purchasing help. For the minority who purchase long-term care services in the home, costs can be substantial. The most severely disabled spent an estimated \$439 per month in 1982. And even people willing to pay face difficulty in finding the services they need and doubts about the quality of those services if they find them.

In 1988, federal and state governments spent about \$7 billion on in-home services—about 37 percent through Medicare, 47 percent through Medicaid, and 16 percent through federal grant or state-funded programs. The programs differ in significant ways, but all are limited in their capacity to finance long-term care.

Eligibility for Medicare is limited to people who are unable to leave their homes (homebound) and who require skilled or professional service. Most

people who need long-term care do not need skilled services, so Medicare is of little help. And few states rely on Medicaid to provide substantial long-term care to disabled people living at home. As with other Medicaid benefits, states control service and spending by limiting amount, duration, and scope of services; payment rates for providers; and eligibility. And the special waiver programs serve very few.

Two other major federal programs—the Social Services Block Grant program under Title XX of the Social Security Act and the Older Americans Act—do not carry stringent restrictions on eligibility, but provide only limited funding for in-home and community-based care. They are fixed-dollar allotments that states can use for many purposes besides long-term care.

A few states are investing substantial resources of their own in designing innovative in-home and community services programs. These initiatives provide models for broader coverage of care for disabled people at home. They are, however, the exception rather than the norm in the nation's effort to provide home and community-based care. Unless frail elderly and disabled Americans need skilled care and qualify for Medicare, or are poor and in a generous state, they must depend on their own resources and on relatives and friends to provide care.

Nursing Home Care—Despite the enormous efforts of disabled persons and their families to manage at home, nursing home care sometimes becomes inevitable. At this point, they face both emotional and financial devastation. Among elderly people with at least \$3,000 in out-of-pocket spending annually, 83 percent of that spending goes for nursing home care. This fact reflects not only the absence until recently of private long-term care insurance (described below), but also the limits to public programs.

Medicare covers nursing home care only as a limited extension of its health care coverage. It does not cover the extended personal care that is the bulk of nursing home service.

Medicaid, on the other hand, provides almost 90 percent of the public financing for nursing home care and more than 40 percent of all nursing home revenues. But people receive Medicaid nursing home benefits only if they are, or have become, virtually destitute. In addition, Medicaid payment rates are so low in many areas that Medicaid patients—particularly those needing extensive care—may have problems finding care at all.

The Emergence of Private Long-Term Care Insurance

Private insurance to protect against financial losses from long-term care has only recently become available. Private insurers historically have been reluctant to offer such policies since it is so hard to predict the number of policyholders who will make claims and the cost of the services they will use. Although general health insurance entails similar risks, they are greater with long-term care. Services are harder to define, and there may be no need for care until decades after the policy is purchased.

Insurers have nevertheless begun to offer long-term care policies, and their availability has grown rapidly. The number of policies sold since 1987 has more than doubled. This does not mean that insurers no longer face risks, but that they have designed and marketed policies to limit their financial liability, thereby protecting their solvency.

Protection for insurers limits benefits to consumers. Insurers do not sell policies to people who are already disabled. Policies that provide some coverage may still leave consumers at risk of substantial expense when they need care.

Creativity and competition among insurers, along with regulatory requirements, have expanded benefits policies offer. But even in most improved policies, benefit levels do not keep pace with increases in service costs. Insurers can raise premiums or cancel policies, even after policyholders have paid substantial premiums.

And decent protection is expensive. The Health Insurance Association of America reports that for a 65-year-old, a relatively comprehensive policy costs about \$1,400 in 1990; for a 79-year-old, the price is \$4,000.

Some argue that more and more elderly will purchase long-term care policies, reducing the need for government protection. The fact is, only about 3 percent to 5 percent of the elderly currently own long-term care insurance. And for many elderly, the financial burden of these policies is patently prohibitive. Only about 6 percent of today's elderly could purchase the relatively comprehensive long-term care policy for as little as 5 percent of their annual income.

The emergence of job-based long-term care insurance, combined with anticipated increases in the elderly's income, makes some observers optimistic that private insurance will fill a considerable part of

the need by the year 2020. But even if private insurance protection grows substantially, critical questions will remain:

- How to protect the currently disabled population as private insurance expands,
- How to ensure that the privately insured receive adequate protection and value for the dollar, and
- How to protect the population that private insurance will inevitably leave out.

Prospects for the Future

Growth in the numbers of people likely to need long-term care makes improvements in the nation's financing of this care imperative for the well-being of all Americans. If disability rates remain what they are today, the number of elderly persons needing help with basic tasks is expected to double between 1990 and 2030—increasing from about 7 million to almost 14 million. The number of elderly requiring nursing home care will more than triple—rising from about 1.5 million to over 5 million (see Figure 5). And the use of high-technology and new medical breakthroughs may continue to extend the lives of disabled people of all ages.

It is highly unlikely that service availability will keep up with these growing needs. Demographic trends predict that fewer family members will be available to care for their disabled relatives. The private marketplace seems unable to develop an adequate home care delivery system even for those who can pay. The two major public programs—Medicare and Medicaid—have structural limitations that prevent them from meeting the projected need.

Without a change in public policy, more and more Americans will have difficulty getting the care they need in nursing homes as well as at home.

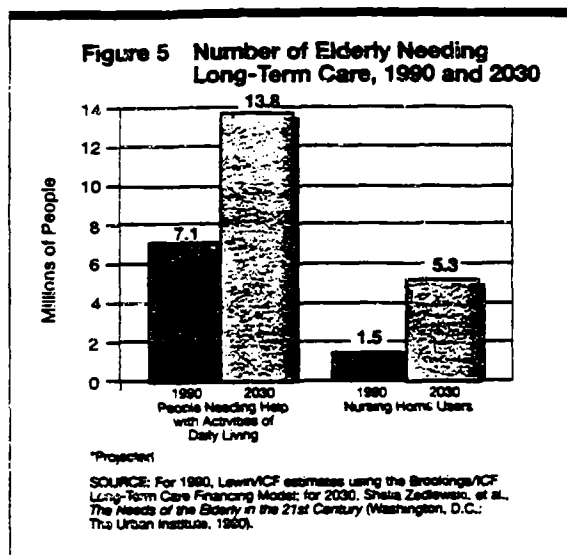
BLUEPRINT FOR LONG-TERM CARE REFORM

The Commission concludes that federal action is essential to change the nation's fundamentally flawed approach to long-term care financing, and that such action should follow an insurance strategy (public or private or both). The Commission rejects the alternative of encouraging private savings to cover long-term care costs. Depending on private savings concentrates the financial burden of severe impairment—an expensive and largely unpredictable event—



ROMAN SAPECK/MOUNT CARMEL HEALTH

By 2030, the number of elderly people requiring nursing home care will more than triple.



on the unlucky few who experience it, rather than spreading it among the many who are at risk of impairment. Failure to reform the system on an insurance basis is not only to abandon today's elderly and disabled but also to condemn growing numbers of Americans to inadequate access to care in the future.

To prevent this outcome, the Commission unanimously adopted the following goal:

The Pepper Commission is committed to the development of recommendations for public policies that give Americans of all ages access to coverage that provides them necessary long-term care and adequate financial protection; that will assure quality care and choice of setting and will control costs; that will provide the financing required to assure access; and that will support research to prevent the need for long-term care.

The Commission explored a range of possible strategies to achieve this objective. One strategy would be to enhance government protection for the low-income population and promote adequate private insurance protection for the better-off. The Commission believes, however, that to build such a two-tiered system would be to repeat the nation's unfortunate experience in health care. Too many people would continue to face impoverishment or find themselves dependent on a welfare-based system, a system unable to ensure access to quality care.

Another strategy would be to develop a comprehensive public insurance program for all long-term care services. The Commission believes that public or social insurance has considerable merit in guarantee-

ing adequate protection to all Americans, regardless of income. However, the Commission is concerned that applying this strategy to all nursing home care, as well as to home care, has disadvantages. Namely, it would require substantial public resources and would provide unlimited protection of assets for people who could well afford to protect themselves through private insurance.

To target public resources most effectively, guarantee Americans of all incomes adequate protection, and achieve an appropriate balance between public and private insurance, the Commission recommends a limited social insurance approach. The Commission believes that federal social insurance for home- and community-based care is essential to ensure the development of an adequate and efficient delivery system for these services and that priority in the use of public resources should go to disabled people at home or able to come home after short nursing home stays. People in nursing homes should be guaranteed an ample floor of protection, ensuring that no one—regardless of length of stay in the nursing home—will become impoverished. All but the poorest should contribute to the costs of their care.

Building a Long-Term Care System

Based on these principles, the Commission recommends developing an integrated public program that would meet the diverse needs of severely disabled people and support private insurance for those seeking broader protection. The blueprint has nine parts.

1. *The Commission recommends social insurance for home and community-based care and for the first three months of nursing home care, for all Americans, regardless of income.* Individuals would be required to contribute to the costs of care, with subsidies for people with low incomes. This protection would sustain resources and standard of living when people need long-term care, just as Medicare or private health insurance does when they need physician or hospital services.

2. *For people with long nursing home stays, few of whom return home, the Commission recommends a floor of protection against impoverishment—protection of \$30,000 in assets (excluding homes) for individuals and \$60,000 for couples—and protection of income for spouses, home maintenance, and a decent allowance for personal needs.* Protected assets are approximately equal to the life savings of three out of five elderly people. People whose assets exceed the floor would not receive benefits until their unprotected assets were depleted. Income above protected amounts would be applied toward the cost of nursing home care.

3. Recognizing that many people will want additional protection for assets and income above levels protected for long stays—as well as for cost sharing obligations associated with other benefits—the Commission recommends measures to promote private long-term care insurance, subject to federal and state oversight. Promotion would involve clarifying the tax code to give long-term care insurance the same preferential tax treatment health insurance now receives. Oversight would entail standards for insurance policies, consumer counseling to evaluate policies, and penalties on insurers for failure to comply.

4. The Commission believes that all severely disabled persons—regardless of age, underlying disease or disabling condition—be eligible for public benefits, at home or in a nursing home. To qualify for long-term care benefits at home or in a nursing home, the Commission recommends that individuals meet at least one of the three following disability criteria: (a) need hands-on or supervisory assistance with three out of five activities of daily living; (b) need constant supervision because of cognitive impairment that impedes ability to function; or (c) need constant supervision because of behaviors that are dangerous, disruptive, or difficult to manage. Individuals assessed as severely disabled would be directed to a case manager for help in obtaining home care or assisted in obtaining a nursing home placement.

5. To ensure that home care services support but do not replace family caregiving and are managed in a fiscally responsible manner, the Commission recommends relying on case managers to develop and oversee individual care plans. Within a federally determined budget, case managers would be free to allocate a broad array of services, tailored to people's needs and preferences. The Commission recommends that benefits include personal care, homemaker/chore services, shopping and other support services, day care (for disabled adults and children), respite services, and training for family caregivers, as well as skilled nursing and rehabilitative care.

6. Under the recommended plan, both federal and state governments would be responsible for financing and administering public benefits. The Commission recommends that the social insurance portions of the public program be fully financed by the federal government. The federal government and the states would share financial responsibility for long nursing home stays.

In administering benefits, the Commission seeks a balance between ensuring equal and adequate protection for all severely disabled, regardless of the state in which they live, and allowing flexibility to tailor serv-

ices to diverse populations and communities. The Commission therefore recommends that the federal government contract with the states to administer the plan. The federal government would be responsible for setting guidelines and adequate standards for this administration. The federal government would certify assessment agencies and develop standardized assessment criteria, set guidelines for certifying case managers and establish their budgets (described below), set guidelines for quality assurance and appeals procedures, and determine provider payment rates. Within federal guidelines, states would develop and certify case management and delivery systems, certify providers, establish review and appeals procedures, and enforce quality standards.

7. The Commission recognizes that financial support for long-term care can be effective only if it promotes and ensures quality of care. Furthermore, to be sustainable over the long term, a program must be designed in a way that controls expenditures. The recommended plan therefore includes several measures to ensure quality and control costs.

The recently enacted nursing home requirements would apply to the recommended nursing home coverage, and standards would be developed for care in the home.

Alongside these standards, the Commission believes that case management, an integral part of its recommended home care benefits, plays a critical role in ensuring quality and managing costs. The Commission recommends that case managers allocate services and monitor service delivery within a budget set by the federal government. This approach would ensure fiscal constraint and the capacity to tailor services to individual needs and preferences.

The Commission further recommends that the federal government establish provider payment mechanisms and determine appropriate rates. Prospective payment systems can be used to ensure access to quality care, efficiently delivered, and to control spending for care.

8. The Commission recognizes both the urgent needs of the currently disabled and their families for public support and the time it will take to build a long-term care system. The Commission therefore recommends that the plan be put into place a step at a time over a four-year period. The program would begin with limited home care benefits to relieve the burdens on family caregivers. Benefits would be expanded over the next four years, until full coverage is reached. Nursing home coverage would begin in year two. Payment rates would be increased gradually over the subsequent two years to ensure adequate supply and quality of service.

9. In establishing a long-term care system, the Commission believes it essential to assess the effectiveness of treatment, delivery, and management of services, and to explore means to prevent the need for long-term care services.

The Commission recommends that the federal government move aggressively to contain costs and mitigate human suffering by funding a research and development program aimed at preventing, delaying, and dealing with long-term illnesses and disabilities.

Research should encompass special problems of minorities; the development of outcome measures and practice guidelines; and evaluation and innovation in assessment, quality assurance, and service delivery mechanisms, especially in care at home.

Beneficiaries and Costs of the Commission's Long-Term Care Recommendations

The Commission's recommendations provide a blueprint for developing a national long-term care system. Home and community-based care would be available and affordable. People who need nursing home care for short periods would have their resources preserved intact to return home. And no one would have to fear impoverishment if they end their lives in a nursing home. People would contribute to the costs of care for all services subject to their ability to pay. They would also have broader access to private insurance to cover these costs. All Americans would benefit from the new public program, for it provides everyone peace of mind in the face of long-term care needs.

But long-term care is expensive—averaging more than \$2,500 per month for nursing home care and over \$60 a visit for in-home support. We cannot build a system that ensures adequate service to people who need it merely by shifting around the dollars we spend today. New expenditures are required.

If the program were in place today, it would serve 4.4 million people at a net new federal cost of \$42.8 billion—\$24 billion for care at home and \$18.8 billion for nursing home care. About three-quarters of total spending would go to the elderly and about a quarter to people under 65 (see Table 2).

For the severely disabled elderly, new federal spending would be split almost evenly between home care and nursing home care (\$15 billion and \$16.8 billion, respectively). For nursing home care, the floor of protection against impoverishment would cost

about \$11.3 billion; broader protection for short stays would cost another \$5.5 billion. For younger severely disabled, most of whom live in the community, almost all new spending (\$9 billion out of a total \$11 billion) would go to home and community-based care.

The new program would serve some 2 million severely disabled elderly people at home every year, doubling the number who now receive paid support. For the 1 million people who would have purchased their own care in the absence of the public program, out-of-pocket savings in 1990 are estimated to be \$900 million—about \$1,000 per user.

Because more people would have access to better nursing home care under the Commission's program, nursing home use is also expected to increase. Under the recommended program, about 1.2 million people a year are expected to enter nursing homes. All would receive some public support. People who would have used the nursing home at their own expense or spent down to Medicaid in the absence of the new program would save \$6.9 billion in out-of-pocket expenses, or about \$3,000 per user. Under the recommended new public program, all 1.2 million nursing home entrants would receive coverage for the first three months of nursing home care. For almost half of all entrants, or 528,000 people, the three-month social insurance bene-

Table 2 Beneficiaries and Net Federal Costs of Commission Long-Term Care Recommendations, by Age Group and Type of Service

	Home Care	Nursing Home Care	Total
Total Beneficiaries (In Millions)			
Elderly	2.0	1.2	3.2
Nonelderly	1.0	.2	1.2
Total	3.0	1.4	4.4
New Federal Costs (In Billions, 1990)			
Elderly	\$15.0	\$16.8	\$31.8
Nonelderly	9.0	2.0	11.0
Total	\$24.0	\$18.8	\$42.8

SOURCE: For elderly, Lawton/ICF estimates using the Brookings/ICF Long-Term Care Financing Model; for nonelderly, Commission staff estimates.

fit would cover their entire nursing home stay. The majority of "long stayers" (425,000 entrants) would have their assets fully protected. A minority (79,000 people) would acquire asset protection during their stay.

Although people would no longer be expected to devote all their resources to long-term care before they could receive public support, all but the poorest would be expected to contribute to the costs of care. Under the Commission's recommendations, individuals could be responsible for cost sharing equivalent to as much as \$12 per home care visit or—for short stays—\$15 per nursing home day. For long nursing home stays, they would contribute assets and income above protected levels. The Commission recommendations would facilitate the purchase of private insurance to cover these expenses, through both assistance and oversight to ensure adequate policies and favorable tax treatment for policies purchased.

This count of people and dollars significantly understates the benefits long-term care coverage would bring. Families of the severely disabled would receive badly needed help in caring for their impaired loved ones. Employed caregivers, or caregivers who could be employed, would be better able to balance responsibilities at home and on the job. Employers would reap the benefits of a more secure and productive work force.

Finally, and perhaps most important, all Americans would benefit from the security of knowing that if the need for long-term care should arise—for themselves, their parents, or their children—they would not be left to cope on their own. The nation would have a system to which everyone in need could turn for help.

REVENUES TO FINANCE COMMISSION RECOMMENDATIONS

The estimated new federal cost of the Commission's recommendations—health care plus long-term care for people of all ages—would be about \$69.6 billion if

fully implemented in 1990. Although some of these funds could be raised from reductions elsewhere in the federal budget, the Commission recognizes that new revenues will be necessary. To finance the new costs of the program entirely through new taxes in 1990 would require about \$430, on average, from each nonpoor American adult. Various tax packages would spread the burden in different ways.

The Commission recommends that three criteria guide the selection of options for raising these revenues:

- Taxes should be progressive, requiring a higher contribution from those most able to bear increased tax burdens.
- Revenues should be able to grow fast enough to keep up with benefit growth.
- Contributions should come from people of all ages.

A CALL FOR ACTION

Congress called upon the Commission to recommend legislation to ensure all Americans coverage for health and long-term care. With this report, the Commission fulfills its task. Now the Commission calls for action from the Congress and the President to turn its recommendations into law.

The Commission's investigations leave no doubt that Americans' fears about their health care system are well founded. Without action, people cannot rely on coverage they can afford or care when they need it.

The Commission not only documents the problems our citizens face; it puts forward workable solutions. In health care, we can build upon and strengthen the coverage we now have. In long-term care, we can identify priorities and build the coverage we now lack. We can build carefully and deliberately, one step leading to the next.

Universal coverage in an effective, efficient system is within our reach. We must act now.