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# issue brief

EMPLOYEE  
BENEFIT  
RESEARCH  
INSTITUTE

MARCH 1991 NUMBER 112



There will be larger expenses for companies sponsoring retiree health plans under FAS 106 than under the current pay-as-you-go system.



## Retiree Health Benefits: Issues of Structure, Financing, and Coverage

- ◆ In December 1990, the Financial Accounting Standards Board approved Statement No. 106, requiring many companies to record a liability for retiree health benefits on their balance sheet in order to comply with generally accepted accounting standards, beginning with fiscal years after December 15, 1992.
- ◆ Employers can provide full retiree health benefits in retirement, make a contribution toward these benefits, or provide a contribution during employment that can be used by employees to pay for the retiree benefits.
- ◆ Currently, employers have few options for tax-favored prefunding of retiree health benefits. Some options are 401(h) accounts, 501(c)(9) trusts, 401(k) options, corporate-owned life insurance, and employee stock ownership plans. Each of these involves significant limitations.
- ◆ Though there are some legal restrictions on changing a retiree health plan, some companies have done so.
- ◆ In 1988, 43 percent of all people aged 40 and over were receiving or were eligible for retiree health coverage through their own or their spouse's current or former employer.
- ◆ Medicare is by far the largest public health care financing program for the elderly. However, between 1984 and 1988, Medicare financing decreased from 46 percent of the elderly's total health care costs to 44 percent.
- ◆ No congressional action is expected on the retiree health issue. Allowing firms to prefund retiree medical liability for current and future retirees would lead to a loss of \$37 billion in one year to the federal government, according to the EBRI Tax Estimating and Analysis Model.

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## ◆ Introduction

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In 1960, 9 percent of the population was aged 65 and over. By 1990, this proportion had increased to 12 percent, and it is expected to increase to nearly 24 percent in the next 40 years as the baby boom ages. These changing demographics are likely to have serious implications for the financing and delivery of health care services because, overall, the elderly use more health care services than others in the population. In 1988, the elderly accounted for 33 percent of all health care expenditures (U.S. Congress, 1989). The combination of an aging population and continued rapid health care cost inflation means that current and future retirees face growing health care expenses.

Since the cost of health care during the later years of life may well exceed many individuals' household income, financing health care for the elderly is an important issue. Currently, some level of health insurance is provided to all elderly persons through a combination of benefits from employers and the government—employer-provided retiree health benefits and Medicare benefits. Both government and employer-based programs face growing financial strains.

Among all people aged 40 and over, 43 percent have or were eligible for retiree health coverage through an employer (either their own or their spouse's) in 1988. Coverage is more likely to be provided to those with higher family incomes and is more likely to be provided directly to men than to women. Sixteen percent of all people aged 40 and over receive retiree health benefits directly from their current employers, while 12 percent work but receive these benefits through their spouses' employers.

Demographics, utilization, and health care costs are increasing the cost to employers of providing this insurance. Many companies currently use pay-as-you-go financing (paying for retiree health care benefits out of current earnings). This method of financing involves no prefunding (that is, setting funds aside to pay for retiree health benefits in the future). Prefunding may increase, though, with the long-anticipated and re-

cently approved Statement No. 106 (FAS 106) from the Financial Accounting Standards Board (FASB), which requires companies to recognize benefit costs and liabilities as they are incurred.

FAS 106 requires companies to record unfunded retiree health benefit liabilities<sup>1</sup> on their financial statements, effective for fiscal years beginning after December 15, 1992. According to current accounting standards, companies only record the existence of a plan and the cost for the current period in footnotes to their financial statements, and rarely include any specific numbers. The Employee Benefit Research Institute (EBRI) estimates that earned liabilities (for current private-sector employees and retirees) were \$241 billion in 1988. For some companies, the retiree health care liabilities required to be listed on the balance sheet in accordance with FAS 106 will far exceed the costs that currently appear in financial statement footnotes.

Retiree health benefits are provided to the majority of those aged 65 and over through the Medicare program. Medicare is funded through a combination of general federal government revenues, payroll taxes, and premiums paid by participants. It has been one of the fastest growing programs in the federal budget, and recent budgets have attempted to slow its rate of growth. In his 1992 budget, President Bush has proposed limiting Medicare spending to \$114 billion instead of the \$117 billion agreed to in the 1991 budget agreement, although this is still an increase from 1991 spending of \$105 billion. For 1992, this decrease in projected spending will occur through reduced payments to some hospitals (primarily teaching hospitals), higher premiums for the elderly, and an increase in the number of state and local employees who pay Medicare payroll taxes. Financing Medicare benefits has caused increasing strain on public funds throughout the 1980s and can be expected to continue doing so in the decades ahead.

<sup>1</sup>FAS 106 relates to all postretirement benefits except pensions. However, the most far-reaching and largest of these benefits for most companies is that of retiree health. Therefore, this *Issue Brief* will focus only on retiree health benefits.

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This *Issue Brief* addresses a wide range of retiree health issues. It begins by reviewing the provisions and potential impact of FAS 106. In response to this newly adopted standard and health care inflation, many companies are considering whether to continue providing a full retiree health insurance benefit or to make a limited contribution toward this benefit. However, changing the benefit promise can prove difficult for employers, as legal issues may arise. Several court rulings have restricted employers' attempts to change retiree health plans, although they have issued conflicting rulings.

For companies continuing to provide some or all retiree health benefits, several methods of prefunding are currently allowed, although they are limited. This *Issue Brief* includes specific examples of how some companies have changed their overall retiree health liabilities and/or used some form of prefunding.



**FASB Statement No. 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions," requires liabilities for retiree health benefits to be recognized explicitly on companies' balance sheets.**



It discusses current coverage of employer retiree health plans as well as which employers are more likely to provide these benefits. Any reduction in coverage may increase pressure on public programs to provide these benefits.

Medicare, the primary source of publicly financed retiree health benefits, is described and the relationship between Medicare and employer plans is discussed. The *Issue Brief* concludes with a discussion of congressional proposals designed to change either employer obligations or the public provision of these benefits.

## ◆ FASB Statement No. 106 on Postretirement Benefits Other Than Pensions

Retiree health benefits were originally offered in the late 1940s and 1950s, when business was booming as a result of economic expansion and there were very few retirees in relation to the number of active workers. The resulting liabilities were not substantial, and the financing of these benefits was not of concern. However, in more recent years, the changing demographics of the work force, coupled with increasing lifespans and rising health care costs, have left many employers with higher retiree-to-active-worker ratios and caused these liabilities to grow.

FASB Statement No. 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions" (FAS 106)—approved in December 1990—requires liabilities for retiree health benefits to be recognized explicitly on companies' balance sheets. FAS 106 applies many of the same principles that were used in accounting for pensions (FAS 87 and FAS 88) to other postretirement benefits (for example, health coverage, life insurance, long-term care insurance, and housing). It applies to current and future retirees, their beneficiaries, and qualified dependents. The statement generally does not cover *postemployment* benefits such as severance pay or wage continuation for disabled or terminated employees.<sup>2</sup>

FAS 106 requires that a liability based on the projected unit credit actuarial cost method (which considers future benefits expected to be earned by the employee) be accrued over the period from the first date that the plan grants credits toward these benefits (generally date of hire) to the date that the employee is fully eligible. Under FAS 106, the amount of a company's accumulated postretirement benefit obliga-

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<sup>2</sup>Employees who become disabled with a certain minimum period of service may be eligible to receive pension benefits and may, therefore, be considered to be employees deemed to be on disability retirement. In this case, the long-term disability health benefits paid to them would fall under the scope of FAS 106.

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tion (that is, the actuarial present value of benefits attributed to employee service rendered to a particular date) that exceeds plan assets will be recorded as a liability on the company's balance sheet.<sup>3</sup>

Even within these guidelines, there are several assumptions that employers must use to estimate postretirement benefit liabilities. Most important is the assumption about health care cost trends. Under FAS 106, employers are required to develop an estimate of the expected future annual change in their health care costs that implicitly considers expected health care inflation, changes in health care utilization and delivery, technological advances, and changes in the health status of plan participants. In making their best estimate of health care cost trends, employers would probably use different estimates for various types of health care services (for example, medical, dental, and prescription drugs) and different rates during various periods of time.

The rates at which the benefits' expected future cost is discounted (to their present value) must also be assumed and should be based on current rates of return on high-quality, fixed-income investments in amounts and with maturities that match the amount and timing of the expected future benefit payments.

As of the date a company adopts FAS 106, there is already an obligation for the postretirement benefits attributable to current and former employees' service to that date (the accumulated postretirement benefit obligation, or APBO). The APBO, less any plan assets and previously accrued costs, is called the transition obligation. This obligation can be recognized on the balance sheet in one of two ways: it can be recognized all at once as a one-time charge to that year's earnings or it can be disclosed in the notes to the financial statements and recognized evenly as a charge to earnings over the plan participants' average remaining years

of service (through the expected retirement date) or over 20 years, if greater.<sup>4</sup>

Increases in postretirement benefits through plan amendments or plan initiation are considered retroactive under FAS 106, unless the plan initiation specifically associates increased benefits with service rendered after the plan initiation date. Any resulting increase in APBO of retirees and active workers is amortized over the remaining service period (to full eligibility date) of active employees not yet eligible but expected to receive a benefit.

Several cost components make up the expense recorded in companies' income statements: service cost, interest cost, return on plan assets, the amortization of prior service cost, gains and losses, and the transition obligation. The service cost is the cost of the benefit earned for employees' service during the year. The interest cost is the expected increase in the APBO due to the passage of time. The return on plan assets (only for funded plans) is the actual earnings on those assets. Amortization of prior service cost is to phase in the cost of plan amendments and/or plan initiation that takes place after FAS 106 is adopted. Gains and losses arise from experience that differs from the assumptions and changes in assumptions and may be recognized either immediately or on a delayed basis.<sup>5</sup> The final component is the amortization of the transition obligation explained above.

The effective date for adoption of this statement is the fiscal year beginning after December 15, 1992, for most employers. However, for certain small, nonpublic employers and non-U.S. plans, the statement is effective for fiscal years beginning after December 15, 1994.

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<sup>3</sup>It is not required that this liability be recognized in its entirety immediately on the balance sheet due to some phase-in and amortization provisions.

<sup>4</sup>However, at any point in time, the cumulative amortization of the transition amount cannot be less than the cumulative amount that would have been recognized on a pay-as-you-go basis. If it is greater, additional amortization of the transition obligation must be recorded.

<sup>5</sup>There is a prescribed minimum amortization of gains and losses based on amounts in excess of a "corridor" that is 10 percent of the greater of the APBO and the market-related value of plan assets.

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Furthermore, the Securities and Exchange Commission (SEC) stated in SEC Staff Accounting Bulletin No. 74 (SAB 74) in December 1987 that public companies must disclose the "material" effects that any currently known changes, including accounting changes, may have on future financial statements. In this bulletin, the SEC states that it wants employers to estimate the effect of accounting changes such as FAS 106 in their next SEC filings if it is expected to be material.<sup>6</sup> Such an estimate is necessary unless the employer adopts FAS 106 or does not know and cannot reasonably estimate what the standard's impact is expected to be in the year of the change.

### ◆ The Costs of FAS 106 to Employers

The projected impact of FAS 106 has been widely studied. There will be higher expenses for sponsoring companies under the new standard than under the current pay-as-you-go system, due to the need to amortize the transition obligation and to expense benefits as earned rather than as paid. Analysts expect employers with these benefits to record significant liabilities on their balance sheets, thereby increasing the amount of debt on the balance sheet compared to equity, a commonly watched ratio (Coopers and Lybrand, 1989).<sup>7</sup> EBRI estimates that the present value of private employers' liabilities for current retiree health insurance obligations was approximately \$241 billion in 1988. It is this amount that employers will be required to recognize in their financial statements with the adoption of FAS 106. The General Accounting Office (GAO) estimates these earned liabilities at

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<sup>6</sup>SAB 74 actually goes beyond this and encourages employers to disclose the potential impact of other significant matters that the employer believes might result from the adoption of FAS 106 or any other accounting standard. SEC Staff Accounting Bulletins are not considered binding but are considered authoritative, and most companies follow them (Williams, 1990).

<sup>7</sup>As a result, this change in the debt-equity ratio may affect the covenants on current or future debt, resulting in higher interest rates or lower amounts of debt allowed. This secondary effect is difficult to estimate.

\$217 billion, and the liabilities expected to be incurred in the future by current employees at \$175 billion, for a total of \$402 billion in 1988.<sup>8</sup>

A study by Hewitt Associates of 463 medium-sized and large private employers found that the median annual medical cost for retirees is 1.1 percent of active payroll, which is expected to increase to 6.25 percent of payroll after FAS 106 is fully adopted (Hewitt Associates, 1990). A survey of 97 large employers by Towers, Perrin, Forster & Crosby Inc. found that FAS 106 would reduce their pretax earnings by 10 percent, on average, among those who answered. However, there were substantial differences among companies. Annual net income of some companies may decrease between 30 percent and 60 percent, by one estimate (Integrated Administrative Services, 1990).

Some analysts believe that the market has already taken these liabilities into account, and their disclosure on the financial statements will not significantly affect stock market prices.

An April 1989 study by Johns Hopkins University and the Health Insurance Association of America interviewed 200 financial officers of companies that offered retiree health coverage.<sup>9</sup> Of those responding, 58 percent believed that FAS 106 would lower profits, while only 19 percent thought it would lower stock prices (Bacon, Kasper, and Gabel, 1990).

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<sup>8</sup>The difference between EBRI and the GAO number for current liabilities is due in part to different assumptions about health care inflation. EBRI assumes that health care cost inflation will continue to exceed general inflation but that the difference between the rates will gradually decline over the next 25 years, converging at 3.5 percent in the year 2013. GAO assumes that health care cost inflation will exceed general inflation by 3.5 percentage points in the years 1988 to 2001, by 2.75 percentage points from the year 2002 to the year 2015 and then by 2 percentage points from the year 2016 on.

<sup>9</sup>On average, these plans covered 3,772 active employees and nearly 2,000 retirees aged 65 and over. The authors note that the study was done fairly soon after the release of the original exposure draft of the statement, so the respondents may not have completely investigated its full impact.

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Considering the magnitude of these retiree health liabilities, putting them on financial statements is unappealing to some companies. Even among companies that advance fund retiree health obligations, very few have fully funded the obligations. Employers offering retiree health coverage may begin reviewing various retiree health plan designs.

### ◆ Plan Design

In reaction to FAS 106 and increases in health care costs, some firms have dropped the provision of retiree health benefits for future retirees entirely, while others have no plans to change their existing plans. In between, some employers may place limits on their postretirement medical benefit promises, tie the promise to length of employment, or comprehensively restructure the plan design. Overall, most companies are or will be evaluating their retiree health liabilities and deciding whether or not changes to the current plan design are necessary.

Companies can design retiree health benefits as either defined contribution plans, defined dollar benefit plans, or defined benefit plans. Defined contribution plans for retiree health are similar to defined contribution plans for pensions—the employer allocates a specified amount to each employee's account and usually relinquishes the investment decisions to the employees through various investment options. This money is then used by the employee to purchase health insurance after retirement. By definition (as in defined contribution plans for pensions), the employer has no liability beyond the contributions, even though the money may not fully cover health insurance costs in retirement.

A second plan design is a defined dollar benefit. In this plan, an employer promises a maximum annual dollar amount after retirement, to be used toward the cost of medical coverage. Under this scheme, the employee is responsible for any remaining cost of coverage and thus carries the full burden of the cost of medical inflation if the employer does not provide increases in the amount contributed.

Third, companies can retain the promise to pay the full cost of medical coverage throughout retirement and, therefore, assume the full risk of medical inflation associated with retiree health care liabilities. These companies may, however, introduce increased cost sharing with retirees through copayments, deductibles, etc. The company also retains the investment risk if there is prefunding. This type of plan design, also called a medical service benefit, was most common when many of the retiree health plans were started in the 1950s and 1960s. These plans present the company with perhaps the largest obstacles for calculating liabilities and funding due in large part to the substantial size of the liabilities and the uncertainties of medical inflation.



**Employees and/or retirees whose benefits were changed (due to FAS 106 or other factors) may feel that these changes were illegal and want to pursue the issue in court.**



Any change in plan design alters an employer's obligation to employees. While reduced or changed benefits may be beneficial from a bottom line standpoint, this action may lower employee morale and reduce a firm's ability to attract and retain employees. Explaining the changes to employees may also be costly for the employer.

### ◆ Court Cases

**Employees and/or retirees whose benefits were changed (due to FAS 106 or other factors) may feel that these changes were illegal and want to pursue the issue in court. The courts must determine the extent of retiree health benefits that employers are obligated to pay on a case-by-case basis. The Employee Retire-**

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ment Income Security Act of 1974 (ERISA) provided reporting, disclosure, and investment fiduciary requirements for pension and welfare plans. It included funding and vesting requirements for pensions but not for welfare plans. As a result, employers have generally not advance funded and have not viewed retiree medical benefits as a vested right.

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**Litigation on the rights of employees to receive retiree health benefits has been decided to date largely through the adoption of generally applicable contract principles.**



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Litigation on the rights of employees to receive retiree health benefits has been decided to date largely through the adoption of generally applicable contract principles. Participants and beneficiaries can bring suit to (1) recover benefits due them under the terms of their plans, (2) enforce their rights under the terms of the plans, or (3) clarify their rights to future benefits under the terms of the plan. In general, the courts have ruled that an employer has a right to terminate or amend retiree welfare benefits, although the employer must prove that such a right has been reserved (or stated) in specific language and on a widely known basis.

Most of the court actions have focused on the issues of the specific benefit promise and employer rights to change the range of benefits offered or the extent of coverage. The issues of which documents legally describe the benefits and if they indicate whether these benefits were to continue throughout retirement were addressed in *International Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Yard-Man, Inc.*<sup>10</sup>

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<sup>10</sup>716 F.2d 1476 (6th Cir. 1983) cert. denied 465 U.S. 1007 (1984).

In terms of the benefit promise, the Sixth Circuit held in *Yard-Man* that certain "extrinsic evidence" (such as memos, pamphlets, and oral statements) could be considered as part of the agreement (or contract) between workers and employers where a collective bargaining agreement did not explicitly state such items. However, in *Moore v. Metropolitan Life Insurance Company*,<sup>11</sup> in which the benefits were not bargained, the Second Circuit ruled that, since Metropolitan Life had reserved the right to change the benefits in its plan documents, other information from the company that seemed to promise lifetime benefits was not binding. Therefore, the totality of the employer's communications to the employees was not the relevant contract. In this case, the relevant contract was the official plan documents and summary plan descriptions.

An additional factor to be considered in determining the parties' intent in the framework of contract law is what the *Yard-Man* court interpreted as a lifetime benefit "inference." The court stated that, if employees forgo wages in return for retiree benefits, there may be an inference that the benefits will continue as long as the retirement status is maintained, thus a "status benefit inference." Some courts, such as the Sixth Circuit in *International Union, UAW v. Cadillac Malleable Iron*,<sup>12</sup> have upheld this type of reasoning. Other courts have disagreed; the Eighth Circuit in *Anderson v. Alpha Portland Industries, Inc.*<sup>13</sup> stated that since Congress exempted welfare benefits from ERISA's vesting requirements, the intent to vest these benefits seems "illogical."

Firms that have filed for Chapter 11 bankruptcy and then attempted to curtail retiree health benefits present a separate set of issues. As a result of the LTV Corporation's attempt to terminate retiree benefit programs after filing for bankruptcy, Congress enacted

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<sup>11</sup>856 F.2d 488 (2d Cir. 1988).

<sup>12</sup>728 F.2d 807 (6th Cir. 1984).

<sup>13</sup>836 F.2d 1512 (8th Cir. 1988).

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the Retiree Benefit Bankruptcy Protection Act of 1988.<sup>14</sup> This act states that, in order for an employer to modify retiree health benefits after filing for Chapter 11 bankruptcy, the change must be (1) necessary to the completion of the reorganization and (2) approved by the court. Any change must be agreed to by retiree representatives, either the union (if collectively bargained) or a court-appointed committee of retirees.

While Congress has passed some legislation, the courts, in applying contract law, have provided a general framework for resolving retiree entitlement questions.

### ◆ Funding Options

Companies maintaining retiree health benefits may have a number of concerns, including reducing costs and cost volatility and managing the effects of the funding on corporate and retiree taxes. As a result, decisions on how to fund these obligations are concerned with both tax-advantaged vehicles and investment strategies. Generally, the choice of vehicle may be largely based on tax ramifications. The investment strategy used within that vehicle, discussed in the next section, may be chiefly intended to exploit tax benefits or to achieve an optimal cash flow.<sup>15</sup>

Figuring a retiree medical health liability is not as simple as calculating the present value of known costs. The unknowns of medical inflation, medical innovations, technology, and utilization patterns complicate the estimation. In addition, the government may change aspects of Medicare, thereby affecting employer plans, or it may enact national health care reform. How, then, can companies plan for and fund their retiree health liabilities?

There are several vehicles for funding retiree health, each with some tax advantages and limitations. Funds must be segregated and restricted (usually in a trust) to be used as an asset against the FAS 106 liability. These vehicles include 501(c)(9) trusts, or voluntary employee beneficiary associations (VEBAs), and 401(h) plans. Alternatively, some plans are used to help employers and employees set aside monies to help plan for the purchase of retiree health insurance, although these funds are not specifically reserved for this purpose. Such plans are 401(k) plans, corporate-owned life insurance (COLI), and employee stock ownership plans (ESOPs). Not all are tax-deductible means of funding or setting money aside, and each has specific limits. The following summary and table 1 outline these differences.

#### 501(c)(9) Trusts or VEBAs

501(c)(9) trusts, also called voluntary employee beneficiary associations (VEBAs), were originally established for use by multiemployer plans through the Internal Revenue Code (IRC) and the Labor Management Relations Act of 1947 (Taft-Hartley Act). As a result of increasing health care costs and increasing inflation, ERISA extended VEBAs to single-employer plans. VEBAs must be based on voluntary membership, and qualifications for membership eligibility must be defined by objective standards of an employment-related "common bond." The employer can make tax-deductible contributions; however, these are limited to essentially only the cost necessary to pay current welfare benefits plus a contribution to a qualified asset account.<sup>16</sup> While the contribution to the asset account is intended to fund the liability over the employees' working life, neither health inflation nor increased utilization can be taken into account when figuring that contribution. Investment income is not exempt from tax for most plans (it is taxable as unrelated

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<sup>14</sup>These provisions were originally included in the Continuing Appropriations for Fiscal Year 1987 for a specified period and then continued with the Retiree Benefit Bankruptcy Protection Act of 1988.

<sup>15</sup>An optimal cash flow in this situation would match cash inflows with cash outflows. In retiree health funding, this means having investments mature when benefits need to be paid.

<sup>16</sup>The formula is benefits actually paid during any year (direct costs), plus a reserve for estimated claims incurred in the year but not yet paid (which must be determined as reasonable by the IRS and cannot exceed 35 percent of the qualified direct costs), minus the fund's after-tax income for the year.

## LOW-INCOME BENEFICIARIES

### Background

Safeguards will be necessary to assure low income beneficiaries high quality care. If current Medicaid beneficiaries and other low-income people are enrolled in purchasing cooperatives, and the government's contribution is limited to the cost of the lowest cost plan, these individuals may have few, if any, choices of plans.

### Options/Issues

- All plans could be required to accept a percentage of low income consumers at no additional cost to the enrollee.
- The government could pay 105 percent of the lowest cost plan.
- Alain Enthoven would allow a subsidy for any health plan at or below the average cost of all the health plans.
- Garamendi suggests putting a cap on how much could be spent on other plans. This would compress premiums by creating a narrow range between the lowest and highest priced plan to ensure quality care in all plans.
- Under Medicaid, disenrollment from a health plan is allowed at any time. Should the Medicaid disenrollment policy be changed to mirror whatever enrollment/disenrollment policies are set for non-low income populations?

Mark-up Book  
Talking Points

MINORITY HEALTH  
African-Americans

Insurance

- African-Americans are almost twice as likely to be uninsured than are white Americans (non-elderly) (22% vs. 13%).

(Source: March 1990 Current Population Survey)

- Those African-Americans who do have insurance are three times as likely to rely on public coverage through Medicaid as are white Americans. (27.4% vs 8.8%)

(Source: Current Population Survey, March 1990)

- African-American children depend on Medicaid more heavily than do white children. In 1986 nearly 15 percent of black children in employed families relied exclusively on Medicaid (compared to 5 percent of white children in employed families).

(Source: Children's Defense Fund, "The Health of American Children", p. 22)

Health Status

- Life expectancy for African-Americans has actually declined while life expectancy for other groups has risen (69.4 years vs 75 years). African-Americans life expectancy is more than 5 years shorter than the overall population. Each year, 60,000 African-Americans die who would live if their death rates had been the same as white Americans.

(Source: Healthy People 2000, Sept. 1990 p. 32)

- Infant mortality among African-American children is significantly higher than white children. Black babies are twice as likely to die before their first birthday than white infants. (17.6% vs. 8.5%)

(Source: Healthy People 2000 p. 33)

- African-American men die from strokes at almost twice the rate of men in the total population, and experience a higher risk of cancer than non-black men.

(Source: Healthy People 2000 p. 32)

- The rate of AIDS among African-Americans is more than triple that of whites.

(Source: Healthy People 2000 p. 33)

#### Access to Care

- African-American mothers are twice as likely to receive no health care or care only in their last trimester of pregnancy than whites.

(Source: Healthy People 2000 p. 33)

- African-American uninsured patients have a higher in-hospital death rate than white uninsured patients.

(Source: JAMA, January 16, 1991, p. 374)

- African-Americans experience lower survival rates than the white population once they develop cancer: Only 38% of blacks with cancer survive five years after the initial diagnosis, as compared to 50% of white Americans.

(Source: Healthy People 2000 p. 33)

- African-Americans are 54 percent more likely than whites to lack a regular source of medical care (20% vs 13%).

(Source: Healthy People 2000 p. 34)

- Hospital emergency rooms and clinics are a more common source of medical care for African-Americans than for whites. In NYC, physician visits by black children are more than three times as likely to occur at hospitals than are physician visits by white children.

(Source: Healthy People 2000 p. 34)

## MINORITY HEALTH

### Hispanics

#### Insurance

- Hispanics are more than twice as likely to be uninsured than the rest of the population. (36% vs. 16%).

(Source: March 1990 Current Population Survey)

- Within every age group, the percent of Hispanic children with health insurance was significantly lower than for non-Hispanic children.

(Source: National Center for Health Statistics, October 1990)

#### Health Status

- The rate of AIDS is three times as high among Hispanics as among non-Hispanic whites. Rates among Puerto Rican-born Hispanics are 7 times higher than for the non-Hispanic population.

(Source: Healthy People 2000 p. 35)

- Hispanic women and children are disproportionately affected by AIDS. The incidence of AIDS is 8 times higher for Hispanic women than among non-Hispanic women. The rate of HIV infection is over 6 times higher among Hispanic children.

(Source: Healthy People 2000 p. 35)

#### Access to Care

- In 1987, 13 percent of Hispanic mothers had late or no prenatal care (compared to 4 percent of non-Hispanic whites). 47 percent of women receiving insufficient prenatal care are of Hispanic origin.

(Source: Healthy People 2000 p. 35)

**MINORITY HEALTH**  
**Other Minorities**

**Health Status**

- The lung cancer rate of 18 percent higher for Southeast Asian men than for the white population. The prevalence of liver cancer is 12 times as great among Southeast Asians than among whites. Hepatitis is significantly more common among Southeast Asians, and the incidence of tuberculosis is 40 times higher among Southeast Asians than among the total population.

(Source: Healthy People 2000 p. 37)

- Life-expenctancy for American Indians (including Alaskan natives) is 71 years, as compared to 74.4 years for the white population.

(Source: Indian Health Service, "Trends in Indian Health", 1981)

- As many as 95 percent of American Indian families are affected either directly or indirectly by a family member's alcohol abuse, and many of the causes of excess deaths in the American Indian population (cirrhosis, homicide, suicide) are related to the prevalence of alcohol use.

(Source: Healthy People 2000 p. 39)

- Diabetes is a major health problem for American Indians, affecting as many as 20 percent of the members of certain tribes (Obesity being a major contributing factor).

(Source: Healthy People 2000 p. 39)

Minority Health Insurance Coverage  
(Nonelderly)

(In Percentages)

| <u>Population</u> | <u>Any Coverage</u> | <u>Employer Based</u> | <u>Public</u> |
|-------------------|---------------------|-----------------------|---------------|
| Total             | 83.9                | 65.9                  | 12.3          |
| White             | 87.6                | 71.8                  | 8.8           |
| Black             | 78.0                | 49.2                  | 27.4          |
| Hispanic          | 64.0                | 44.4                  | 17.3          |

SOURCE: March 1990 Current Population Survey

Mark-up Book  
Talking Points

Women's Health

Insurance

- 15.2 million women in the U.S. had no health insurance from any source in 1989.

(Source: Natl. Commission on Working Women/Wider Opportunities for Women, February 1991, p. 1)

- Almost half of all uninsured women were employed (in 1989).

(Source: Natl. Commission on Working Women/Wider Opportunities for Women, February 1991, p. 1)

- Uninsured women are 7 percent more likely than uninsured men to rely on Medicaid. (23.1 vs 21.6)

(Source: Employee Benefit Research Institute, "Uninsured in the United States", April, 1991, p. 44)

- Divorced or separated women are twice as likely to be uninsured as married women.

(Source: Natl. Commission on Working Women/Wider Opportunities for Women, February 1991, p. 1)

- 26 percent of Hispanic women and 19.1 percent of black women in the labor force are without health insurance compared to 11.5 percent of white women.

(Source: Healthy People 2000, p. )

- Single parent families, nearly 90 percent of whom are headed by women, are especially likely to lack health insurance. One-third of single parent families with a full-time worker are uninsured. (as compared to 12 percent of two-parent families with a full-time worker)

(Source: Bureau of Labor Statistics)

- More than one-quarter of all women of childbearing age, 15 million women, have no private or public health insurance coverage for maternity care. Each year 550,000 women are without health insurance coverage when they deliver their babies.

(Source: Natl. Commission on Working Women/Wider Opportunities for Women, February 1991, p. 1)

- Five million women with private health insurance do not have coverage for maternity care.

(Source: Natl. Commission on Working Women/Wider Opportunities for Women, February 1991, p. 1)

- Maternity care accounts for 27 percent of all hospital charges for patients with no source of insurance.

(Source: Guttmacher Institute, 1987)

- Less than one in eight workers are covered by a group health plan that includes screenings like mammograms and pap smear tests.

(Source: Healthy People 2000 p. )

SOURCE OF HEALTH INSURANCE FOR  
WOMEN

(In Percentages)

|                                     | Direct Emp.<br>Coverage | Indirect Emp<br>Coverage | Medicaid | No<br>Coverage |
|-------------------------------------|-------------------------|--------------------------|----------|----------------|
| Working Women<br>age 18 - 64        | 49.0                    | 24.8                     | 3.4      | 13.4           |
| Non-working<br>Women<br>age 18 - 64 | 4.6                     | 42.4                     | 19.7     | 18.8           |

SOURCE: Employee Benefit Research Institute, "Uninsured in the United States", April, 1991, p. 44

Mark-up Book  
Talking Points

Children Health

Insurance

*Peace Data*

- Almost 10 million American children are uninsured -- this is nearly 16 percent of all children under age 18. \*

(Source: Employee Benefits Research Institute, "The Uninsured in the United States", April 1991, p. 12)

- The problem is not confined to the poor: Most uninsured children were in families whose family head was a full-time full-year worker (56%). \*

(Source: EBRI, "The Uninsured in the United States", April 1991, p. 12)

- More and more employers have dropped coverage for dependents in an effort to reduce their costs. From 1982 to 1988 the proportion of medium- and large-sized employers fully underwriting the cost of dependent coverage fell 25 percent <sup>Now</sup> ~~from more than half to less than 40 percent~~ <sup>do</sup> \*

(Source: Children's Defense Fund, "The Health of American Children", p. 23)

- Black children - even black children in working families - depend on Medicaid more heavily than do white children. In 1986 nearly 15 percent of black children in employed families relied exclusively on Medicaid for their health insurance coverage (As compared to only 5 percent of white children in employed families).

(Source: Children's Defense Fund, "The Health of American Children", p. 22)

- One in five uninsured pregnant women (in 1986) did not seek medical care early in her pregnancy, and the number of babies born to women who did not seek prenatal care grew nearly 10 percent between 1979 and 1988. America ranks a shameful 22nd among developed countries in infant mortality rates.

(Source: The Pepper Commission, "A Call for Action", Sept. 1990, p.35)

## Health Status

- In 1988, death rates for black and American Indian children (49 and 44 per 100,000) were much higher than for white children (30 per 100,000).

(Source: DHHS, "Health United States", 1990, p. 13)

## Access to Care

- Health insurance coverage has a significant impact on children's use of health services, particularly among older children. Insured children were significantly more likely to have had a regular source of primary health care and were more likely to have made at least one preventive health visit during the year.

(Source: Children's Defense Fund, "The Health of American Children, p. 23)

- A quarter of all children do not see a physician even once during the course of a year. Often, for those who do, the only family doctor they know is the hospital emergency room.

(Source: 1986 Robert Woods Johnson Foundation Survey, "Americans Report on Their Health Care", p. 3)

- Millions of American children are failing to receive immunizations that can protect them against diseases that can be prevented, such as polio, measles, and mumps. For example, if the trends in polio immunization rates that prevailed from 1980 to 1985 continue, nearly one in five children will not be fully protected against this crippling disease in the year 2000.

Also, more children died in 1990 from measles than in any year since 1971.

(Source #1: Children's Defense Fund, "A Vision for America's Future, 1990, p. 4)

(Source #2: Children's Defense Fund, "The health of America's Children", p. 3)

- Families and children who are ineligible for Medicaid, or who can not find a provider who will take Medicaid patients, must rely on an underfunded patchwork of public health programs. Our nation's 550 community health centers serve only 5 million patients each year, leaving 20 million eligible people, two-thirds of whom are women of childbearing age and children, without such services.

(Source #1: Children's Defense Fund, "A Vision for America's Future, 1990, p. 10)

PERCENT OF CHILDREN COVERED BY A HEALTH  
INSURANCE PLAN BY AGE,  
RACE AND ETHNICITY  
1988

|                 | All<br>Ages | Under<br>1 year | 1-4<br>Years | 5-7<br>Years | 8-11<br>Years | 12-14<br>Years |
|-----------------|-------------|-----------------|--------------|--------------|---------------|----------------|
| All<br>Children | 83.3        | 80.1            | 83.7         | 83.3         | 83.3          | 82.3           |
| White           | 83.7        | 80.7            | 84.4         | 84.3         | 83.6          | 83.5           |
| Black           | 80.9        | 81.2            | 80.5         | 79.7         | 84.1          | 81.7           |
| Latino          | 70.0        | 62.2            | 75.2         | 76.3         | 65.0          | 68.3           |

(SOURCE: Children's Defense Fund, "The Health of America's Children", p. 23)

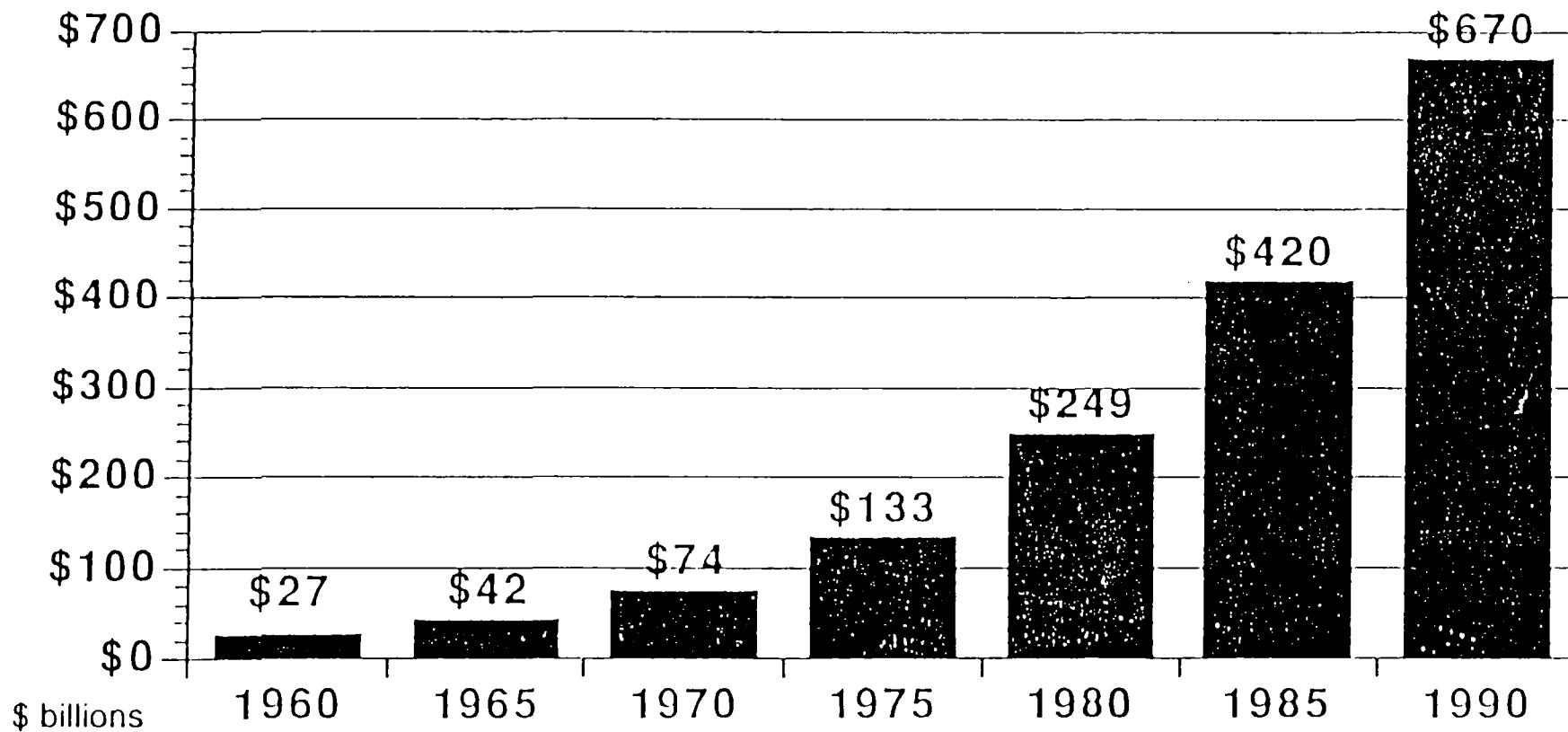
PERCENTAGE OF  
CHILDREN'S HEALTH INSURANCE COVERAGE BY  
INCOME LEVEL

|                        | Insured by Public<br>Private Plan | Uninsured or<br>Unknown Status |
|------------------------|-----------------------------------|--------------------------------|
| Less than<br>\$10,000  | 71.8                              | 28.2                           |
| \$10,000 -<br>\$24,999 | 76.1                              | 23.9                           |
| 25,000 -<br>39,999     | 89.8                              | 10.2                           |
| More than<br>\$40,000  | 92.4                              | 7.6                            |

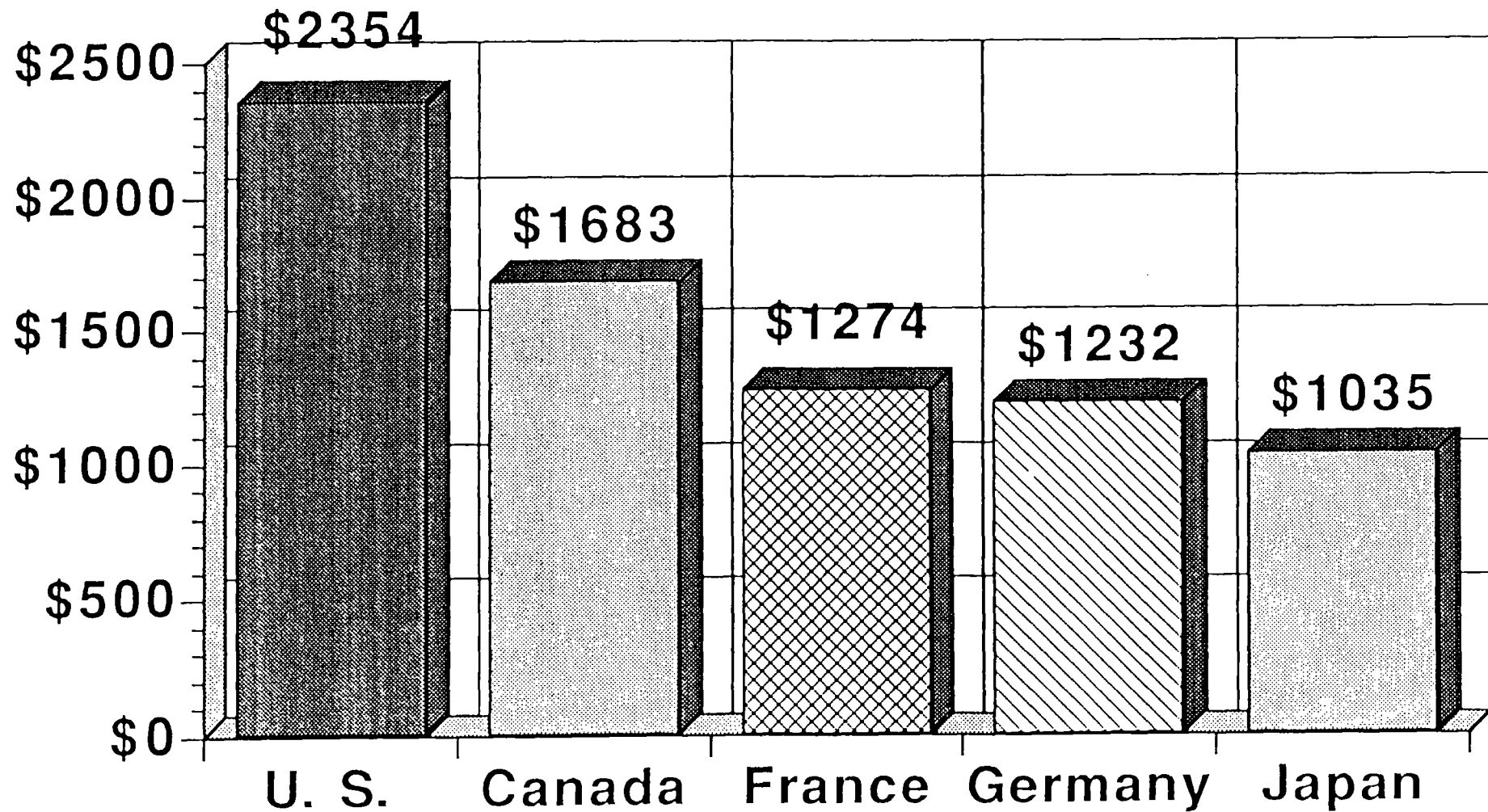
(SOURCE: Children's Defense Fund, "The Health of America's Children", p. 22)

# U.S. Health Costs Are Rising Rapidly

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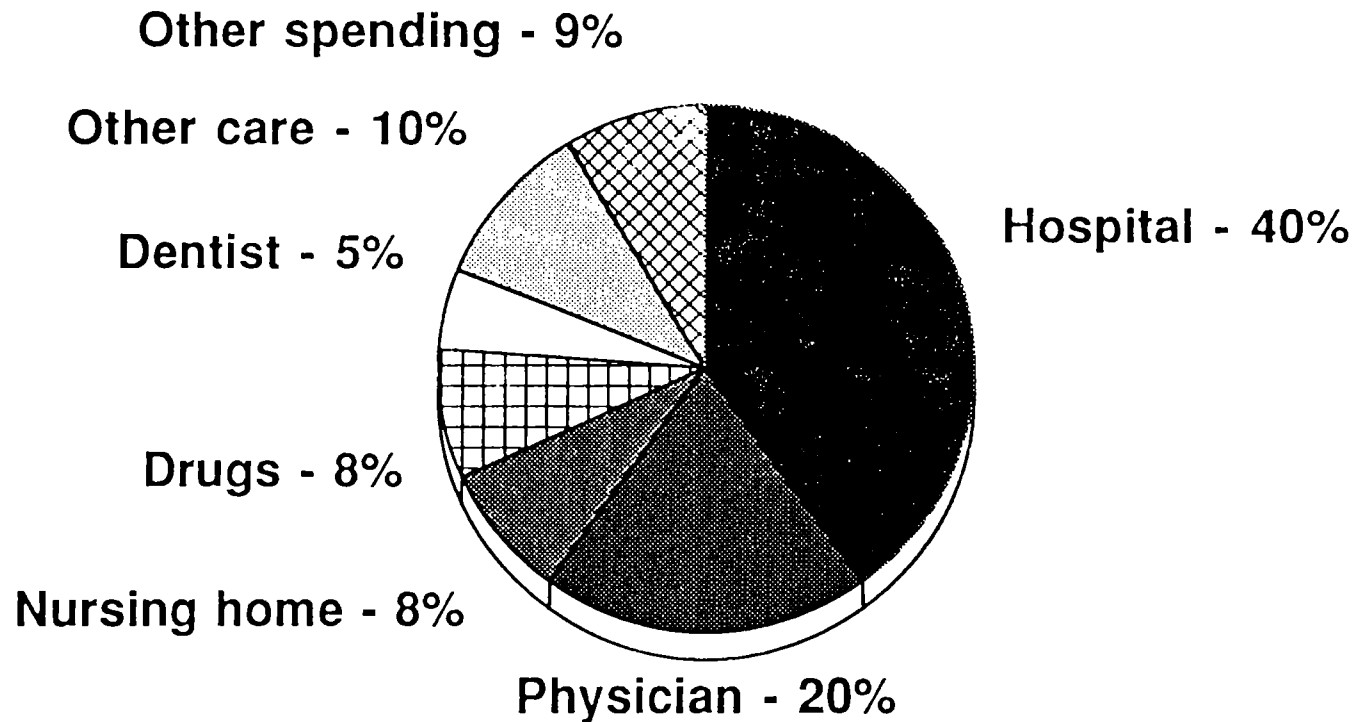


# International Health Care Spending Per Capita, 1989



# Health Care Services

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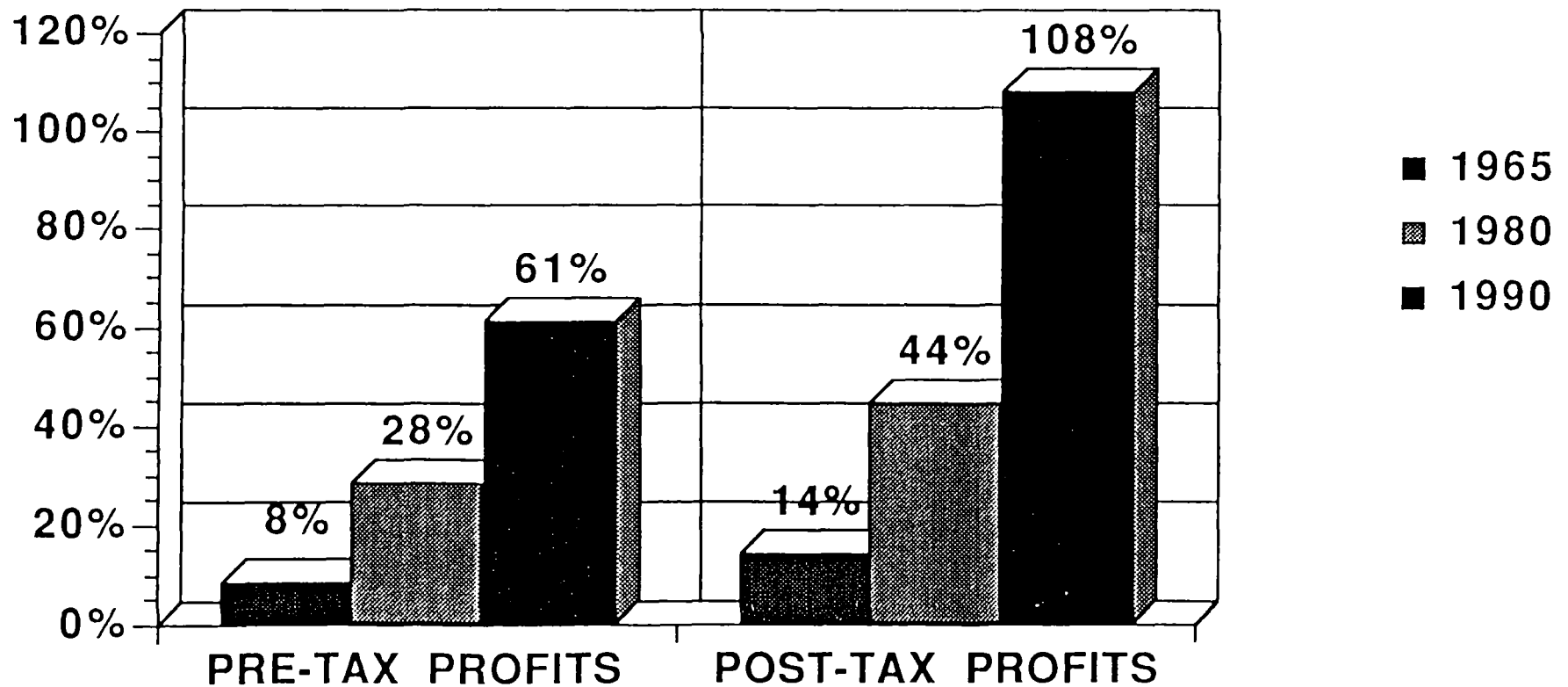


# Federal Budget Projections

|                              | 1993   | 1998   | 2003   |         |
|------------------------------|--------|--------|--------|---------|
| Medicare & Medicaid          | \$226B | \$405B | \$672B | \$+446B |
| Interest                     | 198    | 292    | 437    | +239    |
| Social Security & Retirement | 363    | 464    | 577    | +214    |
| Discretionary                | 547    | 584    | 668    | +121    |
| Other                        | 118    | 94     | 105    | -13     |
| DEFICIT                      | -310   | -357   | -653   |         |

# Corporate Health Costs vs Profits

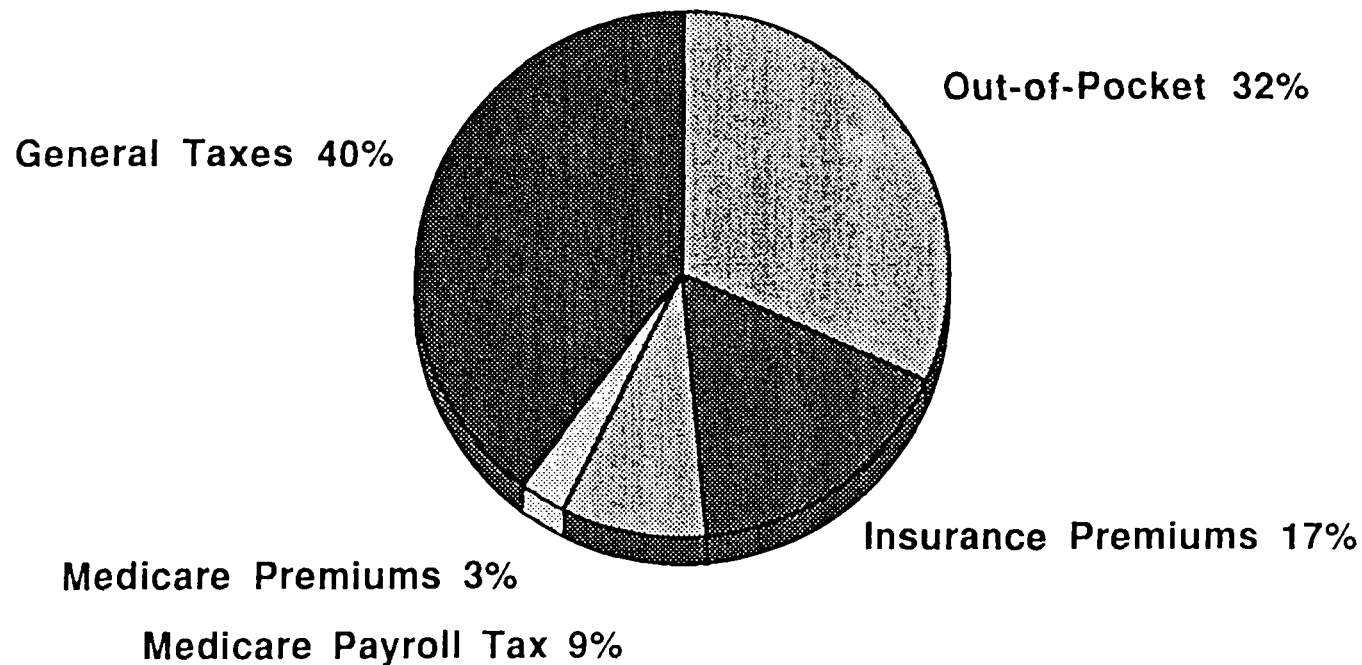
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# Family Payments for Health Care, 1991

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**\$4,296 Per Family**

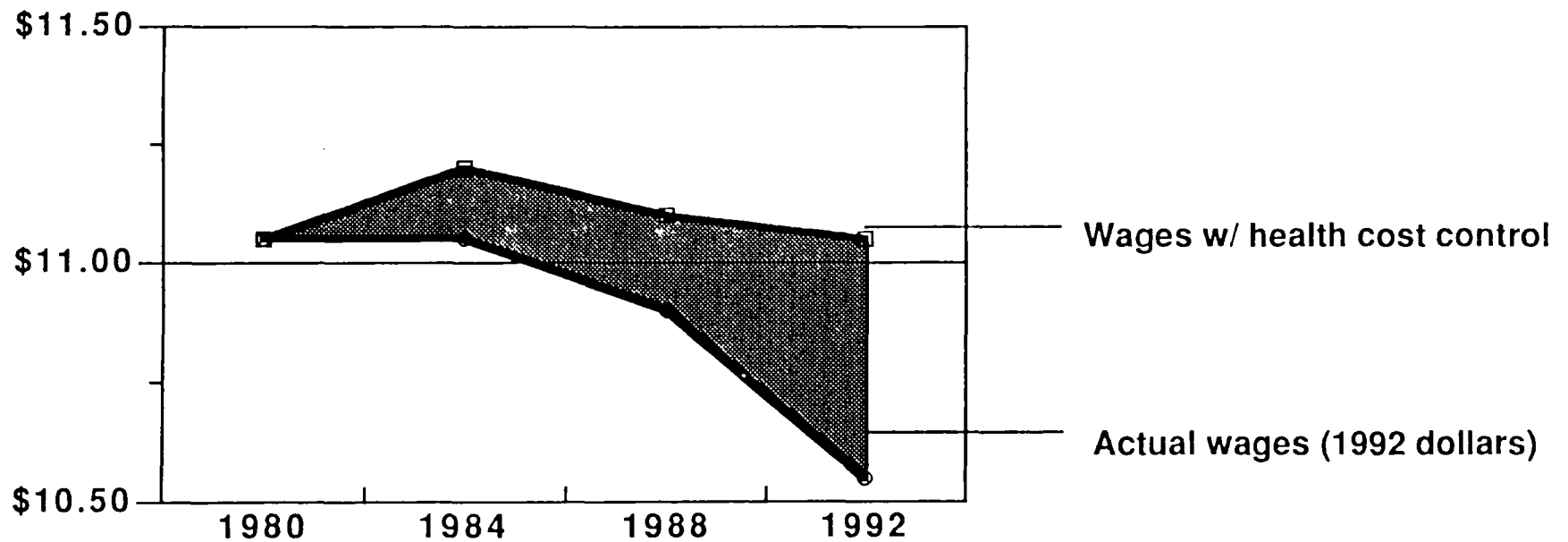


Source: Families USA, Lewin-VHI

# Falling Real Wages

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## Non-Supervisory Hourly Wages, Private Sector



Source: LewIn-VHI, SEIU

# Financial Stakes in the 1990s

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## HEALTH CARE SPENDING 1990-1999 (est)

|         | NATIONAL | CORPORATE |
|---------|----------|-----------|
| 10%/yr  | \$10.7 T | \$3.4 T   |
| 7.5%/yr | \$9.3 T  | \$3.0 T   |
| Savings | \$1.4 T  | \$0.4 T   |

# **Health Care Cost Control**

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## **Two Major Strategies**

- **Government regulation**
- **Market reform - "managed competition"**

# **Government Regulation**

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## **Elements**

- **Set hospital & physician payments, national/regional budgets**

## **Experience**

- **Medicare & Medicaid, other nations**

# **Government Regulation**

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## **Pros**

- **Effective (prices), quick start-up**

## **Cons**

- **Limits (volume, access), symptoms vs problems, micro-management**

# **Managed Competition**

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## **Elements**

- **Organized care plans, pro-consumer markets (plans compete on cost, quality & service, not "risk avoidance"), incentives**

## **Experience**

- **HMOs & other plans, large employers**

# **Managed Competition**

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## **Pros**

- **Effective (inpatient volume), consumer choice, redirects market forces, rewards performance**

## **Cons**

- **Time-consuming, annoyances, possible underservice, not proven nationwide**

# Other Initiatives

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**Administrative costs, clinical effectiveness & guidelines, data systems, health professions policy, life-style changes & personal responsibility, malpractice reform, primary & preventive care, technology assessment**

To: Senator Harris Wofford's Office  
Attn: Darrel J.  
FAX: (202) 224-4161

From: Edrie Cross  
FAX: (814) 944-4831

Date: February 9, 1992

RE: Conference on Health Care Reform

"Wish List" for Health Care Reform

- \* Affordable coverage for everyone.
- \* Coverage without pre-existing condition restrictions.
- \* Coverage which includes a drug program.
- \* A plan which affords the consumer the choice of physician and/or health care facility.....not an HMO!
- \* Possibly a plan which is set up similar to Medicare. Increase the premiums to say \$100/month. Have private insurance industry develop supplemental insurance to pick up where the 'medicare-clone' insurance leaves off. (Patterned after the Senior market.)

# Withdrawal/Redaction Marker

## Clinton Library

| DOCUMENT NO.<br>AND TYPE | SUBJECT/TITLE                                                                                          | DATE   | RESTRICTION |
|--------------------------|--------------------------------------------------------------------------------------------------------|--------|-------------|
| 001. letter              | From: Edrie Cross; To: Senator Harris Wofford's Office; Re: Conference on Health Care Reform (2 pages) | 2/9/92 | b(6)        |

### COLLECTION:

Clinton Presidential Records  
First Lady's Office  
Liz Bowyer  
OA/Box Number: 3979

### FOLDER TITLE:

Pennsylvania Health Care Conference Briefing Book [binder] [2]

2014-0483-S

sb452

### RESTRICTION CODES

#### Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]  
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]  
P3 Release would violate a Federal statute [(a)(3) of the PRA]  
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]  
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]  
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

#### Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]  
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]  
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]  
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]  
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]  
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]  
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]  
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

**RALPH PONTILLO**  
**President, Manufacturers Association of N.W. Pennsylvania**  
**(administrator of the Erie Health Cost Summits)**  
**Erie, PA**

Members of the Erie community were brought together in January 1992 by the realization that the system could not sustain itself economically because of high health care costs. "Pure and economic" conditions drove them to create the Summit.

The Health Care Cost Summit represents about 80 CEOs from the health insurance industry, providers, and employers from the greater Erie metropolitan area.

At the group's first Summit, the attendees agreed overwhelmingly that they should try to hold down health care costs on the community level. A couple of their first findings were the need for tort reform and anti-trust legislation.

In the absence of Federal antitrust legislation, the group put together a piece of state legislation designed to enable the Governor to approve an antitrust waiver allowing two hospitals in Erie (Hammett and St. Vincent's) to collaborate in their planning efforts. Under the legislation, the state Attorney General would oversee activities of the hospitals to ensure that such collaborative arrangement does not develop into a monopoly situation.

Another realization of the community was the extraordinary high rate of infant mortality in the region. When they investigated the problem, they discovered that their data systems were not systematic or compatible so that few hypotheses could be proven with any strong degree of confidence. This led them to their second conclusion: the need for a centralized data system with a standardized reporting mechanism.

Ralph is a strong believer in establishing budgets community by community, but he agrees that different regions have different circumstances and different histories. One of his key points is that communities -- and the system -- must have incentives to be cost-effective at the local level, otherwise cost-shifting from one geographic area to another will continue.

Summit I: January 1992

Summit II: June 1992

Summit III: January 1993

Summit IV: Planned for July or September 1993 (focus will be on medical equipment and pharmaceutical manufacturers)

### Questions

1. How quickly do you think that savings will be in the system realized from the activities you are taking on in Erie on a local level?
2. How would an area such as Erie fit into the framework of a managed competition system?
3. You work with a number of small business persons in your area. For most of them, as for many small business owners and employees across the country, high costs are making health coverage more and more unaffordable. What kind of steps do you think we need to take in the short term if we are to have any impact on the rate of growth in health care costs?

# Health Care Cost Summit

3537 West 12th Street • Erie, Pennsylvania • 16505  
814/833-3200 • FAX 814/833-4844

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## HEALTH CARE COST SUMMIT FAST FACTS

- ESCALATING HEALTH CARE COST IS THE MOST PRESSING ISSUE FOR THE '90S. THERE IS GENERAL AGREEMENT THAT SOMETHING MUST BE DONE, HOWEVER; NO ONE PERSON OR GROUP KNOWS EXACTLY WHAT THAT "SOMETHING" IS. THE GENERAL CONSENSUS IS THAT HEALTH CARE COST IS A NATIONAL ISSUE AND SHOULD BE RESOLVED AT THE NATIONAL LEVEL. IN THE ERIE COMMUNITY, THERE IS A GROWING BELIEF THAT THIS IS, IN FACT, A COMMUNITY ISSUE AND MUST BE ADDRESSED AND RESOLVED ON A COMMUNITY LEVEL.

- ON JANUARY 16, 1992, THE ERIE COMMUNITY SPONSORED A HEALTH CARE COST SUMMIT. FOR THE FIRST TIME, ALL THE MAJOR STAKEHOLDERS OF THIS ISSUE-HEALTH CARE PROVIDERS, INSURANCE COMPANIES, EMPLOYERS, UNION LEADERS AND POLITICIANS- MET TO FORMULATE A COMPREHENSIVE STRATEGY TO ADDRESS HEALTH CARE COSTS IN ERIE. THESE STAKEHOLDERS CAME TOGETHER NOT TO PHILOSOPHICALLY DISCUSS HEALTH CARE COSTS OR TO ASSESS BLAME. THEY CAME TOGETHER TO ATTACK A COMMON ECONOMIC THREAT TO ERIE- SPIRALING HEALTH CARE COSTS.

- AS A RESULT OF SUMMIT I, FOUR COMMITTEES WERE FORMED TO ADDRESS THE FOLLOWING TOPICS:

- 1- DETERMINE WHAT WE- THE ERIE COMMUNITY- REALLY WANT FROM OUR REGION'S HEALTH CARE SYSTEM.
- 2- DETERMINE THE LEGAL/LEGISLATIVE PROBLEMS THAT MIGHT PREVENT OR BECOME AN OBSTACLE TO COLLABORATIVE EFFORTS.
- 3- DETERMINE THE LESSONS TO BE LEARNED FROM PREVIOUSLY SUCCESSFUL AND UNSUCCESSFUL COLLABORATIVE EFFORTS.
- 4- DEVELOP A MENU OF WHAT COLLABORATIVE EFFORTS MIGHT OCCUR.

- THE INFORMATION GATHERED BY THESE FOUR COMMITTEES BECAME THE SUBSTANCE OF HEALTH CARE COST SUMMIT II HELD ON JUNE 30, 1992. SUMMIT II ALSO ALLOWED FOR A GROWING REPRESENTATION AT THE SUMMIT OF COMMUNITY LEADERSHIP. THE EVER GROWING INTEREST IN AND COMMITMENT TO A PROCESS, SUCH AS THE SUMMIT, DEMONSTRATES THE SIGNIFICANCE OF THE HEALTH CARE COST ISSUE TO ERIE. THE SECOND SUMMIT PARTICIPANTS AGREED TO:

- 1- FORM A COMMUNITY HEALTH CARE NEEDS TASK FORCE
- 2- FORM AN ANTI-TRUST/TORTE REFORM TASK FORCE
- 3- FORM AN ADVISORY COMMITTEE COMPRISED OF SUMMIT PARTICIPANTS

# Health Care Cost Summit

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- 4- HIRE A SUMMIT ADMINISTRATOR
- 5- SCHEDULE A THIRD SUMMIT NO LATER THAN SIX MONTHS  
FROM THE SECOND SUMMIT DATE.

- ON JANUARY 12, 1993, HEALTH CARE COST SUMMIT III WILL CONVENE. ONCE AGAIN, INTEREST GENERATED BY THE SUMMIT CONCEPT HAS BROADENED THE PARTICIPANTS LIST. SUMMIT III WILL BRING TOGETHER DECISION MAKERS FROM HEALTH CARE, EDUCATION, INDUSTRY, LABOR, INSURANCE AND POLITICS.

- PLEASE REFER TO THE ATTACHED AGENDA FOR A LIST OF THE TOPICS TO BE PRESENTED AT HEALTH CARE COST SUMMIT III.

# List of Invited Participants

Gerald Alonge  
Anthony Andrezski  
John Aymong  
Gene Barone  
F. Brad Biggar  
Karl Boyes  
Joseph Borgia  
Harry Brown  
Pat Bruno  
Atty. Donald Buseck  
Italo Cappabianca  
Robert Casey  
Robert Cisler  
Allan Concoy  
Donald DiPlacido  
Dr. David Doupe  
Dr. Richard Dreyfus  
Mary Eckert  
Marlin P. Eisert  
Thomas Foley  
Dr. John Fleischauer  
William Fox  
James Freeman  
J. B. Friih  
Dr. Teresa Fryer  
Dr. Yen Jen Fuh  
Frank Gerlach  
Chester Giermak  
Thomas Hagen  
Corrine Halperin  
Sisler Margaret Ann Hardner  
Robert Harrison  
Dr. David D. Howell  
Dr. William Garvey  
Thomas Hoffman  
  
Dr. David A. Klees  
Deanna Klein  
Linda Babko Jones  
Fiore Leone  
Dr. John Leuenberger

Horizon Joint Venture  
State Senator (19th District)  
American Sterilizer Co.  
Blue Cross of Western Pennsylvania  
International Paper  
State Representative (3rd District)  
Erie City Council  
EBC Industries, Erie Bolt Division  
AFL-CIO  
Erie County Bar Association  
State Representative (2nd District)  
Governor  
VA Hospital  
Erie Forge & Steel  
Erie Chamber of Commerce  
Hamot Health Foundation  
Saint Vincent Health Center  
Millcreek Community Hospital  
Erie Insurance Group  
Department of Labor and Industry  
Edinboro University  
Great Lakes Rehabilitation Hospital  
Lorcl Corporation  
Metro Health Center  
Metabolic Disease Associates, Inc.  
VA Hospital  
Saint Vincent Health Center  
Eriez Magnetics  
Erie Insurance Group  
NW PA Area Labor Mgt. Council  
Saint Vincent Health Systems  
JFK Minority Development Enterprises  
Erie County Medical Society  
Mercyhurst College  
Erie Conference on Community  
Development  
Metro Health Center  
Fairview Manufacturing Corporation  
State Representative (1st District)  
Erie County Council  
Intermediate Unit #5

John O'Brien  
Judy Lynch  
Cynthia Maleski  
Ronald Mangine  
Dr. William Makarowski  
Joseph Marchini  
Raymond McGarvey  
Cameron McGinnis  
Michael Mead  
James Merry  
Ronald Mong  
Robert Molsinger  
Louis Musante  
  
Robert Nardelli  
James Nelson  
  
John Peterson  
Louis Pollock  
Ralph Pontillo  
  
Bruce Raimy  
  
Thomas Ridge  
Denise Robison  
M. Shawn Rooney  
Msgr. David Rubino  
Joyce Savocchio  
George Scholfield  
  
Thomas Scrimenti  
Sydney Smith  
Arlen Specter  
Dr. John Tedesco  
John Tramonlano  
Philip Tredway  
Atty. Michael Visnosky  
Fred Williams  
Benjamin Wiley  
Thomas Wedzik  
Harris Wofford  
William Wohlgenuth

Hamot Health Foundation  
Erie County Executive  
State Insurance Commissioner  
General Electric Company  
Great Lakes Rehabilitation Hospital  
Metro Health Center  
Saint Vincent Health Systems  
Erie County Department of Health  
Times Publishing Company  
State Representative (5th District)  
Mong Dairy Company  
General Electric Company  
Westminster Manufacturing  
Corporation  
General Electric Company  
United Electrical, Radio and  
Machine Workers of America  
State Senator (25th District)  
Morris Coupling Company  
Manufacturer's Association of  
Northwest Pennsylvania  
Erie Conference on Community  
Development  
US Congressman (21st District)  
Erie City Council  
Niagara Plastics Company  
Gannon University  
Mayor, City of Erie  
Coalition for Health Cost  
Containment  
State Representative (4th District)  
Union City Chair Company  
US Senator  
Millcreek Community Hospital  
Teledyne Penn-Union  
Erie Molded Plastics, Inc.  
Millcreek Community Hospital  
Martin Luther King Center  
GECAC  
Banking Clearinghouse  
US Senator  
The Travelers

**MICHAEL DOPERA**  
**Manager of Employee Benefits**  
**Bethlehem Steel**

Attached are the reports from the United Steelworkers of America and the National Leadership Coalition for Health Care Reform and a list of corporate and individual supporters of the NLC proposal.

**Background**

In 1989, Bethlehem Steel and four other major steel companies (Inland, National, Acme, Wheeling-Pittsburgh) and the United Steel Workers Association (USWA) agreed to work together for a national policy on health. In March 1991, they adopted a statement of principles for health care reform. Their principles feed directly into the reform proposal developed by the National Leadership Coalition for Health Care Reform which they support.

The approach is built upon the employment-based system, with the addition of a uniform provider payment system and universal coverage through private and public plans.

The proposal would replace the current acute care Medicaid program with a public plan administered by the federal government, although the federal government could contract with state governments or other entities to carry out various administrative functions.

**The National Leadership Coalition for Health Care Reform proposal** is the result of an 18-month consensus building process that balanced the interests of businesses in all sorts of industries, unions of private-sector and public-sector employees, health care professionals, and consumers. Of note is that the proposal--which includes national spending targets--is also supported by 21 academic health centers.

The report outlines a plan designed to deliver higher-quality care than the present system to all Americans at a much lower cost.

The Coalition's plan has eight interconnected elements:

- Initiatives to improve the quality of health care,
- Universal coverage
- Cost controls
- Organized delivery systems
- Management and oversight
- Insurance reform
- Malpractice reform
- Administrative simplicity

The Coalition proposes a multi-pronged approach to controlling health care costs that include: an annual target for health care expenditures for the private and public sectors, the establishment of payment rates for health care services, constraints on capital as well as operating expenses, increased use of preventive care, reductions in the number of unnecessary technologies and procedures, and administrative simplification.

They calculate that implementation of these proposals would save in excess of \$600 million by the year 2000.

### Questions

1. Your proposal includes support for initiatives that would encourage the development of organized delivery systems. You propose that all payers in a state would operate under the same rate schedule -- and all patients would receive the same comprehensive benefit package. Exactly how would competition be structured in your proposed plan?
2. Are regional purchasing cooperatives compatible with your notion of managed competition?

**SISTER JOANNE MARIE ANDIORIO**

**President**

**Mercy Hospital**

**Pittsburgh, PA**

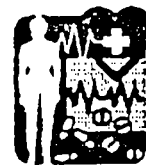
Within the hospital community, Sister Joanne Marie Andiorio is a well-known spokesperson for health care reform. Mercy is a member of the Catholic Health Association. CHA, by its very mission, has been a supporter of universal health care for years.

The foundation of the CHA reform proposal is the formation of coordinated care networks (Accountable Health Partnerships). Thus there are some significant overlaps with the managed competition approach.

Questions

1. What steps do you think we need to take in the short term to bring health care costs under control?
2. The Catholic Health Association's health reform proposal advocates the development of community care networks. Could you comment on how these kinds of systems would be implemented? Would you see a role in the system for some kind of purchasing cooperative to act as the agent for the consumer?

# HEALTH POLICY BRIEFS



BETHLEHEM STEEL CORPORATION, HUMAN RESOURCES DEPARTMENT  
VOL. 1, NO. 9

**"The election of Bill Clinton as the nation's 42nd President is likely to lead to the most sweeping overhaul and expansion of the nation's health care delivery system ever."**

—Business Insurance

## Editor's Notes

*This issue of BRIEFS describes the health policy reform plan of the Joint National Health Care Policy Committee of the USWA and Member Companies, including Bethlehem. The Joint Committee plan calls for national expenditure targets and regulated provider payment rates to control health care costs. During the election campaign, President-elect Clinton spoke of the need for "global budget" ceilings for health costs and fee schedules similar to Medicare. There appears to be some common ground with the new administration. The Steel Companies and the USWA will be working together with the new administration and the Congress for comprehensive health care reform.*

—Ben Boylston

## Steel Companies and USWA Call for National Health Reform

**N**ational debate has finally begun to concentrate on the social and economic problems confronting our health care system. However, pressure on the steel companies and the USWA has already surfaced with regard to the insurance programs for steel employees and retirees.

Health care costs are continuing to escalate at a rate which is unsustainable, thereby putting a severe strain on collective bargaining and the viability of group health plans. Despite joint labor-management efforts at the company and even industry level since 1986 to control costs, we have concluded that fundamental changes need to be legislated at the national level.

Problems of access and cost containment are intertwined in such a way that only a comprehensive national solution will suffice. Piecemeal changes have not given us equitable access, controlled cost, assured quality, or provided public satisfaction. The competitiveness of domestic industry in the international marketplace is at stake.

In 1989, Bethlehem and four other major steel companies and the

USWA agreed to work together for a national policy on health. In March of 1991, a statement of principles for systemic health care reform was adopted (see page 4). Subsequently, the Joint National Health Care Policy Committee of the United Steelworkers of America and Member Companies undertook the task of developing a consensus report. The approach is to build upon the employment-based system, wherein there would be a uniform provider payment system and universal coverage through private and public plans.

The national debate must be infused with a sense of urgency. Fundamentally, a comprehensive public policy decision, which must be made if health care programs are to be sustained, will emerge only if the major segments of our business and labor communities demand action in the political forum and do so in coalition. The report of the Joint National Health Policy Committee represents our strong conviction that a legislative solution must be developed—soon.

The recommendations of the Joint Committee has six essential features which are summarized below.

*National Health Reform, continued on page 2*

## *National Health Reform (cont'd)*

### ☐ *Employer Choice of Public or Private Insurance Coverage*

Under this proposed universal health insurance system, employers would have the choice of providing basic health insurance coverage to workers and dependents privately, or paying a payroll tax contribution toward the cost of their coverage under a nationwide public plan administered by the government.

### ☐ *All Payer Provider Payment System*

An all payer provider payment system would be established for controlling health care costs. Private health insurance plans, as well as public health insurance plans, would pay hospitals, physicians and other health care providers at the same prospective payment rate. Expenditure targets would be established to constrain total health care spending. Under this system, payment rates could be negotiated with providers, or, for example, the Medicare payment system could be extended to all insurance plans.

### ☐ *Quality of Care*

The plan would improve the quality of care available to all Americans through expanded funding of health outcomes and medical effectiveness research, development of national guidelines for medical practice tied to payment, and malpractice reform, including alternative dispute resolution mechanisms. Systems for measuring and monitoring quality of care for individual providers would be developed. Providers not meeting quality standards would not be eligible for participation in public and private health insurance plans. Accreditation of health care facilities would be linked to performance in meeting quality standards.

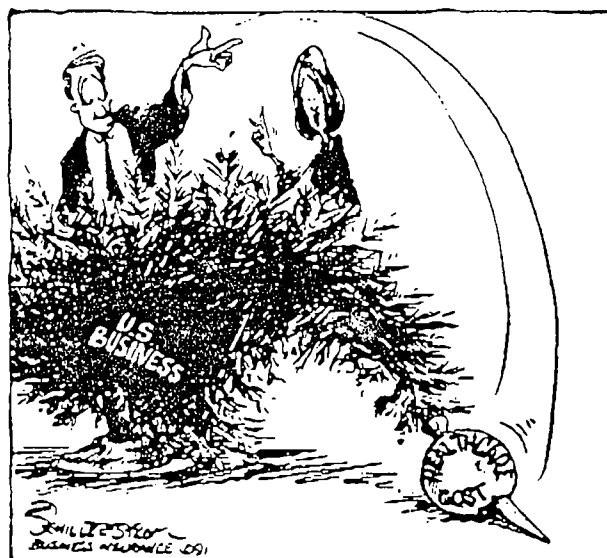
### ☐ *Expansion of Medicare to Retirees under Age 65*

The eligibility age for Medicare would be reduced to age 60. Employers would also be given the option of buying Medicare coverage for retirees under age 60 by making the same payroll tax contribution assessed for active workers covered under the

public plan. Employer health insurance plans would continue to be primary payers for working older adults, while Medicare would be primary payer for retired individuals.

### ☐ *Subsidies for Low-Income Families*

Public plan coverage would be automatically extended to all individuals not covered under a private health insurance plan. The public plan would be a uniform national plan administered by the federal government, although the federal government could contract with state governments or other entities to carry out various administrative functions. Public plan coverage would be provided without charge to those uninsured with family incomes below the federal poverty level. Partial subsidies would be provided to those with incomes up to twice the federal poverty level. This plan would also replace acute care coverage under the current Medicaid program. Low-wage workers covered under employer-provided



"I DON'T THINK IT CAN TAKE ANY MORE ORNAMENTS!"

## National Health Reform (cont'd)

private health insurance would also receive subsidies to offset premium contributions to private health insurance plans, such as an increase in the Earned Income Tax Credit.

### □ Administrative Simplification

The plan would reduce the administrative cost of the current system and make health insurance easier for patients and providers to understand. Creation of a single system of hospital and physician payment would eliminate the confusion of multiple systems now in place. Establishment of a prospective payment system for hospitals based on diagnosis-related groups would eliminate the system of hospital charges which currently requires detail itemization and tracking of services received by patients. A uniform claims form for hospitals and physicians, and other health care providers, would be used by all payers—public and private.

### Summary

The principal advantage of the plan is that it is a feasible approach that draws on the strengths of the current system while simplifying the benefit and provider payment structure and instituting innovations to promote efficiency. It minimizes the need for additional federal outlays. It spreads the financial burden of health spending more equitably among employers and states. It makes health insurance more affordable to small businesses, self-employed, and non-employed individuals.

It builds on the existing administrative system for employer-provided health insurance and medicare, and most importantly, realizes savings from lower administrative costs to these plans. It replaces the current Medicaid program, that has proven inadequate to assure mainstream health care for the nation's poor.

It achieves greater equity within the health care system by reducing the fiscal burden on hospitals, physicians, and primary care centers providing charity care to the uninsured and contributes to their financial survival. It protects all Americans from the financial hardship of health care bills, and it helps get all children off to a healthy start in life through comprehensive coverage of maternal and infant health care.

It eliminates disruptive cost shifting and it should yield effective cost containment through a unified payer approach to setting physician and hospital payment rates within overall expenditure targets similar to those of other industrialized nations. This approach has a minimal disruptive economic impact and is likely to have a negligible impact on employment in small firms, with some expansion of jobs in the health sector. Its design minimizes any inflationary impact on the health sector, while making American products more competitive in international markets through effective cost controls and more equitable sharing of costs among employers.

The U.S. cannot afford to continue on its present course with a costly health system that subjects many of its most vulnerable citizens to inadequate health care. It is hoped that this report will contribute to shaping a consensus for change.

### The Joint National Health Care Policy Committee

#### Co-Chairmen

|                                                                                    |                                                                                    |
|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
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| Benjamin C. Boylston<br>Bethlehem Steel Corporation                                | Andrew V. Palm, Director<br>USWA, District 15                                      |
| William P. Boehler<br>Inland Steel Company                                         | Anthony Rainaldi, Director<br>USWA, District 20                                    |
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|                                                                                    | Ernest Shock, Director<br>USWA, Upstream Division                                  |
|                                                                                    | Raymond MacDonald, Director<br>USWA, Research Department                           |
|                                                                                    | Paul Sechaler,<br>Health Care Specialist, USWA                                     |
|                                                                                    | John J. Sheehan,<br>Assistant to the President, USWA                               |



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LTV Steel Co.  
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National Steel Corporation  
Pittsburgh, Pennsylvania



Inland Steel Industries, Inc.  
Chicago, Illinois



United Steelworkers  
of America, AFL-CIO  
Pittsburgh, Pennsylvania



Armco Steel Co., L.P.  
Pittsburgh, Ohio

## STATEMENT OF PRINCIPLES ON HEALTH CARE REFORM

The USWA and the member companies of the Joint National Health Care Policy Committee have begun an intensive study of the health care crisis in the United States. This crisis has affected the international competitiveness of the American steel industry. It has placed a severe strain on collective bargaining as increasing resources must be dedicated to health care. This problem must be solved. Inasmuch as considerable work remains to be accomplished by the Joint Committee, the following principles will guide the Joint Committee's work.

1. Legislative and regulatory action needs to be taken which simultaneously addresses each of the three facets of the problem—access to affordable health care; quality; and cost containment to address accelerating fees, inappropriate utilization of services, excess capacity and new technology. Actions which address just one facet are likely to aggravate the others.
2. Immediate action is required even though it may entail a consideration of both short-term and long-term strategies.
3. Access to meaningful and affordable health care coverage should be provided all citizens of the United States, with the cost to society of such coverage spread over the broadest possible base.
4. Systems for controlling total health care cost escalation must be implemented based on explicit comprehensive limits on national health care spending
5. Health care delivery systems should be encouraged, which optimize the utilization of health care, while minimizing administrative expense.
6. Federal cost containment legislation is needed to insure that public and private payors pay the same for health care.
7. Public programs such as Medicaid and Medicare and the cost of care for the uninsured have shifted significant costs onto the private sector. These cost shifts must cease.
8. Action is required to control inappropriate utilization of services through the establishment of national medical practice guidelines which would set standards for health care.
9. Specific efforts to maximize the quality of health care delivery should be undertaken, including the use of effective quality measurement systems and improved accreditation processes.
10. Federal legislation providing appropriate limitation should be placed upon provider ownership of ancillary facilities such as medical test labs, rehabilitation facilities and the like to assure elimination of conflict of interest.
11. A better system for handling medical malpractice disputes needs to be developed.
12. We must insure that Medicare remains the primary payor for the elderly.

The Joint National Health Care Policy Committee

Co-Chairmen

A. Cole Tremaine, LTV Steel Co. Leon Lynch, USWA

David Alexander, Armco Steel Co., L.P. • Benjamin C. Boylson, Bethlehem Steel Corp. • William P. Boehler, Inland Steel Co. • Richard P. Corfice, National Steel Corp.

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*Report of*

THE NATIONAL  
LEADERSHIP  
COALITION FOR  
HEALTH CARE  
REFORM

EXCELLENT HEALTH CARE FOR ALL  
AMERICANS AT A REASONABLE COST

EXCELLENT HEALTH CARE  
FOR ALL AMERICANS  
AT A REASONABLE COST

A PROPOSAL FOR THREE-DIMENSIONAL  
HEALTH CARE REFORM

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FROM THE NATIONAL LEADERSHIP  
COALITION FOR HEALTH CARE REFORM



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## P R E F A C E

**T**he National Leadership Coalition is an organization of organizations—of businesses, unions, associations of health care professionals, and consumers—committed to effective reform of the health care system. The report you are about to read describes the plan for reform that the Coalition has developed. It is a *consensus* document; it represents a strategy that all members of the Coalition believe is sound and sensible, but it is not, in all of its particulars, precisely the strategy that any single member might have prepared on its own. And it is intended to be a *living* document; we fully expect that as we engage in a dialogue with other groups, citizens, and political leaders interested in health care reform, the plan will be refined and elements of it more fully developed and strengthened as appropriate.

The past twenty years have taught us that the complex and interrelated problems facing our health care system (cost, quality, and access) cannot be solved with a piecemeal strategy. In recognition of this, our proposal is comprehensive, indeed the most comprehensive yet introduced into the national debate. Many of its elements have already attracted the support of many groups necessary to effect change. Through a balanced mix of competitive and regulatory strategies, our plan would assure control of skyrocketing costs, universal access to comprehensive health care benefits (including preventive services), major initiatives to improve the quality of care, insurance and malpractice reforms, administrative simplification, reinforcement of professionalism, and a new concept for the delivery of care. It is especially sensitive to the needs of small business.

An important strength of our plan is that it builds on American traditions and combines the best of the present system with competitive and oversight approaches compatible with our values. This plan can be put in place without severe disruption to the current system and will give this nation a health care system we can be proud of for the twenty-first century.

We should emphasize that the issuance of this report does not mark the end of the Coalition's work—far from it. To broaden consensus, we will seek the input of others who are concerned with health care issues, including those who have differing views. We will continue to expand and adjust the proposal itself as new information and insights surface. And we will work to build public understanding and support of effective health care reform. In addition, we are preparing, and will be issuing early next year, another report addressing a crucial piece of the health care puzzle that this document does not deal with: long-term care.

The growing seriousness of America's health care problems and heightened public concerns have combined to create a new opportunity to effect major change in our health care system. We believe there is now a clear and compelling case for comprehensive reform. Recognizing the need to combine our efforts with others of like mind who are striving to create and implement a workable strategy, we seek and welcome others who wish to join us in this effort.



## EXECUTIVE SUMMARY

**T**he 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.



# EXCELLENT HEALTH CARE FOR ALL AMERICANS AT A REASONABLE COST

## A PROPOSAL FOR THREE-DIMENSIONAL HEALTH CARE REFORM

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**T**here is a growing consensus that America's health care system needs to be overhauled—because, in plain words, it is not good enough. It is not meeting the needs of Americans, in sickness and in health.

But behind that consensus is a bewildering array of proposals and plans, many of them loaded with terms that only health care experts understand. In truth, the health care system in America is complicated—and its reform cannot be simple. But this much is absolutely clear: Unless we commit ourselves as a nation to building a better health care system—one that brings excellent health care to all Americans at a reasonable cost—we will be jeopardizing America's most important asset: Americans.

This report comes to you from the National Leadership Coalition for Health Care Reform. It is the product of 18 months of study and debate—and, most important, consensus-building. Consensus-building was crucial because the Coalition includes, by design, such a wide range of interests: businesses in all sorts of industries, unions of private-sector and public-sector employees, health care professionals, and consumers. The proposal described in these pages represents a balancing of those interests—the same sort of balancing that any thorough reconstruction of the health care system will have to reflect.

We present this report, and the strategy for reform it advocates, not as Republicans or Democrats, not as businesses or labor organizations, not as providers of health care or consumers, but as interests that came together to develop what we all have a stake in: a plan for a health care system that all Americans can live with into the next century.

The bottom line is this: The plan you are about to read can deliver *higher-quality care* than the present system to *all Americans* at a *much lower cost*. For reasons that will become evident as you read this report, the potential savings are gigantic: by the end of this decade, more than *\$600 billion* a year.

## WHAT KIND OF HEALTH CARE SYSTEM DO WE WANT?

**T**he starting point for deciding how—and, indeed, whether—to fix the health care system is to focus not on programs, rules, and budgets—the standard tools of the policy-making trade—but on the human impact of health care. It is, after all, our health that is in the balance—the health of ourselves and our families, our friends and our co-workers. *Nothing could be more important.* And so we should begin with the most basic question: What kind of health care system do we Americans want? Here are our answers:

1. First and foremost, we want a health care system that provides *excellent health care*—care that maximizes our chances for good health. That is what health care is supposed to do; it is what we count on it to do. And we should accept no less.

2. We want a system that provides health care to *all Americans*. Why? Because America is a humane society, and we believe that no one should die or suffer because he or she cannot afford health insurance. Because we do not want the health of children to depend on whether they had the good fortune to be born into families with adequate health coverage. Because our national prosperity and security depend on the health of our people. Because it is right.

3. We want a health care system that *does not cost too much*. How do we know what too much means? If health care costs are already substantially higher per person in America than they are in other countries, and if those costs are rising more rapidly than the economy is growing, that is too much. Health care is not a luxury; it is a necessity. But that does not mean that we should not ask how much it costs. We need a health care system that costs as much as it must to deliver first-rate care to all Americans—but not more.

These, then, are the three standards that the Coalition used to guide its efforts: excellent care, universal coverage, and reasonable cost. How does the current health care system measure up?

#### WHAT KIND OF HEALTH CARE SYSTEM DO WE HAVE NOW?

**O**n each of these criteria, our health care system falls short. It is not as good as it should be—or, as we shall see, could be.

1. *Excellent Care?* The quality of health care is a function of its appropriateness (is this the right procedure?) and the skill with which it is delivered (is the procedure performed well and efficiently?). The American health care system provides excellent care to many of its patients much of the time, but, on the evidence, not to enough of its patients enough of the time.

There is, to begin with, a stunning amount of variation in the frequency with which particular procedures or courses of care are used. A few examples from recent studies make the point: tonsillectomies were eleven times more common, on a per-capita basis, in one Vermont town than in a neighboring community; hospital admissions for pneumonia are five times more common for adults and ten times more common for children in some Maine towns than in others; and coronary bypass operations are more than twice as common, and carotid endarterectomies less than half as common, in New Haven than in Boston. Why do these differences exist? The central explanation seems to be this: We just do not do enough systematic assessments of the effects of alternative technologies and treatments—and to the extent that assessments are done, their findings are not regularly collected and made readily accessible to health care professionals. As a result, these professionals do not know as much as they would like to know—or as much we would like them to know—about what works, when. This lack of information based on systematic analysis is a major impediment to the delivery of consistently excellent care.

What is more, other factors compound the problem: perverse financial incentives, unrealistic expectations on the part of patients, and the ever-present threat of malpractice suits—all of which may encourage doc-

tors to resolve their doubts in favor of performing more tests and procedures. The former editor-in-chief of the *New England Journal of Medicine* has estimated that at least 20 to 30 percent of what is done by well-meaning physicians in good hospitals is either inappropriate, ineffective, or unnecessary. Many studies support that estimate; for example, one conducted by the RAND Corporation, in which panels of leading physicians examined the use of several major procedures, found that rates of inappropriate care ranged between 14 percent (for coronary artery bypasses) to 32 percent (for carotid endarterectomies). And these statistics mask tragedies: The unnecessary use of otherwise sound technologies and procedures can cause unnecessary harm.

What about the second dimension of quality—the skill and efficiency with which procedures are performed? It is difficult to generalize about levels of skill, but an analysis of hospitals in New York state by the Harvard Medical Practice Study Group is suggestive—and disturbing: If the patterns found in New York are typical of what transpires nation-wide, Americans may experience as many as 1.2 million unexpected adverse effects from hospitalization each year—and as many as 180,000 may die as a consequence. Half of those deaths, according to the investigators, would be due to negligence. And two recent studies found that the in-hospital death rates for patients undergoing heart bypass operations varied by as much as a factor of four from hospital to hospital (3 percent to 12 percent)—and by as much as a factor of five from surgeon to surgeon (2 percent to 10 percent). As to efficiency, two Secretaries of Health and Human Services have estimated that waste in our health care system amounts to between \$100 billion and \$150 billion a year. Even in the best American hospitals, the systems in place to measure and assure efficiency are, by the standards of other sectors of the economy, rudimentary.

2. *Universal Coverage?* It has become almost a commonplace in discussions of health care reform that more than 30 million Americans are without health insurance and that another 30 million or more are underinsured. But we should not let the familiarity of these numbers sap their force and inure us to their meaning: Tens of millions of our fellow citizens—middle-class as well as poor, employed as well as unemployed—must live each day knowing that if they are injured or contract a serious disease, they

either will not be able to afford care—or will be forced to liquidate whatever savings and possessions they have to try to pay for it. They are in constant jeopardy. More than a third of the uninsured are children; another third are between the ages of 18 and 24. These young people represent the future of our society; we cannot turn away from them.

The uninsured and underinsured are especially vulnerable to illnesses because they often cannot afford preventive care and early treatment. As a result, they are on average less healthy than those who have health coverage. When they seek care, it is often only after they have become very sick (and, therefore, more expensive to treat). And the consequences of their misfortune haunt their futures and ours: Mothers forego prenatal care, which can reduce the incidence of serious medical problems for their children; and children go without regular check-ups and inoculations, rendering them still more vulnerable to health hazards.

3. *Reasonable Cost?* Health care in America costs much too much by any measure: what we spend compared to what other nations spend, what we achieve with our level of spending compared to what other nations achieve with theirs, and what we spend now compared to what we used to spend.

≈ The United States spends more per person on health care than any other industrialized nation—by far. In 1989, for example, per-capita health care expenditures were \$2,354 in the United States. Only eight countries spent more than half that; only one—Canada—spent more than 70 percent (\$1,683 per person).

≈ To put these numbers into perspective: The United States manages to mount such a huge lead in spending even though it is the only advanced industrialized nation that does not insure health care for all its citizens—and even though it does not enjoy a commensurate lead in health outcomes. For example, for all of our resources and vaunted medical technology, 22 countries have lower infant mortality rates—the percentage of children who die in their first year of life is fully twice as high in the United States as in Japan, for example—and 15 countries have higher average life expectancies. By international standards, we are not getting our money's worth.

≈ In 1960, the United States spent 5.3 percent of its gross national product on health care. By 1990, that figure had risen to 12.2 percent. In 27

of the 30 intervening years, health care spending grew faster than the GNP. Between 1989 and 1990, expenditures on health care jumped 10.5 percent—from \$604 billion to \$666 billion; this year, according to the Department of Commerce, they are expected to leap as high as \$750 billion. Health care spending has more than doubled since 1983! Is there any reason to believe that we are getting twice as much benefit from our health care system now as we did just eight years ago? Even if we assume that health care in America was a good deal in 1983, it clearly is not now.

What makes these numbers even more troubling is that there is no end in sight to their growth; indeed, the rate of growth is accelerating. The Department of Commerce estimates that over the next five years health care spending will increase 12 to 15 percent per year. That means that unless we do something soon to bring costs under control, our bill for health care in 1995—just four years from now—will be between \$1.1 trillion and \$1.3 trillion. And if the same rate of growth persists through the rest of the decade, we will be spending between \$2.1 trillion and \$2.6 trillion on health care in the year 2000. These numbers are staggering—and they may seem literally incredible, until we consider that our current levels of spending would have seemed equally incredible not so long ago.

Why are health care costs escalating so rapidly? Many factors contribute to their increase—among them fee and wage hikes in excess of inflation; the introduction of and misuse of new and more expensive technologies; the fact that many consumers of health care do not pay for it directly and are therefore price-insensitive; and demographic shifts that increase the proportion of elderly people, who need more health care, in the population. But three factors are especially vexatious. The first is waste—the performance of unnecessary procedures and inefficiencies in the delivery of care—which, as noted above, may account for as much as \$15 billion of our annual expenditures on health care—nearly 20 percent. The second is the cost of health care administration in our enormously complex system, which, according to one recent study, amounted in 1987 to 19 to 24 percent of health care spending in the United States—compared to a range, in Canada, of 8 to 11 percent of health care spending attributable to administration. And the third is that America now has 17

coherent national strategy for instilling financial discipline, and constraining costs, throughout its health care system.

When health care costs soar, all of us lose—and not only because of our direct expenditures, as consumers of health care and insurance and as taxpayers who help to foot the government's health care bill. We also lose because spiraling health care costs are stunting the growth of our economy. Health care is now an issue of economic policy as well as social policy. The more money that businesses must spend on health care, the less money they have to invest in research and development, new plant and equipment, and training—which means not only that economic growth is hampered, but that American firms are at a competitive disadvantage with firms in other countries where health care costs are lower. Across the economy now, health care spending is the equivalent of 40 percent of total corporate profits; it absorbs 36 percent of the annual growth in gross national product. Our mammoth health care bill is imposing an enormous opportunity cost on our economy—a burden that leads to an unfortunate combination of fewer jobs for American workers, at lower pay, for companies that are less competitive in world markets. And it is imposing an opportunity cost of another sort as well: The more our current level of health care services costs us, the fewer resources we have to devote to improving the quality of care and expanding health coverage—and the fewer resources we have to address other pressing domestic concerns, including the deficit.

#### WHAT SHOULD WE DO?

**T**he status quo is clearly unacceptable—and rapidly getting worse. What should we do?

The National Leadership Coalition for Health Care Reform has emerged from our prolonged period of deliberation with this overriding, and heartening, conviction: We can make huge strides forward in this crucial realm of American life and policy. We can build a much better health care system. What we face is not an intractable problem; there is a way, if there is a will.

In the next section of this report, we will describe a plan that can bring better health care to all Americans—and do so at a price well below what the

current health care system would cost us. But first, we want to discuss the principles that guided our development of that plan—and that we believe should frame the debate that America needs to have about health care reform.

#### *1. Reform must be three-dimensional.*

It should tackle the three aspects of our health care challenge—quality, coverage, and cost—at once. There are two reasons. The first is simply this: We need progress on all three fronts. We just cannot postpone any longer efforts to improve the quality of care or to make sure all of our citizens have adequate health coverage or to bring costs under control. Our health care problems are urgent—and they are exacerbated by our delay in acting on them.

The second reason is that partial reform is doomed to fail. The American health care system is exceedingly interdependent. As a practical matter, to make the system work better, we need three-dimensional reform. Anything short of it just displaces detriment. For example, a dramatic expansion of access without commensurate improvements in quality and better controls on cost, will produce an overloaded system that gives more people worse care at much greater cost. The three dimensions of our health care challenge are intrinsically linked; so too must be the steps we take to address them.

#### *2. Reform must be system-wide.*

There are two central lessons to be learned from the federal government's recent experience with measures to control its own health care spending. One is that the mechanisms it has been using to constrain costs work. The other is that when they are applied only in the public sector, they reduce costs in that sector and shift them over to the private sector; that is largely why health care spending by private employers is increasing much faster than health care spending overall. Unless reform is system-wide, gains in some sectors or for some consumers of health care services will be offset by losses elsewhere.

But there is, in addition to this practical consideration, another compelling argument for making certain that reform is system-wide. America is already a country of health care haves and have-nots—some of us have

adequate health care coverage, some of us do not; some of us receive first-rate care, some of us do not. Reform should seek to make sure that all Americans receive excellent health care—and are able to enjoy the quality of life and peace of mind to which it is essential. Piecemeal reform—reform that helps some categories of people to the detriment of others—takes us no closer to an optimal health care system and may make it harder to attain. Let us all move forward together.

*3. Reform would best build on and around elements of the present system.*

Health care reform is a delicate balancing act—not least between the needs of the present and the promise of the future. Simply put, we have to make sure that in trying to create an ideal health care system, we do not in the process undermine our capacity to meet the health care needs of our current population. That is why the Coalition, in considering a range of possible plans for reform, focused on alternatives that did not involve the potential for major disruption in the delivery of health care. We decided to craft a proposal for a public-private partnership that would build on and around institutional arrangements already in place—enhancing our current capabilities, rather than attempting to replace them all at once with one model or another of health care delivery.

We decided as well to build on and around the financial arrangements that currently obtain—chief among them the fact that nearly 70 percent of those Americans with health insurance receive it through their employers—rather than propose a wholly new financial structure, such as a national health insurance system, that could require large tax increases and economic dislocations. The American health care system is bigger than all but six national economies in the world; it is not obvious that it can be taken apart and reassembled so quickly that Americans would not suffer in the interim. Moreover, quite apart from the practical questions that are raised by any plan for wholesale change—such as whether it would work—the inevitable wrangling over its distributional impacts might so tie up the political system that nothing much would get done. There is much to be said for a plan that works from a base that will continue to function, that incorporates mechanisms that we know

will work, and that, in a practical and pragmatic way, achieves major gains with less disruption.

*4. Reform must reinforce professionalism.*

The health care system, as it now functions, is frustrating not only to patients, but also, more than is commonly recognized, to health care professionals. Physicians, nurses, and others who have devoted themselves to health care, and who work very hard to provide it, are powerfully troubled by the inequities and inefficiencies that bedevil the current health care system; they know, more than any other group, how much of a difference excellent health care could make to the lives of those who are now unable to receive it. And they are frustrated by the mountains of forms that have to be filled out for even routine procedures, by the specter of malpractice litigation that looms over them, by the administrative impediments that the current system puts in the way of their focusing on what they trained to do: help patients.

It is vital that reform make the work of health care professionals easier, not harder. In the final analysis, health care in America can only be as good as the people who provide it—and they can only do as well as the system lets them. They need help to give help. That, in part, is why the Coalition decided early in its deliberations that its package of proposals had to include administrative simplification, malpractice reform, and an emphasis on the pursuit of quality and the research needed to attain it.

THE COALITION'S PROPOSAL:  
BETTER HEALTH CARE FOR ALL AMERICANS  
AT LOWER FUTURE COST

**T**he National Leadership Coalition for Health Care Reform has developed a proposal that would produce better health care than the present system provides, for all Americans instead of just some—and for much less money than the present system would cost us. The reform we call for satisfies the principles discussed in the previous section—it is three-dimensional; it is system-wide; it builds a public-private partnership on and around the present system; and it would

reinforce professionalism—and it meets another standard as well: After 18 months of intense deliberation, it commanded support from the remarkable range of interests—businesses in all sorts of industries; unions of employees in the public and private sectors; health care professionals; and consumers—that make up the Coalition. The plan is the product not of a single perspective, but of many—and it is, we believe, the better for it, because it is informed by many views, because it reflects a process in which all conceded something to come to agreement, and because it is as a result a plan that is both far-reaching and practical.

What follows is a description of the Coalition's proposal. Please, in reading it, consider it as it would function—as an integrated plan for thoroughgoing reform of the health system, not as a series of discrete individual initiatives. A more detailed and technical discussion of the plan is available from the Coalition.

The Coalition's plan has eight interconnected elements:

- ≈ Initiatives to Improve the Quality of Health Care
- ≈ Universal Coverage
- ≈ Cost Control
- ≈ Organized Delivery Systems
- ≈ Management and Oversight
- ≈ Insurance Reform
- ≈ Malpractice Reform
- ≈ Administrative Simplification

### *Initiatives to Improve the Quality of Health Care*

The Coalition proposes that America make a major commitment to improving the quality of health care—including research to determine what procedures are most effective in which circumstances and the development of practice guidelines that reflect the findings of that research. This effort could be spearheaded by a new National Board on Health Care Quality, an independent board with a composition—members from both the public and private sectors—that reflects the public-private partnership that the Coalition's overall plan envisions.

The central mission of the Board would be to lead the development of national practice guidelines. These would be based on reviews, by pan-

els of leading health care professionals, of research that has been conducted on the impacts of alternative technologies and procedures—and, for technologies and procedures about which the Board needs additional data before it can develop guidelines, on new assessments that the Board would fund. The Board's guidelines would be used in decisions regarding payments to health care professionals; they would be cited in malpractice cases as evidence of what is considered best practice; and, of especial importance, they would help health care professionals decide how best to help their patients. The Board would continually update these guidelines, as new data—on procedures in current use and on new technologies—became available.

As observed earlier in this report, it is vital not only that we develop more and better information about the effects of alternative technologies and treatments, but also that this information is communicated to health care professionals so that they can act on it. The Board would be responsible for disseminating its practice guidelines to those who deliver care and making them readily available to others—firms that provide health care coverage to their employees, insurance companies, and consumers—who wish to be informed about them. The Board would also develop a national data bank to track the use of major procedures; convene conferences for the discussion of new information about patterns of practice; and establish a forum to sponsor research on the issues surrounding the use of high-technology intervention to sustain patients who are on the verge of death.

The National Board on Health Care Quality would be charged as well with working to upgrade the skill and efficiency with which health care is delivered. The health care system is far behind other sectors of the economy in adopting and implementing programs for continuous quality improvement (CQI). The Board will help health care organizations institute their own CQI programs—by serving as a source of information and technical assistance, by funding demonstration projects, and by establishing a clearinghouse to identify and publicize successful quality initiatives.

### *Universal Coverage*

It is time to close the gap between the health care haves and have-nots by providing all Americans the advantages, to their physical well-being and their peace of mind, of adequate health coverage. The Coalition proposes

that every American—whether privately insured or not—be guaranteed access to a comprehensive package of health benefits; those who are not privately insured would be able to receive their coverage—and the same package of benefits—through a new program, Pro-Health, that would also incorporate Medicaid. The Coalition's proposal would empower *and require* every American to obtain health coverage, at least to the extent of the standard benefit package—from an employer, by individual purchase, or through Pro-Health; having fulfilled that responsibility, an individual would then be free to purchase (or to secure through an employer) additional coverage, over and above that package.

The benefit package designed by the Coalition is summarized in Figure 1. We would underscore four aspects of the package: First, it emphasizes preventive care—including prenatal and well-child care—which would reduce the incidence of serious health problems and also, for that reason, decrease overall health care costs. Second, it is comprehensive; excellent health care presumes, and requires, no less. Third, it would be linked to the practice guidelines established by the National Board on Health Care Quality; payments would be made only for care provided in accordance with those guidelines. Fourth, it would evolve, as the initiatives of the National Board on Health Care Quality, and the advances made by organized delivery systems, improve the state of the art and science of health care.

Coverage would pivot, for those who are currently employed, around employing firms. Each company would have, subject to collective bargaining as appropriate, two options. It could choose to provide *at least* the standard package of benefits to its employees and their non-working dependents through private health insurance. Or it could 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 costs of that coverage. The coverage of part-time workers would be phased in; a firm would be free to select one option for coverage of its full-time employees and the other for coverage of its part-time workers. *All* firms would contribute a small fee of 0.5 percent of payroll, for each employee up to the maximum taxable base under the Medicare program, toward the cost of Pro-Health; individuals would contribute 0.5 percent of payroll up to the Medicare cap.

We recognize that some businesses are concerned that their costs

FIGURE 1: PROPOSED BENEFIT PACKAGE

|                                                                   |                                  |
|-------------------------------------------------------------------|----------------------------------|
| Overall deductible ( <i>person/family</i> )                       | \$200/\$400                      |
| Annual out-of-pocket limit ( <i>person/family</i> )               | \$1500/\$3000                    |
| Hospital services ( <i>365-day maximum stay</i> )                 | 80% (20% co-pay)                 |
| Hospital alternatives ( <i>extended or home health</i> )          | 80% (20% co-pay)                 |
| Surgical services                                                 | 80% (20% co-pay)                 |
| Qualified provider services                                       | 80% (20% co-pay)                 |
| X-rays and laboratory                                             | 80% (20% co-pay)                 |
| Prescription drugs                                                | 80% (20% co-pay)                 |
| Essential emergency services                                      | 80% (20% co-pay)                 |
| Mental health care and substance abuse<br>with a lifetime maximum | 80% (20% co-pay)                 |
| Routine physicals/tests                                           | 80% (20% co-pay)                 |
| Well baby/child with vision, dental, and hearing                  | 100% up to age 18                |
| Estimated premium ( <i>person/family</i> )                        | 80%/20% share<br>(\$1432/\$3720) |

would be driven up by the requirement that they make some provision—either through private insurance or the Pro-Health program—to assure health coverage for their workers. We would make four observations. First, this is a concern to only a minority of businesses—those that do not provide health benefits to their employees now. For these businesses, what the Coalition's plan would do is level the playing field of competition; the companies that until now have offered no health insurance would have to compete not at a disadvantage, but on an equal footing with those that have offered it all along. Second, that means that the Coalition's proposal would *help* the majority of businesses—those that provide insurance and have had

to compete with those who do not. Third, for many small businesses that have not offered health insurance because of the expense of doing so, the option of enrolling their employees in Pro-Health would be *less* costly, in part because the payroll tax is explicitly designed to keep the payments of low-wage firms below the cost of providing the standard package of benefits to their workers—they would be subsidized—and in part because the Pro-Health system would be able to spread administrative costs over a much larger population than the group plans of small businesses. Finally, to cushion the impact of the plan's health care coverage requirements on start-up companies, they would be phased into the plan over the first three years of their lives; existing small businesses would be phased in as well, beginning with firms that have more than 50 employees.

In addition to workers whose firms chose to enroll their employees in Pro-Health, that program would include those who are at any given point in time outside the labor market, unemployed, or in transition. Individuals covered by Pro-Health would pay premiums based on their incomes. If their incomes were below the poverty level, they would be fully subsidized; those with incomes between one and two times the poverty level would contribute—through copayments, deductibles, and premiums—up to 3 percent of their annual incomes.

### *Cost Control*

The Coalition proposes a tough, no-loopholes strategy to bring health care costs, system-wide, under control. The first link in that strategy is the setting of an annual target for health care expenditures—in the private sector as well as the public sector. The health care system—the cost of which has been growing in recent years more than twice as fast as the GNP—needs the discipline of an overall spending limit. Under the Coalition's proposal, a National Health Review Board, with members from the public and private sectors, would set an expenditure target each year and submit the federal component of it to Congress for approval. We propose that the Board aim to reduce the rate of growth in health care spending 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 kept at levels equal to or less than GNP growth.

The second link in the strategy would be the establishment of payment rates for health care services. The National Health Review Board would set these rates—after hearings and in consultation with affected parties—at levels calculated to yield overall health care spending no higher than the annual expenditure target. To eliminate cost-shifting, all payers of health care bills—all private insurance companies as well as Pro-Health and Medicare—would be bound by the rates. Moreover, the rates as set would constitute payment in full, to preclude the possibility of participating health care providers billing consumers for charges above the standard rates. A state could apply to the National Health Review Board for authorization to use alternative payment methods—such as diagnosis-related grouping (DRG) systems, capitation, or selective contracting—so long as its overall payment levels would be kept within its allocated share of the national expenditure target.

Third, capital as well as operating spending would be constrained. The national health care expenditure target would incorporate a target for capital spending each year. Then, in establishing rates for payments to providers, each State Health Review Board would factor in a payment for capital expenditures (derived from the capital spending target).

Other elements of the Coalition's proposal would work in tandem with these three initiatives to control costs: increased use of preventive care, which should decrease overall health care spending by reducing the need for more expensive acute care; increased efficiency in care as a result of the work of the National Board on Health Care Quality and the development of organized delivery systems (see below); reductions in the number of unnecessary technologies and procedures, due to the promulgation of national practice guidelines and their use in payment decisions; a decline in defensive medicine as a consequence of malpractice reform; and administrative simplification. The manifold ways in which the Coalition's proposal would permit us to rein in costs underscore how relatively unconstrained they are in the current health care system.

### *Organized Delivery Systems*

One of the forces working against the improvement of quality and the moderation of cost in the present health care system is organizational fragmen-

tation. With health care provided in so many different contexts—the offices of general practitioners and specialists of many types, hospitals, nursing homes, and ambulatory settings—we typically lack an organizational locus for assuring quality across a continuum of care or for maximizing the cost-effectiveness of the care provided. That is why the Coalition believes that the other initiatives it is proposing must be accompanied by a major effort to encourage the emergence of organized delivery systems (ODSs) that would be responsible, under a single organizational aegis, for a wide range of services—including inpatient, outpatient, and long-term care.

The development of a strong and growing ODS segment of the health care industry would change the nature of competition even as it altered the terms of service delivery. Under the Coalition's proposal, all payers in a state would operate under the same rate schedule—and all patients would receive at least the same comprehensive benefits package. That means that ODSs—charged with attending to the full range of their patients' health care needs—would compete on their ability to manage, effectively and efficiently, the care provided to those they serve. ODSs would have strong incentives to provide preventive care, draw upon the most appropriate care-givers, develop and enforce practice protocols, adopt alternative methods for compensating health care professionals, monitor the outcomes of treatment, and institute programs of continuous quality improvement—and they would have also have powerful motivation to avoid unnecessary procedures, wasteful capital spending, and inefficiency in the delivery of care. And the establishment of a standard benefit package, coupled with a requirement that providers disclose data on utilization and quality, would make it easier for consumers to compare the value delivered by alternative providers—a fact of the new marketplace for health care that would spur the development of more ODSs and the success of the most efficient among them.

### *Management and Oversight*

An independent National Health Review Board—with members representing health care providers, payers, and consumers, as well as government—would be responsible under the Coalition's plan for overseeing and evaluating the ongoing restructuring of the health care system. Each year, the

Board would develop a national health care expenditure target, including the allocation of that target among the states and the portion of the target to be devoted to capital expenditures. The Board would also, as it developed each year's spending plan, update the payment rates derived from the overall expenditure target; establish and maintain a national data bank on the operations of the health care system; and, on the basis of advice from the National Board on Health Care Quality, recommend modifications in the standard benefit package.

Complementing the work of the National Health Review Board would be State Health Review Boards, each comprised of a similarly representative array of members. Among the responsibilities of a State Board would be: administration of its allocated share of the national health care expenditure target; certification of qualified ODSs; management of the Pro-Health program within its state; and the administration of payment methods.

### *Insurance Reform*

Current insurance practices make it difficult for many small businesses to obtain health insurance for their employees at reasonable rates. In the first place, insurance plans for small groups of employees carry higher per-employee price tags than those for larger companies because insurance firms are spreading administrative costs over fewer covered employees; for some small firms, administrative costs can be eight times as much as a percentage of claims as they are for larger companies. And second, insurance companies now compete on their ability to distinguish good risks from bad ones—and to differentiate rates accordingly. That means that some small businesses with high-risk employees are quoted rates they find prohibitive—a problem that larger companies, which can pool good and bad risks, are less likely to encounter.

To address these difficulties, and encourage more small businesses to provide health coverage to their employees directly, the Coalition proposes that each insurer be required to:

- offer small groups the new standard benefit package (all current state mandates regarding minimum benefits would be eliminated)—and accept all groups that seek health insurance in the geographic areas served by the insurer;

≈ set premiums on the same terms, with a return to adjusted community ratings, for all groups in an area—regardless of the size of any given firm, the industry it is in, or the health status of its workers; and

≈ renew all policies with premiums adjusted on an area-wide, not firm-by-firm, basis.

These changes would produce an insurance marketplace in which premiums for small businesses would be lower than they are today—and in which insurance companies would compete on the basis of their capacity to keep premiums down by managing health care well.

### *Malpractice Reform*

Malpractice litigation—or, more precisely, concern about malpractice litigation—has become a constant source of concern, and even trepidation, among health care professionals. Malpractice insurance in many specialties has become enormously expensive, awards in some cases have been stratospheric, and many thoughtful members of the medical community are worried that fear of malpractice litigation is leading too many health care professionals to practice defensive medicine—performing tests and procedures that may not be necessary, just to protect themselves against possible lawsuits.

We have already discussed one element in the Coalition's proposal that will go a long way toward reducing the incidence of malpractice and mitigating these difficulties: the development, and continual updating, of national practice guidelines. Because conformance to these guidelines will serve as evidence in malpractice cases of what is considered best practice, they will help to protect health care professionals from frivolous or wrong-headed lawsuits. Moreover, we have evidence already that the use of practice protocols helps to stabilize malpractice insurance rates.

Beyond the use of practice guidelines, however, the Coalition would propose four other steps to reform the law and policy regarding malpractice:

First, in malpractice litigation involving care provided by health care professionals who are part of an ODS, the ODS itself—rather than the care-givers—should be held responsible. This change in liability would give every ODS strong incentives to assure the adherence by its health

care professionals to the highest standards of care.

Second, the Coalition proposes the conduct of four well-designed demonstration projects to test the impact of alternatives to malpractice litigation: mandatory binding arbitration, voluntary arbitration, arbitration panels, and a no-fault system. Perhaps we can through these tests reach agreement on a way to resolve malpractice cases without resort to the time-consuming, highly contentious process of litigation.

Third, the Coalition urges adoption of a new recredentialing system for health care professionals—one that would involve periodic reexamination of physicians' patterns of practice instead of simply administering written examinations.

And fourth, the Coalition proposes consideration of a package of reforms in tort law, including: controlling how much lawyers can charge in fees in tort cases; requiring a fair distribution of liability among the providers in an incident of malpractice; establishing a fee schedule to assure consistency in awards for pain and suffering; limiting the number of years that minors can wait before bringing a suit alleging malpractice; providing for the use of installments in the payout of especially large awards; and precluding awards from including sums already paid out from other sources, such as health insurance.

### *Administrative Simplification*

The Coalition's proposal would result in a health care system that is less complex, cumbersome, and frustrating for both health care professionals and patients. For example, the establishment of a standard, nation-wide benefit plan would eliminate much confusion. Universal coverage would make it easier for providers to accept patients—precisely because there would be no doubt that they have coverage.

Similarly, the uniformity of rates would ensure that every party to a medical transaction would know what the charges would be. The use of annual expenditure targets would yield predictable rates of increase—rates that everyone in the system could plan for—in health care spending.

Moreover, the simplicity of coverage and billing in the reformed system would lend itself to the use of uniform claims forms and electronic billing. The potential savings from these changes could be very substan-

tial—to say nothing of the benefits, to all concerned, of reducing the hassle of obtaining, or providing, health care.

The startlingly expensive administrative complications of the present system are not productive uses of our scarce resources. We would be better off saving that money—or putting it toward new technologies or organizational innovations that would help improve the health of the American people.

## CONCLUSION

**T**he National Coalition for Health Care Reform believes that the reforms we have called for would produce better health care for all Americans—and that they would do so at a much lower cost than an unmodified present system. In closing, we would emphasize two points. The first is that the increase in *federal* expenditures under the Coalition's plan—\$34.7 billion, as Figure 2 indicates—would be fully offset by the sources of financing described earlier in this report (and summarized in Figure 3). The second is that this additional federal spending would be dwarfed by the overall savings that the Coalition's proposal would produce. How large are those savings? According to our calculations, reflected in Figure 4, the answer is just one more compelling reason to move ahead, without delay, to reform the way we Americans provide, and receive, health care: by the year 2000, savings would exceed \$600 billion a year.

The stakes—for all of us—are enormous. It is time to act.



FIGURE 2: FEDERAL GOVERNMENT  
EXPENDITURES UNDER COALITION PLAN

*Billions of 1991 Dollars*

| Source                                                                                 |         |
|----------------------------------------------------------------------------------------|---------|
| Nonworkers under Pro-Health plan                                                       | \$ 12.7 |
| Subsidy for low-wage workers <sup>a</sup>                                              | \$ 7.4  |
| Payments of premiums and cost sharing for currently insured workers below 200% poverty | \$ 4.6  |
| Augmented Medicaid payments                                                            | \$ 10.0 |
| Total                                                                                  | \$ 34.7 |
| Size of public plan <sup>b</sup> ( <i>Millions of people</i> )                         | 62      |

<sup>a</sup> Represents difference between costs of providing insurance in Pro-Health plan and payroll tax receipts.

<sup>b</sup> Includes Medicaid, nonworkers, employed persons working in non-insuring firms, and those with insurance opting for Pro-Health.

FIGURE 3: FINANCING ACUTE CARE PLAN

- ⌘ All employers offer health insurance or make a 7% of payroll contribution to the public plan.
- ⌘ Employees above poverty pay either 20% of the premium if insurance is offered, or 1.75% of their salary if the contribution option is selected.
- ⌘ All employers contribute 0.5% of taxable payroll (HI wage base) to fund the public plan.
- ⌘ All employees contribute 0.5% of their taxable payroll (HI wage base) to fund the public plan.

TABLE 4: NATIONAL HEALTH SPENDING  
CURRENT POLICY AND COALITION PLAN  
1991-2000

Billions of Current Dollars

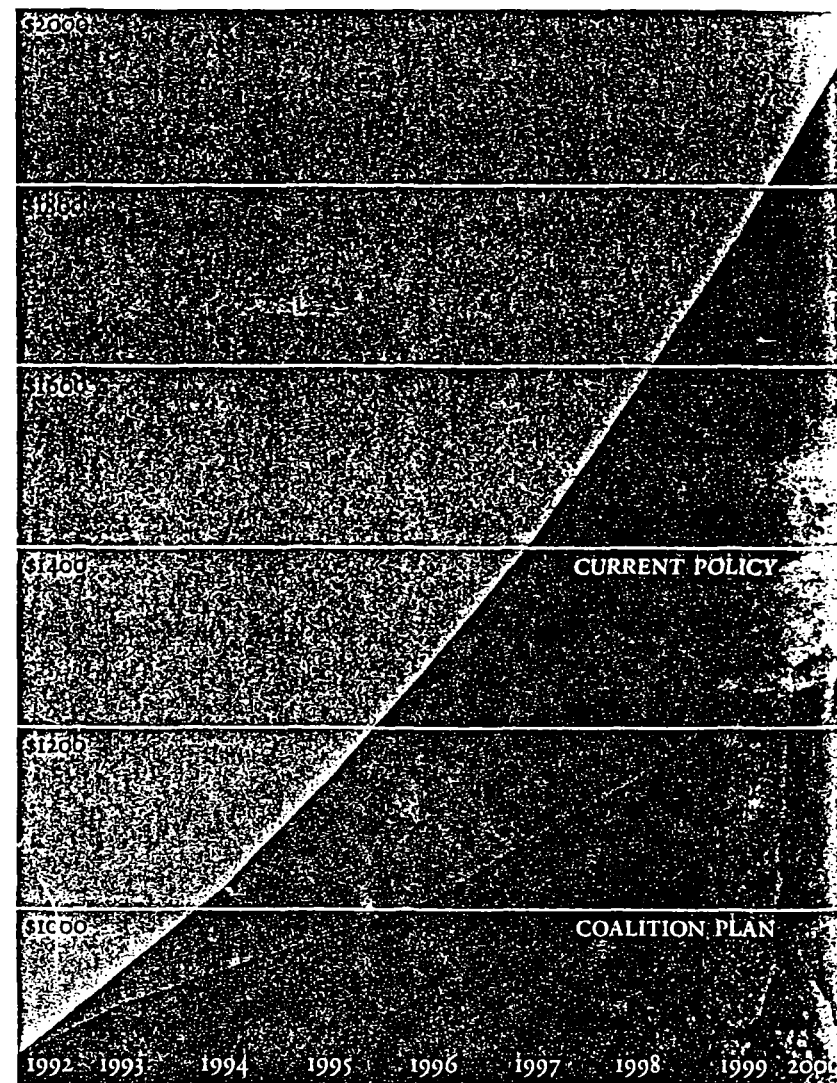
| Year | Current Policy | Coalition Plan |
|------|----------------|----------------|
| 1992 | \$ 839         | \$ 840         |
| 1993 | 931            | 895            |
| 1994 | 1034           | 941            |
| 1995 | 1148           | 977            |
| 1996 | 1274           | 1014           |
| 1997 | 1414           | 1080           |
| 1998 | 1570           | 1150           |
| 1999 | 1742           | 1225           |
| 2000 | 1934           | 1304           |

<sup>1</sup> Current policy assumes a nominal growth of 11 percent per year.

<sup>2</sup> Three year phase-in of providing insurance or contributing 7 percent of payroll to Pro-Health program. Phased-in by firm size. Starting in 1992, all firms with more than 50 employees must provide all employees insurance or make contribution. In 1993, firms with 25 or more employees must provide insurance or make contribution to Pro-Health; and by 1994, all firms must provide insurance or make contribution to Pro-Health.

FIGURE 4: NATIONAL HEALTH SPENDING  
CURRENT POLICY AND COALITION PLAN  
1992-2000

Billions of Current Dollars



## ACKNOWLEDGEMENTS

We are grateful to the many experts in health policy and economics who spoke to and advised the Coalition, in particular Stuart Altman, Chairman of the Prospective Payment Commission and Dean of the Florence Heller School, Brandeis University; Paul Ginsburg, Executive Director of the Physician Payment Review Commission; Henry Aaron, Director of Economic Studies at the Brookings Institution; Richard Kronick, Assistant Professor, Department of Community and Family Medicine, University of California at San Diego; Lynn Erheredge, health policy consultant; Jack Meyer, President, New Directions for Policy; Judith Feder, Co-Director, Center for Health Policy Studies, Georgetown University; Dr. Robert Heyssel, President and CEO, Johns Hopkins Health System; and Dr. John D. Stobo, Professor and Director, Department of Medicine, Johns Hopkins University School of Medicine. We are grateful to them; their advice has deepened our understanding of the issues we have grappled with, and we have no doubt that our proposal is much better for their input.

We especially want to thank five people who have played key roles in supporting the work of the Coalition: Michael Maccoby, President of the Maccoby Group and Visiting Scholar at the Center for Science and International Affairs at the Kennedy School of Government, Harvard University, who acted as facilitator of the Coalition's deliberations and who was masterful at helping us reach consensus; Kenneth E. Thorpe, Associate Professor at the School of Public Health at the University of North Carolina - Chapel Hill, who did a first rate job of preparing economic analyses and models for the Coalition; Mark A. Goldberg, Editor and Publisher of *Domestic Affairs* magazine and guest scholar at Johns Hopkins University, who was a superb editorial consultant; Joy Garney, executive assistant, who was the administrative linchpin of this enterprise; and Jacquelyn Avin, research assistant, who did prodigious amounts of complicated research.

We would also like to acknowledge the help of technical experts on malpractice issues from the American College of Obstetricians and Gynecologists and the American College of Surgeons.

**PETER BOUXSEIN**  
**Deputy Director**  
**American College of Physicians**

Attached is a brief summary of the American College of Physician's health care reform proposal "Universal Insurance for American Health Care."

Background

The American College of Physicians (ACP), which represents 77,000 doctors practicing internal medicine, formally supports a health reform plan that calls for:

- public and private sponsorship of health insurance;
- a national health care budget;
- uniform benefits covering all medically necessary and effective care, including preventive care;
- consolidation and strengthening of public programs so that they offer the same benefits as private insurance,
- regulation of the supply of doctors and medical facilities, with incentives to increase the number of primary care physicians,
- consolidation of Medicaid, Medicare and other public programs.

The ACP's health care reform proposal titled "Universal Insurance for American Health Care," published in the September 15, 1992 issue of Annals of Internal Medicine, goes far beyond the incremental reforms backed by most other sectors of organize medicine.

Questions

1. Managed competition, and the expansions of managed care plans in geographic areas adequate to support them, is viewed by many as a means to control costs and improve access to care. Is managed competition compatible with the broad principles you outline in your proposal?

2. What are the most important aspects of your plan for controlling health care costs in the short-term?

3. In your plan, individual practitioners, managed care organizations, hospitals, and other providers negotiate fees with all payers in the state. Do you envision a need for an intervening organization, similar to a purchasing cooperative, to mediate this process?



**American  
College of  
Physicians**

P L A N F O R

**H E A L T H  
R E F O R M**

The American College of Physicians, the nation's largest medical specialty society, calls for comprehensive reform of America's health care system to assure everyone access to high quality care while also controlling costs. Only fundamental reform can change the damaging course the present system is traveling.

"Universal Insurance for American Health Care" envisions substantial change — universal access, uniform benefits, consolidation of public programs, limits on spending, fee negotiations, a national health care commission representing all sectors of society, and insurance reform.

At the same time, the College plan incorporates values important to American society — excellence and innovation, competition and choice, and a limited role for government. The ACP plan also draws on the virtues inherent in both the "play-or-pay" and single-payer approaches to reform.

## A C C E S S

"Universal Insurance for American Health Care" provides everyone living in the United States with all medically effective and appropriate care, even through job changes and unemployment. Both the government and employers sponsor insurance plans, and both meet the same national guidelines.

### Employer-sponsored coverage

Employers may sponsor coverage for their employees or pay a tax to enroll their workers in a publicly sponsored plan. To make employer-sponsored insurance affordable, the public system covers older workers and people of any age needing high cost care.

### Publicly sponsored coverage

Publicly sponsored insurance covers everyone not enrolled in employer-sponsored plans, including:

- the unemployed or those not in the job market;
- retirees;
- employees over age 60; and
- those in need of more than \$50,000 of medical care annually.

The public system consolidates all current public pro-

grams, including Medicaid and Medicare, and it offers the same benefits as private plans. All employers and individuals benefit from the public plan, forming a constituency sufficiently broad to ensure the system's viability.

## F I N A N C I N G

### Private sector

An insurance-based system offers the best means of fostering an array of practice arrangements to suit the preferences of patients and providers. However, the ACP plan requires the reforms:

- Insurers accept all applicants regardless of pre-existing conditions.
- Premiums are based on the health status of the entire community, not an individual group. This action spreads the risk and the cost of insurance, making it more affordable to small employers.

Insurers compete by offering lower premiums or better value, not by avoiding risk or reducing reimbursement to providers. Premiums can be lowered through efficient administration. Value can be increased by organizing a group of providers believed to offer higher quality care or more choice of providers.

Employers and employees share the cost of private sector insurance. Employers pay at least 50 percent of the premium.

### Public sector

Funding for publicly sponsored insurance comes from:

- payroll taxes from companies not sponsoring insurance for their employees;
- income-related premiums from retirees, collected through the tax system;
- funds now paying for Medicare, Medicaid, and other government health programs; and
- increased alcohol and cigarette taxes.

## C O S T C O N T A I N M E N T

The American College of Physicians commits to working under a national health care budget, which will discourage unnecessary use of expensive procedures and technology. A national health care commission, with extensive input on population demographics and health care needs, recommends national and state-level budget allocations to Congress. Costs are contained through effective management of price, supply, and demand.

### P r i c e

Individual practitioners, managed care organizations, hospitals, and other providers negotiate fees with all payers in a state. The fees are based on a systematic method of valuing services, such as those methods used by Medicare. All fees within a sub-state region are uniform. When multiplied by expected utilization, fees cannot exceed the state's budget allocation for that year. If they do, adjustments are made, such as a reduction in the following year's fee increase, but necessary care continues.

### S u p p l y

Under federal guidelines, communities set targets for health resources including the supply and distribution of physicians and other professionals, hospital beds, and capital investments. The targets are linked to the payment system.

The mix of physicians is changed from 65 percent specialist/35 percent generalist to a more even balance. This change reduces the bias toward use of costly procedures and specialized care by increasing preventive and early intervention services. The shift is accomplished through improved reimbursement for generalists and through financial and other incentives in graduate medical education, including:

- weighting payments for graduate medical education to favor the training of generalists;
- reduced-interest or interest-free loans to residents training to be generalists; and
- other regulatory approaches affecting the number of residency slots for specialists.

## D e m a n d

Efforts to reduce unnecessary demand include:

- patient education on disease prevention and the reasonable expectations of medicine;
- co-payments, except for low-income patients; and
- payment reform to reduce incentives to perform unnecessary procedures.

## Q U A L I T Y C A R E

All health plans — both publicly sponsored and employer-sponsored — provide the same set of medically effective and necessary health services rather than a pre-determined insurance package. Benefits are determined by the national health care commission based on medical effectiveness research and judgment of medical value. This approach provides a mechanism to address the allocation of resources explicitly rather than tacitly.

Quality is also improved by:

- practice profiling to identify physicians performing below acceptable standards of care (replacing intrusive case-by-case review and freeing physicians for the direct care of patients);
- a more responsive malpractice award system;
- increasing health services research; and
- improving the supply and geographic distribution of primary care physicians.

## T H E F U T U R E

"Universal Insurance for American Health Care" is the product of five years of research and collaboration and follows a 1990 College paper supporting universal access. The College will continue its work with the next phase focusing on cost projection and financing arrangements. The College will also continue to work with other medical organizations, with Congress and the Administration, and with all who have a stake in the future of reform to forge a consensus on this crucial issue.

## ABOUT THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians is the largest medical specialty society in the United States, with 77,000 members practicing internal medicine.

Doctors specializing in internal medicine provide non-surgical medical care to adults and adolescents. General internists diagnose and treat illness involving any of the body's internal organ systems. Subspecialists in internal medicine have additional expertise in one particular area, such as allergy and immunology, cardiology, endocrinology, gastroenterology, hematology, infectious diseases, medical oncology, pulmonary disease, or rheumatology. Internists, including subspecialists, provide much of the nation's primary care, managing their patients' overall health care and making referrals to other health professionals when necessary.

Founded in 1915, the College's mission is to foster excellence in the practice of medicine through continuing education and the development and advocacy of public policies affecting public health and medical practice. The College publishes *Annals of Internal Medicine*, the most widely cited medical specialty journal in the world.

For more information about the College, contact the American College of Physicians.

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## HOW THE ACP PLAN WORKS

### Private and public sponsorship

Under the physicians' plan, employers could offer their own health coverage or pay a tax to enroll their workers in publicly sponsored insurance. To make employer-sponsored insurance affordable, the public system would cover workers over age 60 and people of any age needing high-cost care, along with the unemployed and retirees. Employers would share the cost of private sector insurance with their employees.

The public system would consolidate all current public programs, including Medicaid and Medicare, and offer the same benefits as private plans. Because all employers and individuals would benefit from the public plan, its constituency would be broad enough to ensure its viability. This is not the case with Medicaid -- the federal-state program for low-income people -- which excludes more than half the nation's poor people. Funding for publicly sponsored insurance would come from Medicare, Medicaid and other government health programs; payroll taxes from companies not sponsoring insurance and their employees; income-related premiums from retirees, collected through the tax system; and other tax revenue. A nationwide poll commissioned recently by the ACP showed more than half of all Americans -- 56 percent -- support combining public programs.

The ACP plan would retain private sector insurance to foster a choice of medical practice arrangements, including managed care. However, insurers would have to accept all applicants regardless of pre-existing conditions and calculate premiums based on the health status of the entire community, rather than an individual employer. This would spread the risk and the cost of insurance, making it more affordable to small employers.

The ACP proposal would significantly consolidate the insurance industry, ACP leaders said. Remaining insurers would compete by offering lower premiums or better value, not by avoiding risk or reducing reimbursement to providers.

### Cost control

The College proposes to control spending through a national health care budget and management of the price, supply and demand for health care services.

The budget would be developed by a national commission representing all sectors of society and approved by Congress. It would cover public and private spending and account for changing health needs of the population, new technology and general inflation. The plan assumes that the current level of health care spending - \$809 billion in 1992 -- is enough to provide health care to everyone with the elimination of waste such as duplicative efforts of insurance companies in marketing and billing, overuse of expensive procedures and technology, duplicative facilities and equipment and overpriced care.

--more--

Some estimates of waste in health care are as high as \$200 billion -- a quarter of all spending. Even a savings of 5 percent would generate \$40 billion -- enough to extend coverage to all people under most estimates.

Under the ACP plan, physicians, hospitals and other health care providers would negotiate fees with states, and all insurance plans would pay the same fees. Managed care and other organized delivery systems would negotiate separate budgets with insurers and develop their own compensation packages.

Payments could not exceed the allocation for each state. Payments to providers could be reduced if excesses were not attributable to unanticipated illnesses.

Under the ACP plan, supply would be managed using community targets for the numbers and distribution of physicians and other professionals, hospital beds and capital investments. The targets would create an even balance of generalist and specialty physicians, reducing the system's bias toward the use of costly procedures and specialized care and expanding preventive care. Currently, there are two specialists for every primary care physician. The personnel targets would be achieved through improved reimbursement for generalists, financial and other incentives in graduate medical education and limits on the number of specialty residencies. Capital investment targets would be achieved through a requirement for regulatory approval.

Patient demand would be reduced through patient education on disease prevention and reasonable expectations of medicine and through co-payments, except for low-income patients.

#### Comprehensive, quality care

While expanding access to care, the ACP plan would also improve the quality of care. Coverage under both the public and private systems would consist of all medically effective and necessary health services based on patient need instead of a pre-determined benefits package. Benefits would be determined by the national health care commission based on medical effectiveness research and judgment of medical value. In addition to improving quality, this approach provides an explicit mechanism to address the question of rationing, which occurs tacitly under the present system.

Quality would also be improved by using a more efficient method of physician oversight -- pattern profiling -- which identifies physicians whose performance deviates significantly from peers. This would replace intrusive and costly case-by-case utilization review.

"Case-by-case review is expensive -- a \$7.4 billion industry -- and it has not proven to be cost-effective. It has drawn the profession into a permanent game of phone tag with consultants, whose permission must be granted for doctors to treat their patients," Ball said. "Imagine the Internal Revenue Service auditing every taxpayer. Well, physicians are under constant audit. There is a smarter, better, more cost-effective way to perform quality assurance and contain costs."

--more--

The ACP plan would also improve quality with a more responsive malpractice award system and an increase in health services research to reduce the variations in medical practice using scientific data on the effectiveness of treatments and procedures.

- 30 -

**CONTACT: Kathleen Haddad (202) 393-1650 or (800) 633-9400**  
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Talking Points For February 11, 1993, Pennsylvania  
Health Care Reform Forum With Hillary Clinton

AARP shares the President's concern that we must get the economy back on track:

- believe that health care reform is critical to long-term economic growth; and
- understand that everyone will have to share in the sacrifice required to reduce the nation's budget deficit.

Applaud Senator Wofford, Mrs. Clinton and the President's effort to engage Americans in a national dialogue on health care reform because the public must play a role in defining the new health care system if it is to be successful:

- Three years ago, AARP embarked on a campaign to make health care reform a major issue in the 1992 Presidential and Congressional campaigns and to build public consensus around the need for comprehensive reform;
- I am sure that Senator Wofford and President Clinton heard countless stories on the campaign trail of American families who cannot afford the high costs of health and long-term care and who want to see major changes in how our insurance companies, hospitals, and doctors do business;
- I have heard the same stories from Americans of all ages. Last year AARP volunteers -- like myself -- held 6,000 meetings across the country to discuss health care reform; we also received feedback on our own draft proposal "Health Care America."
- From what we have heard, Americans want action from their President and Congress this year -- if not within the first 100 days.

Pleased that the President is committed to expanding health coverage to everyone. Access to health care is not only "the right thing to do" in a country as advanced as ours, it's also "the smart thing to do":

- We need to move people from "high cost" emergency rooms in hospitals to "lower cost" prevention and primary care;
- We need to guarantee coverage for a comprehensive set of benefits -- inpatient and outpatient services now covered by Medicare but also preventive services and

prescription drugs -- so that coverage and affordability problems don't pop up in the future;

- We need to eliminate the "cost shifting" across businesses and between business and the government -- and we need to make sure that costs are shared.

Long-term care is a critical part of health care reform:

- Perhaps the largest hole in today's health care system is the lack of protection against the extraordinary costs of long-term care;
- Want a national social insurance program that includes home and community-based care and protects against the enormous costs of a nursing home;
- Shifting long-term care costs to the states through Medicaid is not a solution, particularly when the states are facing fiscal crises of their own;
- We recognize that a phase-in may be necessary for a new program, but we need to establish at the outset -- and in the same package with other health care reform measures -- that long-term care is critical.

Support the President's effort to take control of health care costs as soon as possible before they completely take over the economy and American families' pocketbooks:

- Need system-wide and effective cost containment that doesn't shift costs between Medicare and the private sector;
- Most Americans want the federal government to limit how much hospitals, doctors, and other health providers can bill for their services.
- Consumers see health care costs in very personal terms -- out-of-pocket costs (i.e., premiums, deductibles, and coinsurance) -- so we need to protect against large increases in these.
- Need to look beyond Medicare budget savings for the resources to pay for health care reform; don't want to turn a very popular program -- Medicare -- into a second-class system;

We expect that financing of health care reform will be fair and shared across all populations, taking into account individuals' ability to pay.

AARP looks forward to working with the President and Congress to enact health care reform this year.

**ERNEST SESSA**  
**Pennsylvania Health Care Cost Containment Council**

Background

The Pennsylvania Cost Containment Council is an independent state agency that was created in 1986 by an act of the Pennsylvania Legislature.

The law is designed to "promote the public interest by encouraging the development of competitive health care services in which health care costs are contained and to assure that all citizens have reasonable access to quality health care."

The law mandated that the Council:

- collect, analyze, and make public data on cost and quality of health care services in the Commonwealth of Pennsylvania;
- study and report to the Governor and General Assembly on the issue of care for the medically indigent;
- review proposals for mandated health care benefits in Pennsylvania.

The Council is financed through the budgetary process of the General Assembly.

The agency is directed by a 21-member Council appointed by the Governor and legislative leaders. The authorizing law specifies membership from business, organized labor, hospitals, physicians, commercial insurance, Blue Cross/Blue Shield, HMOs, consumers, the Secretary of the Department of Health, Secretary of the Department of Public Welfare, and the Commissioner of the Department of Insurance.

The agency has six working committees supported by a 30-member staff. Committees study issues and make policy recommendations to the full Council. These committees and their functions are:

- Executive Committee formulates policy and sets direction based on Act 89;
- Administrative Committee studies issues relating to the effective administration of the Council and its staff;
- Data System Committee is responsible for developing data collection and dissemination to promote a competitive health care marketplace;
- Education Committee focuses on educating consumers and

health care purchasers and providers on how to understand and use the Council's data;

- Indigent Care Committee is charged with defining the problem of the medically indigent, offering solutions to the medical care access issue and developing a plan for indigent care,
- Mandated Benefits Review Committee makes recommendations concerning existing or proposed laws that direct health insurance policies to contain minimum levels of health insurance benefits.

### Reports

The Council prepares an annual report, "Utilization and Financial Report," containing hospital discharge, average length of stay, insurance, service and financial information.

The "Hospital Effectiveness Reports" cover 175 large hospitals in the state and 59 illness categories by comparing a hospital's actual number of patient deaths and the actual number of patients who were medically unstable during the first week of hospital treatment to expected numbers calculated from a comparative database of similar hospitals throughout the nation and Pennsylvania. The report will also show additional points of comparison such as the number of patients treated, the average length of hospital stay, and the average amount a hospital charged for treatment for each DRG category. To date, 40 reports have been completed.

In 1988, Lewin and Associates prepared a series of reports on health care for the medically indigent in Pennsylvania. The reports gave the first detailed information on the percent of uninsured by region and income, and the number of uninsured children. The reports provided information for the recent passage of the Children's Health Care Program and health reform proposals sponsored by Representative Allen Kokovich and Governor Casey.

Two other important reports: "The Small Area Analysis" details comparisons of hospital utilization rates between communities and counties; and "The Consumer Guide to Coronary Bypass Surgery" provides consumers and purchasers a focused look at hospital quality and charges for open-heart surgery and, for only the second time in the U.S., mortality rates by physician.

# Pittsburgh Post-Gazette

MONDAY, MAY 18, 1992

## A proven health-cost cutter

For the first time in its 116-year history, St. Vincent Health Center in Erie announced in January a reduction in charges for major medical procedures. Under the new rates, the price of open-heart surgery, for instance, dropped from \$40,000 to \$32,000. All told, the price cuts in heart procedures should save patients or their insurers about \$5 million yearly.

One factor in the rate reduction was a report issued in August by the Pennsylvania Health Care Cost Containment Council that showed the hospital's charges for heart cases \$10,000 to \$15,000 higher than its chief competitor. The report was one of the annual regional studies that the council does on the 175 acute-care hospitals in the state with 100 or more beds.

From the data, which are adjusted for various factors that differ among hospitals, come cost and mortality comparisons. Naturally, some of the numbers have been controversial, particularly for facilities that rate poorly in a given category. But there is growing evidence, at a time when 13 percent of the nation's gross national product is spent on health care, that the council's information is being not only studied but also implemented on a case-by-case basis to reduce health-care expenses.

That's why Gov. Casey's attempt to tamper with the council is so oddly timed. Given his actions of the last few months, it's hard to figure out what he wants to do with the agency. Our best advice is to leave it alone.

In February, when he unveiled his 1992-93 budget proposal, the \$1.7 million line item for the independent (though state-funded) council had been eliminated and the state Insurance Department was allocated an additional \$900,000 to carry out the council's functions.

But a month later, in response to criticism from business and labor, the administration suddenly beefed up its proposed appropriation to Insurance for performing the council's duties to \$2 million, with the additional directive that it begin compiling and releasing data on outpatient treatment and physician services.

The administration argues that the Insurance Department could compile and analyze health-

care data more effectively and more cost-efficiently, but there is no documentation to suggest that this is so. What keeps surfacing in our memories is the governor's budget address three months ago, in which "downsize" was the operative word. Given Pennsylvania's limited resources, that is certainly the course to take, but you can downsize government sensibly, or you can do it in a way that ultimately costs the public more money than it saves. That's what we fear will happen if the governor has his way on the council.

Perhaps there are efficiencies that the council should be adopting. If so, they should appear in a performance audit due out at the end of the month by the Legislative Budget and Finance Committee. But it's hard to argue with the results the council's work is beginning to provoke statewide:

- Hershey Foods is using the council's data to develop a preferred network of health-care providers that, if used by employees, could save the corporation 10 percent of its annual health-care costs.

- The State Employees Health Benefits Trust Fund has hired a consultant to evaluate the data with an eye toward holding down the cost of health benefits for state workers.

And, of course, there is the showcase example in Erie. One hospital, one category of procedures, \$5 million a year saved.

Because health-care costs have become such an issue in labor negotiations, and because the council's reports provide information that suggests ways to overcome high costs, the Pennsylvania Chamber of Business and Industry and the Pennsylvania AFL-CIO have wholeheartedly supported the preservation of the cost containment council.

Obviously, the council will not solve all of our health-care problems, particularly issues like access and availability. But until we have a system that takes care of everyone's needs, the council will remain an important tool for helping the present system be more competitive. This is one budget cut Pennsylvanians can ill afford.

## HEALTH

# Pennsylvania Heart Surgeons Rated by State

By RON WINSLOW

Staff Reporter of THE WALL STREET JOURNAL

A baseball fan need only open a newspaper to compare Joe Carter's batting average with Wade Boggs's. But if he needs heart surgery, there are almost no statistics that rank his local heart surgeons.

That is beginning to change. A Pennsylvania health-data agency issued a report on coronary bypass surgery yesterday that includes the first state-authorized rating of individual physicians according to death rates.

The report, sharply criticized by doctors and hospitals, is the latest move by government agencies and consumer groups to publish data comparing health-care providers by name. They expect employers and consumers armed with such information will reward quality by seeking cost-effective providers, while poor performers will be spurred to improve or leave the business.

The federal Health Care Financing Administration and data agencies in many states produce reports rating hospitals on costs, mortality rates and other areas. But except for results published in New York newspapers after a freedom of information lawsuit last year, the new report is believed to be the first to name doctors.

"A lot of people feel that the physician drives the health-care system and is an important factor in improving quality and reducing costs," says Ernest Sessa, executive director of the Pennsylvania Health Care Cost Containment Council, which is publishing the report. "We're showing . . . that you can produce reliable outcome information at the physician level."

## Criticism of Report

Doctors and hospitals say the report is suspect because the results don't adequately account for the impact on surgical mortality of differences in the seriousness of patients' illnesses. They assert public disclosure of death rates will impair health care by leading doctors to refuse treatment to high-risk patients. And they say other research shows that in complex procedures such as bypass surgery, quality depends not only on doctors, but on a chain of people and services from a patient's admission through discharge.

"You could be a virtuoso in the operating room and get untoward outcomes because of how care in the hospital is organized and delivered," says David B. Nash,

But Mr. Sessa says the council spent three months analyzing and adjusting the data to account for the medical community's concerns and that the report is weighted to reflect differences in the illness of patients. In addition, the report rates performance on three levels — the hospital, a physician's practice group, and the individual physician.

The study lists 170 cardiac surgeons who performed 14,895 coronary bypass operations at 35 hospitals in 1990: 580 patients, or 3.9%, died before leaving the hospital. The 36-page report names 14

surgeons with more deaths than expected, two surgeons with fewer than expected and 31 who didn't perform at least 30 operations at one hospital — the minimum the council considered necessary for meaningful data. Deaths for the other 123 doctors fell within an expected range, which depended on the severity of patient illness.

## Charges for Operation Vary

Doctors and their practice groups are listed under the hospitals where they worked in 1990. The report tells how many patients each doctor treated, how many died, and how many statistically would be expected to die. The study also names seven hospitals with higher-than-expected death rates and four with performances that were better-than-expected. And it found that average charges for coronary bypass ranged from \$21,000 to \$84,000—a fourfold difference. The statewide average was \$44,649.

Hospitals and doctors insisted that they don't object to public accountability, but even those with good results complained that a severity score used to rank patients according to risk is flawed. The score diminishes the significance of important factors, including a measure of the heart's pumping efficiency known as ejection fraction, and whether surgery was an emergency case or a repeat operation, doctors said.

These and other reasons prompted doctors to reject the report as "a consumer guide," as it is called in its title. "The report is a basis for asking questions and obtaining more information," says Kenneth P. Heaps, vice president of medical affairs at York Hospital, York, Pa. "It's not a batting average of hospitals or surgeons."

In any event, health-care consumers, including businesses, are poised to use the data. Hershey Foods Corp., Hershey, Pa., used previous hospital data published by the council to select a network for 10 hospitals for its employee health plan beginning in January. "It will be a great tool for us in identifying the doctors associated with these quality hospitals," says Richard Dreyfuss, director of executive compensation and employee benefits. "We don't intend to use it as a weapon, but we want to use it to improve the health-care system."

It's not clear how soon publication of physician data will spread. In many states

that report on hospital results, laws currently prohibit disclosure of physician performance, says Mark Epstein, executive director of the National Association of Health Data Organizations, Washington. But insurers and employers are beginning to develop similar reports from their own insurance-claims data, and pressure could build for more public disclosure. "Employers will see it, insurers will see it. The only group that won't see it will be the public," he says.

# Council keeps eye on costs

200 MS

In 1986, the Pennsylvania General Assembly created the Health Care Cost Containment Council to introduce competition into the health care market as a way to contain the cost and improve the quality of health care.

Recently, Gov. Robert P. Casey proposed placing some of the council's activities under Pennsylvania's Insurance Department. This plan would eliminate the Council's independent status and reduce its operating budget from \$1.7 million to \$900,000.



ERNEST  
SESSA

The governor's desire to continue providing information about the cost and quality of health care to the public is laudable. Despite difficult economic times, the Council is a good investment that can save money in the long run. And the Council is starting to make a real difference. However, completing the job will be difficult under the Insurance Department's proposal. Outpatient, rehabilitation and psychiatric care would remain unexamined, as well as hospital and physician payments, mandated benefits, and other important projects. The Council's upcoming hospital/physician report on coronary bypass surgery could be the first — and last — of its kind.

In what areas is the Council making a difference?

Hospitals now compete by adding redundant and costly services. However, the Council's public reports are fostering real competition based on what a hospital charges and the quality of care it delivers. St. Vincent's Hospital in Erie recently reduced charges for certain heart procedures, including open-heart surgery, in a move that will save patients \$5 million annually. St. Vincent's acknowledged that it was competing with a neighboring hospital, shown to be less expensive by the Council's public reports.

Large purchasers of health benefits can now identify the most efficient, effective providers. The Hershey Foods Corp., which employs 6,500 people in Pennsylvania, is using the Council's data to bring together the quality hospitals and doctors and, through incentives, encourage their employees to use them. This strategy re-

The Council is a cooperative partnership between business and labor, as well as consumers, insurers, and the medical community. Since division over health benefits is now the leading cause of strikes, the partnership approach, a major theme of the Casey administration, cannot be overemphasized.

State government is Pennsylvania's largest employer, and purchases health benefits for about 100,000 employees and their families. It insures another 1.5 million people through the Medicaid program, and pays the cost of workers compensation. One study has estimated that using the Council's data could save 2 percent (\$5 million) of the commonwealth's employee health costs, and that 10 percent was more likely. The Pennsylvania Employees Benefit Trust Fund is now examining the Council's information. Medicaid and workers compensation may be worth considering in this light as well.

According to The Wall Street Journal, "Pennsylvanians have access to more information about their hospitals than most Americans." The Council's information gives consumers the ability to ask educated questions of doctors and hospitals and make more informed choices. It is disturbing that in today's information society, consumers can obtain more details about which is the best car to buy than about which is the best hospital. In Pennsylvania, that is changing as evidenced by the thousands of people who have requested our reports.

Policy-makers can benefit from the Council's wealth of health care information. The Council has provided the Legislature with information on primary care access in rural communities, cost-benefit analyses on proposed mandated insurance benefits, and other projects.

The naysayers claim that you can't measure quality in health care. Former Surgeon General Dr. C. Everett Koop disagrees. In a letter to U.S. News and World Report, Dr. Koop wrote: "The only way to determine improvement in hospital and physician performance is by repeated documentation made available to the public on a continuing basis. This public and professional examination of performance is essential no matter what direction America takes in restructuring and refinancing its health care system. In the effort to measure quality, Pennsylvania is furthest along."

Accurate health care information such as this is the key to controlling costs — for businesses, their employees, consumers and government. We can identify the best value — price plus quality — for our health care dollar. The Health Care Cost Containment Council is a good investment that makes a lot of sense.

□ □ □

Ernest J. Sessa is executive director of the Pennsylvania Health Care Cost Containment Council.

MUTUAL  
PRESS CLIPPING SERVICE

MAR 15, 1992

YORK SUNDAY NEWS  
YORK, PA

SUN - 54,000

September 6, 1992



Sunday Patriot-News

# BUSINESS

## Employers shop for health-care buys

By Phil Galewitz

Patriot-News

When the price of Crayola Crayons increases, runaway health-care costs may be to blame.

Executives at Easton-based Binney & Smith Inc., the manufacturer of Crayola Crayons, have seen employee health costs rise more than 20 percent a year since the mid-1980s, faster than the price of raw materials or wages.

In response, Binney & Smith and several other Pennsylvania companies have begun using new data developed by the state's Health Care Cost Containment Council to comparison-shop for health-care benefits.

But just as this potentially revolutionary development is getting under way, Gov. Robert P. Casey's administration has moved to end the council's independence and assign its data-gathering functions to another agency.

Two years ago, for the first time, Binney & Smith required its 1,300 employees and their dependents to start paying annual premiums for health-care coverage. But medical costs kept rising — from \$6 million in 1989 to \$7 million last year.

"This is an uncontrollable situation," said Drew Landis, the company's vice president of human resources.

Binney & Smith and other Pennsylvania employers plan to change that situation.

For the first time, those businesses are armed with detailed information that compares the cost and quality of the state's hospitals and doctors. Using that data, businesses are revolutionizing the way they buy health care.

Employers, who once let any licensed doctor or hospital treat their employees, are becoming more selective, and they're being more aggressive in telling hospitals and doctors what they'll pay for that care.

They judge quality of care based on indicators ranging from a hospital's Caesarean delivery rate to mortality rates for heart

that care be provided at a competitive price.

"We're talking about value. This is the new trend," said James Meade, president of Capital Blue Cross.

### Shopping around

Before 1992, health-care providers who delivered low-quality care at high prices had no reason to worry. The consumers and purchasers of that care did not make comparisons.

Indeed, comparison shopping for health care was almost impossible. There was no easy, objective way to measure quality, and doctor and hospital costs were rarely made available.

The state's Health Care Cost Containment Council, formed in 1986, has changed that.

When the agency's reports comparing quality and cost at Pennsylvania hospitals first appeared in 1989, many health-care economists said the information was almost worthless because consumers had no incentive to use it.

They were wrong. Employers were increasingly losing profits to rising health costs.

"For years people talked about the idea of buying health care based on quality and value," said Ernest Sessa, director of the cost containment council. "What we have done is give them the information to do it."

Although the Health Care Cost Containment Council's five-year work is beginning to pay dividends, the Casey administration wants to end its independence by moving its data-gathering function into the state Insurance Department.

Labor and business groups oppose the proposal. The council's reports are the only way they can measure quality and cost in choosing hospitals, they say. And they don't want those reports and other work done by the council influenced by the politics of state government.

The council's first report on individual physicians, to be released next month, will compare doctors who perform heart-by-

**HEALTH — From Page F1**

pass surgery.

Earlier this year, a handful of large Pennsylvania companies, such as Pittsburgh-based Mellon Bank and Duquesne Light, set up programs with Pennsylvania Blue Shield called Blue Choice that require physicians to meet certain cost and quality criteria before they will be allowed to treat the companies' employees.

Mellon bank had offered its employees the option of using health-maintenance organizations, which originated the concept of managed health care by screening physicians and controlling access to certain expensive tests and procedures.

Mellon officials said many employees would not use HMOs. They didn't believe the HMOs gave them enough flexibility in choosing doctors and hospitals.

So Mellon began offering its 16,000 employees the Blue Choice option.

Like an HMO, the new plan involves a primary-care doctor to act as a gatekeeper for allowing patients access to a range of medical services and specialists. Unlike most HMOs, however, the plan allows employees to go to doctors outside its network if they are willing to pay an additional out-of-pocket fee.

Several thousand of Mellon's 16,000 employees have chosen Blue Choice.

**Setting a trend**

Hershey Foods Corp. is taking a similar approach. Starting Jan. 1, about 6,000 Hershey em-

ployees will be able to select an insurance plan that uses a network of doctors and hospitals chosen for their high quality and low cost.

Capital Blue Cross is working with Hershey to select hospitals that meet certain cost and quality standards. Of 23 hospitals that serve Hershey employees in central Pennsylvania, the company is in the process of contracting with 10 for its new health-insurance option.

In the Harrisburg area, Holy Spirit Hospital in East Pennsboro Twp. and Community General Osteopathic Hospital in Lower Paxton Twp. have been excluded, not because they are bad hospitals, Hershey officials say, but because they do not meet specific needs of the company.

Hershey had offered HMOs, but only about 20 percent of employees joined. So about two years ago the company proposed forming its own health system.

To select the hospitals in the Hershey experiment, Blue Cross and Hershey looked at mortality and morbidity data from the cost-containment council, average length of stay, use of Caesarean compared to natural childbirth, the comprehensiveness of a hospital's services, the use of certain procedures and access of the hospital to employees.

Hershey has not asked its network hospitals or doctors for deeper discounts than they already have made through Blue Cross/Blue Shield. Instead, Hershey has asked the providers to control use of services and subject themselves to detailed review every two years.

Hershey spent nearly \$1 million to develop the program, which will emphasize preventive care to help cut the chocolate maker's health-benefit costs by at least 2 percent in 1993 and 30 percent by 1998. Hershey spent about \$19.2 million last year to cover its midstate employees.

The company is hoping the investment will pay off not just by lowering health-benefit costs, but by making Hershey's products more competitive in a world market where many foreign companies don't have to pay as much for employee benefits.

Company officials said they were surprised that hospitals agreed to take part in the experiment because they did not think Hershey had enough employees to use as leverage. But the potential for more patients and the knowledge that many other large midstate employers will likely follow Hershey's lead influenced the hospitals' decision.

**Some doubts**

Stephen Male of the state Health Department has doubts about the future of such managed health care. He said few companies have the resources needed to develop their own health network.

Such "preferred-provider" systems cannot control costs as can HMOs, which cap payments to doctors and strictly control the consumer's use of services.

Even when employers contract with specific low-cost providers, Male said, the doctor or hospital still can increase costs by simply delivering more services.

**EDITORIALS**

# Rating the city's hospitals

*The agency's report may not be perfect  
— but it's a necessary start*

All across Philadelphia, hospital officials are, well, jumpy. They've had their first thorough going-over by a state agency that presumed to lift the veil of secrecy surrounding their business. And, like anyone suddenly exposed to unaccustomed public glare, they are flinching.

The report that has them defensive was compiled by the Pennsylvania Health Care Cost Containment Council (HCCCC), which since 1986 has had, among other duties, a mandate to publicize cost and quality information about hospitals. The theory was that, unless there was a way to measure and compare hospitals, they'd remain forever immune to the sort of competition-driven efficiencies that doctors and administrators fondly advocate for other economic sectors.

The report contains some hum-dingers. It found the price of a heart bypass at Graduate Hospital more than twice as high as at Presbyterian. Statistically, Thomas Jefferson Hospital had fewer deaths than would seem normal, St. Joseph's Hospital more. And so forth.

We're not experts. Maybe the report isn't perfect; its methodology is subject to all manner of niggling criticisms. But it is not a seat-of-the-pants effort, either. City hospitals were consulted and suggested refinements in the study. It's not as if the process had taken place on another planet.

So, we'd like to say this much, without endorsing every single figure in the report: It's about time. With medical inflation totally out of whack, with wild stories of billing craziness and street talk about the reputations of hospitals, consumers (including companies, insurers and trade unions) deserve to be able to look at data that — prudently interpreted and combined with other relevant information — could help them to make more effective health-care decisions.

A complicated dynamic has been spending America into the poor-house on health care: Medical services are rendered often without rigorous evaluation of their benefit; patients don't care about costs because they're usually not paying directly; hospitals operate noncompetitively, with the differences between them unclear and many of their claims untested. The HCCCC's report isn't going to turn things around, but it's a way to start cutting through the fog, and allowing the public to participate in what has been an insider's debate.

Indeed, the doctor-knows-best attitude came through loud and clear in a Delaware Valley Hospital Council press release that warned against

over-reliance on a report that's "simplified for a mass audience." Well, well. The last time hospitals in this area compared themselves, they did it behind the shield of anonymity (Hospitals A, B, C, etc.), finding that one hospital had half the death rate from heart bypass operations as some others. Researchers weren't certain exactly why. But wouldn't you like to know which hospital had the low death rate? (This wouldn't preclude you necessarily from listening to other hospitals present the mitigating circumstances that might explain their higher rates.)

Another point the hospital association raises is that Philadelphia has a huge population (425,000) of Medicaid-eligible people. Since they have limited access to primary care, it says, they are admitted sicker, require longer stays and are higher risk. It says that skews the HCCCC report. (The HCCCC denies this, saying that it took into account the conditions of individual patients in very specific terms.)

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Be that as it may, it should be noted that figuring ways to provide access to medical care for the poor — including tens of thousands of working poor who don't qualify for Medicaid — was another major mandate of the HCCCC, one that has not been accomplished.

Caring for them, whether it skews hospital comparisons or not, certainly does push up hospital costs. Yet, Harrisburg seems to have given up on the problem. The HCCCC's "indigent-care committee" doesn't even bother to meet anymore. Nor is there any sign from the federal government or the Casey administration of any urgency on this front.

It would be a happy occasion indeed if hospitals' complaints trigger a resumption of the state's moribund discussion on extending health coverage to the working poor. The question of access to care should always have been part of the crusade to contain costs and maintain quality — not apart from it.

# Health care

## Accurate data offers key to controlling costs

By ERNEST J. SESSA

THE PENNSYLVANIA Health Care Cost Containment Council, an independent state agency, recently published a Region 5 Hospital Effectiveness Report for all acute-care hospitals with more than 100 beds. Region 5 covers Adams, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lancaster, Perry and York counties.

There is an old saying that "a journey of 1,000 miles begins with a single step." The new Hospital Effectiveness Report marks a key milestone in the process of Pennsylvania's health care strategy. The council released preliminary reports last year. The latest report represents an unprecedented 12 months of information about hospital performance. For the first time, consumers and purchasers of health benefits now have significant information to use — in conjunction with their health-care providers — in obtaining the most efficient and effective health-care services.

Good health-care consumers generally want answers to the following questions. What will a particular treatment cost? How effective is the hospital in treating a particular illness of medical condition? How much experience do they have?

Can the Hospital Effectiveness Reports assist consumers and purchasers in answering these questions? Absolutely. To see how, let's look closely at the categories of cost, effectiveness and experiences.

**COST:** For each illness category (known as a DRG or diagnosis related group), the report will show the average amount each hospital charged for treatment over a 12 month period. While charges are not always identical to the actual hospital bill (due to fixed Medicare and Medicaid payments and selective discounts), charges are a reasonable and consistent basis of comparison. The average charge shows the amount of a typical bill that might be expected from area hospitals. It starts the buying process in the right direction because it represents the "list" price. Potentially, a discount can then be negotiated with the hospital. Of course, some purchasers and individual consumers do pay the full charge amount. The Hospital Effectiveness Report allows consumers and purchasers to compare the charges at various hospitals when seeking health care. For example, the average charge for a normal childbirth, without complications, in South Central Pennsylvania ranged from a low of \$934 at one area hospital to a high of \$2,196 at another.



Sessa

**EFFECTIVENESS:** The Health Care Cost Containment Council measures hospital effectiveness by comparing a hospital's actual number of deaths during hospitalization, and the actual number of patients who were medically unstable during the first week of hospital treatment, to expected averages. These "expected" numbers come from a data base of over 800,000 patient records from hospitals in Pennsylvania and throughout the country. Consumers can determine which Pennsylvania hospitals had actual numbers which were fewer, greater, or similar to expected number from similar hospitals. These numbers are adjusted to account for the degree of patient illness upon admission to the hospital, patient age differences (over and under 65 years of age), and for the impact of cancer cases. These adjustments place hospitals on a level playing field so that fair comparisons can be made.

**EXPERIENCE:** The report shows the number of patients treated at each hospital for the 57 illness categories. This may be an important factor when considering the experience of a hospital. The council's hospital effectiveness reports from other counties can help doctors and patients evaluate hospitals — from both inside and outside their area — which specialize in performing complicated procedures. Consumers should ask their doctor if the number of patients a hospital has treated is important for a particular illness.

Large purchasers of health benefits can compare the information in the Hospital Effectiveness Report with the claims experience of their employees or members. They can examine which hospitals their people are going to. Purchasers can then compare the charges and treatment information from these hospitals to those of other providers to see if they are getting the best use of their health-care dollar.

Accurate health-care data such as this, when used effectively, is key to controlling health-care costs. Hospital administrators can compare their charges and treatment effectiveness to those of their competitors; businesses and labor unions can use the information to evaluate benefits and providers; consumers can seek care based on treatment effectiveness as well as hospital charges; and government will have useful data as it works to control costs and improve quality in current programs.

The Hospital Effectiveness Reports provide to consumers, purchasers, health-care providers, insurance companies, and policy-makers, the most concrete, comparative information available today about health-care costs and quality. Let's begin using it to make a difference about one of the most pressing issues of our time.

Ernest J. Sessa is executive director of the Pennsylvania Health Care Cost Containment Council.

*Handwritten:* Harrisburg PATRIOT NEWS 5-17-91

**Statement of A. N. "Jerry" Karabelas, PhD  
Senior Vice President, Marketing, U.S.  
SmithKline Beecham Pharmaceuticals**

**Pennsylvania Health Care Conference  
Pennsylvania State University  
Harrisburg, Pennsylvania**

**February 11, 1993**

Senator Wofford, I am Jerry Karabelas, senior vice president of marketing for SmithKline Beecham Pharmaceuticals in Philadelphia. While my responsibilities are in marketing, my training is in pharmacokinetics. I am here in response to your kind invitation to our chairman, Henry Wendt. He is sorry he can't be here today, but he asked me to give you his best regards.

As you know from your conversations with Henry Wendt, SmithKline Beecham believes that universal access to quality, cost-effective health care belongs at the top of the American agenda. That's where it is now, and we're proud that the wake-up call on health care originated in Pennsylvania with your Senate campaign.

We share your belief in the need for universal health insurance. We don't often say it, but for thousands of people working at SmithKline Beecham, we chose this career because we want to work in an organization whose products and services improve the lives of people. I know from direct experience what a difference medicines can make in saving life and restoring hope and dignity to people. Those benefits must be available to every American as a matter of right.

We also share your belief that the managed competition model, encouraging economical, quality health care, holds real promise to serve unmet patient needs and encourage economy and quality health care.

SmithKline Beecham has been studying the many issues surrounding health care reform for some time. Among other things, we believe that the new health plan must offer administrative simplicity. It must encourage consumer participation in their own health care management. And it must utilize market forces as incentives for appropriate utilization of products and services.

These goals are widely shared. No one is pretending that achieving them will be easy, because there are many contrasting points of view, and no choice is without cost.

While I am prepared to discuss health policy reform in general, we know the pharmaceutical industry best, and I therefore will confine the rest of my comments to the need for a drug benefit as part of the reform package.

Prescription drugs, as the most cost-effective element in health care, must be integral to the basic benefit package. Although they take only 5 per cent of the health care dollar and are therefore a small part of the cost problem, they are a major part of the solution to health costs -- because they can obviate the need for more costly care.

Nevertheless, consumers -- particularly the elderly -- feel the cost of drugs, because they are the largest out-of-pocket health expenditure. We must change that, with a sound prescription drug insurance benefit.

Doing so will save money in overall terms, by ensuring that medicines that can keep people well and out of the hospital are universally available when needed.

My own company's product Tagamet is a classic case in point. It may cost the patient \$2 per day, but it can prevent \$25,000 worth of gastric surgery.

But Tagamet and our other successful drugs and vaccines do more than save money in their own right. They also support SmithKline Beecham's research, development and marketing programs, under which we discover and develop therapeutic innovations and teach physicians how to use them most effectively.

That is what the patient is paying for with each SmithKline Beecham prescription. Not just the cost of the product prescribed, but the search for solutions to unmet needs. Let me mention quickly just a few examples from our current late-development product portfolio.

**It includes:**

- **a vaccine against Lyme disease**
- **a selective agent to control nausea and vomiting in cancer chemotherapy**
- **an improved treatment for Parkinson's disease**
- **a new agent against ovarian, brain, lung and breast cancers**

**I think you will agree that programs like these should not be put at risk in a short-sighted drive to cut costs at any price. We must set our sights on two essential goals: We must encourage economical drug therapy, but we must also preserve and enhance the climate for research and development. If we meet both objectives, we will have something for the world to envy.**

**If we are to continue to make progress in health care, it is critical that the pace of drug discovery continue while market forces work to control prices. And market forces *are* working. The Consumer Price Index for drugs fell dramatically last year, dropping 40%, from 9.4% to 5.7% while medical care costs in general rose over 7%. SmithKline Beecham's overall net prices rose only 1.6%, and we strive, in every therapeutic class we serve, to offer the best value. We provide cost-effectiveness data on our new products and set our prices based upon an effort to balance the interests of patients, physicians and shareholders.**

**We are, in short, responding forthrightly on pricing, while supporting universal prescription drug insurance as part of overall health care reform.**

**In conclusion, SmithKline Beecham looks forward to working with you and our colleagues on these issues. As you know, Henry Wendt wrote to you last fall pledging SmithKline Beecham's support in the development of a universal plan. We're ready to move ahead on this.**

**This concludes my formal statement, Senator Wofford. I hope it responds to your request, and I will of course welcome your comments and questions.**

## COST- Background

- ◆ Costs in PA
- ◆ Fiscal Clarity
- ◆ Federal Deficit

### *THE PENNSYLVANIA EXPERIENCE*

Personal health care expenditures in 1990 in Pennsylvania were \$30.5 billion. Health care costs are expected to be as high as \$41 billion in 1993 and could reach \$78 billion by the year 2000.<sup>1</sup> These figures include spending on hospital care, physician services, nursing home care and drugs and other medical sundries.

Individuals, businesses and state government all feel the pressure from rising expenditures. Currently, individuals in Pennsylvania pay for 32 percent of all personal health care, federal, state and local governments pay for 40 percent and businesses pay for 28 percent. In Pennsylvania, state and local governments pay for about one-fifth of the total government share.

Mark-up Book  
Talking Points

**MINORITY HEALTH**  
**African-Americans**

**Insurance**

- **African-Americans** are almost twice as likely to be uninsured than are white Americans (non-elderly) (22% vs. 13%).

(Source: March 1990 Current Population Survey)

- Those **African-Americans** who do have insurance are three times as likely to rely on public coverage through Medicaid as are white Americans. (27.4% vs 8.8%)

(Source: Current Population Survey, March 1990)

- **African-American** children depend on Medicaid more heavily than do white children. In 1986 nearly 15 percent of black children in employed families relied exclusively on Medicaid (compared to 5 percent of white children in employed families).

(Source: Children's Defense Fund, "The Health of American Children", p. 22)

**Health Status**

- Life expectancy for **African-Americans** has actually declined while life expectancy for other groups has risen (69.4 years vs 75 years). **African-Americans** life expectancy is more than 5 years shorter than the overall population. Each year, 60,000 **African-Americans** die who would live if their death rates had been the same as white Americans.

(Source: Healthy People 2000, Sept. 1990 p. 32)

- Infant mortality among **African-American** children is significantly higher than white children. Black babies are twice as likely to die before their first birthday than white infants. (17.6% vs. 8.5%)

(Source: Healthy People 2000 p. 33)

- **African-American men** die from strokes at almost twice the rate of men in the total population, and experience a higher risk of cancer than non-black men.

(Source: Healthy People 2000 p. 32)

- The rate of AIDS among **African-Americans** is more than triple that of whites.

(Source: Healthy People 2000 p. 33)

### **Access to Care**

- **African-American mothers** are twice as likely to receive no health care or care only in their last trimester of pregnancy than whites.

(Source: Healthy People 2000 p. 33)

- **African-American** uninsured patients have a higher in-hospital death rate than white uninsured patients.

(Source: JAMA, January 16, 1991, p. 374)

- **African-Americans** experience lower survival rates than the white population once they develop cancer: Only 38% of blacks with cancer survive five years after the initial diagnosis, as compared to 50% of white Americans.

(Source: Healthy People 2000 p. 33)

- **African-Americans** are 54 percent more likely than whites to lack a regular source of medical care (20% vs 13%).

(Source: Healthy People 2000 p. 34)

- Hospital emergency rooms and clinics are a more common source of medical care for **African-Americans** than for whites. In NYC, physician visits by black children are more than three times as likely to occur at hospitals than are physician visits by white children.

(Source: Healthy People 2000 p. 34)

## **MINORITY HEALTH**

### **Hispanics**

#### **Insurance**

- **Hispanics** are more than twice as likely to be uninsured than the rest of the population. (36% vs. 16%).

(Source: March 1990 Current Population Survey)

- Within every age group, the percent of Hispanic children with health insurance was significantly lower than for non-Hispanic children.

(Source: National Center for Health Statistics, October 1990)

#### **Health Status**

- The rate of AIDS is three times as high among **Hispanics** as among non-Hispanic whites. Rates among Puerto Rican-born Hispanics are 7 times higher than for the non-Hispanic population.

(Source: Healthy People 2000 p. 35)

- **Hispanic** women and children are disproportionately affected by AIDS. The incidence of AIDS is 8 times higher for Hispanic women than among non-Hispanic women. The rate of HIV infection is over 6 times higher among Hispanic children.

(Source: Healthy People 2000 p. 35)

#### **Access to Care**

- In 1987, 13 percent of **Hispanic** mothers had late or no prenatal care (compared to 4 percent of non-hispanci whites). 47 percent of women receiving insufficient prenatal care are of Hispanic origin.

(Source: Healthy People 2000 p. 35)

**MINORITY HEALTH**  
**Other Minorities**

**Health Status**

- The lung cancer rate of 18 percent higher for **Southeast Asian** men than for the white population. The prevalence of liver cancer is 12 times as great among Southeast Asians than among whites. Hepatitis is significantly more common among Southeast Asians, and the incidence of tuberculosis is 40 times higher among Southeast Asians than among the total population.

(Source: Healthy People 2000 p. 37)

- Life-expenctancy for American Indians (including Alaskan natives) is 71 years, as compared to 74.4 years for the white population.

(Source: Indian Health Service, "Trends in Indian Health", 1981)

- As many as 95 percent of **American Indian** families are affected either directly or indirectly by a family member's alcohol abuse, and many of the causes of excess deaths in the American Indian population (cirrhosis, homicide, suicide) are related to the prevalence of alcohol use.

(Source: Healthy People 2000 p. 39)

- Diabetes is a major health problem for **American Indians**, affecting as many as 20 percent of the members of certain tribes (Obesity being a major contributing factor).

(Source: Healthy People 2000 p. 39)

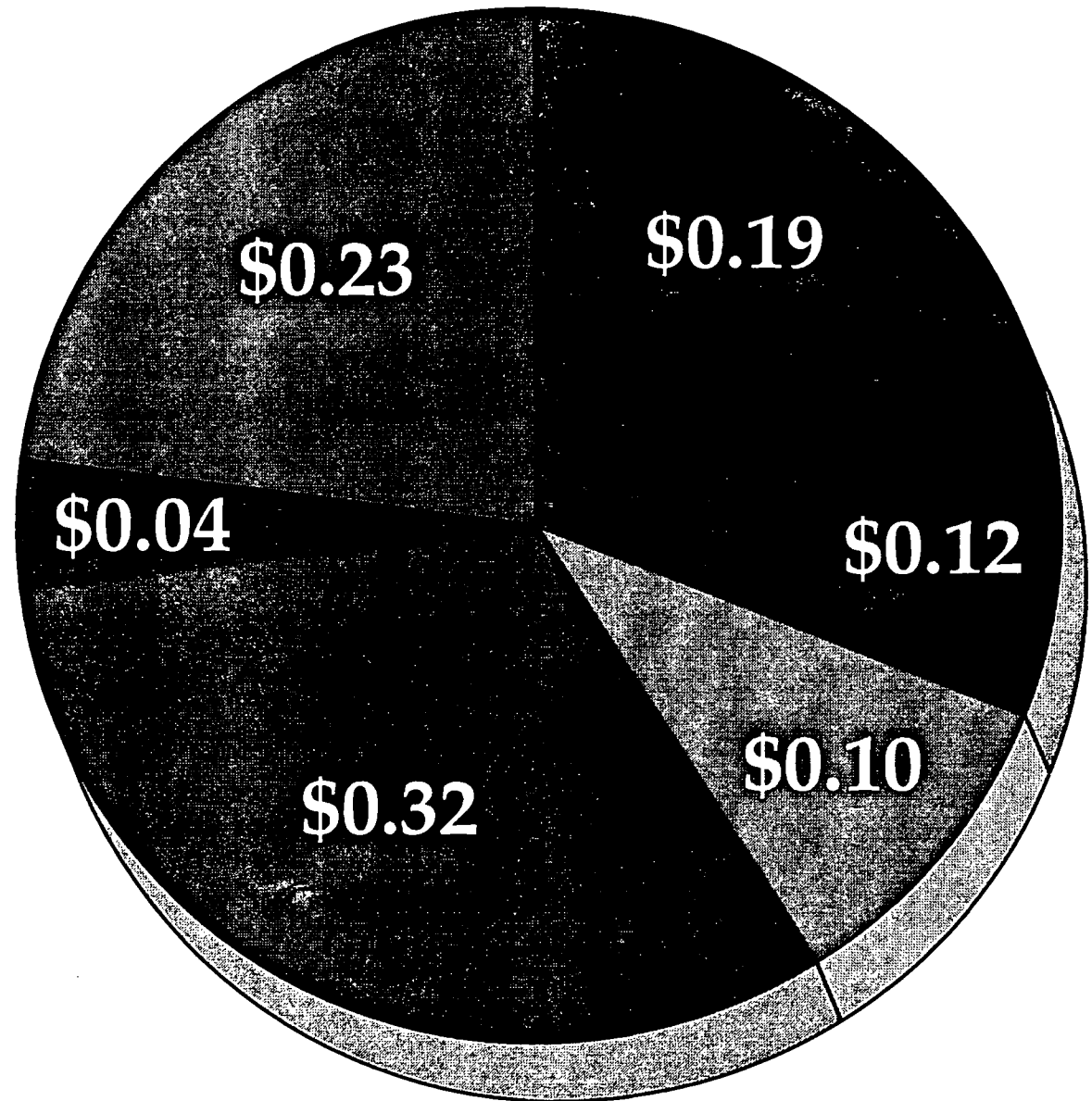
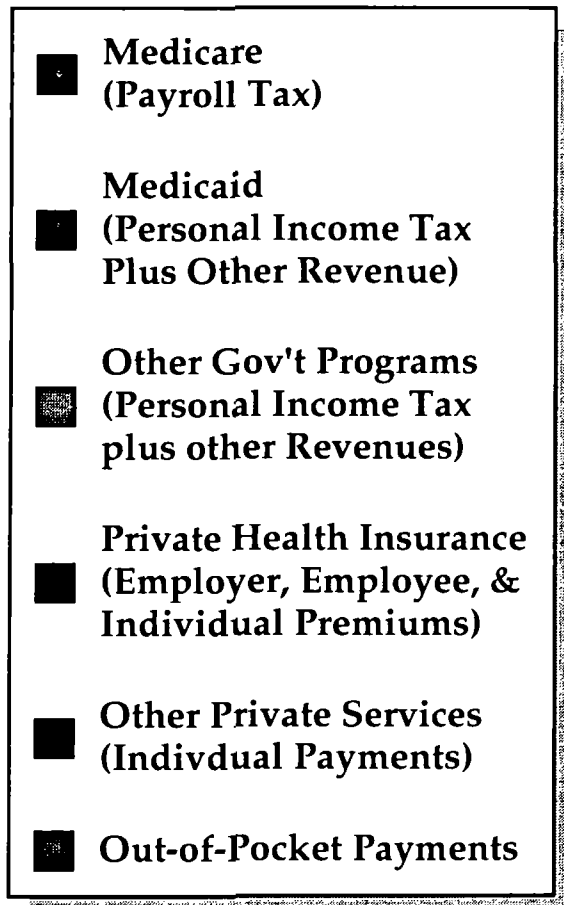
Minority Health Insurance Coverage  
(Nonelderly)

(In Percentages)

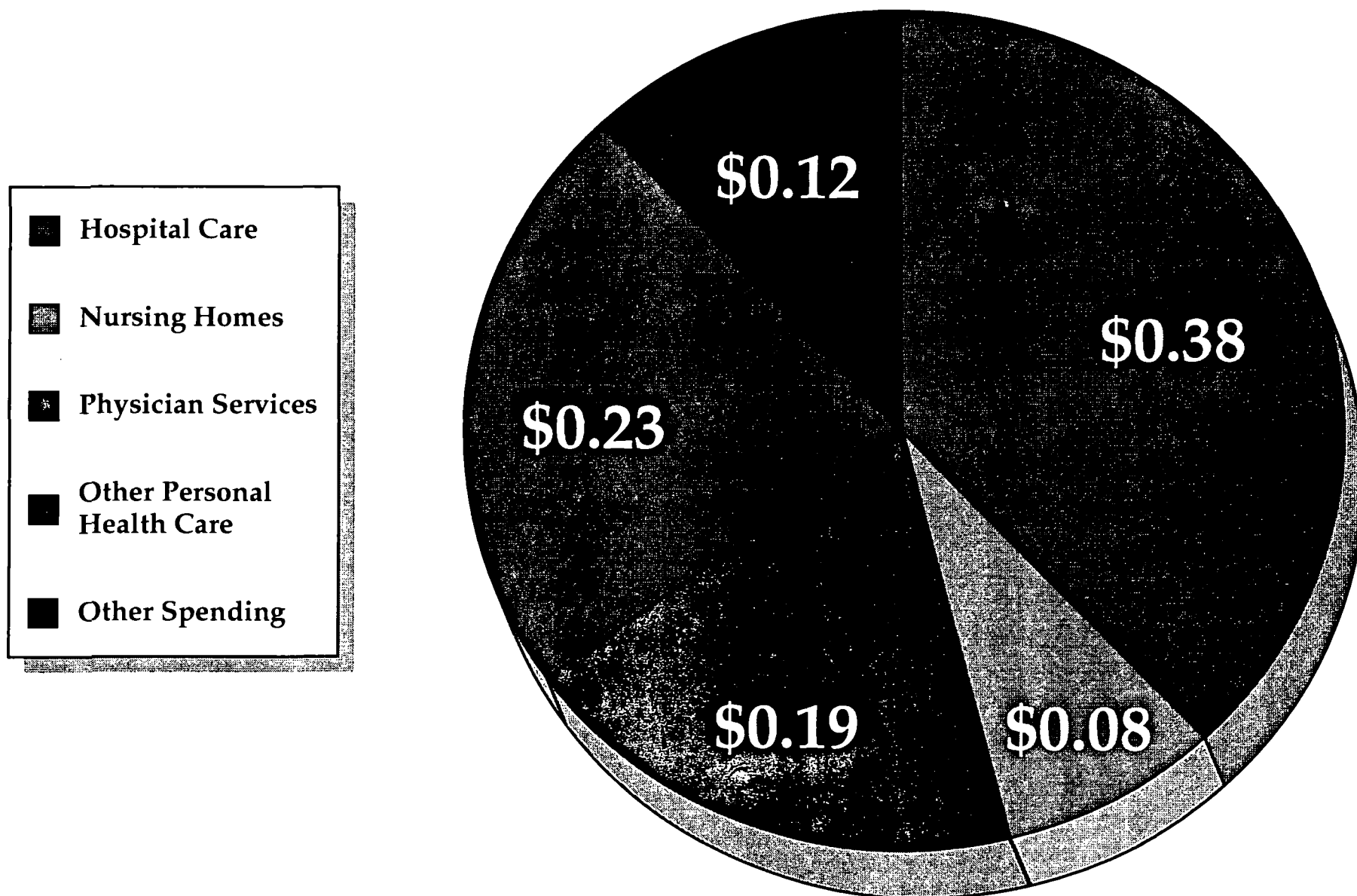
| <u>Population</u> | <u>Any Coverage</u> | <u>Employer Based</u> | <u>Public</u> |
|-------------------|---------------------|-----------------------|---------------|
| Total             | 83.9                | 65.9                  | 12.3          |
| White             | 87.6                | 71.8                  | 8.8           |
| Black             | 78.0                | 49.2                  | 27.4          |
| Hispanic          | 64.0                | 44.4                  | 17.3          |

SOURCE: March 1990 Current Population Survey

# Where does the health care dollar come from?



# Where does the health care dollar go?



## HEALTH CARE COSTS AND THE FEDERAL DEFICIT

Rising health care costs are a significant factor in the the increasing size of the federal deficit. Attached are relevant sections from the recent Congressional Budget Office budget projections showing the relationship between rising health care costs and the deficit.

**Table 2-4.**  
**The Budget Outlook Through 2003 (By fiscal year)**

|                                       | 1993  | 1994  | 1995  | 1996  | 1997  | 1998  | 1999  | 2000  | 2001  | 2002  | 2003  |
|---------------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| <b>In Billions of Dollars</b>         |       |       |       |       |       |       |       |       |       |       |       |
| Revenues                              | 1,143 | 1,215 | 1,291 | 1,356 | 1,414 | 1,482 | 1,540 | 1,600 | 1,664 | 1,733 | 1,804 |
| Outlays                               |       |       |       |       |       |       |       |       |       |       |       |
| Discretionary                         | 547   | 539   | 539   | 554   | 569   | 584   | 600   | 616   | 633   | 650   | 668   |
| Mandatory                             |       |       |       |       |       |       |       |       |       |       |       |
| Social Security                       | 302   | 319   | 335   | 351   | 368   | 385   | 403   | 420   | 439   | 459   | 480   |
| Medicare                              | 146   | 167   | 188   | 211   | 234   | 259   | 286   | 316   | 350   | 389   | 432   |
| Medicaid                              | 80    | 92    | 105   | 118   | 131   | 146   | 162   | 179   | 198   | 219   | 240   |
| Civil Service and Military Retirement | 61    | 64    | 67    | 71    | 75    | 79    | 82    | 85    | 89    | 93    | 97    |
| Other                                 | 180   | 175   | 171   | 163   | 176   | 182   | 187   | 192   | 197   | 203   | 208   |
| Subtotal                              | 770   | 816   | 866   | 913   | 984   | 1,051 | 1,119 | 1,193 | 1,274 | 1,362 | 1,457 |
| Deposit insurance                     | 3     | 10    | 11    | -1    | -14   | -10   | -9    | -10   | -10   | -9    | -9    |
| Net interest                          | 198   | 211   | 231   | 250   | 270   | 292   | 314   | 339   | 368   | 400   | 437   |
| Offsetting receipts                   | -65   | -68   | -72   | -73   | -76   | -78   | -81   | -84   | -87   | -91   | -94   |
| Total                                 | 1,453 | 1,507 | 1,575 | 1,643 | 1,733 | 1,839 | 1,943 | 2,055 | 2,178 | 2,312 | 2,458 |
| Deficit                               | 310   | 291   | 284   | 287   | 319   | 357   | 404   | 455   | 513   | 579   | 653   |
| Deficit Excluding Deposit Insurance   | 307   | 282   | 273   | 288   | 333   | 367   | 413   | 465   | 523   | 589   | 663   |
| Debt Held by the Public               | 3,290 | 3,585 | 3,874 | 4,169 | 4,496 | 4,863 | 5,275 | 5,739 | 6,261 | 6,850 | 7,512 |
| <b>As a Percentage of GDP</b>         |       |       |       |       |       |       |       |       |       |       |       |
| Revenues                              | 18.5  | 18.7  | 18.8  | 18.8  | 18.7  | 18.8  | 18.8  | 18.7  | 18.7  | 18.7  | 18.7  |
| Outlays                               |       |       |       |       |       |       |       |       |       |       |       |
| Discretionary                         | 8.9   | 8.3   | 7.9   | 7.7   | 7.5   | 7.4   | 7.3   | 7.2   | 7.1   | 7.0   | 6.9   |
| Mandatory                             |       |       |       |       |       |       |       |       |       |       |       |
| Social Security                       | 4.9   | 4.9   | 4.9   | 4.9   | 4.9   | 4.9   | 4.9   | 4.9   | 4.9   | 4.9   | 5.0   |
| Medicare                              | 2.4   | 2.6   | 2.7   | 2.9   | 3.1   | 3.3   | 3.5   | 3.7   | 3.9   | 4.2   | 4.5   |
| Medicaid                              | 1.3   | 1.4   | 1.5   | 1.6   | 1.7   | 1.9   | 2.0   | 2.1   | 2.2   | 2.4   | 2.5   |
| Civil Service and Military Retirement | 1.0   | 1.0   | 1.0   | 1.0   | 1.0   | 1.0   | 1.0   | 1.0   | 1.0   | 1.0   | 1.0   |
| Other                                 | 2.9   | 2.7   | 2.5   | 2.3   | 2.3   | 2.3   | 2.3   | 2.2   | 2.2   | 2.2   | 2.2   |
| Subtotal                              | 12.5  | 12.5  | 12.6  | 12.7  | 13.0  | 13.3  | 13.7  | 14.0  | 14.3  | 14.7  | 15.1  |
| Deposit insurance                     | a     | 0.1   | 0.2   | a     | -0.2  | -0.1  | -0.1  | -0.1  | -0.1  | -0.1  | -0.1  |
| Net interest                          | 3.2   | 3.2   | 3.4   | 3.5   | 3.6   | 3.7   | 3.8   | 4.0   | 4.1   | 4.3   | 4.5   |
| Offsetting receipts                   | -1.1  | -1.0  | -1.1  | -1.0  | -1.0  | -1.0  | -1.0  | -1.0  | -1.0  | -1.0  | -1.0  |
| Total                                 | 23.5  | 23.2  | 23.0  | 22.8  | 23.0  | 23.4  | 23.7  | 24.1  | 24.5  | 24.9  | 25.4  |
| Deficit                               | 5.0   | 4.5   | 4.1   | 4.0   | 4.2   | 4.5   | 4.9   | 5.3   | 5.8   | 6.2   | 6.8   |
| Deficit Excluding Deposit Insurance   | 5.0   | 4.3   | 4.0   | 4.0   | 4.4   | 4.7   | 5.0   | 5.4   | 5.9   | 6.3   | 6.9   |
| Debt Held by the Public               | 53.3  | 55.1  | 56.5  | 57.9  | 59.6  | 61.8  | 64.4  | 67.2  | 70.3  | 73.8  | 77.6  |

SOURCE: Congressional Budget Office.

a. Less than 0.05 percent of GDP.

cannot plausibly appropriate funds right up to the budget authority ceilings without flouting the caps on outlays.

The estimates in Table 3-2 provide the raw material to construct a variety of possible approaches to complying with the 1994-1995 caps. For example, if policymakers chose to shield domestic and international discretionary programs by funding them at the 1993 level adjusted for inflation, this strategy would swallow up \$262 billion and \$271 billion, respectively, of the allowable outlays in 1994 and 1995. Defense would get whatever is left: \$276 billion in 1994 and about \$268 billion in 1995, with correspondingly deep cuts in budget authority. This level of 1994 spending is \$17 billion less than 1993's outlays of \$294 billion. Although it is unlikely to be used, another approach would preserve defense spending and let domestic and international programs shoulder the necessary cuts.

In sum, complying with the discretionary caps for the next two years requires that the managers of discretionary programs live with '93's nominal resources during this period. Within this constraint, policymakers will be forced to pick the programs they consider most deserving of funds.

## Entitlements and Mandatory Spending

About half of all federal spending pays for entitlements and mandatory spending programs. Such programs make payments to recipients--usually people, but sometimes businesses or state and local governments--who are eligible and who apply for funds. Formulas set in law govern these payments, which are not constrained by annual appropriation bills. The CBO baseline depicts the likely path of spending for entitlements and mandatory programs under current laws. In the baseline, this spending grows from 12.5 per-

cent of GDP in 1993 and 1994 to 13.3 percent of GDP in 1998.

The BEA lumped mandatory programs together with revenues and subjected them to pay-as-you-go discipline. Consequently, the Congress must match any liberalizations in mandatory programs, such as changes in eligibility rules or payment formulas, with cutbacks in other mandatory spending or tax increases. Similarly, the Congress can fund tax cuts by increasing other taxes or cutting mandatory spending.

A little more than one-fifth of this spending is means tested--that is, paid to beneficiaries who must prove their need based on limited income or assets and, in many cases, age or family status as well. Medicaid, a joint federal and state program, accounts for a little less than half of all means-tested spending.

The remaining four-fifths of entitlement dollars go to beneficiaries who do not have to satisfy a test of means. Social Security is by far the largest non-means-tested program, followed by the smaller but faster-growing Medicare program. The remaining entitlements are retirement and disability programs (chiefly for federal civilian and military retirees and railroad retirees); unemployment compensation (boosted in 1992 and 1993 by the recession and by three separate legislative liberalizations); and other programs, including veterans' benefits and farm price supports.

## Means-Tested Programs

Medicaid, the joint federal and state program that provides medical care to some of the poor, currently accounts for almost half of all spending on means-tested entitlements and fuels two-thirds of the projected growth of such spending over the 1993-1998 period. Medicaid spending has grown sharply over the past several years. After climbing an average of about 13 percent annually from 1985 through 1990, the cost of the program jumped by 28 percent in 1991 and 30 percent in 1992; CBO estimates it will increase by 18 percent in

1993. After 1993, the CBO baseline projects that the growth rate will subside to rates typical of the late 1980s, driving federal Medicaid spending to \$146 billion by 1998 (see Table 3-3). This growth constitutes a substantial 82 percent rise in spending over the five-year period.

The rapid growth in Medicaid spending continues to be driven by pressures from increasing population and higher costs, and by the fiscal concerns that push state and local governments to secure the maximum in Medicaid funds from the federal government. For example, states that formerly funded programs for mental health services and developmental screening are shifting these activities into Medicaid to gain federal matching payments. The program has also seen a continuing surge in the number of disabled poor people applying for benefits, a change that affects the Supplemental Security Income program as well (see below). The effects of nursing home reforms, enacted in 1987 but only recently effective, are uncertain. Finally, a rash of lawsuits has resulted in sharply higher reimbursements to health care providers under a 1980 law, which requires that Medicaid payments to health care providers be "reasonable and adequate."

CBO projects that spending for other means-tested programs will increase as well. The baseline shows that the Supplemental Security Income program for aged, blind, and disabled people is expected to grow from \$20 billion to \$30 billion over the 1993-1998 period, as more beneficiaries, especially disabled people, are added to its rolls. Another growing program in this category is the refundable portion of the earned income tax credit (EITC) for low-income working families with children. The budget treats direct EITC payments to families who otherwise owe no income taxes as an outlay because they are tantamount to benefit payments. The rapid growth in EITC outlays between 1992 and 1995 reflects a phased-in benefit increase that the Congress enacted in 1990. These outlays are expected to reach \$14 billion by 1998. In contrast, CBO expects that growth in the Food Stamp and

family support (Aid to Families with Dependent Children) programs will be modest--particularly in the latter, as financially squeezed state governments place limits on eligibility and benefits.

## Non-Means-Tested Programs

Social Security has now overtaken the defense budget as the government's single biggest spending item. The CBO baseline shows Social Security benefits increasing in a relatively modest fashion--from \$302 billion in 1993 to \$385 billion in 1998. This 27 percent increase over the period is largely the result of relatively slow growth in the number of new recipients of old-age and survivors benefits, and relatively low inflation.

Social Security disability benefits, however, are growing rapidly; CBO estimates that they will increase about 44 percent over the 1993-1998 period. The Disability Insurance Trust Fund faces ever-increasing annual deficits, with the recession and projected slow nominal wage growth eroding the trust fund's income. At the same time, caseloads are expanding because of increased claims, higher rates of claims allowances, and lower rates of termination. CBO estimates that the Disability Insurance Trust Fund will require additional resources by 1996.

Most Social Security beneficiaries participate in Medicare as well. Although Medicare outlays currently are roughly half those for Social Security, the rates of growth projected for Medicare rival those of Medicaid: from outlays of \$146 billion in 1993, Medicare is projected to grow to \$259 billion in 1998, a 77 percent increase over the period.

During the past decade, Medicare spending grew by an average of 10 percent a year, compared with 6 percent annual spending increases for Social Security. Neither program faced acute demographic pressure during this time: only a small fraction of their growth was driven by increases in their beneficiary populations, which generally grew between 1 per-

**Table 3-3.**  
**CBO Baseline Projections for Mandatory Spending,**  
**Excluding Deposit Insurance (By fiscal year, in billions of dollars)**

|                                                                | Actual<br>1992 | 1993       | 1994       | 1995       | 1996       | 1997       | 1998         |
|----------------------------------------------------------------|----------------|------------|------------|------------|------------|------------|--------------|
| <b>Means-Tested Programs</b>                                   |                |            |            |            |            |            |              |
| Medicaid                                                       | 68             | 80         | 92         | 105        | 118        | 131        | 146          |
| Food Stamps <sup>a</sup>                                       | 23             | 24         | 24         | 24         | 24         | 25         | 26           |
| Supplemental Security Income                                   | 18             | 20         | 24         | 24         | 24         | 28         | 30           |
| Family Support                                                 | 16             | 17         | 18         | 18         | 19         | 19         | 20           |
| Veterans' Pensions                                             | 4              | 3          | 3          | 3          | 2          | 2          | 3            |
| Child Nutrition                                                | 6              | 6          | 7          | 7          | 8          | 8          | 9            |
| Earned Income Tax Credit                                       | 8              | 9          | 10         | 13         | 13         | 14         | 14           |
| Stafford Loans <sup>b</sup>                                    | 2              | 2          | 3          | 3          | 3          | 3          | 3            |
| Other                                                          | 3              | 3          | 3          | 3          | 4          | 4          | 4            |
| <b>Total, Means-Tested Programs</b>                            | <b>146</b>     | <b>165</b> | <b>183</b> | <b>200</b> | <b>214</b> | <b>234</b> | <b>255</b>   |
| <b>Non-Means-Tested Programs</b>                               |                |            |            |            |            |            |              |
| Social Security                                                | 285            | 302        | 319        | 335        | 351        | 368        | 385          |
| Medicare                                                       | 129            | 146        | 167        | 188        | 211        | 234        | 259          |
| Subtotal                                                       | 414            | 449        | 486        | 523        | 562        | 602        | 644          |
| Other Retirement and Disability                                |                |            |            |            |            |            |              |
| Federal civilian <sup>c</sup>                                  | 37             | 39         | 41         | 44         | 48         | 51         | 54           |
| Military                                                       | 24             | 26         | 27         | 28         | 29         | 31         | 32           |
| Other                                                          | 5              | 5          | 5          | 5          | 5          | 5          | 5            |
| Subtotal                                                       | 67             | 70         | 73         | 77         | 82         | 86         | 91           |
| Unemployment Compensation                                      | 37             | 33         | 26         | 25         | 25         | 25         | 25           |
| Other Programs                                                 |                |            |            |            |            |            |              |
| Veterans' benefits <sup>d</sup>                                | 16             | 16         | 18         | 17         | 16         | 18         | 18           |
| Farm price supports                                            | 9              | 16         | 10         | 9          | 9          | 9          | 9            |
| Social services                                                | 5              | 5          | 6          | 5          | 5          | 5          | 5            |
| Credit reform liquidating accounts                             | 4              | 3          | 1          | -2         | -9         | -6         | -6           |
| Other                                                          | 13             | 13         | 14         | 11         | 9          | 9          | 9            |
| Subtotal                                                       | 47             | 54         | 48         | 40         | 30         | 36         | 36           |
| <b>Total, Non-Means-Tested Programs</b>                        | <b>565</b>     | <b>605</b> | <b>633</b> | <b>666</b> | <b>699</b> | <b>749</b> | <b>796</b>   |
| <b>Total</b>                                                   |                |            |            |            |            |            |              |
| <b>All Mandatory Spending,<br/>Excluding Deposit Insurance</b> | <b>711</b>     | <b>770</b> | <b>816</b> | <b>866</b> | <b>913</b> | <b>984</b> | <b>1,051</b> |

SOURCE: Congressional Budget Office.

NOTE: Spending for major benefit programs shown in this table includes benefits only. Outlays for administrative costs of most benefit programs are classified as nondefense discretionary spending; Medicare premium collections are classified as offsetting receipts.

- a. Includes nutrition assistance to Puerto Rico.
- b. Also includes Supplemental Loans for Students (SLS), Parent Loans for Undergraduate Students (PLUS), and the direct loan pilot programs.
- c. Includes Civil Service, Foreign Service, Coast Guard, and other retirement programs, and annuitants' health benefits.
- d. Includes veterans' compensation, readjustment benefits, life insurance, and housing programs.

cent and 2 percent a year. General inflation accounts for the remainder of the increase, supplemented--in the case of Medicare--by rapid increases in the cost of medical care and the use of covered services.

The rapid growth in spending for Medicare and Medicaid (as discussed earlier) is a continuing saga, and it presents the Clinton Administration with one of its most urgent and potentially explosive challenges. Reducing the deficit will be difficult unless this growth is curtailed. At the same time, however, the Clinton Administration's desire to make affordable health care coverage available to all Americans will make it difficult to reduce total spending for health care--even if the Medicaid and Medicare programs are reformed to make them more efficient.

Other retirement and disability programs--which, taken together, are less than one-quarter the size of Social Security--are dominated by benefits for civilian and military retirees of the federal government and railroad retirees. This category includes fast-rising health care costs for Civil Service annuitants, another aspect of the government's growing health care bill. Unemployment compensation and farm price supports are among the few entitlement programs that are expected to shrink in the next few years. Unemployment Insurance benefits totaled \$37 billion in 1992, a new record, but will taper off to \$33 billion in 1993 and \$25 billion by 1998 as the unemployment rate falls. Farm price supports, after peaking at \$16 billion in 1993 because of an unusually large harvest that caused market prices to drop, fall to roughly \$9 billion annually through 1998.

Other non-means-tested entitlements encompass a diverse set of programs, mainly veterans' benefits and certain social service grants to the states. The credit reform provisions of the BEA created an unusual (and fading) member of this category. The act dictated that, beginning in 1992, the government must measure any new loans on a subsidy-cost basis--the amount that the government expects to lose over the lifetime of the

loan--rather than on the old cash flow basis. This accounting change does not affect loans that were obligated before 1992. Instead, those loans have been moved wholesale into the mandatory category, because only a narrow range of legislative actions (such as beefed-up collection efforts or decisions to forgive debts) can alter their future path.

## Deposit Insurance

CBO's projections of outlays for deposit insurance reflect the estimated cost of the savings and loan cleanup as well as the estimated cost of protecting deposits in troubled banks. These estimates depend on a number of factors that are both volatile and difficult to forecast, such as macroeconomic conditions, especially changes in the level and structure of interest rates; economic conditions in certain areas of the country, particularly in the real estate market; the effects of legislation, such as the imposition of risk-based premiums; the availability of funding for the savings and loan cleanup; and regulatory behavior, including how strictly institutions are regulated, how many are closed, the form of the resolutions, and the methods used to dispose of acquired assets. In addition, the failure of even a small number of large institutions can significantly affect outlays in a particular year.

Spending for deposit insurance in the baseline reflects a general pattern, as shown in Table 3-4. It begins with positive net outlays in the short run, as the Resolution Trust Corporation and the Bank Insurance Fund disburse funds to protect the depositors of failed institutions. These net outlays eventually turn negative, as the government receives more proceeds from selling assets acquired from closed institutions than it disburses to resolve newly failed institutions. But net outlays tell little about the overall picture for deposit insurance and merely sum up much larger flows of funds. Deposit insurance outlays include spending for losses, which are funds that the government will not recover,

# DEFICIT IMPACT OF UNIVERSAL HEALTH INSURANCE UNDER VARIOUS COST CONSTRAINT SCENARIOS

|                                                                  | <u>94</u> | <u>95</u> | <u>96</u> | <u>97</u> | <u>98</u> | <u>5 Yr Deficit Impact</u> |
|------------------------------------------------------------------|-----------|-----------|-----------|-----------|-----------|----------------------------|
| Cost of Universal Coverage                                       | 8         | 11        | 12        | 31        | 81        | 143                        |
| <i>Red Savings From White cost constraint</i><br>GDP + 4,3,2,1,0 |           |           |           |           |           |                            |
| Savings                                                          | - 1       | - 6       | -14       | -33       | -65       | -119                       |
| Net deficit impact                                               | 7         | 5         | -2        | - 2       | 16        | 24                         |
| GDP + 3,1.5,0                                                    |           |           |           |           |           |                            |
| Savings                                                          | -3        | -11       | -21       | -41       | -68       | -144                       |
| Net deficit impact                                               | 5         | 0         | -9        | -10       | 13        | -1                         |
| GDP                                                              |           |           |           |           |           |                            |
| Savings                                                          | - 9       | -21       | -35       | -63       | -105      | -233                       |
| Net deficit impact                                               | -1        | -10       | -23       | -32       | -24       | -90                        |
| GDP + 2,0                                                        |           |           |           |           |           |                            |
| Savings                                                          | - 5       | -12       | -21       | -39       | -64       | -141                       |
| Net deficit impact                                               | 3         | -1        | -9        | -8        | 17        | 2                          |

NOTE: Each option is expressed in terms of various levels of cost containment, as related to the five-year moving average of the annual increase in the gross domestic product. The "basic proposal" assumes no cost containment. The option labelled "GDP + 4, 3, 2, 1, 0" assumes that national health care cost increases would be constrained to the increase of the GDP plus 4 per centage points in the first year, GDP plus 3 points in the second year, and so on. The option labelled "GDP" assumes that cost increases are held to the 5-year moving average of the GDP in each year. In each case, it is assumed that increases in health expenditures for Medicare and other Federal programs (except Medicaid) are reduced proportionately. Savings come primarily from Medicare and tax expenditures. All figures shown are net of the cost of model universal

coverage program similar to the Clinton campaign program. Estimates were constructed assuming 1992 enactment and would have to be slipped forward an additional year.

Program assumptions include:

- Large businesses over 100 pay full cost of health plan, with subsidy for low wage firms;

- Small businesses pay nominal six per cent of payroll; additional subsidies reduce the average rate per firm to 4 per cent.

- States share in public cost according to matching formula comparable to current Medicaid

- Subsidies for working and non-working low-income are part of plan.

- Coverage phased in as follows:

  - o first year: mandatory coverage for employees and dependents/businesses with 100 or more employees, plus all uninsured children and pregnant women

  - o fourth year: mandatory coverage for businesses 25-99

  - o fifth year: mandatory coverage for businesses 2-24, coverage for adult unemployed and out of the labor force.

- Relatively comprehensive benefit package, no long-term care or Medicare improvements.

## COST - Issues

- ◆ Managed Competition
- ◆ Nat'l Budget/Rate Regulation
- ◆ Other Cost-containment Strategies
- ◆ Drug Prices
- ◆ Retirees
- ◆ Workers' Compensation
- ◆ Financing Options

## MANAGED COMPETITION AND HEALTH CARE COSTS

Attached are materials discussing managed competition, health insurance purchasing cooperatives, and health care cost control. The Alain Enthoven and Paul Starr articles offer contrasting views of purchasing cooperatives, "the Jackson Hole HIPC" versus the "Garamendi HIPC."

The article by Uwe Reinhardt offers an excellent discussion of managed competition as an alternative to top-down budgeting. The Paul Starr and Karen Davis testimonies at the Senate Labor Committee hearings focus on managed competition and cost controls.

### Background

Managed competition rests on three central ideas: (1) economic incentives for individuals to choose more efficient health plans; (2) growth of cost-effective managed care organizations like HMOs; and (3) establishment of health insurance purchasing cooperatives.

#### --Economic incentives for choice.

Currently, most employed individuals enroll in a health plan that their employer chooses for them. When the employer does offer a choice of plans, the individual gets little economic benefit from choosing the less costly plan, since a typical employer might pay 80 percent or more of the cost of whichever plan the employee chooses, regardless of the cost of the plan (so the employee only gets 20 percent of the savings from choosing the cheaper plan.) Under the managed competition model, employees would be offered the choice of a number of plans, and the employer and the employee would make an equal dollar contribution to each plan. Thus, if the employer paid \$100 a month, an employee choosing an \$80 per month plan would get \$20 a month back. If the employee chooses a \$120 per month plan, the employee would have to pay the extra \$20 out of his or her own pocket.

#### --Cost-effective managed care plans.

The second step in the managed competition argument is the growth of managed care plans (also referred to as qualified health plans, community care networks, organized delivery systems, and integrated systems of care). Advocates of this theory believe that effectively managed health plans can achieve big savings. Under fee-for-service, the argument goes, doctors and hospitals always have economic incentives to provide more care, even if the care is of marginal value. Care is episode-of-illness oriented rather than health oriented. Care tends to lack continuity, quality, and efficiency as patients move between

generalists and specialists, inpatient and outpatient care, with no central authority taking responsibility for the total package of health care.

Under a managed care plan--where the organization providing the care and receiving the premium are essentially the same entity--the incentive is to deliver care as efficiently as possible and effective management of the total package of care is much more likely. The purest example of managed care plan is the HMO, and advocates point to studies showing that the best HMOs have reduced hospitalization rates by as much as 40 percent, while maintaining high quality.

Under the managed competition theory, once individuals have incentives to choose less expensive, more efficient insurance plans, managed care plans will take over most of the health care system, since they are best suited to deliver high quality care at low cost.

#### --Health Insurance Purchasing Cooperative.

Central to the current managed competition idea is the creation of the Health Insurance Purchasing Cooperative (cooperative). These cooperatives are state-chartered entities that take responsibility for contracting with insurance carriers and managed care plans and deciding which will be allowed to offer benefits to a defined population. In most managed competition scenarios, the defined population is all employees of small business and the unemployed within a geographic area. The cooperative acts as a group purchaser for these individuals, negotiates premiums with each plan, collects premiums from employers and individuals, provides information to all eligible individuals so that they can decide in which plan to enroll, handles enrollment in the various plans, and structures individual choices by assuring that benefits are standardized and that a reasonable range of choices are offered to individuals. In many respects, the cooperative acts like the benefits manager of a large firm would and brings the benefits of purchasing power and expertise to small business and individuals.

There are several other ideas that are associated with managed competition. The first is that there should be a cap on the amount of employer contribution to employee health benefits that should be exempt from income tax. (See separate memo on tax cap.) A second idea is that of community-rating and open enrollment. Under a managed competition system, the amount the cooperative pays the plan should be risk-adjusted. In other words, a plan gets paid more if it has more people likely to have high health care costs: a plan should succeed based on the efficiency with which it delivers health care to the people who enroll in it, not based on the characteristics of the people who happen to enroll.

## Issues / Concerns

- A significant advantage state/regional purchasing cooperatives is that they will be responsive to local circumstances. For example, they should have flexibility in adapting the payment rules to fit the degree of market penetration by managed care or conventional plans.
- Uwe Reinhardt notes that purchasing cooperatives furnish the platform for top-down budgeting should managed competition fall short of expectations.
- Enthoven, Starr, and Garamendi believe that purchasing cooperatives must act as aggressive purchasers for all consumers of health care enrolled in the cooperative, whether they participate in managed care plans or fee-for-service plans.
- Starr believes that it is essential to managed competition -
  - particularly as a strategy for universal health insurance -- for mandatory participation by all employers or at least a broad base of employers. Starr argues that voluntary participation, without the imposition of at least a demographically rated premium, would allow larger employers (with high-cost employees) to join while enjoying the benefits of a community rate. This could result in raising the costs for those in the purchasing cooperative and would become more severe the lower the cut-off.
- Garamendi argues that the more limited the inclusiveness of the purchasing cooperatives, the less able they will be to act as a mechanism of global budgeting the health care system. The Garamendi purchasing cooperative is an instrument for budgetary control; regulating what money flows into and out of the cooperative.
- While increasing the choices available to most people, the purchasing cooperative will sharply reduce the total number of health insurance plans nationally resulting in administration savings.
- Purchasing cooperative should act as their negotiating agents, so its relationship with insurers and providers should be arms-length.
- Karen Davis (Labor Committee testimony) maintains that managed competition cannot be the sole response to controlling costs for three reasons:
  - o evidence is lacking that it will slow increases in health care costs,
  - o there are insufficient quality controls in managed care to assure appropriate care,

- o some populations -- chronically ill patients, addicts, people with AIDs, the frail and poor -- may not be well served by managed competition.
- Additionally, Karen Davis notes that a system of expenditure limits have strong advantages over managed competition; they have been shown to work in other countries and in the Medicare program.
- Starr believes that from the point of enacting legislation, the target for operational HIPC might be 18 months - six months for the states to designate HIPC areas and establish purchasing cooperatives; another year for the cooperatives to enter into contracts with employers and health plans.

## HEALTH CARE IN AN AGE OF CONSTRAINED (THOUGH NOT SHRINKING) BUDGETS.

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Princeton University  
January 11, 1993

If one wished to paint with a very broad brush the evolution health policy during the past four decades in the industrialized world, one might describe it as a gradual but inexorable shift from *expenditure-driven financing of health care* towards *budget-driven delivery of health care*.

### A. EXPENDITURE- vs. BUDGET-DRIVEN HEALTH SYSTEMS

Under *expenditure-driven financing*, the providers of health care were allowed to do for patients whatever they saw fit and to send the rest of society a bill at prices that seemed "reasonable." Typically, those presented with that bill paid without reservations or, if they had reservations, they paid the bill nevertheless because they lacked the countervailing power present in normal markets without third-party payment. Naturally, under this open-ended approach the supply side of the health sector became a rich economic frontier that attracted both the genius of private entrepreneurship and its relentless search for mammon. Technological innovation flourished under this approach as the health sector stood an old adage on its head: instead of necessity being the mother of invention, invention became the mother of necessity. Once a technical innovation was at hand, its application was quickly deemed a "medical necessity" as long as it promised any additional benefits at all to the patient. Benefit-cost ratios played no role in this world, because the denominator (costs) was deemed irrelevant. Indeed, even to consider costs was deemed ethically unacceptable, because that consideration might lead to the "rationing" of health care, which was deemed unacceptable on its face.

Under the second approach, *budget-driven health care delivery*, society establishes some sort of prospective budget for health care and tells providers to do the best they can with that budget. Typically, the establishment of the overall budget has been rather arbitrary in practice, in the sense that the budget is tied to some arbitrary criterion--such as a fixed percentage of the GNP or a fixed annual growth rate. Ideally, of course, this approach should lead the budgeteers to explore what additional benefits might be had by incremental expansions of the budget and to set the ultimate budget limits in that way. In any event, however, the application new medical technologies in this world will typically be subjected to rigorous benefit cost analysis before payment for such technologies will be made out of the fixed budget. Merely demonstrating promised benefits is no longer sufficient and will not be accepted by those who would stand to lose from applications of novel technology within the given budget constraint.

During the first two decades following World War II, when the industrialized world experienced rapid economic growth, many nations were willing to adopt *expenditure-driven financing* of health care. That policy was most exuberantly pursued by the former West Germany, whose health spending until 1975 rose faster than that in any other industrialized country. Since the mid 1970s, however, most of the industrialized world has attempted to shift towards *budget-driven health care delivery* with varying degrees of success. Some countries, notably England and Sweden, had already adopted top-down budgeting before the mid 1970s. And even the conservative, market-prone Kohl government of Germany last month introduced a new health-reform law that provides for strict, global, top-down budgeting of all sectors of the health system effective January 1, 1993.

In this respect, the United States remains the odd one out, because it is only just thinking about moving in that direction. For the most part, both the government and private-sector payers in the United States are able to figure out what they have spent on health care in any given year only with a lag of a year or so. In fact, the announcement of total national health spending in recent years has lagged actual spending by close to two years. That announcement is eagerly anticipated by all concerned, and the actual numbers always come as a complete surprise (and, typically, as a complete shock as well). In 1992, for example, health spending may well climb to 14% of the gross domestic product. A forecast published by the Congressional Budget Office of the United States Congress predicted a ratio of 18% for the year 2000.

## B. THE PROSPECT FOR A BUDGET-DRIVEN AMERICAN HEALTH SYSTEM

In view of these sobering portends, there seems little doubt that the 1980s were the last decade of the completely open economic health-care frontier in the United States. Several recent health-reform proposals--including the proposal put forth by President-elect Clinton during his campaign and one put forth by the prestigious American College of Physicians--have called for a global national health care budget. That budget is to be determined by a national board of stakeholders, somewhat akin to Germany's *Konzertierte Aktion* which had set recommended national expenditure targets there for about a decade.

But while there is now a rising chorus for *budget-driven health-care delivery* in the United States, such a policy is not easily implemented, because the country still lacks the institutional framework through which global budgets--or global expenditure targets--would be established at the national level and apportioned to regions and individual institutions. Therefore, a good part of the coming year is likely to be spent (a) debating further the philosophical pillars for or against the global-budgeting approach and (b) researching the institutional changes needed to make a switch to more explicit budgeting practically feasible. As part of that debate, the United States is likely to look intently at the experience of other nations whose experts will find here a new market for their insights.

Philosophical opposition to prospective budgeting for health care usually rests on two pillars: first, that the size of any such budget is *arbitrary*, and, second, that any such budget will engender *rationing* at the margin.

Implied in the first argument is the notion that, until we have a scientifically valid of mechanism for setting the percentage of the GNP that should go to health care, it is safer to let doctors and hospitals tell us what we should spend. Alas, honest scientists must confess that we are unlikely soon to develop the requisite objective criteria. Alas, too, it is unrealistic to expect government and the business sectors to stand by idly until such criteria are at hand, all the while letting their budgets hemorrhage into the health-care sector.

Implicit in the second argument is the notion that *rationing* in health care is evil on its face. In the United States, vehement opposition to rationing is sometimes voiced almost as if the United States had never engaged in the rationing of health care. In fact, of course, we have always rationed care, as have other nations. Only the methods have differed. Broadly speaking, it can be said that most other nations have tended to withhold a few costly, potentially beneficial medical interventions from all of the people, while the United States has chosen to withhold a very wide range of even highly beneficial medical interventions from some of the people (poor, uninsured individuals), while bestowing every conceivable medical intervention on the rest of society, as long as the intervention's benefit-cost ratio was ever so slightly above zero. Indeed, there is mounting evidence that many well insured Americans actually receive interventions whose implied benefit is *negative*--that are unnecessary and even harmful.

People accustomed to defending our *expenditure-driven financing of health care* with appeals to the threat of "rationing" are likely to discover, in the course of the looming debate on health policy, that this

argument will lose its power. The word "rationing" per se is not likely to frighten those in the private and public sector who yearn for firm, prospective health-care budgets. These budgeteers will be moved to added outlays on new technologies only by compelling evidence of high benefit-cost ratios. Furthermore, they are likely to compensate the producers and users of new medical technology only at prices that imply the full utilization of any associated fixed-capital investments.

### C. MANAGED COMPETITION AS AN ALTERNATIVE TO TOP-DOWN BUDGETING

Opponents to global budgeting in the United States offer as an alternative the strategy of *managed competition and managed care*. Some proponents of that approach market it as the Last Hurrah of the free market although, in fact, the approach is inherently regulatory in nature. To make it work properly, a myriad of new government regulations must be spelled out that will force competing *managed-care* systems to compete fairly, without violating ethical standards. The approach is, therefore, more accurately described as *regulated competition*.

By *managed care* in the American context is meant the external monitoring and co-managing of an *ongoing* doctor-patient relationship, to make certain that the attending physician prescribes only "appropriate" interventions, where the term "appropriate" certainly excludes procedures without any proven medical benefit, but may also eventually exclude beneficial procedures with a low benefit-cost ratio. Proponents of *managed competition and managed care* who believe that the approach will not lead to rationing are either deluding themselves or others. There is bound to be rationing of various sorts, but it will be decentralized and subject to checks through consumer preferences at the more local level, at least in principle.

By *managed competition* is meant a highly structured and highly regulated framework that forces vertically integrated, income-seeking *managed care* systems--preferably, but not necessarily, capitated systems--to compete for patients on the basis of premiums and quality, where the latter is to be measured by both clinical outcomes and the satisfaction of patients. Central to the strategy is the idea to put competing *managed care* systems each into transparent, statistical medico-fishbowls that can be compared by both patients and those who pay on behalf of patients--for example, government agencies or business firms procuring health-insurance coverage for their employees.

Canadians and Europeans still appear to believe that the best way to control overall health spending is to (a) constrain the *physical* capacity of the health system, (b) control prices, and, for good measure, (c) impose something as close as possible to global monetary budgets on the entire system. Within these constraints, however, they allow doctors and their patients considerable clinical freedom, on the thought that in this way the system will tend to maximize the benefits that are wrung out of the constrained set of real and financial resources. In other words, there is (as yet) considerable trust in the medical establishment's willingness and ability to use the resources made available to it properly, without the need for day-to-day supervision. Direct co-managing of an *ongoing* patient-doctor relationship on the American model is still rather rare in Canada and in Europe.

By contrast, the American proponents of *managed competition* believe--and the proper word is *believe*--that, by paying for everything that is beneficial, but denying payment for everything else, the nation can avoid setting an arbitrary global budgets and will, in the end, devote the "right" percentage of the GNP to health care. These proponents have considerable faith in the ability of ordinary consumers to choose wisely among the alternative cost-quality combinations offered to them by competing *managed-care* systems in the health-care market. On the other hand, they have little faith in the ability or willingness of the individual physician to use scarce resources wisely in the treatment of patients and, therefore, would subject each doctor to constant statistical monitoring and hands-on supervision.

While the concept of *managed competition* has enormous intuitive appeal, its proponents must concede that it is at yet a theoretical blueprint without a full-fledged real-life counterpart. Although the nation has been well served for decades by vertically integrated health systems--such as staff or group model Health Maintenance Organizations--none of them has so far competed on the terms foreseen by the strategy. While the full implementation of the strategy *might* obviate the need for top-down, global budgeting--which would be a relief, indeed--there is no convincing evidence that it *will* achieve that end.

That circumstance confronts President-elect Clinton with a troublesome political dilemma: Should he set aside global budgeting for now, gambling his first-term health policy on the *faith* that managed competition will perform as advertised, or should he be cautious and couple a move towards *managed competition* with a global budget?

This question confronts the proponents of the concept with an equally vexing and moral dilemma they ought not to overlook: Can they *in good conscience* persuade the President-elect to take that gamble, to eschew global budgets, at the risk of entering the Presidential campaign in 1995 with a visibly broken promise expressly made during the campaign of 1992, namely, that he would bring health-care costs under control? In this respect, he clearly has so much more to lose than the policy analysts who are marketing the theory.

Fortunately, pursuit of *managed competition* does not erect barriers to the eventual establishment of top-down budgeting later on, even if it were now decided to set aside that powerful instrument for the time being. On the contrary, *managed competition* based mainly on capitated *managed care* furnishes the ideal platform for top-down global budgeting. It should be very easy to graft global budgets on a capitated health system, certainly much easier than attempts to impose them on fee-for-service systems.

Thus, ironically, while the proponents of *managed competition* see their concept as the last bulwark against global budgeting, they are actually designing the perfect infrastructure for that policy.

### C. IS THERE A FUTURE FOR HEALTH CARE IN AMERICA?

Do these prospects outlined above portend dire straits for the American health sector--particularly for those who call health spending "income"?

They do, in the sense that completely open-ended financing of health care is always more comfortable for providers than will be prospective budgets. On the other hand, these prospects merely represent attempts to shift the American health sector more towards the tough, prudent buying that is observed elsewhere in our market economy, or at least towards the principles that are used elsewhere in the industrialized world to allocate resources to the health sector and among competing uses within that sector.

A sensible posture towards these developments would not be to hearken back to the "good old days" of open-ended health-care budgets and to frighten the world with hysterical allusions to "rationing" or other forms of disinformation. A sensible posture will be one that obeys the following sensible admonition:

*Praise the Lord, never stand between a dog and a lamp post, and exploit the inevitable.*

In seeking to exploit the inevitable, the providers of care, and the manufacturers of medical equipment standing behind these providers, should prepare themselves to demonstrate convincingly the benefit-cost ratios implied by their various offerings--particular by offerings that are embodied in costly, new medical technology. They should also get ready, of course, to anticipate the errors that naturally occur in

any budget-driven health system and to *cooperate* with the private- and public-sector budgeteers in attempts to avoid such errors.

#### D. DEFINING "EQUITABLE ACCESS"

As we explore these issues in the year ahead, it would be helpful if the participants in that debate articulated very clearly their particular own interpretation of the word "*equity*" and "*rationing*". If ration we must and will, should we follow the dictum that *if everyone who "needs" it cannot have access to a new, expensive, beneficial procedure, then no one in society should have it?* Or should we settle on an alternative definition of equitable."

For example, we could define the phrase "equitable access to needed health care" in at least the three distinct ways, as follows:

**A. Socio-economic egalitarianism:** A Martian visitor should never be able to discern a patient's social and economic class by observing the medical treatment he or she receives for a given illness, by observing the process by which that treatment is applied or by observing the setting in which that treatment is rendered.

**B. Medical egalitarianism:** The probability of surviving a given medical condition should be the same for all citizens, regardless of their socio-economic status. On the other hand, neither the process by which the requisite medical treatment is delivered nor the setting in which it is delivered need to be independent of socio-economic status. (Concretely, for example, it is acceptable to force publicly financed patients into Health Maintenance Organizations with limited panels of doctors and hospitals while permitting the well-to-do to procure with their own funds health insurance policies that grant patients completely free choice of doctors and hospitals).

**C. Constrained egalitarianism:** Every one in society should be guaranteed access to a defined basic package of medical benefits which may not include certain potentially beneficial, high cost, high-tech treatments (e.g., liver transplants or MRI scans for routine headaches). Well to do persons, however, should be permitted to procure such treatments with their own funds or privately purchased health insurance policies. This approach would have the well-to-do finance the expensive cutting edge of technical progress and also to offer their own bodies for experimental medical science. It is they who would finance the gradual slide down the medical learning curve until the point is reached at which a new technology can be more widely shared, even with the poor in future generations. On the other hand, of course, the approach does raise issues of fairness among contemporaries. In effect, it might link the probability of surviving a given medical condition to the person's socio-economic status.

Which definition should be the basis of American health policy?

## RATE-REGULATION / NATIONAL SPENDING BUDGET

Expenditure limits would be enforced by limiting the annual premium (or their rate increase) for plans participating in the system of managed competition. Systems will work best to the extent that they are dominated by managed care plans, because of their greater ability to control costs (PPRC staff report).

Rate regulation could be incorporated as an optional cost containment tool for fee-for-service plans and could follow the Medicare Fee Schedule. This could be optional since some plans may find other fee schedules preferable. This approach could also be used during transition period and in areas where managed competition cannot work.

Most other countries set expenditure targets for health care spending and then regulate payments to doctors, hospitals, and other providers in order to achieve the targets. A number of American states have set up similar systems for hospitals, most notably, Maryland. The Medicare program currently regulates payments to hospitals and doctors, and in the case of doctors, has an explicit expenditure target.

While most countries that use these systems continue to feel that costs are going up too fast, it is generally conceded that this kind of system is effective in reducing health care expenditure growth. Apart from the question of effectiveness, however, there are a number of problems with this kind of approach to cost control:

- It involves detailed government management of the price of thousands of services provided by hundreds of thousands of providers.

- The system creates perverse incentives and locks in inefficiencies. Doctors tend to respond to price controls by seeing more patients and performing more services, so that they can keep their incomes high even as the price they are paid for each service declines. The incentive is not to become more efficient but to increase volume. Other methods of regulating payment, such as giving the hospital a relatively fixed total budget, also tends to create incentives that do not necessarily improve efficiency or the quality of care. The Medicare DRG system provides good incentives to provide care efficiently within the hospital setting, but it also provides incentives to render care on an outpatient basis, whether the care should be there or not, and there is an incentive to increase hospital admissions, although, so far, this does not seem to have happened in practice.

President Clinton has proposed to blend competition and regulation by setting up a purchasing cooperative / managed competition system in most parts of the country but assuring cost

savings with a national expenditure target. A national expenditure target, however, is not worth the paper it is written on unless there is an enforcement mechanism.

Paul Starr has proposed to enforce the national expenditure target by capping the premiums insurance companies can charge, consistent with the national budget. It would then be up to the insurers to control the cost of services. They would have every incentive to do so, because they would go out of business if they could not. While there are many technical issues to be resolved in such an approach, the basic problem is that it is a leap of faith to think that the insurance companies--which have been almost totally unable to control costs up until now--will be able to do so simply because the government regulates their premiums. It is not clear that CBO would credit savings from such a proposal.

Managed care plans and HMOs might be able to live within the caps, because they have contractual arrangements with their providers and are able to exert control over both what they pay them and, in the HMOs, on other kinds of spending--equipment purchases, for example. Fee-for-service plans, however, can control costs only by reducing what they are willing to pay doctors, who are free to accept or reject insurance company fee schedules. If plans are unable to control costs, there are a number of undesirable possibilities that could result: widespread insurance company bankruptcies, additional costs passed on to insured patients, abrupt limits on freedom-of-choice of provider.

One option that has been discussed is to put a rate-regulation structure alongside managed competition. Under this approach:

- Managed competition structures would be put in place.
- Premium caps consistent with a national budget would be established for all plans.
- Negotiated all-payer rates would be established at the national or state level. Plans would have the option of using these rates to pay providers, but would not be required to do so. In effect, the rates would be a crutch to help fee-for-service plans to live within the premium caps.

Over time, this structure should result in the growth of managed care plans, if they function as effectively as the proponents of managed competition say they will. By treating patients more efficiently, contracting only with cost-effective providers, and so on, they should be able to deliver more value for the money that fee-for-service medicine. Thus, over time, a larger and larger share of the population will choose to enroll with them. Moreover, because providers will want to escape from the detailed fee controls of the private controlled sector, they should be anxious to sign up with good managed care plans.

**CONTROLLING HEALTH CARE EXPENDITURES:  
EXPENDITURE LIMITS AND MANAGED COMPETITION**

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Testimony before the U.S. Senate, Committee on Labor and Human  
Resources, December 16, 1992.

CONTROLLING HEALTH CARE EXPENDITURES:  
EXPENDITURE LIMITS AND MANAGED COMPETITION

Karen Davis

Thank you, Mr. Chairman, for this opportunity to testify on effective strategies for controlling health care expenditures. The nation's economic problems can not be solved without addressing out-of-control costs in the health care sector. Rising health care costs are undermining the competitiveness of American products, contributing to a reduction in the real earnings of workers, and imposing intolerable burdens on federal, state, and local government budgets. Health care reform must be a top priority for action if we are to address our nation's economic and budgetary problems as well as assure all our citizens access to affordable health care.

Health care reform must achieve two overarching goals -- universal health insurance coverage and bringing increases in health care expenditures in line with growth in the nation's economy. No health care reform plan can be considered acceptable unless it covers all Americans -- ensuring access to

DEC 14 '92 11:00 COMMONWEALTH FUND 212 249 1276

P.4

needed care and providing financial protection against burdensome health care bills.

Today, however, I would like to focus on the second goal of health care reform and examine strategies for bringing health care costs into line with the rest of the economy. Two major strategies will be reviewed: expenditure limits and managed competition, as well as ways in which these strategies can be combined.

#### The Need for Action

The Congressional Budget Office has recently estimated that health care expenditures will double between 1992 and the year 2000, from \$800 billion today to over \$1.6 trillion by the year 2000 if we stay on our present course. As a share of the Gross National Product, health care spending will increase from 13 percent today to 18 percent in the year 2000.

Our per capita expenditures on health care are 40 percent higher than that of the next highest nation Canada, and double the per capita health cost of Germany and Japan. To the extent that higher health costs in the U.S. are reflected in higher prices of U.S. goods, U.S. products are less competitive in an international marketplace.

Employee health care costs now average 12 percent of employee wages and are a major cause of labor-management disputes. These costs are either borne by workers directly -- as employers substitute health benefits for wages -- or indirectly as employers raise prices paid by all consumers thus lowering real wages. A recent study by the Service Employees International Union found that real worker wages declined from \$11.03 in 1980 to \$10.55 in 1992, measured in 1992 dollars. If health costs had risen no faster than GNP over this period, real wages would have been constant rather than falling.

The Congressional Budget Office projects devastating effects of health care costs on the federal budget in the next eight years. Federal budget health outlays will increase from \$253 billion in 1992 to \$566 billion in the year 2000. Holding health care to the rate of growth of GNP would lower outlays in the year 2000 to \$346 billion -- a savings of \$220 billion in one year alone.

State and local governments are also struggling under the burden of rising health care costs. In 1992, they spent \$115 billion on health care. By the year 2000 this will increase to \$244 billion, according to CBO. Holding health care spending to the growth in GNP would lower state and local government

DEC 14 '92 11:01 COMMONWEALTH FUND 212 249 1276

P.6

health care spending to \$175 billion in the year 2000, a savings of \$69 billion in that year.

These projected increases are staggering. Prompt action to alter the course of health care outlays immediately should be a top priority.

#### Managed Competition

One strategy that has been advanced to lower health care costs is managed competition. Under a system of managed competition employers or health insurance purchasing cooperatives would give families a choice of health plans, including capitated health maintenance organizations. Employers would pay some fraction of the premium of the cheapest plan (say 80 percent) and workers would be required to pay the remaining premium. Workers, therefore, would face steep financial penalties if they failed to enroll in the cheapest plan offered. In some versions employers would be assessed penalties if they paid more than the cost of the minimum plan; contributions by the employer over the minimum would count as taxable income to the worker.

While managed care can be part of a reformed American health care system, it cannot be the only response. This is true for three reasons:

- 1) there is not enough evidence that it will slow the increase in health care costs;
- 2) there are insufficient quality controls in managed care to assure appropriate care; and
- 3) some populations—chronically ill patients, addicts, AIDS victims, the frail and poor—may not be well served by managed competition.

Does Managed Care Reduce Costs?

Managed care plans, in the form of HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organizations), and their variations, have proliferated during the past decade as a response to escalating costs of health care coverage. Today, 95 percent of all working families are enrolled in some type of managed care plan, including 20 percent who are enrolled in health maintenance organizations.

But there is no solid evidence that managed care achieves consistent savings over time. The Congressional Budget Office analyzed the impact of managed care in 1992, and reported mixed results. It found that savings varied significantly depending upon the type of managed care plan. Staff model HMOs, which employ their own physicians and operate clinical facilities, seem to generate 10 percent savings compared with traditional

fee-for-service health care. These savings are achieved largely through reduced hospitalization rates. In recent years, however, even the fee-for-service system has experienced a sharp contraction in days of hospital care -- narrowing the difference between HMOs and fee-for-service plans. IPA models (Independent Practice Association) which contract with physicians in private practice, show little or no savings.

It is unlikely that the capacity of staff model HMOs could be expanded rapidly enough to cover significant portions of the population in the near term. Currently, 13 million Americans are enrolled in such plans. Even with strong incentives to join such plans, it takes time to build facilities and develop arrangements with physicians and other care providers. Even under an accelerated pace of development, such plans are unlikely to be able to accommodate more than a 5 to 10 percent annual growth in enrollment.

Finally, it is particularly troubling that studies to date have found no difference in the rate of increase in health care costs over time between staff model HMOs and indemnity insurance plans. A long range strategy must be capable of altering the upward trend in health care spending as a percent of GNP.

Quality of Care and the Problem of High-Risk Patients

Managed care plans benefit from having healthy subscribers who need limited medical care. Thus, there is a built-in incentive to exclude groups of subscribers in high risk occupations, or with disabilities or chronic illnesses or at high risk for becoming ill.

Advocates of managed competition argue that disincentives to enroll sick patients can be ameliorated by paying plans a "risk-adjusted" premium. But to date, the methods of setting such premiums are crude and administratively cumbersome. Current methodologies do not account for much of the variation in health expenditures across different population groups. As a result any plan which either by design or by chance enrolls a relatively healthier population will make substantial profits, while those with even a few very sick patients will incur substantial losses.

Advocates of managed competition also contend that the enrollment process will be open to all. Plans will be required to take all comers. But HMOs can avoid sicker patients through a variety of methods, including marketing strategies, location of facilities, selection ("redlining") of physicians, and encouraging patients who become sick to disenroll.

economically poor communities, particularly some rural areas, may also be excluded.

The incentives that drive HMOs to avoid sicker patients also pose the potential for withholding or limiting appropriate and necessary care. Patients may not be able to obtain specialized care, even for complex medical problems. Waiting times for appointments may keep patients from receiving prompt treatment -- thus incurring avoidable pain or anxiety.

Experience with enrolling low-income Medicaid patients in managed care plans has not been encouraging. The Congressional Budget Office finds that most savings from lower Medicaid costs of care have been offset by higher administrative costs. On balance such plans save about 2 percent of Medicaid costs on a one-time basis. Quality problems have also been raised by the enrollment of Medicaid patients in HMOs. The recent measles outbreak in Wisconsin among Medicaid children who have been enrolled in HMOs is a case in point.

Medicare demonstrations of HMOs for elderly and disabled beneficiaries have found that the method of setting premiums does not reflect the risk of seriously ill patients -- leading to serious financial problems for HMOs that get even a few high-cost patients.

but even many middle class Americans may find that capitated health plans do not meet their needs. The fact that only 30 percent of Americans now enroll in HMOs despite aggressive marketing and supportive employer and government policies for over a decade should at least raise questions about their attractiveness to patients. Such plans severely restrict patients' choice of physician -- and without severe financial pressure on families most people do not want to give up physicians with whom they have established a long and trusting relationship. Such plans rarely give patients the option of being cared for in a major teaching hospital where the latest advanced in modern medicine are at the patient's bedside.

If managed care is adopted as a wholesale strategy, strong quality assurance systems will be needed to monitor the delivery of care and outcomes. These are not currently available.

Controlling costs is not the only goal in health care reform. Assuring access to quality services must also guide the reform effort and managed care programs present a special problem in achieving this goal.

Expenditure Limits

The truth is we do not know enough about the impact of managed care on costs or on quality to embrace it as a national system. The American population is too diverse to be equally well served by a uniform approach to health care delivery, particularly by a system that has not been fully tested.

Models for cost containment exist, both internationally and within the U.S. The major industrialized nations have achieved lower per capita health care spending than the U.S., with patient care outcomes in some countries as good and sometimes better. These countries use a national system of government controls to set or negotiate hospital budgets and physician fees.

The U.S. is not without positive experience with government health care cost controls. State all-payer hospital payment systems have slowed the increase in hospital costs by about three percent annually. The Medicare prospective payment system for hospitals, instituted in 1983, has substantially curtailed Medicare hospital spending growth. Early evidence indicates that the new Medicare system for paying physicians on a government-established fee schedule subject to overall expenditure targets is slowing growth in physician costs.

A far sounder approach would be to build on the Medicare experience. Physicians, for example, could be paid using the Medicare fee schedule in private insurance plans as well as Medicare. Expenditure targets could be established to control the rate of increase in total health expenditures. If spending rose in excess of targets, any overage would be subtracted from future physician fee increases.

Expenditure targets could be established and enforced nationally or could be based on local areas. They could be based on the experience of all patients -- including Medicare and Medicaid beneficiaries and individuals covered by small and large businesses. Or separate expenditure targets could be established based on source of payment.

Such a system is not inconsistent with offering patients a choice of capitated HMOs and could easily be integrated with such a system. National expenditure targets per capita could be established and translated into area expenditure targets per capita. Indemnity fee-for-service insurance plans would pay providers according to the all-payer provider fee schedules and expenditure targets per capita would be established for all persons enrolled in such plans. Care of patients enrolled in capitated HMOs could be exempt from the expenditure target, or

the per capita expenditure target could serve as a guide to the establishment of average capitated premiums for such plans.

A system of expenditure limits has strong advantages over a "pure" managed competition approach. It guarantees budgetary savings and restraint in growth in health care outlays over time. It is a system which has been tried in other countries, and currently exists in the Medicare program.

Most importantly it would continue to offer patients a wider array of choice. They could continue to be cared for by their own physician without incurring severe financial penalties. The option of enrolling in either a capitated HMO or a fee-for-service plan should help assure better care in both systems. If HMOs were not responsive to patient concerns, had long waiting times, and substandard providers, patients could disenroll and be cared for in the fee-for-service system. If expenditure limits and price limits made fee-for-service unattractive to physicians, they could join HMOs. The best competition should come from having attractive alternatives, rather than forcing all Americans into capitated health plans.

The crisis of inadequate health insurance coverage and escalating health care costs must be addressed. The nation can not afford to continue on its current course. But neither can

it afford to rely on an untested approach which is unlikely to generate substantial savings over the near term and in which patient choice of physician and access to quality care is not assured.

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**MANAGED COMPETITION AND GLOBAL BUDGETS:  
FITTING FISCAL DISCIPLINE TO MARKET FORCES**

Prepared by Larry Levitt  
For the Henry J. Kaiser Family Foundation

December 1992

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**INTRODUCTION**

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In the debate over health care reform, there is an emerging consensus that some form of managed competition should be an element of reform. However, as a broader array of analysts, elected officials, and interest groups consider the implications of managed competition, there is a growing perception that managed competition may not be a complete solution.

There are many areas of the country where organized systems of care (e.g. HMOs) are not yet developed, or where their market penetration is low. There are other, more rural, areas of the country where the density of the population can never support multiple, competing organized delivery systems. In these areas, a companion strategy to managed competition will be necessary — either on a transitional or a permanent basis.

In addition, there is a belief among some that managed competition — even in areas where it can function best — may be insufficient to address some of the factors driving up the cost of health care (e.g. new technologies or new uses for old technologies). In this respect, too, some form of regulatory discipline may be a desired companion to managed competition.

A health reform policy that combines the best of market innovation with the best of regulatory discipline may be one that merges elements of managed competition with some notion of a global budget for health care spending. Little detailed work has been done to determine how global budgets and managed competition could, in fact, coexist. But several recent proposals — by California Insurance Commissioner John Garamendi, U.S. Senator Jeff Bingaman, and, in outline form at least, by the Clinton campaign — move in this direction.

This paper argues that pure managed competition cannot, by definition, coexist with a global budget. However, the paper discusses a number of approaches for disciplining managed competition through global budgeting (and, if necessary premium regulation). It also considers the issues raised by regulation of provider prices along with a managed competition strategy.

To ensure common understanding of the ideas expressed in this paper, I begin with

some definitions.

### WHAT IS MANAGED COMPETITION?

Managed competition — originally developed by Alain Enthoven — has come to mean many different things to many different people. In many respects, the term — which itself implies a blend between regulatory and competitive forces — has become at least as important as the underlying ideas developed by Enthoven and others.

In the context of this paper, managed competition is taken to mean a general strategy of controlling costs and allocating resources through competition between private health plans. Among the specific elements are:

- Health Insurance Purchasing Cooperatives (HIPCs) — likely organized regionally — would manage competition between health care plans. All consumers, or at least most of them, would obtain coverage through a HIPC. Some proposals suggest competing HIPCs within a given region, while others would give a HIPC a franchise for a region (i.e. a "monopsony" HIPC). In any of the formulations, HIPCs are viewed as empowering the demand side of the health care market, with the assumption that the supply side is sufficiently empowered already.
- Over time at least, it is presumed that health plans would become larger and more organized. Many managed competition advocates, though not all, point to vertically integrated HMOs like Kaiser Permanente as a model for they types of plans that would compete successfully (hence the confusion between "managed competition" and "managed care"). However, as long as a wide variety of health plans are permitted to compete, no one can predict with certainty the types of organizations that will be most successful. In fact, one of the virtues of a competitive strategy is that market forces have the potential to promote continuous innovation.
- Health plans would be forced to compete over the value they offer to consumers, rather than over their ability to select healthy individuals and avoid sick ones. This would be accomplished through market rules (e.g. no underwriting, no pre-existing condition exclusions, standardized benefits, etc.), through mitigation of the financial incentive to avoid higher risks (e.g. through risk adjustment of premiums), and through active monitoring by the HIPC of health plan marketing and enrollment activities.
- Individuals rather than employers would choose health plans. Today, some large employers offer employees a choice of health plans. However, for most small and medium-sized employers, offering multiple plans is not feasible (or

even permitted by insurance companies). Smaller employers must choose one plan for all employees, and generally this plan is a fee for service arrangement to that each employee can choose his or her own physician.

- Individuals would be made fully conscious of the cost implications of their decisions in choosing health plans. Currently, employers (for a variety of reasons) often contribute towards health coverage in excess of the lowest cost plan available. Therefore, employees have no financial incentive to choose a lower cost plan over a higher cost one. Under managed competition, a HIPC (or an employer) would contribute a fixed dollar amount towards health coverage and no more than the lowest cost plan available. Consumers, then, would have to pay the full difference in cost between the lowest cost plan and one that was more expensive. The tax treatment of health benefits would be restructured consistent with this objective (e.g. employer and employee contributions would be tax exempt only up to the lowest cost plan in a region).

Through the combination of strategies described above, market forces would be focused on providing value to consumers. The presumption is that the market would become far more price competitive, forcing health plans to control costs and allocate resources more efficiently (e.g. using more primary care physicians and fewer specialists).

Managed competition could operate under a variety of different structures. For example, the Garamendi Proposal for California is based on tax-based financing with all residents covered through regional HIPCs. Other proposals require small and medium-sized employers to provide coverage through the HIPC, while large employers could arrange for coverage directly or join the HIPC. For ease of presentation, I assume in this paper a Garamendi-type plan, where everyone would be covered through a single, regional HIPC.

### WHAT IS A GLOBAL BUDGET?

Like managed competition, the term "global budget" has come to mean many different things. To some, it means a facility-specific budget (e.g. a global budget for a hospital). To others, it means the same thing as an expenditure cap: a cap on overall spending in a particular sector (e.g. all physicians or all hospitals) or on total health care spending. While most think of a global budget as a defined dollar amount (e.g. a \$25 billion cap on physician spending in California), it can equivalently be defined as a regulated rate of increase (e.g. physician spending can rise by no more than 6% over last year).

In the context of this paper, I use a broad definition of a global budget as a cap of some kind on some or all of health care spending. In the interest of simplicity, I frame the budget as a cap on the annual percentage increase in spending. This avoids issues of how a budget would be allocated across regions or facilities. Also, I am primarily concerned here with how a global budget would be enforced. For example, how, operationally, do we ensure

that health care spending will not rise by more than 6%? Ultimately, regulation — whether it is regulation of premiums or regulation of provider prices — must be invoked to enforce a budget. This, of course, begs the question of how we decide whether the rate of increase should be 6% or 8%. That topic, however important, is not within the scope of this paper.

With terms defined, I first consider the question of whether managed competition and global budgets can, in fact, coexist.

### ARE MANAGED COMPETITION AND GLOBAL BUDGETS COMPATIBLE?

In the strictest sense, pure managed competition is fundamentally at odds with any form of global budget, however it is enforced.

Managed competition grows out of the notion in economic theory that markets are the best mechanisms to provide signals about how much should be spent on health care, and how resources should be allocated within the health care system. If one HMO is able to stay in business with a rate of \$100 per person per month, while another is able to succeed at a rate of \$120, then economic theory tells us that it must be the case that the more expensive HMO is providing services to consumers worth the extra \$20. If this were not the case, then consumers would not be willing to pay the extra \$20.

Any attempt to impose a global budget on the system would result in an inefficient allocation of resources. Forcing the \$120 plan down to \$100, for example, would prevent consumers willing to pay the extra \$20 from doing so. Furthermore, controlling underlying provider prices could undermine a health plan's effort to allocate resources in a different (and maybe more efficient) way.

(Note that while economic theory would argue against any disruption of the market with price regulation, *premium* regulation should generally be considered preferable to regulation of physician and hospital *fees*. This is because regulation of the premium allows health plans to determine how best to allocate resources within the overall premium. Regulation of fees — which, when combined with adjustments for increases in the volume of services, amounts to sectoral budgets for physicians and hospitals — does not allow such reallocation. Premium regulation, however, is only appropriate where a health plan has substantial control over its providers (e.g. HMOs). Otherwise, the health plan would have no way of responding to the limit on its premium.)

Of course, this view assumes that the market could be made to function properly. But even under pure managed competition, there are reasons to believe that the market might not, in fact, function properly:

- **Barriers to market entry.** Managed competition is expected to drive smaller insurers out of the market, leaving a small number of large, organized delivery

systems. Once that happens, it might be quite difficult for a new health plan to enter the market. This would be particularly true if the existing health plans were vertically integrated, meaning they owned their own hospitals and had their own physician networks. This so-called "barrier to entry" is one of the reasons why markets can fail. Anti-trust actions can be used to prevent collusion among the plans and price-fixing, though enforcement might be quite difficult with a product as complicated as health care.

- **Lack of consumer information.** Managed competition envisions dramatically expanded efforts to inform consumers, with HIPCs actively collecting and disseminating quality, outcomes, and satisfaction data. But consumers may still have difficulty judging differences in quality or amenities across plans. If consumers are unable to choose wisely, competitive forces are attenuated.
- **Control of technology.** Competitive forces alone may not be sufficient to control the emergence of new technologies or the more intensive use of old technologies. This may be true not only of medically unnecessary care, but also of medically necessary care that yields small benefits for large costs.

Many believe that control over health care costs ultimately requires setting some limits on medical technology and practice. A global budget may be the best way — indeed, it may be the only way — to force us to come to grips with such limits. Even if market mechanisms could be used to impose limits, they might result in more disruption and less equity than a more public, budget-setting process.

A number of managed competition advocates — the Jackson Hole Group, for example — do suggest that government could play role in defining which technologies should be included in a universally-guaranteed benefits package. I remain unconvinced, however, that government is willing to impose tough limits unless it must somehow pay for not setting limits (e.g. by having to raise taxes and/or having to explicitly increase the global budget).

None of this is meant to suggest that a managed competition strategy is doomed from the start. Indeed, our current system is so oriented towards anti-competitive strategies that introducing managed competition would likely yield startling results. And to be fair, many of the elements of managed competition are designed to address precisely the types of potential market failures described above (i.e. the "managed" side of managed competition. Given that, one could certainly argue that we should give a relatively pure form of managed competition a chance to work.

However, there two reasons, in particular, why giving pure managed competition some time to work may not be a viable strategy. First, there are many areas of the country where

managed competition cannot work immediately because there are few organized delivery systems. And, there are some areas of the country where managed competition in its pure form can probably never work, because the population is not dense enough to support competing systems. So some sort of blended approach is necessary.

Second, while ten or twenty years ago we may have had the luxury of experimenting, today costs are so high relative to the rest of the industrialized world that we now need a more aggressive strategy. Tom Rice from UCLA, for example, argues that in the current environment macro efficiency (i.e. health care costs as a percentage of the gross domestic product) may be more important than micro efficiency (i.e. the appropriate allocation of resources within the health care sector). By that reasoning, even if a global budget distorted the health care market somewhat, it might still be the best policy. And, if employers are asked to finance the bulk of universal access through some sort of mandated contribution, they may require in return some sort of guarantee that costs will rise at a slower rate.

The remainder of this paper explores blended strategies for reform, neither pure managed competition nor pure global budgeting.

### **BLENDING MANAGED COMPETITION AND GLOBAL BUDGETING**

The challenge in designing a blended approach of managed competition and global budgeting is to develop a budgeting method that provides sufficient restraint, while at the same time not providing so much restraint that price competition among health plans is effectively destroyed. This section lays out several approaches for combining managed competition and global budgeting in those areas of the country where there is — or will be — substantial penetration of organized delivery systems. The following section, which discusses the potential role for provider price regulation, addresses how a budget might work in those areas of the country where organized delivery systems are not yet prevalent.

There are fundamentally three elements to a budgeting process: (1) A definition of what is being budgeted; (2) A mechanism for enforcing or implementing the budget; and (3) Determining the level of the budget or the maximum rate of increase from year-to-year. The third element — determining the actual budget cap on an annual basis — is certainly important. But this paper does not address the range of issues involved in that problem, and instead simply assumes that a budget cap is established within some range of reasonable values.

Following are a series of approaches for implementing a global budget in the context of managed competition.

### **BUDGETING THE CONTRIBUTIONS BY THE HIPC**

*Description:* One approach to budgeting — which, in fact, is not even in conflict

with the theory of pure managed competition — is to budget the HIPC's contribution to health plans on behalf of consumers. For example, in the first year a HIPC might contribute 75% of the lowest cost plan available (how the HIPC obtains the revenue to make that contribution is not relevant to this discussion). Thereafter, the contribution might rise along with the increase in the gross domestic product (GDP). So if health plan premiums rose faster than GDP, consumers would be responsible for an increasing share of costs. (The HIPC might still commit to contributing more on behalf of low income consumers so that premiums did not become burdensome.)

**Enforcement:** No enforcement is necessary, since this type of budget does not directly constrain health care costs.

**Discussion:** By and large, this type of budget does not conform with the notion of global budget envisioned in this paper. Health plan premiums would be set by market forces, so costs would not be constrained in any way. The financing of the system would in some sense be constrained, though in reality the financing burden might simply be shifted to individuals over time.

That is not to say that this type of budget has no value. If consumers were forced to pay directly ever increasing premium contributions, there would over time be enormous pressure to constrain costs (e.g. by setting limits on new technologies). Requiring consumers to pay a large share of costs directly might, in fact, be a quite effective method of forcing us to come to terms with certain limits of what we can afford to provide. This type of budget would not, however, address the variety of reasons why managed competition might fail to generate efficiencies in the system.

## A BUDGET TIED TO THE AVERAGE COST OF ALL HEALTH PLANS

**Description:** The base for the budget would be defined as the weighted average premium for all the plans participating in the HIPC. So, if the budget were allowed to increase at 6%, then the budget would be met as long as the average premium increase were less than 6%.

**Enforcement:** Operationally, a HIPC would probably begin by soliciting bids from plans for the following year's premiums. As long as the weighted average of those bids — based on the previous year's enrollment — were within the maximum allowed increase in the budget, the HIPC might negotiate only moderately with the plans. However, if the bids implied a rate of increase in excess of the budget cap, then the HIPC would have to initiate a series of actions designed to bring the bids to within the allowable budget. It might begin by negotiating actively with plans. Ultimately, the HIPC might have to regulate premiums. It might have some flexibility in establishing the allowable premiums, though two natural courses of action would be: (1) To reduce all bids by an equal percentage; or (2) To require all plans to accept the same rate of increase over the previous year. These two strategies

imply different economic incentives, and which is preferable may depend on a variety of market conditions.

If large numbers of HIPCs were consistently unable to meet their budgets, a strong signal would be sent to the federal government that the system is not stable (e.g. the budget cap is too low or controls over new technologies are inadequate). If only a few HIPCs are experiencing difficulty in meeting their budgets, it would indicate that the system is working well but that there is something amiss in those regions. In such a region, the HIPC, working with the health plans and providers, would have a strong incentive to act collectively to address any problems. For example, they might begin to regionalize certain high cost services to reduce costs. The important observation is that once a global budget — enforceable through premium regulation — is in place, all stakeholders have an interest in meeting the budget with the least disruption.

*Discussion:* A budget that is tied to the weighted average premium for all plans implies that all spending within the system would fall under the budget. For example, lower cost HMOs might be increasing at a reasonable rate, but the budget limit could be reached because large numbers of people were choosing to enroll in more expensive plans. All plans would offer the same benefits, but the higher priced plans might offer certain amenities (e.g. a wider choice of providers). In other words, the government would be regulating how much consumers could choose to pay out of their own pockets, and without any tax subsidies. Of course, this type of budget could also result in less regulation, particularly in the short term. It is expected that the incentives intrinsic to managed competition would result in large numbers of individuals enrolling in *lower cost* health plans. As this occurs, the *weighted average* premium in a HIPC might rise at a much slower rate than the simple average of all the plans' premiums. Therefore, the budget might require minimal enforcement, at least in the short term.

However, there is no denying that in the long term, after enrollment has stabilized, this approach could require regulation of discretionary spending by consumers. Though some might find such a heavy regulatory hand unappealing, it does have a certain logic. Increasing numbers of people choosing to enroll in more expensive plans might be evidence that the market is not functioning appropriately. For example, such consumer behavior might indicate that quality of care in the lower cost plans is deteriorating, or that the system is becoming stratified by income. Therefore, a budget operating on all spending — even discretionary spending by consumers — might be an important element in ensuring that quality of care be maintained in lower cost plans.

While enforcement of this type of budget is admittedly messy, price competition among plans is given a fair chance to operate. Enforcement becomes an issue only if the average cost in a region is increasing at rate faster than what is permitted under the budgeting scheme.

## A BUDGET TIED TO THE LOWEST COST PLAN IN A REGION

**Description:** Under managed competition, consumer spending in excess of the lowest cost plan in a region is discretionary. Given that, it might be sensible to tie a global budget to the lowest cost plan in a region rather than to an average across all plans. Only mandatory spending would be budgeted.

For example, under the Garamendi Proposal, HIPCs would be funded through payroll taxes paid by employers and employees. Using the revenue from these taxes, a HIPC would be required to contribute for each consumer an amount equal to the premium of the lowest cost plan in the region (adjusted for risk). A global budget is naturally created, whereby a HIPC is required to offer at least one plan with a premium no higher than the per capita revenues available.

**Enforcement:** By and large, the enforcement mechanisms for this approach are the same as for the budget tied to the weighted average premium of all plans in the region. One enforcement strategy that might at first appear attractive would be to regulate the premium only of the lowest cost plan. However, this approach would likely have disastrous consequences, and should be avoided. It would provide a strong incentive for a plan *not* to be the lowest cost plan, which is just the opposite of what we want to encourage. And, it could cause deteriorating quality in the lowest cost plan, inducing middle and upper income individuals to escape to higher cost plans. The result might begin to resemble the school system in many of our inner cities. Applying enforcement of the budget equivalently to all plans should minimize this problem.

**Discussion:** Unlike the budget tied to the weighed average premium for all plans, this budget would seek to control only what consumers are required to pay. This notion is appealing, but there are at least two potential liabilities with this approach.

First, the system might be somewhat unstable, since the budget would be tied to the single lowest cost plan in the region. This plan could have only a small number of enrollees, and therefore be largely irrelevant to overall health care costs in the region. Even if the lowest cost plan were large, any year in which it required a large increase would trigger a complicated enforcement mechanism. It might not be appropriate to hold the entire region's budget accountable to bid of a single plan. One solution to this problem would be to tie to the budget not to the single lowest cost plan, but to several of the lower cost plans. For example, the budget could be tied to the three lowest cost plans. Or, it could be based on the weighted average premium of the lowest cost plans with combined enrollment equal to one-third total enrollment in the HIPC. Either of these approaches would make the budget more stable.

Second, there would be no check on ever increasing numbers of individuals leaving lower cost plans to enroll in more expensive plans. The risk would be that lower income

individuals - who might lack the resources to enroll in more expensive plans — would be stuck in the lowest cost plan, and that support for this plan would deteriorate over time. One way of addressing this problem would be to provide lower income individuals with subsidies that allow them to enroll in more expensive plans. These subsidies might be on a sliding scale basis so that the poor were not advantaged relative to the near-poor. Another approach would be to establish an expenditure *target* for discretionary spending over and above the lowest cost plan. Spending in excess of the target would trigger a review of enrollment patterns within the HIPC.

## A BUDGET DEFINED AS AN OVERALL MAXIMUM PREMIUM

**Description:** A wholly different approach to budgeting under managed competition would be to establish an overall maximum premium for each region, and allow health plans to compete freely below that maximum. A federal formula could be used to establish the maximum premiums across regions. Over time, the maximum premium would rise at some federally-determined rate.

For example, the maximum premium in a region might be set at \$150. No bid on excess of \$150 would be accepted by the HIPC. The following year, assuming the federal government allowed a 6% increase, the maximum premium would rise to \$159. Again, no bid in excess of this maximum premium would be accepted by the HIPC. If premiums rose over time at a rate slower than the maximum premium, managed competition would be permitted to operate unencumbered. However, if premiums consistently rose faster than the maximum premium, then all plans would eventually end up being paid the maximum premium. Thereafter, all premiums would rise along with the maximum premium.

(Note that the maximum premium might apply only to managed care plans. The premium for a fee for service plan — of which there would likely be only one in each region — could be regulated separately.)

**Enforcement:** This approach would not require any active enforcement by the HIPC. If and when health plan premiums reached the maximum premium, they would be automatically capped.

**Discussion:** There are many appealing aspects to this approach. It gives price competition the maximum room to maneuver. And, enforcement would be much simpler than under the other approaches. If competition in a region were working to control the rate of growth in health care costs, then the budget would be largely irrelevant. However, if costs continued to grow faster than the budget cap allowed, then the system would naturally evolve to a more regulatory approach. In this regard, those regions where competition was not working would, over time, resemble proposals like ColoradoCare, Senator Kerrey's Health USA plan, and the Catholic Health Association's proposal. In these proposals, all health plan's are paid the same capitation rate (risk adjusted), and therefore do not compete over

price.

While these characteristics are attractive, this type of budget cap has one major liability: It would not necessarily reduce growth in health care costs in the short-term. While some of the higher cost plans in a region might reach the budget cap quickly, many plans could raise premiums at a rapid rate and still take several years to reach the cap. If managed competition advocates are correct, price competition may very well control the rate of growth in health plan premiums. However, a maximum premium approach cannot *guarantee* short-term costs savings.

While none of these approaches is perfect, they are all viable strategies for blending managed competition with global budgeting. They would work best under a HIPC that covered the entire population, which is the structure I have assumed in this paper. However, they could also work in a system where the HIPC covered the majority of the population, and large employers were able to arrange for coverage independently or join the HIPC. Within that structure, the global budget would operate through the HIPC, and large employers providing coverage outside of the HIPC would be largely on their own. This type of arrangement implies some important features of the system:

- In order for the global budget to be effective, the HIPC would have to be the predominant source of coverage in a community. Requiring all employers with fewer than 1,000 employees to join the HIPC, for example, would put nearly two-thirds of the labor force in the HIPC.
- Some managed competition models would prevent large employers from joining the HIPC. But where a global budget is imposed on the HIPC, there may be a temptation to cost shift to large employers. Therefore, it is probably necessary to permit large employers to join the HIPC and escape cost shifting. Large employers would presumably have to pay a risk-adjusted premium to join the HIPC, since any other arrangement would result in higher risk groups tending to join and lower risk groups tending to provide coverage independently.
- A HIPC responsible for enforcing a global budget — and covering the vast majority of the population — has enormous power over the marketplace. It is probably appropriate for such a HIPC to be a quasi-governmental organization, rather than a private, non-profit entity as some have suggested.

### HOSPITAL/PHYSICIAN RATESETTING AND MANAGED COMPETITION

The previous section outlined several approaches for blending managed competition with some notion of a global budget. These approaches generally take the view that price regulation is better implemented by controlling *premiums* than by controlling the underlying

*fees* of hospitals and physicians. The logic is that health plans, operating under a regulated premium, can best decide how to allocate resources among different types of providers. In contrast, regulating fees — particularly in conjunction with volume controls that translate increased utilization into lower fees — locks in a particular allocation of health care resources that would be quite difficult to change. Any attempt at reallocation would pit one provider group against another and likely leave Congress or a federal health board politically stalemated.

While premium regulation is the preferred approach, it relies on health plans having direct relationships with their providers. It works best where the insurance and delivery functions are explicitly linked (e.g. as in a prepaid group practice HMO). However, these types of health plans do not now have substantial market penetration everywhere, and in more rural areas they may never become a significant force.

Therefore, we need to consider an alternative approach for enforcing a global budget, both as a transitional strategy for those areas where organized delivery systems are not yet prevalent, and as a permanent strategy for more rural areas. And even in those areas where organized delivery systems already have a significant presence, we need some way of budgeting the portion of the market that will continue to function according to fee for service principles.

Establishing all-payor physician and hospital rates — though anathema to many managed competition advocates — may provide a mechanism for enforcing a global budget in these circumstances. Making regulated provider rates available would permit global budgeting through premium regulation across most of the country, and it would allow global budgeting to be implemented in rural areas of the country where competing delivery systems are not appropriate.

#### **WILL RATESETTING DISRUPT COMPETITION?**

Neither all-payor ratesetting for physicians and hospitals nor managed competition have ever been tried on a widespread basis, and they have certainly never been tried together. So no one really knows whether the two can peacefully coexist.

The purest of managed competition proponents argue that the two approaches are in many respects incompatible. As advocates of market forces, they argue that price controls do not work to control costs and, in fact, result in a misallocation of resources. Some further suggest that implementing managed competition alone will require substantial effort, both political and administrative. Requiring implementation of an all-payor ratesetting as well will result in delays and imperfect results. It is hard enough for government — or any organization, for that matter — to focus on one major sea change, let alone two. For example, the data systems work alone required to implement all-payor ratesetting is significant.

These arguments are compelling, and the conclusion may very well be that ratesetting *will* disrupt competition. However, no one may be able to project how large the disruption would be. And, given our need for a transitional strategy and for an approach in more rural areas, the important question may be how to minimize the disruption.

## DEVELOPING A RATESETTING SYSTEM THAT PRESERVES MANAGED COMPETITION INCENTIVES

A key element of managed competition lies in the economic pressure it puts on health plans to continuously improve efficiency. The assumption is that plans where the insurance and delivery functions are linked will prove best able to compete. Blending a global budget with managed competition can be expected to strengthen the economic pressure. Thus, in developing a ratesetting system, the most important principle may be to ensure that providers have a strong incentive to organize into accountable delivery systems.

Among the fundamental design elements are:

*Allowing health plans to negotiate alternative reimbursement arrangements with providers.* Some of the most important innovations among HMOs concern how they pay physicians and hospitals, and the financial incentives that those payment mechanisms imply. Allowing health plans to use these innovations — and to develop new ones — is critical to the success of managed competition.

Ken Thorpe, for example, suggests that HMOs may have succeeded in Massachusetts under hospital ratesetting in part because they could negotiate fee arrangements outside of the regulated payment system. But given that organizing physicians is generally considered the key in creating an accountable delivery system, the physician payment structure may be the most important consideration. Health plans need the flexibility to pay physicians salaries, or to capitate them as part of multi-specialty medical groups.

In fact, properly structured, a physician ratesetting system could actually promote the growth of organized delivery systems. For example, consider a system that regulated physician fees, and that reduced fees to the extent that the overall volume of services increased from year to year. In other words, total expenditures for physician services would be capped. A plausible scenario is that each individual doctor would seek to increase the volume of services he or she provides in order to maximize income. The result could be a spiral of ever-increasing volume and ever-decreasing rates. A health plan able to control volume could offer physicians a much easier way of maintaining income. And, if the health plan also had the ability to shift resources from hospitals to physicians, it could offer a physician an even higher income than he or she could achieve in the fee for service sector. In this scenario, it is ironically not important that health plan's be allowed to pay a rate lower than the regulated fee, but actually that they be allowed to pay a *higher* rate.

*Determining at what level to set regulated physician and hospital rates.* In developing an all-payor ratesetting system, a decision must be made as to how high to set the rates. They could, for example, be set at approximately the current levels and then be allowed to increase at a constrained rate. Or, in the extreme, they could be ratcheted down to a level consistent with per capita expenditures in efficient HMOs. In the short-term, this decision could have a significant effect on the competitive position of HMOs and other organized health plans. Particularly in areas where organized delivery systems are not yet prevalent, the fee for service rate levels may be quite important. A new HMO may, for example, need a larger premium advantage to get started than to maintain enrollment over time.

However, in the long-term, and in areas where HMO penetration is already high, the level of fee for service rates may not be important. There is, for example, only one labor market for physicians services. If rates — and, by extension, incomes — are constrained in one part of this market, then the effects should spill over into health plans that do not pay the regulated rates. Physician salaries are capitation payments in HMOs would adjust downward, and any efficiency advantage enjoyed by an HMO should be maintained.

*Allowing states and/or regions to use alternative approaches.* How ratesetting will interact with managed competition will depend to a large extent on unique circumstances in a given region. Prices and volumes vary tremendously across the country, and even within a given state. Politics and provider cultures also vary, as do market dynamics (e.g. whether there are competing hospitals or a sole community provider). These variations require flexible responses at the local level, which is precisely the appeal of regional HPCs. A federal ratesetting system could be developed as a default mechanism, but states (or regional HPCs) could be permitted to use different approaches, as long as they remained accountable to a global budget. For example, in a particular region it might be more appropriate for the HPC to negotiate with provider trade associations than to use federally-set rates.

Thus, while ratesetting might indeed "disrupt" competition at some level, the disruption can be minimized. And, if properly designed, a ratesetting system could actually promote some of the same changes promised by managed competition.

### SUMMARY

A strategy blending managed competition and global budgeting has the potential to control health care costs in ways that neither approach alone could accomplish:

- While managed competition may be an effective approach for allocating resources within the health care system, global budgeting may be necessary to attack other factors — like new technologies — driving up costs. The preferred approach for enforcing global budgets is regulation of premiums rather than regulation of provider rates.

- There are some areas of the country where competing organized delivery systems will never be appropriate, and larger areas where the competing systems are not yet prevalent. A global budget may be necessary to constrain costs in these areas in the short-term.
- All-payor ratesetting has generally been anathema to advocates of managed competition. It may, however, be a necessary companion, both as a transitional strategy and as a long-term approach for rural areas and for the presumably dwindling fee for service sector

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## OTHER COST CONTAINMENT STRATEGIES

### Outcomes Research

The Omnibus Budget Reconciliation Act of 1989 created the Agency for Health Care Policy and Research. In that legislation, Congress concentrated attention on a major new program of research that emphasizes effectiveness (refers to the results of clinical interventions provided in typical, "real world" patient-provider situations) and appropriateness (care for which the health benefit exceeds the negative consequences by an acceptable margin) of health care services and procedures.

This new research effort on medical treatment effectiveness or patient outcomes research is known as the Medical Treatment Effectiveness Program (MEDTEP). Outcomes of interest include objectively measured consequences of treatment, such as morbidity, mortality, complications, and readmissions, plus outcomes that are measured in terms of patients' individual expectations, values, and preferences. This includes satisfaction with care and self-assessments of functional capacity, health status, and quality of life. The goal of MEDTEP is to improve the effectiveness and efficiency of the health care system, by helping to differentiate those clinical interventions whose effects are demonstrable and beneficial from those whose effects are adverse, equivocal, improbable, or unimportant.

MEDTEP research projects build on work that documents variations in patterns of care that can neither be attributed to patient need nor clearly linked to patient outcomes.

The Patient Outcome Research Teams (PORT) project represents a "showcase" investment under the MEDTEP program. PORT projects are large-scale, long-term, multifaceted, multisite, and multidisciplinary grants and contracts. The goals of PORT projects are to identify and analyze the outcomes and costs of alternative interventions for a given clinical condition, in order to determine the most effective and cost-effective means to prevent, diagnose, treat, or manage it and to develop the test methods for reducing inappropriate or unnecessary variations.

The clinical recommendations developed by PORTs are intended to be a primary source of scientific information for use by independent panels in the eventual development of practice guidelines. The Office of the Forum for Quality and Effectiveness in Health Care within AHCPR supports panels of experts to develop guidelines, standards, review criteria, and performance measures.

A group called the National Committee for Quality Assurance recently announced plans to support the development of a national data collection system that would produce a consumer "report card" on the quality of medical care in different health plan

## Uniform Claims Form and Billing Procedure

There is evidence that significant savings could be realized in the system with the adoption of a uniform claims form and standardized billing procedures. Most Federal legislative initiatives also call for the development of "Smart Cards" for health coverage.

### PORTS in Pennsylvania:

- \* "Outcomes Assessment of Patients with Biliary Tract Disease", ~~III~~.

Dr. Sandy Schwartz, P.I.  
University of Pennsylvania

- \* "Assessment of the Variation and Outcomes of Pneumonia" (community acquired <sup>rather than</sup> ~~is~~ HIV) ~~III~~.

Dr. Wishwa Kapoor, P.I.  
University of Pittsburgh

# The medicine makers

*U.S. drug companies lead the world,  
but consumers pay too heavy a price*

America's drug industry is healthy and wealthy. But it has not been entirely wise. In pure business terms, it is a success story: While overseas competitors were eating the lunch of U.S. automakers, pharmaceuticals remained strong, innovative, vigorous — and, forget the recession, highly profitable.

That boom hasn't been lost on greater Philadelphia. Sparkling laboratories continue to spring up on the city's flanks, the most concentrated collection in what was once farm country near Collegeville, Montgomery County. "Golden geese," some call them.

But today those same fat profits — raked in during the overheated '80s — have made the industry an inviting target. Prescription drugs aren't Barbie Dolls. They aren't frills or luxuries or conveniences that can typically be done without. So, for the acutely ill and those with years-long chronic conditions, for retirees on fixed incomes and Clinton health-care reformers, their costs — which are often a bigger out-of-pocket expense than doctors and hospitals — have become a high-profile issue.

That profile is about to get even higher, the result of a five-part Inquirer series last week, "Making Medicine, Making Money." In it, staff writers Donald C. Drake and Marian Uhlman have taken a microscope and tweezers to the nation's most profitable industry, examining its claims that high research costs drive prices, that promotional expenses amounting to \$13,000 per doctor are justified, that its products are a bargain compared to the alternatives — worsening health, costly surgery, death.

They found those claims didn't tell the whole story. The highest price inflation occurred not on new blockbusters, but on drugs that have been around for years — sometimes decades. The price of Merck & Co.'s 38-year-old drug for Parkinson's disease, for instance, shot up 208 percent between 1981 and 1991, while general consumer prices rose just 50 percent.

They found that 20 cents of every dollar you spend on a brand-name drug goes to promote and market it; that a booming army of sales representatives pursues doctors from med school to the grave; that PR stokes demand for new drugs, as one former public relations executive for a drug giant

told Congress in 1990, "beyond the medical need."

They found, depressingly, a West Philadelphia woman who stopped taking high-blood pressure and diabetes medicines that were costing her more than her groceries or her mortgage. She ended up in the hospital, near-dead from hypertension.

And they told the happy story of Bridesburg electrician John Forrest Jr., who was released — in a mere 2½ hours — from the agony of a heart attack by a single infusion of a "wonder drug," a bioengineered, clot-dissolving medicine called TPA.

At bottom, they found an industry that says it's a classic free-enterprise model, pushed to invent — and to lead the world — by the market. But they found something else, as well —

an industry that gets big benefits from high-risk research funded by public dollars, an industry that gets huge federal tax concessions (at a rate of more than \$70,000 per job) for jobs it creates in economically depressed Puerto Rico, an industry that guards pricing information so jealously that doctors themselves frequently have no clue about the prices of equivalent products.

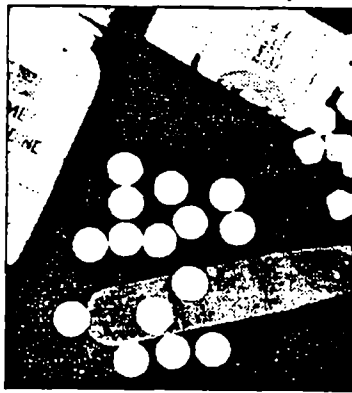
In other words, America's medicine makers operate in a special market, nurtured by government incentives, protected by extended patents and insulated to a degree from comparison shopping.

Now it's time to turn to the people who have been footing the bill — the taxpayers, company health plans and consumers, especially the hard-pressed elderly.

That doesn't have to mean killing the goose. It can mean quite the opposite — as leaders in the pharmaceutical industry seemed to finally acknowledge last week in meetings with the Clinton transition team: If drug prices can be held in check — either voluntarily or, eventually, through negotiations with managed-competition brokers — the greater the chance of getting expanded coverage for prescription drugs in new health-reform legislation.

That could mean both a larger share of the health dollar for the drug industry and wider use of drug therapies that keep people out of costly hospital rooms. The moment is at hand for drug-makers to serve their private and the public's interest.

They would be wise to seize it



*There's no need  
to kill the golden  
goose. Holding  
down the price of  
drugs can be  
a win-win  
proposition.*

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# WALL STREET JOURNAL

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MONDAY, JANUARY 4, 1993

WHITE OAK, MARYLAND

## MEDICINE

### Drug Concerns Promise to Curb Price Increases

By MICHAEL WALDHOLZ

Staff Reporter of THE WALL STREET JOURNAL

Drug-industry leaders, scrambling to head off price controls, are promising Clinton administration transition officials they will sharply reduce annual price increases, a move that would slash industry revenue by hundreds of millions of dollars a year.

Moreover, drug makers say they wouldn't fight the new administration if it sought legislation to reimburse the cost of prescription medicines to elderly people covered by Medicare. The industry has long resisted Medicare coverage of prescription drugs, for fear that it would lead inevitably to tough price controls.

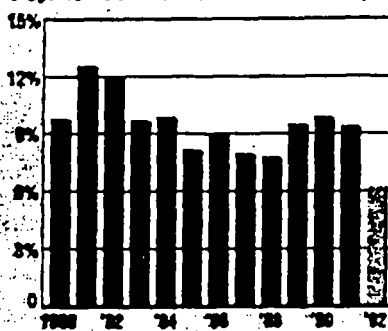
Several major drug makers, including Glaxo Inc. and Merck & Co., say they might accept some limited form of price regulation on prescriptions paid by Medicare. But the exact nature of the controls is a point of such fierce debate among drug company executives that it may scuttle the deal, several industry executives say.

In recent weeks, representatives from the industry's trade association and from individual companies have initiated discussions with officials of President-elect Clinton's transition team in an effort to negotiate an understanding on any new health-care laws. Mr. Clinton has promised to overhaul the U.S. health-care delivery system to expand access to the uninsured and attack spiraling costs. In particular, Mr. Clinton has targeted drug companies for the high cost of their products.

Although company executives and transition officials say talks haven't produced definitive agreements, both sides say drug companies are pledging to lower average annual price increases of their

#### Drug-Price Rises Slow

Annual percentage price increases of prescription drugs from December to December of each year



\*Change from October 1981 to October 1992

Source: U.S. Bureau of Labor Statistics

drugs to between 3% and 4% in 1993, keeping the price rises in line with consumer price inflation. Between 1982 and 1991, drug prices rose an average of two to three times the rate of inflation.

Moreover, company officials say they would be willing to produce periodic audits to the new government as proof they are keeping their promise.

"The Clinton people certainly have gotten the industry's attention," says Charles Sanders, chairman and chief executive officer of the U.S. unit of the giant British drug maker, Glaxo Holdings PLC.

Many drug company executives argue that drug costs represent only a fraction of the total U.S. health bill. Yet, high-priced medicines for AIDS, cancer and other ills have made the industry an easy object for action by the incoming administration.

Indeed, many drug makers see a voluntary pledge on prices as a significant concession. "It's a major step on the part of industry to hold price increases to the rate of inflation," says John R. Stafford, chairman and chief executive officer of American Home Products Corp., New York.

As a result of threatened price controls from several bills proposed and defeated in Congress in 1992, American Home and

Please Turn to Page B2, Column 3

# WALL STREET JOURNAL

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MONDAY, JANUARY 4, 1993

WHITE OAK, MARYLAND

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## Drug Firms Promise Clinton Team To Curb Price Increases Sharply

*Continued From Page B1*

other drug companies already put the brakes on pharmaceutical inflation. Mr. Stafford says for the first 10 months of 1992 his company raised prices on average "about 3%," down from 5.8% in 1991.

The Pharmaceutical Manufacturers Association, the industry's trade group in Washington, says prescription prices rose 6.3% in the 12 months ended Oct. 31, down from a 9.4% jump in prices during 1991.

Mr. Stafford and other company executives say the industry is wary of making a collective pledge about prices for fear of violating federal antitrust rules, but they say, if asked, the companies might proffer promises individually. "We welcome initiatives from several drug companies to work with us in expanding access and restricting costs of prescription drugs," says Judith Feder, director of the new administration's health-care transition team. "We are concerned as to how we can be certain these objectives will be achieved."

Some company lobbyists suggest the drug makers take what for them is an unusual step: publicly releasing monthly or quarterly reports documenting product price increases. The transition team says it will consider such offers.

Securities analysts who follow the drug industry say holding price increases to the rate of consumer inflation is in itself noteworthy, given the fact that some company's profit growth has depended heavily on rising prices. Christina Heuer, a veteran analyst with Smith Barney, Harris Upham & Co., says smaller price rises will reduce drug-industry profit growth to a 10%-11% range in 1993, down from 17% in 1991.

The moderating rate of price increases "shows you that a very real threat of regulation may be more powerful than any law you could pass," says Uwe Reinhardt, a professor of economics, specializing in

health issues at Princeton University. "The drug companies fared very well during the '80s," and now they could face "some very tough restrictive policies."

But transition officials say a price pledge may not be enough. The transition team says it hopes to cobble a comprehensive health-care reform plan that the president-elect could present to Congress during the administration's first 100 days in office. Key to this is something called "managed competition," which would encourage Americans to select from competing health insurance plans that, in turn, would negotiate price discounts from doctors and hospitals, and, perhaps, drug companies.

The industry's trade group says prescription drugs should be included as a standard benefit in these newly developed insurance plans, a move that would expand drug coverage to millions of working Americans. Industry executives say they expect these competing plans would exact sharp price discounts from drug makers in order to be included in the benefit.

Transition officials, however, also want to provide a drug benefit to millions of elderly people who must pay from their own pockets for drugs, since Medicare doesn't cover them. "We understand the elderly on fixed incomes are hurt by rising prices," says one industry official. "But our concern is who will pay the cost of the bill. We are adamantly opposed to forcing the drug makers to carry the load by discounting prices."

Companies say they already are smarting from a 1991 federal law requiring them to discount drugs used by state Medicaid plans, which cover some health costs for the poor. The industry says these rebates will cost drug makers \$6.4 billion between 1991 and 1995. "Medicaid represents about 10% to 15% of our business," says Bob Allnutt, executive vice president of the Pharmaceutical Manufacturers Association. Because Medicare eligible recipients buy about 30% to 40% of the industry's medicines, "a Medicaid-like rebate for Medicare would significantly hurt the industry's ability to conduct research on promising medicines," Mr. Allnutt says.

In 1988, Congress extended Medicare coverage to prescription drugs, but the bill was repealed in 1989 following a flood of complaints over higher monthly premiums that were charged to recipients to pay for the Medicare coverage.