Retiree Health Benefit Plans and FAS 106

Attached are materials prepared by the Employee Benefit Research Institute regarding the issues surrounding retiree health benefit plans and FAS 106.

Background. Several corporations have or are considering terminating or cutting back on their retiree health benefit plans. As the reason for this action, they cite the Financial Accounting Standard Board's issuance of Statement 106 (FAS 106), which becomes effective during the first quarter of 1993 for large, public corporations and during the first quarter of 1995 for non-public firms.

FAS 106 requires that companies accrue on a current basis their future costs associated with existing benefit packages. Under current practice, most companies finance retiree health benefits as they occurred. Because of rapidly increasing health care costs, this practice left significant liabilities undisclosed. FAS 106 requires disclosure of these "hidden" liabilities.

Because FAS 106 will require the disclosure of increased liabilities, a corporation faces lower net income and reduced shareholders' equity. In response, firms have basically two options to reduce their liabilities: (1) changing or terminating their retiree health benefit plan, or (2) "prefund" the plan, either by taking a one-time charge or by amortizing the liabilities over 20 years. For example, General Motors announced it was taking a $20.8 billion accounting charge to meet the new standards. GM will also be taking an annual charge of $1.4 billion indefinitely to account for the unfunded liability.

Those firms that are eliminating or reducing their liabilities are mostly in mature -- often unionized -- industries. Those workers that will be most affected are those that retire or planned to retire before the age of 65 and are not eligible for Medicare. Medicare eligible retirees may lose any supplemental insurance provided by their former employers.

It should be noted that the impact of FAS 106 on multi-employer plans and on public employee plans is not now clear.

Legislative Response To FAS 106. At this time, there has been no legislative response to the reduction or termination of retiree health benefits in response to health benefits. We and the offices of Senators Kennedy and Metzenbaum are all at this point working on responses but not yet collectively. You should probably not speak about any of this activity during the forum.

FAS 106 and National Health Care: Solution and Problem. You should note that the termination of retiree health benefit plans could affect the development of a national health care system.

Plan terminations certainly highlight the weakness of the employer-employee relationship to properly allocate health care and will increase the call for national health care reform.

But, the plan terminations could also impact the financing of a national health care system. A national system could relieve firms of significant liabilities for their retirees' health care. And presumably an equitable financing mechanism would take into account the relief of those liabilities and cause firms that are relieved to pay more into the system. But, it comes down to a timing question --- if firms now terminate their retirement obligations will they not have to contribute for their retirees' health benefits in the future. If they do not, the public costs of any program could increase dramatically.

Philadelphia Inquirer

JAMES M. NAUGHTON, *Executive Editor*
STEVEN M. LOVELADY, *Managing Editor*
RONALD PATEL, *Associate Managing Editor*
SANDRA L. WOOD, *Associate Managing Editor*
DAVID R. BOLDT, *Editor of the Editorial Page*
DONALD KIMELMAN, *Deputy Editorial Page Editor*
ACEL MOORE, *Associate Editor*

ACCOUNTING

Health-care future shock arrives

A new rule is forcing companies to account for the costs now. Some will show huge losses.

By Ian Johnson
BALTIMORE SUN

NEW YORK — What's a *fas-bee* and why is it terrorizing America's largest companies — and their retirees?

Just the Financial Accounting Standards Board, a body of seven accountants that makes the rules governing corporate America. But one new rule, FASB 106, has sparked turmoil by forcing companies to estimate future retiree health-care costs — and to put the astronomical expense on their financial statements now.

The Ford Motor Co., the Westinghouse Electric Corp. and other companies are shuddering from the effect of the rule. Some have taken multibillion-dollar charges against earnings — turning a year's profit into a record loss. And in response, many are slashing retiree health-care benefits or re-examining early-retirement programs.

In an age of global competition, the rule also highlights the unusual position of U.S. companies. Alone among major international competitors, they provide health and retirement benefits to current and former employees. In other industrialized countries, either government medical plans or private insurance covers medical costs.

The new rule crystallizes a problem ignored for decades: Companies have long been promising health-care benefits to retirees without any idea how to pay the increasingly expensive tab.

The FASB's response was simple enough. Its rule, which will affect most financial statements in April, forces companies to add up the costs of providing health care for retirees and for current employees when they retire.

Companies must treat the health-care cost as a liability on their balance sheets. And although they do not have to set aside money now to pay for it, they must subtract it as an expense when calculating profits.

Previously, companies had to show only how much they were paying for retirees' health care.

"All the rule does is tell companies to put down on paper the cost of what they've promised their employees. Most companies have no idea what this [amount] is," FASB spokeswoman Debbie Harrington said.

The new rule is a blow to America's fading corporate stars. Most of the new liabilities — estimates start at $400 billion — will hit older industries that led the way in providing millions of Americans with insurance coverage.

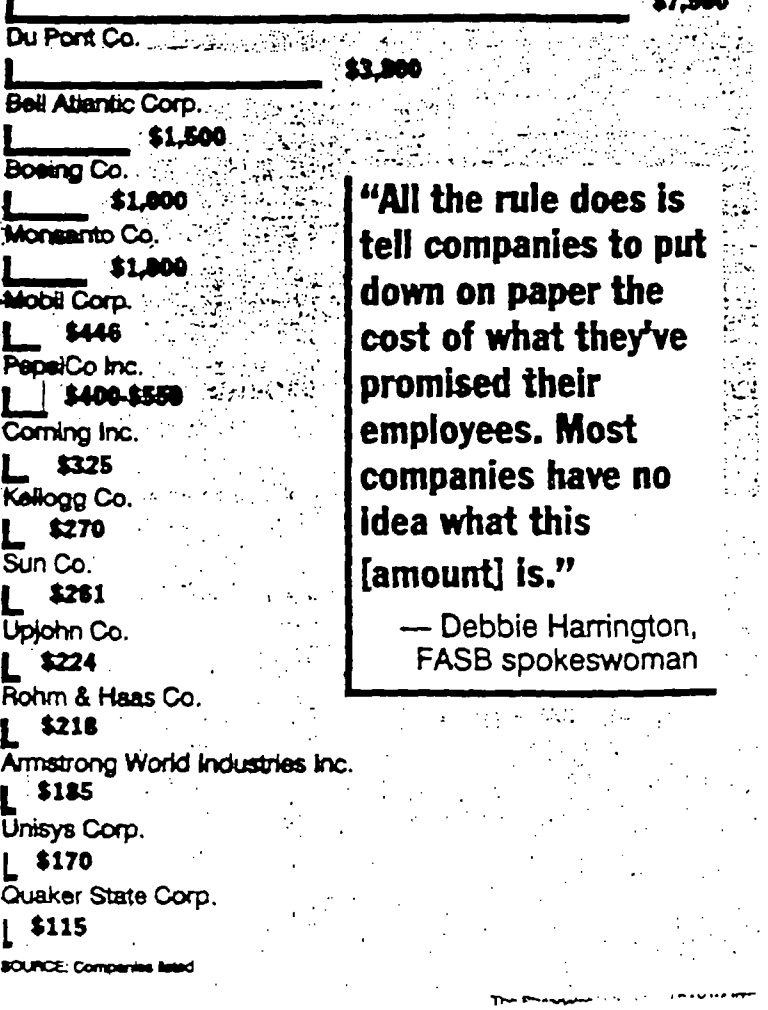
In the most drastic case, the General Motors Corp. faces as

See **FASB** on D5

Accounting for FASB 106

Selected companies that have taken a charge against their earnings to cover the cost of future health-care benefits for employees and retirees. For some companies, the charge includes small amounts for other accounting changes in addition to FASB 106. Also, some companies are considering a reduction in future health-care benefits, which would lower the cost.

In millions



SOURCE: Companies listed

"All the rule does is tell companies to put down on paper the cost of what they've promised their employees. Most companies have no idea what this [amount] is."

— Debbie Harrington, FASB spokeswoman

The Philadelphia Inquirer

MAXWELL E.P. KING, *Editor* *Executive Vice President*
GENE FOREMAN, *Deputy Editor and Vice President*
JAMES M. NAUGHTON, *Executive* *r*
STEVEN M. LOVELADY, *Managing Editor*
RONALD PATEL, *Associate Managing Editor*
SANDRA L. WOOD, *Associate Managing Editor*
DAVID R. BOLDT, *Editor of the Editorial Page*
DONALD KIMELMAN, *Deputy Editorial Page Editor*
ACEL MOORE, *Associate Editor*

Some firms are slashing benefits

FASB from D1

much as $24 billion in future retirement health-care costs — two-thirds of the automaker's book value.

Ford has already announced that it will take a $7.5 billion charge for 1992, turning a profitable year into the worst loss in U.S. corporate history. And the Bethlehem Steel Corp. could face a $1.6 billion charge to pay for its 68,000 retirees.

Companies are allowed to account for the cost as a one-time charge, as Ford is doing, or spread the expense over 20 years. Most companies, including GM and Bethlehem Steel, have not announced what they are going to do.

Bond-rating agencies say the new liabilities will influence how they rate companies, especially older ones with a lot of retirees and generous benefits.

The Standard & Poor's Corp., which rates the ability of companies to repay debts, has already downgraded four companies because of their future health-care liabilities, said Scott Sprinzen, a corporate finance analyst for Standard & Poor's Rating Group.

Wall Street's critical eye also extends to stock ratings and prices. Although no brokerage firm has recommended selling a company's stock because of the new liabilities, strategists say the new numbers should wipe 9 percent to 13 percent off the book value of the 500 most important stocks.

"It should influence their [investors'] thought process. You're acknowledging a liability, one that will keep growing," said Robert Willens, a tax and accounting specialist for the brokerage of Shearson Lehman Bros. Inc.

Bethlehem Steel could face a $1.6 billion charge for its retirees.

Although analysts and investors should have known all along that GM, Westinghouse and other big companies had huge commitments to pay retiree health benefits, they sometimes ignored what they didn't see on a financial statement, Willens said.

To bolster their financial statements, about two dozen companies, including the McDonnell Douglas Corp. and the Unisys Corp., have cut health-care benefits to retirees or have told current employees not to expect health-care benefits after retirement.

This development has sparked an outcry against the new rule. Many retirees say companies were just using the rule as an excuse to slash health-care expenses.

But company executives say the rule has forced them to look hard to determine whether they can afford to pay for retirees' health care.

"I really think it is ridiculous for us to account for this. The end result is that thousands lose their health care at a time when we're worried about 36 million people being without health insurance," said Robert Ripston, the vice president for human resources at the Ingersoll-Rand Inc., a maker of construction equipment.

The Inevitable Happens: Making the Improbable Possible

by Selwyn Feinstein, EBRI Fellow

Uncertainties entangle retiree health benefits.

Employers—along with investors and lenders—brood over potentially staggering costs and ponder how to bring liabilities under control.

Workers delay retirement until they earn postcareer benefits, and then agonize whether promises will be kept.

Government officials weigh pleas for tax relief against demands for budget restraint.

Policymakers deliberate a national health reform that could alter the premises on which all plans are built.

Amid the doubts, however, one point appears certain: tomorrow's retirees will be asked to assume a larger share of their own and their families' health bills.

[redacted] of the participants in this EBRI-ERF forum made the [redacted] that economic necessity is forcing the benefit shift. The Financial Accounting Standards Board's (FASB) Statement No. 106, which requires companies to acknowledge retiree health liabilities, simply accelerated the inevitable, the panelists said. Several participants outlined changes in benefit plans that they had already installed or were offering to clients. Most other companies were expected to act soon.

This inevitable recognition spurred by FAS 106 may have another even more pervasive consequence: the galvanization of a constituency for change that could alter the national health debate.

How different from seven years ago, observed EBRI's Dallas L. Salisbury. At an EBRI-ERF policy forum on retiree health benefits then, he recalled, the overriding sentiment was, "Why would anyone want to talk about this?"

◆ Background

[redacted]ee health coverage first started appearing in the late [redacted]s and 1950s as what Diana J. Scott of Towers Perrin called a "throw-away benefit." For most companies, those were plush times, with growing needs for workers and relatively few retirees. When Medicare took over much of the retiree health bill in 1966, the benefit became even more appealing to employers.

The coverage was far from universal. EBRI figured that only 43 percent of Americans aged 40 and over had employment-based retiree health coverage in 1988. Currently, only one in three retirees, or some 7.8 million people, benefit from the coverage, according to Nora Super Jones of EBRI. "Typically, these retirees have proportionately higher incomes than other retirees. They tend to work for large firms or public employers and are more likely to be unionized," she said. Nearly three-quarters of these workers also receive pensions, added Christopher J. Ruhm of the University of North Carolina at Greensboro. However, large groups have been locked out, he said. "Only 19 percent of female retirees, 30.6 percent of Hispanics, and 14.2 percent . . . of those with 1988 household incomes below $7,500 received retiree health coverage," he said.

For those covered, most plans a few years back simply carried the health benefits of active employees into retirement years for workers and their spouses, said Stewart Lawrence of Martin E. Segal Co. "There was a promise of a service or a benefit, as opposed to the promise of a cost or the promise of a current funding or contribution level," he explained.

Length of employment rarely was a factor in deciding who received full benefits. Workers, however, had to remain with the company until retirement or lose it all.

Few companies then asked retirees to help pay for the coverage, and none asked active workers to help prefund it, Lawrence said. Some firms even picked up the cost of Medicare Part B, Supplementary Medical Insurance.

The coverage was financed pay-as-you-go from current operations. Few companies acknowledged the liabilities on their books or set aside money for future needs. Unlike the requirement for pensions, the government did not require prefunding, and the tax code offered few breaks.

To Robert L. Clark of North Carolina State University, "most employers appeared to be unconcerned with the current and possible future costs" of the benefits they were offering.

Consider the taxi driver encountered some years ago by Howard A. Freiman of Fidelity Management Trust Co. This cabby, Freiman said, had been given free medical coverage for himself and his wife and four children as an inducement to retire from a large manufacturing plant, although he was only 31 years old at the time and had worked at the company for just 12 years.

Asked Freiman in disbelief: "Did the company's actuaries calculate the cost" of providing that family with "medical benefits for the next 30 to 50 years?"

Many firms, Clark asserted, "seemed to believe that they could cancel retiree health plans whenever they chose."

What Clark called "a series of new realities" began intruding in the 1980s. Not the least of these was a string of court rulings, starting in 1983, that employers could amend or terminate retiree health benefits only if they had specifically and publicly reserved that right. So the promise could be binding.

And it was proving a heavy load. Americans were getting older and living longer, and they were retiring earlier, many under prodding from employers dangling retiree health benefits designed to entice workers to leave in what had become difficult times. The ratio of active workers to retirees dropped in some industries from eight or nine to one in the late 1960s to as low as two to one, Donald P. Harrington of AT&T said.

The health benefits that retirees were carrying out with them were sharply escalating in cost. From 1987 to 1989, according to a Wyatt Co. survey, outlays for active and retiree medical benefit plans by the nation's largest industrial companies surged at an average annual rate of 21 percent.[1] That was twice as fast as the national health expenditure growth rate, which, in turn, was swelling more than two percentage points faster than the Gross National Product.

[1]The Wyatt Company, *Managing a Changing Work Force: It's Time to Take a Look at Your Retiree Benefits* (Washington, DC: The Wyatt Company, n.d.).

Exacerbating the problem, said William W. Spievak of Ball Corp., was cost shifting, the "hidden tax" he put at 40 cents on the dollar that a local hospital was imposing on Ball's health plan "to make up for Medicare, Medicaid [and] indigent care." Hewitt Associates, he said, estimated that cost shifting was responsible for "one-third of the health plan premium increases between the years 1987 and 1988."

What had started out as a throw-away benefit had become a formidable commitment.

"Companies have found they are no longer in the business of merely making widgets. They are in the business of making widgets and also in the insurance business," asserted William Reimert of Milliman & Robertson. "What kind of risk are you really ready to put your company on the line for?" he asked.

◆ FASB Issues Statement 106

Enter FASB to force companies to assess just how large those retiree health benefit risks really were. Scott, who served as a FASB project manager before joining Towers Perrin, explained the board's mission, as assigned by the Securities and Exchange Commission and the accounting profession: to establish and improve accounting and reporting standards; to enhance the credibility, faithfulness and fairness of financial statements.

A decade of considering retiree health benefits led to the conclusion that pay-as-you-go accounting "ignores the measurement and recognition of the financial effects of promising to provide these benefits, and of the service that employees are rendering in exchange for those benefits," Scott said.

The accrual accounting mandated by FAS 106 in December 1990, she continued, "attempts to remedy that situation by recognizing the effects of events as they occur, even though the cash flows may not be affected for many years after."

Without such a recognition, she said, "management doesn't really have the relevant information with which to manage the company. Creditors don't have relevant information on which to base credit decisions. Investors don't have the relevant information on which to base their investment decisions."

Such an accrual approach "certainly is not revolutionary," she emphasized. Companies must use it to account for other forms of deferred compensation, including, most notably, pensions.

Under the board's edict, companies have until fiscal years beginning after Dec. 15, 1992, to start recording on their balance sheets those retiree health benefit liabilities that have not been funded. Accumulated past obligations could be charged off at once or spread out over as long as 20 years.

Even amortized, however, such liabilities could be an awesome jawfull for many companies to swallow.

Douglas J. Elliott of J.P. Morgan said market analysts generally had figured a company's retiree health care liabilities at 10 to 15 times its current pay-as-you-go expense. Announcements to date, however, show "this number seems to be misleadingly low." The true figure, he suggested, could be "20 times or more."

Alcoa, whose liabilities had been estimated at $538 million, said its figure was closer to $1 billion, Elliott related. General Electric said its liabilities were $2.7 billion, rather than the $1.77 billion that had been figured by the analyst rule-of-thumb. IBM, whose liabilities had been estimated at $1.89 billion, announced a figure of $2.3 billion but said 40 percent to 50 percent had already been funded. Elliott said Lockheed's announced liabilities of $1 billion more than doubled the estimated $450 million. USX put its liabilities at $2 billion to $3 billion, although the analyst rule-of-thumb figured a $1.95 billion hit.

By EBRI's estimate, FAS 106 will force all private employers to recognize $241 billion as the present value of health obligations due current retirees through 1988.

If all companies recorded their liabilities on their books today, said Elliott, quoting a study by Mark Warshawsky for the American Enterprise Institute, their net worth would drop 15 percent. EBRI quoted a Towers Perrin survey that FAS 106 would reduce pretax earnings of some large employers an average of 10 percent.

"In retrospect," observed Clark, "it is very puzzling why the leaders of corporate America instituted such contracts without more forethought for the costs and liabilities associated with retiree health plans."

Harry Smith, a retiree who helped implement such policies while at Sun Co., wondered aloud if "this situation is really a failure of American industry, a failure of consultants to advise what they were getting into as early as 1974, 1975 perhaps. . . . I just wonder," he added wistfully, "if a group of this type can't come up with studies, ways of preventing these things from happening."

While bewailing the liabilities, no one at the forum faulted the FASB for prodding the projected cost onto center stage.

Technical points were raised. Dale B. Grant of Segal suggested that a company with a fixed-dollar benefit would "show up with a much lower FASB expense" than a company that asked retirees to pick up 25 percent of the cost of an otherwise unchanged plan. "Yet," she said, "I would bet over time that the one with the fixed-dollar benefit is going to spend more in retiree health benefits."

Michael J. Gulotta of Actuarial Sciences Associates complained that differences allowed by FAS 106 for handling plan changes, past service liabilities and health care projections could lead to results that would not be comparable from company to company. Scott acknowledged the point but said that she "believes that, overall, the new accounting standard produces information that is more credible and revelent than in the past."

Still, Gulotta said later, FASB "did us a service" in forcing companies to address the cost of retiree health benefits.

Said Richard Ostuw of Towers Perrin: "FAS 106 has not changed the cost of retiree welfare benefits; the change in accounting rules merely accelerates the timing of recognition of this cost."

David Skovron of Kwasha Lipton agreed. "FAS 106 put truth in packaging." But, he quickly added, "perhaps an unintended effect has been the taking away of benefits that might not otherwise have occurred at the same point in time."

Grant said that some employers were reducing retiree health promises now to cut "FAS exposure as low as possible," with the expectation that they could always "worry about it later." But later may never come for companies that encounter rough times, go bankrupt or are sold, she said.

Such benefit reductions are "unfortunate but probably very necessary," Scott stated.

◆ Companies' Response to FAS 106

For better or worse, FAS 106 has forced companies to confront a new set of unappetizing options.

- Do they acknowledge unfunded accumulated liabilities with a single devastating write-off the first year that would slash net worth and overwhelm earnings? Or do they amortize the obligations over 20 years and thus erode accounts for the next generation?

  "It's an emotional issue to write off, say, a billion dollars. . . . Chairmen don't like to do that sort of thing," Elliott allowed. "But if you can see your way clear to doing it, I think the stock market will reward you relatively for writing it all off in the beginning. It basically removes an overhang of future earnings penalties that otherwise is going to exist for you for 20 years."

- Do employers strip cash from balance sheets, immediately or over a period of years, to fund at least some of these obligations, a step that would both wipe away liabilities and assure workers that promises will be kept?

  Some companies will choose to prefund, predicted Ostuw, "because they think benefit security is appropriate, and/or they just think that it's tidy to match assets and liabilities and keep them all off the balance sheet."

  But others, said Elliott, may decide not to prefund because they see more attractive ways to invest their money. Or, suggested Grant, they may be wary that national health insurance, if enacted, could reduce their retiree health liabilities. Then they would "be stuck with all those assets and look stupid," she said.

- If obligations are prefunded, how are the dollars to be squirreled away? The Tax Code grants favored treatment for money that companies set aside to finance pensions. But it allows few tax breaks for advance payments that companies make for retiree health plans.

  Some limited funding options are available. Charles C. Morgan of Prudential Asset Management Co. listed 13. These included voluntary employee beneficiary associations, (VEBAs), so-called 501(c)(9) plans for their Tax Code designation; 401(h) health benefit savings plans and 401(k) retirement savings plans; and various forms of corporate and trust owned life insurance. Each had some tax or other advantage; each was restricted in the way it could ease the load.

But the primary questions that companies must ponder are: what retiree health commitments are appropriate for employers and how much of the cost and risk should workers be left to bear?

"Two equally important but potentially incompatible interests must be reconciled," Morgan declared.

"1. Employers want flexibility to manage their finances—including the power to terminate plans if the expense becomes financially crippling, and

2. Employees want security—they want to receive benefits that they have been promised."

Ostuw looked at such options and concluded that most employers "will reduce their commitment to retiree health care benefits within the next two years—if they have not already done so."

Clark presented data from the Bureau of Labor Statistics to show that many medium and large firms already had RIFed their retiree health plans. In 1986, he said, 63 percent of the full-time participants in employer health plans were enrolled in programs that offered coverage to retirees under 65 years old. By 1989, however, the number had dropped to 41 percent. For retirees over age 65, the coverage rate sagged from 57 percent to 36 percent.

Ostuw said companies will continue to reduce coverage because the cost, as measured by FAS 106, "will be unaffordable"; because the current commitment is open-ended, tied as it is to health care costs that are beyond the company's control; and because benefits now "are not structured equitably," in that they make no distinctions for length of service and retirement age or between coverage for employees and their dependents.

Fully 70 percent of major employers will make "fairly significant changes," Ostuw predicted. "Maybe another 20 percent will make relatively minor changes, and the balance will make little or no change." The restructuring will come, he said, even if Congress allows the same tax

eaks for funding retiree health programs that are cur-ntly allowed for pension plans.

Few companies will terminate their retiree health benefits, though some may make workers pick up the full cost, Ostuw said. Many employers will impose caps on pay-outs by setting defined dollar benefits. Other will redefine their commitment from a defined benefit to a defined contribution.

"We will see a fair amount of complaint. . .that companies are cutting back on these benefits, shifting costs to retirees," Ostuw said. But, he quickly added, "An affordable commitment is much more secure than an unaffordable commitment, and I think that's a healthy change."

Meredith Miller of the AFL-CIO was less sanguine. "We are fearful that this reexamination of retiree health benefits is going to lead to a reexamination of other benefits," she said. "I think we are heading towards a new definition of necessary benefits, or a core set of benefits, that employers are going to be willing to provide, and those are the predictable ones, the capped ones, and more manageable for them."

.e answer, the AFL-CIO asserted in a pamphlet distributed at the forum: "Keep benefits, cut costs."

Ball Corp., however, viewed the issue differently. Even though its retiree health payments were limited to lifetime maximums of $30,000 each for employees and spouses, Ball decided it could not afford to retain its retiree health benefits, Spievak said.

The company, he explained, had looked at placing more of the cost on retirees with bigger deductibles, co-pays or increased contributions. It had considered curtailing some of the coverage. It had pondered ways to reduce charges imposed by providers. None of the approaches, however, offered "significant relief," he said.

"So we took steps that for many in this room would be very drastic. We said that anybody employed after 1/1/90 does not have access to a defined benefit retiree medical plan. We're out of the defined retiree medical plan business at least for future hires," he stated.

'alled in its place starting 1991 was a voluntary con-.atory program that allowed salaried employees—both new and previous hires—to invest at least 2 percent of their base pay, all after-tax dollars, for their post-career health needs.

So far, though, few workers have taken Ball up on its offer. Without a matching contribution from the company, which Ball is not now making, "you are not going to get a lot of people," Spievak allowed.

Whatever money is contributed by workers goes into a group annuity contract that accumulates earnings tax free. These earnings are then credited back to the individual contributor's account.

At retirement, the contributors have two choices. They or their beneficiaries can submit medical bills or health insurance charges for tax-free reimbursements until the account runs dry. Or the retirees can buy an annuity that makes periodic fully taxable payments. Workers who leave before retirement can withdraw their account balances as either a lump sum or annuity, with taxes due on accumulated earnings. Beneficiaries of active workers get a lump sum.

With such a plan, said William J. Miner of The Wyatt Company, who helped design the program, workers get a way to accumulate money that will be spared from taxation if used to pay for postretirement health care. As a nonqualified plan, the coverage is not subject to contribution limits or to nondiscrimination requirements applied to highly compensated executives.

But most importantly, Miner suggested, the plan "facilitates change. . . . You have a take-away from the employee in terms of increased cost sharing, but, at the same time, you can offer this program to employees as a vehicle to save for some of those expenses."

Other companies will be following Ball's example, Spievak predicted. Big companies, he explained, have the clout to negotiate "favorable arrangements" with health providers that "minimize the impact of cost shifting" by federal, state and local health programs. But small companies will drop out. This will leave "a disproportionate share of cost shifting" on medium-sized employers, who "will see their retiree health plan costs increase even more," he stated. "It is our belief that more and more employers are going to stop providing retiree medical care."

Robert F. Seeman of American Airlines said the carrier also did "a lot of hand wringing" about its retiree health

care liabilities of nearly $800 million. FAS 106 was "the straw that broke the camel's back," he said.

Still, rather than eliminate retiree coverage or drastically reduce it, which were considered, "we chose the alternative of trying to continue providing a reasonable level of retiree coverage," he said. "We want our employees to feel good about the company."

The carrier decided that retiree benefits would be retained, but workers would have to prefund 30 percent of the cost, with after-tax dollars deducted from paychecks during their active work years. This was "more equitable," the company said, than "requiring employees to pay for retiree health care after they retire."

Starting in 1990, all U.S.-based employees except pilots and flight attendants must make monthly contributions for at least 10 years prior to retirement if they want to participate in the company's retiree health program. Just about everyone accepted, Seeman said.

Monthly contributions, all through after-tax payroll deductions, initially were set at $10 for current eligibles and at a sliding scale of $12 for 30-year olds to $91.50 for those aged 49 years or older who joined the plan later.

The contributions go into separate 501(c)(9) trusts for union and nonunion employees, to take advantage of tax code breaks for programs established through collective bargaining. But Seeman said the company still was negotiating with FASB to see if assets held by the trusts satisfied conditions imposed by FAS 106, a question raised because the trusts will pay benefits at termination and death as well as for retiree health.

Did "allowing or actually requiring" employee contributions to these trusts solidify a corporate "promise and commitment" to continue a retiree health program? Reimert asked.

"Certainly, on paper, we reserved the right to modify, amend, terminate, suspend the health programs," Seeman responded. But he agreed, "I think, in fact, we feel that we have somewhat solidified that promise."

Quaker Oats Co., too, reassessed its coverage and concluded it was possible both to control liabilities and provide "a good retiree medical plan," said Melanie Pheatt.

The company devised a program, effective in 1989, that recognized length of service, incorporated cost controls and provided broader coverage than the series of plans that the company had first started offering in 1955. Unlike American Airlines, though, Quaker Oats asked employees to contribute to the program after they had retired, not while still on the active payroll.

Retirees with 30 years of service pay 5 percent of the plan cost for themselves and 10 percent for spouses. Retirees with 10 years service pay 25 percent for themselves and 30 percent for spouses. Both pay 25 percent for each covered child. Because Medicare picks up most of the health bills of retirees over age 65, these older participants pay one-third as much as their younger colleagues for the Quaker Oats plan.

Benefits also are linked to years of service, with each retiree getting an annual health expense account equal to $12.40 in 1991 for each year of qualified service. This pays for deductibles and co-pays as well as vision, dental and hearing care. Out-of-pocket limits also are keyed to years of service.

"Employee acceptance has been excellent," Pheatt stated. And results from cost-containment efforts in the first 18 months of operation were "promising," she said.

John K. McMahon of TRW Inc. said a series of divestitures forced that diversified company to come to grips with its retiree health liabilities in 1985 and 1986. "Lo and behold, we became startled at what we considered to be the potential liability for the promises that were out there," he declared.

The present value of future medical benefits due 55-year-old retirees with 10 years service, McMahon explained, was half again larger than the pension liabilities for this group. For retirees at age 65 after 30-year careers, by contrast, medical benefits ran just one-seventh of the pension load. "We [were] doing it wrong. Providing these benefits was inconsistent with our other reward systems like pensions, vacations, etc., which were based on long service," he asserted.

Effective with retirements after Aug. 1, 1988, TRW adopted a defined dollar benefit plan linked to years of service that had the effect of requiring no contribution at all in the first year from retirees who had been with the

›any for 20 years. Actually, this was the maximum .ed dollar amount plan. Each of TRW's constituent businesses was given the option of deciding how much of the maximum it would award.

Gulotta of Actuarial Sciences Associates, which is owned by AT&T, said the telephone company confronted two issues when it evaluated its retiree health benefits: how to redesign its program to snap the link with health costs that "automatically escalates benefits without the corporation getting any credit, and whether money should be set aside to fund these benefits."

AT&T decided to set defined dollar benefits, or caps, to limit its "open-ended commitment" to finance retiree health coverage. The decision won union assent in 1989.

Anyone retiring after March 1, 1990, had to bear the brunt of any cost increases over the caps, which ranged initially from $500 for single retirees eligible for Medicare to $5,650 for retired couples under 65. But no retiree would have to pay anything before July 1, 1995.

"The risk of future medical care was shifted" from the ›any to its retirees, Gulotta said. "It was now up to union to bargain increases in benefits."

On prefunding, AT&T saw a promise of reduced cash flow in later years that more than compensated for increased cash flow in the near term, Gulotta said. Important, too, funding secured promised benefits, enhancing the company's "reputation as a caring and concerned employer."

As at American Airlines, separate 501(c)(9) trusts were established for union and nonunion employees. The tax code favored funding the union plan, Gulotta explained, because contributions to collectively bargained trusts can be unlimited, are deductible and accumulate tax free. A trust for nonunion workers was less favored by the tax code, but management needed benefit security as much as union workers, he said. This fund was invested in trust owned life insurance.

In response to union concern about the security of health benefits of current nonmanagement retirees, AT&T also transferred assets from an overfunded pension program to (h) plan.

Prudential Insurance Co., for its part, started funding its postretirement health benefits back in 1986, Morgan said. Its current target is the FAS 106 accrual figure rather than the amount it can deduct. "We are motivated by the employee security and the desire [to build] an asset more than a lot of other issues that get addressed," he declared. The money gets invested in insurance continuance fund and trust owned life insurance.

At Phillips Petroleum Co., by contrast, "I don't think that we. . . would ever consider funding the medical plans," Robert Nash said, citing "too many complications. . . and the problem of excess funding potentially, getting it back or not getting it back, and not knowing where you go in the future."

Fidelity Investments knew all about the complications. Freiman related how it had run into a stone wall when it had asked the IRS about using profit-sharing plans as retiree medical funding vehicles.

Fidelity had wanted to amend its 401(k) profit-sharing program to allow employees to allocate a portion of the company's contribution towards retiree medical insurance premiums. When it went to the IRS to ask if profit-sharing plans could be used to fund retiree medical benefits, "the IRS did issue a favorable determination letter, and so we believe the answer is yes," Freiman said.

Fidelity got less satisfaction, however, when it asked for a private letter ruling on the tax issues, specifically: are company contributions to the plan tax deductible? Can earnings accumulate in the plan tax free? Do retirees have to pay taxes on plan benefits paid out for medical insurance premiums?

Freiman said a district IRS office determined that employer contributions are deductible and plan earnings can accumulate tax free.

On the taxability of benefits to retirees, though, "the IRS declined to rule," Freiman said. Nonetheless, fortified by an opinion from the law firm of Ropes & Gray, Fidelity decided to go ahead.

Navigating retiree health plans in the "post-FASB environment" does, indeed, mean piloting through a morass clogged by unanswered questions. How will the IRS rule?

How will the financial community react? What will workers do? What will Congress decide?

◆ Tax Implications of FAS 106

Michael Thrasher, deputy assistant chief counsel at the IRS for employee benefits and exempt organizations, offered some insights into the tax issues in response to questions posed by Harry J. Conaway of William M. Mercer, Incorporated.

His answers, Thrasher cautioned, were his "personal views. . . . The Service, the Treasury and, in fact, the Congress have not taken positions on a whole host of these issues. It's cutting-edge stuff," he contended.

With that caveat, they plunged ahead, with interpretations that immediately proved contentious to some.

When Conaway asked if section 72 granted a tax exclusion for health benefits paid through an annuity, as Miner had stated was the authority for Ball's plan, Thrasher suggested, without talking specifically about Ball, that such an "exclusion may not be available." Section 72-15, he said, "just sends you over to 105, 106 and so forth," and 105-2 "says if you are going to get the money anyway it's not excludable."

The IRS official took a similarly hard line on flexible spending accounts for health. The basic thrust of proposed section 125-2 regulations, he said, bars a carry-over of benefits from year to year.

This was an interpretation that prompted Conaway to observe: "Some of the retiree health plan designs that we've heard about today, even though they are not fashioned as under a cafeteria plan, arguably would qualify as flexible spending arrangements under those regulations, and, therefore, would become subject to the 12-month period of coverage rule, the use-it-or-lose-it rule, and the uniform coverage rule, and that is an issue that people need to be aware of."

Miner protested stoutly. "This concept that's being posited here, that a retiree health plan that would qualify as a flexible spending arrangement has to. . . have these risk-sharing, risk-distribution characteristics and meet the use-it-or-lose-it rule and others, is really not something that has been embedded in the rules for years and years but is rather something of a novel or new creation within the past decade," he contended. The regulations under section 72, which date back to the 1960s, include an example of an accident and health plan that qualifies as a flexible spending arrangement but does not have the risk-sharing and distribution characteristics.

"It seems to me," he continued, "what the Service has done here with this rule is really enact some legislation without really any statutory change that would substantiate it." It was a point to which Thrasher responded: "Any time we do more than simply repeat the statute we can be accused of that."

Thrasher also had little comfort for plan designers who believe that contributions to 401(h) postretirement medical accounts attached to pension plans can amount to 25 percent of the combined pension-401(h) contribution. The old law did provide such a safe harbor, he said. But the law passed in 1989 came up with a different definition. "They didn't say 25 percent is okay. They just said over 25 percent is not." In his view, the test is not 25 percent but whether the postretirement medical plan is subordinate to the pension. "I think you have to be careful there," he warned.

◆ FAS 106 and the Financial Community

Plan designers need to be equally cautious in figuring how the financial community will react to the liability requirements imposed by FAS 106.

"Neither I nor anyone else legitimately knows what the stock market is going to do with these retiree health numbers," Elliott asserted. "There simply haven't been enough announcements to have any sort of base, [and] I do not believe that analysts have made up their minds how to think about this number yet."

Still, he predicted the market will react to announced liabilities that are surprises. It will react, too, to very large numbers, even if anticipated. One large manufacturer's estimate that its liabilities will be $4 billion to $6 million "is likely" to have an effect "over time," Elliott said. "The market is rational, but it's not that rational."

Even while emphasizing the massive imponderables, Elliott ventured what he called "a blatant guess," that

aybe half the obligation is really reflected in the stock ce."

He had more confidence in predicting how debt markets will react. For the average company, the effect of FAS 106 disclosures is going to be "fairly minimal," he declared. "Sophisticated investors and the rating agencies are already aware of the problem." Most will look at cash flows rather than the new liability numbers, he said. Then, too, the maturities of debt issues are shorter term than the retiree health obligations.

As in the stock market, though, big negative surprises "could precipitate stronger reactions," including higher costs on borrowings and a market reluctance to lend.

Companies would do well to make certain the market is prepared for whatever liabilities are reported, Elliott advised. The firms need not rush to adopt FAS 106 before the deadline; most would do better blending in with the crowd, he said. But he would write off the full retiree health liabilities immediately rather than let them nibble away at profits for 20 years. "The stock market is basically cted more by earnings than it is by book value," he ained.

Effects of Reduced Benefits on Work and Retirement

Far more complex are decisions about work and retirement and how they might be affected by FAS 106 and the certain curtailment of retiree health benefits.

A recent *EBRI Issue Brief* on retiree health benefits indicated that benefit cutbacks "may lower employee morale and reduce a firm's ability to attract and hold employees."[2] This has not happened at Ball Corp., however. "We have not, as yet, and I emphasize as yet, had the first rejection of an employment offer for lack of a retiree medical plan," Spievak said. "Younger new hires don't even want to hear it," he explained. "Their attitude is, gee whiz, I never really expected it to be there. I don't expect Social Security to be there. I'm not even sure that [the] time when I'm going to retire is ever going to come."

Even less certain is how a change in retiree benefits will affect the timing of a worker's decision to retire.

A survey conducted for EBRI by The Gallup Organization, Inc. found that 55 percent of nonretired Americans would not retire without employer-provided health insurance before they were eligible for Medicare.[3] In another EBRI/Gallup poll, 69 percent said they would rather have employer-paid retiree health benefits than company stock that could be cashed out at retirement.[4]

"In the absence of retiree health insurance, the high cost of individual health insurance for persons aged 50 to 64 is an important factor discouraging many older workers from retiring," Clark said, adding: "I believe that economists and other policy analysts have systematically overestimated the importance of pensions in the retirement decision and underplayed the role of retiree health insurance."

Still, said Clark, citing the 1988 Current Population Survey, 55 percent of all retirees over 55 years old had neither a pension nor retiree health benefits.

Ruhm offered a different perspective. "Very large financial incentives are required to induce substantial changes in average retirement ages," he said. One study he cited calculated that a 30 percent reduction in Social Security benefits for persons retiring at age 62 would raise average retirement ages only three months. A 20 percent across-the-board cut would keep workers around only two months longer.

"The financial impacts associated with changes" in retiree health benefits, however, "are likely to be quite small," he declared. Assuming only one in three retirees receives the benefits and employers further limit their commitment, "the increased annual expense to retirees . . . will average only $257 a year," he said.

"Small average effects do not eliminate the possibility of large impacts in individual cases," he acknowledged.

Jennifer Davis, "Retiree Health Benefits: Issues of Structure, ıancing, and Coverage," *EBRI Issue Brief* no. 112 (Employee Benefit Research Institute, March 1991).

[3]Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Medicare and Retiree Health*, EBRI Report no. G-20 (Washington, DC: Employee Benefit Research Institute, 1991).

[4]Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Employee Ownership*, EBRI Report no. G-4 (Washington, DC: Employee Benefit Research Institute, 1989).

Nonetheless, "changes of this magnitude are likely to have only slight impacts on retirement decisions, particularly since [retiree health benefits are] typically provided to relatively well-off workers, who are least often liquidity constrained."

Harrington, however, came to a different conclusion. He laid out a series of scenarios to show how "alternatives in employer-provided health benefits will impact retirement ages and security."

As for employers offering pensions and company-paid retiree health benefits starting at age 55, he said, dropping the health plan could force would-be retirees to work another five years to make up for the cost of buying their own replacement coverage.

For workers retiring at age 65 or older, however, the focus shifts. With Medicare picking up a large share of a retiree's medical cost, Harrington said, retiree health benefits cost companies considerably less. And retirees lose less if the employer benefits are terminated.

If workers remain on the job after age 65, the company continues to be the primary medical payer, so it ends up with higher medical bills, although it retains an experienced worker and is spared a pension cost.

A company's response to such variables, he concluded, rests largely on its employment needs: those companies with well-funded pension plans and surplus workers should do "nothing with respect to changing the age at which retiree medical coverage commences." For companies that want workers to remain, however, "a change in the age at which retiree medical benefits begin is in order," he said.

"Whether to continue to absorb full medical cost inflation is another issue." Employees will have to share in the cost, he said.

◆ Public Policy Issues

Broader public-policy questions get bundled into the retiree health issue, including the nation's labor force needs. As expressed by Jones of EBRI: "Companies have often responded to economic downfalls by reducing their work force through early retirement rather than layoffs. But is this approach best for society as a whole?"

With a graying population, she asserted, the coaxing out of older workers "may lead to a loss of skilled workers and production in the economy." Workers, moreover, may need the added years to save. Keeping them active also could reduce the drain on Social Security and Medicare and increase revenue from income tax.

Conversely, though, "It may not always be desirable to force individuals to work until they reach age 65," she said. Their jobs may be too demanding.

Also at issue, said Jones, is whether "scarce tax dollars should be used to subsidize benefits concentrated among the higher income employees, or the middle-income employees, while doing nothing for the uninsured population as a whole."

EBRI estimated that granting tax breaks to companies to prefund all their current and future retiree medical liabilities in one year would have cost the U.S. Treasury $37 billion in 1989. If amortized over 15 years, the first year tax loss would have been $9 billion in 1989. Tax breaks such as these "would have to be offset by either a tax increase or some reduction elsewhere," Jones said.

This against a backdrop that includes 34.4 million Americans under age 65 with neither private health insurance nor access to publicly financed care in 1989, and a federal budget deficit that is expected to swell to $348 billion in fiscal 1992.

And, perhaps the most difficult problem to resolve: amid cries for an overhaul of the entire U.S. health delivery mechanism, should retiree health benefits be treated independently or as a subset of the whole?

To David Hirschland of the United Auto Workers, the answer was clear. "There is a fundamental problem with how we provide health care to retirees in this country, which warrants systemic reform," he said. Worrying about funding "takes us off on the wrong track."

Spievak agreed. "We need health care reform as a whole," he said. "We intend to support state and federal initiatives aimed at providing universal access."

While the general health debate has seethed, policymakers have considered four options for retiree health care, according to Jones.

Prefunding Incentives

Several proposals were introduced in the 101st Congress to provide at least limited tax breaks to companies prefunding retiree health benefits. None garnered much support, however, despite business backing, and no similar legislation has been introduced in the 102nd Congress.

ERISAfication

Some policymakers have suggested this as a *quid pro quo* for prefunding incentives, Jones said. The Employee Retirement Income Security Act of 1974 set minimum funding, participation and vesting requirements for pensions. Now some advocates would extend these to retiree health plans, as well.

COBRA *Extension*

The Consolidated Omnibus Budget Reconciliation Act of 1985 requires employers to allow workers, their families and beneficiaries to purchase health insurance for a limited period after the employees leave their jobs or die. The charge is usually 102 percent of the company's premium. Proposals introduced in Congress in 1991 would expand the coverage to widowed, divorced and legally separated spouses aged 50 and older until they attain other coverage or become eligible for Medicare.

Medicare Expansion

Rep. Dan Rostenkowski (D-IL), Chairman of the House Ways and Means Committee, introduced a comprehensive health care reform proposal in 1991 that, among other features, would gradually reduce the Medicare eligibility age from 65 to 60 by 1997. The proposal won the backing of the AFL-CIO, to "level the playing field" for companies with a disproportionate number of retirees, Miller said. But the federation still pushed for national health care reform.

Three congressional staffers held out little chance that any legislation would emerge soon.

Rick Grafmeyer, tax counsel for the Senate Finance Committee, said it would be "real difficult, real difficult" for any prefunding tax incentives to pass in the next couple of years.

"A lot of folks," he said, "would feel that if we're going to spend the precious federal dollars that we have, it's better off trying to increase access to the people who have no health care coverage, and/or trying to reduce the overall cost of the system, versus trying to provide a security blanket, or something akin thereto, to a group of people who may very well be covered by Medicare."

Rather than broaden tax breaks for employer-provided health care, "some people in Congress" would cut them back, he said. "Right now, the tax expenditure for health benefits on the federal level is about $38 billion for 1991, and on the state and local level it's potentially about $20 billion," he stated, citing a Congressional Budget Office study.

"There are some people," he declared, "who would say that we should take some of those dollars away from people who are receiving what they would deem to be better health benefits than most people get in the country, and allocate that money to people who have no health benefits and try to increase the access."

Chris Jennings, deputy staff director of the Senate Special Committee on Aging, said that members of Congress and their staffers recognize that retiree health benefits are a problem. But, he said, they are "scared" of the issue because they do not have any answers, can find no offsetting revenue-raising possibilities and see more importance in helping the uninsured and containing costs.

On the specific policy initiatives advanced so far, Jennings forecast that little progress would be made. The huge potential cost dooms prefunding tax incentives, he said. ERISAfication is unlikely unless there are some "major, major problems that are very visible to the Congress." A COBRA extension would be cheap to the federal government but "business will hate it and retirees will say, what the hell is going on" when they see bills of $2,000 to $3,000. Medicare expansion, too, is likely to get mired. He did not see it moving without "a comprehensive reform approach, which I don't see happening this year or next year."

Tricia Neuman, on the professional staff of the House Ways and Means Committee, made it unanimous for the congressional aides. Citing a preliminary estimate from the General Accounting Office, she said that the Medi-

care expansion bill could reduce a company's health costs "up to 60 percent per retired employee" over the lifetime of the retiree. But this is a break, she indicated, that probably will elude employers for a while. "This year . . . it's highly unlikely that there will be any legislation that would even make incremental improvements in health coverage."

Deborah J. Chollet, of Georgia State University and an EBRI Fellow, sensed, however, that pressure is building for change that could smash through the legislative bottleneck.

The very retirees who forced the repeal of the Medicare Catastrophic Coverage Act in 1988—because they felt the government was unfairly charging them for benefits their former employers already were providing—are the same people who are likely to leap into action again if they see their employer-based retiree health benefits slip into jeopardy, she said.

Many of these are middle-income retirees, most with annual earnings between $35,000 and $50,000, a minority in the general population, she said. But "the poor in this country are not the people who drive public policy," she asserted. "It's middle-income voters who drive public policy." In Chollet's view: "The political and policy impact of this group of people is highly disproportionate to their numbers."

And these people, Chollet said, are "going to be spectacularly unhappy" at the realization that they are being asked to carry more of both the absolute cost of retiree health care and the risk of inflation. "Just as they defeated Medicare Catastrophic, my guess is they will be right there ready to bring it back when, in fact, the baby boom is at risk of inadequate insurance benefits in retirement."

Early retirees, she said, also will press for change as they increasingly find themselves, first, abandoned by employers and, then, unable to purchase health insurance on the private market.

A minority of the population always has found itself uninsurable, she explained. Now, however, this group is expanding with "a growing baby boom, who, in larger and larger numbers, are going to find that they themselves are medically underwritten out of insurance plans, that they are uninsurable," she said. "Suddenly, uninsurables can very well become virtually the majority population," all pushing for private insurance reform, she said.

And there is yet a third constituency, Chollet said, this one for a "global solution" for medical cost inflation, by people suddenly placed at risk.

"Employers say that they themselves can't control health care costs. It is not an unreasonable thing for people to conclude that [if] their employer is not willing to bear that risk, and not capable of managing increasing health care costs, how in the world are they going to be capable of doing that?" she asked.

"It's likely," she said, "that people will look even more strongly to the federal government for a cost control solution, and that is likely to be a regulatory action."

Miller, too, saw pressure for change not evident before FAS 106 and the resultant redrafting of retiree health plans. Prefunding tax incentives would not be coming from Congress "this year, next year, or in the next few years," she said. But, she reported, the retiree health issue has prompted employers and workers to sit down together, in committees established through collective bargaining, to look at the broader issue of national health care reform.

So, at the very least, FAS 106 has forced employers to acknowledge retiree health care liabilities. It has accelerated the inevitable recognition that some of these costs will have to be shed.

But, more than that, the accounting standard has fueled the debate for change, of not just retiree health benefits but of our national health care system.

It still is far too early to predict how this debate will evolve. Dragging new politically potent constituencies into the deliberation, however, almost certainly is going to produce actions on a timetable unimaginable before FAS 106 burst onto the scene.

FINANCING OPTIONS

Premiums, taxes, or savings from the system are the three basic options for financing the system. Either of these mechanisms must cover not only the cost of coverage now being paid through the employer-based system, but also the costs of expanding coverage to those currently uninsured. Financing must also cover the administrative structures to run the system (local boards) and for the national data system and infrastructure to monitor and improve practice patterns (PPRC staff paper).

Issues/Options

Paul Starr believes that a premium-based approach to financing is preferable to taxes, since it keeps the funds out of government revenue streams and is more likely to be politically feasible.

In this approach, employers and employees would pay toward the costs of a community-rated premium tied to the low-cost plan. Paul Starr (statement to Labor Committee) suggests that employers would pay some minimum share -- perhaps 75 percent; employees, the remainder. The self-employed, unemployed, and others would be required to pay the premium--but within limits. For persons with incomes below poverty, they would pay little or nothing; if above, they would pay some percentage of income in excess of the poverty line.

Washington Post, Wednesday, Feb 3, 1993

'Managed Competition' No Cure-All

CBO Sees Little Change in Health Care Outlays Under Proposal

By Dana Priest
Washington Post Staff Writer

"Managed competition," a type of health care change favored by President Clinton, could allow up to 20 million Americans who are now uninsured to be covered but "would leave national health care expenditures at approximately the same level they would reach" without the change, Congressional Budget Office director Robert D. Reischauer said yesterday.

The CBO's preliminary assessment of a managed-competition bill introduced last year by Rep. Jim Cooper (D-Tenn.) is that health expenditures would increase at first as the uninsured move into the system, Reischauer told a House Ways and Means subcommittee.

Cost increases would then gradually slow because most people would receive medical care from Health Maintenance Organizations, whose prices are 10 to 15 percent lower than in the traditional fee-for-service system of private doctors used now by most people.

Reischauer said the savings from HMOs—which generally charge members a flat yearly rate and have most of their providers on salary—would eventually offset the cost of covering more uninsured individuals.

Cooper's bill would establish a national health board that would define a standard package of health benefits for all Americans. Health insurance cooperatives would negotiate prices from competing health plans, and individuals and businesses would buy coverage from the cooperatives.

The board would also set standards for collecting information on price, health outcomes and customer satisfaction with each health plan that customers could use to decide which plan to purchase. The tax code would be changed to limit the amount of tax-free health benefits that employers could provide to the cost of the lowest-priced health plan in a given region. Now most health benefits are tax-free to employees.

Under the plan, most people would probably be forced to join super HMOs, which would remain under the control of private companies. Critics assert the health care market would become oligopolistic with fewer, but much larger, health plans in operation.

Managed competition attempts to change the behavior of consumers and providers; to break what many believe to be the incentives in the current system for hospitals, doctors and other health care providers to spend money on often unnecessary care and technology. But critics say HMO patients sometimes find it hard to see a doctor when they want to and that access to specialists and some type of technology is harder than under the current system.

During the campaign, Clinton endorsed the concept of managed competition with some type of cost controls, which he has not defined.

Reischauer yesterday acknowledged that the CBO is unable to fully analyze the potential savings from such a sweeping reorganization of the health care system.

"The devil in health reform may very well be in the estimates as well as the detail," said Reischauer. Congress uses CBO's cost estimates to determine how much a law would cost the federal budget.

As a result, Congress might find it difficult to decide whether to adopt a new and unproven revision whose potential savings cannot be entirely calculated, or to move to health care systems that exist now and can be judged, such as the one in Canada.

The CBO staff believes that the most successful way to limit costs is with a national "single-payer" system, like Canada's, coupled with limits on an individual's ability to buy health care outside the national system and price controls on hospitals, doctors and other providers.

But, said Reischauer, "cost controls restrain the freedom of consumers and providers." Under such plans, consumers would get more limited medical care because HMOs, for example, theoretically could no longer afford every kind of treatment. Doctors and hospitals, on the other hand, could not charge the prices they believe they deserve.

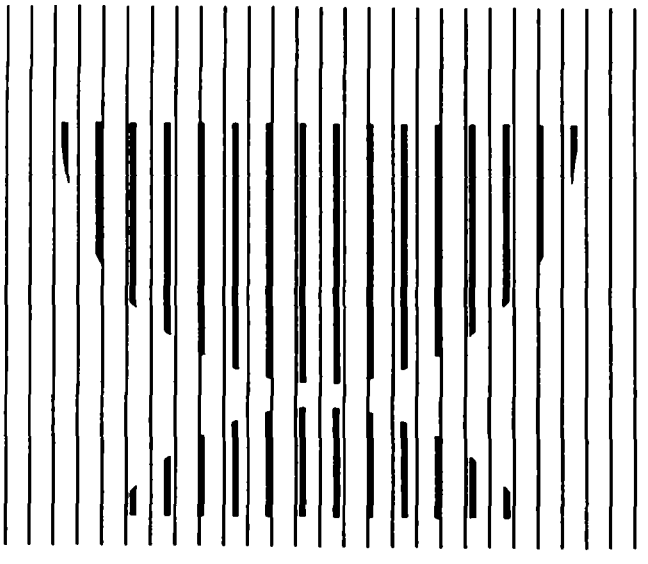
At yesterday's hearing, Republican members of the committee came to the defense of managed competition, as did Rep. Michael A. Andrews (D-Tex.), a co-author of Cooper's bill.

"I hope Congress is not seduced by budget numbers that will look good on paper but that will not stand up to the real world," said Rep. William M. Thomas (R-Calif.).

CBO STAFF MEMORANDUM

THE POTENTIAL IMPACT OF CERTAIN FORMS OF MANAGED CARE ON HEALTH CARE EXPENDITURES

August 1992
(Revised)



CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

INTRODUCTION

Managed care has attracted considerable interest as a possible way to curb rapidly rising health care expenditures without encountering some of the difficulties that more radical changes in the health care system could entail. Managed care seeks to modify the delivery and financing of health care in an attempt to eliminate unnecessary and inappropriate care, thereby improving quality and reducing costs. The current health care system already uses it extensively. Among employees who in 1990 were covered by private insurance based on employment, fully 95 percent were in plans that incorporated some form of managed care.[1] These diverse forms include several kinds of health maintenance organizations (HMOs), numerous forms of utilization review (UR), and various arrangements--sometimes optional for consumers--that are based on specified networks of providers. There is evidence that some forms reduce costs, but there is no such evidence for others.[2]

Advocates of managed care hope that channelling a greater share of health care services through the more effective forms of managed care might significantly reduce expenditures on health care. Advocates note that various forms of managed care have been incorporated into both indemnity and prepaid insurance arrangements and that they are compatible with a predominantly private health care system. Further, strong evidence exists that some reduce the costs of care.

People who counsel against expecting too much from managed care observe that its existing forms vary widely in their apparent effectiveness at reducing costs. Moreover, to be effective, policies to expand managed care would need to include enough constraints or incentives to induce consumers and providers who would not otherwise have done so both to participate and to change their behavior in ways that reduce costs. In addition, expanding managed care would not, on its own, address other concerns--such as access to health care services--that are a focus of more radical proposals for change.

This memorandum is an illustrative exercise designed to provide a sense of the order of magnitude of the reductions in national health expenditures (NHEs) that might result from universal adoption of two specific forms of managed care. One is staff- and group-model HMOs--the forms of managed care for which demonstrated cost savings are greatest. The other is "effective" forms of UR, which the Congressional Budget Office (CBO) interprets to mean utilization review that incorporates precertification and concurrent review of

---

1. See Elizabeth W. Hoy, Richard E. Curtis, and Thomas Rice, "Change and Growth in Managed Care," *Health Affairs*, vol. 10, no. 4 (Winter 1991), pp. 18-36.

2. See Congressional Budget Office, "The Effects of Managed Care on Use and Costs of Health Services," CBO Staff Memorandum (June 1992). The memorandum reviews available evidence about the effectiveness of managed care and contains a glossary.

inpatient care. CBO does not present similar estimates for HMOs modelled on independent practice associations (IPAs) because there is no reliable evidence about their effects.

The illustrative analysis in this memorandum suggests that, if all health care services for people who are insured were delivered through staff- or group-model HMOs, NHEs might be lower by almost 10 percent. Alternatively, if all such health care services were instead delivered through arrangements that embodied relatively effective forms of UR, the resulting reduction in NHEs might be no more than about 1 percent.

For several reasons, these illustrative estimates should be interpreted with considerable caution. The results presented are CBO's best estimates of the potential that staff- and group-model HMOs, and effective forms of UR, have to reduce NHEs; they should not be generalized to other forms of managed care for which there is no evidence. By necessity, the analysis incorporates a large number of assumptions, but the data or evidence supporting many of them have significant limitations.

Another important qualification is that managed care might have quite different effects if it were applied to all consumers, providers, and services--rather than just to part of the health care system. One possibility is that the effects of universal managed care arrangements could be larger than those reported here. As Alain Enthoven has noted, if the change to universal managed care were part of a comprehensive restructuring of the health care system that included incentives to choose efficient arrangements, the managed care component of the package might have a larger impact than if it were adopted on its own.[3] That is because, under the present structure of competition among insurers, managed care arrangements may not be delivering all of the cost savings that they could potentially yield.

Currently, managed care organizations compete with traditional insurers for enrollments. Enrollments in these managed care organizations would have declined under this system if effective managed care had resulted in consumers perceiving either that they received fewer services that they wanted--whether beneficial or not--or that they waited longer for services because of prior authorization requirements. Declining enrollments among consumers insured through their work place would have been especially likely where employees who opted for unmanaged, traditional insurance plans were not required to pay

---

3. Alain Enthoven, "Multiple Choice Health Insurance: The Lessons and Challenge to Employers," *Inquiry*, vol. 27, no. 4 (Winter 1990), pp. 368-375; and Alain Enthoven and Richard Kronick, "Universal Health Insurance Through Incentives Reform," *Journal of the American Medical Association*, vol. 265, no. 19 (May 15, 1991), pp. 2532-2536.

the excess of these plans' higher premiums over those of less costly plans incorporating effective managed care. Because of the nature of competition in this market, HMOs could have been less aggressive in attempting to limit unnecessary care than they would have been in a market where consumers faced strong financial incentives to choose more efficient insurance arrangements. HMOs may also have used savings they achieved by managing care to broaden the range of services that their plans cover.

It is at least as likely, however, that mandating universal adoption of managed care might have smaller effects than estimates based on past experience would suggest. That could result because, if all consumers and providers were required to adopt managed care arrangements, the new participants' levels of commitment to the processes and values implicit in managed care approaches might be less than those of the current participants, who have voluntarily chosen these arrangements. Furthermore, extending managed care arrangements could increase administrative costs, offsetting some of the savings in the costs of health care services. (Because of data limitations, any increases in administrative costs are not included in the analysis.)

An additional reason for caution when interpreting the estimates presented here is that they relate to the level of--rather than the rate of increase in--health care costs. The limited available evidence suggests that managed care does not affect the underlying rate of growth in those costs; we assume that mandating managed care would not affect the rate.[4] It might slow that growth, however, if it were introduced as part of a comprehensive restructuring of the health care system that incorporated strong incentives to choose efficient arrangements. In such a setting, universal managed care could facilitate greater control over the adoption of new technology--for example, if it led to better ways to identify new technologies and to develop guidelines for their use. However, under the present system, with its recent high rates of costs increase, even a reduction of about 10 percent in NHEs would be offset by approximately one year's increase in health care spending. Thus, universal adoption of some forms of managed care could yield substantial one-time savings; but in the absence of substantial restructuring of the health care system, that would not address the longer-term issue of the underlying rate of growth in health care costs.

Against this background of rapidly rising costs and of diverse forms of managed care that vary widely in their apparent effectiveness, the memorandum outlines the assumptions that underlie the analysis and presents

---

4. See, for example, Joseph Newhouse and others, "Are Fee-for-Service Costs Increasing Faster than HMOs' Costs?" *Medical Care*, vol. 23 (August 1985), pp. 960-966.

the estimates obtained. An appendix describes the data and provides additional technical information.

BACKGROUND

Managed care represents one approach to reining in health care costs that continue to climb rapidly in both the federal budget and the nation as a whole. Real spending per person for health care grew at an average rate of about 4 ½ percent a year between 1980 and 1990, substantially outstripping the 1 ½ percent annual growth in real gross domestic product per person over the same period.

Partly because of that rapid growth, the share of federal spending devoted to health care grew from 10.5 percent in 1980 to 13.4 percent in 1990. CBO has projected that, under current policies, spending on health care would climb to nearly 22 percent of the federal budget by 1997 and to 28 percent by 2002.

Forms of Managed Care

Managed care is one of numerous strategies that have been advocated to contain rising costs, although its supporters also see it as a way to assure the appropriateness--and thus the quality--of care. Managed care comprises any type of intervention in the delivery and financing of health care that is intended to eliminate unnecessary and inappropriate care and thereby to reduce costs. The best known form of managed care involves HMOs, which combine insurance coverage with defined delivery systems and which ordinarily pay benefits only when the insured population uses the organization's delivery system. Another common form of managed care is utilization review. Various other forms that have been developed--for example, preferred provider organizations and hybrid plans that offer managed care choices to patients at the "point of service"--are not discussed in this section.

Health Maintenance Organizations. HMOs can be structured in various ways. A staff-model HMO owns the clinical facilities that the insured population must use and employs salaried physicians to serve the HMO's members exclusively. Staff-model HMOs, along with group-model HMOs, have integrated their systems for financing and delivering care. In this way, they differ from the majority of today's managed care organizations.

CBO TESTIMONY

Statement of
Robert D. Reischauer
Director
Congressional Budget Office

before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

February 2, 1993

NOTICE

This statement is not available for public release until it is delivered at 10:30 a.m. (EST), Tuesday, February 2, 1993.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee. My testimony today will cover the Congressional Budget Office's (CBO's) methods for examining the effects that cost containment provisions in health legislation would have on national health expenditures. These methods will be illustrated using two bills that were introduced in the last Congress.

THE EFFECTS OF COST CONTROL PROVISIONS ON HEALTH EXPENDITURES

Over the past two decades, both public and private payers have made concerted efforts to apply many cost control strategies to the current health care system. As a result, there is evidence of how at least some types of cost containment approaches affect health care spending.

To give you an understanding of CBO's estimating methods, let me describe several options for controlling health care costs and the issues that these options raise for cost estimating. Where possible, I will also indicate the magnitude of the potential reduction in national health expenditures that might be estimated for each proposal.

Increased Cost Sharing for Health Services

Strategies that would raise the out-of-pocket costs of health care for consumers are predicated on the assumption that consumers would become more cost-conscious if they paid more. In other words, they would be more likely to consider whether the value of an additional visit to the doctor was worth the extra cost or they would seek out providers who were more economical or charged less. In considering this strategy, however, it is worth noting that average cost sharing in this country is continuing to decline. Consumers paid 27 percent out-of-pocket for their health care in 1980, but only 22 percent in 1991.

Cost sharing for health services could be increased in a number of ways. One could mandate minimum cost-sharing requirements for private insurance, eliminate dual insurance coverage that offsets cost-sharing requirements of individual policies, or prohibit the use of flexible benefit accounts to pay deductible amounts and coinsurance requirements.

As an example, if mandated cost sharing had been set at a level that increased out-of-pocket costs for the population with private fee-for-service health insurance by 40 percent in 1990, then national health expenditures would have been about 1 percent to 3 percent lower. This effect would be

relatively small because consumers are not particularly sensitive to changes in their out-of-pocket costs. The reason is, in part, that they lack knowledge about alternative treatments, their costs, and their efficacy and, therefore, they delegate decisionmaking to physicians and other providers.

Expanded Controls on the Use of Services

Managed care can reduce inappropriate or unnecessary health care. Overall, however, the evidence of its effectiveness in reducing costs--other than through fully integrated health maintenance organizations (HMOs) with their own delivery systems--suggests that substantial savings could not be achieved by extending it to more people. Some reduction could occur, however, if expanded controls on the use of services were concentrated on populations with above-average hospital use.

One legislative approach might be to provide federal financial incentives to expand enrollment in HMOs. Incentives, however, would not necessarily elicit the desired increase in voluntary enrollment in HMOs unless the incentives were very large. Further, because only some types of HMOs are effective at reducing use and expenditures, only a portion of any new enrollees would actually use fewer services. Finally, the federal costs of the financial

incentives to expand enrollment in HMOs could be as high or higher than the savings.

Another legislative approach would be to require that all consumers receive care through managed care organizations. For example, if everyone were required to enroll in a staff or group model HMO--the only type of managed care that has to date been demonstrated to achieve substantial savings--CBO estimates that national health expenditures could decline by as much as 10 percent. This is not an insignificant amount of savings; in 1991, national health expenditures were $752 billion, and a 10 percent drop would be $75 billion. Since there is no evidence, however, that even effective HMOs have been successful at reducing the rate of growth of health spending, and health care has been increasing recently at a 10 percent to 12 percent annual rate, we would still face the problem of higher health care costs in every subsequent year after these savings occurred.

Price Controls

Price controls could be effective in reducing both the level and the rate of growth of spending, but their impact would be partially offset because providers would increase the volume of services (or change billing practices)

to recover lost revenues. In addition, price controls applied to only one segment of the market would generally result in higher spending in other segments of the market.

For example, if the prices of physician services under the Medicare program were reduced 10 percent, CBO estimates that Medicare's spending for these services would drop 5 percent. This estimate reflects our assumption that physicians would offset about half of their potential revenue loss through increased Medicare volume. If providers attempted to keep their overall revenues constant, spending on physician services by the non-Medicare population could also rise. As a result, although Medicare's spending for physician services would decline 5 percent, that reduction might not significantly affect the level of national health spending.

Stringent price controls may also affect access to care in some segments of the market. Access to care by Medicaid beneficiaries, for instance, has been adversely affected by the much lower prices that providers are offered in some states for serving this population.

Alternatively, government regulation could set maximum prices for physician services that all payers would have to follow. In other words, insurers would not be allowed to pay more, and physicians would not be allowed to bill

patients for amounts above the regulated prices. Under such an all-payer system, providers could increase volume to offset some, but probably not all, of their lost revenue. Administrative costs would decline somewhat, since providers would not have to maintain and monitor many separate price schedules and claim forms. In addition, the authority that determined prices would also control their rate of increase. If the legislation included rules that would limit the growth in prices to less than the projected rate, then price controls in an all-payer system could generate lower national health expenditures than would otherwise occur.

Price controls carried out through a single-payer system could also reduce reimbursements and sharply cut administrative costs for insurers and providers. In fact, the one-time drop in the cost of administration could have been around $30 billion to $35 billion in 1991, under the conservative assumption that only the administrative costs related to billing and processing of claims would be reduced, if a single-payer system had been fully in place that year. National health expenditures would, however, have fallen by this full amount only if prices paid to providers had been reduced to reflect the lower administrative costs that they would have incurred.

In both an all-payer and a single-payer system, legislation that included provisions for uniform monitoring of providers' patterns of care would have an

even greater impact than price controls alone. Such monitoring could reduce the magnitude of the response in volume and would allow the rate-setting process to take any volume increase into account in determining the next year's reimbursement rates.

Limits on the Tax Exclusion for Employer-Paid Health Insurance Premiums

In 1993, federal income and payroll tax revenues will be about $70 billion lower because health insurance received through employment and health care costs paid through flexible benefit accounts are not treated as taxable income. Limiting the tax exclusion for employer-paid health insurance coverage could reduce health spending by inducing employers and employees to change the provisions of their insurance policies. If the new policies incorporated higher cost sharing by consumers, for example, the number of services used would fall. Alternatively, consumers might join effective HMOs, with the same result.

One way to limit the exclusion would be to treat some tax-exempt employee health benefits as taxable income. In 1990, for example, employer contributions averaged about $110 a month for individual coverage and $270 for family coverage. If the tax exclusion had been capped at those levels, the implicit federal subsidy for health insurance would have been reduced by about

$10 billion in that calendar year. National health expenditures would also fall in response to the lower subsidy, but by less than the reduction in the subsidy.

If such limits were enacted, workers who currently have coverage above the limits would have two choices. They could continue their current coverage and pay federal income and payroll taxes on the excess coverage. Alternatively, they could negotiate with their employers to cut back some, or all, of the coverage above the limit in exchange for higher wages, thereby also raising their taxable incomes. (Most employers would probably be indifferent between continuing current health benefits or substituting higher wages for them because both are tax-deductible business expenses.)

Lower amounts of coverage could be accomplished in several ways that would also help to control health care costs. First, traditional insurance could be replaced with effective HMOs. Second, higher copayments could be used to lower the cost of coverage. Third, coverage for some benefits (for example, chiropractic and dental care) might be dropped or scaled back. Finally, insurers could reduce the level of their reimbursement to providers, although this possibility would either limit the insured consumers' choice of providers or increase their out-of-pocket costs.

Limits on Expenditures

Legislation that provided for prospective budgets for hospitals, expenditure targets for physicians, or caps on overall national health spending would involve major changes in the existing U.S. health care system, but it could substantially reduce the rate of increase in health spending. The legislation would, however, have to include specific details of the mechanisms for setting, monitoring, and enforcing the limits.

For example, suppose legislation was passed that established prospective budgets for hospitals, with specific formulas for setting and updating them. Assume also that there was no leeway to increase the budget for a hospital when overruns occurred. In such a case, the impact on national health spending would be the difference between total spending for hospital services under the budgets and projected spending without the legislation. Similarly, if legislation set caps on expenditures for various segments of the health care sector, specified the formulas to determine the annual rate of increase in the caps, provided for monitoring performance under the caps in a timely way, and put in place enforcement mechanisms that would either make it impossible to exceed the cap or would make it possible to fully recover excess spending after it occurred, then one could estimate the savings by comparing the caps with projected spending in their absence.

Based on our assessment of the evidence on the effectiveness of limits on expenditures as they have been applied in the United States and in other countries, CBO believes the likelihood of success increases with a single payment mechanism or clearinghouse, restrictions on the ability to purchase health care outside the regulated system, and global budgeting for hospitals and other institutions. In addition, a continuously adjusting payback mechanism for physicians, as has been used in Germany and in some Canadian provinces, and budgeting or rate setting that applies to all providers and services would be effective in enforcing the limits. A good data system with uniform reporting by all providers to allow quick feedback would also be an important component of an effective strategy for limiting expenditures.

CBO's approach to estimating the potential impact of limits on expenditures in legislative proposals is to examine the proposal with respect to both the stringency of the limits and the specified enforcement mechanisms. Based on our best judgment, we then assign a rating for effectiveness, with a fully effective limit receiving a 100 percent rating and a completely ineffective proposal receiving a rating of zero. The estimated savings for any expenditure limit would equal the difference between the projected costs without the limit and the expenditure limit, multiplied by the effectiveness rating.

To illustrate the effect on national health spending of a fully effective cap, assume that legislation had been put in place beginning in 1986 that included a cap constraining the increase in national health expenditures to the rate of population growth (1 percent a year) plus 2 percentage points above the rate of general inflation. If such a cap were fully enforced, we estimate that national health expenditures would have been only $651 billion in 1991, or about 13 percent lower than the approximately $752 billion that was actually spent that year.

If, however, limits on expenditures were applied selectively to some groups and not others, then providers could increase prices and the volume of services for other groups in order to maintain revenues, without incurring penalties for exceeding the limits for the covered population. Although the market segment subject to the limits would realize savings, national health expenditures might not fall much.

Managed Competition

Managed competition is the central feature of proposals to restructure the health care market in ways that would create incentives for consumers to be more cost-conscious in their insurance and health care decisions. Increased

cost-consciousness by consumers would give insurers and providers, in turn, the incentives to become more cost-conscious and efficient.

Many different proposals have been put forth under the "managed competition" umbrella. Some proposals of this kind could reduce health care costs, and others would have little effect. CBO is currently preparing a paper on managed competition. It will identify features that would help maximize the savings in national health expenditures under that approach. These elements include:

- The creation of regional organizations (for example, health insurance purchasing cooperatives, or HIPCs) that would oversee and operate the restructured insurance market and help consumers make better-informed choices;

- Limitations on the tax-exempt amount of employee health benefits and a requirement that employers contribute no more than a fixed dollar amount toward their employees' health benefits;

- Standardized benefits and copayment rules, with a prohibition on supplemental insurance that would cover out-of-pocket costs under the standard package;

- The availability of uniform, reliable data on costs, outcomes, and quality;

- Universal insurance coverage;

- The requirement that all insurers offer open enrollment periods and base premiums on community rating;

- An accurate method to adjust for differences among insurers in the health status of their enrollees; and

- A significant reduction in the number of insurers and the creation of insuring organizations that would offer substantially nonoverlapping networks of affiliated providers.

In combination, these changes to the current system could result over time in a reduction in the rate of increase in national health spending. Omitting some of these elements from a proposal for managed competition would significantly

lessen its potential effectiveness. Even if all these elements were included, however, it would be extremely difficult for CBO to estimate the magnitude and the timing of the effects on national health spending, because of the complexities of analyzing a dramatic restructuring of the markets for health insurance and health services.

Two aspects of these proposals do provide some indication of the direction CBO's cost estimates will take. First, we have consistently taken the position that savings could be achieved by moving people from fee-for-service medicine into group or staff model HMOs. Thus, estimated savings would depend on the extent that a particular proposal would shift people into these types of managed care organizations. In addition, most proposals for managed competition would limit in some manner the tax-exempt amount of employee health benefits. Federal revenues would be increased to the extent that the limits are tightened. If employees then chose insurance with more limited benefits and higher cost sharing because there was less subsidy to health insurance, there could also be a further impact on national health expenditures.

Assessing the full effect of restructuring the entire health insurance market, however, is much more difficult. Little information from either the United States or abroad is available on the time that it would take for all the changes to occur or on the magnitude of the impacts of these changes once

they were fully implemented and all behavioral responses had occurred. We are convinced, however, that even if a managed competition approach with all the critical elements described above were carried out, its effects would occur over an extended period of time. Significant savings in national health expenditures would probably not occur within the usual five-year time horizon of CBO cost estimates.

A PRELIMINARY ASSESSMENT OF THE COSTS OF TWO LEGISLATIVE PROPOSALS

Estimating the potential costs or savings of health reform proposals is one of the most difficult tasks CBO has attempted. First, health expenditures are currently about 14 percent of gross domestic product and are projected to rise to at least 18 percent by the year 2000. The effects of changes in this large a system must be uncertain. It is often difficult even to forecast spending in current federal health care programs, as CBO has found in recent years when Medicaid spending increased by 19 percent in 1990, 28 percent in 1991, and 29 percent in 1992, far exceeding projections. Moreover, many of the health reform proposals under consideration include provisions for which there is no actual experience and no solid evidence to be used as the basis for our estimates.

The task of estimating costs becomes even more complex since five years--the usual time frame for cost estimates--is not a long enough period for forecasting the impact of some health reform proposals. Some of them might require longer than five years to be fully carried out, and cost estimates that stop at five years would not provide the information that is needed to assess all their effects.

In addition, CBO is being asked not just to estimate the impact of these proposals on the federal government's budget, but also to examine their effect on national health expenditures and on the number of people with health insurance. National health reform involves important interactions between the private sector and the federal budget, but analyzing these interactions and their impacts is extremely difficult. As a result, estimating the costs and savings associated with health reform proposals requires more thought, more coordination and consultation with other federal offices such as the Joint Committee on Taxation, and more time than most cost estimates.

To illustrate the estimating issues and principles, CBO is providing a preliminary assessment of two health reform bills introduced in the 102nd Congress: H.R. 5936, the Managed Competition Act of 1992, and H.R. 5502, the Health Care Cost Containment Act of 1992. Although they are not current bills, the proposals represent different approaches to health reform and

illustrate the complexity of making cost estimates in this area. CBO has not yet completed year-by-year estimates for the two bills, but it is possible to give you an outline of their probable effects on national health expenditures.

Our analysis reflects H.R. 5936 as introduced and H.R. 5502 as reported by this subcommittee. For both bills, we have delayed the implementation dates by one year to reflect possible enactment in late 1993. The Congressional Budget Office and the Joint Tax Committee have worked together in examining the effects of changes in the tax law.

The Managed Competition Act of 1992

H.R. 5936 would attempt to control costs and expand access to health insurance by restructuring the way health insurance is provided. The bill would establish a National Health Board to define a standard health plan; to establish standards for reporting prices, health outcomes, and measures of consumer satisfaction; and to provide information to consumers on the quality of care. Plans that met board standards would be defined as Accountable Health Plans (AHPs).

Changes in the tax code would encourage the use of AHPs, because employers paying more than the cost of the lowest priced AHP in the area would be required to pay a 34 percent excise tax on the costs above this amount. The self-employed would be allowed to deduct 100 percent of the costs of the lowest priced AHP. In each state, Health Plan Purchasing Cooperatives (HPPCs) would be established, and all individuals except those working for businesses with more than 1,000 employees (up to 10,000 employees at each state's option) would be required to purchase their health insurance through the HPPC to receive the favorable tax treatment. Individual contributions for health insurance could be deducted for tax purposes only up to the cost of the lowest priced AHP.

Finally, H.R. 5936 would replace the Medicaid program with a new federal program that would help purchase health insurance coverage through HPPCs for low-income individuals. Individuals and families with incomes below the poverty level would be eligible to join AHPs with no premium and only nominal copayments. Individuals and families with incomes between 100 percent and 200 percent of poverty would be responsible for paying a portion of premiums, based on a sliding scale.

CBO's preliminary assessment is that, after a few years, H.R. 5936 would leave national health expenditures at approximately the same level they

would reach otherwise. Initially, however, national health expenditures would increase. This result stems in large measure from the assumption that the National Health Board would select a comprehensive set of benefits for its AHP. Because these benefits would be available to a larger group than is currently covered by health insurance, national health expenditures would be higher in the first few years.

The growth in per capita health expenditures would gradually slow, however. Because group model or staff model HMOs can provide health care more efficiently than other organizational forms, they would probably be the lowest priced bidders in many HPPC areas. Based on past performance, we expect their prices would be 10 percent to 15 percent below the price of similar fee-for-service plans, and the cost of enrolling in these HMOs would be fully tax-deductible. Thus, enrollment in them would probably rise more rapidly under managed competition than under current law, thereby slowing the growth in national health expenditures. After a number of years, these savings could offset the increased health care costs resulting from extending access to those who currently lack health insurance.

The Health Care Cost Containment Act of 1992

H.R. 5502, the Health Care Cost Containment Act of 1992, would attempt to control health costs by establishing limits on national health expenditures. Separate limits would be applied to Medicare spending and to national health expenditures. Limits would be enforced through rate setting, although states with approved programs and federally qualified HMOs would be exempt from the maximum rates. Access would be extended by expanding Medicaid coverage for pregnant women and children with family incomes below 200 percent of poverty and for all nonaged individuals with incomes below 100 percent of poverty. Medicaid payment rates would also be increased, and a new federal health insurance program for children would be started. Finally, Medicare would expand its coverage of certain prevention benefits and add a new prescription drug benefit.

CBO estimates that H.R. 5502 would reduce national health expenditures about 5 percent by the year 2000. Our preliminary assessment is that the Medicare expenditure limits would be 75 percent effective. We have a great deal of experience with rate setting and potential volume offsets in the Medicare program, which indicates that expenditure limits could be reasonably effective in controlling Medicare spending. At the same time, we are much less sanguine about the effectiveness of limits on other health spending. States

would be permitted to operate their own systems as long as the growth in health care spending did not exceed what it would have been under the maximum rates. This calculation would be very difficult to make, and specific data on states would not exist in usable form for several years. Finally, the bill exempts federally qualified HMOs from rate setting. Federally qualified HMOs are more broadly defined than group or staff model HMOs and include organizational forms that have not been shown to be cost-effective. Because of these and other potential sources of leakage, we have assumed that the limits on expenditures for non-Medicare spending would be only 25 percent effective. It is our understanding that H.R. 200, the Health Care Containment Act of 1993, would limit the HMO exemption to group or staff model HMOs. While we have not completed an assessment of H.R. 200, we expect that its expenditure limits will be more effective than those in H.R. 5502.

The savings from the limits on Medicare and national health expenditures would be partially offset by provisions in H.R. 5502 that would expand insurance benefits and extend the population covered by health insurance. Overall, however, we estimate that H.R. 5502 would result in national health expenditures falling about 5 percent below the level they would otherwise reach by the turn of the century.

CONCLUSION

In the past, most health care legislation changed payment methods or levels in relatively small, discrete ways or expanded eligibility for existing programs. Thus, CBO has considerable experience estimating the impact on costs of such changes to Medicare and Medicaid. In general, reasonably good data and research studies permit us to develop well-founded estimates.

The task we are facing today, however, is a much more difficult one. Reform of the health care system is likely to involve massive changes in current health care financing and delivery systems and perhaps comprehensive restructuring of the markets for health insurance and health services. Estimates of the effects of such sweeping changes on overall health care spending, as well as on individual components such as federal health spending, will be much less precise than estimates of changes in Medicare and Medicaid. For one thing, past experience does not encompass changes of this magnitude. Although there is some evidence from other countries, these findings must be used cautiously, because the substantial differences in cultures, politics, and economic systems mean that the responses of citizens, providers, and insurers in other nations may have only limited relevance to the United States.

In addition, it is likely that any health reform policy would require a number of years of development and would be phased in over a period of time. Moreover, it might take a few more years before it would be possible to discern the behavioral responses of all the participants in the health care and health insurance markets who would be affected. At the same time, of course, many other things will be changing, including overall economic conditions, the introduction of new technologies for diagnosis and treatment of illness, and--as our experience with AIDS and the recurrence of tuberculosis in recent years has shown--even the health status of the population. Thus, considerable uncertainty surrounds any estimates of the longer-term effects of health reform proposals on national health expenditures and on the federal budget. Nonetheless, estimates of the effects of different health reform approaches will provide useful comparative information on the relative costliness of, or the potential savings to be gained from, alternative proposals.

TAX CAP

Managed competition "purists" argue that in order to make consumers fully price sensitive, we must cap the amount of employer-paid health insurance that can be excluded from income tax purposes. They would argue that the exclusion is inequitable and promotes health care cost inflation by lowering the real cost of insurance.

Alain Entoven supports the tax cap. Other managed care proponents, however, are less emphatic about the tax cap than they are with the structure of managed competition. Paul Starr, for example, when asked whether he thought that the tax cap was critical to the success of managed competition had this reply, "Entoen places hnearly his whole emphasis on individual costs and quality consciousness. I think those are very important, but I place an equal emphasis on the countervailing power of the purchasing cooperative, its ability to bargain and negotiate on behalf of large blocks of subscribers. And the tax issue would in no way affect that element of countervailing power. I see a lot to be gained from this with or without the cap."

Arguments against the tax cap:

1. Raising taxes on millions of middle-class Americans is not a preferable way to solve the cost problem.

2. The only reason the exclusion is inequitalbe is because people who have no health insurance do not benefit. This will not be true if comprehensive health care reform is passed. For people who have health insurance today, lower-income workers actually benefit more than upper-income people.

3. There is no evidence that imposition of the cap will reduce health care costs. The theory behind the cap as a cost-control device is that raising the cost of health insurance to individuals will give them the incentive to buy more cost-effective health insurance policies. But it is hark to see why more incentives are needed when health care costs have more than tripled since 1980, from $250 billion to $840 billion. And, in most cases, it it businesses who decide what insurance policy to offer to workers, anyway.

4. A tax cap would be unfair to the old, the sick, women, those who live in high-cost areas, and those who work in risky industries. All those factors raise health care costs and would result in higher taxes for these groups than someone else buying an absolutely identical policy. Anyone hwo thinks the current policy is unfair should take a close look at the alternative.

Beaver County Times
December 27, 1992

A BETTER WAY

Another option on health-care reform

THE ISSUE: *Major business groups are pushing for the taxation of health benefits.*

WE SUGGEST: *This proposal could lead to a breakthrough in health-care reform.*

Although much of the attention on health-care reform has been concentrated on Washington, corporate America could very well be the driving force in this area.

The Wall Street Journal reports that an influential committee of the Business Roundtable is pushing for the taxation of some health benefits. When the Roundtable speaks, people listen. Its membership includes executives of some of the largest corporations in the United States.

The Roundtable isn't alone. The insurance industry's reform proposal is similar.

The paper reported the Roundtable committee recommended supporting caps both on the level of benefits excluded from employees' taxable income and on how much of the cost of providing health coverage employers can write off.

Currently, all employee health benefits are exempt from workers' taxable income and companies can deduct the entire cost of the coverage from their taxable income.

But the current system is flawed because neither patients nor doctors have any reason to control costs. "Many economists have complained that such tax breaks reduce the incentive to question health care prices and to shop for better deals," The Journal reported.

Why should people shop around? Under the current system, an anonymous "somebody else" is picking up the tab. It's time we understood that "somebody else" is us.

As Bob Moos, a columnist for the Dallas Morning News, wrote, "the current employer-financed system isolates consumers from the cost of their heath-care decisions. Even if employees pay for part of the premium, there is little reward for economizing. Under these conditions, it is difficult to control heath-care costs.

"Back when doctors were paid out of patients' pockets, there were natural brakes on the amount of medical services provided and the fees charged," Moos wrote. "Physicians knew their decisions could devastate a family's finances. Nowadays, though, insurance has become a blank check."

The savings could be used to pay for covering the 35 million Americans who are uninsured, Moos reports.

Least anyone think this is some wild-eyed liberal scheme to raise taxes, Moos points out the Heritage Foundation, a conservative, Washington-based think tank, was one of the early proponents of curbing the tax exemption for employer-paid health insurance.

Here's how the proposal would work, according to Moos. If a basic package of health-care benefits cost $3,000 per year but an employer has been paying $4,000 for a more generous package, the employee would begin paying income taxes on that additional $1,000. Because *his* money is now involved, the employee will be more inclined to question costs and look for the best deal.

This proposal isn't perfect. It doesn't address the rising costs of Medicare and Medicaid, and it relies too heavily on an over-idealization of the free market.

Still, the proposal is worth pursuing because it keeps government out of the health-care business and empowers employers and employees. These two points alone give it a huge advantage over most of the other proposals (pay-or-play, the Canadian plan) that have been floating around the nation's capital.

The New York Times

NEW YORK, TUESDAY, DECEMBER 22, 1992

A Tax Cap for Health Reform

Tax cap. These two words could mean political dynamite. They could mean successful health care reform. They could mean both, which is why, by endorsing them, President-elect Clinton now sends such a positive message. It suggests he has the policy sense — and the political courage — to push worthwhile reform through Congress.

The tax cap in question applies to health insurance premiums paid by employers. Commonly, this form of compensation is not taxed, no matter how extravagant the coverage. But unless unlimited coverage can be capped, runaway health care costs cannot be controlled.

With a tax cap, premiums in excess of a set amount would be counted as taxable income to workers. And that's what Mr. Clinton endorsed, in an interview with The Wall Street Journal — even though a tax cap would mean some people would have to pay higher taxes.

To see why a tax cap is necessary, consider the two ways to control skyrocketing medical costs. Government could impose price controls on doctors and hospitals — an option Mr. Clinton rightly rejects. Price controls would create an administrative nightmare and rob providers of any incentive to innovate and improve.

A better option is to rely on competition to control costs by impelling consumers to choose plans that keep premiums low. But under current law, consumers have little incentive to choose low-cost plans because premiums are tax-deductible.

The unlimited deduction is doubly wrong. The subsidy favors the rich: It's worth twice as much to a family in the 31 percent tax bracket as to one in the 15 percent bracket. And by offsetting 30 or 40 percent of the extra cost of lavish policies, the subsidy encourages wasteful coverage.

With a tax cap in place, consumers would pocket the saving from choosing cost-effective plans. That's important if managed competition — the reform plan endorsed by the President-elect — is to work.

Under the plan, consumers would join together into large purchasing cooperatives. The cooperatives would negotiate with providers, forcing them to compete for enrollees by offering quality care at attractive prices.

The key to passing a tax cap is to set it high enough so that every American could, tax free, buy a generous package of basic health benefits. People who insist on more lavish coverage would pay the extra cost without subsidy by other taxpayers. In recent weeks the National Governors' Association, business groups and health insurance companies have endorsed a tax cap.

That should make Mr. Clinton's reform task easier. It also helps that a tax cap will generate tens of billions of new revenue. The still-more-important purpose of a tax cap, however, is to unleash the powerful competitive forces that will equip the consumer, and thus society, to make sensible choices about health care.

The Washington Post

THURSDAY, JANUARY 7, 1993 C

Draft CBO Report Backs Tax on Some Employee Health Benefits

By Dana Priest
Washington Post Staff Writer

Taxing some employee health benefits is a "critical element" of health care overhaul without which the new system advocated by President-elect Clinton will be "ineffective," according to a draft Congressional Budget Office report.

The CBO, which is analyzing the "managed competition" model of health reform embraced by Clinton and many political and industry groups, recommended that government tax the amount by which employer-provided health premiums exceed the cost of a "standard" benefit package that would be established as part of the plan.

The goal is to use the tax code to change consumer behavior. Unlike salaries, employer-provided benefits to employees are not subject to tax. Taxing those benefits, many economists say, would force employees to choose less expensive insurance plans and push more people into health maintenance organizations (HMOs), the most cost-effective form of health care.

At present, many of the 140 million Americans whose health premiums are largely paid for by employers have no incentive to choose less expensive insurance plans.

Here's how the tax change might work:

Company X currently pays the full premium for Worker Y's family health insurance—$4,743 a year (the average cost of a family premium). If the cost of the least expensive standard benefit package in the worker's region is $4,020 (the average cost of a family HMO policy), then the worker would be taxed on the difference: $723. If the worker is in the 15-percent tax bracket, the tax would amount to $108.45 a year.

Proponents of managed competition believe the worker would change to a plan that costs $4,020 rather than pay the tax. Health insurers also would realize this and would try to offer plans at or near the tax-exempt amount.

"The most powerful incentive is the tax code," said Bernard Tresnowski, president of the Blue Cross Blue Shield Association, whose 72 plans insure more Americans than any other company. "We've been through five decades of teaching the individual that health care is a free good. If you're going to change that, you're going to have to go where the rubber meets the road. I can't think of anything better than changing the tax code."

The idea of taxing premiums is politically charged. Both Clinton and President Bush avoided the question during the campaign. Since the election, employer coalitions, industry trade groups and a coalition of the nation's governors and local elected officials have backed limiting the tax preference for health benefits.

The CBO's analysis will likely lend credibility to the idea. The final report is expected to be released at the end of the month and will contain the office's estimate of cost savings from managed competition.

Critics believe the model cannot produce sufficient savings to lower the rise in health care spending, which climbed 11.5 percent last year and now accounts for 14 percent of the nation's total economic output. Advocates argue managed competition is the best way to cut costs while preserving quality.

Cost information was not included in the draft obtained by The Washington Post. CBO's deputy assistant director for health, Kathryn Langwell, declined to comment on the draft.

Managed competition aims to make health care available to everyone regardless of health status and to restructure the current system so that the providers of health care services are forced to compete for consumers' business and to be more accountable to patients.

The CBO draft says that for managed competition to work, it must include eight elements that "appear particularly critical to achieving the maximum potential savings." They are: insurance purchasing cooperatives that negotiate with health plans; a standard package of benefits required of all insurers; federal oversight of the cost, quality and efficiency of health service providers; additional compensation for plans that happen to enroll a disportionate number of sick people; limiting the number of health plans for which most doctors could work; and taxation of some health insurance options," the draft says. Such an incentive can only exist if employer-paid premiums over the amount needed to purchase a national standard benefit package are "included in employees' taxable personal incomes."

Taxing benefits is opposed by labor unions, which

EXCERPT FROM GOVERNOR'S PROPOSAL

THE STATE'S ROLE

States are in a position to influence significantly the delivery and financing of health services within their borders. State governments finance health care for many medically indigent families, provide health care benefits to their employees, regulate insurance providers, license health practitioners and facilities, train health care professionals, allocate capital resources and deliver health services.

In Pennsylvania, the state government plays an important role in several areas central to the health care market. The major functions of state government include:

- *PAYING FOR AND DELIVERING HEALTH CARE.* The Medical Assistance Program administered by the Department of Public Welfare pays for health care services for about 1.6 million low-income Pennsylvanians. The Pharmaceutical Assistance Contract for the Elderly (PACE) administered by the Department of Aging assists elderly Pennsylvanians in paying for prescription medications. The Department of Health has several public health functions, including drug and alcohol treatment, state health centers and school health.

- *COLLECTING AND DISSEMINATING HEALTH DATA.* The Health Care Cost Containment Council collects, analyzes and disseminates health care costs and quality information to purchasers, providers and consumers. The State Health Data Center coordinates the collection and dissemination of health statistics in the Commonwealth.

- *REGULATING AND LICENSING THE HEALTH CARE MARKET, FACILITIES AND PRACTITIONERS.* The Department of Insurance has regulatory responsibility over health insurers. The Departments of Insurance and Health regulate Health Maintenance and Preferred Provider Organizations. The Department of Health also regulates the construction of and licenses health care facilities. The Department of State licenses health practitioners.

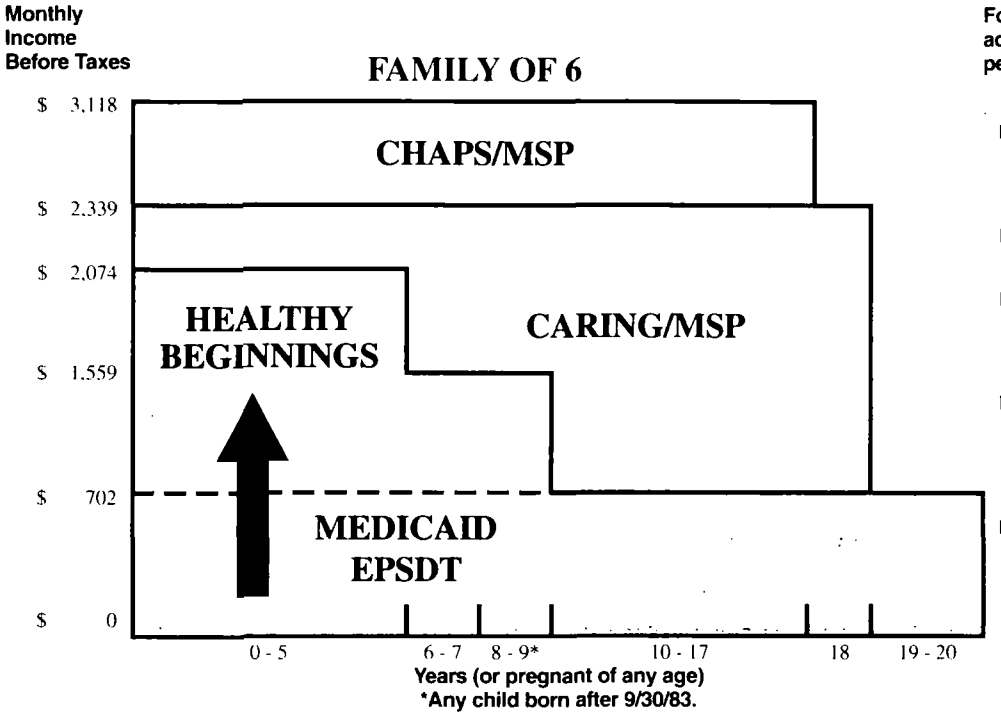
ANN BACHARACH
Executive Director
PA Healthy Mothers / Healthy Babies Coalition
Bryn Mawr, PA

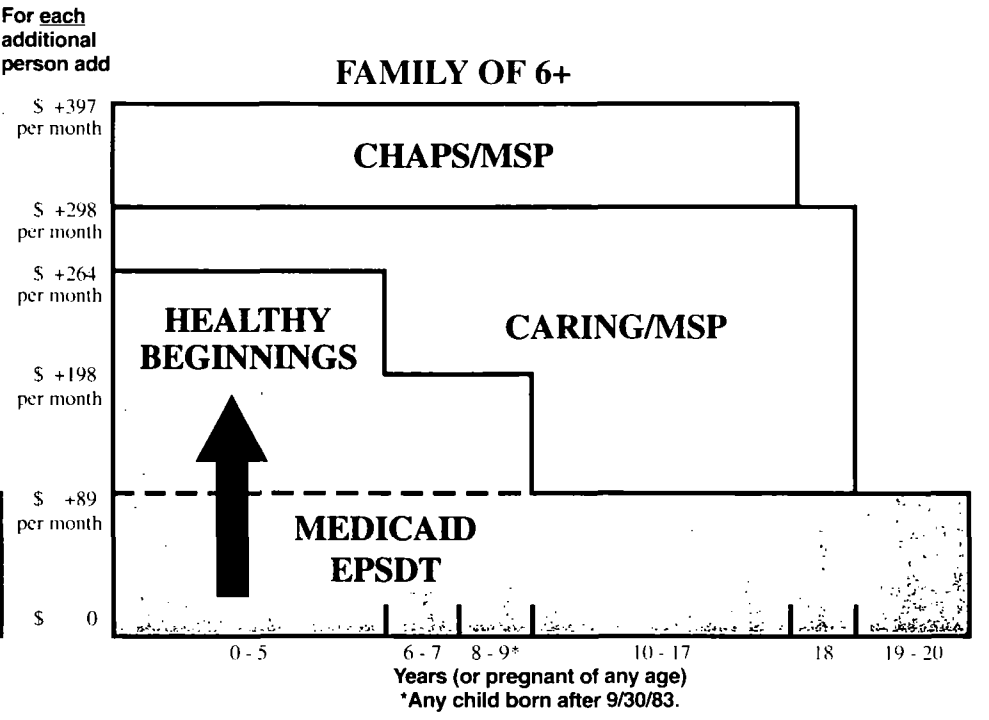
Ann Bacharach is the director of a statewide organization that is very active is trying to ensure adequate coverage for pregnant women and infants.

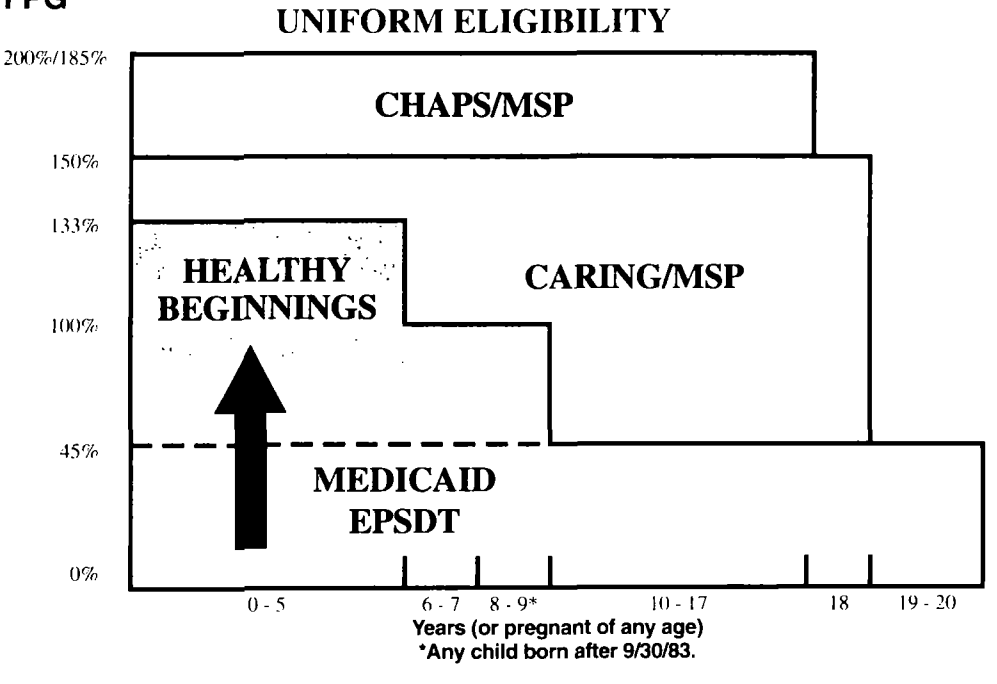
Questions

1. If you were designing a health system around managed care, what specific kinds of consumer protections would you build into the system?

2. Are there any lessons you have learned from your experience in Pennsylvania concerning adequate coverage of benefits under managed care plans that you think would be relevant to national legislation?





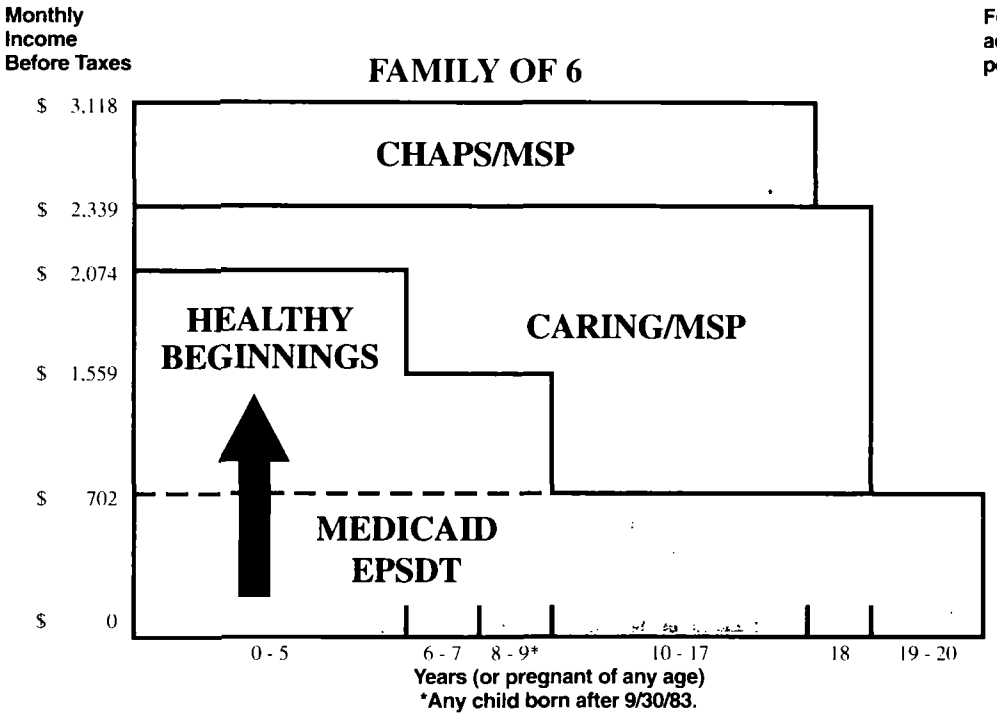


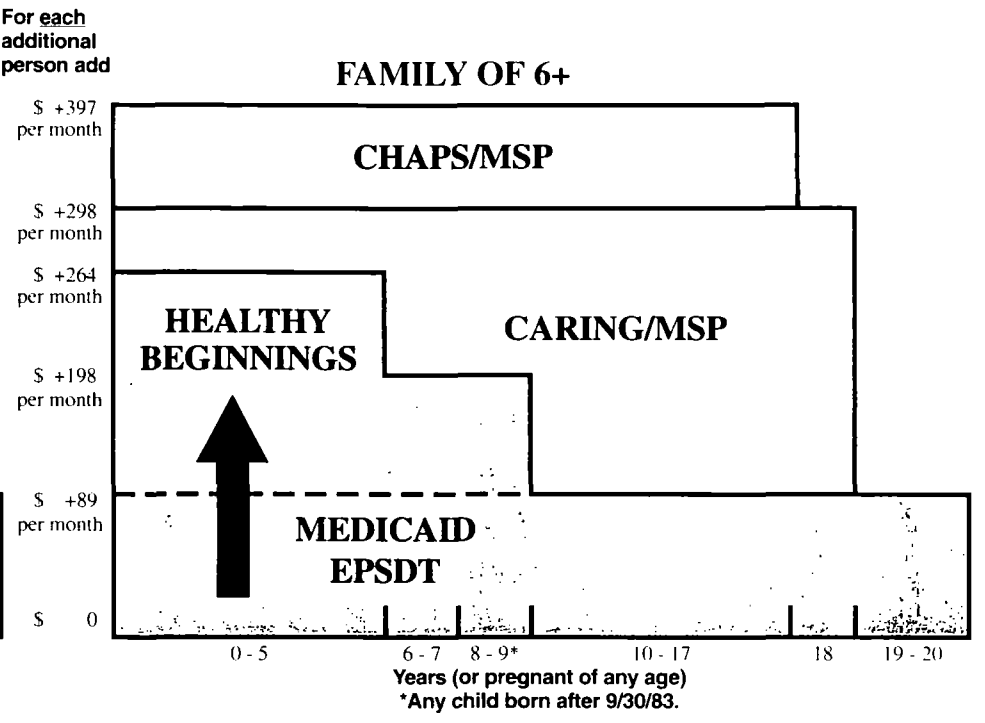
FOR MORE INFORMATION OR TO ENROLL IN A PROGRAM

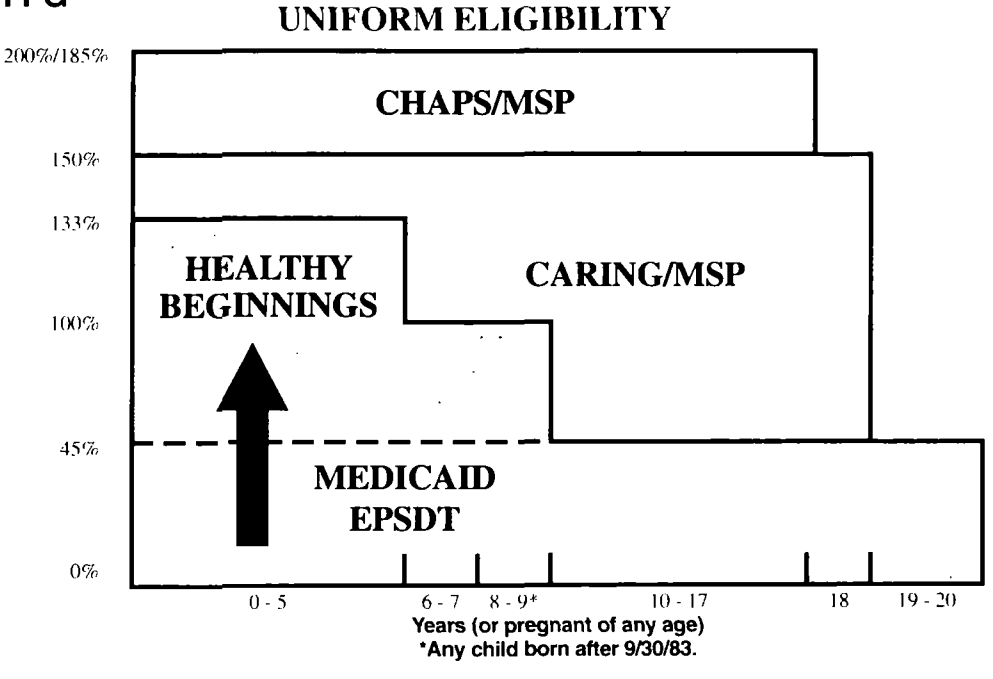
CHILD HEALTH WATCH can help you enroll in the right program:

PCCY (Philadelphia)	563-5848
WNAC (Germantown)	843-9748
NSCA (North Philadelphia)	426-8734
Medical Assistance (DPA, Medicaid)	560-2547
Healthy Beginnings	560-2547
Early Periodic Screening Diagnosis and Treatment (EPSDT)	800/543-7633
The Caring Program for Children (Caring)	800/464-5437
Children's Access to Primary Services (CHAPS)	563-5848
Maternity Services Project (MSP)	985-3300

Family size is parent(s) or guardian(s) plus children.
For example, 1 grandparent with 2 children is a family of 3.





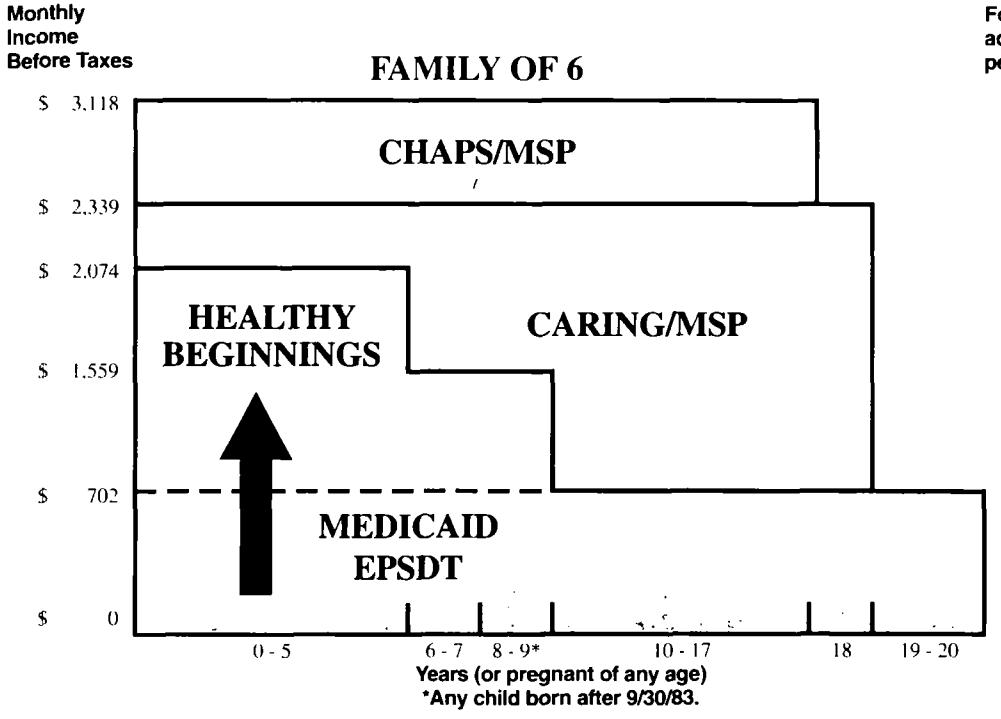


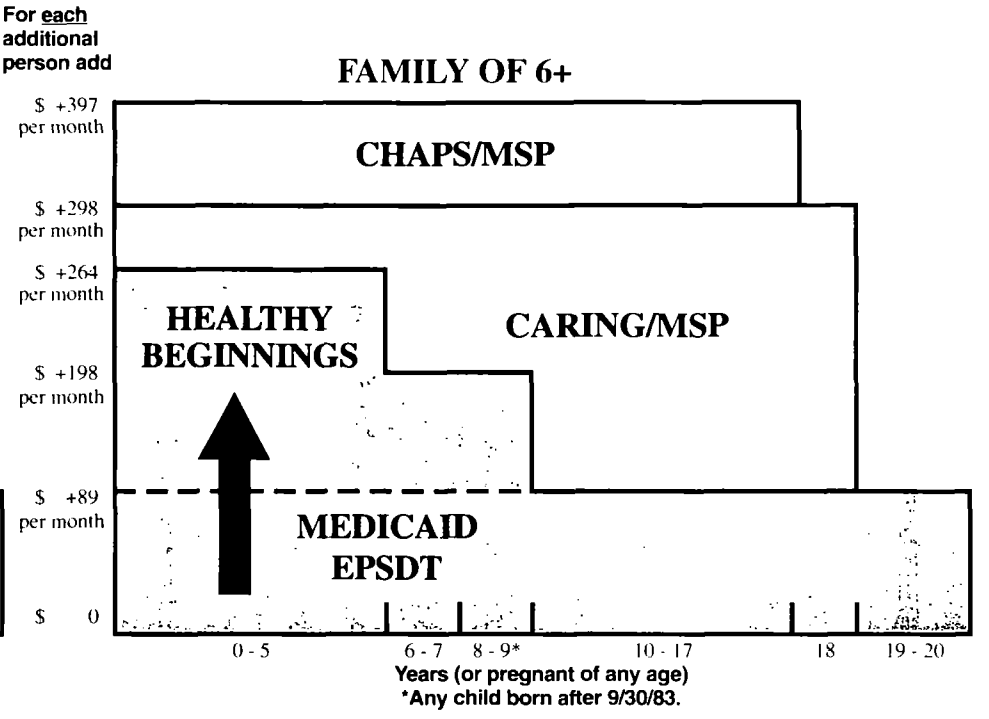
FOR MORE INFORMATION OR TO ENROLL IN A PROGRAM

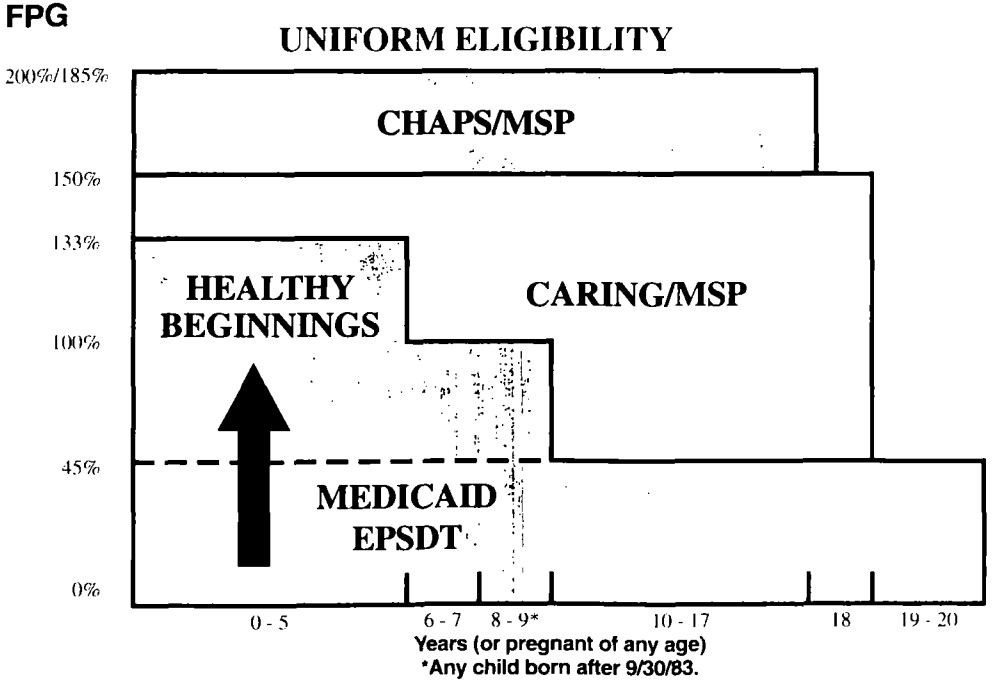
CHILD HEALTH WATCH can help you enroll in the right program:

PCCY (Philadelphia)	563-5848
WNAC (Germantown)	843-9748
NSCA (North Philadelphia)	426-8734
Medical Assistance (DPA, Medicaid)	560-2547
Healthy Beginnings	560-2547
Early Periodic Screening Diagnosis and Treatment (EPSDT)	800/543-7633
The Caring Program for Children (Caring)	800/464-5437
Children's Access to Primary Services (CHAPS)	563-5848
Maternity Services Project (MSP)	985-3300

Family size is parent(s) or guardian(s) plus children.
For example, 1 grandparent with 2 children is a family of 3.





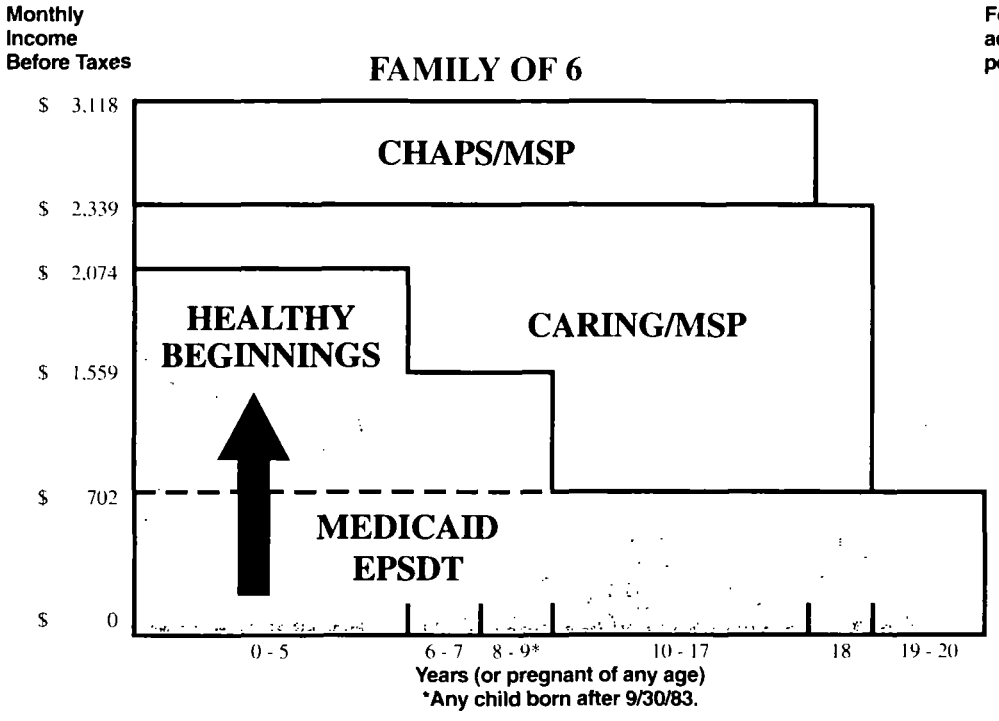


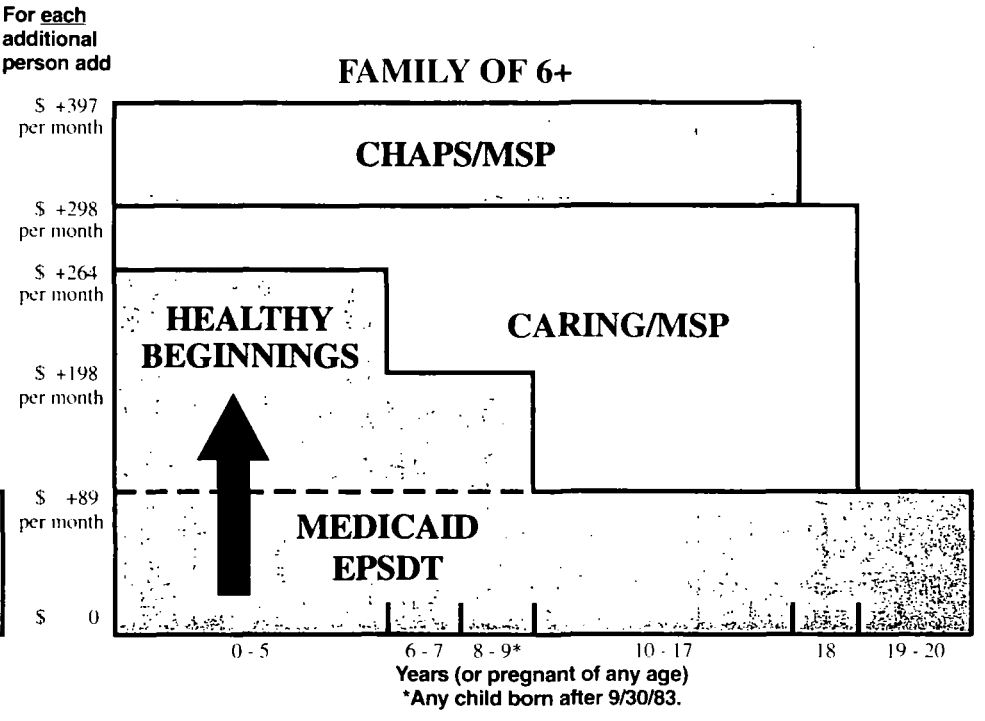
FOR MORE INFORMATION OR TO ENROLL IN A PROGRAM

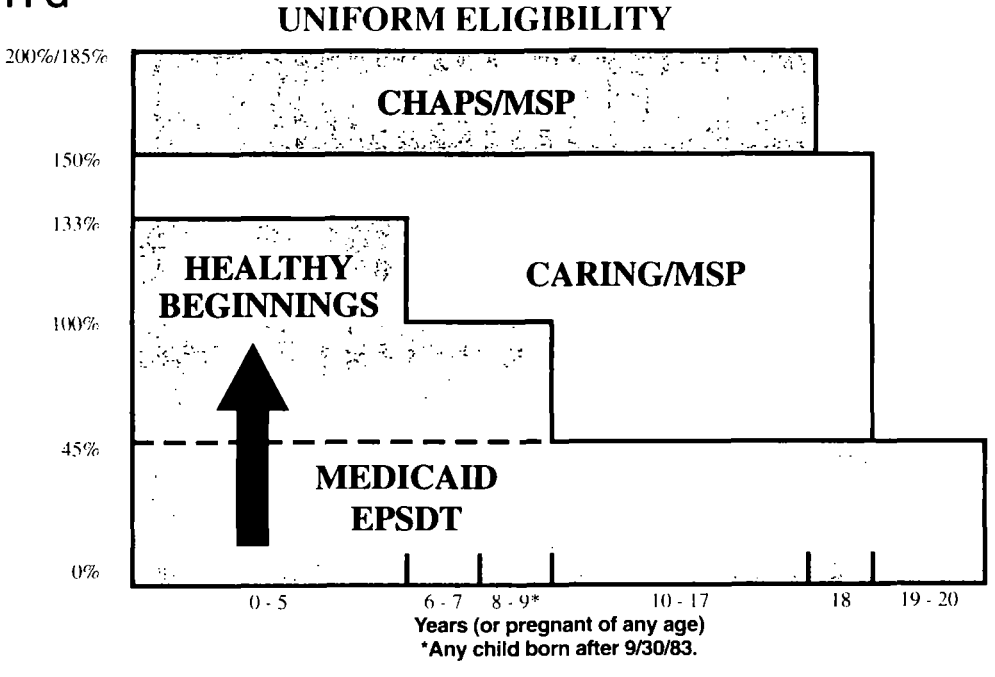
CHILD HEALTH WATCH can help you enroll in the right program:

PCCY (Philadelphia)	563-5848
WNAC (Germantown)	843-9748
NSCA (North Philadelphia)	426-8734
Medical Assistance (DPA, Medicaid)	560-2547
Healthy Beginnings	560-2547
Early Periodic Screening Diagnosis and Treatment (EPSDT)	800/543-7633
The Caring Program for Children (Caring)	800/464-5437
Children's Access to Primary Services (CHAPS)	563-5848
Maternity Services Project (MSP)	985-3300

Family size is parent(s) or guardian(s) plus children.
For example, 1 grandparent with 2 children is a family of 3.







FOR MORE INFORMATION OR TO ENROLL IN A PROGRAM

CHILD HEALTH WATCH can help you enroll in the right program:

PCCY (Philadelphia)	563-5848
WNAC (Germantown)	843-9748
NSCA (North Philadelphia)	426-8734
Medical Assistance (DPA, Medicaid)	560-2547
Healthy Beginnings	560-2547
Early Periodic Screening Diagnosis and Treatment (EPSDT)	800/543-7633
The Caring Program for Children (Caring)	800/464-5437
Children's Access to Primary Services (CHAPS)	563-5848
Maternity Services Project (MSP)	985-3300

Family size is parent(s) or guardian(s) plus children.
For example, 1 grandparent with 2 children is a family of 3.

MATERNITY CARE COALITION
OF GREATER PHILADELPHIA

NATIONAL HEALTH CARE REFORM: INCLUDING WOMEN AND CHILDREN

Any Health Care Reform Plan must include:

Guaranteed coverage for all families regardless of age, income, employment status, citizenship status or family composition with no period of ineligibility for care. Coverage must be portable and not restricted as a result of preexisting conditions or poor health status. There will be no eligibility requirements and one identification card for services, the same for all persons.

Elimination of all financial barriers: No co-payments, no deductibles and no means tests.

A comprehensive benefit package including all preventive, primary, reproductive, acute and rehabilitative care with both high-touch and high-tech services available. Benefit package must include prenatal and pediatric care and all diagnostic services, social work services, nutrition counseling, care coordination, patient education, parenting education, home health services, home visiting services, genetic screening and treatment, comprehensive family planning services including pregnancy termination counseling and services, smoking cessation services, and durable medical goods. Also included must be dental care, vision services, prescription drugs, mental health services and alcohol and drug addiction treatment and services. HIV screening, counseling and AIDS treatment and services must be covered in this system.

Provision of community-based, family-centered, culturally sensitive, prevention-oriented health care with involvement of consumers at all levels of the service delivery system and inclusion of women and children in the health research agenda.

Development of a system of care infrastructure that includes assessing needs, planning for resources, developing adequate capacity, evaluating impact and assuring quality at all levels. Included in this is the need to promote clearly the role of the federal, state and local public agencies and providers and providing the necessary resources.

Establishment of reimbursement rates that adequately cover the comprehensive services of a wide range of health care professionals including midwives and nurse practitioners and that accommodate client choice of provider. Training of all health providers to emphasize health promotion and prevention in addition to treatment of disease. Special attention must be paid to assuring adequate resources for traditionally underserved populations.

Establishment of streamlined administrative, billing and enrollment procedures to maximize the funding and provision of patient care.

Development of comprehensive outreach programs and public education campaigns targeted to policy makers and the general public.

A mechanism for assisting families which have suffered adverse perinatal events or other health outcomes and a system to address liability concerns of providers while maintaining consumer protection.

Special thanks to the following organizations and/or publications whose work contributed to this document: "A Pound of Prevention: The Case for Universal Maternity Care in the U.S.", March of Dimes Birth Defects Foundation, Children's Defense Fund, Association of Maternal and Child Health Programs, Campaign for Women's Health, Institute of Medicine, Foundation for Public Health Policy, National Women's Health Network, American Public Health Association, Alan Guttmacher Institute, League of Women Voters, Women's Institute for Childbearing Policy.

511 NORTH BROAD STREET/9TH FLOOR • PHILADELPHIA, PENNSYLVANIA 19123 • (215) 922-6300; FAX (215) 922-6416

INCLUDING CHILDREN AND PREGNANT WOMEN IN HEALTH CARE REFORM

From: Including Children and Pregnant Women in Health Care Reform:
Summary of Two Workshops
National Research Council Institute of Medicine

HEALTH INSURANCE: Access and Benefits

Goal 1: All children and pregnant women have continuous access to health insurance.

Goal 2: Personal expenditures for the health care of pregnant women and of children, including insurance premiums, deductibles, and other co-payments, are affordable.

Goal 3: Coverage is provided for a continuum of services that emphasizes primary and preventive care and includes the diagnosis and management of a variety of diseases and conditions, as well as specialized care to handle complex health problems.

Goal 4: An objective process is established for refining and updating the benefits package to accommodate changes in the health care needs of children and pregnant women, in the ability of health care to address these needs, and in available funds.

RESOURCE DEVELOPMENT: Services and People

Goal 5: Health services are provided by qualified providers in a wide variety of settings that are effective in caring for children and pregnant women, especially the medically underserved.

Goal 6: The number and diversity of qualified providers caring for children and pregnant women is increased, particularly for those who are poor, high-risk, or living in inner-city or isolated rural areas.

ADMINISTRATION

Goal 7: The administrative complexity of the health care system is substantially reduced from the perspective of both providers and consumers.

Goal 8: Cooperative, complementary administrative structures are established spanning public and private sectors to monitor and improve the health care system used by children and pregnant women.

Goal 9: The future role of existing government grant programs in maternal and child health is explicitly considered in reforming the health care system, with regard to both the personal health services supported by these grant programs and to their planning, evaluation and training functions.

COST MANAGEMENT AND QUALITY ASSURANCE

Goal 10: Cost management measures accommodate the special needs of children and pregnant women.

Goal 11: Vigorous, well financed systems of quality assurance and research are supported.

DEBORAH BECK
President
Drug and Alcohol Service Providers Organization of PA
Harrisburg, PA

Deborah Beck is a very active consumer advocate on the issue of coverage for alcohol and drug treatment. She was one of the principle lobbyists for enacting mandatory coverage for alcohol and drug treatment. Deborah is concerned that managed care is destroying coverage for drug treatment services--and that under managed care you have to build in strong consumer protections.

Questions

1. If you were designing a health system around managed care, what specific kinds of consumer protections would you build into the system?

2. Are there any lessons you have learned from your experience in Pennsylvania concerning adequate coverage of benefits under managed care plans that you think would be relevant to national legislation?

The Washington Post

FRIDAY, JANUARY 15, 1993

Health Care Organizations Back National

By Dana Priest
Washington Post Staff Writer

Thirty major managed-care health organizations yesterday agreed to support the creation of a national data-collection system that would produce a consumer "report card" on the quality of medical care in different health plans.

In a letter to President-elect Clinton, the group said that the report card would allow consumers to compare data on factors including how effective each health plan is in treating chronic illnesses such as asthma and diabetes and success rates for surgical operations. It would also score health plans on patient satisfaction.

The group proposed that the system be developed and implemented by health care companies along with business, labor and consumer groups, and that external mechanisms be set up to audit the information. The initial information collection would be completed by March and the first data would be available to the public by 1994.

The 30 companies include such industry heavyweights as Kaiser-Permanente, Blue Cross and Blue Shield and US Healthcare.

Information on quality of care "is absolutely critical," said Richard I. Smith, public policy director for the Washington Business Group on Health, a coalition of 175 Fortune 500 companies that buys health coverage for members' employees. "The real revolution that is going to occur in health care reform is accountability."

The agreement marks a departure from the longstanding reluctance of many health care companies to disclose detailed information on medical outcomes publicly—in part because they feared the scrutiny, and in part because they could not agree on a methodology for collecting it. Consumer and business groups have argued that the data are crucial to making educated decisions about which hospitals and doctors to use.

Revolution in health care will be in "accountability."

—Richard I. Smith, of Washington Business Group on Health

Providing consumers with quality and cost data is also a key part of Clinton's health care overhaul proposal known as "managed competition." During the campaign, he called for the creation of a national database to collect and analyze quality and price information that could be used by consumers when they chose a health care provider.

Database to Rate Their Plans

The agreement yesterday is a way for these companies, most of whom are well positioned to prosper under Clinton's plan, to back the idea.

"Managed care" refers to health care provided by health maintenance organizations as well as companies that contract with hospitals and doctors to create looser networks of providers for members. Managed-care companies closely scrutinize the type and frequency of procedures used in an effort to be more cost-efficient.

While there are many critics of managed competition, most advocates of health care overhaul favor the disclosure of price and quality data.

In its letter to Clinton, the group said the data would also help health plans improve the quality of their care by identifying the most successful ways to treat certain maladies and specific areas where they need to improve.

The group has been meeting with the assistance of the National Committee for Quality Assurance, a nonprofit external review organization for managed-care companies. The companies have asked the committee to develop performance measures and methods to collect the data and audit the findings.

The managed-care plans that endorsed the proposal yesterday have 55 million health care subscribers among them.

A number of large businesses also endorsed the plan, among them Bank of America, Chrysler Corp., General Electric and Xerox Corp.

Consumers would get the report card during their annual "open enrollment" period in which they have the chance to change health plans.

DRAFT--PENNSYLVANIA HEALTH CARE CONFERENCE
Lee Van Valkenburgh, Capital Blue Cross

In *The Public Use of Private Interest,* Charles Schulze argued that government can often achieve its best results by actions that channel private economic interest to meet public needs, rather than through "command and control" strategies or direct government operations.

That, we believe, is the right model for government's role in health care reform. Here's an example.

In Pennsylvania, there is *theoretically* no problem of access to health insurance. Blue Cross and Blue Shield will sell comprehensive individual or group coverage to anyone. We do not underwrite based on health conditions, and in the individual and small group markets we spread the cost equitably by community rating.

But other insurers in the individual and small group markets *do* select which risks they will accept and which they will not. This has meant that more and more bad risks come to us, and in the individual market it has driven our rates to the point where many people can no longer afford our coverage. So there's no access problem--but the affordability problem creates the same result.

Federal reforms, with state enforcement, could create standards for Accountable Health Plans, such as open enrollment, equitable rating methods, managed care options, portability of benefits and active quality assurance programs. Only plans that meet these standards could market a Basic Health Care Plan that would be available to every American. To do business at all, insurers would have to compete based on their ability to accept and manage risk, not on their ability to avoid risk. More people would have more options, at more equitable rates.

This is an example of "the public use of private interest," but it is only one. Similarly, tax incentives could be created for employers to purchase coverage only from Accountable Health Plans and to move an increasing percentage of their employees into managed care plans. Other incentives could increase the number of primary care physicians or encourage state experimentation.

There are other essential roles for government. For instance, as a partner with private organizations in outcomes research, so doctors, hospitals, insurers and patients would all have a better basis for determining what works best in health care; or in funding technology assessment activities to help avoid costly and inappropriate uses of technology.

We believe what the federal and state governments can do best is to set standards and goals and create the incentives, positive or negative, that will drive private activities toward the attainment of public goals. On the other hand, the least practical role for government is to try to manage and control the thousands of subsystems and millions or interactions that occur daily in something as complicated as health care delivery.

Senator, we have appreciated your continuing interest in hearing our views on these critical issues in health care reform. We at Capital Blue Cross and throughout the Blue Cross and Blue Shield system share your belief that reform is essential, and we want to help bring it about. Thank you.

MARY KAY PERA
PA Association of Home Health Agencies
Lemoyne, PA

Attached are Ms. Pera's comments and a statement of home health services as a part of health care reform.

Background

The Pennsylvania Association of Home Health Agencies (PAHHA) is a statewide membership association that represents nearly 250 Medicare-certified home care agencies, hospices, private care, homemaker/home health aide organizations, and affiliated professionals. PAHHA members provide professional and paraprofessional care and support services, at home, to persons who need help during as acute or long term illness.

Some of the services which are now available through home care, include: nursing, physical, occupational and speech therapies; home care aide services; specialty services, such as intravenous antibiotics, chemotherapy, AIDS care, homemaker services, and medical social services, etc.

Medical technology now allows services heretofore available only in a hospital to be safely carried out at home, at significantly less cost.

Questions

1. As you know, most public assistance available for long-term care is currently spent on coverage for nursing home care. With growing public support for increased coverage for home and community-based care, what do you think is the appropriate role of government in redirecting public dollars toward this kind of care?

2. Most managed competition proposals fold the acute care portion of Medicaid into the new proposed purchasing cooperatives. This would leave untouched many programs under Medicaid, such as nursing home coverage and special programs for persons with disabilities.

Given the difficulty in financing expanded long-term care, what role do you think the state and Federal governments can and should play in reforming these "residual" Medicaid programs? What other measures should the state and Federal government consider as incremental pieces toward comprehensive coverage of long-term care?

The Role of Government in Health Care Reform from the Perspective of Home Health Care

My name is Mary Kay Pera, Executive Director of the Pennsylvania Association of Home Health Agencies (PAHHA), and I am pleased to participate today. It should come as no surprise to you that my perspective is biased toward provision of health care in the community and particularly at home. In fact, I believe that part of the solution to the health care crisis lies in home health care. Let me elaborate.

Home care is rooted in a strong tradition of community service, begun in this country in the mid-1800s. The health and well-being of individuals, families and the community have always been at the heart of home care, and home health agencies adapted their services over the years to community needs as they arose.

This commitment to service and improved community health continues today. As our nation seeks to build a more efficient and responsive health care system, PAHHA believes that the basic principles upon which home care was founded apply. Government should exercise the necessary leadership to refocus the provision of health care, based on these principles:

1. The individual and family are the center of health service delivery and health promotion.

2. The objective of care is to promote, maintain, and/or restore health; to minimize the effect of illness and disability; and to provide care to terminally ill patients and their families during the dying process.

3. Everyone should have access to appropriate and necessary care no matter what their age, financial status or where they live.

4. When feasible, treatment for acute and chronic illness is preferable through primary care and home care. Home care permits earlier discharge from the hospital or eliminates institutionalization altogether. Home care allows technology-dependent infants and children to come home. Home care keeps families together, fosters independence, control and security and, comparatively speaking, costs less.

These tenets are so basic but bear mentioning, because we have moved so far away from community service and improved health in our preoccupation with technology, bricks and mortar, cutting costs and fierce competition for health care dollars.

In addition to refocusing the health care system, there are other major roles for government in the necessary reformation of the health care system. Government should:

1. Define the basic acute care benefit package, which should emphasize community and home-based health services.

2. Develop a comprehensive long term care component which provides an array of coordinated home care services.

2. Establish minimum standards of acceptable quality of care and mechanisms to insure adherence to those standards.

3. Develop standards in managed care systems which provide for both appropriate utilization and assurance of necessary services to those who need them. The Medicare hospice benefit is a good example of a capitated managed program, under the care management of the hospice provider, which incorporates home care and institutional care, according to patient need.

5. Set a payment methodology which is fair to both the consumer and provider.

6. Establish accountabilities that hold providers responsible for certain outcomes of care and the improved health of the population being served.

7. Provide a mechanism to give patients information for decision-making with regard to treatment.

7. Provide leadership to reduce the costly and duplicative paperwork associated with multiple billing systems.

"Making a reformed system happen" will take great commitment and courage on the part of you, our political leaders. We want to help you in every way we can. We ask only that you give us the flexibility to receive health care at home, where appropriate. It makes sense in every respect of the word. Thank you.

Mary Kay Pera
Executive Director
Pennsylvania Association
of Home Health Agencies
February 11, 1993

National Home Health Services Alliance

c/o 1320 Fenwick Lane
Silver Spring, MD 20910

"Any Health Care Reform Must Include Home Care as a Core Benefit – Because Home Health Care Is Part of the Solution."

Phone: 301/588-1454 or 703/836-9863 FAX : 301/588-4732 or 703/836-9866

HEALTH CARE REFORM: HOME HEALTH IS PART OF THE SOLUTION

The National Home Health Services Alliance urges the Clinton Administration and Congress to recognize home health services as a key component in reform of our nation's health care system.

Home health care is much more affordable than inpatient care and a majority of Americans now have access to home care as a basic benefit. Home care is an existing foundation on which a reformed health care system can be built.

Inclusion of home health as a key cost-saving component of most insurance plans indicates that home health care makes good economic sense to the private sector. It should also make economic sense to the new Administration and Congress to maintain home care as an essential part of the nation's health care system. This means that home care must be part of any mandated minimum benefits package contained in managed competition legislation or any other health care reform legislation.

Americans Prefer Home Health Care

Home health care is the choice of consumers and is the preferred modality of care. In many rural and underserved areas of the country, home care is the health care delivery infrastructure, the only access to health care services, even for patients who are not homebound. Home health is preferred because it is humane. It maximizes independence and dignity for those unable to leave home for services.

Home care keeps our parents and grandparents out of nursing homes. It brings our at-risk babies home from the hospital, and it enables families to care for chronically ill children in the home. It enables disabled family members and neighbors to remain independent, at home, and in their communities.

Home health care is preferred because it permits earlier discharge from the hospital or eliminates hospitalization altogether, and facilitates an earlier return to work. Most importantly, studies show that individuals recover more quickly and their potential is maximized at home, whether they are being treated for an acute, chronic, or catastrophic illness.

Home Health Is Ready to Respond

Home health care constitutes the most viable opportunity for curbing our nation's bill for health care in the coming years as access to health care coverage is extended to more Americans.

Because of their large numbers, baby boomers will require more health care services as they age. More low birthweight babies will survive, but with disabilities, and in need of continuous preventive care. The HIV infected population will increase exponentially. Technology development has enabled home care to respond by making possible provision of services in the home which were available only in hospitals ten years ago. These services include:

- chemotherapy
- IV antibiotic therapy
- parenteral and enteral nutrition therapy
- respiratory therapy
- AIDS treatment
- premature and low birthweight infant care
- high risk pregnancy monitoring
- head and spinal cord injury care
- hospice care for the terminally ill

Home Health Is Already a Key Component of Our Health Care System

Employers and private insurers recognize the cost effectiveness and quality of home health care through its inclusion as a standard benefit in health insurance plans:

- The Blue Cross and Blue Shield Association of America reports that 90 percent of Blue Cross Blue Shield plans included home health in traditional benefit packages in 1990, up from only 46 percent in 1974.

- The Health Insurance Association of America found that in 1990 home care coverage existed for 83 percent of insured employees in conventional health plans and 86-89 percent in HMOs and PPOs.

- Data from the Bureau of Labor Statistics indicate that 75 percent of insured employees of medium and large employers had home health coverage in 1990 compared to 46 percent in 1984; BLS also found that 79 percent of covered employees in small businesses had home health coverage in 1990.

The Blue Cross and Blue Shield Association states that its members' policies contain home health services because such care reduces hospital stays, leads to shorter recovery time, and produces a better patient psycho-social outlook. Business and Health magazine, published by the Washington Business Group on

Health, reported in April, 1992, that "Savvy employers can save thousands of dollars by judiciously using home health care instead of hospital care...Employers and insurers are taking advantage of home health care benefits as never before by expanding home care's traditional role of being used only for after-hospital care to using it to prevent hospitalization."

The Federal government recognizes the vital role of home health care. Medicare has included home care as an acute benefit since its inception in 1965. Congress expanded availability in 1980 by eliminating the prior hospitalization requirement and limit on the number of visits. Medicaid has required states to include home care services since 1970. Federal requirements for HMOs have mandated provision of home health since 1973.

Home care has strong bi-partisan support in Congress. Republicans and Democrats both recognized the role of home health care in health care reform legislation introduced in the 102nd Congress. Key committee and subcommittee chairmen in the House of Representatives, including Congressmen Dan Rostenkowski, Pete Stark, John Dingell, and Henry Waxman, included home health as a core benefit in their respective bills.

Home Health Care is Cost Effective

The cost effectiveness of home health care is indicated by a number of studies, including the following:

- The Visiting Nurse Service of New York has an average daily census of 1,150 AIDS patients in its At Home Options Program (AHOP) for Empire Blue Cross Blue Shield subscribers. A preliminary study indicates that while receiving home care, AHOP participants each incurred $5,068 less for inpatient admissions, $720 less in outpatient institutional claims, and $347 less in hospital-related home care costs than non-participants.

- A 1991 Lewin/ICF found considerable savings per episode for three different diagnoses when hospital care is used in conjunction with home care rather than without it. The home health/hospital savings per episode are as follows:

  hip fracture - $2,300
  amyotrophic lateral sclerosis with pneumonia - $300
  chronic obstructive pulmonary disease - $520

  The study indicated that annual savings for just these three diagnoses would be $624 million.

- U.S. News & World Report, on January 25, 1988, reported dramatic savings for a number of types of patients through use of home care services, including the following costs per patient:

chemotherapy - $10,500 per month in the hospital versus $3,500 per month at home

tube feeding - $16,600 per month in the hospital versus $6,000 per month at home

spinal cord injury - $23,800 per month in the hospital versus $13,900 per month at home

- Aetna Life & Casualty Co. has reported a $78,000 per case saving for victims of catastrophic accidents through its Individual Care Management Program utilizing home health services.

- Aetna, in 1986, indicated significant savings by treating newborns with breathing and feeding problems in the home; the cost was $20,000 per month with home care compared to $60,000 per month in the hospital setting.

- Aetna also reported in 1986 that it saved $200,000 a year per case by treating technology-dependent children in their homes. At home care averaged $50,000 compared to $250,000 in the hospital.

- The Center for Health Care Law reported in 1992 that Blue Cross Blue Shield of Harrisburg, Pennsylvania, realized a savings of $2,200 per day through care of ventilator-dependent children at home compared to hospital services.

- In a study conducted in one Veterans Administration hospital, as reported in Health Services Research in 1992, terminally ill patients were randomly assigned to an experimental group receiving home care and to a control group receiving traditional care. While there was no difference in survival rates, patients in the home care group reported higher satisfaction than those without home care. Participants in the home health group were hospitalized an average of 5.9 fewer days in a six-month period and had costs that were 18 percent lower.

Home Health Agencies Are Also Managers of Care

Home health agencies have a record of successful and cost-effective coordination of health care and social support services in the community setting. In accordance with their legal mandates under the Medicare and Medicaid programs, home health agencies already provide assessment and care management for their patients. In fact, the Medicare home health benefit was expanded in 1989 to include "Skilled Management and Evaluation of a Care Plan" as a separate reimbursable nursing service.

In any health care reform legislation that it enacts, Congress must permit any qualified organization--public or private, non-profit or

for-profit, provider or non-provider--to participate as a case manager or managed care provider. Established standards of professional performance and the capacity to perform interdisciplinary assessments must be the qualifying criteria for case management organizations, not tax or provider status. Congress should not take the extreme measure of excluding health care providers who are currently familiar with, and providing, assessment and care management.

A case management system must be developed that will:

- target case management only to those who require such services;
- limit unnecessary expenditures for case management services;
- prevent creation of an unneeded layer of bureaucracy;
- prevent bottlenecks to care which occur when there is a single model of entry into, and management of, the health care system;
- use the skills of experienced health care professionals who are monitored on a regular basis for the quality of the care they provide, including their case management services;
- ensure that the relationship between the caregiver and the provider is maintained without third-party interference; and
- provide measurable outcomes and accountability.

For any reform based on managed competition, capitated payments, or bundling of services, any qualified organization, including home health providers, must be allowed to freely compete for contracts to serve as the managed care provider. A qualification for selection should be a track record of providing quality care in the service area.

Home health agencies have a very successful record of providing cost-effective coordination of health care services and other resources--and are closer to the community and people served than most other providers.

RICOH FAX 35

FACSIMILE TRANSMISSION

Page 1 of 3

Date 2/10/93

To: Ms. Darrell Jodrey

Location:

Telephone #: (1-717)233-1856

Fax #: (1-717)238-2238

From: Ronald Heigler, Executive Director

Location: Greater Philadelphia Health Action, Inc.

Telephone #: (215)288-9200

Fax #: (215)288-7671

Remarks: The following is an organizational profile on Greater Philadelphia Health Action, Inc. Hope it is helpful. I am looking forward to meeting you on February 11th.

Any problems with this transmission, call 288-9200. Thank you.

ORGANIZATIONAL PROFILE--GREATER PHILADELPHIA HEALTH ACTION, INC.

History and Mission

Greater Philadelphia Health Action, Inc. (GPHA) is a private, non-profit 501(c)3 corporation. GPHA is a Section 330, Public Health Service (PHS) Grantee. It was organized over 20 years ago to provide comprehensive, coordinated, accessible health care services to medically underserved Philadelphians. Since its inception, GPHA has grown from a single site operation to eight sites in major underserved areas of Philadelphia.

Scope of Services and Service Population

GPHA operates four primary health care centers, two comprehensive school-based health clinics, a drug and alcohol counseling and treatment program, and a day care center. Through its network, GPHA serves four major areas of the city - the northeast, south, southeast and southwest. Our success is apparent by the increased numbers of residents who seek care at our neighborhood health centers. GPHA served over 21,000 patients in 1992, generating over 100,000 patient encounters. Forty-one percent of the patients are male and 59 percent female (38 percent of whom are of childbearing age). Sixty-nine percent are enrolled in Medical Assistance or the HealthPASS program; 3.0 percent Medicare; 4 percent private insurance; and, 24 percent are uninsured. The majority of users, 87.4 percent, are at or below 100 percent of the poverty level; 6.1 percent are between 101-150 percent of poverty; and only 6.5 percent are over 151 percent of poverty.

Primary care (Pediatrics, Internal Medicine), OB/GYN (featuring a case managed comprehensive prenatal program and Family Planning), Podiatry, Dental services, Social Service, health education and nutritionist support are available at each health center.

Like Philadelphia and other major, economically disadvantaged urban centers, the residents suffer from many of the same health care problems which are strongly associated with poverty status--a 17.7 percent infant mortality rate; 11.9 percent low birthweight rate; 27 teen pregnancies per thousand; increasing rates of sexually transmitted diseases (including AIDS). In January of 1991, GPHA received a grant to provide early intervention and case management services to HIV positive patients. As a result, GPHA tested over 1,100 patients during calendar year 1991. Since GPHA began its grant funded program, over 2,000 patients have received early intervention services. One thousand four hundred of these patients are currently open cases, with 540 of these being HIV positive. Sixty of these patients are HIV positive women representing an increase of 25% over 1991.

In response to major needs of users, a variety of program initiatives have been developed by GPHA to supplement service delivery, including: (1) perinatal case management program; (2) school-based health centers; (3) adolescent pregnancy childbirth education program; (4) HIV case management program; and, (5) an adolescent peer education STD/substance abuse prevention program.

Summary of Four Major Policy Options Related to School-Based Health Centers

Greater Philadelphia Health Action, Inc.
Philadelphia, Pennsylvania

Option 1: Improve Childrens' and Adolescents' Access To Health And Related Services Via School-Based Health Centers.

- State (Congress) should adopt strategies to improve childrens'/adolescents' access to appropriate health and related services through the provision of care at school-based health centers.

Option 2: Identify Long-Term Funding Sources For School-Based Health Centers.

- State (Congress) should establish support for long-term funding for comprehensive school-based health care.
  - There is a critical need for long-term stable source of funding. Who will fund? States? Feds? Medicaid? What about the uninsured? Who will absorb these costs?

Option 3: Take Steps to Improve Childrens' and Adolescents' Financial Access to Health Services.

- Mandate on immediate expansion of Medicaid eligibility for children and adolescents. One out of three adolescents (approximately 2.76 million) poor adolescents are not covered by Medicaid.
- Mandate that employers provide health insurance for their currently uninsured workers and those workers' dependents.
  - Many uninsured children and adolescents are the dependents of parents who work but whose employment benefits do not include health insurance.

Option 4: Support State Data Collection/Applied Research On School-Based Health Centers

- State/congress should rigorously support evaluated demonstration programs on the costs/benefits of school-based health center programs.
- State could create a locus for a strong state role in addressing child/teen health issues.

MATERNITY CARE COALITION OF GREATER PHILADELPHIA

NATIONAL HEALTH CARE REFORM: INCLUDING WOMEN AND CHILDREN

Any Health Care Reform Plan must include:

Guaranteed coverage for all families regardless of age, income, employment status, citizenship status or family composition with no period of ineligibility for care. Coverage must be portable and not restricted as a result of preexisting conditions or poor health status. There will be no eligibility requirements and one identification card for services, the same for all persons.

Elimination of all financial barriers: No co-payments, no deductibles and no means tests.

A comprehensive benefit package including all preventive, primary, reproductive, acute and rehabilitative care with both high-touch and high-tech services available. Benefit package must include prenatal and pediatric care and all diagnostic services, social work services, nutrition counseling, care coordination, patient education, parenting education, home health services, home visiting services, genetic screening and treatment, comprehensive family planning services including pregnancy termination counseling and services, smoking cessation services, and durable medical goods. Also included must be dental care, vision services, prescription drugs, mental health services and alcohol and drug addiction treatment and services. HIV screening, counseling and AIDS treatment and services must be covered in this system.

Provision of community-based, family-centered, culturally sensitive, prevention-oriented health care with involvement of consumers at all levels of the service delivery system and inclusion of women and children in the health research agenda.

Development of a system of care infrastructure that includes assessing needs, planning for resources, developing adequate capacity, evaluating impact and assuring quality at all levels. Included in this is the need to promote clearly the role of the federal, state and local public agencies and providers and providing the necessary resources.

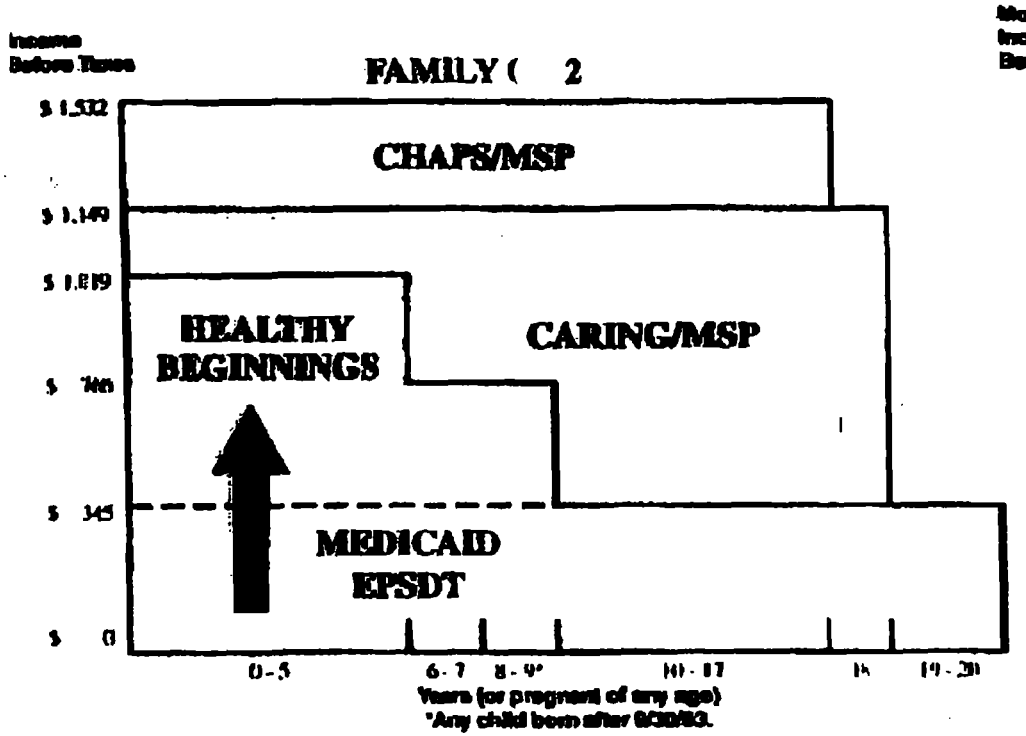
Establishment of reimbursement rates that adequately cover the comprehensive services of a wide range of health care professionals including midwives and nurse practitioners and that accommodate client choice of provider. Training of all health providers to emphasize health promotion and prevention in addition to treatment of disease. Special attention must be paid to assuring adequate resources for traditionally underserved populations.

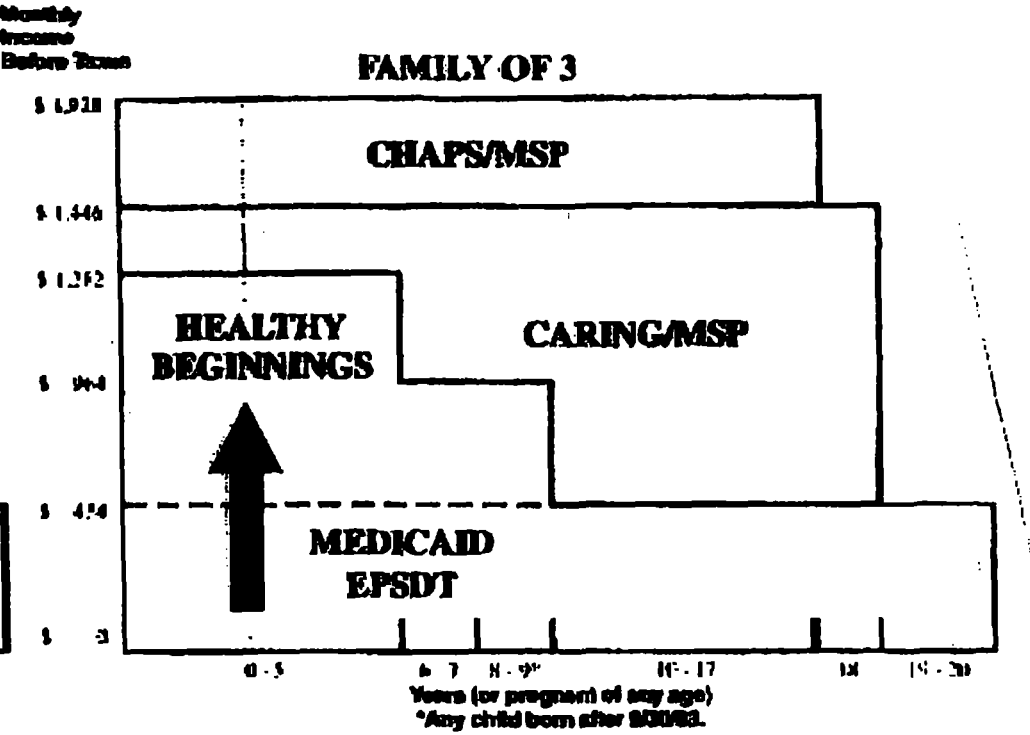
Establishment of streamlined administrative, billing and enrollment procedures to maximize the funding and provision of patient care.

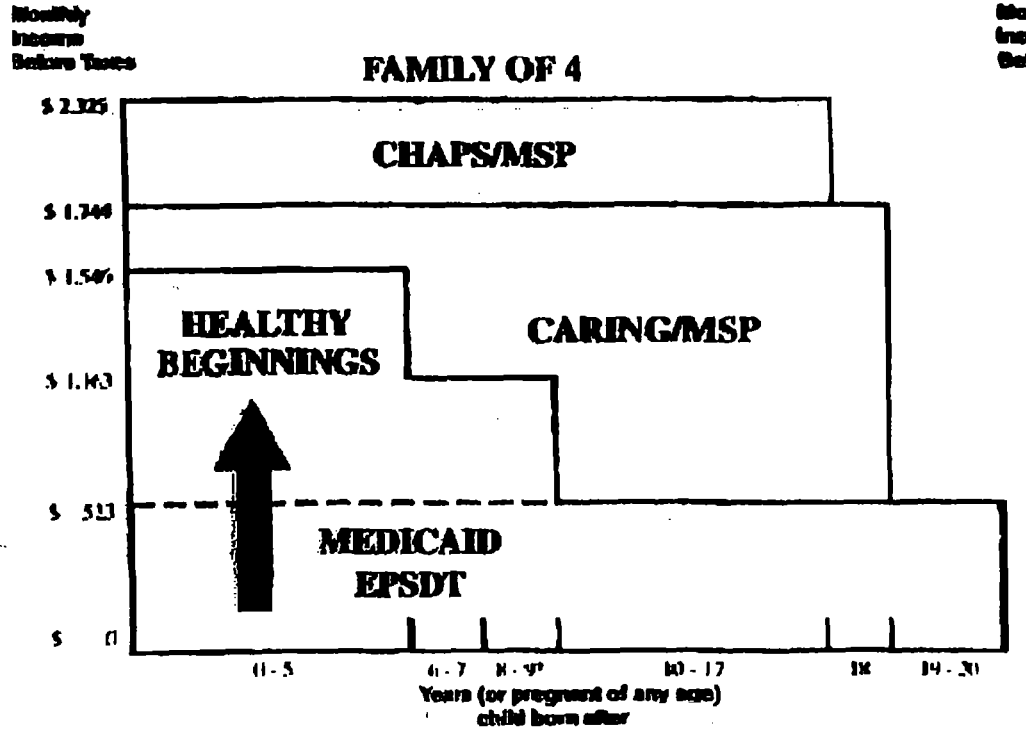
Development of comprehensive outreach programs and public education campaigns targeted to policy makers and the general public.

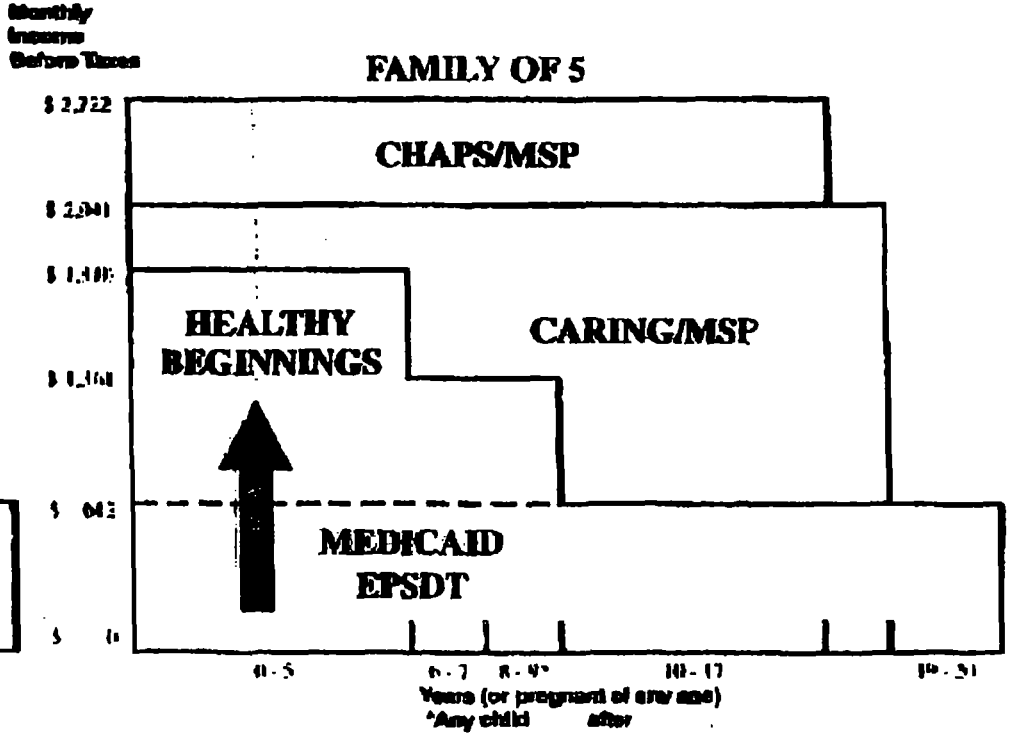
A mechanism for assisting families which have suffered adverse perinatal events or other health outcomes and a system to address liability concerns of providers while maintaining consumer protection.

Special thanks to the following organizations and/or publications whose work contributed to this document: "A Pound of Prevention: The Case for Universal Maternity Care in the U.S.", March of Dimes Birth Defects Foundation, Children's Defense Fund, Association of Maternal and Child Health Programs, Campaign for Women's Health, Institute of Medicine, Foundation for Public Health Policy, N[illegible] Women's Health Network, American Public Health Association, Alan Guttmacher Institute, League of Women Voters, Women's Institute for Childbearing Policy.


Income
Before Taxes
FAMILY (2
$ 1,532
$ 1,149
$ 1,019
$ 765
$ 345
$ 0
CHAPS/MSP
HEALTHY
BEGINNINGS
CARING/MSP
MEDICAID
EPSDT
0 - 5
6 - 7
8 - 9*
10 - 17
18
19 - 20
Years (or pregnant of any age)
*Any child born after 9/30/83.

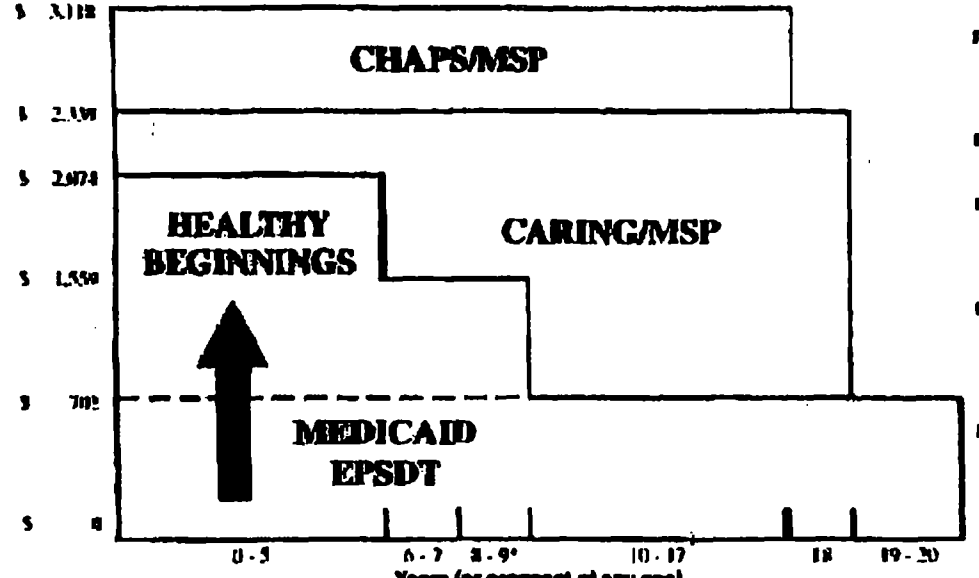

Monthly
Income
Before Taxes
FAMILY OF 3
$ 1,938
$ 1,446
$ 1,292
$ 964
$ 434
$ 0
CHAPS/MSP
HEALTHY
BEGINNINGS
CARING/MSP
MEDICAID
EPSDT
0 - 5
6 - 7
8 - 9*
10 - 17
18
19 - 20
Years (or pregnant of any age)
*Any child born after 9/30/83.


Monthly
Income
Before Taxes
FAMILY OF 4
$ 2,325
$ 1,744
$ 1,549
$ 1,163
$ 523
$ 0
CHAPS/MSP
HEALTHY
BEGINNINGS
CARING/MSP
MEDICAID
EPSDT
0 - 5
6 - 7
8 - 9*
10 - 17
18
19 - 20
Years (or pregnant of any age)
child born after

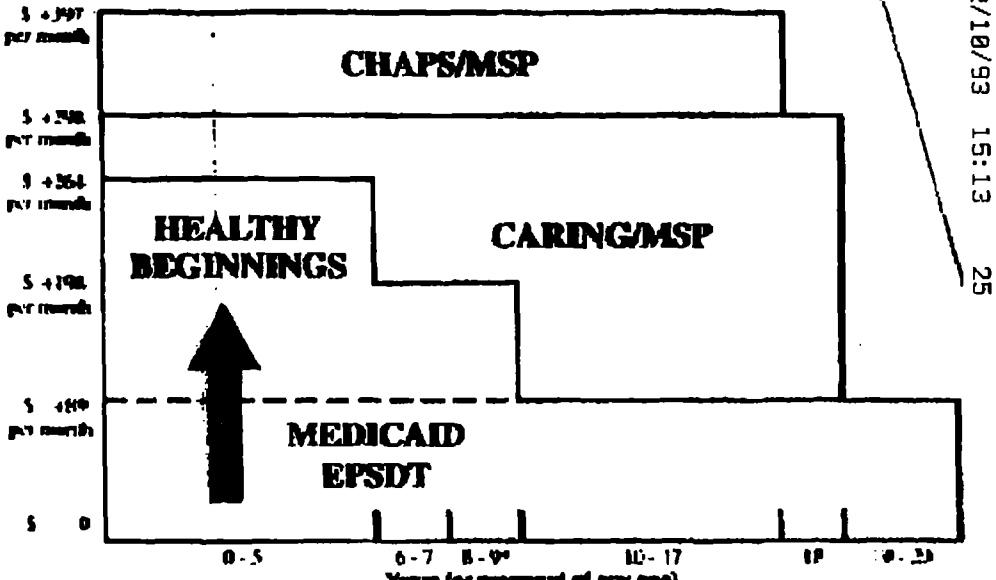

Monthly
Income
Before Taxes
FAMILY OF 5
$ 2,722
$ 2,041
$ 1,813
$ 1,361
$ 612
$ 0
CHAPS/MSP
HEALTHY
BEGINNINGS
CARING/MSP
MEDICAID
EPSDT
0 - 5
6 - 7
8 - 9*
10 - 17
19 - 20
Years (or pregnant of any age)
*Any child after

Before Taxes

FAMILY OF 6

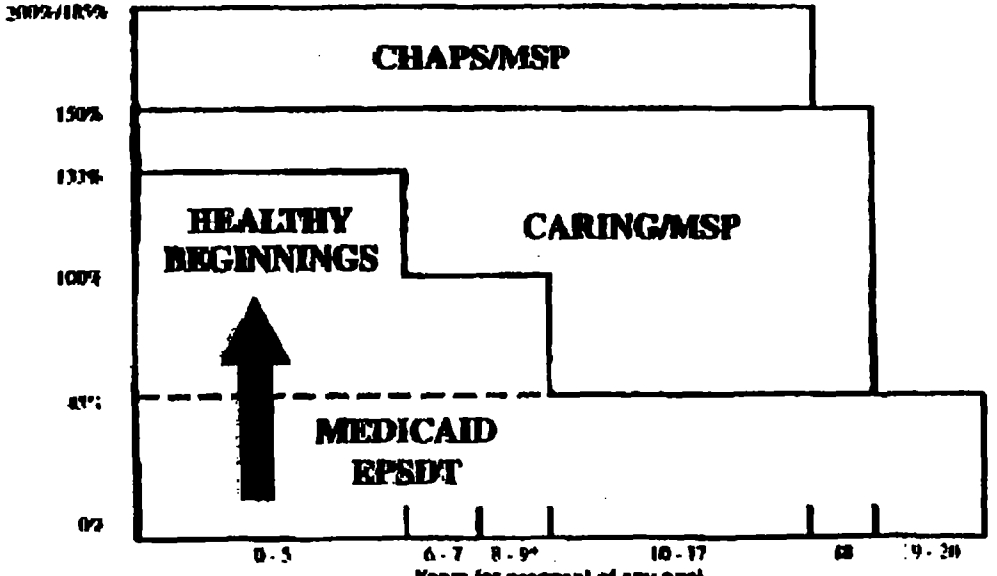


FAMILY OF 6+



FPG

UNIFORM ELIGIBILITY



FOR MORE INFORMATION OR TO ENROLL IN A PROGRAM

CHILD HEALTH WATCH can help you enroll in the right program:

PCCY (Philadelphia)	563-58
WNAC (Germantown)	843-97
NSCA (North Philadelphia)	426-85
Medical Assistance (DPA, Medicaid)	560-28
Healthy Beginnings	560-25
Early Periodic Screening Diagnosis and Treatment (EPSDT)	309/541-76
The Caring Program for Children (Caring)	800/854-54
Children's Access to Primary Services (CHAPS)	563-58
Maternity Services Project (MSP)	985-32

Family size is parent(s) or guardian(s) plus children.
For example, 1 grandparent with 2 children is a family of 3

MEMORANDUM

Post-it™ brand fax transmittal memo 7671 | # of pages ▸

To Alyse Levy	From Mary Fagin
Co. Gov. Clifford	Co. School of Nursing (Penn)
Dept.	Phone # 215-898-6088
Fax # 717-238-2238	Fax # 215-898-6920

DATE: February 10, 1993

TO: Alyse

FROM: Mary

RE: Claire Fagin's Remarks

Claire will stress the following in her remarks:

1. The federal government must eliminate barriers to reimbursement of nurse practitioners, nurse midwives, clinical nurse specialists etc. in order to achieve goals of cost-containment and access to health services by all citizens.

2. The standard benefits package should initially be targeted at women and young children. Ultimately this package must address the long-term care needs of the millions of people living with chronic illnesses.

3. The federal government must eliminate barriers to state and local initiative designed to meet the health needs of a community (e.g. ERISA, Medicare waivers that currently take up to two years to obtain).

4. The federal government must provide the financial support for clinical research to assess the cost and effectiveness of new models of care. The government must also provide continued support for the development of clinical practice guidelines.

5. The federal government should reform the health insurance market and eliminate practices that are denying citizens with essential coverage.

6. State and local governments should have the autonomy to develop and oversee systems of health care within a framework of managed competition. These governments should also assure that these system are delivering expected services and keeping within their budgets.

7. State and local governments should promote the development of primary care practices based in such community settings as schools etc.

8. The state government should assure that consumers have access to an excellent information base upon which they can make their health care choices.

Wofford Panel on Costs

Senator Wofford, your commitment to quality health care is well recognized and deeply appreciated by the citizens of Pennsylvania and the nation. I am pleased to have the opportunity to share my views on the primary issue that is driving the health reform debate. The perspectives I share are the result of more than 25 years as a nurse clinician and administrator.

Past attempts to contain costs through regulation have been unsuccessful in achieving significant reform. The same can be said for the more recent philosophy of depending on market forces to control health care spending. While reason would argue that neither approach should be abandoned, experience would argue that more systemic change is in order.

Such a change would depend on a fundamental shift in the definitions of health care services and health care providers. While an initial reaction might be that broadening services would increase costs, more careful study shows that by changing the nature of services and the kind of providers, demand and costs can be lowered and quality maintained and in some cases enhanced. Among the primary changes called for are reforms in the areas of guaranteed benefits, alternative systems of community based care, insurance reimbursement policies, tax policies and consumer information. It is important to note that these areas for reform are inter-dependent for their success.

1. **Guaranteed Benefits.** A comprehensive package of relatively low to moderate cost health care services, guaranteed by

all insurers, will go a long way to decrease the aggregate costs of care by reducing the demand for higher cost services. This package must include at the minimum: preventive services including regular check-ups, pre-natal and well baby care, immunizations, primary care, home care and mental health services. One example of reducing costs while increasing access is evident in the United Kingdom where 75% of prenatal care and normal births are safely handled by certified nurse midwives. In the U. S. less than 4% of normal births are handled by certified nurse midwives despite that fact that the total cost of such care is 1/3 (at most) of traditional obstetrician care.

2. **Alternative System of Community Based Care.** Efforts to reduce costs would be better achieved by replacing the current maze of disjointed, fragmented services with a "more seamless" system of coordinated, community based care. Community settings have been shown to increase access to preventive services which, in turn, decrease the demand for higher cost health care. In such systems, the role of the nurse is essential. Serving as a gatekeeper and accustomed to providing services in primary care sites such as schools and work settings, nurse coordination of family access to health care has been shown to reduce costs while increasing access. Nurses have the best record of providing such services in underserved rural and urban areas and are notable for utilizing appropriate preventive, low tech interventions rather than the costly high tech interventions now so customary. These roles are particularly suitable in managed care arrangements and will offer planners competitive pricing in local and national

health reform efforts: providing that barriers to practice are removed.

3. **Insurance Reimbursement Policies.** These barriers include private, state and federal insurance reimbursement policies. Currently, the policies of third party payers allow only the most costly of services by the most costly of providers despite the considerable and growing body of scientific literature that supports nurse practitioners, certified nurse midwives and clinical nurse specialists as providers who can assure cost-savings and quality of services.

4. **Tax Policies.** The issue of a tax cap for employer-paid health benefits and the need for local adjustments to any national index is a question to be resolved if significant cost savings are to be achieved.

5. **Consumer Information.** Unconscionably absent from the current health care system are consumers who are knowledgeable about health care costs. Efforts to achieve cost containment must begin with informed consumers who will contribute to decisions related to how much we will spend on health care and how these dollars will be allocated.

In summary, a new vision of reform to reduce cost and guarantee access requires a restructuring of the health care delivery system which assures a standard of care, uses health resources effectively and efficiently, and balances efforts to promote health with the capacity to cure disease.

Thank you.

(Moccia and Fagin, February 10, 1993)

DR. ROBERT DOE
President, Medical Society of Lancaster County
Conesta, PA

Lancaster County Task Force

Attached are comments from the Lancaster Task Force on their model for health care reform: managed competition with expenditure limits.

Background

This group has established a coordinated care system for Medical Assistance recipients in Lancaster County. It has the support of the community, the Department of Public Welfare and the Health Care Financing Administration. Three local hospitals have donated $50,000 to develop a database for the program. Savings to the Commonwealth are projected at 10-20 percent.

Dr. Doe supports managed competition with expenditure limits as a promising model for health care reform. His concerns and recommendations are the following:

-- managed care plans should be defined in broad terms to include both staff-HMOs, as well as preferred provider plans (PPOs);

-- Health Insurance Purchasing Cooperatives could become a new and expensive layer of bureaucracy. HIPC cost effectiveness could be increased if they were limited to providing services to Medicaid and low income rcipients, individual purchasers of insurance, and small businesses;

-- regional expenditure targets could interfere with the market forces set up by the managed competition approach;

-- the Oregon approach (prioritization of services to be covered) should be used to create a national definition of a mandated benefits package;

-- other important initiatives to control costs should be implemented such as uniform claim forms, uniform reimbursement rules, elimination of the practice of denying coverage because of pre-esisting conditions, malpractice and anti-trust reform, uniform data collection standards, and limiting provider fees.

Questions

1. I am aware of your fear that health insurance purchasing cooperatives could become a new and expensive layer of bureaucracy. However, couldn't regional purchasing cooperatives serve to eliminate the wasteful duplication of health benefit management functions currently found in most businesses and organizations?

2. How can we ensure that Medicaid and low income groups receive the same benefits and services as do middle and upper income groups?

Thomas Jefferson stated many years ago when questioned about health "With your talents and industry, with science, and that steadfast honesty which eternally pursues right, regardless of consequences, you may promise yourself everything-but health without which there is no happiness.

For several decades the American health care system has been constructed piecemeal, without overall strategy. Today this trend must be reversed in order to create an improved health care delivery system which is more fair and cost effective yet maintains quality, cutting-edge technology and individual choice of provider. To facilitate this change, health care reform must be initiated at the federal level, permit state variation and encourage the creation of locally controlled health networks. Imagine creating a paper mache sculpture. The wire frame of the piece is created federally and given to the States. Each State determines the method for purchasing the glue, plaster and paint. The local community receives the frame and materials and completes the sculpture with its own local color and artistic interpretation.

In specific terms, the federal government must define the rules the health care system. This includes defining a basic efit package for all Americans, relaxing regulations, and tort reform. At the State level, payment mechanisms for the basic benefits package could vary allowing States funding options. Local communities need to be empowered to create networks of providers and community agencies to deliver coordinated care. More than one network should exist in each area to maintain consumer choice and competition yet cooperation on use of expensive technologies must be encouraged. A federal funding source and clearing house for project development information should be created to aid in this process.

As an example of this approach, a coordinated care network for Lancaster County Medical Assistance patients is being established pending HCFA approval of a waiver. The program began from the work of a County Health Task Force composed of providers, consumers, business, insurance, labor and community agency representatives. Through a cooperative effort with the Pennsylvania Medical Society and the Pennsylvania DPW the final program was designed. The system will link all MA patients to a primary care provider, facilitate provider cross coverage networks to ensure 24 hour care access, and track patients who fail to show for well child care, immunizations or prenatal care. A community based computer network linking out patient providers to hospital emergency departments is being developed. This r Server based system will maintain a data base for providers rning medicines, allergies, and immunizations. This will te a permanent childhood immunization record and allow tracking of individuals for well child care.

We must accept the challenge to refine our nation's health care system. Government must unleash the creative genius of local

communities and avoid the yoke of a system too tightly defined at the national level in the name of cost control. As Jefferson said, "The time necessary to secure this...should be devoted to it in preference to every other pursuit."

COMMENTS ON MANAGED COMPETITION WITH EXPENDITURE LIMITS AS A MODEL FOR HEALTH CARE REFORM - Lancaster County Task Force

The are several aspects of the managed competition approach which have great promise. First, the creation of Area Health Plans as a cooperative venture between insurers and providers would facilitate the expansion of primary care networks, access to care for all, and allow for local creativity within the plans to deliver cost effective, high quality health care. By placing these plans in competition with one another, market forces would be brought to bear into the health care system. The emphasis of these plans would be toward the goal of assuring a primary care source for all citizens which would serve to emphasize preventive and early diagnostic aspects of health. These efforts would go toward improvement in both cost reduction and quality of life. It must be recognized, however, that the HMO model of Health Plan is not the only structure which could achieve these goals. Preferred provider networks with selection of a primary care giver as gatekeeper/advice giver can also improve the proper utilization of health care by the patient. The difference between this model and an HMO is that there is no capitation of the primary care physician and financial penalty for the primary care giver to refer to a specialist is avoided. Under the HMO model, the gate keeper looses money from his/her own income when making referrals. This is a potential conflict of interest for the referrer. Area Health Plans of both types should be allowed to compete.

Under the "Jackson Hole" proposal for Managed Competition, regional Health Insurance Purchasing Cooperatives would be formed. This entity would pass through the premium monies to the AHP's which qualified to be offered by the HIPC. The HIPC is envisioned as a monitoring agency for the health plans, a regulator of premium cost and a collector of data on health quality and cost. The personnel of the HIPC unfortunately would add a new layer of bureaucracy to the health system and I caution whether it would be cost effective. However, if the HIPC were limited to providing service to Medicaid, low income recipients, individual purchasers of insurance, and small industry, perhaps the cost of running the HIPC could be reduced. This would leave large industry to shop for the AHP's of its choice without the intermediary of the HIPC.

The other envisioned role of the HIPC is to be the arbitrator of the regional expenditure target set by a national board. The Lancaster County Task Force is concerned that such budgeting may interfere with the market forces set up by the Managed Competition approach. In particular, localities that are spending less than their allotted budget would be encouraged to find ways to spend the extra money so that their budget would not be reduced the following year. If expenditure limits are selected, however, we would recommend that be accomplished through the mechanism described in the next paragraph.

The most important step in controlling health cost will be to create a national definition of a mandated benefits package. A process similar to the Oregon approach for medicaid reform should be considered. Once a prioritization of services list is created, a line drawn in the list would determine those services that would be covered and the expected cost for delivering these services. If the year's expenditure target were exceeded, then the national panel would need to look at the list and decide if the covered services should be changed or if the budget was invalid. Initially, expenditure targets should only be used on a trial basis in selected regions to determine if the model can work. At the inception they should not be binding.

In order to gain near term control of expanding health care cost, a series of important initiatives need to be implemented early in the transition to whatever new health system is selected. 1)uniform claim forms 2)uniform rules for regulation and reimbursement of the basic health package mentioned above 3)elimination of refusal or cancellation of insurance for prior health conditions 4)malpractice reform 5)anti-trust exemption for provider cooperation and fee negotiation-also to encourage improved provider peer review
6)revision of tax exempt status of health expenditure to allow both individuals and corporations the right to deduct the cost of the basic health care package but not extra coverage beyond this standard--money saved by government could be used to expand medicaid coverage 7)establish data collection standards for inpatient and outpatient services to allow monitoring of utilization and reduce duplication of services by providers (ie Lancaster County Outpatient provider computer network) 8)limit provider fee increases to inflation index and encourage voluntary freeze-this is to include suppliers, pharmacy etc. 9)begin development of definition of basic health benefit package 10)revise laws preventing creative managed care options (Moynahan Bill)

I suggest that congress consider enacting a package of new laws outlined above while convening a series of regional consumer/provider roundtable forums to attempt to reach consensus on the structure of the final health system to be selected. In the interim, useful steps toward cost containment will have begun.

Sincerely,

Robert G. Doe MD
213 Tomahawk Dr
Conestoga, Pa. 17516
President, Medical Society of Lancaster Co.
LANCASTER COUNTY TASK FORCE

GOVERNOR CASEY'S HEALTH CARE REFORM PROPOSAL

Attached are materials concerning Governor Casey's health care reform plan that proposes a system of "managed competition" for Pennsylvania.

Background

In November 1991, Governor Casey asked the Pennsylvania Economic Development Partnership to determine what could be done to reduce health care expenditures, broaden access, and improve the delivery of health care services in Pennsylvania. Jay Tolson, Chairman and Chief Executive Officer of Fischer and Porter Company, and Bill George, President of the Pennsylvania AFL-CIO, co-chaired the committee that produced the attached report (which was released November, 1992).

Governor Casey plans to conduct a series of public hearings, the first of which took place in Erie on December 17, the second was in Scranton on Jan 29, and the third was in Altoona on Jan 26. Three more are planned: February 26 in Philadelphia; February 22 in Pittsburgh; and Harrisburg-no date set.

Governor Casey will use the testimony presented at these hearings and other comments received to draft legislation for presentation to the General Assembly sometime this Spring.

Summary of the PEDP Proposal

The proposal has several components:

1. Guarantees every Pennsylvanian a basic package of health care services.

2. A Health Policy Board would be created to oversee and regulate the health care system. The Board would be an independent state agency whose members would be appointed by the Governor and approved by the Senate. The Board could consist of both consumers and providers.

   Note: The Board is not a Garamendi style HIPC; it will not function as a purchasing agent for consumers, but instead will determine the ground rules for competition among certified plans.

   The major functions of the Board include:

   - Defining a group of services which constitute the basic health care package,

- o Certifying Managed Care Networks within prescribed regions (MCN),
- o Setting procedures, measuring and monitoring product and process quality in managed care networks,
- o Establishing standards for managed care networks,
- o Setting payment schedules for employers, employed and unemployed individuals, and state and federal programs.

3. Each individual or family would enroll directly in a **managed care network (MCN)**. Managed care networks are defined as health maintenace organizations or any other institution or combination of institutions that agree to provide the basic health care package.

4. While individuals or employers could purchase supplementary health coverage from MCNs, it would also be possible to purchase traditional indemnity insurance with fee-for-service reimbursement from traditional insurers.

5. State mandated benefits would cover people's basic health care needs, with an emphasis on preventive care.

6. Coverage for additional services, not included in the basic plan, may be provided to individuals through employers, unions, membership organizations, and other groups.

7. Medical Assistance (Medicaid) recipients would be included in the plan from the start; Medicare recipients would be incorporated over time.

8. Businesses, state and national governments, self-employed individuals, and others who have the ability to pay would contribute to covering the cost of the basic benefit package.

10. Employers would pay for employees' health-care coverage, but would not have to administer benefits. There would be some subsidy to low-income employers and the unemployed.

11. Individuals would cover co-payments and deductibles. A program of coverage during periods of unemployment would be developed.

12. Payments would be made on a capitated basis to the managed care plans. It is not clear whether payments to providers would be risk-adjusted.

Recommendations for Immediate Action.

Included in the report is a list of "receommendations for immediate action." This list includes:

1. Improvements in the Certificate of Need Program (CON),

2. Exploring operations of the CON program within an overall dollar cap.

3. Restrictions of provider self-referrals to facilities in which they have ownership interests.

4. Requirement for hospitals and other providers to share technology and coordinate major investment with their community -- this recommendation has anti-trust implications.

5. Development of uniform claim forms and electronic billing procedures.

6. Efforts to encourage the growth of managed care in the commonwealth in employer-based coverage and through the state Medicaid program.

7. Encourage preventive care and healthy living. Insurers should provide discounts to employers who develop work-site health and wellness programs.

8. Insurers should: use community-rating; increase payments to primary care providers; and adopt open enrollment policies.

9. Develop and market low-cost basic benefit packages to small employers.

Analysis

The PEDP proposal contains many of the key elements of comprehensive reform, although it leaves a number of important questions unanswered.

Under the proposal's system of managed competition, it is unclear precisely how coverage will be guaranteed for all state residents. Would all individuals receive coverage through a certified Managed Care Network? How are low-income persons treated? What kind of subsideies would there be for small employers?

A Health Policy Board would be created to perform many of the functions of a purchasing cooperative--and would act as one purchasing cooperative for the entire state. The proposal would allow providers to be members of the Board without giving any

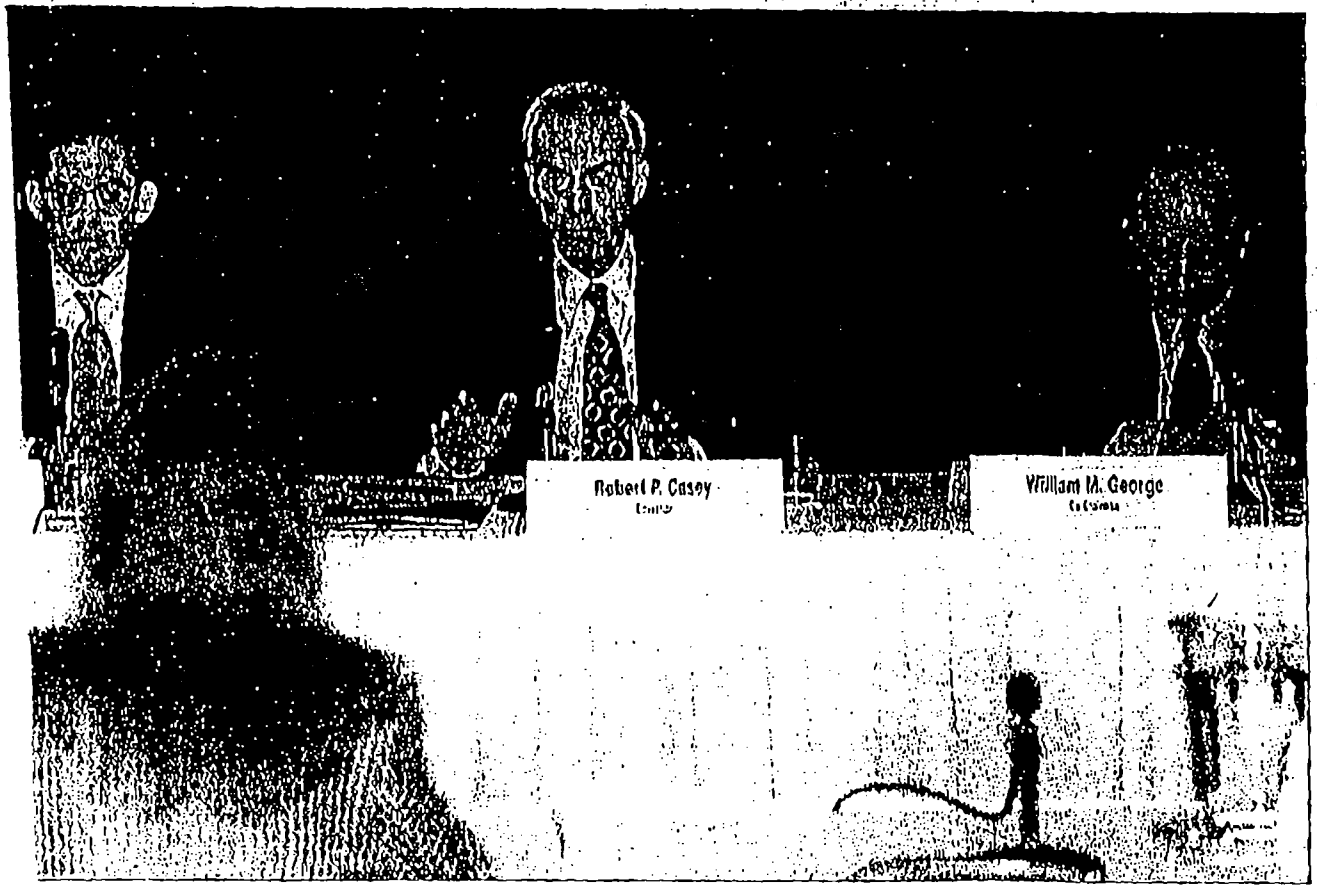
portion of the provider community "undue influence." Most experts agree that providers should not be allowed be members of the purchasing cooperative.

Under the proposal, the Board would set capitation rates for the basic health plan. This payment rate would be set without reference to the amount of service utilized and would be based on community experience. There is no mention of the need to risk-adjust premiums for those plans that accept a greater proportion of high risk patients.

Budgeting is a part of the plan only to the extent that Managed Care Networks would be required to live within a total determined by the number of enrollees and the per capita rate. This is cost containment from the bottom up: the plan includes no specific state role in setting overall spending targets.

The Scranton Times JAN 2 9 1993

Panel Told of Health Care Woe



Robert P. Casey, flanked by Andrew Greenberg, state ry of commerce, left, and William George of the AFL-CIO, sks a question of Ruth LaFountain, a small-business owner from Stroudsburg, during a state hearing conducted at the Marywood College campus on health care reform. (Staff Color-photo by Timothy Butler)

Witnesses Describe Insurance Problems

By LYNNE SLACK SHEDLOCK
Times Staff Writer

Gov. Robert P. Casey and a panel of officials who are developing a health care reform proposal for the state today took testimony from individuals, the insurance industry and the medical community on the problems of health insurance.

The hearing, held at Marywood College, was the third of six such forums being conducted across the state to gain public input before the proposal is presented to the General Assembly in the spring.

Casey, indicating that the state and the nation are facing a health care crisis, said: "The time is past for wringing hands. It's time now to strive for solutions, no matter how difficult that may be."

A large amount of the testimony dealt with the problems encountered by those with pre-existing conditions who are either unable to obtain coverage or who are forced to endure a waiting period until their conditions are covered by their insurance plans.

Connie Stackhouse testified that the premium for herself and her husband, Dale, a self-employed mechanic, had grown beyond what they could handle. The couple decided to search for a group plan and found one through membership in the Small Business Bureau. But Mrs. Stackhouse said that in order for her to join the group plan, she would be forced to go a year without payment for her pre-existing heart condition.

As a result, she said, she probably will remain in the more expensive individual plan the couple is now using while her husband enters the group plan.

"They have me trapped," she said. "I've never asked for anything free, only for something we can afford. We've even thought about divorce and then maybe I could get the (state assistance) blue card."

Ruth LaFountain, a small business owner from Stroudsburg, testified on the difficulties she has had in obtaining family insurance coverage for herself and her two employees, one of whom has a pre-existing condition.

LaFountain said in many cases the insurance companies would not cover the employee with the pre-existing condition, and she and the other employee would then not have the numbers to be considered a group.

She encountered other problems as well. Premiums ranged from $600 to $860 a month — almost 60 percent of her current payroll. Some companies insisted that she purchase life insurance in addition to health insurance, saying that it was state law. It is not.

"We've been lied to a lot," LaFountain said, suggesting that the state develop a booklet for small businesses that outlines insurance

(Continued on Page 12)

The Scranton Times
JAN 29 1993

Casey, Others Told Of Health Care Woes

(Continued from Page 1)

guidelines.

In the meantime, she remains without coverage.

"We're out there hanging on the limb and gambling that one of us does not get ill," she said, worrying that she could lose her business if she became sick.

Keith Williams of the Pennsylvania Center for Independent Living urged the state to look into the problem people with disabilities encounter in purchasing needed equipment. Some insurance companies will cover purchase for items such as power wheelchairs, while others do not.

He also expressed concern about the suggested managed care component of the state proposal. He said that often health management organizations use "gatekeeper" physicians who must make referrals for specialist visits. Using the gatekeepers may limit needed access to specialists for those with disabilities.

"I hope any plan can empower people to have choices," he said.

Paul Holdren, vice president of marketing, business affairs and operational development for Blue Cross of Northeastern Pennsylvania, said the three components needed for health insurance reform are community rating, open enrollment and basic benefits packages free of state mandates.

"Access is not the main issue in Pennsylvania," he said, citing the low percentage of uninsured in the state. "The main obstacle is making it affordable."

Panel members questioned Holdren's testimony, saying that freeing basic benefit packages of mandates would actually result in less coverage. Instead, they suggested reducing costs by forcing providers to control costs through such measures as eliminating unnecessary tests and over utilization.

But Dr. Peter Cognetti of the Pennsylvania Academy of Family Practices told the panel that testing is often done because of the unrealistic expectations of the lay public and because of the fear of lawsuits.

Cognetti made several suggestions to the panel including educating the public about their options and tort reform. Costs could also be controlled, he said, through deregulation of laboratory tests and standardization of forms. He said any health care management program must include preventative care and education on what he called "the number one health hazard of nicotine."

The proposal by the Economic Development Partnership would provide health care to every Pennsylvanian while saving at least $5 billion annually by the year 2000 through a system of managed care networks.

Under the proposal, insurers or managed care companies — such as health maintenance organizations — would organize networks that would contract with hospitals, physicians, clinics and other providers. Individuals would have a choice of managed care networks in their region.

All networks would be required to offer a standard benefits package, but additional services could be purchased separately. Employers would be required to make payments to networks on behalf of employees. Networks could not deny coverage based on a pre-existing condition.

ECONOMIC DEVELOPMENT PARTNERSHIP

Robert P. Casey
Chairman

Andrew T. Greenberg
Executive Director

COMMITTEE ON HEALTH CARE MEMBERSHIP

Co-Chairmen

William M. George
President
Pennsylvania AFL-CIO

Jay H. Tolson
Chairman of the Board and President
Fischer and Porter Company

Committee Members

Mary Del Brady
Vice President
Allegheny Health Education and Research Foundation

A. James Freeman
President
Lord Corporation

Edward J. Keller
Executive Director
AFSCME
Council 13

Dr. Donald Mattison
Dean
Graduate School of Public Health
The University of Pittsburgh

Bruce H. Raimy
Chief Executive Officer
Welder's Supply Company

Geri Swift
President
Geri Swift Associates

Karl Krieger
President
Transtech, Inc.

Thomas P. Foley, Ex-Officio
Secretary of Labor and Industry

Andrew T. Greenberg, Ex-Officio
Secretary of Commerce

Cynthia Maleski, Ex-Officio
Acting Insurance Commissioner

Dr. Allan S. Noonan, Ex-Officio
Secretary of Health

Linda M. Rhodes, Ex-Officio
Secretary of Aging

Karen Snider, Ex-Officio
Secretary of Public Welfare

John T. Tighe III, Ex-Officio
Deputy Chief of Staff for Operations and Administration
Governor's Office

Designated Representatives

Janet Kail
Executive Assistant
AFSCME
Council 13

Donald Saurer
Manager Public Relations
Lord Corporation

David Wilderman
Vice President
Pennsylvania AFL-CIO

State Agency Staff Representatives

Scott Bair
Director, Economic Development Policy Office
Department of Commerce

Martha Bergsten
Economic Development Policy Specialist
Governor's Policy Office

Richard Browdie
Deputy Secretary
Department of Aging

Sherry Knowlton
Deputy Secretary
Office of Medical Assistance Programs
Department of Public Welfare

David Meyers
Special Assistant to the Governor
Governor's Office

Ken Slaysman
Economist
Department of Commerce

Janie Snyder
Director, Office of Policy, Planning, and Evaluation
Department of Labor and Industry

Donna Wenger
Deputy Secretary for Planning and Quality Assurance
Department of Health

Ken Wolensky
Director, Program Services Office
Department of Insurance

~~CONFIDENTIAL~~

STAFF RECOMMENDATIONS: COMPREHENSIVE HEALTH REFORM LEGISLATION

The staff has reached a consensus recommendation on major elements of a comprehensive health reform bill and identified a limited number of important issues that will need to be resolved by the members. The staff recommend a program that includes strong cost containment, universal health insurance coverage, and measures to improve the health care delivery system and foster health promotion and disease prevention. The program is built on the best ideas of the comprehensive Democratic bills introduced during the last session of Congress, the work done by the group prior to the election, the program advanced during the Clinton campaign, and new ideas introduced by members of the group subsequent to the election.

COST CONTAINMENT

Cost containment is achieved through a national health care budget implemented by a combination of managed competition, capitated premium limits, and negotiated rates, where necessary. In addition, a number of other steps are taken to assure that the program addresses all aspects of the cost problem.

--Global budget. The national health care budget is established by a new, independent health board patterned after the Federal Reserve Board. The Board establishes budgets for States, as well as the nation as a whole. The national budget will be related to the long-term growth in the economy, but the Board is given flexibility to respond to unforseen events and national health needs.

--Managed Competition. Health Insurance Purchasing Cooperatives (HIPCs) are established in each State, as described in the universal coverage section below. HIPCs aggressively negotiate with health plans to assure quality, cost-effective care for individuals enrolling through the HIPC. Enrollees have financial incentives to choose the most cost-effective plans, and the combination of enrollee incentives and HIPC purchasing power will promote the growth of HMOs and other forms of managed care capable of reducing health care costs. HIPCs purchase health care from all plans within a budget established consistent with the national and state budget.

employer-paid health insurance premiums or the deductibility by the employer of such premiums?

UNIVERSAL COVERAGE

All Americans are guaranteed affordable private health insurance coverage, with benefit packages meeting national standards.

--Insurance mechanism. A Health Insurance Purchasing Cooperative is a state-chartered organization with a board of directors representing purchasers of health care services. Coverage is provided by a choice of competing health plans selected by a HIPC in the geographic area in which the enrollee resides. Payment of a mandatory premium by businesses and workers entitles the worker and the worker's dependents to enroll in low cost health plans offered by the HIPC without further premium charges. Individuals may enroll in more expensive plans by paying an additional, voluntary premium. Employers may contribute more than the mandatory amount, but any additional, voluntary contribution would have to be the same for any plan chosen by the worker, with cash rebates to workers choosing less expensive plans. The unemployed and those out of the labor force pay a premium related to income, up to the actuarial value of the plan.

HIPCs would be required to offer a choice of plans to enrollees, including freedom-of-choice plans. Covered benefits would be standardized, enrollment in any plan would be available to any HIPC participant, and, if the required benefit package is less than comprehensive, several levels of coverage would have to be made available. Payments by the HIPCs to the plans would be risk-adjusted, so that plans would not be penalized for enrolling higher risk individuals, and plans would have to meet a variety of other standards, including quality and disclosure of information, in order to be offered by a HIPC.

--Benefits. The staff recommends that required benefits be as comprehensive as possible, consistent with member decisions about the total cost of the program. Specifically, the staff assumes that required benefits will include all medically necessary physician services (including services performed by such non-physician professionals as advanced practice nurses and physician assistants), hospital services

(including hospice services), diagnostic tests, mental health and substance abuse benefits, pre-natal and maternity care, EPSDT services for children, and specified preventive benefits for adults. In addition, the staff recommends, subject to decisions about the total cost of the package, coverage of all recommended prevention benefits, prescription drugs, rehabilitation services, durable medical equipment, family planning services, improved mental health and substance abuse benefits, and home health and skilled nursing home benefits when such benefits are an alternative to hospitalization.

--Special Provisions for low-income individuals. If required benefits are less than comprehensive, low-income individuals will be provided an expanded package of benefits comparable to current Medicaid mandatory and optional services. Cost-sharing and premiums will be subsidized for the low-income. Provisions will be included in the program to safeguard quality for low-income beneficiaries and to avoid segregation of low-income enrollees in low-cost plans.

MAJOR ISSUES ON WHICH THERE IS NO CONSENSUS STAFF RECOMMENDATION:

--Should all employees be required to receive coverage through HIPCs or should large employers be allowed to provide coverage directly?

--Should the Medicare program be eliminated and Medicare enrollees be required to receive their coverage through HIPCs?

--Should long-term care be a required benefit?

--Should there be special provisions to assist firms that provide retiree health benefits?

IMPROVING THE HEALTH CARE DELIVERY SYSTEM

The staff recommends a program that establishes a new emphasis on health promotion and disease prevention, moves the health delivery system in the direction of primary care and greater coordination of services; and provides a variety of special programs directed at underserved rural, inner-city, and minority populations for whom insurance coverage alone is not sufficient to assure good health care.

--Preventive health. As noted above, the staff recommends that the required benefit package include coverage of the full range of preventive services recommended by the U.S. Preventive Services Task Force, including pre-natal care, well-baby and child care, and adult services such as pap smears and mammograms. All children will be guaranteed EPSDT coverage. Existing Federal health promotion and disease prevention programs will be supplemented by additional grant programs directed at high priority problems.

--System Reform. New grant programs will be established to encourage development of integrated community care networks. Antitrust laws will be clarified to encourage providers to work together at the community level to eliminate duplicative, wasteful services and fill gaps in the delivery system. State barriers to the development of integrated systems of care will be pre-empted, and loans will be available to develop new primary care clinics in rural and other underserved areas.

The supply and distribution of primary care physicians and non-physician professionals will be improved by: expanding programs to recruit students likely to choose primary care careers; encouraging health professions training programs to increase emphasize primary care; and by improving reimbursement for primary care specialists relative to other specialists. Training programs for non-physician primary care specialists will be enhanced. The negotiated rates established by Federal Board and the States will be required to reimburse institutions for medical education in a way that will provide an appropriate balance between primary care training and other specialty training. The program will incorporate the recommendations of the Physician Payment Review Commission expected in March or will establish a separate Commission appointed by the Federal Health Board to assure to develop detailed recommendations to achieve an appropriate supply and distribution of health manpower.

--Populations with special needs. The Community Health Centers program service capacity will be tripled, to 15 million people annually. The National Health Service Corps will be will be increased to 1400 new physicians yearly and a field strength of 4200 physicians. Efforts to expand the supply of minority and other physicians and other health professionals interested in serving special needs populations will be enhanced. Expanded outreach in poor and minority communities will be

required. Grants will be provided to local health departments and other facilities serving populations with special needs. Data-gathering on health status and needs of minority populations will be expanded, and representatives of underserved populations will be included on all boards and commissions established by the legislation. The rural health transition grant program will be expanded. A program of school-based or school-related clinics will be established, as will an initiative directed at reducing infant mortality and improving the health status of infants and young children at high risk, including a program to assure universal childhood vaccinations.

The staff recommends that high priority should be given to adequate funding for these initiatives, including consideration of funding some subset of these programs as capped entitlements from the revenues or savings provided in the comprehensive reform legislation.

FINANCING

The program will be funded by a combination of business and individual premium contributions, with subsidies provided to low-income individuals and to small businesses requiring assistance in meeting their additional responsibilities. Consideration has been given to a payroll-related premium as a financing device, with subsidies to small business based on either limiting the percentage of total payroll contributed by the business or limiting the required percentage of pay contributed on behalf of any individual.

Subsidy costs for businesses and individuals could be raised either through cost-containment or new revenues.

ISSUES ON WHICH THERE IS NO STAFF CONSENSUS

--Should cost containment be established at a level that will fully fund program costs not covered by premiums, that will result in deficit reduction, or that will require additional general taxes?

--What should be the basis on which premiums are assessed on businesses and individuals and the level at which they are set?

--What should be the basis for providing subsidies to small

businesses?

STATE FLEXIBILITY

States shall be allowed to adopt and operate comprehensive health programs as long as those programs meet Federal standards for assuring coverage, access, and quality, and controlling costs.

DISCUSSION DOCUMENT
COMPREHENSIVE HEALTH REFORM

GLOBAL BUDGETING RECOMMENDATIONS

I. Principles -

a) growth of budget related to long term growth in economy
b) budget is overall "fence" with tools to control costs
c) flexibility for unforseen events

II. Design and Enforcement of Budget

a) The Federal Health Expenditure Board sets an aggregate global budget at the federal level; which is then allocated to state and HIPC levels, using data from HIPCs and States

b) HIPC receives global budget which is used to establish premium rates for all HIPC plans. These rates are risk-adjusted

c) Certified plans can set their own payment rates to providers or use those established by the National board or the states, as long as they stay within the per capita rate

d) States will have the ultimate responsibility for the failure of plans to live within their budgets, unless a State asks the Federal government to assume responsibility for the cost control system within that State.

e) National, state, and HIPC budgets for subsequent years are based on allowed premiums for the budget year, not on actual expenditures by the plans for health care services, so any overages are not built into the base. (What if they spend less?)

III. Budgets for Large Business outside the HIPC

a) Allocation - Limits set to a base year amount. The plans are allowed no more than a per capita percentage increase over the prior year, based on the percentage increase allowed in the overall budget. Flexibility for changes in population covered, etc.

b) Enforcement - Self-insured firms bear the financial risk. Firms may use the regulated rates or negotiate their own arrangements with providers. For large employers that work with insurers - the insurance company assumes the risk-

If self-insured businesses fail to stay within budgets after three years, they will be forced to join the HIPC.

IV. FEDERAL AND STATE ROLES FOR GLOBAL BUDGETING

Federal Government

1) designs national structure to contain costs including minimum benefit package, global budeting, rate-setting and managed competition.

2) sets annual national budget for health care, allocates among the states using demographics, historical spending and other appropriate factors

3) federal government assumes responsibility for data collection, technology assessment, outcomes research, physician supply and other tools needed to control health care costs.

4) establishes rates through negotiations to be used by states where managed competition is not viable, or as a tool to help states live within budgets, for optional use by health plans where the State prefers not to set its own rates, or as a last resort when states fail to meet global budget target.

Enforcement: if a state fails to live within budget set by federal government over a three year period then:
the federal government should deem a state out of compliance and the state may lose its right to design its own cost control system

STATE GOVERNMENT

1) States establish an authority/function (HIPC) in-state that would be responsible to structure the health care system so that federal cost control and performance goals are met.

2) States may opt out of the national system provided they can meet federal access and cost containment requirements

3) States are responsible for allocating their budgets and responsible for enforcement.

4) States are responsible for enforcement of state global budgets, using HIPC purchasing power, and where appropriate - rate-setting - to control costs and meet budget.

Open Issue: Are changes to ERISA necessary to help states tocontrol costs?

V.SPECIAL PROVISIONS WHERE MANAGED CARE IS NOT VIABLE

1) Rates will need to be established for use in places where managed competition is ineffective and to provide optional assistance for fee-for-service plans in meeting the premium cap.

2) Volume performance targets will have to be used in combination with rate-setting to control volume

3) standardized all-payer rates will be set, preferably through negotiations at the federal level; they can be used by self-insured plans as a tool to stay within budget targets

4) states will have the option to negotiate their own rates

5) Medicare payment methodology and volume performance standards should be used as a guideline in the establishment of rates and volume performance standards for health care delivery outside of the Medicare Program under a health care reform proposal

VI. Data Collection - We need to do more work to improve the collection and coordination across existing payers.

OUTSTANDING ISSUES

1) Standard Benefit Package - outstanding issues which relate to cost containment.

a) How comprehensive will the standard benefit package be ?
b) Will there be "richer" packages available for business and or/employees to purchase ?
c) If richer packages are available, will they be purchased with after-tax dollars ?
d) How will such health care costs outside a basic package be included in a global budget ?

2) Does the budget include only covered services or all expenditures?

HEALTH INSURANCE PURCHASING COOPERATIVES
RECOMMENDATIONS

IN GENERAL:

* HIPCs will act as aggressive purchasers for all consumers of health care enrolled in the HIPC, whether they participate in managed care plans or fee-for-service plans. It will select participating health plans and establish allowable premium charges for each plan

* The HIPC will handle enrollment and premium collection. It will assure quality of plans and will collect and disseminate information to assist consumers in choosing a plan. It will risk-adjust premiums to participating plans. It will assure standardization of benefit packages across plans

* Participating health care plans will, to the extent practicable, be paid on a capitated rate. They have the option of living within the capitated amount, using any methodolgy available to stay within the budget, or using the negotiated reimbursement rates as a tool to stay within the budget, accompanied by Volume performance standards, similar to those used under the Medicare physician payment reform law.

* The national all-payer rate system will be used for fee-for-service providers in the HIPC program, unless the State chooses to run a different cost-containment program for all payers

GOVERNANCE

Federal Government - establishes broad guidelines for establishment and operation of HIPCs and consumer protection standards.

State Government - States charter HIPCs. Design and enforce consumer protection and other requirements within federal guidelines. Design intrastate and interstate compacts.

Governing Board - The federal government should provide parameters on qualifications for membership in particular that it is representative of the purchasers. To make sure that the HIPC is responsive to local needs, however, the procedures for exact representation, size and appointment should be within a state's discretion.

HIPCs should be cooperatives for purchasers, and act as their negotiating agents, so its relation with insurers and providers should be arms-length. Instead, providers and insurers should form advisory boards that periodically meet with the HIPC board

Model of Governance - HIPC as a Public Corporation

* a non-profit entity, established by the state for exclusive purpose of assisting employers and individuals purchase health insurance, subject to federal standards

* Models exist such as Port Authority

* California Public Employees Retirement System

FEDERAL BENEFIT PACKAGE

* One comprehensive standard benefit package will be offered by all HIPC plans. The benefit package will be standardized so that benefits, definitions, format and terms are the same.

* HIPC must offer at least one fee-for-service plan

Outstanding Issues:

* Will benefits be allowed to be sold outside the benefit package and if so, will such "wrap around" benefits be standardized like Medigap.

* If a broad benefit package cannot be included for cost reasons, the HIPC could offer several limited, standardized benefit packages

* Will each HIPC be required to establish a public plan ? Will such plan be administered by the HIPC?

PHYSICIAN INCENTIVES - the following policy options may be used as incentives for physicians to participate in managed care plans:

* Actions violating anti-trust and safe harbor provisions between physicians or groups of physicians and accountable health plans must continue to be prohibited

CONSUMER INCENTIVES -

* Mandatory premium contributions by individuals and businesses set at a level sufficient to purchase the lowest-price plan or the average of the three lowest-price plans (or some similar measure)

* More expensive plans must be purchased by voluntary contributions by businesses or individuals. If businesses voluntarily contribute more than the mandatory amount, the contribution must be equal for all p lans. If an individual chooses a plan costing less than the sum of the voluntary and mandatory contribution, a cash rebate must be provided.

RURAL ISSUES

1) States should be given authority to make a finding that all or regions of their territory should be exempt from managed competition requirements and prescribe the alternative system that will assure coverage and meet budget requirements.

Such a finding should be certified by the National Board (or HIPC). More work needs to be done to define exactly what national requirements these areas could be exempted from.

Studies should be supported by HRSA to develop a better information base or criteria to assist states in determining what numbers of people and health providers are needed to effectively support managed competition.

2) HIPCs will be established for every territory, whether or not managed competition is viable.

3) Technical grants and other assistance should be available to help States and regions where managed competition cannot work to develop community care networks

4) States should be allowed to develop interstate agreements to allow for coverage of residents of adjoining boarder areas. Regional HIPCs encompassing a number of states should also be allowed.

5) A comprehensive set of proposals to assist rural areas in recruiting and retaining primary care doctors and other health professionals must be included in legislation

Open Issues - Quality protections for Medicaid beneficiaries in HIPCs. - Group is working with Children's Defense Fund and other advocacy groups to develop specific quality protections, including solvency standards.

* Quality protection must be assured for all beneficiaries.

* How do we prevent low-income people from being segregated into a low-cost (or second-tier) plan?

Open Issue: Should large employers be allowed to opt out of the HIPC; if so, what size firm should be allowed to opt out?

SERVICE DELIVERY RECOMMENDATIONS

I. Supply and Distribution of Health Care Professionals.

a) The Physician Payment Review Commission is scheduled to report to Congress in March, 1993 on physician supply and distribution issues. Health Care Reform legislation should include provisions which incorporate the recommendations of PPRC to address the supply and distribution of physicians and other health care professionals.

b) The legislation should further direct PPRC to undertake additional analysis of how such recommendations are to be implemented. For example, if PPRC recommends a reduction in the aggregate supply of physicians, further recommendations should be made to determine which specialties need to be reduced, and by what percentage, and what programs need to be implemented to assure access to primary care physicians in underserved areas.

c) Alternatively, the legislation may establish a separate Commission, to be appointed by the Federal Health Board to make recommendations about the implementation of anappropriate level of health manpower.

(i) The Commission will include members from the academic health centers, medical schools, practicing physicians, including specialty societies, nursing schools, mid-level practitioners, health policy experts and consumers.

(ii) In making recommendations about implementation, the Commission shall consider changes in the financing of graduate and undergraduate medical education, increases in the training of nurse practitioners, other mid-levels, and non-physician providers, limitation and allocation of residency slots, expansion of training opportunities in community-based and public health settings, and any other options that may achieve the objective of an appropriate supply and distribution of health professionals.

d) The Commission shall make recommendations to the Federal Health Expenditure Board, the Congress and the President for appropriate legislative and/or executive action to achieve the goal of a balanced health workforce policy.

II. Anti-Trust Initiative

a) Health Care Reform legislation will include a clarification or modification of anti-trust law to encourage collaborative efforts between health care institutions to encourage the development of community care networks that will reduce unnecessary and costly duplication of services and to improve the availability of needed services. Such anti-trust legislation should include government oversight to ensure consumer protection and prevent anti-competitive behavior.

III. Expansion of Standard Benefit Package

All of the following recommendations are pending approval based on cost-estimates from CBO.

a) Rehabilitation Services -Rehab services provided by Comprehensive Outpatient Rehab Facilities (CORFs) and outpatient services provided by physicial therapists, occupational therapists, and speech therapists would be included in the standard package.

b) Durable Medical Equipment - DME coverage included similar to the current Medicare DME benefit; specify that DME includes "assistive devices" such as communication devices for persons who cannot speak.

c) Alternatives to Hospitalization - add home health, short-term skilled nursing home benefit as an alternative to hospitalization, similar to hospice benefit.

d) Family Planning Services - coverage for prescription and non-prescription birth control devices; ensure that physician and other health professional visits in connection with the provision of family planning services are covered.

e) Expanded Mental Health Benefit - the group has not finished its work on this issue; therefore this is a placeholder for a possible expansion in benefits covered for mental health. There has been criticism that the current mental health benefit is inadequate and discriminates against people with mental illness.

f) Prescription Drugs - inclusion of benefit, pending cost estimates

IV. Every effort will be made to fund preventive care benefits and primary care initiatives, including the possibility of designating some as capped entitlements.

V. Additional Public Health/Preventive Benefits - Recommended for inclusion pending cost estimates and feasibility of implementation

1) School-linked clinics - bring services to adolescents (or all school-aged children and youth) through school-based or school-linked health clinics

2) expand comprehensive services to pregnant women and young children to age 3 through an "Early Start" program

3) a universal childhood immunization program

OUTSTANDING ISSUES

1) Increase funding for Health Care for the Homeless

2) What services should be covered as part of the standard benefit Package? Can people purchase supplemental benefits

3) How do we best integrate issues not directly related to health services or the provision of health services and financing with health reform? (e.g. funding for lead paint programs and other public health initiatives which contribute to the poor health and increased health care costs of populations.)

4) Moving away from a list of services and allow a community to address its own health needs within a global budget, using health outcomes to measure success.

5) How will abortion be covered in the health benefit package?

6) Will the health benefit package include long term care?

12/03/92 15:00

FOR IMMEDIATE RELEASE
December 3, 1992

CONTACT: Don White
202/223-7782

Health Tech

HIAA

Health Insurance Association of America

NEWS RELEASE

HEALTH INSURANCE INDUSTRY RELEASES PLAN FOR COMPREHENSIVE REFORM OF HEALTH CARE DELIVERY SYSTEM

WASHINGTON, D.C., December 3 -- In a radical break from previous policy, the Health Insurance Association of America (HIAA) today approved circulation of a discussion paper that would provide universal health care coverage and generate substantial revenue to help pay for health programs.

Under HIAA's draft reform proposal, the federal government would require all individuals to carry, and all employers to offer, an essential, continuous package of health care coverage. Funding to help pay for coverage for people below the poverty line would come from eliminating favorable tax treatment for benefits that go beyond the essential package.

"This reform proposal marks a fundamental shift by insurers and indicates our deep commitment to meaningful health care reform that ensures coverage for all Americans while preserving the tradition of high-quality care," noted Ian M. Rolland, Chairman of the Board of HIAA. "We expect that these measures will lead to universal and more affordable health care for the country. It is also fair to say that it heralds a new era for hospitals, doctors, and insurers."

The HIAA Board of Directors strongly endorsed comprehensive reform of the health care system, consistent with the set of

- more -

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7783 FAX 202/223-7896

principles outlined in the draft proposal. The Board also directed that the draft be distributed to all HIAA member companies for additional comment and refinement, according to Mr. Rolland, who is the Chairman and Chief Executive Officer of the Lincoln National Life Insurance Company of Fort Wayne, Indiana.

The new proposal rests upon four cornerstones:

- o Universal Coverage: HIAA's draft proposal ensures health care for all Americans, eliminating the problem of the uninsured. Under this program, everyone would be covered -- by law -- under an essential package of care, either through an employer or their own means. Private insurers would agree to provide coverage to everyone. The government would pay for health insurance for people below the poverty line. Private insurers and HMOs would provide managed care to the poor in order to encourage preventive treatment and wellness care.

- o An Essential Package of Benefits: Each individual would be guaranteed an essential package of benefits, which includes primary and preventive services as well as catastrophic coverage. Coverage will be designed to meet the essential needs of Americans, and consumers also would have the option to purchase supplemental coverage for additional benefits. People above the poverty line and people below the poverty line would receive the same package of benefits, and government would help define the essential package of coverage.

- o Cost Control Features: HIAA's cost control prescription includes the elimination of cost shifting from Medicare and Medicaid patients to privately insured individuals. It also includes new approaches designed to discourage excessive doctor visits, the unnecessary use of technology, and unnecessary hospital or specialist care.

- o An Equitable Tax Policy: To promote equitable tax policies, premiums paid for an essential package would be excluded from employee or individual taxable incomes. However, premiums paid by an employer for benefits in excess of the essential package could be deemed taxable to the employee. Monies generated from this tax preference would help finance health care coverage for the poor.

- more -

One important component of the proposal is the further development of integrated financing and delivery systems -- we're calling them Responsible Health Systems (RHSs), which will compete with one another and other forms of health insurance in offering the essential package and supplemental coverage. The proposal calls for flexibility in how future care will be delivered.

"Our program is designed to provide everyone in the United States with health insurance coverage and to help people become healthier while holding down costs," observed HIAA President Carl J. Schramm.

"This new initiative will jump-start health care reform," noted G. David Hurd, HIAA's incoming Chairman of the Board and a primary architect of the proposal. "With this approach, all Americans can be assured of coverage. Costs will be stabilized and the quality of care, especially for the poor, will improve dramatically," added Hurd, who is also President and Chief Executive Officer of The Principal Financial Group of Des Moines.

HIAA is a Washington, D.C.-based trade association representing the nation's leading commercial health insurance companies.

# # #

HIAA

Health Insurance Association of America

Creating a Working Health Care System: Key Points

1. Guiding Principles to Achieve High Quality, Affordable Care for All:

   - Healthy and productive life, maximizing dignity and quality of life for all
   - People's health care costs are stabilized

2. Pluralistic Financing and Delivery Systems

   - Based on competition on a level playing field
   - Evolving and flexible
   - Open to innovation
   - Private sector is empowered by government which removes barriers to growth of pluralistic, competitive systems
   - Based heavily on employer system

3. Cost Containment is Centerpiece

   - Relies on managed care in many evolving forms.

   - Responsible Health Systems are one form -- other forms also compete with Responsible Health Systems on a level playing field

   - Characteristics of Responsible Health Systems:

     - Combine all sources of financing, including government, with the delivery of care.
     - Accountable to patients and the community
     - Competes to meet the needs of a community
     - Competes in offering an essential package and supplemental coverage
     - Integrates all levels of care
     - Develops and discloses quality measures
     - Provides incentives for healthy behavior
     - May pay providers in a variety of ways

   - A government-empowered, self-regulatory organization comprised of providers, insurers, employers and the public will establish "rules of the road" for all players in the health care system. This entity would:

Revised
12/3/92

1025 Connecticut Avenue, N.W., Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

  - establish consistent payment methodology for all payers
  - eliminate cost shifting
  - define basic benefit plan
  - pre-empt conflicting state laws
  - authorize technology assessment and coordinate technology/resource allocation

- Employers/Responsible Health Systems provide incentives for healthy behavior for example, by discounts, promotions or education.

4. <u>All Americans have continuous coverage for an essential package -- not bare bones -- of health care.</u>

   - Covers primary, preventive and catastrophic care
   - Essential package is the same for the poor and nonpoor

5. <u>All Americans who are not poor must pay for coverage on a continuous basis -- healthy people cannot opt out.</u>

6. <u>Employers remain central</u>

   - Must offer a plan and offer payroll deduction
   - May pay for (in part or in total) employee and dependents
   - Provides incentives to promote healthy behavior

7. <u>Government pays for all the poor -- buys care like other payors and pays full cost like other payors. Does not underpay and shift costs to others.</u>

8. <u>Equitable Tax Policy</u>

   - Tax incentives for the essential package will be extended to individuals as well as employees.

   - Any health benefits in excess of the essential package will be treated as taxable income to employees, or paid with after-tax dollars for individuals.

   - Revenues from tax changes help government pay for poor and stop cost-shifting.

9. <u>Results and trends are measurable and will compare favorably to other nations on a variety of measures such as costs, mortality, percent who smoke, height/weight standards, and gunshot wounds.</u>

10. Systemic factors driving costs are slowed.

- Responsible Health Systems and other payment approaches are financially designed to discourage excess doctor visits, unnecessary hospital and specialist care, and technology use.
- Physicians empowered to practice effective, not defensive, medicine.
- Diminished use of inappropriate and unnecessary care.
- Administrative simplicity and uniformity save money and help control fraud and waste.
- Incentives for healthy lifestyle choices pay off.

TALKING POINTS -- ADMINISTRATIVE COSTS

-- One of the major problems in our current health system is the large amount of administrative waste. This waste is largely due to the hundreds of different forms and billing procedures throughout the system and underwriting practices in the small group market.

-- A recent study estimated that of the $281 billion in hospital spending in 1991, $93.9 billion -- or 33 percent -- will be attributed to administrative functions.

-- An estimated 14 percent of administrative costs ($13.5 billion a year) could be saved by moving to a system that: eliminated individual patient billing and accounting; eliminated selective contract negotiations; and regulated the distribution of profits to shareholders in for-profit hospitals.

-- Hospitals alone spent about $7.4 billion on patient accounting and credit and collections in 1991.

-- A typical US hospital has 50 billing clerks sending and tracking bills. The equivalent Canadian hospital has three such clerks who are mainly involved with billing American Visitors.

-- One study shows that 23 percent of US health care spending (over $130 billion) goes to managers, administrators, insurers, lawyers, and other paper pushers.

-- Between 1970 and 1985, the number of health administrators rose three times faster than the number of physicians or other health care workers.

-- In 1985 health insurance overhead alone consumed $106 per capita, as much as research, public health programs and new health facility construction combined.

-- For small businesses, for every one dollar they pay in premiums, 25-40 cents goes to cover administrative expenses.

MALPRACTICE REFORM

Arguments Against Major Malpractice Reform:

--Malpractice premiums are not a significant part of the health care cost problem. They account for less than five per cent of doctor's costs and less than 1 per cent of hospital costs.

--The evidence on the costs of defensive medicine is weak and is complicated by a lack of clear definition as to what defensive medicine is. The Congressional Research Service summarized the most recent, comprehensive study, by saying, "the Harvard study provides some evidence that the current malpractice tort system has the effect of encouraging additional medical services, which adds to the cost of the health care system. But it is not clear from this study whether these services constitute wasteful defensive medicine or efforts to improve patient outcomes." (Congressional Research Service, Medical Malpractice, a report prepared for the Ways and Means Committee, April 26, 1990), p.63.

--But regardless of the cost of defensive medicine, there is no evidence that changes in the tort system will reduce it or impact on health care costs. Virtually every state has enacted tort reforms of the type proposed in this amendment in the last two decades, but health costs are going up faster than ever.

--Physicians practice defensive medicine because they do not want to be sued, and it stretches credulity to believe that they will change their practice patterns because awards are a little lower or it is a little harder to get into court.

One should put these aggregate costs of medical practice insurance in perspective, by relating them to the total health care costs for the nation. In 1987, when health care costs were roughly $500 billion, medical malpractice premiums consumed slightly more than one percent of our health care dollars (up from .5% of health care dollars in 1960).[5] True, $4 billion of these premiums charges were borne by physicians, as compared with $103 billion spent on physicians services. But while malpractice premiums do represent a somewhat higher share of physician services, four percent of gross physician revenues is not an extraordinarily high bill to pay for liability insurance.

These overall figures, however, tend to understate the acuteness of the problem in specific situations. There is a great deal of variation in premiums by specialty and by geographic location.[6] For example, while general

---

5. Levit, Freeland, National Medical Care Expenditures, Health Affairs (Winter 1988) 124. See also P. Weiler, Medical Malpractice: (ALI Background Paper, 1987).

6. Premiums are based on claims history of the geographic location and the individual specialty. Since certain specialties are known to lead to many more claims than others, specialty designation has the greatest impact on one's insurance premium. For instance, St. Paul's rates specialties according to eight classes. Family practice, class four, is indexed at 1.0. Physicians who do no surgery, including allergists, dermatologists and psychiatrists, are in class 1A and indexed at .32. On the other hand, neurosurgical physicians are in class eight, and are indexed at 3.48. This means that in a given state, if family practitioners are charged $10,000 for malpractice premiums, psychiatrists are charges $3,200 and neurosurgical physicians are charges at least $35,000. In major metropolitan areas, malpractice premiums are quite a bit higher. For instance, St. Pauls charged class four physicians $43,900 in California in July of 1989. In Los

"Medical Malpractice", A background Paper Prepared for The Pepper Commission, February 21, 1990

1. Hospitals

More limited information is available on insurance costs for other providers. A 1986 GAO report[66] estimated that total hospital malpractice insurance costs increased 57 percent over the 1983-1985 period, from $849 million to $1.336 billion. Total costs include self-insurance costs, premium costs, and estimates of uninsured losses. The average cost per inpatient day increased by 85 percent over the period--from $3.02 to $5.60. The higher percentage increase figure per inpatient day reflected the 13 percent decline in number of inpatient days over the period. The report observed significant variations in hospital insurance costs by region and hospital size.

In 1989, the St. Paul Company reported a recent slight decrease in claims frequency and a moderation in the growth of claims costs for its hospital policyholders. As a result the company reported that it would be seeking hospital rate decreases averaging 2 percent nationwide in 1989. The company determines individual premiums for its policyholders by the State or territory where the facility is located, the number of occupied beds and outpatient visits, the limits of liability selected, the number of years insured under claims made coverage, the deductible option selected, and experience rating. The average countrywide acute care bed rates for mature claims-made coverage at $1 million/$3 million coverage levels would be $1,480 in 1989 when all rate filings were approved. This compares with $1,516 in 1988. Table 4.6 shows the company's proposed hospital average bed rates for 1989.

[66] Nye, David, et.al., *The Causes of the Medical Malpractice Crisis*, p. 1502.

Table 13

National health expenditures aggregate amount and average annual percent change, by type of expenditure: Selected calendar years 1965-2000

Type of expenditure	2000	1995	1990	1987	1986	1985	1984	1980	1970
	Amount in billions								
National health expenditures	$1,529.3	$999.1	$647.3	$496.6	$458.2	$422.6	$391.1	$248.1	$75.0
Health services and supplies	1,493.8	972.1	626.5	479.3	442.0	407.2	375.4	236.2	69.6
Personal health care	1,398.1	900.5	573.5	438.9	404.0	371.3	341.9	219.7	65.4
Hospital care	621.0	393.6	250.4	192.6	179.6	167.2	156.3	101.6	28.0
Physician services	319.6	209.0	132.6	101.4	92.0	82.8	75.4	46.8	14.3
Dentist services	89.6	62.2	41.8	32.4	29.6	27.1	24.6	15.4	4.7
Other professional services	60.4	38.1	22.9	16.2	14.1	12.4	10.9	5.7	1.6
Drugs and medical sundries	102.6	65.4	42.1	32.8	30.6	28.7	26.5	18.8	8.0
Eyeglasses and appliances	24.7	16.7	11.2	8.8	8.2	7.5	7.0	5.1	1.9
Nursing home care	129.0	84.7	54.5	41.6	38.1	35.0	31.7	20.4	4.7
Other personal health care	51.2	30.8	18.0	13.1	11.9	10.8	9.4	5.9	2.1
Program administration and net cost of private health insurance	57.7	44.4	34.6	25.9	24.5	23.6	22.6	9.2	2.8
Government public health activities	38.0	27.2	18.5	14.4	13.4	12.3	11.0	7.3	1.4
Research and construction of medical facilities	35.5	26.9	20.7	17.3	16.3	15.4	15.6	11.9	5.4
Noncommercial research[1]	20.2	15.3	11.5	9.0	8.2	7.4	6.8	5.4	2.0
Construction	15.3	11.6	9.3	8.3	8.0	8.1	8.9	6.5	3.4

CALCULATION

$ 1.3 billion in malpractice insurance costs divided by $ 167.2 billion in total hospital care expenditures (1985 data) = 0.8 %

estimated $11.7 billion represented the costs of defensive medicine.[98] For hospitals, the liability system cost about $2 billion in 1985, relative to an expenditure for hospital services of $167 billion. The major cost component was premiums. Defensive hospital expenditures, such as increased admissions, longer stays, and more intensive stays were not considered in the hospital calculation. However, Sloan and Bovbjerg, researchers who have examined the malpractice issue, speculate that hospital admissions, stays, and inpatient procedures might have fallen even more than they did had there not been an increased threat of malpractice suits.[99]

For Medicare, the cost of defensive medicine was estimated by the Health Care Financing Administration to be $2.5 billion in fiscal year 1987. They derived this estimate using an assumed annual national volume of defensive medicine of $10.2 billion, an earlier AMA estimate.[100]

The costs of defensive medicine have also been examined at the level of the individual hospital. The Harvard study of New York physicians and hospitals hypothesized that if there is a deterrence effect resulting from the threat (real or perceived) of malpractice litigation, then where the threat is greater, hospitals should respond by providing more services and a higher intensity of services (such as increased tests), and taking other actions to reduce patient adverse events.

However, a number of factors complicate the testing of such a hypothesis. One factor is that malpractice insurance insulates the physician or hospital from the full effects of a law suit. The insurer pays the claims, and in general, the premiums charged to the physician or hospital do not reflect their past malpractice claims experience. Another complicating factor may be that a high claims rate for a hospital may reflect the presence of a concentration of less competent physicians and thus more adverse events in the hospital's area. Other methodological issues, such as sample size, add to the difficulties of a quantitative approach to this question.[101]

---

[98] Sloan, Frank A. and Randall R. Bovbjerg. p. 25. The AMA derived these estimates from a survey of physicians. The estimate of the cost of defensive medicine was thus based on physician self-reporting of practice changes attributed to liability risk. The AMA's researchers also did a separate calculation of defensive medicine using econometric techniques, and concluded that for 1984, defensive medicine accounted for $12.1 billion. See Sloan and Bovjberg. p. 27.

[99]Ibid.

[100]Department of Health and Human Services. Task Force Report. p. 97-98.

[101] ·d Medical Practice Study. p. 10-2.

The Harvard study nevertheless produced results indicating the following: in 1983, there was some relationship between hospitals' rates of claims and the cost per discharge. Hospitals with a higher rate of malpractice claims against them tended to be ones with relatively higher total costs per discharge, thus indicating higher intensity of services, that is, more procedures, time spent with the patient, etc. It was not clear, however, whether this intensity of services reflected wasteful defensive medicine or more resources effectively being used to prevent patient injury. Most of the statistical tests applied to this research question pointed to a positive relationship between malpractice claims rates and injury rates. As claims increased, so too did injuries. This suggested that the litigation threat was not producing fewer adverse events, and was not, therefore, an effective deterrent. Stated differently, had New York State's tort law provided an effective deterrence, the instances of doctor negligence and patient injuries would have fallen with increased claims. Again, methodological difficulties led the researchers to say that these findings "are at best weak evidence of no deterrence."[102] They expressed much caution in concluding that State tort laws are ineffective deterrents to negligent or incompetent medical care.[103]

In short, the Harvard study provides some evidence that the current malpractice tort system has the effect of encouraging additional medical services, which adds to the cost of the health care system. But it is not clear from this study whether these services constitute wasteful defensive medicine or efforts to improve patient outcomes. It is also not clear whether the threat of malpractice litigation serves as an effective deterrence to negligence or other behaviors which produce adverse patient outcomes.

Many doubt that it will ever be possible to obtain an accurate measure of the true costs of defensive medicine given all the factors that enter into medical decision making. However, it is clear that a large proportion of the medical profession believes that physicians are altering their practice patterns in response to malpractice premiums and out of fear of the legal consequences of their decisions.

---

[102]Ibid. p. 10-5, 10-44.

[103]Ibid. p. 10-46.

CRS "Medical Malpractice" Opn. 10

NUMBER OF STATES ENACTING
SPECIFIC TORT REFORMS
(In effect as of April 1990)

Attorney fee Regulation	25
Collateral Source Rule	29
Joint & Several Liability Rule	28
Limits on Recovery	25
Periodic Payment of Damages	31

(Source: Congressional Research Service, "Medical Malpractice", A report prepared at the request of the House Committee on Ways and Means, April, 1990, p. 113)

MEDICAL MALPRACTICE

S. 489, "The Ensuing Access Through Medical Liability Reform Act (Hatch Bill)

Chief Sponsor: Orrin Hatch (R-Ut)

[Senator Hatch has introduced medical liability legislation six times since 1985. S. 489 is identical to a bill the Senator introduced a year ago on which no action was taken.]

S. 489 would:

- preempt state law and require the application of several "reforms" in all state and federal court medical malpractice actions:
  - * $250,000 cap on awards for non-economic damages;
  - * limits on contingent fees;
  - * mandatory periodic payments of future damages exceeding $100,000;
  - * mandatory offsets of awards for collateral sources of recovery;
  - * uniform statute of limitation that in most cases would run from the time of injury.

- authorize incentive grants to states that implement alternative systems.

  strengthen authority of state licensing and medical discipline agencies.

S. 1123, "The Health Care Liability Reform and Quality of Care Improvement Act" (President's Bill)

Chief Sponsors: Orrin Hatch (R-UT) "By Request"
John Danforth (R-MO) "By Request"

S. 1123 would:

- withhold one percent of certain Medicare funds and two percent of certain Medicaid funds in order to create a pool of incentive money to be distributed to states that implement the following medical malpractice

tort "reforms:"

* $250,000 cap on non-economic damages;
* mandatory periodic payments of future damages;
* mandatory offsets of awards for collateral sources of recovery;
* provisions for alternative dispute resolution.

S. 1232, "The Medical Injury Compensation Fairness Act"
(Domenici Bill)

Chief Sponsor: Pete Domenici (R-NM)

S. 1232 would:

- remove virtually all malpractice claims from the courts entirely and resolve them instead through binding arbitration. (Participants in all Federal health care programs -- any person accepting or providing health care paid for in part or entirely with Federal money -- would be required to resolve medical malpractice disputes through mandatory and binding alternative dispute resolution. Tax deductions for employer funded health plans would be disallowed unless all employees covered by the plan agreed to participate in the binding arbitration system.)

- place limits on awards made by the arbitration system:
  * $250,000 cap on non-economic damages;
  * offset of awards for collateral sources of recovery;
  * mandatory periodic payment of future damages;
  * punitive damages payable only to the state.

- Authorize the Secretary of HHS to determine medical practice guidelines which then would be deemed to supply the standard of care for determining liability.

Doctors' malpractice premiums to fall 25%

Decision affects most Mass. physicians

By Elsa C. Arnett
GLOBE STAFF

Malpractice premiums for Massachusetts doctors will drop an average of 25 percent this year – the sharpest decline in 15 years – according to a decision issued by the state's Division of Insurance yesterday.

The nearly $50 million reduction on annual aggregate premiums of about $180 million will affect rates for all physicians whose policies are issued by the Medical Malpractice Joint Underwriting Association of Massachusetts – which insures 60 to 80 percent of the state's doctors – and doctors insured by any other providers licensed by the state. Doctors buying policies from insurers not licensed by Massachusetts will not be affected.

Susan K. Scott, acting insurance commissioner, said the decreases, effective July 1, were approved because fewer patients are suing doctors, and the sizes of jury awards and settlements have leveled since their peak in the mid-1980s.

"This is a turning point in malpractice rates, and our hope is that it will attract medical business to Massachusetts," Scott said.

Tracy Gehan, a spokeswoman for the Joint Underwriting Association, a nonprofit medical insurance company, said the premium reduction reflects the trend toward fewer claims and smaller lawsuit awards. "This is good news. Everyone benefits," Gehan said.

Specifically, doctors with "$1 million/$3 million occurrence policies" – which means those insured for up to $1 million for each claim up to a

MALPRACTICE, Page 16

Globe 3.2.91

Globe 3.2.91

Doctors' malpractice premiums to fall 25%

MALPRACTICE
Continued from Page 15

maximum of $3 million dollars a year – will see an average 25 percent reduction in their premiums.

For example, an obstetrician who paid $146,234 for such a policy in 1990 – the current average for obstetricians in Massachusetts – will pay approximately $34,400 in 1991. Gehan said 81 percent of JUA's doctors are enrolled in this policy.

Gehan said some doctors will see less than a 25 percent drop in their premiums, but all will see at least an 18 percent decrease, including those, who hold only the minimal policy. Meanwhile, doctors who hold "$2 million/$6 million" occurrence policies could see decreases of slightly over 25 percent.

Generally, doctors' actual malpractice premiums vary according to the type of policy purchased, the level of coverage purchased, the physician's specialty risk calculation and whether the physician is eligible for discounts.

An additional component of the rate decrease is that physicians are being forgiven the fees they previously would have been required to pay this year based on certain past claims, known as "deferred premium liability" payments, estimated at about $20 million.

Yesterday's decision is a victory for Massachusetts doctors, who have argued that high malpractice premiums, combined with high overhead costs and incomes lower than the national average, make Massachusetts an unattractive place to practice medicine.

"It's been extremely difficult for doctors to survive in Massachusetts, so this is definitely going to make it a little easier," said Barry M. Manuel, president of the Massachusetts Medical Society.

Malpractice premiums increased about 400 percent during the 1980s, according to Manuel. However, during the past several years, changes in tort laws and a decline in the number of law suits and the amount of the awards have led to a much-needed correction in the costs, said Paul Weiler, a law professor at Harvard Law School, whose specialities include medical malpractice.

The six-State GAO review cited earlier[28] also recorded significant differences among states both in the level of paid claim severity and in the rates of increase over the 1980-1984 period. Variations also occurred among specialties; these tended to be somewhat erratic because of the small number of paid claims and the wide range of awards.[29]

3. *Claim Characteristics*

Claims involving diagnostic issues are the most expensive of those filed against physicians and surgeons insured by St. Paul. These claims accounted for 34 percent of the total costs incurred for claims reported in 1987 and 1988. Failure to diagnose cancer was the most frequent allegation of this type. Tables 2.4 and 2.5 provide additional information on the types of allegations made during 1987 and 1988 for physicians insured by St. Paul.

TABLE 2.4. St. Paul Company: Major Allegation Groups by Frequency, 1987-1988

Group	Number	Percent of total claims	Percent of total incurred cost
Surgery	2,867	28.8%	25.8%
Failure to diagnose	2,771	27.8	34.4
Improper treatment	2,672	26.9	29.7
Anesthesia	366	3.7	3.6
Other issues	1,271	12.8	6.5
Total claims	9,947	100.0	100.0

Source: *Physicians' and Surgeons Update.* The St. Paul's 1989 Annual Report to Policyholders. p. 4.

[28]GAO, *Six State Case Studies*, p. 18.

[29]Danzon, Medical Malpractice Liability, p. 106.

TABLE 2.5. St. Paul Company: Top Five Allegations for Surgery, Failure to Diagnose, and Improper Treatment, 1987-1988

Allegation	Number	Percent of allegation group
Surgery		
Postoperative complication	1,474	51.4%
Inadvertent act	375	13.1
Postoperative death	258	9.0
Inappropriate procedure	233	8.1
Delay/complications	164	5.7
Total top five	2,504	87.3
Failure to diagnose		
Cancer	607	21.9
Fracture/dislocation	304	11.0
Infection	220	7.9
Pregnancy problems	217	7.8
Abdominal problem	190	6.9
Total top five	1,538	55.5
Improper treatment		
Birth-related	661	24.7
Drug side effect	288	10.8
Insufficient therapy	277	10.4
Fracture/dislocation	272	10.2
Infection	225	8.4
Total top five	1,723	64.5

Source: *Physicians' and Surgeons Update.* The St. Paul's 1989 Annual Report to Policyholders. p. 4.

4. *Physician Demographics*

Several studies have attempted to analyze the claims experience of physicians to determine the characteristics of those with favorable versus unfavorable experience. A recent study[30] of the Florida malpractice database

[30]Sloan, Frank A., Paula M. Mergenhagen, Bradley Burfield, Randall R. Bovbjerg, and Mahmud Hassen. Medical Malpractice Experience of Physicians, Predictable or Haphazard? *Journal of the American Medical Association*, v. 262, no. 23. Dec. 15, 1989. p. 3291-3297.

examined the concentration of losses among physicians, predictability of claims experience, and effect of claims experience on physicians' practice decisions and on actions taken by the state licensing board. For purposes of analysis, physicians were divided into three groups--low risk medical specialist, obstetrics-anesthesiology, and surgical specialties. A review of the data showed that most payments by insurers involved a comparatively small number of physicians. Eighty-five percent of those in the low risk medical specialty group did not even have one incident that resulted in payment (indemnity payment and/or associated loss expense) between 1975-1980. The figures dropped to 66 percent for the obstetrics-anesthesiology group and 52 percent for the surgical specialty group. In all three groups, a large share of total payments involved a comparatively small number of physicians. In the medical specialty group, 85 percent of payments were made for 3 percent of physicians. In the obstetrics-anesthesiology group, more than 85 percent of payments were incurred by 6 percent of physicians. For surgical specialties, three-fourths of the total payment was made on behalf of 7.8 percent of physicians. Physicians with relatively prestigious credentials (board certification status, prestige of medical school, and U.S. or Canadian medical school) had no better and for some indicators, worse claims experience.

The Florida study also noted that physicians with adverse claims experience were less likely than other physicians to make subsequent major changes in their practice such as quitting or moving to another state. Physicians with very poor claims histories were more likely to have complaints filed against them with the State licensing board; however, sanctions imposed against physicians with either poor or excellent histories were not severe. Physicians with adverse claims experience over the 1975-1980 period were far more likely to have worse claims experience from incidents arising during 1981-1983. The authors noted that past experience may predict future claims experience. However they caution against linking malpractice experience with the quality of care delivered. For example, those with a higher number of claims may be taking on more complex cases.

Another study[31] of demographic characteristics focused on those whose standard line insurance was terminated and who subsequently obtained insurance from surplus line companies. The study covered the 1983-1987 period. It found that certain specialties (such as neurosurgery, plastic surgery, obstetrics/gynecology, and orthopedics) were overrepresented in the surplus line pool. Physicians in the 45-54 year age group were also overrepresented. On the other hand, the percentage of those who were board certified or foreign medical graduates was comparable to that in the general population.

[31]Schwartz, William B., and Daniel N. Mendelson. Physicians Who Have Lost Their Malpractice Insurance, Their Demographic Characteristics and the Surplu[illegible] Companies that Insure Them. *Journal of the American Medical Associ[illegible]* 262, no. 10, Sept. 8, 1989. p. 1335-1341.

D. Other Providers

More limited information is available on claims experience for other nonphysician providers. St. Paul Company reports a slight decrease in claims frequency and a moderation in the long-term growth in cost of claims for its hospital policyholders. The 1988 rate of 3.4 claims per 100 occupied beds represents a continuing decease from the high of 3.8 reported in 1985. The decline in claims frequency was accompanied by an increase in claims severity. The average cost per reported claim, including defense costs and capped at $100,000 was $16,472 in 1988 and $13,965 in 1987.

St. Paul reports that the average *paid* medical liability claim with losses capped at $100,000 and including defense costs was $58,046 in 1988, nearly 60 percent higher than the $36,694 recorded in 1985. The average with losses capped at $1 million was $86,170, an increase of 52 percent over the $56,537 recorded in 1985.

Allegations involving treatment issues accounted for 47 percent of the claims and 58 percent of total incurred costs reported by St. Paul insured hospitals over the 1987-1988 period. Claims alleging delayed or omitted treatment are the most costly among treatment issues. The most frequent allegation involves treatment complications with a bad result. Nearly three-fourths of the claims that occur in the inpatient surgery area cite treatment issues while such issues constitute about one-third of claims in the emergency department.[32]

St. Paul also reported some limited information concerning nursing home claims. Falls involving residents accounted for 37 percent of all claims and 35 percent of the total costs of claims occurring in nursing homes insured by the company.[33]

[32]*The St. Paul's Hospital Update*. 1989 Annual Report to Policyholders. St. Paul, Minnesota. p. 4.

[33]*Nursing Home Update*. The St. Paul's 1989 Annual Report to Policyholders. St. Paul, Minnesota. p. 2.

Special Communications

The Cost of Medical Professional Liability

Roger A. Reynolds, PhD; John A. Rizzo, PhD; Martin L. Gonzalez, MS

The high cost of medical professional liability is a source of growing concern among policymakers, health care consumers, and the medical profession. While the concern is widespread, to date there has been little quantitative evidence on the overall economic impact of the problem. Utilizing data from the American Medical Association's Socioeconomic Monitoring System, the impact of medical professional liability (PL) on the cost of physicians' services has been estimated employing two different methods. Both estimates indicate that the costs of PL are substantial. In particular, the two methods yield estimates of the total cost of PL in 1984 of $13.7 and $12.1 billion, respectively—or approximately 15% of the total expenditures on physicians' services. Furthermore, increased costs associated with PL from 1983 to 1984 alone are estimated under the two methods to have accounted for 63% and 57%, respectively, of the increase in expenditures on physicians' services. These costs include PL insurance premiums, costs of practice changes made in response to increasing PL risk, and costs of incurring claims that are not covered by PL insurance.

(*JAMA* 1987;257:2776-2781)

AFTER abating as a problem in the late 1970s, medical professional liability (PL) has once again become an important policy concern. Recent trends indicate that the incidence of malpractice claims, settlements, and PL insurance premiums are increasing.

The average physician's risk of incurring a medical malpractice claim has increased nearly threefold since 1980. Information from the American Medical Association's (AMA's) Socioeconomic Monitoring System (SMS) survey conducted in the last quarter of 1984 indicates the number of claims filed against physicians increased from an average annual rate of 3.0 per 100 physicians before 1980, to 7.8 from 1980 to 1983, and 9.3 in 1984. In addition to the incidence of claims, awards and other losses per claim have increased. The St Paul Fire and Marine Insurance Co noted a 63.5% increase (from $9998 to $16 343) in average total losses per claim (awards plus expenses) from 1976 to 1981.[1] More recent data from the American Medical Assurance Co suggest that increases in the severity of losses have accelerated. From 1981 to 1983 alone, the average paid loss increased by 70.2% (from $42 432 to $72 243).[2] Figures reported by Jury Verdict Research of Solon, Ohio, indicate that malpractice awards rose at an average annual rate of 24.7% during the period 1979 to 1983.[3]

See also pp 2801 and 2807.

A central aspect of the concern precipitated by medical PL trends is their impact on the cost of physicians' services. Increasing claims, settlements, and awards affect health care costs through several channels. These include (1) higher PL insurance premiums; (2) changes in practice patterns designed to reduce PL risks, but that ultimately also affect fees and utilization levels for physicians' services; and (3) costs associated with incurring claims that are excluded from PL premiums.

Professional liability insurance premiums are the most readily quantified of the cost elements. After a moderate rate of growth of 4.0% from 1976 to 1982, following the last malpractice crisis, premiums are rising rapidly again. From 1982 to 1983, the average premiums paid by physicians increased by 22.4% from $5800 to $7100. In 1984, premiums rose by another 18.3% to an average of $8400—or 4.0% of gross revenues of the average self-employed physician. Applying this percentage to aggregate US expenditures on physicians' services ($75.4 billion), estimated total premiums paid by physicians were $3.0 billion in 1984.

Although data on premiums are readily accessible, there has been relatively little quantitative evidence on the actual effects of the current PL system on the other channels through which health care costs may be affected. A 1983 report by the AMA Committee on Professional Liability placed the total costs associated with PL at between $15 and $40 billion.[4] This suggests that premiums account for only a small portion of PL costs. However, these estimates necessarily relied to a large degree on subjective judgment, given the limited information available then. The lack of better estimates of the overall costs associated with PL has made it difficult to gauge the actual scope of the problem. In this article, two distinct methods are employed to develop estimates of the costs associated with PL. The first approach uses direct data on PL insurance premiums, practice changes physicians have made in response to increased claims risk, and other costs of incurring malpractice claims to derive estimates of the major components of PL costs. The second approach employs a multivariate analysis to infer costs from the impact of variations in PL insurance premiums on physicians' fees and utilization rates for a range of procedures.

The similarity of estimates derived from the two methods contributes to our confidence about the general order of magnitude of the PL effect on the cost of physicians' services. In particular, the two methods yield estimates indicating that PL costs were responsible for $13.7 and $12.1 billion, respectively, of the total expenditures on physicians' services of $75.4 billion in 1984.

The next section describes the SMS surveys that serve as the principal sources of data employed in the analysis. This is followed by a presentation of the methods and results. We conclude with a discussion of the limitations of our results and their policy implications.

From the Department of Medical Practice Economics, Center for Health Policy Research, American Medical Association, Chicago.

The authors are respectively Department Director, Research Economist, and Staff Associate in the Department of Medical Practice Economics, Center for Health Policy Research, American Medical Association. The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy of the American Medical Association.

Reprint requests to Department of Medical Practice Economics, Center for Health Policy Research, American Medical Association, 535 N Dearborn St, Chicago, IL 60610 (Dr Reynolds).

SMS SURVEY DATA

Information from SMS physician surveys conducted in the fourth quarter of 1984 and second quarter of 1985 provided the principal data used in our analysis. (Data from other SMS surveys and other sources were used in an ancillary role.) The SMS is a survey program conducted by the AMA to provide frequent and timely information on major socioeconomic characteristics of physicians' practices and physician responses to important changes in the medical marketplace. Samples for each survey are drawn from the AMA Physician Masterfile in a manner representative of the population of nonfederal patient care physicians, excluding residents, in the United States. Surveys are conducted by telephone. Advance information is sent to sample physicians regarding the content of the survey so that physicians may review their records on appropriate items before being interviewed.

The fourth quarter 1984 survey included questions asking physicians how many claims had been filed against them in their career, in the last five years, and in the last year. Responses to these questions, coupled with AMA Masterfile data on the years each physician had been in practice, provided the basis for computing the annual claims rates reported above. Physicians were also asked a series of questions as to whether they were maintaining more detailed records, prescribing more diagnostic tests and treatment procedures, spending more time with patients, and having more follow-up visits with patients in the last 12 months in response to the growth in malpractice claims. If they responded affirmatively to any of these items, they were asked to quantify the change in percentage terms. Some of these questions were skipped for physicians with practices for which the questions were deemed inapplicable. Since the wording of these questions referred only to changes made in response to the growth in claims, responses included both changes that might be deemed to have medical benefit and those that were made merely to provide additional validation or to serve as a basis for subsequent evaluation of medical judgments. Finally, physicians who reported having claims filed against them in the last five years were asked about days they had lost from their practice and attorney fees related to their claims but not covered by their insurance. Information from the questions on practice changes and costs to physicians of settling claims provided the basis for estimating components of the costs associated with PL under the first method below. The fourth quarter 1984 survey included 1202 completed interviews and had a 65.1% response rate.

The second quarter 1985 survey included questions on physician income and expenses, including malpractice insurance premiums, in 1984, as well as questions on fees and recent utilization levels for selected procedures. These questions are included in the SMS survey conducted in the second quarter of each year, coinciding with tax filing time, to ensure physicians had completed their accounting for the previous year and were able to provide the most accurate information possible on their income and practice expenses. Information from this survey was used to estimate costs under our second method. The survey included 4040 completed interviews and had a 62.0% response rate. Further details on the SMS survey program design and methods are described elsewhere.[6]

COST ESTIMATE METHODS AND RESULTS

Although the available data made it possible to directly estimate aggregate premiums, costs associated with practice changes and other costs of incurring claims were more difficult to quantify. Given the need to rely on some assumptions in deriving estimates of those cost components, the use of two different methods served as a check on their reliability.

Ultimately, our purpose was to assess the impact of increasing PL risk on aggregate expenditures on physicians' services. Two conceptual points should be noted in this regard. First, in extrapolating from the impact of PL on the average physician to the aggregate level, use was made of the identity that aggregate expenditures on physicians' services equals the sum of revenues across all physicians' practices. Since resistance among patients to higher fees may prevent physicians from passing on the full amount of their cost increases, such increases may not result in correspondingly higher average physician revenues. Assuming that cost increases are fully reflected in higher physician revenues, therefore, may result in overstatement of the impact of PL costs on expenditures on physicians' services. Our first method had this limitation since it attempted to infer the impact on expenditures from estimates of costs faced by physicians attributable to PL; our second method avoided this problem since it developed estimates of changes in fees and utilization levels that can be directly related to revenue changes associated with PL risk.

Second, the analysis under both methods was necessarily limited to self-employed physicians because gross revenue and practice expense information was not collected in the SMS surveys from employee physicians. However, revenues attributable to employee physicians in the SMS sample population (other than hospital employees) were represented in aggregate expenditures on physicians' services as defined in the national health expenditure accounts.[6] In our analysis, we made the assumption that the relative impact of PL on employee physician revenues reflected in aggregate expenditure figures was similar to that of self-employed physicians. (Appendix tables, referred to below, are filed with NAPS, No. 04492.)

Method 1

This approach directly estimates the increases in several major components of PL costs in 1984. While information on premium levels has been collected on an annual basis by the SMS, the fourth quarter 1984 SMS survey is the only source of information on the magnitude of practice changes and other costs of incurring claims.

Practice Changes.—Table 1 indicates the widespread and expanding extent of selected practice changes made in response to growing PL risks. The first column indicates responses to questions in the third quarter 1983 SMS survey that asked whether or not physicians had recently increased their time spent with patients, record keeping, and prescribing of tests and treatment procedures in response to increased risks. Seventy percent of physicians reported having made at least one of these changes. Increased record keeping was the most common change identified. Unfortunately, the magnitude of the changes was not obtained.

The second two columns of Table 1 show the percent of physicians making practice changes and the magnitude of these changes (expressed in percentage terms) in 1984 in response to continuing increases in risk. This information was collected in the fourth quarter 1984 SMS survey. The results indicate that 41.8% of physicians either made additional changes in their practices or adopted changes for the first time in 1984. In terms of magnitude of change, the average physician increased record keeping costs by 2.9%, prescribed 3.2% more tests and treatment procedures, increased follow-up visits by 2.6%, and spent 2.4% more time with patients. Other information in SMS surveys on fees, total amount of time practiced, earnings, expenses, and revenues made it possible to estimate the costs per

Table 1.—Practice Changes in Response to Increasing Professional Liability Risk*

Activity	% of Physicians Making Change: Prior to 1984	% of Physicians Making Change: 1984†	Average % Change per Physician in 1984†‡	Cost of Change per Physician in 1984, $†‡
Increased record keeping	68.9	31.0	2.9	900
Prescription of more tests or treatment procedures	43.0	20.0	3.2	§
Increased time spent with patients	35.9	17.0	2.4	1800
Increased follow-up visits	NA‖	17.0	2.6	1900
% of physicians with at least one listed practice change	70.0	41.8	...	...
Average Total Cost per Physician of Listed Practice Changes in 1984	...	...	...	4600

*Source: third quarter 1983 and fourth quarter 1984 American Medical Association's Socioeconomic Monitoring System surveys.
†Figures reflect only new or increased practice changes in 1984. Physicians making practice changes and the amount of these changes made prior to 1984 in response to liability risks are not reflected in these figures.
‡Calculations include zeros for physicians who did not make any practice change in 1984.
§Lack of data on the average cost of an additional test or treatment procedure make it impossible to fill in this item.
‖NA indicates not available.

physician associated with each type of practice change, except the prescription of additional tests and treatment procedures. (The detailed calculation of these costs is shown in the NAPS appendix tables A1 to A3.) The total cost of the selected practice changes considered was $4600 per physician in 1984. These are costs attributable to practice changes in 1984 alone and do not include costs of practice changes effected before 1984, relating to increasing levels of malpractice claims risk.

Two tentative implications can be drawn at this point. First, the cost of practice changes was more than three times the $1300 increase in average PL insurance premiums in 1984. This suggests that focusing on premiums alone considerably underestimates the economic effects of PL trends. Second, the combined cost of higher premiums and practice changes of $5900 per physician represents 63% of the increase in average total practice revenues of physicians of $9400 in 1984. This indicates that increasing PL risk plays an important role in contributing to recent increases in national expenditures on physicians' services.

Since our results only reflect a limited set of practice changes that add to the cost of physicians' services, our figures may underestimate the total impact of PL in placing upward pressure on health care costs. Conversely, increased risks may cause physicians to curtail some of the services they provide, and the higher fees resulting from passing on some of the costs of PL may discourage patients from utilizing as many services as they might otherwise. The reductions in utilization through these means will provide some offset to cost increases due to higher premiums and other practice changes. However, while utilization reductions may produce some cost saving, they reflect an adverse consequence of increasing PL risk by restricting access to care.

Although the available information has made it possible to estimate the incremental cost of practice changes in 1984, it is still impossible to estimate the total cost of practice changes, including those adopted before 1984, without resorting to some assumption. Two considerations regarding the relationship between practice changes and insurance premiums seem to be useful in developing such an assumption. First, the marginal effect of taking additional measures to reduce the risk of incurring a claim is likely to diminish as total expenditures on such measures increase. This will likely cause the rate of practice change costs to diminish relative to the rate of premium increases. The ratio of incremental costs of practice changes to premiums would, therefore, be less than the ratio of total cost of practice changes employed to reduce risks to insurance premiums. The other consideration is that increases in premiums are likely to have been associated with changes in the malpractice litigation environment that increase the effectiveness of devoting resources to reducing claims. This would cause change expenditures on risk-reducing practice changes to increase at a greater rate than premiums.

If these two effects approximately offset each other, the ratio of the increment in practice change costs to the increase in premiums equals the ratio of total expenditures on defensive medicine to total premiums. Given the average premium paid by self-employed physicians in 1984 of $8400, this implies that the total cost of practice changes made through 1984 in an effort to reduce the risk of malpractice claims was $29 700, or 14.1% of average physician revenues. In the aggregate, this indicates that practice changes made in response to PL risk accounted for $10.6 billion of expenditures on physicians' services in 1984.

Other Costs of Incurring Claims.—For physicians incurring PL claims, insurance does not always cover all of the associated costs. Among such costs are those relating to time lost from work and hiring an attorney in addition to that provided by the insurance company. According to SMS information, the average physician with at least one claim in the last five years lost 2.7 days per claim from practice and paid $725 per claim in outside attorney fees. Given the average incidence of claims and resource cost of running a medical practice, these costs are estimated to have amounted to $270 per physician or approximately $0.1 billion in the aggregate in 1984. (Details of the calculation of these costs are given in NAPS appendix Tables A4 and A5.)

Additional costs may result from the potential damage to reputations and dysfunction among physicians when claims are filed against them. These costs cannot be easily measured. However, their importance is reflected in changes made by physicians in their practices to reduce the probability of malpractice claims.

Total Costs.—Given the $3.0 billion aggregate level of premiums and the estimates of $10.6 billion attributable to practice changes made to reduce PL risks and $0.1 billion in other costs of incurring claims, aggregate PL costs are estimated to have been $13.7 billion in 1984. This represents 18.2% of total expenditures on physicians' services in that year.

Method 2

The second estimate of the cost of physicians' services attributable to PL was developed from an analysis of the impact of PL risk on physician fees and utilization rates for a range of representative services and procedures. While the first approach provided estimates of the economic effect of PL on the cost of physicians' services, this approach provides estimates that are more directly related to expenditures.

The effects of PL risk on the fee and utilization level for a given service is derived from the impact of the risk on both patient demand and physician supply. The quantity of a service demanded at any fee level will be increased to the extent that more of the service is required by physicians to curtail their increased risks. Fees that physicians require to supply each quantity of a service will increase with PL insurance

premiums, costs of additional resources employed to reduce risk, and other costs associated with potential claims that may arise from providing the service. Both the supply and demand effects of increased risks will tend to increase fees. However, they will have opposite influences on utilization: increased demand will tend to increase use of the service, while higher costs will discourage utilization. This causes the net effect on utilization to be ambiguous. The impact of higher costs on utilization subsumes the possibility that physicians may cease providing some types of services altogether. While the first method only captured the effects of PL causing utilization to increase, method 2 captures the net effect of both positive and negative influences of PL on utilization.

Regression analysis was employed to distinguish the effects of increased PL risk on fees and utilization from the effects of other costs and factors affecting the demand facing physicians. Rather than estimating structural equations specifying the number of services demanded at different fees and the fee levels required to induce physicians to supply different quantities of various services, the equations we estimated are "reduced form" equations. These reflect the solution by physicians of the supply and demand equations for the optimal fee and utilization levels. The reduced form equations generally include all variables that affect supply and demand, including PL risk.

To quantify PL risk for purposes of the regression analysis, it is assumed that PL premiums act as a signal to physicians of their exposure to liability risk. Changes in fees and utilization in response to premium increases, therefore, reflect the direct effect of premium costs, as well as the practice changes in response to PL risk and other costs of incurring claims. Since actual premiums paid by physicians are an imperfect measure of their exposure to risk, an errors-in-variables problem exists that would cause biased regression results if actual premiums were directly used in estimating the regression equations. A standard procedure of using "instrumental variables" estimates of premiums in place of actual premiums was used to avoid biases in estimating the fee and utilization equations.[7] Variables used in developing instrumental variable estimates of premiums and in estimating the reduced form fee and utilization equations are similar to those that have been employed in other studies of premiums, physician fees, and utilization patterns.[8-10] (Descriptions and sources of these variables are given in NAPS appendix Table A6.)

Table 2.—Effects of Professional Liability Premiums on Physician Fee and Utilization Levels

Procedure	Coefficient	SE	% Change in Fee or Utilization per % Change in Premiums*
Fees			
Established patient office visit	0.85	0.17†	0.272
New patient office visit	1.16	0.37†	0.212
Follow-up hospital visit	1.18	0.22†	0.340
Electrocardiogram	1.48	0.46†	0.205
Obstetric care, normal delivery	22.24	4.53†	0.427
Hysterectomy	25.38	5.74†	0.349
Hernia repair	3.11	5.66	0.069
Cholecystectomy	−2.36	8.60	−0.033
Monthly utilization			
Established patient office visit	−66.41	28.97†	−0.171
New patient office visit	−13.81	7.33‡	−0.209
Follow-up hospital visit	−45.15	20.84†	−0.297
Electrocardiogram	8.06	34.99	0.073
Obstetric care, normal delivery	1.46	1.31	0.188
Hysterectomy	−0.48	0.63	−0.276
Hernia repair	−0.51	1.12	−0.224
Cholecystectomy	0.70	0.95	0.217

*The premium levels employed in the computation are the averages for the specialties used in estimating the premium effect for each procedure. For patient visits, these include all specialties except radiology, psychiatry, pathology, and anesthesiology; for electrocardiograms, general-family practice and internal medicine; for obstetric care and hysterectomies, obstetrics-gynecology; and for hernia repairs and cholecystectomies, general surgery.
†Indicates regression coefficient is different from 0 at the .01 significance level.
‡Indicates regression coefficient is different from 0 at the .10 significance level.

The analysis was performed with data from the second quarter 1984 SMS survey. Fee and utilization information available from the survey was limited for each procedure to physicians in specialties that regularly perform the procedure (see footnote in Table 2). As demonstrated below, the procedures and services included in the analysis directly account for 70% of expenditures on physicians' services.

The effects of PL on fees and utilization derived from the regressions are shown in Table 2. (The full regression results and sample statistics are given in NAPS appendix Tables A7 to A22.) The first two columns report the regression coefficient of premiums and its SE. The regression coefficient directly indicates the estimated effect of a $1000 change in PL insurance premiums on the average fee or annual utilization for each procedure. The last column provides an estimate of the percentage change in the fee or utilization level per percentage change in premiums. This measure, known as an elasticity, has the advantage over the regression coefficients of providing a standardized basis for comparing results across procedures.

The results indicate that fees are positively related to PL insurance premiums for all procedures examined except cholecystectomies (for which, in any event, the regression coefficient is not statistically significant). The services for which fees are most sensitive to premium increases are obstetrical care, hysterectomies, and follow-up hospital visits. These findings appear sensible to the extent that obstetric and gynecologic services precipitate a disproportionate share of malpractice claims, and most incidents resulting in malpractice claims occur in the hospital. The results may also reflect that there are greater opportunities available to make practice changes that will reduce risks associated with these services than are available for other services.

With respect to utilization patterns, all three types of visits considered decrease with PL risk. This is indicative of the discouraging impact that higher fees can generally be expected to generate on relatively elective services, such as patient visits. This apparently dominates any increase in visits that physicians may specifically request in an effort to reduce risks. By contrast, the relatively small positive elasticity for electrocardiogram utilization suggests that the negative influence of higher fees and the incentive to increase tests to reduce risk appear to have approximately offsetting impacts. Although the absolute magnitudes of the surgical utilization elasticities are similar to those for visits, the direction of the premium effect differs across procedures.

The relatively large SEs of the premium coefficient in the electrocardiogram and surgical procedure utilization equations indicates imprecise coefficient estimates. This suggests

Washington Post, Wednesday, Feb. 3, 1993

'Defensive Medicine' Changes Could Save Billions, Study Says

By Spencer Rich
Washington Post Staff Writer

The nation's health care system could save $36 billion or more over the next five years by reducing or eliminating the practice of "defensive medicine," according to a study released yesterday.

"A billion here, a billion there and pretty soon you're talking about real money, as Senator Everett McKinley Dirksen once said," said Raymond Scalletar, chairman of the board of the American Medical Association, at a news conference here.

The $36 billion figure is a middle-range estimate and under different assumptions could reach $76 billion, said Robert J. Rubin, former assistant secretary of health and human services and now president of Lewin-VHI, a health policy analysis firm that prepared the study.

The study was released by the National Medical Liability Reform Coalition, consisting of more than 60 business, health and insurance groups including the AMA. It was undertaken to determine the real cost of defensive medicine, which Rubin defined as care that does not really benefit patients but "is provided solely to avoid malpractice claims," such as many clinical tests or X-rays given primarily to insulate doctors from later accusations of insufficient care in diagnosis.

Rubin and associate Daniel Mendelson said the probable real cost of defensive medicine alone—not including $9 billion annually in malpractice insurance premiums—was about $10 billion in 1991 and would rise to about $15 billion in 1998, measured in 1991 dollars, for an eight-year total of $99 billion.

Rubin said it might be realistic to expect that $36 billion of this could be saved over the next five years. Among the possible strategies cited in the study: finding ways to resolve malpractice disputes without going to trial, such as creating administrative boards to make preliminary recommendations on settlement of lawsuits; tightening laws to block excessive damage compensation when cases go to court; and granting physicians and hospitals immunity from suits if they follow government-set guidelines for appropriate treatment.

Using broader assumptions, Rubin and Mendelson calculated that defensive medicine might cost $148 billion in 1991-98. Five-year savings could be as high as $76 billion if doctors and hospitals were totally freed of malpractice liability and there was a "no-fault" system similar to workers' compensation.

Roxanne Barton Conlin, president of the Association of Trial Lawyers of America, called the potential annual savings "a drop in the health care bucket that would be wiped out by cost increases in two months" at a time when total health costs exceed $800 billion a year.

Paraphrasing a 1992 Congressional Budget Office statement, she said: "Much of what is called defensive medicine would probably be provided to patients in the absence of legal concerns. So-called defensive care improves the accuracy of medical diagnosis."