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HEALTH CARE COSTS AND LACK OF ACCESS TO HEALTH INSURANCE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

JUNE 6, 1991

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HEALTH CARE COSTS AND LACK OF ACCESS TO HEALTH INSURANCE

THURSDAY, JUNE 6, 1991

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:32 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Rockefeller, Breaux, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H-19, May 24, 1991]

HEARING PLANNED ON AFFORDABILITY OF HEALTH CARE EFFORTS BY INSURERS; SMALL BUSINESS TO BE HIGHLIGHTED

WASHINGTON, DC—Senator Lloyd Bentsen, Chairman, announced Friday that the Finance Committee will hold the third in a series of hearings exploring the twin problems of access to health insurance and the affordability of health care.

The hearing will be at *9:30 a.m. Thursday, June 6, 1991* in Room SD-215 of the Dirksen Senate Office Building.

"Americans are finding it more and more difficult to afford health care. More than 30 million Americans—9 million of them children—don't have any health insurance. Many of these uninsured people have jobs but they work for small businesses, which themselves have trouble obtaining affordable coverage, if they can get coverage at all, for employees," Bentsen said.

"The Senate Finance Committee is working this year on ways to make health care more accessible and affordable, and any solution will require cooperation between the public and private sectors. This hearing will focus primarily on efforts by insurers to restrain rising health care costs and on ways to improve access to affordable health insurance coverage for employees of small businesses and their dependents," Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. If you will please be seated and cease conversation, this hearing will commence.

Today's hearing is the third hearing on the question of accessibility and affordability of health care. The hearing is intended to provide the committee with a comprehensive examination of this issue from a variety of viewpoints. We will be hearing today about some of the details in the efforts to improve the availability of health insurance to small businesses.

It is an issue of great interest to me and my own State, which has the highest rate of uninsured in the country—26 percent—most

of whom are employees, or dependents of employees, of small businesses.

What we are finding today as the cost of health insurance increases—now some 26 percent of the cost of doing business—employers raise the deductible, increase the co-insurance, drop their dependents, and then finally give up and drop the insurance altogether. Small business thinks it is one of the most serious problems they face. Many of these small businesses cannot find insurance companies that are willing or able to insure them, or if they are able to find the coverage, pay the very high premiums that are charged. It is obviously time to do something about this problem. Because what we are seeing is more and more of the uninsured appearing as more and more small businesses drop the coverage.

A number of members of this committee share my concern about the unique problems facing small employers seeking to purchase health insurance. Senator Durenberger introduced a bill earlier this year targeted to address these problems. Senator Rockefeller included small group insurance reforms in the Pepper Commission health care bill he introduced a few weeks ago.

A similar proposal is included in the legislation introduced by Senators Mitchell, Riegle, Rockefeller, and others yesterday. We have with us today a number of witnesses who have offered proposals to improve the availability of small group health insurance, and I look forward to those suggestions.

And from those suggestions, plus what we have seen in these other plans, on this committee we will seek to bring together a consensus behind a piece of legislation that will make some very serious progress in this area.

Our first panel consists of two economists who have distinguished themselves as experts on the American health care system. Dr. Uwe Reinhart of Princeton University, and Dr. Jack Meyer, of New Directions for Policy, will provide us with their views on the nature of the health care costs and access problems and efforts to solve these problems. They will be followed by a panel of insurance industry executives representing a cross-section of companies. The insurance industry has taken the initiative to propose reforms intended to improve the availability of health insurance to small businesses.

In addition, we will be hearing about the managed care approach for restraining growth in health care costs. During our last hearing, we had some testimony on that. I can recall, in particular, the testimony of Ed Hennessy, on the remarkable progress he was able to make in his company with some 75,000 employees in reducing the cost of health care by almost a quarter, as I recall.

Next, we are going to hear from Mr. David Lyons, who will speak on behalf of the National Association of Insurance Commissioners. NAIC has under development a model State law designed to improve the availability of health insurance to small businesses. I have been looking at that, and I see many aspects of it that I think would be quite helpful in meeting our objectives.

Finally, Mr. John Polk, the executive director of the Council of Smaller Enterprises, will discuss his organization's innovative approach for making health insurance available to small businesses in the Cleveland area.

We have an impressive list of witnesses, and I look forward to their testimony, and hope to continue to work with them as we consider this legislation. This is one of the major priorities for this committee this year, and we will be pushing hard to see that we get implementation as early as possible.

I would like to now call on Senator Durenberger for any comments he might have.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you. I certainly agree with you on the characterization of the challenge, and on the character of the witnesses. And I would ask that my full statement be made part of the record.

[The prepared statement of Senator Durenberger appears in the appendix.]

The CHAIRMAN. Without objection that will be done. Senator Grassley, any comments you might have?

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Yes, Mr. Chairman. Since we last met, the Democratic leader and several Democratic colleagues have offered a major proposal for health care system reform. And I am sure that Republicans will be offering a proposal very soon, so the prospects since our last hearing for action by this Congress have probably increased considerably. And our hearings now become even more timely and important.

Our hearing today provides us with some perspective on the health insurance marketplace and proposals to reform it, and assuming that any eventual reforms of our health care system retain an employer-provided insurance as a basis of this system—as these proposals probably will—reform of this marketplace is a very important piece of the whole puzzle.

The several proposals on small group health insurance marketplace reform indicate pretty clearly that it is now widely accepted that the writing and underwriting practices of insurers are contributing to the access problems faced by many of our fellow citizens.

These proposals also indicate, it seems to me, that it should be possible, perhaps as soon as this year, to get some helpful changes in these practices. And I confess to some concern about the possibility that we would subvert McCarin Ferguson were we to press ahead from the Federal level with some of the reform proposals that have been circulating, and that will be discussed today. But that may be necessary, since we need to do something about these problems, and small group health insurance market reform is a promising place to start.

Mr. Chairman, as I am sure you know, there is an Iowan on panel three, and so I want to welcome to this group of Senators on the Finance Committee, Dave Lyons, the insurance commissioner from my State of Iowa, and he is speaking today for the National Association of Insurance Commissioners. Thank you.

The CHAIRMAN. Thank you very much, Senator. Our first two witnesses will be a panel with Dr. Jack Meyer, if you will come forward, please. And Dr. Uwe Reinhardt. Dr. Meyer is the president of the New Directions for Policy based here in Washington, DC.

Dr. Meyer, if you would proceed.

STATEMENT OF JACK MEYER, PH.D., PRESIDENT, NEW DIRECTIONS FOR POLICY, WASHINGTON, DC

Dr. MEYER. Thank you very much, Mr. Chairman. I think that despite all the ideological debate over health care, there is a remarkable consensus growing about how we should reform the system. Let me mention a few brief items of consensus.

First, I think we widely agree now that we must move toward universal coverage; that discriminating against people on the basis of their income or their health risk is just unconscionable. That is not a liberal or a conservative idea; it is generally accepted. We differ on how to get there, of course.

Second, I think there is growing agreement that any expansion of access and extension of care must be addressed in the context of controlling overall system costs. How to do so divides us.

And third, I think there is growing consensus on the need to measure quality and outcomes, and a growing concern about the amount of unnecessary care and inappropriate procedures being performed. Correcting this is vital to getting costs under control.

Let me outline some areas where various people differ, and give you my preferences. I have laid out an approach to this in very brief form in my testimony, which I submit for the record.

First, though we agree we must move toward universal coverage, there is a great debate over whether to put the primary onus initially on employers or on government to subsidize low and moderate-income people who are currently uninsured—screened out of Medicaid, and falling into the cracks between public and private insurance.

I believe that an attempt to put the onus totally on employers will be passed on primarily to workers and consumers. I believe that an employer mandate is a regressive head tax, which will have an unfair burden, although that is certainly not the intent. We have to look at not just what we shoot at, but what we hit when we adopt measures like this. It certainly is a sweeping way to extend coverage, however.

I tend to prefer some sort of a refundable tax credit along the lines that you introduced, I believe, last year, for low and moderate-income people, which would be scaled to income. This does not have the disadvantage of being a regressive head tax, which would be passed back to workers in the form of unemployment and lower wages, but it does have the problem of requiring some new Federal money, which is hard to come by in this era of high deficits.

However, I do believe—and I mention in my testimony—that there are some potential sources of revenue, but to tap them requires that we make some hard choices. I do not think many people believe we can deal with this problem without coming up with some new revenue.

I tend to prefer keeping income tax rates and payroll tax rates where they are and broadening the base of taxation to finance government's share of this problem. I believe that we can tax employer contributions to health insurance above some limit, as Senator Durenberger and others have proposed in the past, and use that revenue to help our very neediest citizens obtain health care.

It is very unfair that we are presently underwriting through the tax system the podiatry and chiropractic care of wealthy Americans at the same time as we fail to subsidize even basic health care for our neediest citizens.

Another area that divides us, frankly, is how to control costs. And here I want to be very honest, and say that we should avoid a quick fix with early results, and choose a longer term strategy that will be a little more painful and a little less quick, but that I believe will get us toward a more efficient system.

I am referring to the choice between whether to go the route of global budgeting and fee schedules and controls on providers, or a different route that features the following: determining and measuring outcomes and quality; contracting selectively—in the private sector and in Medicare and Medicaid—with those providers shown to have the best performance records based on both cost and outcomes; and creating incentives for employees and government beneficiaries who can afford to pay to use those providers with the best outcome records.

This, in my view, is a preferable approach, given the goal of having an efficient, productive system. It will not, however, stop costs in their tracks. It is going to take a number of years to learn how to do this. It is in its adolescence now.

But I believe it is preferable to differentiate among providers based on their performance, rather than to do what we have so often done in government policy and private business practices, which is to treat all providers alike, squeeze them, ratchet down their fees, and put on controls.

We know how do to a quick fix. Other countries have done it. They have limited technology, they have hammered down fees. But I do not think it leads you to a more productive system, and I do think it has adverse side effects in terms of access to the fruits of our technological innovation. So we face a tough trade-off between short-term relief, and longer term movement toward a more efficient and effective medical system.

I believe, in closing, that what we need is a multi-faceted approach that features the reform of our Medicaid system, tax reform, and regulatory reform. We need to eliminate anti-managed care laws even as we talk about spreading managed care, we need to roll back State benefit mandates; we need to reform the tort system and medical malpractice, which is driving up costs. We need to learn how to purchase prudently in the public and private sectors through the methods I have outlined.

In addition, I think we will have to consider some sort of rationing, because other measures will not fully bring costs under control. Thank you.

The CHAIRMAN. Of course, we will take your entire statement in the record. We have a time limitation here so the members can get a chance to really discuss with you and ask questions.

Dr. MEYER. Right.

[The prepared statement of Mr. Meyer appears in the appendix.]

The CHAIRMAN. Dr. Reinhardt.

STATEMENT OF UWE REINHARDT, PH.D., JAMES MADISON PROFESSOR OF POLITICAL ECONOMY, WOODROW WILSON SCHOOL, PRINCETON UNIVERSITY, PRINCETON, NJ

Dr. REINHARDT. Mr. Chairman, thank you very much for inviting me before this committee. I have brought my most important assistants today, Mark and Kara Reinhardt. I would like them to see the political process in action and hope that one day they can do better than their father and get to the other side of this table.

The CHAIRMAN. There are days I am not sure it is the better side of the table, but go ahead. [Laughter.]

I have submitted a statement that ranges over a larger number of issues than just insuring small business, but it is important to keep this back-drop in mind.

The first section of my paper is addressed to the issue of rationing. You will hear in testimony, and I am sure have heard, that the danger with all the health insurance approaches used in other countries is that they "ration," health care and that we do not. I would urge you to keep in mind what is meant by "rationing" in this debate. Most other countries withhold some procedures from all of the people. We Americans withhold all procedures from some of the people. It is not clear to me which approach to rationing would please God more. When we discuss rationing, let us please keep in mind that in this country we ration quite brutally by income and ability to pay. Other countries ration through planning and by means other than income and price.

The second issue I raise in my paper is one that was put to you by the business community, namely, that health spending harms the economy. That is true, but not the way business people have put it to you. They claim that they cannot compete with foreign producers because of high American health care costs. That is a bogus issue. I have written at length on it in other papers and have testified on it before the Joint Economic Committee on May 23, 1990.

It has little to do with competitiveness. It has to do with the labor market. Basically, health insurance premiums paid by business are shifted backwards into the cash wages of workers. For unions of the auto workers, for example, it simply means their cash wages will be lower.

That is all right as far as unions go, because they are usually well-paid to start with. It is less all right for small business in low income industries where ultimately this shift can kill the entire labor market. That is, when health insurance premiums eat too deeply into cash wages, then workers will eventually prefer not to work at all.

That is why worrying about low-wage—usually small—business is legitimate. As I say in my paper, my advice to you would be to do nothing whatsoever for big business. They do not need your help and they do not deserve it. Indeed, most of the problems in American health care today were actually created by the executives of

large American corporations. You would be very ill-advised to do anything to help them out of their current predicament in the health insurance market. But small business does need help.

Now, what are your policy options? When you think about health insurance, you are always told to "build upon the present system." I would like to explore with you how good this system actually is.

Suppose your committee were asked to design a health insurance program for the American people. Would you propose as a cornerstone of this system private insurance policies that tie the health insurance of a family to one particular job whose existence, in fact, depends on what Akio Morita in Tokyo thinks about as he maps his competitive strategy for the future? After all, every job in Peoria now is subject to managerial decisions in Singapore, Frankfurt, and Tokyo.

Yet we do now have a system—upon which we are urged to build—that ties the insurance of an American child to managerial decisions in Tokyo. I think this committee would never design such a system, nor would it design a system that experience-rates insurance premiums over a group as small as 10 employees. When a small business is experience-related in this way, one single employee with a chronic illness can drive up the premiums of other employees quite substantially.

People who urge you to build upon this present system should be challenged by you to do for America the following for us: Give us, from the private sector, a portable insurance product; give us from the private sector an insurance product that is administratively simple; and give us from the private sector an insurance product that is community-rated and that does not punish an individual because God afflicted him or her with illness. If the private insurance industry can deliver that, it deserves to survive. If it cannot, I hope it will disappear from our health insurance system, and the quicker the better for all of us.

In my written statement I have laid out an entire menu of options that we could pursue in this respect. I know the new proposal coming from the Democratic side mandates business to offer insurance, and then tries to help business to get insurance product.

I have proposed some time ago an alternative approach where I would mandate the individual to be insured. I would take this burden off business altogether, but mandate that whoever is not privately insured automatically is insured by a public fail-safe system. It could be "Americare," an ingenious name, by the way. Let me stop at this point. We can explore the issue of cost containment later.

[The prepared statement of Mr. Reinhardt appears in the appendix.]

The CHAIRMAN. Well, you have made some very interesting, and some of them somewhat provocative, statements. Let me state before too many people grin, I agree with much of it. I am deeply concerned about what I see in the way of cherry picking among small companies. I am deeply concerned when they look at companies that just have young employees without pre-existing conditions.

I am really upset when I see job lock in a fellow that has a pre-existing condition with a child and he is afraid to go to another

company, because he is afraid he is not going to be covered. As far as I am concerned, we are going to do everything we can to correct that kind of a situation. I really want to see something in the way of reasonable pricing taking place.

We cannot discriminate between the older and the younger employees as much as we are seeing happen now. So, I think there are going to be some very substantial changes coming out of this committee.

I understand the political realities, too, in trying to get something accomplished rather than just have an issue. I want to see that we have legislation that we can effectively pass through this Congress and get signed into law, because I think this is one of the most critical things facing the nation today. And trying to move on it is not going to be an easy thing to do.

When you talk about keeping it administratively simple, I think that is one of the toughest parts of the job. Because as I look at the private sector and the great multitude of companies and different plans, and trying to get that leavened out without just really eliminating the private sector—which I do not want to do—is not going to be an easy thing to accomplish.

And Dr. Meyer, as I looked at your comments, I share all of that about reform this, and reform that, and reform this, and reform that. That is like saying we are going to get rid of waste. I assume in your testimony you have some specifics.

Dr. MEYER. Well, I do, sir. I suggest——

The CHAIRMAN. In your written testimony.

Dr. MEYER. Yes, I do.

The CHAIRMAN. You did not have time to get into those, I assume.

Dr. MEYER. Well, yes. I only had 5 minutes.

The CHAIRMAN. Yes.

Dr. MEYER. But basically, what I recommend to deal with the problem that you have been highlighting here——

The CHAIRMAN. That is like solving inflation in 30 seconds on a TV program.

Dr. MEYER. Right. Well, it seems to me that we could put together a package of specific reforms, a number of which have been discussed and debated in Congress. Some of the following reforms, to address the problems that we have all been talking about, have been enacted in various States.

First of all, we can reform the insurance market to deal with adverse risk selection by requiring open enrollment, guaranteeing renewability for small firms, and eliminating medical underwriting of individuals.

There is probably only one way in which I speak with more authority than Uwe on this subject, and that is as a small employer in a small firm. I have eight employees, and I know the problems involved. But we can put some limits on premium increases. We can set up re-insurance pools so that carriers that have to accept all risks can be protected against getting a disproportionate share of high-risk workers.

But we must also change the features of government policy at the State and Federal level that work against affordable health care. I mentioned two of them in my opening remarks and my tes-

timony. First, State mandated benefits have proliferated to over 700, all well-intended, which load up the cost of the insurance package to the point where small business cannot afford it. So that a firm that wants to employ a gas station operator who is 20 years old, has to provide him with in vitro fertilization coverage, and acupuncture coverage, and podiatry care. Whereas, if they could offer him just hospital, doctor, X-ray and lab, they might be able to afford it.

The CHAIRMAN. Doctor, I have got the same 5 minute limitation you had, so let me interrupt here.

Dr. MEYER. All right.

The CHAIRMAN. I certainly am in accord with your comments concerning access to health care. But when you talk about some of these things, the analysis of the quality and the cost of the health care, it seems to me that is more long term.

Dr. MEYER. It is.

The CHAIRMAN. And how can we start in the short term?

Dr. MEYER. I acknowledge that in my testimony, but the things that are most worth doing are the hardest to do. It is very easy to——

The CHAIRMAN. I am not negating what you say in the long term.

Dr. MEYER. Yes.

The CHAIRMAN. But I also must see something in the short term, because we have got a crisis facing us here.

Dr. MEYER. I agree, Mr. Chairman. But I also think that some of the short-term measures we take can block us from achieving our long-term goals. If you put a Canadian-type system of controls on spending, I think that it will deflect us from searching for good quality and good value. It will tend to squeeze technology and control costs by limiting technology.

That does not mean we should not do it, but let us not kid ourselves. There are some very sober tradeoffs here between access to care and cost control. And it seems to me that yes, it is worth investing in years of research and learning how to measure quality, and building that into reimbursement decisions, but I am not trying to kid you and say it will stop costs overnight.

The CHAIRMAN. Dr. Reinhardt, in studying the West German system, and then studying the system in the Netherlands—but particularly the German system—they really moved, it seemed to me, to reasonable cooperative efforts.

They did away pretty well with the for-profit companies. There are still some there, I recall. The top 8 percent of the people still had an option to choose. And amongst the companies, they could choose a not-for-profit or for-profit company. But they seemed to play a much more limited role than they do in this country. How would you comment on that?

Dr. REINHARDT. Well, in every country there is usually a well-monied elite that would like to have something extra in health care. You will find in the European setting that usually 5 to 10 percent of the population has private insurance that allows it to jump a queue, or get more personal attention from the chief of surgery in a hospital.

Ninety percent share one health system that is usually administratively quite simple, that frees the patient and the doctor almost totally from administrative hassle, and that spends probably no more than 6 to 7 percent of the health care funds on administration.

In Germany, it happens to be a private not-for-profit system of sickness funds that is government-regulated. That is to say, health spending is not in the Federal or State budgets, per se. It is a payroll tax turned over to the private sector which uses and manages these funds with Federal guidelines. It is a quite clever approach. Imagine, if you wish——

The CHAIRMAN. And they bargain with the providers.

Dr. REINHARDT. They bargain with the providers in a process that is subject to recommended economic guidelines promulgated by a board similar to the one that is being proposed for Americare. All of the stakeholders in German health care have to meet once a year in the capital and lay down these guidelines for the entire system. How much should health spending grow overall, how much should the doctors' take grow. These guidelines are not binding, but they are powerfully persuasive for negotiations at the State and local level.

We were in Germany last year with a few members of the Physician Payment Review Commission, and we asked them how it is that the negotiating parties usually agree, rather than go to compulsory arbitration. And here is the trick: They said there is a compulsory arbitration board, usually with an economist as a chair. And no one knows what an economist will do, once unleashed with power in a compulsory arbitration. So both parties would usually rather settle than putting their fate into that economist's mercy. [Laughter.]

That is what we were literally told.

The CHAIRMAN. Not as many lawyers.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you very much. I am certainly gratified by your comments in reaction to the witnesses. As sort of an information item on the issue of employer mandates versus personal mandates, this year the Minnesota legislature, in an effort to get at universal access, did a variety of things, including all the underwriting reforms, and coverage for some preventive benefits. In addition, it mandated proof of personal financial responsibility in the health area by 1997. I urged the Governor to veto the bill, and he did veto it. Not because of that, however, because I think philosophically where I come down is that when we eventually get to universal access it ought to be a personal responsibility.

I urged Governor Carlson to veto the bill because it did not include a plan for how to get from here to there and, when the mandated landed on you, how much you were going to have to pay for it. And Minnesota has a very Democratic legislature. As I tried to say yesterday on the floor, I do not think there should be any politics at all in this business. It is tough enough to do health care reform—just understanding it—so I hope we are able to keep the partisan politics out of this process.

I have two questions, but in the interest of time I better just ask one of them. The concern that I have—that I would like to see you express yourself on—is universal access to what? And there are two ways, it seems to me, to look at universal access. One is access to financial security. And that is the approach that I have taken in S. 700. This bill lays out, in effect, a plan that protects every family in America against financial catastrophe. That and that is the old definition of an insurance plan. However, people out there do not talk about truce insurance. They talk about provider access. And then we disagree on this long list of providers, because we become used to this notion of health insurance being provider access rather than insurance against financial ruin.

So, one thing I think we need to decide is, when we do reform, whether we should guarantee financial security or provider security.

A second issue that must be addressed is the role of the intermediary in this country. And that is really what I started out to do with S. 700. A big issue is whether we consumers continue to need an intermediary between us and the providers of health care and, if so, should that be a single or multiple intermediary?

Should that intermediary solve all of our problems for us—the need problem, the quality problem, and the price problem? If so, do we have to move this up to the national level and design a national intermediary and specify the qualifications of people who can serve this function? Could I ask that by way of a question?

The CHAIRMAN. You may.

Dr. MEYER. With regard to your first question, it seems to me what we should do is have a refundable tax credit equal in value so that all low/moderate income people could buy a basic plan. And by basic, I mean hospital, doctor, X-ray and lab. I do not like the idea of subsidizing providers and letting it trickle down, saying, well, you have such and such uncompensated care, so we will give you so much money. I like enfranchising the consumer.

But then you must make sure they have a vehicle to buy into. Therefore, I would couple that with a mandate on employers to make an insurance vehicle available, but not necessarily to fund insurance costs. That is a leaner kind of mandate, so that all employees have a group policy to buy into.

Insurance market reforms are also needed so that people do not have to pay $10,000 a year if they are high-risk. But it seems to me that kind of payment or credit going right to the family to cover basic care, with them supplementing it themselves for any extras they want, is the best idea.

With regard to the second question, the role of the intermediary, that is a tough one. I guess I would say that you have to weigh the disadvantages of one payer against the advantages. We have heard a lot of talk about the advantages, and the obviously leaner administrative costs of a one-payer system, the lower loading factors, and so on. I do think, however, we live in a pretty pluralistic country. We are not a small European country. Tastes and preferences differ around the country. And I think we have seen a tendency of one payer systems to suppress costs and the availability of technology. Therefore, I think we have to ask whether that is worth the

administrative savings. I do not know how we will come out on that.

Senator DURENBERGER. Why do you not just add some comments for the record, if you would, to follow up on that.

Dr. MEYER. Pardon?

Senator DURENBERGER. Just add some comments for the record to follow up on that one.

Dr. REINHARDT. I think when it comes to access, we are concerned that American people have access to needed health care without suffering financial ruin. So, it is both. You really do need both. These packages, what is needed can be defined. We did, after all. You have done it for Medicare, and most insurance policies define it. We could settle that issue.

I disagree with most of my colleagues in economics in that I do not think of the people who cause the bulk of health care expenditures as "consumers." Medstat, a company that tracks health care utilization data for selected industries, recently published numbers that show that 2 percent of insured households tend to account for 50 percent of all health spending in any given year and 11 percent of all insured households account for about 80 percent. The consumers my worthy colleagues always talk about account for only about 20 to 30 percent of total health spending. The rest are "patients," that is, "sick people." They are not consumers, and the economist's dream to have these sick people participate meaningfully in the Health Care Consumption Act as they lie there frightened, and aching, and dying, is truly bizarre. That idea could occur only to economists, and only so long as they remain vertical. Once economists lie horizontally, that is, once they are truly sick, they very quickly change from consumers into patients. [Laughter.]

My colleague on the right here will not behave guile as a consumer when he or his children get critically ill. Ultimately the decision then made involve people other than the patient as a consumer, and I would plead with you not to listen too courteously to the vertical economists' prattle about national health care consumers. In fact, when you hear "consumer" in this context, a red light should go on. I noticed this one in front of you just turned red. [Laughter.]

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Yes. Thank you, Mr. Chairman.

The CHAIRMAN. It sure is difficult for me not to interrupt, but go ahead.

Senator GRASSLEY. Dr. Reinhardt, there is a point you made that I would like to have you elaborate on, and it is where you said, "It can be fairly said that the evident lack of control over spending that this system affords society is an inherent feature of this awkward cornerstone of health care financing." I assume that awkward cornerstone is private health insurance system?

Dr. REINHARDT. Yes. There are several reasons why I would say this. First, we have in this country divided the flow of money from patients to providers into thousands of little capillaries, some bigger, than smaller, such that no one actually knows what anything costs.

For example, a Medicare patient who has a hip replaced will pay him or herself a little; maybe one, or two, or three Medigap policies

may pay a little; and Medicare pays more than a little. But no one really knows what the entire hip replacement costs. That is one drawback of our multi-pipe health care financing system.

Unfortunately, these multiple money pipes are not coordinated. I am a member of the Physician Payment Review Commission. With much research and effort, we have tried to develop a fee schedule that is based on relative costs. And we would pay for a coronary bypass, say, $2,000. But private insurance pays anywhere from $3,000-$10,000 in my neck of the woods—Philadelphia and New York.

And then, of course, the private payers come before you and complain about losing competitive edge because they pay too much for health care. I always tell the corporate executives when they lapse into their health care cost laments: "Why then do you insist on paying $8,000-$10,000 for a coronary bypass, when research suggests that relative to what internists and others earn, a $2,000 fee is adequate?" I find it remarkable that business and their allies, the insurance executives, come before you and complain about health care costs to you, all the while insisting on paying fees that are way out of line with what research suggests is reasonable.

And that is why I blame most of the health care cost problem in this country not on the government. The government is way ahead in the effort to control health care costs. I say in my testimony, I praise this committee and others for the vision they have brought to the issue of health care cost control.

If it were not for this committee and the House Ways and Means, business would not even know how much inappropriate care it is now paying for. The entire program of "outcomes research" has been funded by Congress and implemented by the much maligned Federal bureaucracy. When it comes to payment reform of hospitals, who was the leader here? Government was. When it comes to payment reform of physicians, who is the leader here? Government is, almost all along the line.

Therefore, the notion that you have heard that most of our health care costs are really the government's problem is not correct. Business and the private insurance sector will follow step-by-step what the Federal sector is actually doing in health care.

Senator GRASSLEY. And those very same businesses want the Feds to take the responsibility off their hands?

Dr. REINHARDT. They want you to take the responsibility off their hands now, and they will blame you for everything that might then go wrong. That is, I tell my students, that is the customary way among corporate executives.

Senator GRASSLEY. I also appreciated your statement that the citizens of other countries get solid peace of mind as a consequence of the health insurance systems in their respective countries.

But I was also intrigued by an introductory comment to that point, and this is, I think, the quote. "Research has only recently begun to explore precisely what these countries' citizens miss in health care that we Americans do get for our much higher spending." Was that a sarcastic——

Dr. REINHARDT. No, that was sincere. And this actually came out of——

Senator GRASSLEY. Well, then we do have some research that shows that we are getting more from our system?

Dr. REINHARDT. We do have that, yes. For instance, there was a study by Dr. Rubely of the American Medical Association which showed that we have far more highly sophisticated technology per capita in this country than do Canada and Germany. What I meant with that remark in my paper is that we do not know what the availability of that technology actually means in terms of the quality of life of the patients here and abroad. For instance, we have in this country four times as many mammography machines as we need under current usage. That paper was just published. So, sure. You can show we have more mammography machines per capita, but they are under-used. And at the same time, poor women who cannot afford the $100 fee for that mammography go without it.

So, the next piece of research needs yet to be done. The question is this: Are we Americans, in fact, healthier for all the extra spending we have; do we have a higher quality of life than the average Canadian. Quite sincerely, that research is doable, but it has not yet been done. I think it should be undertaken, and it probably will be, with the help of Congress.

Senator GRASSLEY. Well, do not all societies measure quality of life if you live longer? I mean——

Dr. REINHARDT. Living longer is one thing, but living with free function is something else. It is conceivable, for example, that the British live as long as we do, but they might be more impaired on average than is an elderly American. That could very well be the case.

The British, for example, might not have as easy an access to hip replacements as Americans do. So, in all fairness, we should see what it is we actually are getting for the extra expenditures we make. It is researchable, and really has only in a very limited way begun.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. Dr. Meyer, you talk about the refundable tax credit as being a good way to solve these problems. What is your cost estimate for a refundable tax credit system?

Dr. MEYER. Well, it could be done in different ways, but one that I have——

Senator ROCKEFELLER. No, no. I am not asking about the way, I am asking about the cost.

Dr. MEYER. I realize that. I want to tell you, sir, that the cost varies depending on the generosity of the design. I have estimated about $10-$12 billion for a refundable tax credit that covers all the expenses of the people living below the poverty line, and phases down over a range of 100-150 percent of poverty.

And over that range, it covers half the cost of purchasing an insurance policy. Another credit that goes up to 200 percent of poverty is going to cost more. But my estimate of one that phases down to 150 percent of poverty is approximately $10-$12 billion in the first year.

I also have estimated—this is not my estimate, but based on Congressional Budget Office figures—that if we put a ceiling on the employer contributions that could be excluded from income, as Sen-

ator Durenberger has proposed, along the lines of his numbers, and updated for inflation, that it would raise about $10 billion per year on average. So——

Senator ROCKEFELLER. If I could interrupt, because you have answered my question. I find that very interesting, and I will be interested to trade information with you. Lewin ICF calculates that if there were universal access using the refundable tax credit, that the cost of that would be $226 billion. The difference between that, and what you suggest. I find extraordinary. And I think we should talk further.

The CHAIRMAN. Well——

Senator ROCKEFELLER. Second, you have suggested a Medicaid buy-in alternative, have you not?

Dr. MEYER. Yes, I have. I just want to mention the only way you get a number like that is if they are talking about a tax credit that were available to all Americans.

Senator ROCKEFELLER. That is correct.

Dr. MEYER. But I am not talking about that. I said specifically I was talking about a tax credit that went to low and moderate income Americans. We are comparing apples and oranges.

Senator ROCKEFELLER. Yes. So, in other words, in that 70 percent of Americans who do not have health insurance are above the poverty level, and if you are setting it at 150, that probably means something like 50 percent of Americans are above the 150 percent of poverty level. You are excluding about half of the uninsured in that——

Dr. MEYER. No. That is not the case.

Senator ROCKEFELLER. Tell me how you are not excluding them.

Dr. MEYER. All right. According to estimates I have received from the CBO, if you covered people up to 150 percent of the poverty line, you would be covering approximately two-thirds of the uninsured, not half. It is true that there would be another one-third of the uninsured who would not be addressed by this.

My answer to that would be a variety of insurance market reforms designed to make sure that somebody at say, 200 or 250 percent of poverty, would be able, with a reasonable contribution, to get insurance. Obviously, if you want to go up to 200 percent of poverty, you would be in a higher range. So——

Senator ROCKEFELLER. Do you know what 200 percent of poverty is?

Dr. MEYER. Yes. I have seen estimates.

Senator ROCKEFELLER. What is the number?

Dr. MEYER. I have seen estimates that going up to 200 percent poverty——

Senator ROCKEFELLER. No, no, no. What is 200 percent of poverty?

Dr. MEYER. Oh. Well, today, the Federal poverty line for a family of four, if we had the current numbers—we have last year's—is about $13,500. So 200 percent of poverty is $27,000 a year for a family of four.

Senator ROCKEFELLER. I think that makes a point, does it not? So you are going to go 50 percent below that.

Dr. MEYER. I would go up to about $19,000 for a family of four. Obviously, we could subsidize people out of this treasury up to

$40,000 if we wanted. I am suggesting, you know, there are budget concerns.

Senator ROCKEFELLER. And I understand.

Dr. MEYER. So, I am trying to suggest something——

Senator ROCKEFELLER. And I understand. So now I just want to make the point that you did not admit that at the very least your plan leaves out one-third, and by my estimates, it would——

Dr. MEYER. No. It does not leave them out. It does not cover them through Federal outlays. I have other approaches.

Senator ROCKEFELLER. Fine. Now, the other thing you suggested was a Medicaid buy-in.

Dr. MEYER. Right.

Senator ROCKEFELLER. The Pepper Commission looked at that, and so did the Children's Commission. It turns out—and tell me if you disagree—that, in fact, that approach leaves out 14 million uninsured Americans, which is close to one-half of those that are uninsured, and it costs twice as much as what it was that we suggested in the Pepper Commission. Would you disagree with those figures?

Dr. MEYER. If you only look at the buy-in part, it is only geared to people phasing out of coverage in the range of the near-poor. So obviously, it would not cover people under the poverty line who would not be expected to purchase their care, and it would not be covering higher income people. So, yes. I do not know the exact number, but it would exclude people.

I view the buy-in as a way of smoothing the transition from public-only money to private-only money, and it would be graduated. So I do not think it would cover—obviously, it would not cover everyone.

Senator ROCKEFELLER. And you would accept with the Medicaid buy-in the enormous differential among States setting their Medicaid eligibility differentials?

Dr. MEYER. No, I would not. Because I have indicated in a number of things I have written, including a submission I made to your Pepper Commission, that I believe the Federal Government ought to set a floor on eligibility for Medicaid that would end the unconscionable differences across States. Clearly, that is an important problem. That would cost some money. I estimate about $3.5 billion to set a floor equal to about two-thirds of the poverty line under AFDC and Medicaid eligibility. So, you must do that, otherwise a family in Alabama is going to have one-eighth of the Federal poverty line as their target.

Senator ROCKEFELLER. Mr. Chairman, a one sentence question. Do you favor universal access for all Americans who do not have health insurance, or do you not?

Dr. MEYER. Yes, I do. And I indicated that in my opening remarks.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Just very briefly. Dr. Reinhardt, you mentioned that the government—specifically this committee and the House Ways and Means Committee—have provided much of the impetus for cost control measures both for physicians, and for hospital costs.

Let me ask you, what are your thoughts about—we have seen some evidence of larger companies that have testified before the committee about some of the managed care programs that they have instituted as a means of cost savings that seem to have been very effective for their own needs. Do you have any thoughts about managed care as an approach towards lowering costs?

Dr. REINHARDT. Managed care, is in its infancy. One of the points I make in my testimony is that the clinical basis on which payers manage care is information that came out of research funded not by the private sector, but by government. That is the point I would like to stress here.

There are two options this country faces in connection with cost control ultimately, and I have these in my figure 7 in the testimony.

You can either go the West German route and have all the payers jointly negotiate with counterpart associations, usually at the State level, binding fee schedules for physicians, for equipment; and, with each hospital, negotiate a global budget. That is how Germany and many other countries ultimately do it. They operate a multiple payer, single fee-schedule system. That gives one enormous potential for cost control.

The alternative is to erect the kind of system Alain Enthoven talks about, which one might call "pick your own private regulator." You pick your own private regulator, say, a PPO or an HMO. That private regulator does all the deals for you when you are sick, and you pick them when you are healthy.

As a consumer, you have a choice among private regulators under this system and they would use managed care. They would negotiate either capitation or a fee schedule with doctors. They would negotiate managed care approaches, utilization review, or concurrent review. When consumers are sick, these private regulators take over the economic decisions that patients are not fit to make.

However, it would require considerable, sophisticated regulation to make sure that the insurance industry does not pick among risks. The untoward underwriting practices into which that industry has driven itself has caused a lot of the problems of the uninsured; durational underwriting, where you sign up a small company and then after 2 years, you look at the health spending and then you jack up their rates.

That a social form of underwriting has to be regulated out of existence.

Senator BREAUX. Under that type of regulated scheme, the government necessarily sets the ceilings and the limits on any of the charges?

Dr. REINHARDT. On the multiple payer?

Senator BREAUX. Yes.

Dr. REINHARDT. No. In West Germany, the government is not in it at all. It is negotiated between doctors and insurance associations. There are a thousand different non-profit insurance funds in Germany, but they are joined together at the regional level and jointly negotiate binding fee schedules with providers.

The only thing the government asks is that before these negotiations take place, all the stakeholders set overall parameters that

are very much alike to the Volume Performance Standards Congress now sets for spending by Medicare on physician services.

Senator BREAUX. Yes.

Dr. REINHARDT. And if those standards are violated and, therefore, the payroll taxes of workers go up too fast, the government will then swing into action every 5 or 6 years with some cost control device that it legislates. But usually the private payers and providers try to avoid government interference and, therefore, they come to terms. That is what I meant by the Damocles Sword that hangs over their heads. It is a system of managing by exception.

It is only when the private sector drives up health care costs too rapidly that the government springs into action at all. By contrast, to hospitals the U.S. Medicare program actually has its rates set unilaterally by the Congress. Actually, that approach is closer to Soviet-style pricing than is the German approach.

Why the Soviet-style American approach to hospital rate setting should be preferable to negotiating pries is not clear to me. To my mind, Germany is much closer to the market than is half of the American hospital market, which is much closer to pre-glasnost Soviet pricing. It is ironic, and I am sorry to put it that way in these hallowed halls, but it is a fact. [Laughter.]

Senator BREAUX. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Well, that is very interesting testimony. And I think really it is quite helpful, and somewhat provocative, obviously. And frankly, I would like to keep you the rest of the morning, but we have other panels. So, gentlemen, thank you very much for your testimony.

Dr. REINHARDT. Thank you.

The CHAIRMAN. Our next panel consists of Ken Evason, who is the chairman and chief executive officer of the Association Life Insurance Co. of Brookfield, WI. If you would come forward, please. Robert Laszewski, who is the executive vice president and chief executive officer at Liberty Mutual; Mr. Robert O'Brien, who is president, Employee Benefits Division of CIGNA; Bernard Tresnowski, who is the president of Blue Cross and Blue Shield Association. Gentlemen, we are pleased to have you. Mr. Tresnowski, if you would proceed, please.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, CHICAGO, IL

Mr. TRESNOWSKI. Thank you very much, Mr. Chairman. I would appreciate it if the committee would accept my full testimony into the record. And I will summarize——

The CHAIRMAN. Your entire statement will be put into the record, and for each of you that will be the case.

[The prepared statement of Mr. Tresnowski appears in the appendix.]

Mr. TRESNOWSKI. Thank you. In my testimony, I point out that as a historical point, that the Blue Cross and Blue Shield organization was created in the depths of the depression in response to the severe economic problems that we faced at that time. It was designed to serve the American people by developing and improving the pluralistic system of health financing and delivery in the

United States, which is much maligned, but, I think, very much appreciated by the American people today.

Developments during the last several years have convinced us that fundamental reform in health delivery and financing is absolutely necessary. In my full statement, I lay out the historical context. And the reason that I do that, I think it is important in a public policy context to understand the supply and demand forces that we have set in motion over a series of decades. It was our public policy to enact the Hill-Burton Program to finance the National Institutes of Health, to issue health manpower grants, and we set in motion a supply strategy that significantly heated up the engine.

And then in the midsixties, we enacted public policy on the demand side when we passed the Medicare and the Medicaid laws, which stoked the engine even further. And all of that was happening at a time in our history when we enjoyed double digit economic growth and, in fact, health care inflation was moderate—about 7 percent.

We find now, though, that these demand and supply decisions fueled inflation. Our demographics have changed significantly. Economic growth has slowed, and health care expenditures have increased, resulting in very significant problems of affordability and, therefore, increasing numbers of Americans that lack health insurance.

In my testimony, I lay out in some detail an action taken by the board of directors of the Blue Cross and Blue Shield Association in February of this year, which they unanimously approved to reform the insurance practices in the small group market, and I would be pleased in the question period to respond. It is an aggressive position on our part which calls for very substantial reform of the insurance industry, both the underwriting practices, as well as the rating practices. But beyond that, we in Blue Cross and Blue Shield are committed to a broader challenge of assuring affordable coverage for all Americans within our pluralistic health care system. And we do endorse three strategies.

One is universal access for all Americans through a combination of public and private programs. Secondly, we should drive to make benefit coverage more affordable. And third, we should assure a well-functioning and competitive insurance market.

Our universal access strategy should be related to the employer base. Most uninsureds, as we know, are workers or dependents. We need to take a fresh look at how we use tax subsidies for that structure. We need to look at the question of continuity of coverage during lapses of employment, and how that can be solved. We need to look at efforts to improve affordability to go a long way to easing the burden on the employer.

I would say the affordability strategy, our second point, is a tough one, but it is not hopeless. We need to strike at the heart of the price utilization equation by more effectively managing the number of services provided, and to assure the quality of those services. We need to look at benefit design that balances the competing needs of adequate protection, affordability, and incentives for appropriate use of services. We need to look at ways to streamline paperwork requirements placed on providers, and we need to

engage all the players and think about the nature of the incentives that drive the system and how to change the behavior.

In conclusion, what I would point out is there has been a lot of discussion recently about administrative costs of our current system. Many people point to the administrative costs of insurers as a target for cost savings, and question the fundamental value of a private health insurance system. I would say on behalf of my organization, the Blue Cross and Blue Shield plans, they are very proud of our record in providing an average of 90 cents in benefits for every $1.00 in health benefits premium.

In conclusion, Mr. Chairman, I would acknowledge that the problems of the uninsured population is, indeed, very serious. It demands a concerted effort by both the private sector and government. And we, in our organization, stand ready and willing to move ahead with government to develop a series of well-planned, coordinated steps to assure access and to control costs.

Thank you very much.

The CHAIRMAN. Mr. O'Brien.

STATEMENT OF G. ROBERT O'BRIEN, PRESIDENT, EMPLOYEE BENEFITS DIVISION, CIGNA CORP., HARTFORD, CT

Mr. O'BRIEN. Good morning, Mr. Chairman, and members of the committee. CIGNA is a large insurer and one of the largest operators of managed care networks in the United States. We are very concerned, as all Americans are, with the rising cost of health care that we have witnessed in the last decade. We believe that through a public-private partnership we can address the two major needs; one of access and the other one of cost.

We believe that the private sector should address the needs of those individuals that are employed, and their families. To do this that we need major reform in the insurance small-case market, so that individuals are not denied coverage over the longer term.

We also believe that the cost issue can be addressed by overriding some State mandated benefits that have proven very costly over the years, and through the use of managed care, which has demonstrated over the last several years that it has an impact, not only on cost, but insuring quality of care for all the individuals covered in the network. Managed care relies on a medically-trained individual to help the individual patient access the health care system and primary care physician acts as the family doctor did many years ago, and that is helping the individual to determine what care they need from the health care system, and how they should go about obtaining that care. The primary care physician then refer the individual into the specialist market, or to a hospital, this allows the individual of the primary care physician to then have an impact on the utilization of services, and also the cost.

The normal way that an individual chooses their primary care physician is through the recommendation of a friend, a neighbor, or perhaps a business associate. Very seldom does selection have anything to do with medical credentials. The primary care physicians and specialists that are incorporated as a part of our managed care networks have gone through a credentialling process

where other physicians have examined their credentials so that they are, indeed, the appropriate people to be delivering care.

Our experience at CIGNA with managed care has cut the rate of inflation in half. We have demonstrated through the use of these managed care techniques that, in fact, the escalating factors in managed care are half what they are in our indemnity business.

This was recounted to you when Mr. Hennessy testified before this committee. He indicated that they had realized substantial savings. Managed care also brings some new things to the table that have not been done before, such as patient satisfaction surveys to determine how the individuals feel about the care that they are receiving. And fed back to the physicians improve their practice patterns.

Also, through the data we collect and analyze by other physicians, there are decisions made with regard to private patient and private physician practice patterns. And this, again, is used to be assured that the individuals are practicing appropriate medicine.

And finally, there is additional physician-to-physician counseling with regard to treatment patterns. We are, today, confronted with numerous State laws that are beginning to be passed, which I would say are anti-managed care legislation that prohibit the further use of these networks across the country, and this is causing costs to continue to escalate, and also, the State mandated benefits.

Although I think they were appropriate when they were initially conceived, they do add costs to the program, such in a couple of States, we have hair replacement, and also marriage counseling, just to pick a couple. We believe that the managed care environment, and also, the concept would work also for public dollars.

We are anxious to move into the small case market and wholly support reform in this market. Small employers should have access to coverage, and we intend to make that happen.

As Chairman of the Health Care Leadership Council—this is a group of 50 CEO's from the health care industry—we have supported some overall concepts which we agree to. One is the small case reform that I just referenced. The other is pre-emption of State mandates, and the pre-emption of State anti-managed care laws; reform of medical malpractice, and improvement in programs for the poor.

Thank you very much for your attention.

[The prepared statement of Mr. O'Brien appears in the appendix.]

The CHAIRMAN. Mr. Evason.

STATEMENT OF KEN L. EVASON, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, ASSOCIATION LIFE INSURANCE CO., INC., BROOKFIELD, WI

Mr. EVASON. Thank you, Mr. Chairman. I am grateful for the opportunity to appear before you today to address what most observers would agree is the country's most important domestic issue, and that is how to best provide health care coverage to all at the most affordable price.

My perspective, Mr. Chairman, is based on my role as a board member of the Health Insurance Association of America, and as

the chairman and CEO of Association Life Insurance Co.—a company formed some 37 years ago—which is exclusively focused on the small employer group health insurance market.

But my opinions are also based on my personal experience with the Canadian health care system, a system that is certainly getting considerable discussion these days in this country. As a Canadian citizen now living in the United States, I am convinced that a Canadian-style national health system will not work in this country.

Rather than import the Canadian system with its many shortcomings, I firmly believe it is best to work upon the existing strengths of the U.S. system and extend this system to the 13 percent of the population currently in need of coverage. I am not here today to tell you that the U.S. system is not without its faults; we all know there are faults. It is, however, meant to convey that the private commercial health insurance industry has recognized the problems that exist, and is developing solutions that will make the system better.

First, as a board member of a Trade Association representing more than 300-member companies, I believe the health association has put together a workable proposal. In 1989, the latest year for which we have data, we see that all private insurers covered 76 percent of the population, or 190 million Americans.

When you add the public sector to that role, over 217 million Americans are covered by the health system. 87 percent of this population has access to the highest quality health care system in the world, undeniably. Unfortunately, there is a gap between those covered and the total population. It is a tragedy that there is a gap existing in such an affluent country. The HIAA has developed its proposal on health care access only after very exhaustive analysis of the data.

We believe the solution to our problem really requires a combination of efforts—efforts between the public sector and the private sector. Our multi-point program requires actions that we, in the private sector can take; action you, as Federal legislators can take; and actions appropriate for State initiative. In the private sector, we have worked for more than 3 years attempting to solve the access equation for the small employer market—the area where almost two-thirds of the 31 million uninsureds currently rest.

Developing a proposal that would meet the needs of the market while at the same time making it possible for traditional providers of coverage—such as Association Life—to continue to participate in this market, has been very difficult.

HIAA's board unanimously adopted a set of precepts which all carriers must adhere to, and are significant and important reform to address this access issue. Let me outline to the committee the four key precepts.

First of all, the precepts have an anti-exclusion requirement, so high health risk individuals cannot be excluded from coverage.

Secondly, there will be portability. There will be continuity of coverage between employers without a new set of pre-existing conditions.

Three, assured renewability in spite of a group's increasing health risks. And four—and importantly in this small employer

market—pricing constraints that would limit the extent to which demographically similar groups could vary.

Using these precepts as a base, we have developed model legislation that we believe State legislators can and should adopt to implement small market reform. In addition to adopting our model bill at the State level, we call on the States to authorize the establishment of a private sector re-insurance entity to permit carriers to spread those losses for high-risk people equitably across the system.

For the medically uninsurable, Mr. Chairman, individuals who are not part of an employer group, we advocate the creation of State risk pools. Thirty-three States thus far have enacted or are considering legislation establishing risk pools.

To Federal legislators, we call on the Congress to take the following initiatives. First of all, we see it important to extend to all insured plans the same exemptions from State-mandated benefits currently enjoyed by self-insured plans.

Two, we would like to see small business helped by extending to the self-employed a 100-percent tax deduction for health insurance. Three, we need to target new subsidies to financially vulnerable groups. Four, Federal Government has to restore the promise of Medicaid for the poor and near-poor by expanding Medicaid to cover all those below the Federal poverty level. Medicaid now reaches only approximately 42 percent of this group.

And finally, I think the Federal Government is on the right track in encouraging the development of a national data base from which meaningful costs and utilization guidelines can be derived.

The national resource-based relative value schedule is an excellent initiative. I will stop there, Mr. Chairman. In summary, the three players Federal and State government and the private sector, have to work together to come up with an affordable health care system for all.

Thank you.

[The prepared statement of Mr. Evason appears in the appendix.]

The CHAIRMAN. Thank you. Mr. Laszewski.

STATEMENT OF ROBERT L. LASZEWSKI, EXECUTIVE VICE PRESIDENT AND CHIEF EXECUTIVE OFFICER, LIBERTY MUTUAL INSURANCE GROUP, DOVER, NH

Mr. LASZEWSKI. Thank you, Mr. Chairman. I am Robert Laszewski, executive vice president of the Liberty Mutual Insurance Group. My company pays over $2.5 billion in health care costs among its various businesses.

Let me begin by being very clear on the issue of insurance company rating practices for the issuance and renewal of group health insurance, specifically, small group insurance.

We, at Liberty Mutual, believe that we are long past the point when reform should begin. Insurance underwriting practices for small employers have reached the point where too often insurers see their business mission as figuring out which Americans to cover, rather than seeing a role for themselves in contributing to a seamless system of universal access for all Americans.

At Liberty Mutual we believe has a special compact with the American people. In other industrialized nations, social benefits are more often provided in the private sector; social health insurance programs, for example. In the United States, we tend to rely upon the private sector means to provide many of these benefits. The American people have long supported this tradition or social compact with the private sector because we have been able to do it effectively and universally. Yes, we have always practiced underwriting and risk classification, but as a means to provide equitable pricing while still generally providing affordable pricing to the consumer.

The notion of a smoker paying a little more than a non-smoker, someone with many traffic tickets paying more for auto insurance has always been considered reasonable and appropriate.

However, in recent years, we have fallen off the track in the health insurance business. Our underwriting behavior has become so widespread and aggressive that we now find ourselves contributing to the access to health care dilemma rather than meeting the demands of our informal compact with the American people to facilitate their access to health care.

Make no mistake about it. Certain risk classification factors are legitimate, and in the best interests of an orderly market, so as to insure affordability for both young and old, and so smaller insurers are able to enter new markets and carriers that have historically practiced more responsible behavior are not penalized by these needed reforms.

But where Liberty Mutual would draw the line is when risk classification goes beyond a defensive necessity to protect the orderliness of the market to an offense tool for the profit and one that is at the expense of many of our citizens.

Not only should we reform the small group market to improve access, but we must also be certain that rating reforms work to motivate insurance companies to drive down administrative overhead, and better control health care costs.

So long as risk classification is seen by some carriers as a primary means to profit and a basis of competition, my industry will not do its share to contribute to a more efficient system. It will not see lower administrative overhead and managed health care costs as its primary objective.

Included in the more lengthy documents I have provided to the subcommittee are specific proposals from Liberty to deal with this dilemma. We clearly stand for immediate reform, and reform that restructures the insurance industry's approach to health insurance so as to contribute to the creation of a seamless system of health care where no one is denied access.

The health insurance industry must begin to move back to the notion that insurance is about healthy people and sick people coming together to create one pool, the cost of which is spread across a large number of people. Today I might be the sick person who takes disproportionately, and tomorrow it is my neighbor. That simple concept of an insurance community is what enabled the American people to accept this compact I have spoken of, and it is the moving away from this community concept that has created the dilemma you are investigating today.

While we very much appreciate the interest of this committee and are most interested in seeing Congress deal with this issue by enacting the reform necessary to create new roles for insurance underwriting that restore this compact, we must also tell you that alone is not close to being enough.

In our home State of Massachusetts we have State involvement in the creation of publicly subsidized insurance for small business groups that before had difficulty finding a carrier, but were able to afford the cost of group insurance.

Today, because of that State program, there are many businesses that have access. However, the subsidized cost per family in the Boston area is almost $400 per month for a family, or almost $5,000 per year. The good news is that there is access, but the cost is not affordable. There are, perhaps, 37 million Americans without rational access to health care. Perhaps 1-2 million of them because of these onerous underwriting rules we are discussing. That is wrong. We should fix it—fix it now—and you have our proposals to do so.

But really, the major problem is not access, it is cost. Only 45 percent of those under 100 percent of the Federal poverty level are covered by Medicaid because Federal and State Government cannot afford to cover more of the needy. Two-thirds of the uninsured either are working, or part of a family where someone is working, but their employer does not provide a group plan for them, most often because it is too expensive to do so.

You can create insurance access reforms, and you should. But doing that alone is a very small part of the answer. In fact, I will suggest by itself it is a cynical answer. You have created access, but to what? Access to a system that is unaffordable to more and more of government, business, and individuals every day.

Also in the more lengthy package, we have provided you with suggestions for Health Care Financing reforms that can begin to restructure and then begin to fix an out-of-control and irrational health care financing system. And most of our suggestions do not require additional government or private sector expenditures. Whether you look at Liberty's proposal specifically for insurance underwriting reform—those of the HIAA, NAIC, Blue Cross, Kaiser—you find no disagreement within the industry that reform is necessary and overdue. That is no longer the debate. You will find differences of approach, but mainly these are technical in nature. We are now at a point where small group insurance underwriting reform is conceded to be necessary.

It is necessary now to slay that dragon, but let us not kid anybody, either. The real dragon is cost. Cost is out of control because we have a dysfunctional health care economy with too many incentives in the wrong place.

Thank you.

[The prepared statement of Mr. Laszewski appears in the appendix.]

The CHAIRMAN. That is interesting. But when you talk about costs, part of that cost—looking at the New England Journal of Medicine—showed that 11.9 percent of the premium for insurance companies was dedicated to administrative cost, as compared to 3 percent for Medicare and Medicaid, as compared to 1 percent for the Canadian system. And then the authors go on to argue that in

addition to that, an enormous amount of additional administrative costs are put on the providers; put on the hospitals; put on the physicians.

And trying to figure out the different billings of a great variety of companies—something has to be done about that if we are going to preserve the private sector in this deal. If you are going to be a part of it, then you have to find some way to try to cut that down. Would you all support a uniform billing system—a national, uniform billing system?

Mr. LASZEWSKI. Senator, we have had a Federal clearing system for checks in the banking system for years. The technology is there and clearly can and should be done.

The CHAIRMAN. How about some of the rest of you?

Mr. O'BRIEN. Absolutely. We were one of the founders of an organization called the NEIC which clears, on an automated basis, checks from physicians and other providers. They are on a standard format, and transmitted electronically to reduce the cost a lot. And responding to your earlier point, administrative costs clearly are an issue. At CIGNA, our costs for benefits comparable to Medicare are 4.8 percent.

There is a big difference in the marketplace, and the commercial buyers are becoming much more astute in looking at prices and charges today than perhaps they were 10 years ago.

Mr. EVASON. I think at the HIAA level, again, we are very supportive of initiatives to reign in the administrative costs and ease the burden on all providers in complying with health insurance company forms and procedures. I would point out to the committee, however, that within the New England Journal study, the number shown for administrative cost also includes taxes on the private sector. The State premium tax is a couple of percent. The Federal tax burden, corporate taxes, plus the recently enacted DAC tax, which is an $8 billion hit to the insurance industry, shows up in the number.

Mr. Chairman, I am suggesting to you that we should look more carefully at those numbers to make sure that we are not comparing apples and oranges.

The CHAIRMAN. Well, Mr. Evason, I do not question what you are saying. But with that kind of disparity that we are looking at, there has to be a lot of room insofar as trying to get some uniformity and trying to clear up some of the incredible problems that the providers are facing and the physicians are facing.

Mr. EVASON. I agree. I am not disagreeing with you, Mr. Chairman. Again, let's look at other areas within the industry. For example we might look to the Rand study completed in 1989 which showed unnecessary medical services provided, cost the system about $70 billion. There are many areas within this health care industry where substantial cost savings can be gained.

The CHAIRMAN. Oh, I do not question that there are a lot of areas, but do not walk away from this one. This is the one I am talking about right now. And let me state something else insofar as the attitude of the Chairman on this situation.

The Majority Leader, Senator Rockefeller, and others presented a plan yesterday for health care. I think it is very interesting. I

think it has excellent ideas, and we are sure going to be considering it as one of the serious options.

And there will be one, I assume, presented by the Republicans, and we look forward to that one. And we will try to glean the very best from each of those, and the Chairman will be proposing a plan to this committee—hopefully with the support of both sides of the aisle—to bring something about that is meaningful in the way of reform and not just nibbling at the edges. But I also want something that we could pass and put into law, and we will be working at that and trying to expedite it.

Mr. Evason, last year we put in, as was alluded to by Dr. Reinhardt, I believe, a $426 tax credit for dependents. And that phased in, as I recall, from $11,000, then phased out at around $21,200. I was talking to one employer down in my home State the other day who is going to use it. Never had covered farm workers in his business, but he said this is ideal for that. And said, "I have not even covered the employee in that regard." But said, "Now I think I can do it. Because," he said, "that is their wage scale, and it is meaningful, and I can take care of the dependents."

Now as we were working on that last year, there were some companies that said they were going to try to provide a product to the consumer that would inculcate that, that would include that. Have any of you been able to make any headway in that regard?

Mr. TRESNOWSKI. No, sir.

Mr. O'BRIEN. No, sir.

Mr. EVASON. No, sir.

Mr. LASZEWSKI. No, sir.

The CHAIRMAN. Have not. Thanks a lot, fellahs. Seems to me that is an opportunity. All right. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you. Let me just begin by saying don't look to me for a Republican comprehensive reform proposal. I do not believe in Democratic proposals, I do not believe in Republican proposals. I think any proposals should be bipartisan. Two years ago, at the beginning of the last Congress, when you had to reorganize the subcommittees here, you very cordially set up two subcommittees where there had been one before in the health area, anticipating all of this work. And Senator Rockefeller took on the Medicare Subcommittee, and Senator Riegle took on the Families and the Uninsured. And I must say to those who have not noticed what is going on around here—and I know I neglected much to my chagrin to mention this yesterday on the floor—that Senator Riegle spent two solid years trying to get Republicans and Democrats to agree on something.

I mean, we were in his office I do not know how many times, up to 20 Senators—Republicans and Democrats—trying to find a bipartisan approach to comprehensive health care reform. So, if you cannot find that and it happens to be a so-called Democratic leadership proposal, this Republican believes that it is just the majority party in the Senate acting responsibly in laying out an agenda.

And I do not think it appropriate for us to respond to that by saying this side has got its agenda, and then spend the rest of the time debating whose agenda it is. I think this is much more important. I just wanted to, as one member on this side, go on the record in that regard.

But with regard to what we might be able to get done in the near term, let me just ask a couple of questions and see who disagrees with it. We are very close to some kind of a consensus that we need small group insurance reform. Can we reach a consensus that if, in this committee, or someplace else up here, we mandated this reform for all the country that we would get it done quickly; we would probably get it very close to what each of the States individually would be doing, but we would have a national system? Would that be preferable to waiting for the HIAA and the NAIC to do it State by State?

Mr. O'BRIEN. Mandating would certainly get the issue on the table and get it resolved fairly quickly. Our support depends on the impact it would have on small employers. There would be other voices that would be more intelligent on that than I am.

Mr. TRESNOWSKI. I would draw on our experience with Medigap legislation where the Federal Government sets the standard, leaves the responsibility, and gives them a timeframe for the NAIC to act. And if they do not, then something else kicks in. And I think that has worked very well in Medigap. I think it would work well in small group market reform.

Senator DURENBERGER. Then the related question I suppose, is the definition of "small employer." The definition my particular bill uses it up to 50 employees. In my State, the legislature passed a bill using a definition of 2-29. I know Blue Cross/Blue Shield, at least in my State, prefers that smaller group. Is there some reason why we cannot include the self-employed in this area? Is there some reason why we cannot include the self-employed all the way up to 50?

Mr. TRESNOWSKI. No.

Senator DURENBERGER. No?

Mr. TRESNOWSKI. No. I have no objection to that.

Senator DURENBERGER. Then do you agree that we need a basic benefit package guarantee to which we will open enrollment, or guaranteed issue?

I believe we need a basic benefit package and I think you know what basic benefits I have set up in S. 700. This package is nothing that I invented. It represents a consensus that has been developing over time. But it includes the co-pays and the deductibles and the stop-loss, and so forth. Number one, do we need this basic benefit package in order to get rid of State-mandated benefits?

Mr. EVASON. Yes.

Senator DURENBERGER. And is the benefit package in S. 700 satisfactory to everybody who is testifying here today?

Mr. EVASON. I have not looked, and I apologize for not knowing the details of your base package. But some type of prototype that lowers the cost of health insurance is a desirable way to go. As you may know, there are 18 States today that have rolled back mandates to allow companies to place in the market a more affordable product—a prototype covering the key areas. I think it is a good initiative.

Senator DURENBERGER. Then the next question is——

Mr. O'BRIEN. Could I respond to that?

Senator DURENBERGER. Please.

Mr. O'BRIEN. I think it would be important to keep in mind in prototype benefits that managed care has made some real inroads across the country. And if there was going to be a prototype, I think it should incorporate some of the benefits of the managed care product. I think the others would support.

Senator DURENBERGER. I am not going to be able to ask a question about ERISA, but I would like some written comments. Do we have to do ERISA reform?

Senator ROCKEFELLER. Go ahead.

Senator DURENBERGER. Thank you. My other question regards the necessity to mandate this reform on all employers, and that is a pretty important question. Because if you do not have an attractive enough benefit and most of the small employers sit on the sidelines, then the cost of this gets spread across a smaller base, and it becomes a penalty on people. So, would you express yourselves on whether or not you think we need the mandate?

Mr. TRESNOWSKI. That is the critical question, Senator, because if you enacted small group market reform along the lines you described a moment ago, and you moved to rating reforms and began to collapse the rating bands significantly, coming closer to community rating, then you are going to find a lot of people are going to opt out—particularly the healthier, younger people are going to opt out of the market. And, as you say, your risk pool begins to diminish. You are immediately then faced with the mandate question.

And the real issue before us in reform is how can you take a piece of reform like small group market reform without at the same time addressing the question of whether people have to carry health insurance. And my own personal preference is that as much as I would like to see insurance reform take place quickly, I do not know that you can do that piece without taking the other pieces together.

Mr. EVASON. I think you will need your ERISA reform to extend the subsidies across the self-insured plans, because the minute you start to drive towards rating reform, as mentioned, you push up the price and employer groups out of the system.

Senator DURENBERGER. And we will probably also need to do something about the tax subsidy, because that would help provide an incentive to the people to buy the plans, or even if they were mandated, it would help spread the cost of those plans a little better.

Mr. O'BRIEN. In the ideal world, from a cost standpoint, the more that are included, the better you are, including the sick and the ones that need the insurance.

Mr. LASZEWSKI. I think it will be more important for you to have within your bill the cost containment features we have discussed before. There is an opportunity, I think, to add a number of those that are revenue-neutral now; they can begin to re-balance the system.

Because, as in Massachusetts—and I think really in response to Senator Bentsen's earlier question—is a $400 subsidy effective in Massachusetts or Texas? It will have a little more impact in Texas, but fundamentally, a $400 subsidy against a $5,000 family cost is not going to get the job done. So cost containment is as important as any of those.

Senator DURENBERGER. Thank you very much.

Senator ROCKEFELLER. Thank you, Senator Durenberger.

Senator Grassley.

Senator GRASSLEY. Thank you, Senator Rockefeller. Maybe some of you could tell us what percentage of the work force is covered under self-funded plans, but before you answer that, I think that one or two of you noted that self-funded plans are exempt from State mandated benefits and from State premium taxes, and from State-run risk pools. But to what extent has a withdrawal of State-funded plans from the health insurance marketplace contributed to some of the difficulties faced by health insurers which lead them to resort to the underwriting and rating practices that push small employers out of the market?

Mr. TRESNOWSKI. It is a very significant part of it. I would be interested in the estimates of the other members of the panel, but in our experience, about 50 percent of our book of business is self-insured. I mean, our book in the sense that we provide administrative services to these self-funded.

It has been a very significant factor, they pulling out of the risk pool, leaving the risk pool smaller, and causing people to—and with rising health care costs on top of that, causing the insurance industry to move more aggressively in the direction of trying to protect themselves. So, your question is a very appropriate one. It has been a significant contributor to the crisis that we face.

Mr. O'BRIEN. I would also agree that it is about 50 percent of our book, also. And what is has done is to leave some of the residual cost to others to pick up, as opposed to everyone participating in some of the costs of the institutions, un-reimbursed care being one of them.

Mr. LASZEWSKI. I would suggest that there has been an impact—and there has certainly been an impact on insurance underwriting practices because of it—but I would also suggest that the large self-insured employers have tended to take care of their own pretty well. They have not been excluding people and pushing them in the un-reimbursed pool, if you will, to the extent that that has occurred in the small area.

I think that it has an impact, but I think what we really need to do in terms of small group reform is operate in ways where we take responsibility for that as a class of business. There should be no reason why 50 percent of the commercial marketplace in American cannot be a pool large enough to spread the risk appropriately.

So, I have difficulty with the notion that is has had a dramatic impact. Yes, it has had an impact on our behavior, but I am not sure that it should have.

Mr. EVASON. I participate in the market comprised of groups under 50 lives, and in that market the self-insured part is very small, but growing, as the incentives to avoid State mandates, et cetera, are there. The healthier groups are seeing an advantage in going the self-funded route, and that makes it increasingly difficult for those that stay in the indemnity side of the house.

Senator GRASSLEY. Let me ask you, Mr. Evason. You noted that you believed that managed care is more likely to achieve cost control without the kind of economic disruptions associated with rate

setting. Give me some idea of these economic disruptions that you referred to.

Mr. EVASON. Well, I think that is a broad-based economic question, Senator. But to me, if we can get to some of the relative value guidelines, some good data on the cost of provider services, et cetera, that we would be a lot farther ahead than forcing a system with a rate setting practice.

It is just not, in my thinking, the appropriate way to go. I know we have heard, in Canada and several other countries, that rate setting apparently works, but I do not support it. I believe that managed care driven through appropriate broad-based data to support the pricing is less disruptive.

Mr. TRESNOWSKI. Senator Grassley, I think the point that Uwe Reinhardt made—remember, he described the two alternatives; either a single payer approach where everybody pays in the same context, or, as he said, "select your own regulator"—and I think your question is what is wrong with the first alternative as contrasted with the second.

My concern with the first alternative is two-fold. One, if you have a single payer on a delivery system as it has evolved in this country, you tend to sanctify that delivery system the way it now exists. I think anybody in this business anytime at all understands that we need a lot of change in the way health care is delivered in this country, and we need flexibility and variation in accomplishing that.

The second concern I have about a single payer is it will inevitably become political. The pressure points are significant under that kind of an arrangement, as contrasted with select your own regulator, where the own regulator can manipulate and negotiate in that marketplace with a great deal more flexibility.

Senator GRASSLEY. Maybe one final question. I think, Mr. Evason, maybe you would be the appropriate one to answer it. But I would like to have some comment on Mr. Laszewski's comments to the effect that re-insurance programs and risk pools should be financed by the industry rather than the government.

Mr. EVASON. Well, indeed, this is the position we, at the HIAA, are taking. Health insurance for high-risk individuals in the small group market will be funded through a non-profit re-insurance mechanism authorized at the State level. It will be a private sector solution to a problem for all employed workers.

Senator GRASSLEY. Thank you, Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Senator. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. Mr. O'Brien, you had talked about managed care a little bit in your testimony and mentioned some of the State obstacles that you would like to see eliminated, perhaps, by the Congress overriding some of these State rules and restrictions. What type of State restrictions are we talking about, and why would States be restricting managed care from being attempted in their own States?

Mr. O'BRIEN. That is a good question, Senator. I would offer a couple of examples, and there were some more in my written testimony. For example, the pharmacist in a State would pass legislation that we would have to do business with all of the pharmacists in the State——

Senator BREAUX. Yes.

Mr. O'BRIEN [continuing]. As opposed to contract with selected ones where we would have a discount that could be passed onto the buyer.

Senator BREAUX. We have seen that problem.

Mr. O'BRIEN. Another example would be the physicians in a particular State would say that they would be the only ones that would be able to determine utilization review, as opposed to physicians from, say, other States. It is a little bit of the people in the State joining together to say that they will determine what is going to happen in the State. And where we had one or two of these several years ago, there probably are 20-25 right now in the forms of bills across the United States.

Senator BREAUX. Does insurance, from your company's standpoint, operate pretty much the same way, funding a managed care program, as it does with just a private selection process?

Mr. O'BRIEN. No. I would say there is a substantial difference between the normal indemnity fee for service insurance program, which we sell, and is probably 60 percent of our book of business, and the managed care, which is the other portion of our book of business.

In the managed care, the individuals go into a network of primary care physicians that we have credentialed and that are under contract to us, and where we have monitor their practice patterns. So, when the individual needs care, you have an informed medical professional determining what they should purchase and where they should purchase it.

What we have found is that it has impact on two things. One, it impacts utilization, which is lower because you have a medically-trained person determining what ought to be done, and because we have contractual relationships with specialists and hospitals, the prices that we pay is less.

Senator BREAUX. What is your comparable cost increase with your regular provider program versus the managed care system?

Mr. O'BRIEN. At the two ends of the spectrum, in the fully managed care program, the cost increase in 1990 was about 9-10 percent. On the other side, with no cost containing measures at all, it was 20-22 percent. And depending on what managed care plan they had in the interim, it would vary between the 9 and the 20 percent.

Senator BREAUX. From your information, what does the patient feel that they give up by participating in a managed care system, as opposed to the other systems? I mean, there must be some. I know there are reasons out there.

Mr. O'BRIEN. That, again, is an excellent question. And the patient does have an initial negative reaction. Normally involves the individuals will have to change their primary care physician. They may have been getting care with one particular family practitioner or pediatrician, or something like that, and that individual may not be in our network, which means that when they go into the managed care environment, they will have to move to a new primary care physician and form a new relationship.

We have found that this initially causes some problems with regard to the employees and their families. Communications can

help to negate that a little bit, but there still is a negative reaction. But we have found once they have an encounter with the new physician, they will use the networks 95 percent of the time, which means it is a matter of changing who you are used to working with. And that is a difficult thing for human beings to do, including myself.

Senator BREAUX. May I ask just a general question? And I do not have time to get into it, but the Majority Leader has thrown out a major proposal supported by a number of members of the Senate for health care insurance. And I was wondering if anyone has had a chance to look at it in any kind of broad review and have any thoughts about it, of any of the panelists.

Mr. TRESNOWSKI. I have looked at a two-page summary which I received the other day.

Senator BREAUX. Yes.

Mr. TRESNOWSKI. And I issued a statement yesterday in which I said I think the real value of it is it represents a responsible set of ideas that will, I hope, generate real serious debate on what needs to be done. I met with Senator Mitchell, and he says that it is open for modification and discussion, and we accept that in the spirit in which it was presented. And I hope that it, in fact, does serve that purpose.

Senator BREAUX. Well, I have a lot to learn about it, as well. I was intrigued by the National Health Care Expenditure Board that the proposal would establish, and I am not sure how that would work. Anybody have any thoughts about that?

Mr. TRESNOWSKI. Well, it is not a particularly new idea. A lot of people have been kicking around the whole notion of how do you put a cap on the amount of money that flows into the health care system in this country. And people are trying to look across the regulatory structure we have created over time to find out whether there are any appropriate analogies; the Federal Reserve Board; I have heard people talk about a Securities Exchange Commission-type structure.

The important question is if you are going to really get to health care cost control, you have got to limit the amount of money that flows into the system. And the idea in the proposal that was presented yesterday is to set this limit and then let carriers negotiate within that framework.

Senator BREAUX. Yes.

Mr. LASZEWSKI. I think what is significant about the proposal—and I have not studied it in detail—but clearly, what is happening or beginning to happen is there is much concern about cost as access. And when this whole debate began, it was solely about access. And now I think a lot of people are asking access to what. And while that bill has got a long way to go, and I am sure it is going to look a lot differently should it ever come to fruition, what is important is that the debate is now going to beyond just the access issue in going toward bringing costs under control, and I think that is a very constructive development, given what we have dealt with before.

Senator BREAUX. All right.

Mr. EVASON. We at HIAA support health care cost containment aspects of the bill. There are some things in the bill that we might not fully support, but in principle it is moving the debate forward.

Senator BREAUX. Thank you, gentlemen. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Breaux. I might just point out that that national board does not stand by itself, that right underneath as part of cost containment is a State-level entity, with its many variations, that has the capacity to do a lot of the same negotiating. So it is a double-tier system, which I do not think, Barney, has probably been put out before.

Before Chairman Bentsen left, I struck a deal with him, and that is because the question that I am going to ask—which I think really gets to the basis of this whole question of rating structure and practices—is long, and has different parts. So I agreed not to ask the NAIC representative any questions if I could extend my question here, and he said all right, and then left. [Laughter.]

So here we go. I had congressional Research Service do some modeling—this is addressed to all of you—to do some modeling for me on premium adjustments based on a few demographic factors such as age, sex, geography.

First, I want to point out that these are merely illustrative examples. There is no standardization of rating practices yet, and insurance practices obviously vary. But I do think that these examples can give a sense of the current marketplace, and that is what I want to probe.

Second, I want to point out these examples only take into account age, sex, where a person works, where a person lives. None of these examples take into account health status or past claims experience, which is an adjustment most insurance companies make in addition to age, sex, where you live, and industry.

Health status adjustments obviously make an enormous difference, but are not included in what I am about to present. Third, again, these are illustrative premium rates for companies who are lucky enough to even get coverage. Some companies, as we all know, are red-lined out of being able to buy any insurance at any price.

Now, the first example. Under current rating practices—again, these are tables given to me by CRS—a retail firm in Frederick County whose employees are males under the age of 30 would pay $58.95 per month for each single employee for a benefit package that on average costs $150.

A law firm in Washington, DC, who employs males between the ages of 55 and 59, on the other hand, would pay $461 per month for the exact same $150 policy. The older, all male law firm in D.C. then would pay 683 percent more for their health insurance policies than the young males in Frederick County.

Now, I have other examples, but from what I have heard from various insurance company representatives, this type of practice is, in fact, perfectly acceptable and actually good policy because the male lawyers in D.C. certainly could afford to pay the extra costs of these premiums, so these types of rating practices make it possible for the younger males in Frederick to get health insurance.

Question: Is that correct, and is a spread of 683 percent reasonable?

Mr. LASZEWSKI. A spread of 683 percent is not reasonable. I think that it is pretty clear that it is not reasonable. What you, I think, are really outlining is the need in underwriting reform to strike a balance. On the one hand, in order for the marketplace to be orderly, there is going to have to be some modicum of variation; even your bill allows for that. Because things we know about the system in terms of the cost of younger groups going up dramatically if we immediately went to community rating, and older groups being just extraordinarily high priced.

Senator ROCKEFELLER. Well, we allow up to 10 percent on age and sex.

Mr. LASZEWSKI. I understand that.

Senator ROCKEFELLER. Right.

Mr. LASZEWSKI. But you also allow significantly more than that the first year so you know the need to crank that down slowly.

Senator ROCKEFELLER. Right.

Mr. LASZEWSKI. So, you understand what we have to go through in the marketplace, and I applaud you for that. So, what we have got then is we have got some decisions to make about the level of cross subsidy we are going to make. On the one hand, 600 percent is bad news, and it is not appropriate in terms of the cross subsidies that have to go on in our society. On the other hand, it tells you something practically about risk and what health care costs for various age groups. It is a practical problem that we are going to have to deal with. And at Liberty what we have proposed is that those ranges need to be crunched significantly and brought down, as have many of the other proposals.

I think a fundamental difference between what we have suggested and what some of the other proposals have suggested is I think it is a function of how far you compress it, and I also think it is a function of how much of not only age/sex rating, but also medical underwriting and so forth remains in the rates.

What I would suggest to you is that the kind of reform that we have to have is one that does compress the rates to socially acceptable levels, still allows for an orderly market, but more than anything else, sends a clear message to the insurance industry that competition over this kind of underwriting practice is not going to be where competition is anymore.

It will be over administrative costs, which we have talked about. It will be over managed health care, because reform has got to push insurance companies to bring those two things into control, not make profit or not see their business mission as underwriting.

Senator ROCKEFELLER. All right. Can I have one more person give an answer? Then I want to continue with the question, if anybody else wants to.

Mr. TRESNOWSKI. I just wanted to clarify. Are you saying that this difference in rate is accountable only by age, sex and location?

Senator ROCKEFELLER. Correct.

Mr. TRESNOWSKI. Then that does not sound——

Senator ROCKEFELLER. And industry.

Mr. TRESNOWSKI. That does not sound right to me.

Senator ROCKEFELLER. Well, I have seen very often instances where age 30 to age 60 might have a 300–400 percent range.

Mr. TRESNOWSKI. All right. Senator Rockefeller. Just if that is what they were. Now, whether it is 400 percent, 350 percent, or 600 percent, I do not think is your point.

Senator ROCKEFELLER. Yes, Barney, this is the point that I am bringing out. I mean, these are real examples; these are not made up.

Mr. TRESNOWSKI. Yes, I understand that.

Senator ROCKEFELLER. And I am trying to make a point.

Mr. TRESNOWSKI. I understand your point and I agree with you. I do not think that you can account for age, sex, and location on a 600 percent variation.

Senator ROCKEFELLER. All right. So that is interesting then, that you question how they get to those figures?

Mr. TRESNOWSKI. That is right.

Senator ROCKEFELLER. Yes. All right.

Mr. EVASON. We do not accept the approach as we go forward. As you know, the HIAA proposal has a limitation of a high to low band of 2 to 1. So, indeed, some cross subsidization, but without destroying the experience rating in the private sector, is the position we would like to take. Your suggestion that it is absurd is one that we would readily agree with.

Senator ROCKEFELLER. All right. Now, proceeding again, with the CRS examples. Young female, private school teachers in D.C. would pay $244.25 for that same $150 policy; 162 percent more than the $150 month price of the policy, and 414 percent more for their insurance policies than the young males. Obviously, you see what I am getting at here.

And the justification is that they—that is, the young female private school teachers—are of child-bearing age and that they should pay 400 percent more than the young males and 162 percent more than the average value of the health benefit package.

Middle-aged male construction workers in D.C. would pay $312 a month for that same $150 policy; more than 500 percent more than those young males, and over 200 percent more than the value of the policy. Again, gentlemen, the defense for that, or the rationale for that, I welcome your comments.

Mr. LASZEWSKI. I would suggest that it might be appropriate for you to run some of those same objectives through the NAIC proposed reforms, because this is just a raw age/sex table, correct? I mean, this is sort of before reforms?

Senator ROCKEFELLER. As we are now.

Mr. EVASON. You are just turning a book open to a page of some insurance company based on actuarial tables showing the incidence of experience against those three groupings. That is what you are doing. Both the NAIC and HIAA are attempting to correct that.

Mr. LASZEWSKI. And I think the real issue as the committee looks at reform is to take the models that have been proposed, and I think we have got to make a public policy decision about how much compression we want. I will argue for one level, HIAA might argue for the same level, or another level.

But I think that is the trade-off we have to get to so that we are going to have to have cross subsidy, or people are going to say, wait

a minute, I am not going to pay twice as much as someone else. There is the notion that cross subsidy must occur.

Senator ROCKEFELLER. All right. Well, now maybe it could be pointed out that if HIAA sticks with the philosophy, that those who can afford to pay more should do so, women, on average, earn much less than men, so should HIAA not do away with the gender rating altogether?

Mr. LASZEWSKI. Liberty would have no objection to unisex rates in health. We would still maintain some degree of age range within a certain level of compression, and some modicum of industry, but not coming anywhere near the examples that you have given.

Senator ROCKEFELLER. Yes.

Mr. TRESNOWSKI. I think, if I can, I am trying to understand what is behind your questions. I think what you are trying to do is take the range of rates that exist in the marketplace today, the rating bands for all of these factors and bring them closer together, obviously, to at some point achieve community rating. None of these factors are taken into account. And I think that is a very worthwhile objective.

I think the NAIC model rating bill goes a long way to achieving that. And I think that eventually, associated with other kinds of insurance reforms that we have talked about, you would get very much closer to community rating, which I think is the burden of your question. The real issue before us is how fast do we get there, and what kind of dislocation do we incur in the meanwhile. And it gets back to the question, I think, that Senator Durenberger was asking. Can you really make a large leap to reducing those rating bands and not have a mandate of some kind so the people do not just decide that all of a sudden they are going to pay a lot more money and they are going to get out of the marketplace. I am not trying to anticipate what you are getting at, but I think what you are saying is this is unconscionable, and that if you had community rating, these kinds of things would not exist. And I agree with you on that.

Senator ROCKEFELLER. You got the drift. Yes.

Mr. LASZEWSKI. And I would suggest that the objective as you go through this process is to take each of these proposals and look at the ranges that they do produce. And then we are going to have to make a public policy decision as to how much of a trade-off there is going to be at any point in the game.

What I will suggest to you is that the objective needs not only to be community rating, if you will, if that is the ultimate objective, but it needs to be the sense in the insurance industry that the basis of competition is not a function of being able to select risk. That becomes a level playing field issue. It becomes a function of administrative costs which are way too high, and particularly they are high with the small carriers. Because a 15 life group might have a 30 percent expense margin. But an association of 15 life groups might have a 6 or 7 percent expense margin.

So we know that there is wide room for improvement in the industry and expenses, but if you can compete on the basis of risk classification, there is not the motivation to do that, and there is not the motivation to manage health care as Mr. O'Brien has said,

from CIGNA, because they can compete on the basis of risk classification.

So the reforms, or the means of cranking these things down has got to send a clear message that that is not the way we compete anymore. And we can, in sort of a staff environment, kind of figure out how to do that.

I think what is clear is there is not any disagreement in the industry. We have to get to that point. I might be 20 points off one of these guys, and they might be 30 points off. But I think we ought to get on with it. But I will tell you this, I am also going to hold you accountable to making sure that we get on with the cost containment issues as well, because access to what.

Senator ROCKEFELLER. And that is entirely fair, and I fully accept——

Mr. LASZEWSKI. All right.

Senator ROCKEFELLER [continuing]. That responsibility. Let me just ask a final question. This is a fascinating debate on health care reform. Proposals come from here and there, and they do not come from here and there. When a proposal comes out, immediately it is dissected, and experts come forth to say why this or that would not work.

And the particular exercise that we have just been through is actually just one tiny part—although a very basic part—of the whole question of how health insurance is provided. It delves into unbelievable complexities, whereupon it is easy to become confused. The public looks at this confusion and arrives at the conclusion that nothing is going to happen.

The White House looks at the confusion and is joyful because the Congress is confused and, therefore, they do not have to do anything. So we go right along and do nothing.

So, it seems to me that the people who ought to be most fearful about this scenario are the four of you. That is, those who are in the health insurance business. Because to me, I expect to be debating this issue for a number of years to come. And I think the question of how many number of years is the difference between whether you all have an industry, or whether you all are out on the street and your employees are out on the street. I fully believe—and I want you to respond to this—I fully believe that unless everybody pulls together—the insurance industry, providers, large businesses, small businesses, Congress, the White House, Republicans, Democrats, Labor—that unless we pull together, we have a classic formula for disaster.

This one will wipe us out if we do not solve it. It will simply wipe us out. I therefore predict that we will be handed national health insurance on a platter with each of your four heads, and many others, with the public then having to understand why it is being hit with a $325 billion comprehensive national health insurance tax.

Do you not see this—this argument which has now commenced, Senator Durenberger taking a very bipartisan point of view—as basically the last shot for the existence of the health insurance industry in this country? And how many employees, incidentally, do all of you have as a whole industry?

Mr. TRESNOWSKI. Well, the actual answer is we have 136,000 employees.

Senator ROCKEFELLER. No, no. I meant the entire industry.

Mr. TRESNOWSKI. I do not know.

Senator ROCKEFELLER. Between 1 and 2 million? Between about a million?

Mr. TRESNOWSKI. Senator, let me pick up your point about the incredible complexity of this issue. I agree with you that it is incredibly complex, but I would differ with you in terms of the complexity serving as a barrier to resolution.

I have been around this business for a long time, and I have seen in the last 5 years a greater resolution of this complexity around some common ideas of what reform is all about.

You do not hear anybody today disagreeing with the fundamental premise of achieving universal access. You used to, but you do not hear that today. You do not hear anybody disagreeing with the need for some aggressive cost containment strategies. You used to hear a lot of disagreement with that, but you do not hear that today.

You are hearing today the importance of insurance market reform from people sitting at this table. You did not hear that 5 years ago. So, the complexity is beginning to resolve itself. It is a process, I think, of maturation. I think we all need to come to grips with the issues, understand them a little better, understand how much each of us has to give—and I do not mean just the insurance industry, but I mean government, I mean the employer, I mean the consumer, the provider—I think we all have to kind of feel our way through this. And that is why I applaud this committee. I applaud you for helping to sharpen those issues so that we then can begin to build our awareness and say, yes, I think we do have a solution to this complex problem.

Senator ROCKEFELLER. Barney, I want to make one comment to that. Yes, 5 years ago, not everyone agreed about universal access and cost containment. People now agree on that, but the different factions, interest groups, don't come close to agreeing on a solution.

For example, providers are all for access until you start talking about cost containment, which involves the government, and small businesses who desperately want to give health insurance are all for this. But then, on the other hand, if you use the word mandate, or try to disguise it with some Chinese word, but nevertheless it still translates into something like mandate, they are gone. And then there are some people that really do not believe the government ought to have anything to do with it at all. Dr. Reinhardt said in Germany it works that way. So, are we really making that kind of progress? And the question is will we make progress in time for all of you to survive?

The Pepper Commission plan—and the plan introduced yesterday is intended for your survival, but counts upon behavior modification on your part. Do you think that, in the aggregate, this behavior modification will come in time, and are you willing to do what you have to to make sure that it does?

Mr. LASZEWSKI. Well, we have an extraordinary national problem in the cost and quality of health care because of the cost of health care. And we are in an interesting dilemma where it seems

as though the special interest players are being expected to come to the table and essentially reform themselves.

And I think that that is fine when the insurance industry can come to the table and be constructive. But I think what is missing from the national health care debate is leadership. I mean, I have heard the Secretary talk about the Bush Administration waiting until the country builds a consensus before we go forward. When I was growing up in Wisconsin watching Walter Cronkite every night, I thought the Presidency was about leadership. And I think that we do not have the focus on this health care issue. We have little bits and pieces. We have the AMA doing constructive things. We have people in the insurance industry.

You have taken a significant amount of risk, Senator, in terms of where the Pepper Commission has gone. But there is not leadership building a consensus. The special interest groups are not going to overwhelm each other. A sense in America that things must change dramatically, and a mainstream sense of things must change is going to have to occur before that happens. And that is what leadership is about.

Mr. O'BRIEN. I would offer a couple of observations on this, and that is, as you have stated, this is an extremely complex issue. It is fraught with emotion, because when you and one of your family members needs health care, that is the primary concern at that point in time.

But I do think that there is agreement among people on the Hill, among business people, among providers and physicians, and so forth with regard to some of the changes that are necessary now. So my urging would be look for those where there is a common ground, make some improvements right now, and then work on solutions as we move into the future. And I think that can be done, and I think with the leadership of this committee, things can happen on that.

Mr. LASZEWSKI. And there are a whole series of revenue-neutral things that can be done and start to rebuild the system. We will not do this over night. It took us 25 years to screw it up. It will take us 25 years, probably, to straighten it out.

Senator ROCKEFELLER. And one of those revenue-neutral things that can be done is health insurance reform.

Mr. LASZEWSKI. Do it. You have got the insurance industry sitting here saying, do it. What is keeping you?

Senator ROCKEFELLER. Because I am not sure that when you get down to issues like guaranteed issue as opposed to guaranteed availability, that, in fact, the same HIAA folks who are saying do it will be there on that issue.

Mr. LASZEWSKI. Senator, put it on the table, get a consensus, and let us see if, in fact, the members of the HIAA do not come constructively and come and support.

Senator ROCKEFELLER. I think there is——

Mr. LASZEWSKI. Are you waiting for the industry to agree? Are you waiting for a head count? I talked to my friends in the industry all the time, and I think we are ready. I think we are past ready.

Senator ROCKEFELLER. You are talking to your bigger friends in the industry.

Mr. LASZEWSKI. I am even talking to my smaller friends.

Senator ROCKEFELLER. Really?

Mr. LASZEWSKI. Yes. I have no doubt about that.

Senator ROCKEFELLER. Well, but then how is it that——

Mr. LASZEWSKI. That is not universal, Senator, but I do not think we are waiting for 51 percent of the insurance companies to give you permission, are we?

Senator ROCKEFELLER. No. I mean——

Mr. LASZEWSKI. I think the 51 percent has got to be in the Senate, not at the HIAA.

Senator ROCKEFELLER. No. It would be my hope that we would go ahead and do what, in fact, that we did in October to the Medigap industry, and that is prohibit adjustments for health status. Bob, that I believe you agree with.

Mr. LASZEWSKI. That is right. And I think——

Senator ROCKEFELLER. We are quite capable of doing it, but that was done in a reconciliation bill. There is no more reconciliation——

Mr. LASZEWSKI. Well, I do not think you need to do this one in the dead of night, and I think as Bob O'Brien pointed out, there are a whole bunch of things there is agreement on that we can start working on. Not universal agreement. You will not get all the trial lawyers to agree to tort reform, but you will get just about everybody else to agree to it. Now, do we have to wait for them to agree to it?

Senator ROCKEFELLER. Well, what about the 66 lawyers in the Senate?

Mr. LASZEWSKI. Well, you know, I thought you guys had rules about you could not get income from anything other than Senate now, so I am presuming you are going to be objective. [Laughter.]

Mr. O'BRIEN. But I think the point we are trying to make is that it is a very, very complex issue. We have studied it. I think there are some common grounds that everybody supports, and I would urge action on those now and then work on the other ones, because you are right.

Senator ROCKEFELLER. I am incredibly encouraged by what each of you have said, I genuinely am. And I thank you. Senator Durenberger, did you have any other?

Senator DURENBERGER. No, sir. I was going to explore other issues. But in light of this sort of fevered pitch for us to act—— [Laughter.]

Senator DURENBERGER [continuing]. On a bill that I invented last year and you have incorporated large parts of it. Let us have a mark-up next week. [Laughter.]

Mr. LASZEWSKI. Senator, I was sorry that you left the room. You were on a roll there. By noon I figured you would have had a consensus on everything.

Senator ROCKEFELLER. Thank you all very, very much. Thank you for waiting, and thank you for adding so much.

David Lyons is the Commissioner of Insurance from the State of Iowa, and he represents the National Association of Insurance Commissioners who, obviously, will have a very large role in all of this.

Senator DURENBERGER. Mr. Chairman, our colleague from Iowa who is currently on the floor where I just was making a speech on the crime bill asked me if he did not get back from making his comments on the crime bill that I indicate to Mr. Lyons that he would like to have been here at the beginning and during his presentation, but he is part of a dialogue on the floor right now on the crime bill.

Senator ROCKEFELLER. Mr. Lyons, you are welcome to proceed. Thank you for your patience.

STATEMENT OF DAVID J. LYONS, COMMISSIONER OF INSURANCE, STATE OF IOWA, DES MOINES, IA, REPRESENTING THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. LYONS. Good day, Senators. I do not know if I can bring it to quite the fevered pitch you had right before I got here. Today we are here to discuss the tragic fact that over 33 million Americans have no health insurance and therefore, lack what we deem to be meaningful access to the health care system.

Specifically, I have been asked to discuss the issue of whether the private insurance market, as we know it today, can be modified and reformed to do three things. First of all, eliminate abuses which presently exist; second, meaningfully increase the access to health insurance and therefore, health care; and third, to do so within a structure which will hopefully be affordable to a much broader spectrum of society than today.

Discussion so far today, I think, had been attempting to angle toward small businesses, (2-25) and I think we should re-stress the focus back to that point. There are two major reasons for our attention to this area. First is the fact that about 60 percent of the uninsured are connected to small business. They are either working for small business, or they are a dependent of someone who works for or owns a small business. Second, it represents the area of the market most pressured by the abuses that we have been talking about, and least able to defend itself. Since you wanted me to address small business today, I will do so in the most frank and brutally practical way I can.

We, in the States, have heard the same hue and cry from small business you have, and I respond to a Governor, and I respond to a State Legislature, and I respond to a populace which has made their problems known in a very straightforward manner.

What I would like to do is go through those problems just the way you are hearing them from small business and give you what my answer and the answer of the NAIC is to those problems.

First problem: We do not have the information up front regarding how their rates are set and how they can change in the future. That is what small business says. Answer: We should require disclosure to consumers of all rating insurance methods and practices before insurance is ever bound.

Second problem: There is too much volatility because of durational—which is the time-oriented rating—or tier—which is the experience-oriented rating—in rating practices for us to continue to participate in small group insurance. My answer: We should place

strong limitations on rate disparity and caps on annual rate increases.

Third problem: Small business does not believe that State regulators have enough information to adequately regulate rating practices on the State level. My answer: We should require actuarial certification of all rating methods used for small business, with approval of those methods by the State.

Fourth problem: Small business feels they have insurance needs that there is nothing available to fill. My answer: We should guarantee small businesses that health insurance will be available to them at normal, across society, group rates.

Fifth problem: Small business feels they have no control over the decisions by insurers to terminate them or to refuse to renew their coverage. Answer: Again, simple. We should put the strictest of limitations on termination of a policy, and we have to guarantee the renewability of coverage.

Sixth problem: Interruptions to coverage can be disastrous, both for the small employer and that small employer's employee. They cannot move from carrier to carrier, they cannot move from employer to employer. Answer: Prohibit new waiting periods across the board. Answer: Prohibit pre-existing exclusion provisions. Answer: Guarantee portability of the coverage from job to job, insurer to insurer. Answer: Make sure that if you move from a small employer to a large employer, or a small employer to a self-employment situation that you continue to have access to group rates.

Mr. Chairman and Honorable Members, the answers small business have asked for and I have reviewed are exactly what is contained in the NAIC Model Rating Act, and is also what will be contained in the NAIC Model Act to guarantee availability of coverage.

Are we proceeding on those models? Yes, we are. We adopted the rating model in December. Already six States, including Iowa, have adopted the model.

Are we proceeding on the availability Act? Yes, we are. It will be adopted, hopefully, at our meeting in about a week. I perceive that you will have a majority of the States moving very quickly.

I would note that there are a lot of similarities between what is contained within the recent bills I have seen given out in Washington the last 2 days, and our provisions, and I would note that we can work together on these solutions.

I would note that we would hope to be moving faster on the small business issues on the State level than is presently marked up in the versions of the Federal legislation I have seen.

But this does not answer all the questions. There are still two problems that are being told to us every day that are not answered by these models, and I want to be frank about that. First of all, this basic statement, "I cannot afford health insurance even if it is available." Our model does not adequately address this issue. Its effects will incrementally increase for the majority of people the cost of health care, and significantly decrease the cost of health care for a small percentage.

There is room for a State and Federal partnership on health care financing, and I think there are a lot of good ideas floating in Congress and the States right now.

The second issue is is that there are good risks fleeing to ERISA and self-insurance, leaving us with a commercial market that cannot transfer risks and losses across a broad enough cross-section of society. We are doing many things in the State in the multiple employer trusts and the multiple employer welfare arrangements to make up some of these disparities.

I would also note that this bill does not do, nor can it do anything about ERISA programs, and I would note simply that there is a Federal role in bringing ERISA plans within the reform equations that we are both working on.

Thank you.

[The prepared statement of Mr. Lyons appears in the appendix.]

Senator ROCKEFELLER. Thank you very much, Mr. Lyons.

Senator Durenberger.

Senator DURENBERGER. Well, first, Mr. Chairman, let me thank Mr. Lyons for being here and also thank NAIC for the leadership that they have shown in this area. We have worked closely together now for better than a year, and I had the opportunity to speak with NAIC a couple of months ago. I congratulate the Commissioners for their leadership.

One of the differences here, of course, is how much has to be done at a national level, and how much can be done at a State level. And you have already pointed out the fact that the best way to keep prices somewhat affordable is to make some appropriate ERISA changes to ensure that all plan administrators are playing in the same ball game.

And I am assuming when we go beyond the rating and renewal area and we get into some of the availability issues that you raised—the costs of people with pre-existing problems, some of the medically uninsurable—that it becomes even more important that we get EARISA reforms so that everybody is playing in the same ball game. Is that not correct?

Mr. LYONS. That is correct.

Senator DURENBERGER. And one other point. is how do we do all of these kinds of reforms, and not deal with the State-by-State issue of mandated benefits, the issue of discrimination against managed care plans, and other such things that really get in the way of healthy competition?

I am trying to get you to give us some idea of what is the appropriate level at which we do various of these things, all of which will put a better product on the market for a lower price to as many people as possible.

Mr. LYONS. When you look at national versus State regulation, or vice versa, I think the most important issue to key on is whether there is one certain and correct answer for each of the populations you are trying to serve? Until there is, I think there is room for work on the State level within parameters of minimum standards, and that is exactly what you are seeing from these model acts.

But those minimum standards can be tailored to fit the populace, because we are still in the experimental stage of this reform, and we are still in the experimental stage of increasing access for health care to all Americans.

So, you are going to see a lot of activity being done in the States, and particularly being done in the offices of the Insurance Commis-

sioners, because a lot of the tailoring we have to do has got to be very flexible, very fast. I can operate, for example, on 30 days' notice and have a restriction, or prohibition, or a new requirement in place in Iowa. I do not think necessarily the State Governments and Federal Government can move quite that quickly.

So, I am saying there is room for a partnership, but is there necessarily a requirement of Federal preemption at this time? I do not think so. You see many States differ in mandates, as well.

Senator DURENBERGER. Yes. One of the things I am getting at is, do we not have to reach some kind of an agreement on basic benefits? Would it not make the market work better if we had an agreement on a basic benefit plan?

This would be the plan across the country that we agree guarantees financial access for most people that we're going to call insurance. This is the plan against which all the rating, and renewal, and issuance, and all of the other underwriting things are written. And then if you want to legislate no additional mandated benefits against that, you can do it.

That would not preclude any State from adding benefits. But to try to get a definition of a basic benefit, some of my colleagues are punting to the Secretary of HHS. Others are punting to 50 State Legislatures. I am just saying one of the most important things we could do in this country is to give ourselves a definition of insurance and describe it in terms of doctors, and hospitals, and surgery, and diagnostic, and co-pays, and deductibles, and so forth. What is wrong with our trying to find agreement here on that?

Mr. LYONS. The short answer is that uniformity will move the process along quicker.

Senator DURENBERGER. Yes.

Senator ROCKEFELLER. Senator Grassley.

Senator GRASSLEY. How confident can we be that the States are going to act aggressively in implementing reforms? Because that is a basis whether or not we should get involved, and maybe we can get involved, too.

Mr. LYONS. I would say very confident of action for two reasons. One, you have seen the track record of six States already passing it in the first 3 months it was available to them, and at least another six which are negotiating for its passage now. And the remainder of the States are calling very loudly for the NAIC to finish its work in June so they are ready for the next legislative session. So you have seen a good track record.

The second is that the political and practical pressure on State Legislatures is as bad, or in some circumstances maybe worse, than that being placed on Congress. And as you feel your requirement to act, I think you should know that the requirement to act is being felt on the State level. And I think it is being felt very keenly, very acutely, and I believe that this model that I have presented today will form the basis for the majority of action in a majority of States in the next 2 years.

Senator GRASSLEY. Well, then I want to follow that with an important question. If the legislation is passed, would the States vigorously enforce those reforms that they might legislate? Because, you know, you already get the argument even under present insur-

ance laws, the States are not doing enough, and that more regulation ought to come from the Federal Government.

Mr. LYONS. I have seen no indication and no evidence that these will not be vigorously enforced on the State level. All of the States which have put them in place already have kept very strong regulatory control over the implementation dates, the implementation requirements, minimum benefits that have to be provided, and have put themselves on a very short timeframe to have the plans up and running.

In Iowa, our anticipation is that we will actually have the plans and rating restrictions, additionally with a minimum package and with a tax incentive for below 150 percent of poverty level, up and running in policy form by September 1.

Senator GRASSLEY. Following up a little bit on a point that Senator Durenberger brought up, were Congress to conclude that the States were not acting aggressively enough and enact some reforms that we have been talking about here at the Federal level, just what would your attitude be about that?

Mr. LYONS. My attitude is if Congress sets specific deadlines, the States will strive to meet those. It is not unusual for Congress in the last several years, members of both the House and the Senate, to be very strong in stating that, it is a "trust you" to this point.

If you do not have a significant enough percentage of movement by X date in the future, then it is done according to Federal requirement. Is that an option for you, considering your position, to consider now? Yes, it is.

Senator GRASSLEY. Iowa has a risk pool for uninsurables. I would like to have you comment on Mr. Laszewski's comment to the effect that the reinsurance programs and risk pools should not be publicly funded.

Mr. LYONS. First of all, I would have a comment relating to—and I am not sure which of the gentlemen on the panel before me made the comment—about how the risk pools should be industry supported, supported by the industry and industry dollars. I would simply make the point that if they made that statement, their position has always been they support, but they want the authority to cap any pay out. They support, but they want the authority to pass along administrative costs without regulatory oversight. They support, but they want the statutory right to take a dollar-for-dollar premium tax offset from any payments made.

Now, if we allow all three of those support requirements, we will have State support of the guaranty funds in place in all the States, not industry. And right now, we have all of those three items are in place in the Iowa risk pool, and we are looking at an increase over the next 2 years of a $3 million to a $10 million premium tax loss for the State.

Senator GRASSLEY. Does your association have a position on mandated benefits and on proposals, some of which you have heard earlier this morning, to the effect that the Federal Government should override such laws, preempt these laws?

Mr. LYONS. One general comment, and one specific comment. The general comment is the NAIC does not have a position on mandated benefits. We believe the States should be able to act in a cost-effective manner for their citizens, so we do not take a position

either for or against, although we do recognize that mandated benefits will be part of any debate which you have.

The second is a specific issue of caution. There are some mandated benefits which do things which you are specifically seeking to have done. For example, continuity of coverage. If you have to have conversion privileges, if you have to have newborn or adoptive children coverage, et cetera.

Those mandates provide some continuity that you are trying to establish on a general level, as well. I would ask that if you are looking at a preemption on the Federal level, if you feel you must look at a preemption, look at a preemption that is designed to still allow those mandates, or the authority for those States to interpret the need for a mandate which still serves the purpose of the legislation which you passed.

Senator GRASSLEY. I would like to have your judgment on how much you might expect rates for lower-risk groups being increased if the reforms of the small group health insurance market most frequently discussed here this morning were to be implemented.

Mr. LYONS. We can provide some detailed information for the record relating to what we believe the bottom percentages would go up, but we believe the overall percentage for the low rates would not be significant; would be probably in the range of five percent. And then the amount it would come down for the high-risk would be significantly more.

But let me get for you, and for the record our specific review of what we think the numbers will be.

[The information appears in the appendix.]

Senator GRASSLEY. Senator Rockefeller, I am done. Thank you.

Senator ROCKEFELLER. Mr. Lyons, thank you very much. I may have some questions which I will submit to you in writing, per my previous agreement.

Mr. LYONS. Additionally, I listened to the questions you asked the previous panel, and we will be answering those questions and submitting material as well on those.

Senator ROCKEFELLER. Good. Good. Thank you very much.

Mr. LYONS. Thank you.

Senator ROCKEFELLER. I very, very much respect the work of NAIC.

Mr. LYONS. Thank you.

Senator ROCKEFELLER. Very much respect it.

John J. Polk is the executive director of the Council of Smaller Enterprises in Cleveland, OH. And Mr. Polk, we welcome you and look forward to what you have to say.

STATEMENT OF JOHN J. POLK, EXECUTIVE DIRECTOR, COUNCIL OF SMALLER ENTERPRISES, CLEVELAND, OH

Mr. POLK. Thank you, Mr. Chairman. I have prepared some somewhat more expansive remarks, which I hope to submit for the record.

[The prepared statement of Mr. Polk appears in the appendix.]

Mr. POLK. And in the interest of time, let me summarize as quickly as I can, because I am particularly interested in getting to your questions.

The Council of Smaller Enterprises is the largest local organization of its kind in the country. What is unusual about our organization is that we extend to our members the opportunity to participate in what is arguably the largest and most successful proprietary health plan for small employers.

Some 8,000 member companies provide coverage to some 60,000 local employees through our plans, and those employees, together with their dependents, mean that about 145,000 Greater Clevelanders are covered through programs that we sponsor and manage on behalf of our members. Those member companies will invest about $165 million in group health care coverage in this contract year.

There are a number of things which are unusual about our programs. In general, I would say that most of our practices flout the conventional wisdom of the insurance industry, and not a single one of our practices has ever resulted in any significant problems occurring in our plan.

While our group itself is very large, the average size of a company participating in our plan is a company with eight employees. Two-thirds of our member companies employ fewer than five people, which means that our programs are having a significant impact in our community where the demographic problem truly is.

About 20 percent of the companies that enroll in our sponsored health care plans tell us that prior to their having joined the organization they did not have group health care coverage.

So, while our program is not specifically designed to meet the needs of the uninsured, as a result of our effective management, we have been able to make insurance coverage available and affordable to companies that, in previous periods, were not able to obtain it.

Companies which did have insurance coverage prior to their having joined our plans report to us routinely savings that range between 35 and 50 percent on their annual premium at the time they enroll in our programs. Since 1984, the costs entailed in the operation of our plans have increased our members' prices by an average of a little bit under 7 percent per year. That is roughly a third of the conventional practice in the insurance industry.

Senator ROCKEFELLER. A 7-percent annual increase?

Mr. POLK. On the average.

Senator ROCKEFELLER. That is interesting.

Mr. POLK. And COSE's business is profitable for its insurer even at that rate. I would point out that since 1984 the trend factor increases charged by commercial insurers in the small group market in Cleveland have driven up the price of insurance for small companies about 176 percent. In the same period of time the costs entailed in the COSE programs have raised our members' prices a total of about 45 percent.

There are a number of factors that are, I think, critical to our success—our size and the local concentration of our purchasing power—have given us significant negotiating power with our insurers and with the provider community locally.

It also confers a higher level of actuarial credibility on our program, which means that the chances that our insurer is going to "have a bad year," or sort of mis-price our plans and require significant rate increases in a future period are very, very minimal. Our

philosophy of aggressive management enforces accountability, both on our insurers, and on the behavior of our member companies to make certain that our members play by the rules.

Our information system enables us to keep more informed about utilization and the financing of our programs from day to day than our insurance carriers are. I would like to say that that is a huge challenge, but it is not particularly challenging to be smarter than most insurers about how they operate their small group plans.

Most importantly, COSE enjoys a productive and very creative partnership with a significant local health insurer, Blue Cross and Blue Shield of Ohio. One of the things I found interesting about the previous panel of insurers is that everybody seems to know what steps they are supposed to take in order to reform the small group market, everybody agrees what they are, but none of them have actually tried to do anything yet.

There are many, many problems in the small group health care market which can be addressed through a consolidated purchaser-driven approach to health care cost containment for small employers. We have got to deal with State mandated benefits, too. They cost our members tens of millions of dollars. The administrative costs in our program are running about 11 percent of premium now, in comparison with an average of 25-30 percent for commercial carriers in the small group market. We have to deal with issues of cost shifting, as well. Nonetheless, our plan has grown and is successful in the current regulatory environment. And I think that our plans demonstrate that the private sector can deal with the dual challenges of access and affordability for health care coverage for small employers if we wish to be creative.

A couple of other lessons, I think, to be learned from our programs. First: The first lesson is about the thousands of little decisions and the thousands of problems that need to be addressed every day over years to implement and manage an efficient and cost-effective health care program at the grass roots.

Irrespective of how policy is made in Washington, the real test of the effectiveness of health care reform will be how the plan works for individuals and small employers in local communities where services are delivered and financed. Our job as an organization is to take the marketplace as it exists and to make it work for small employers and for their workers.

Finally, our model should have some value to you all, not just as an example of a creative private sector approach to managing health care access and affordability for small employers, but also as a means to bridge the gap between broad policy, however it is enacted, and its actual impact on real people. Ours is a model that works. And as the debate in Congress rages on over the next 5 years—in the past 5 years, as the debate has sort of heated up in the Congress, our group has doubled in its size. We expect that in the next 5 years, as the debate continues, our group will double once again in its size.

While we are all talking in Washington and in our State capitals about how to fix the system, there is a program operating in our local community which is doing something about access to affordable coverage for small employers.

Senator ROCKEFELLER. Mr. Polk, that was one of the best pieces of testimony I have heard in several years, and you are a breath of fresh air.

Mr. POLK. Thank you very much.

Senator ROCKEFELLER. Can you explain to me why it is important for small business to have health insurance? Why is it important? Let us say you are running a restaurant, or you are a florist, or you are running a small roofing company. And health insurance is expensive. Yes, you have banded together with others, but there is always the choice of not providing health insurance. What is it about having health insurance which benefits small business?

Mr. POLK. I will speak to our experience in Cleveland, Ohio, which is an old-time, old-line, metal-bending, manufacturing town with a high incidence of negotiated agreements between labor and management, and generous benefit plans which basically set the standard in our community. If you are a small business owner operating in Cleveland, Ohio, and you expect to be able to attract decent employees into your company and keep them, the least you have got to be able to offer in order to be competitive in our local labor market is health insurance coverage. So that is sort of a business management reason. On the other hand——

Senator ROCKEFELLER. Well, let me challenge that for a second. You say that the least you have got to be able to offer in order to attract those employees, you probably have a lot of people in Cleveland, as in other places, as in my home State, who would just be glad to get a job, even if it did not offer health insurance—although they would prefer to have health insurance—but they would be glad to have a job.

Mr. POLK. There is no question about that. And I think that the health insurance component of labor costs is a very important consideration as we consider the enactment of broad reforms.

I work for the Chamber of Commerce in Greater Cleveland, and I am aware that labor costs, particularly the cost of Worker's Compensation, Unemployment Compensation, and health care coverage, are among the factors which make our area of the country less competitive for business investment than our neighboring cities and States, and that is a very important consideration. On the other hand, most of the very smallest companies that do not have access to health insurance coverage are companies which involve the owner and his or her family as employees.

So, this is not just a business management problem. This is literally as much a life or death situation for small business owners as it is for the so-called uninsured workers that we hear about in the congressional debate.

Many, many, many of those uninsured workers are my members; people who own and operate little companies and whose earnings and livelihoods are at risk, whose businesses are at risk in the event that they are unable to obtain adequate health insurance coverage.

Senator ROCKEFELLER. But still—and I can totally agree with that—explain to me, nevertheless, simply for the record, why, in your judgment, an employee who has health insurance is, from management's point of view, a better employee, and why it is in

management's interest within the small business community to offer health insurance.

Mr. POLK. I think that you are asking me sort of a philosophical question, the fundamental premise of which I am not sure I agree with totally. I would like to keep it on a human-to-human kind of a term. In a small employer workplace, the owner of the business knows each and every one of his workers, or her workers by name; knows their families; understands, in many cases, their specialized problems.

It is a very difficult situation for a small employer to find himself, because of the way the insurance market works, in a position when shopping for health insurance coverage of being able to provide coverage for seven-eighths of his eight employee work force who happen to be free of medical problems, but unable to extend that same benefit to that one person in the company, who, by dint of a pre-existing health condition, really needs the help.

That is a terribly unfortunate consequence of a lot of the pre-existing conditions exclusions that have been enacted by insurers in the small group market. We forbid our insurers to practice that kind of activity within our plans. It has never hurt the financial integrity of our plans at all.

Senator ROCKEFELLER. I still want you to answer my question. [Laughter.]

Mr. POLK. Perhaps if you sort of help me get a sense of the answer you were looking for, I could help you. [Laughter.]

Senator ROCKEFELLER. We will get there. Of all the small businesses in this country that employ 10 or fewer people, in fact, 46 percent of them do offer health insurance coverage to their employees.

Now, you have got to assume that these people are paying a lot, because they are probably being insured by companies that have 30-40 percent overhead, companies that have that overhead by sending out people to do background medical checks and medical underwriting to look for pre-existing conditions as a reason for not providing the health insurance. So that when it finally comes to most, or half, or all of the employees, it is more expensive.

So, you could argue that for a small business which is struggling to make it—the little restaurant which is owned by a family but there are two or three employees helping that family—and I have listened to them—they say, well, look, the $150 or the $250 that it is going to cost me for each employee is just more than I can handle. I want to be able to do it, but it is more than I can handle. So, again, what difference does health insurance make within the strain of that context to the employer in making the decision to buy health insurance, they must do it for a reason. And I am just trying——

Mr. POLK. One of those reasons is purely self-serving. And that is that given the way small group health care coverage is marketed in this country, the business owner is incapable of providing group health care coverage for himself and his family without also extending that benefit to his employees.

Senator ROCKEFELLER. What I am trying to get you to answer is simply that an employee that has health insurance has the security and the knowledge that the health insurance is there if he or

she is going to need it, and that, indeed, if his or her child comes up with some difficult disease, that the health insurance is going to be there.

Is that employee better able to focus on his or her work, is that a more productive employee, is that a more satisfied employee, is there a difference between the insured employee and the uninsured employee within the small business context?

Mr. POLK. The answer to that question is purely yes. I will use an anecdotal situation involving my own experience. The one thing my mom and dad told me when I graduated from college it does not matter what job you take, make sure that your employer offers you health insurance. Does not even matter what your wages are. Because should you ever become ill, or should you ever become injured, you will welcome—you will need that benefit.

Offer a potential employee two employment situations, one of which with an employer that offers decent wages and no health insurance, and one from an employer whose wages are a little bit lower but offers health insurance coverage, a wise consumer—an employee operating as a wise consumer—will undoubtedly gravitate toward the employer that offers health insurance.

Many of the difficulties that we have seen in Cleveland involving programs to assist Medicaid subscribers, unemployed, uninsured people, getting them into the employment market is the requirement with many of the local programs that we work with that the employers to which these Medicaid subscribers go offer fully paid health insurance coverage to those employees. Very important in order to reduce the public welfare burden.

I have never—and I have been doing my job for about a dozen years—I have never talked with an employer who had consciously made the decision to exploit his workers by not offering them access to group health insurance coverage, that's of course, in Cleveland, OH, and I believe that there are significant regional variations in this. Cleveland is going to be different from a lot of communities in the south and in the west—employers who were not prepared to pay some price, however unreasonable, if paying that price could result in getting access to insurance coverage for themselves, their families, and their workers and their families. I have simply never experienced that.

Senator ROCKEFELLER. Now, taking that entirely progressive philosophy and approach—practical, progressive, laudable—tell me why it is that small business trade associations, when they come to the word "mandate" pale? And by that, I mean—well, you know what I mean by pale. If mandates were required immediately, then I could understand that.

Forty-six percent of small businesses having 10 or fewer employees do provide health insurance, obviously that means that 54 percent do not. So there is work to do.

Now, if a plan comes along like the Pepper Commission plan, or the plan that was offered yesterday by the Democrats in which, for example, we bend over backwards to make, through cost containment, and over a period of time and tax credits, health insurance affordable as well as available for small business.

In one plan, 40 percent of the health insurance premium will be paid for by the Federal Government for a period of 5 years. That is

a pretty good deal. While in the meantime, cost containment measures of all kinds are being undertaken, therefore, to drive the general pressure on the cost of health insurance down. And in the Democratic plan 40 percent becomes 25 percent of the cost of the health insurance premium for small business. On the other hand, it is permanent. In other words, government is reaching out. Self-incorporated, unincorporated self-employed businesses would get 100 percent deductibility; now it is only 25 percent.

And even, in fact, at the end of 5 years if 75 percent of those businesses which previously had not been offering health insurance do now offer health insurance, there is no requirement. There is no mandate to offer health insurance. So it is a mandate, but it is conditional. It is struggling to reach out to small business.

And I have talked with many of the representatives of small business in Washington, DC, and elsewhere, and they understand, and they agree, and they like all of that. But when we come to the word mandate, everything comes to a dead halt, because it implies government intervention. It is a word which they find difficult to sell to small businesses out across America.

Help me understand what it is that we can do. If we are talking about universal coverage, we have got to be serious about it, and you have got to assume that there will be some people who will choose not to offer it if they do not have to offer it. Help me understand that difficulty.

Mr. POLK. Let me try to answer that question in three ways. All right. First, as a member of the staff of a local employer's association, I am sort of required by my members to say we will fight you on the beaches, we will fight you in the skies, we will never surrender. All right. So, we will set that part aside with respect to mandates.

However, I think that there is a certain understandable ignorance on the part of the small business community about the effectiveness with which the Federal Government can manage broad programs, or micro-manage complex programs based on a certain lack of empirical evidence that the public sector can operate more effectively and efficiently than the private sector can in most instances.

I am certain we can find some places where the Federal Government operates programs that are models of efficiency. By and large, those models are lost on the average small business owner.

Third, I would like to keep a very sharp focus, as we do in our organization, on the difference between passing laws and solving problems. I think that entrepreneurs have reason to be suspicious, given Congress's track record, particularly over the last several years in the enactment of health care reform legislation. Let us take a look at COBRA, section 89. The Catastrophic Coverage legislation enacted and then repealed under Medicare.

They have a certain understandable reluctance to abandon their own ability to shop in the marketplace to the collective wisdom of the Congress, or of some new, and as yet unformed Federal bureaucracy. I think that is an understandable reluctance. I frankly share it.

I do not believe that in Cleveland, OH that Federal Government would have anywhere near the prayer, based on their own experi-

ence in Medicare and Medicaid as it is operated in our county, of operating our members' group health care programs more effectively and efficiently than we can in the voluntary marketplace, despite all the barriers that exist.

And that is one of the reasons why I would hope that our organization can serve, not just as another business organization, sort of naysaying progressive reform. Because let us face it, the Federal Government buys about 40 percent of the health insurance coverage in this country today. It does not always buy it particularly smartly. There is going to be a broadened Federal role in health care reform in this country. While we are figuring out what that role is going to be, would it not be helpful to take a look at a few models that currently exist and currently operate in this country in the private sector, in the voluntary marketplace to see what we can learn from them?

Senator ROCKEFELLER. And, in fact, your Council of Smaller Enterprises, 10,000 small business members is precisely the aggregation of individual employers who, in and by themselves, would not have the market power to be able, as you indicated, to negotiate in health insurance. But by becoming 10,000 members joined together, you have enormous market power. It is precisely that ability which the bill which was introduced yesterday, for example, contemplates.

Mr. POLK. One of the differences, I think, is that our power with our insurance carrier is largely based on our ability if they do not do a good job to go someplace else.

Senator ROCKEFELLER. Right. And that is because you negotiate with them, and if you do not like what it is they negotiate, you can turn to somebody else and start negotiating.

Mr. POLK. And that is why one of my very broad questions—and this is probably for a different type of forum—is let us pretend that the Congress, in its collective, infinite wisdom, enacted the legislation that was introduced yesterday, and let us assume for a moment that the President signed it. Then what? How do we build a real program that maintains the best elements of private sector entrepreneurship under the umbrella of some type of progressive Federal reform?

I would add one other thought in very broad response to this question, and that is this. I am not certain that our market, as it exists, has been currently sufficiently fine tuned, that we must make the next step—the next leap in logic to assume that mandates are the answer.

There may be a time when the private market has evolved to a point where it is truly more user-friendly and more cost-effective and efficient at getting care to people so that everyone who wishes to purchase health insurance coverage in the private market has the means to do so in a cost-effective way.

There might be a time in the future where the Federal Government must enact a mandate in order to deal with the rock-heads who simply refuse, even though the means are available to them. I am not certain that we have reached that level of development in the small group market and until we do, I think that the danger of holding a mandate over insurers' heads, for example, is that over the 4-year period during which this broad Federal program would

be implemented, you would see a huge amount of imperceptible practice changes on the part of the insurance industry, which would result in taking a whole bunch of people who are questionable risks and dumping them off those plans, which would significantly add to the burden of a publicly financed group health care program.

Senator ROCKEFELLER. And you, yourself, just a few moments ago, said that you were fascinated by the fact that all of the four insurance company representatives were saying, "Go ahead, do it," to us, but they were not going ahead and doing it themselves.

Mr. POLK. I think that one of our organization's experiences is that we are perfectly capable of running our program right now in the marketplace as it exists. Nobody needs to pass a law to help us. I think that if the insurance industry really does, in its collective, consensual wisdom, recognize the need to take some steps to reform the group health care market, why isn't anybody talking to us?

You would think with $165 million health insurance plan, CIGNA, or Travelers, or Aetna, or somebody would be sort of knocking on our door and saying we think maybe we can do a better job for you than your current insurer. Not a single one. We talked to dozens of Chambers of Commerce and employer associations around the country every month who are looking for information on our group health care programs, because they would like to establish them in their communities. There is not a single insurer that has expressed a willingness to do business with any of those organizations.

Senator ROCKEFELLER. What does that say to you?

Mr. POLK. What that says to me is that there are no aggressive advocates for the purchaser at the community level around this country to force insurers to the table.

If there is a particular value to the legislation that was introduced yesterday and in prior Congress by Senator Kennedy and his colleagues, it is to hold a heavy club over the insurance industry in the hope that over time out of desperation and a sense of the need for self-preservation, they will begin to sort of develop a more flexible attitude toward their small group market practices. We have not see it yet, and it is very possible that that will occur only in the face of impending Federal action.

But the marketplace for small employers, clearly, is not working as well as it could. And I am not certain that passing a law will, in and of itself, take any major steps forward in changing the market.

Most of the private sector reforms that have been introduced by HIAA, by Blue Cross and Blue Shield, the Insurance Commissioners, do nothing to address the issue of what the base rates will be, what the effect will be on the actual prices that small employers pay. Mostly, they focus on better management of the differentials within a pool between high-risk groups and lower risk groups and younger people, et cetera. There is nothing in any of those proposals that would preclude the possibility that health insurance premium rates would continue to escalate at 35-50 percent a year as is typically the behavior in the small group market now.

Senator ROCKEFELLER. This will be my final question. Within your organization, do you, in fact, take any small business which

comes to you and wants to belong, or do you engage in any selection process based upon medical underwriting?

Mr. POLK. Our only screen is a health screen, and we have negotiated underwriting rules——

Senator ROCKEFELLER. What do you mean by a health screen?

Mr. POLK. We have negotiated health screening rules with our insurers such that, for example, in a company that has an individual employee with an active metastatic disease probably is not going to get access to our health care programs.

Senator ROCKEFELLER. Well, now, that is interesting then. So, in what respect do you differ?

Mr. POLK. Well, I think there are a number of very important differences. First, we have a tendency when we talk about the difficulties of medical underwriting to focus on those individual sort of catastrophic anecdotes—individuals with cancer who cannot get health insurance coverage.

The primary barriers in the commercial marketplace are not related to catastrophic situations, because we understand that those exist. It has to do with things like emphysema, and diabetes, and asthma, and high blood pressure, and other conditions which are controllable, which are treatable, which do render an individual insured a little bit more expensive, and possibly a little bit more risky than others.

We have attempted to focus our negotiations with our insurance carriers on increasing the flexibility which we can extend to those individuals that have chronic, manageable, pre-existing health conditions. We do have programs available to our members through a couple of HMOs in our community which do not underwrite medically.

So, an individual with an active metastatic disease can obtain some coverage through our group health care programs, not through our fully insured plans, but through a couple of HMO's. There is some difficulty in persuading an individual, even one who desperately needs health care services to—as Mr. O'Brien pointed out before—abandon a relationship which might have existed over years with a specific physician in order to make a move into a closed-panel delivery system. But because our organization exists, because we do have the ability to negotiate that kind of flexibility with our insurers, we can provide small employers with more options and with some flexibility and guarantee them access to some level of coverage, not always the type of coverage which they most fervently desire.

Senator ROCKEFELLER. Blue Cross/Blue Shield says that you deny 20 percent of the small businesses that make application to join your plan, is that correct?

Mr. POLK. Blue Cross and Blue Shield denies routinely somewhere between 10 and 20 percent per month of the groups that apply. I think there are a number of reasons for that. One of them is——

Senator ROCKEFELLER. First of all, I want you to differentiate between you and them.

Mr. POLK. Right.

Senator ROCKEFELLER. In other words, you set the rules because you do the negotiating.

Mr. POLK. Right.

Senator ROCKEFELLER. But you say they did the denying.

Mr. POLK. Right. We purchase health insurance coverage on behalf of our members. We are not, ourselves, an insurer. All right. There are a number of reasons for that relatively high level of turn-downs, which is a significant degree higher than it was a couple of years ago. First is, that as our group has expanded, the number of groups with severe pre-existing health conditions trying to get into our plan is increasing relative to the uninsured population in our community.

So, we are seeing more applications from individuals with pre-existing health conditions. I am not happy with our health screening rules, and I think that occasionally our insurer has a tendency to play fast and loose with them. But those underwriting turn-downs also include individual companies who select themselves out of our programs because of their inability to meet with our eligibility rules.

An example being Joe Small Business Owner, whose mother-in-law in Florida needs Medigap coverage, which the employer wishes to take a tax deduction for. If his mother-in-law in Florida is not an employee, he or she is not eligible for coverage under our plans.

A good example, you mentioned the restaurant in the inner city. We have a number of members who are restaurants who have imposed some fairly significant—from our standpoint, unfair—waiting periods on new hires. And because of our requirement that all full-time employees who have been in the business for more than 90 days be required to participate in our group health care programs, there are companies, that when they learn about those rules, choose not to participate in our health care program. So that 20 percent turn-down rate has to do with health to a certain extent, but also has to do with companies' inability to live up to the rules that we have established for the operation of our programs.

Senator ROCKEFELLER. And you are stating that positively, and I am not trying to quibble, but, in effect, all of the exclusion is not done by Blue Cross/Blue Shield. Because you do the negotiating with them, and you do set the rules which guide you in your negotiating with them, so you accept part responsibility. I am not trying to blame you, because——

Mr. POLK. No. There is no question about that.

Senator ROCKEFELLER. Yes.

Mr. POLK. And let me focus on that for a minute, because between 1978 and 1982, our program was the only program in Greater Cleveland for small employers which guaranteed issue of coverage and practiced a strict community rating formula.

And over that 5-year period, the prices that our members paid for health insurance increased about 130 percent in total over 5 years because, since we were the only program in the community operating in that fashion, our programs were the best deals in town for individuals who were old and sick.

Senator ROCKEFELLER. I do understand that. My net reaction is that what you are doing is terrific in the sense that you are making health insurance available at a much lower cost to an enormous number of employees that could not possibly otherwise have it, and I applaud that.

I just note that within, as you would say, the real world, for whatever reason, that there are some who by rules that are set by you in terms of negotiating with Blue Cross/Blue Shield, et cetera, do not meet the criteria. And I am not saying that to criticize you. I am simply stating that for the record.

Mr. POLK. Very true.

Senator ROCKEFELLER. My overall comment would be that what you are doing is superb, and that is the whole point. Small business has to aggregate.

Mr. POLK. That is right.

Senator ROCKEFELLER. They have to have market power, and that is what you have successfully done.

Mr. POLK. I would point out a couple of other thoughts related to that. First, there is no way on earth that any health care reform strategy will be able to avoid wrestling with these same types of tough decisions that we need to make on behalf of our member companies every day. It pains us when a company that has a work force of five or six people, for some reason, is not able to participate in our program. Because I would like the world to operate differently from that.

But we have been forced to make some changes in our programs which are not terribly popular in response to the way the marketplace works. I think that our standards are much more reasonable than you would find in the insurance industry generally, but we still have to do some things to protect the integrity of our plans for the broad welfare of our general membership. That is really unfortunate, but it is what we have been forced into by conditions in the marketplace.

Second, we are by no means perfect. We just, I think, from our standpoint, represent sort of the best we have to offer right now.

Senator ROCKEFELLER. Mr. Polk, I think you have been an extremely honest, extremely forthcoming, and very, very helpful witness.

Mr. POLK. Thank you, sir.

Senator ROCKEFELLER. I thank you very much. This hearing is adjourned.

[Whereupon, the hearing was concluded at 12:35 p.m.].

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Mr. Chairman, let me begin by thanking you for holding the third in a series of hearings on the important issue of health care. As you know, the focus of today's hearings, "Access and Affordability" is a continuing problem in our health care system. I have spent a great deal of my time and energy along with many of our colleagues, especially those who served with me on the Pepper Commission, trying to find solutions to the access issue. I regret that my dear friend John Heinz is not with us, as I know this was an issue very close to John's heart as well.

Mr. Chairman, I am looking forward to the comments by the experts you have assembled today. The availability of insurance is the key to access in our health care system. I want to understand what kind of realistic solutions the insurance experts are proposing. The challenge is to reconcile the economic imperatives of the marketplace with the social needs of the public.

Mr. Chairman, it has been suggested to me that reforming the insurance market boils down to two simple tests for the industry:

(1) *The market test*—can insurance carriers give us what we want at a price that serves their economic goals: market share and profit margin.

(2) *The social test*—can insurance carriers give us what we want—namely access to financial protection, affordable premiums and coverage for the health care services we most need?

Mr. Chairman, I'm afraid that our current course in the private health insurance market will fail both of these tests!

Mr. Chairman, the insurance industry is in a period of serious challenge. The industry is facing a severe test of public confidence in its ability to provide the financial security and peace of mind all Americans have come to expect. Unless we act now to create equal access to affordable health insurance, the future of the private insurance industry will be in grave jeopardy.

As all of us assembled this morning know, there are over 30 million uninsured Americans that lack rational "access" to the health care system we have established in this country. Significantly, most of these uninsured are not jobless! It has been estimated that 70 percent of the uninsured, about 20 million people, are either employed workers or their dependents. Further, three out of every four working uninsured persons are employed in small businesses, with the greatest gap in health insurance coverage occurring in companies with fewer than 25 employees.

Is there a gap because small employers don't want to offer health insurance to their employees? No! The fact is that many small firms want desperately to provide these benefits, but when they go to the private insurance market to get them, they run into serious obstacles.

Insurance companies can and do refuse to accept groups, or simply cancel contracts unilaterally. They can and do selectively deny or restrict coverage for specific employees or an employee's dependent children for pre-existing medical conditions. They can and do charge prohibitive "high risk" premiums. Insurers often "low ball" the premiums offered to an employer in the first year, and once they've hooked the account, raise premiums abruptly in later periods by 20, 30, 40 percent or more.

These practices foster enormous instability and turnover, especially among small employers who do try to buy health benefits, and discourages many employers from even trying.

Mr. Chairman, what can we do to help small employers? I believe we need to tackle these problems by setting uniform standards nationwide that require the following:

(1) Guaranteed issue of policies.

(2) Limits on insurers' ability to impose coverage restrictions due to pre-existing conditions.

(3) Guaranteed renewability of policies.

(4) Restrictions on experience rating and limits on annual increases in premiums.

(5) In addition, I would propose a core benefit package, exempt from State benefit mandates, designed expressly with the needs of small businesses in mind.

To this end, I have introduced S. 700, the American Health Security Act of 1991.

I am pleased that the "HEALTHAMERICA" bill introduced yesterday contains many of the pieces I have just described to help small employers.

Mr. Chairman we all look forward to seeing what you put forward on the issue.

Again Mr. Chairman, I thank you for conducting these hearings and I anticipate some enlightening discussion.

PREPARED STATEMENT OF KEN L. EVASON

Mr. Chairman and members of the Committee, I am grateful for the opportunity to appear before you today and to address what most observers agree is this country's most important domestic issue—how best to provide health care coverage to all.

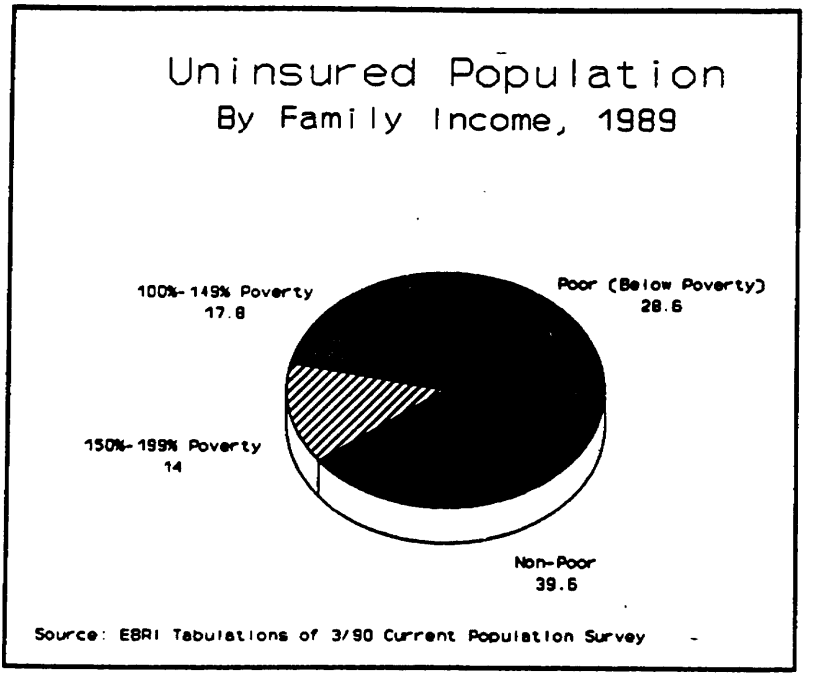
Admittedly, my perspective is based in part upon my experience as a board member of the Health Insurance Association of America (HIAA) and as the chairman of Association Life Insurance Company. But my opinions are also shaped by my personal experience with the Canadian health care system—a system that is certainly getting considerable discussion these days.

As a native Canadian now living in the U.S., I am convinced that Canadian-style government-as-single-payer national health insurance would not work in this country. Rather than import the Canadian system, with its many shortcomings, I firmly believe that it is best to work upon the existing strengths of the U.S. system, and to extend that system to the 13 percent of the population currently in need of health care coverage.

This is, by no means, meant to imply that the U.S. system is not without its faults. It is, however, meant to convey that the private commercial health insurance industry in the U.S. has recognized the problems that exist, and has developed solutions that will make the system better.

First, I would like to offer this perspective as one who serves as a Board member to a trade association of more than 300 member companies in the business of providing health insurance. In 1989, the latest year for which we have data, all private insurers covered 76 percent of the population or 189.0 million out of 249.9 million Americans. Persons covered either by private or public health insurance totalled 216.6 million—87 percent of the U.S. population.

But, clearly there is a gap between those covered and the total population. In other words, HIAA member companies (and Blue Cross/Blue Shield) don't cover every American nor can they. It might help to understand this particular dynamic by quickly looking at a profile of the uninsured.



While these numbers are no more original than the oft repeated claims about the crisis referenced at the start of this statement, they frequently don't get the attention they merit and require if all of us participating in the debate truly want to come up with some workable solutions.

As the above chart shows, in 1989, approximately 28.6 percent of the uninsured were below the federal poverty level; 17.8 percent had incomes between 100 percent and 149 percent of poverty; 14 percent were between 150 and 199 percent; and 39.6 percent had incomes 200 percent or more above poverty. **Of those with family incomes below the Federal poverty level, Medicaid reaches only 42 percent of them.**

The Health Insurance Association of America developed its proposal on access only after a very exhaustive analysis of the data just provided and collateral data on cost and industry practices. HIAA believes that only through a combination of efforts between the public (federal and state) and private sectors can we hope to stabilize the present and improve access into the future.

We've broken down our multi-point program into three parts: actions we can take, actions you as federal legislators can take and actions appropriate for state action. The three taken together will achieve the objective of access for all Americans.

INDUSTRY STEPS

For more than three years, HIAA wrestled with perhaps one of the most complex parts of the access equation—the small employer market. Developing a proposal that would meet the needs of that market while at the same time making it possible for traditional providers of coverage to continue to participate in that market was difficult—but not impossible. The Association adopted a set of precepts, a full summary of which is attached to this statement. In brief, they are:

- Guaranteed access to coverage
- coverage of whole groups
- renewability of coverage
- continuity of coverage
- premium pricing limits
- market viability

Using these precepts as a base, we've developed model legislation that we believe state legislatures can and should adopt to implement small market reforms.

STATE STEPS

In addition to adoption of our model bill, we also call on the states to establish a reinsurance entity to permit carriers to spread losses for high-risk people equitably across the market. Under the HIAA proposal, no employer would have to pay more than 150 percent of the relevant market averages for basic coverage.

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

State risk pools are designed to guarantee the availability of individual private health insurance to all Americans under age 65 who want to purchase protection but who are not considered to be insurable for health reasons. At this time 33 states have enacted, or are considering, legislation establishing state risk pools.

Those states that have established risk pools include:

California
Colorado
Connecticut
Florida
Georgia
Illinois
Indiana
Iowa
Louisiana
Maine
Minnesota
Mississippi
Missouri
Montana
Nebraska
New Mexico
North Dakota
Oregon
Rhode Island
South Carolina
Tennessee
Texas
Utah
Washington
Wisconsin
Wyoming

There are other steps we also believe states should take to improve access such as repealing state statutes that stand as obstacles to managed care arrangements.

The HIAA is aggressively pursuing legislation affecting small groups at the state level. Virtually all of the 49 states in session for 1991 are currently studying the problem of the uninsured or have introduced legislation targeted at the problem. The HIAA has testified in 41 states regarding possible solutions to the growing number of uninsureds and has reported over 500 bills to its membership.

The National Association of Insurance Commissioners (NAIC) is also actively involved with legislation at the state level. Model legislation on small group rating and renewability has been adopted by the NAIC and has been enacted by, or passed at least one legislative body, in Arkansas, Indiana, Florida, North Dakota, New Mexico and South Dakota. The NAIC will also consider model legislation at its June 1991 meeting aimed at assuring the availability of private insurance to all small employers and assuring the stability of the small employer health insurance market.

Legislation at the state level generally falls into one of the following categories:

1. comprehensive small employer market reforms and reinsurance structures;
2. rating and renewability requirements;
3. state sponsored health coverage; and
4. employer mandates.

After three states, Oregon (1989), Kentucky (1990) and Connecticut (1990) enacted comprehensive measures, several states followed by introducing legislation affecting the small group market. For example, Alaska, California, Maine, Minnesota, Nebraska, New Jersey, New York, Ohio, Texas, Vermont and Wisconsin have introduced comprehensive small group reform packages. These bills encompass a broad spectrum of proposals which would impact rating, underwriting, benefits and reinsurance. The Ohio Department of Insurance has established a commission to study small employer market reforms. This commission, "Access Ohio," recently issued its report calling for a number of legislative initiatives.

Other states which have introduced legislation focusing on the uninsured include Arizona, Alaska, Colorado, Iowa, Louisiana, Massachusetts, Michigan, Mississippi, North Carolina, South Carolina, South Dakota, Vermont and West Virginia.

To encourage small employers to offer health insurance, Arkansas, Florida, Georgia, Illinois, Kentucky, Maryland, Minnesota, Missouri, Rhode Island, Virginia and

Washington have passed legislation which exempts policies issued to small employers from certain state mandates. This type of legislation has also been introduced in Arizona, Kansas, Montana, Nevada, New Hampshire, Ohio, Tennessee and Texas.

State regulators also have been actively confronting the issue of the uninsured. For example, the New York and Pennsylvania Insurance Departments have both issued regulations restricting the underwriting practices for small groups (e.g. denying coverage to certain occupations and unhealthy individuals within the group).

HIAA anticipates that many more states will enact legislation affecting small employer groups during the remaining portion of their 1991 legislative sessions.

FEDERAL STEPS

We call on the federal government to take the following steps:

- ensure that the states have the authority to extend the market reforms to all plan administrators and insurers in the small employer market
- extend to all insured plans the same exemption from state mandated benefits enjoyed by large self-insured employers.
- help small business by extending to the self-employed the 100 percent tax deduction for health insurance.
- target new tax subsidies to financially vulnerable groups.
- restore the promise of Medicaid for the poor and near poor by expanding Medicaid to cover all those below the federal poverty level.
- extend the Medicaid "spend-down" program to all states and set eligibility thresholds so that no one is impoverished by medical expenses.
- allow low-income individuals above the poverty level to "buy into" an income-related package of primary and preventive care services.

COST CONTAINMENT

No one single step can achieve on its own the results we all seek. Just as we must take those steps necessary to improve and reform access to care, so too must we come to grips with perhaps one of the most significant components to the problem—cost.

During the past five to ten years, the health care delivery and financing system in this country has evolved at an impressive pace. The most visible change has been the explosion of what are becoming known as managed care delivery systems, of which HMOs and PPOs are the best known.

Managed care embraces a variety of existing and developing structures. It may be defined as those systems that integrate the financing and delivery of appropriate health care services to covered individuals by means of the following basic elements:

- arrangements with selected providers to furnish a comprehensive set of health care services to members;
- explicit criteria for the selection of health care providers;
- formal programs for ongoing quality assurance and utilization review; and
- significant financial incentives for members to use providers and procedures associated with the plan.

In 1989, one out of three employees had health coverage provided through an HMO or PPO. Enrollment in HMOs has more than doubled between 1983 and 1989. There were approximately 33 million Americans in HMOs in 1989 or approximately 13.2 percent of the population. When we calculate in point-of-service plans (generally PPOs), and managed fee for service, the number of Americans covered by some form of managed care would approach 75 million.

Continued growth and use of managed care arrangements represent our best hope of reigning in health care costs. Moreover, managed care, as contrasted with an all payer system of rate setting, is more, not less, likely to achieve cost control results without the kind of economic disruptions associated with rate setting.

CONCLUSION

A constructive national debate, predicated on a rational discussion of the dynamics of our health care system, can be founded only on an approach which recognizes that each of the three players—the federal government, the states and the private sector—has a responsibility to meet. The health insurance industry has developed its action plan with this concept as its cornerstone. We are prepared to work with each of the other players to achieve a responsible and more affordable health care system for all.

Attachment.

(April 5, 1991)

HEALTH INSURANCE ASSOCIATION OF AMERICA
PROPOSAL ON PROVIDING HEALTH CARE FINANCING
FOR ALL AMERICANS
(In Detail)

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

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

The HIAA proposal takes into account the important policy implications of the relationship between income, the workplace and health care coverage. The vast majority of Americans with adequate incomes have health coverage. Ninety percent of all nonelderly Americans with incomes of over three times the poverty level have some form of coverage. Approximately 150 million nonelderly in this country obtain health coverage through an employment-based plan.

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

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

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

Finally, HIAA also believes that efforts to expand the nation's health care financing system must be complemented by responsible cost-containment measures. HIAA's policy on cost containment includes an emphasis on the development of managed health care systems. It also calls for greater scrutiny of one of the major causes of high costs ---the use of new, often unproven technologies and procedures. We also strongly supports wellness and prevention activities, as well as economic incentives for the consumer to be "cost conscious" in the use of medical resources and in choosing a health plan. A more detailed discussion of HIAA recommendations follows.

I. ADOPT REFORMS TO ASSURE THE AVAILABILITY AND RELIABILITY OF PRIVATE HEALTH INSURANCE COVERAGE.

The small employer health benefit market is receiving increasing attention. This is largely because a high proportion of workers without health care coverage --- fully two-thirds --- work for an establishment with 25 or fewer employees at that business unit's location. This is not surprising since only one in three firms with fewer than 10 employees offers health benefits.

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

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

In general, then, small employers have greater difficulty than large employers in affording and sometimes even obtaining health coverage. Furthermore, the greater frequency with which small employers change carriers and their workers change jobs exposes individuals in this market to greater risk of being left out of the system. Finally, small employers are highly sensitive to very large, unanticipated premium increases and may fail to initiate or retain coverage in a marketplace where individual employer experience is highly unpredictable.

We have now reached the point where substantial small group market reforms are needed if health insurers are to serve the broader interests of small employers and their employees. HIAA has developed and is recommending a comprehensive set of legislative reforms that we believe can be implemented while allowing a viable private marketplace.

- **Small Employer Market Reforms**

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

- *Guaranteed Availability*. All small employer groups would be able to obtain private health insurance regardless of the health risk they present.

  The HIAA proposal would require the "top ten" carriers in a state (defined by their small employer market share) to guarantee to issue health care coverage to any legitimate small employer group. Other carriers would be strongly encouraged to guarantee to issue coverage through favorable reinsurance terms.

- *Coverage of Whole Groups.* Coverage would be made available to entire employer groups; No small employer nor any insurer would be able to exclude from the group's coverage individuals who present high medical risks.

- *Renewability of Coverage.* At renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be canceled because of deteriorating health.

- *Continuity of Coverage.* Once a person is covered in the employer market and satisfied an initial plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.

- *Premium Pricing Limits.* Insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

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

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

- **Private Reinsurance**

A private marketwide reinsurance system would make these small employer reforms possible. Reinsurance means to "insure again." Under reinsurance, an insurance company, called the ceding or direct-writing insurer, purchases insurance from the reinsurer to cover all or part of the loss against which it protects its policyholder. The reinsurer is, in a sense, a silent partner of the original insurer. Reinsurance enables an insurer to accept a greater variety of risks. By sharing these risks with a reinsurer, the ceding insurer obtains an adequate spread within which the law of averages can operate.

Reinsurance will allow individual insurers (or other small employer health plan entities) to implement reforms without facing high financial losses. Reinsurance will allow carriers to assure small employer groups presenting a high

health risk access to a basic set of benefits at a rate no higher than 50 percent above the applicable average market premium. For groups already covered by an insurance carrier, the premium pricing limits described above would pertain, and would in many cases limit a high risk employer's rates to a level below the guaranteed marketwide maximum level of 50 percent above average.

Under the approach developed by HIAA, the "top ten" carriers in a state's small employee health benefit market (defined by small employer premium) would be required to guarantee to issue health coverage to any legitimate small employer group applicant. Other "non top ten" carriers would not be required to guarantee issue coverage but would be strongly encouraged to do so through better reinsurance terms for guaranteed issue carriers. Guaranteed issue carriers could: (a) reinsure entire high-risk small employer groups at a reinsurance premium price of 150 percent of average market costs or (b) reinsure high-risk individuals within groups at 500 percent of average market costs. (Individual reinsurance would include a $5,000 deductible.) To reduce the volume of reinsured claims, reinsurance would be on a three-year basis. (If reinsurance were permitted annually, carriers would declare more groups or individuals high-risk and utilize reinsurance more often increasing reinsurance losses to unacceptable levels.) Nonguaranteed issue carriers would only be permitted to reinsure new entrants to existing groups through individual reinsurance. This reflects the fact that under the "whole group" rule, all carriers would have to make coverage available to any new employees entering a group they already insure.

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

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

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

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

- **Establish State Pools for Uninsurable Individuals**

  Even with increased employer-based coverage and with Medicaid expansions (see below), medically uninsurable individuals who are not part of an insured employer group would remain without coverage.

High-risk pools should be established to make coverage available to such individuals. Pool losses should be funded by general revenues or similar sources, which spread the cost broadly across society.

As of December 1990, 25 states have enacted broad-based pools for uninsurable individuals.

II. ALLOW INSURERS TO OFFER MORE AFFORDABLE BENEFIT PLANS TO SMALL EMPLOYER GROUPS.

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

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

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

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

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

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

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

III. PROVIDE TARGETED TAX ASSISTANCE SO THAT SMALL EMPLOYERS AND THEIR FINANCIALLY VULNERABLE EMPLOYEES CAN AFFORD HEALTH INSURANCE COVERAGE.

Small businesses tend to be younger, financially less stable and employ a lower wage work force. Thus, health benefits often represent a greater financial burden to small businesses, who are far less likely to offer them than are other employers. A 1989 HIAA survey found that only 33 percent of firms with fewer than 10 employees offer health benefits. Conversely, over 96% of firms with more than 25 employees offer health benefits.

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

The financial vulnerability of small employers and uninsured workers, as well as government fiscal realities, suggest that additional tax assistance should be carefully targeted to those populations most in need. For instance, government should:

- Direct new tax subsidies to assist employers and individuals with inadequate financial resources (e.g., certain small employers) in purchasing private coverage. Sliding scale subsidies should be targeted, for example, to small employers paying average wages of less than $18,000 annually. The subsidy rate for such employers should increase as the percent of total payroll going to hospital and medical benefits increases. A temporarily higher subsidy could be given to firms offering benefits for the first time;

- Target subsidies to low-income individuals and families. A refundable tax credit equaling 50 percent of the employee share of premium cost could be made available for taxpayers at or below the poverty level. (A ceiling on qualifying premium costs would equal the median employee share of premium for employer-sponsored coverage nationally or about $360 for individual and $800 for family coverage in 1989. Above poverty, the percentage credit would decrease as income rises and phase our completely at twice poverty. Advance payment of the tax credit through the employer should be made for employees with little or no income tax liability; and,

- Extend to the self-employed the 100 percent tax deduction enjoyed by other employers (as long as they provide equal coverage for their employees, if they have any).

IV. EXPAND PUBLIC COVERAGE FOR THE POOR AND NEAR POOR.

Thirty percent of the uninsured have family incomes below the federal poverty level ($10,560 for a family of three in 1990). Another 17 percent have family incomes between one and one and a half times the federal poverty level. The current federal/state Medicaid program covers only four out of ten poor Americans. Many states do not have a medically needy program, and Medicaid income eligibility thresholds for the non-elderly generally fall far below the poverty level.

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

- The Medicaid program should be extended to cover all poor Americans regardless of age, family structure or employment status. To carry out this recommendation fully, Medicaid eligibility will have to be independent of cash assistance programs such as AFDC. Moreover, fiscal constraints suggest first priority should be phasing in coverage to all poor children under age 18.

- For poor workers with access to employer-based private coverage, HIAA supports appropriate state implementation of recent federal legislation regarding a "buy-out" employed individuals and their families from the Medicaid program. States should pay the poor employees' premium contributions and cost sharing (co-pays and deductibles) associated with available employer plans when Medicaid outlays would be reduced on an average per capita basis. This will help ease individuals' transition into economic self-reliance and often improve access to medical care.

- Near-poor individuals with family incomes between one and one-and-a-half times the federal poverty level should be allowed to "buy in" to a package or primary and preventive care services only. Limited premiums would be based on a sliding scale related to their income. This would target government assistance to the primary and preventive services the near poor most often forgo and for which employer sponsored plans cost-sharing sometimes presents a financial obstacle for the near poor population.

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

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

for poor uninsured populations is far less expensive on a per capita basis.

V. IMPLEMENT STRATEGIES TO CONTAIN HEALTH CARE COSTS

Efforts to improve access will be thwarted, at least to some extent, if we cannot find a way to constrain escalation of health care costs. As the cost of care continues to rise, employers who are on the margin with respect to decisions to offer coverage will find coverage unaffordable. Solving the cost problem is a prerequisite to solving the access problem.

- Although there are no simple solutions to the cost problem, a key component of any effective cost containment strategy is the further development of managed care systems of financing and delivery --- HMOs, PPOs, point-of-service plans, and the like. Since physicians make most of the key decisions that determine how expensive treatment will be, it is imperative to make sure that patients get care from physicians (and other providers) who use resources efficiently. Managed care systems build on that premise by selecting panels of providers for their networks who meet specified criteria and who agree to be monitored to assure that they continue to provide high-quality cost-effective care. Patients are then given financial incentives to choose these providers as their caregivers. By integrating the financing and delivery of care, managed care improves quality while constraining costs.

- A second major element in effective cost containment must be improved knowledge about what constitutes cost-effective care. New technologies that promise better care are often introduced into medical practice, often at great cost, before anyone has made a careful assessment of their cost-effectiveness. They may be better, but is the extra benefit sufficient to outweigh the extra costs? Insurers, government, and all who pay for medical services have a stake in developing better mechanisms and procedures for answering that question about new technologies and procedures.

- Related to the need for better knowledge about technologies is the need for better information about what constitutes good medical practice. There are many areas of medicine where there is broad variation in the way patients are treated even when their conditions vary little. Physicians often have insufficient information to know what constitutes cost-effective care. Increased efforts should be directed to filling this knowledge gap by establishing mechanisms and financing to develop medical practice guidelines and protocols which define the range of acceptable medical practice for particular conditions. The task is so large that it will require a large commitment of resources, from both government and the private sector. Providing these kinds of advances in medical knowledge will help to improve utilization review activities by providing standards that are accepted by both physicians and, very likely, the courts as well.

- As implied, government also has a vital role to play in the battle against costs escalation. Government has a key role, particularly with respect of funding, in technology assessment, in protocol development, and in collecting and analyzing data that can be used to develop more accurate measure of cost, use, and medical outcomes. Government also needs to create a legal climate that is hospitable to the growth of managed care, which means not limiting insurers' ability to employ appropriate utilization review techniques and not outlawing managed care plans that require patients to pay significantly more when they opt to get care from non-network providers and thus generate significantly higher costs.

- Government can also help to reduce administrative cost by encouraging and cooperating with industry-wide efforts to utilize common claims forms and greatly expand electronic collection, analysis, and payment of claims. Finally government has to take the lead in malpractice reform, which has two components: (1) reducing the incidence of malpractice by encouraging better risk management activities by providers and by policing provider ranks to assure that only competent providers treat patients, and (2) by making legislative changes in the malpractice system to assure that awards are appropriate and that the process of adjudication does not absorb an excess percentage of the costs of righting the wrongs done to patients.

PREPARED STATEMENT OF ROBERT LASZEWSKI

In an earlier paper, I discussed a general outline for rationalizing the American health care financing system.

In this paper, I will concentrate on one aspect of that: the underwriting behavior of health insurance providers and the manner in which it should be improved.

At the outset of insurance, the customer need was to simply provide for the pooling of unforeseen and significant risk. As time went on, the more entrepreneurial group health insurance underwriters came to realize that certain customers, particularly in the small employer market, tended to have better claim experience than others. This led to the collection and interpretation of data that could provide a competitive advantage. Carriers began to compete over first knowing who the "best risks" were and then providing rate discounts to attract and hold them. The objective was to have the "cleanest," and therefore most profitable pool of risks. Later, not only did carriers seek out the best risks at the time of the initial underwriting, but they also learned how to discard the poorer risks from their existing block of business. If they were wrong about a risk at the point of initial selection, or if the case deteriorated over time, the response might be to eliminate that group through cancellation; or more often to charge a higher rate to compensate. Many carriers became astute at risk selection and the churning of their business. At the extreme, the most controversial behavior occurred when groups with very large claims were cancelled and found themselves in a position of not being able to find group coverage; or if they did, having difficulty covering the most severe claims or forced to pay a very high price for it.

No insurance carrier has been immune from being able to avoid at least some of this behavior. Any carrier that acted otherwise would find itself inundated by "poorer" risks that could not find coverage elsewhere. The only practical course is to practice some form of medical underwriting or customer selection in order to protect the insurance company's financial integrity; or, move out of the small employer market where such practices are common.

The group insurance marketplace for companies with greater than 100 employees tends not to be burdened by these difficulties because risks of this size are most often "experience rated" or stand primarily on their own claim experience. As a result, the emphasis on risk selection, churning of business, cancellation, or claim exclusion is not so great a problem as it is for the very small employer.

Inevitably, health care reform debates focus on the issue of access to health care and ultimately come to an examination of these underwriting practices. And, this is appropriate.

However, while access and the impediment to access that these problems raise is indeed a fundamental issue, I will argue that an even more fundamental problem is the cost of health care. The fact that we spend 12% of this nations GNP on health care versus 8-9% for other western industrialized nations is not because of access. In fact, the high cost of care is one of the fundamental problems that drives the access problem.

Any solution to the access problem must be constructed in such a way as to also address the issue of cost. The overriding problem in America's health care system is that the health care economy is dysfunctional. The health care market suffers from great inefficiency because the basic system of supply and demand is not working.

As we deal with the access problem, we must recognize that access for those now excluded must occur; but, it must occur in a way that is consistent with seeing the market more efficient.

For example, many would argue that those who are "uninsurable," but able to pay for insurance, should enter a more rationalized system through risk pools These risk pools could be constructed at the state, or perhaps, federal level, to provide health insurance for those unable to get it because of existing underwriting practices. The objective is to cover these people at a reasonable price without the private sector having to be burdened by these "poor" risks.

The use of these risk pools is well meaning, but it violates the most basic requirement of effective health care reform—that the system must be made more cost efficient.

Creating risk pools in, for example, the states would be the wrong thing to do because:

1. The value of the private sector is that as entrepreneurs we will be most effective at managing our customers money. Those individuals now considered poorer risks are at great risk of having very sizable claims. They are the most in need of cost management technique. If these people are pushed off to risk pools, there will

not be the financial accountability in a state risk pool that there will be in a private payers plan, and these large and expensive claims will not be as well managed.

2. Politically controlled risk pools are nothing new. The workers compensation and private passenger auto markets have had them for years. They have not made those products more efficient. Rather, both the auto and workers compensation markets are in more crisis than they have ever been. It would be an incredible irony if the group health industry went the way of state run risk pools just as:

a. Proposition 103 has occurred in the California auto insurance market where risks pools have existed for years.

b. New Jersey voters recently elected a governor on a platform of auto insurance reform where the management of that state's system, including risk pools, has brought a crisis to the state's drivers. New Jersey now suffers with a $3 billion dollar deficit in its auto insurance pool!

c. The Texas legislature just concluded a special two week session to reform the workers compensation system where risk pools have been in force for many years.

Time and time again, we have learned that when risk pools are created and put under a political jurisdiction, they are managed to respond to political pressure as opposed to being managed in a manner that encourages financial efficiency.

3. Risk pools can take two basic forms, those that operate to reinsure carriers who "insure" the claims but pass losses on to the pool; or, risk pools that actually sell insurance to those who can not get it.

In the case of the public risk pool that reinsures carriers, the problem is that the carrier does not have economic incentive to manage the risk. This is simply a pass-through. The carrier can continue to medically underwrite and churn its business. This sort of arrangement is nothing more than a means of subsidizing those carriers who want to continue to make money churning the market rather than managing health care risks. The risk pool absorbs the poorer claims and charges each carrier a proportional charge. It's a level playing field and a simple pass through for everyone. That's fine for the insurance companies but it does little to help bring the health care economy to an efficient point. The carrier can continue its underwriting practice and let the public system worry about those that are left out.

In the case of the public risk pool that is actually in the business of accepting risk from those who can not find coverage in the private sector, the problem of insurance companies being able to push off the "poor" risk and continuing to compete on the basis of "creaming the market" continues. But, in addition a new problem occurs. These pools set their own rates. In a period of significant price increases, politicians often find it difficult to increase price as much as necessary. The result is that pool deficits occur and they are passed on to those carriers operating in the market in proportion to their market share. That works well in the beginning, but ultimately the "high risk pool" price too often becomes cheaper than what a "regular" risk might find in the private market. Suddenly, the state pool begins to grow and what should have been a pool for 2% or 3% of the market becomes a pool for 20% or even 50% of the market. The marketplace simply becomes dysfunctional. An unrealistic prediction? One need only look at the New Jersey and Massachusetts auto pools to see that this has in fact already happened. In fact, there are few auto or workers compensation risks pools that are not already at this point or alarmingly close to it.

Both the workers compensation and auto insurance markets now face a major crisis. Why? Because the response to insurance company underwriting practice and escalating claim levels was to create risk pools where no one really had financial accountability. Politicians controlled the prices, insurance companies focused on risk selection, and fundamental reform was avoided. The result was an even greater crisis.

If we are to rebalance this out of control health care economy we must do it by reinforcing financial accountability, not by diluting that accountability with risk pools. We must drive insurance companies to compete on the basis of who can best manage their customers health care dollars most effectively, not who can churn business and find the "cream" most effectively. And, we must address other fundamental issues that prevent the health care system from operating efficiently.

In the short run, risk pools take insurance companies off the hook and in the long run they become political monsters that no one has the courage to control. And in the final analysis, they do not make the health care financing system more efficient.

They do solve at least part of the access problem. That problem must be solved. The question then remains how do we grant access to those Americans who can pay

for insurance but are unable to get it because of existing underwriting requirements?

On the surface, the simple answer is to eliminate such requirements But, the answer goes farther than that. Not only is access an individual problem for those people who have significant health problems, it is also a problem for employer groups who have a disproportionate number of high risk or chronically ill participants.

It is not enough to eliminate the offending medical underwriting practices. It is also necessary to dismantle the method by which carriers cull and churn their blocks of business competing on the basis of being the one with the most "select" portion of any given market. As long as those who are supposed to be managing their customers' health care dollars most efficiently instead turn their attention to which group is likely to be the healthiest we will not have an efficient supply and demand health care economy. Insurance companies, HMO's etc., are the method by which the consumer and employer attempt to be an efficient demander. Any reform that occurs must recognize that and must either force or encourage people to take on that role. Any reform that dilutes the incentive to be aggressive in the role of an intelligent demander or manager of health care dollars is counter-productive.

I would argue that reform designed at both solving the access and cost issue would look as follows:

1. First, divide the market into two parts: those employers with 100 or more employees and those with less than 100 employees. The reason for the division is that groups of 100 employees tend to be primarily experience rated and therefore, not subject to the culling and churning that goes on with totally "pooled" business.

I have chosen 100 employees as the break point because the level of credibility for cases smaller than this is relatively low. When, cases of less than 100 employees are allowed to stand on their own, it is because they are deemed to be a superior case. The result is the culling and churning that does not serve the cause of market efficiency.

2. With respect to the market of less than 100 employee groups, all restrictions to participating in the program on the basis of medical condition would be eliminated. As long as the employee qualified as a full time employee (perhaps 20 hours per week), paid their portion of the premium, and served a reasonable qualifying period (perhaps 60-90 days) there would be no barriers to participate in the employer plan.

In addition, all insurance carriers serving the market would be required to "community rate." That is, regulations would define communities (most probably geographic areas of at least 250,000 in population) that the carrier would either choose or not choose to compete in. The carrier would be free to set whatever rates it wished under the presumption that it would provide the lowest cost by keeping its expenses under control and being most effective at managing its claim costs through provider negotiations and management. The "community rate" would include the following provisions:

a. One block rate for each community.

b. Each carrier "takes all comers."

c. In calculating a given customer's group rates, an industry standard age table should be used as well as a limited number of industry classifications.

Such provisions used in this manner would serve to both prohibit the "cherry picking" and "churning" of business while still enabling small carriers to either a market without having to fear taking on an overly expensive block of business.

The carrier could vary its rates by type of coverage. Those employers wishing to exceed a minimum level of required benefits could do so and would pay accordingly. Those buying expensive or inefficient plan designs would pay for that luxury.

In my earlier paper, I discussed the need for a plan of minimum benefits that would apply; as well as, certain tort reform preemptions that would serve to make such a health plan less costly.

3. Those groups of more than 100 employees would be subject to pricing on the basis of their experience. This is almost universally the case now and it does not cause the inappropriate churning problems that exist in the small case market.

Groups of over 100 lives would also not be subject to any medical underwriting requirements subject to the employee being a full time employee and serving a relatively short qualifying period.

The purpose of requiring insurance companies to cover all employees and their dependents, even those with serious or chronic conditions, is to force as many Amer-

icans as possible into a rational system that concentrates on delivering effective medical care at the lowest possible cost. The only consideration that third party payers should have on their mind is how to keep their overhead under control and purchase required medical care for their customers at reasonable cost.

An industry risk pool for very large shock claims will be necessary. Such a pool should be administered by the industry. On a given day, the barriers to access will come down and a flood of disabled and chronically ill people will descend on the nations private pay system. Therefore, a pool will be necessary. But carriers must know that they will be ultimately accountable for these claims and they must begin to manage them. And, they must know that their ultimate survival as a competitor will depend upon how effectively they do that; not upon how effectively they avoid those who need coverage the most.

It is probable that many carriers will want to "reinsure" their large claim exposure. That is commonly done even today. This reinsurance, or pooling for insurance companies, is a viable business and this can be accomplished as it always has been in the private sector. And, for the sake of market efficiency, this reinsurance need should continue to be met in the private sector where there can be financial accountability.

For example, if a carrier finds itself with a $500,000 claim but has all amounts over $50,000 reinsured to a government pool, who has accountability to see that the remaining $450,000 of exposure couldn't have been managed to $350,000? If a private reinsurer or an insurer administered pool is on the hook, it will either be managing that claim to reduce its liability or, it will have an agreement in place to have the primary carrier managing it. If the primary carrier proves not to be a good manager, the reinsurance costs will rise. In any event, with reinsurance in the private sector, there will be an incentive for these large claims to be managed. This serves to improve the health care systems efficiency.

In conclusion, I would argue the following:

1. Access is a problem which must be solved.

2. But, access should be solved in such a way as to promote more market efficiency since lack of efficiency is an even more fundamental problem.

3. The construction of public risk pools does not promote efficiency. In fact, the private passenger auto and workers compensation risk pools that are currently in crisis prove that.

4. Insurance carriers churn business and exclude individuals from coverage. This is not good social policy and it does not contribute to the efficiency of the health care system. The best way to manage these costs is to have the private sector take responsibility for them and therefore, have the incentive to manage them.

5. Barriers to access, now in place in insurance contacts, should be eliminated. Insurance company rating for small groups should be on a community basis. The business of insurance companies should be the basic pooling of risk and the effective management of health care dollars.

6. While a risk pool is necessary, the private sector can and should continue to provide reinsurance. If there is government reinsurance, the carriers will pass their bad claims on to the pool and will have no incentive to compete on the basis of who is the best manager of expensive claims. Expensive claims are the ones that need the most management.

7. Insurance carriers must act in a socially responsible manner. And, carriers must act in a way that enhances the efficiency of the health care economy. Both of these things are one and the same.

8. Solving the problem of access through insurance underwriting reform is only one of many elements that must be addressed. To address only underwriting reform and not address the need for tort reform, simplified benefits, better information about appropriate care, appropriate provider and facility capacity and consistency in data reporting, will fall short of the comprehensive reforms that are necessary.

And, reform can not come piecemeal and uncoordinated if it is to be effective. It can not be limited only to efforts to improve access. Time is running out. More people are outside the system each year and health care is becoming more and more unaffordable as the crisis grows. Reform will need to be comprehensive if there is any chance of gaining the concessions necessary from the various special interests. It will be far easier for any one party to give up something if it sees another side doing the same.

Given the state of our nation's fiscal affairs, and that of so many state and local governments, it is not realistic to expect that all of the necessary steps that government must take can occur at one time. Nor is it appropriate to believe that government should solve the problem through the creation of some "Great Society" spending program. At $675 billion, we already spend far too much. The challenge is not to

spend more, but to get reasonable efficiency and access from what we now spend. The comprehensive reform that is necessary probably can not happen at once. It is important to recognize the principals that must be achieved over time. I would suggest the following long term objectives be included:

1. That a seamless system of universal coverage be created where the needy are covered by government and those that can pay have unimpeded access to purchase insurance on a non-discriminatory basis.

2. That public programs reimburse providers at a reasonable level and that reimbursement programs emphasize primary care as well as preventive programs.

3. That the nation's Tort system be overhauled. The right to sue should be maintained, but only after first submitting malpractice claims to arbitration that encompass reasonable professional standards as a defense.

4. That the administrative costs and burdens of the existing system be dramatically reduced through the implementation of a common system of electronic claim filing and payment for all payers and providers.

5. That data be compiled and made available to doctors, consumers and payers as to what treatments work and who successfully provides those treatments at the lowest cost.

6. That based upon this data, we reimburse the most efficient and effective doctors and hospitals. That "Centers of Excellence" be designated to provide expensive and complex high technology and/or high risk procedures and treatments.

Within the context of these six principles, it is possible to move forward with a number of steps that could begin to have an impact and still require little or no additional public spending.

1. Toward a seamless system—health insurance reform can be enacted which does away with the "medical underwriting" and "pre-existing conditions" provisions that serve to exclude people. These provisions should be eliminated. Some reform proposals would allow them to continue with those who would have otherwise lost coverage shifted to state-run pools. Having such pools would simply allow insurers to "cream the market" and pass responsibility to these pools. If insurance companies are to participate in creating a more efficient system, they must compete on the basis of finding the lowest cost, highest quality providers on behalf of their customers rather than continuing to be adept on who not to cover or who to pass-off to a government-run pool. These "have your cake and eat it too" proposals fall far short of the kind of reform the industry must undergo.

2. Toward improved public programs—government must move to broaden the safety net for those who can not afford to purchase health insurance. While fiscal problems preclude immediate broadening of eligibility, existing dollars should be refocused to emphasize primary care especially for pregnant women and children. To the extent coverages can be granted to those now not eligible, it should be done first by providing primary care benefits. Since no seriously ill individual can be denied care, the uninsured already receive catastrophic care benefits. To the extent we have limited new dollars to spend they should go to preventing these serious illnesses. Our first priority should be on expanding primary care benefits for the poor. A dollar spent on prenatal care, for example, saves $7 in pre-mature birth catastrophic costs.

3. Toward Tort reform—Tort reform is a much needed effort and can be accomplished without substantial government spending.

Much of the systems paranoia can be relieved if, before filing a suit, the plaintiff were to submit their claim to arbitration. If the plaintiff felt that the outcome of arbitration were unsatisfactory, they could than bring a court suit. This would serve to more quickly and responsibly resolve complaints while still protecting the consumers' right to sue.

In addition, physicians must be held accountable to standards which are consistent with reasonable standards of care not some "god-like" standard of perfection.

4. Toward lower administrative costs—currently, various insurers, government agencies, and Medicare use different claim forms and procedures. The technology has existed for some time that would enable all payers to use one system of electronic claim filing and payment, dramatically reducing the cost and burden of administration. Requiring payers to move to such a standard system would have little or no net cost to the tax payer in the short run and save considerable amounts in the public and private systems in the longer run.

5. Toward reimbursing the most efficient and effective providers—a common system for filing claims could be the basis for information on relative costs among providers. In addition, "outcomes" research can tell physicians, consumers and payers a great deal about the most effective treatment path.

The cost to tax payers would be small and could be paid for by the organizations that used the data.

6. The designating of "Centers of Excellence" by public payers would create an environment of reimbursement only for the appropriate number and type of high technology or high risk/high cost facilities.

For example, only certain hospitals would be designated and eligible for public reimbursement for MRI procedures. The number designated would be appropriate to the population, and therefore, serve to reduce the "hospital arms race."

The small cost in tax revenue to administer such a program would be quickly made up in savings.

These steps can provide a meaningful start toward a more rational health care system. *Each of these first steps are essentially "revenue neutral" given contemporary fiscal realities.*

PREPARED STATEMENT OF DAVID J. LYONS

Mr. Chairman and Members of the Committee, thank you for this opportunity to discuss the important topic of access to health insurance.

I am David J. Lyons and I am the Insurance Commissioner for the State of Iowa. I am here today representing the National Association of Insurance Commissioners ("NAIC"), which is a nonprofit association whose members are the insurance officials of each state, the District of Columbia, and four U.S. Territories.

One of the most important public policy issues facing state and federal officials is the tragic fact that over 33 million men, women and children have no health insurance and therefore have severely limited access to health care itself. The core problem under lying this tragedy is the seemingly intractable issue of soaring health care costs.

Unfortunately, the rating and underwriting practices in the health insurance marketplace also are contributing to the access problems of many Americans. These problems have caused state regulators, and others, to look more closely at the practices of health insurers and their effect on consumers. My testimony will describe recent activities by the NAIC both to improve the fairness of health insurance rating in the small group market and to increase access to insurance for small businesses.

MODEL LEGISLATION

State insurance regulators have received growing numbers of complaints from small employers about practices in the health insurance market. Large rate increases and refusals to renew coverage are frequently cited problems. Further, the total inability of some small businesses to get coverage because of the health problems of their workers is an area of growing concern.

The NAIC is addressing both of these problems through model legislation. Last December the NAIC adopted a model law to address rating abuses and renewability problems in the small group market. We currently are developing model legislation aimed at assuring availability of coverage for small businesses, regardless of their employees' health status or claims experience. We expect adoption of this model later this year.

Rating And Renewability Model Act

Premiums for small group health insurance are for the most part determined through competition. In recent years, insurers have begun competing for business by offering low rates in early years and "building in" rate increases if the group continues with the insurer. This is called "durational rating." Low initial rates are possible because insurers medically underwrite (use health screening) to assure that the group is healthy before they accept it for coverage. A healthy group will generally produce lower than average claims experience, so the insurer can charge lower rates initially. However, the benefit of health underwriting "wears off" after two or three years (some employees will become sick or have accidents), requiring the insurer to raise rates to fund the predictable increase in claims.

Insurers also increasingly are using claims experience and/or health status to determine rates in this market. Because initial rates are low, insurers, on average, need to raise rates for groups that continue with the insurer. However, if the insurer builds-in rate increases for all groups, the healthier groups (who can pass medical underwriting with another insurer) will move to another insurer to keep a low initial rate. In response, insurers have developed "tier rating." In tier rating, the claims experience of a group is used to select its premium level at renewal. Insurers

increase rates more for groups with poor claims experience (e.g., high claims frequency, employees with serious or expensive illnesses). In some cases these rate increases have been extremely high.

In many cases, insurers also can choose not to renew coverage for a group. For example, an insurer may choose not to renew a group's coverage because the group has poor claims experience or because an employee or dependent has developed a serious medical problem or disability. Groups that are not renewed for these reasons will have a hard time finding replacement coverage because they will be unable to meet insurer medical underwriting standards.

As rapidly rising health care costs gradually erode the affordability of coverage for small businesses, the problems inherent with these rating practices are exacerbated. Price competition to produce the lowest rate for new business appears to be causing more aggressive use of these rating practices. Groups with higher claims experience are more and more experiencing large premium increases or, sometimes, nonrenewal of coverage. In some cases, these groups can and do reduce their costs by dropping a sick employee from the group, leaving that employee uninsured and sometimes uninsurable. The market's focus has shifted away from long-term sharing of risk across a relatively large number of groups and towards providing a low, short-term price to select groups.

In response to these problems, the NAIC in December of 1990 adopted model legislation aimed at rating and renewal practices in this marketplace. The Model: (1) places limits on certain rating practices and requires actuarial certification of rating methods; (2) limits significantly an insurer's ability not to renew a group's coverage; and (3) requires increased disclosure to consumers of insurer rating methods.

The rating limitations in the NAIC Model provide that: (1) within any class[1] of small group business, rates for similar groups for similar coverage can vary by no more than 25% around the midpoint; (2) for all classes of business, the midpoint rate of any class may not be more than 20% higher than the lowest-rated class of business; and (3) in any year, the maximum increase that an employer may receive would be equal to the change in the rate for new business in that class plus 15%. A change in the number or make-up of employees also could affect the employer's rate at renewal.

Essentially, in any year, the maximum change in rate that could be attributable to a group's health status, claims experience or duration of coverage is 15%. Otherwise, the annual rate change is based primarily on the change in rate for new business—which should reflect the trend in health care costs and utilization. The new business rate was chosen as an index because insurers are heavily penalized if they cheat: if they raise it too much they would be uncompetitive for new business; if they keep it too low, they would be underpricing the entire class and incur significant losses.

The overall rate bands described above are designed to assure that rates will not vary excessively within a class of business or within the insurer's entire book of small group business. The NAIC Model permits some variation in the rates of an insurer (if based on actuarially sound principles), but its enactment would significantly compress current degree of rate variation.

The NAIC Model also requires each insurer to keep on file for examination a detailed description (including documentation) of the insurer's rating methodology and underwriting practices. In addition, each insurer must file an annual actuarial certification that the insurer's rating methods are based on sound actuarial principles. These requirements will improve the ability of insurance regulators to monitor the rating practices of insurers and enforce the limits on rating practices described above.

In addition to the rating provisions, the NAIC Model significantly limits the ability of insurers to nonrenew coverage. The NAIC Model: (1) generally prohibits nonrenewal by the insurer of individuals or dependents within a group; (2) generally prohibits the nonrenewal by the insurer of groups within a class of business; and (3) permits nonrenewal of a class of business only upon notice to the groups and to the commissioner.[2] An insurer that does not renew a class is prohibited from starting business for a new class for a period of five years.

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[1] Insurers use separate "classes" or "blocks" of business to distinguish different groups of business that should produce different results. Different classes include business that is insured through or for a bona fide association, business marketed through a different method of distribution (e.g., agent sold or direct marketed), and a class acquired from another carrier.

[2] Nonrenewal also would be permitted in cases of fraud, failure to abide by provisions of the contract, or if the small employer is no longer engaged in business.

These renewal provisions go a long way toward guaranteeing renewability of coverage for small businesses and their employees. Nonrenewal of specific groups or individuals is generally prohibited. Further, the penalty for nonrenewal of an entire class (i.e., prohibition against writing new classes of business for five years) should discourage nonrenewal except in the most extreme cases where the insurer is unable to continue to provide coverage or is leaving this market altogether.

Finally, the NAIC Model requires insurers to disclose the following information at the time of purchase: the insurer's right to change rates; any factors, including the group's claims experience, health status, or duration of coverage, that could affect the group's rate; the class of business the group would be placed into; and the conditions that affect renewability of coverage. Disclosure of these factors will enable small businesses to make more informed purchases of group coverage and to better understand how their rates may change at renewal.

Together, we believe that these rating and renewability provisions will improve the stability and fairness of the small group health insurance marketplace. The NAIC will continue to monitor the practices in this marketplace and will amend or add new provisions to this model law when warranted.

Improving Availability of Coverage

In conjunction with its work on rating and renewal practices, the NAIC also is investigating ways to improve availability of health insurance coverage for all small groups. Currently, in order to protect themselves against adverse selection,[3] insurers medically underwrite small groups before accepting them. Groups that have sick or disabled employees or dependents often find it extremely difficult, or impossible, to get health insurance. Sometimes these groups deliberately exclude the sick individual from the group plan in order to obtain coverage for the remainder of the group. In addition, some insurers refuse to write coverage for groups in certain professions or occupations that they consider higher risk.

To address these problems of availability, the NAIC has formed a working group to develop model approaches to assure that all small employers have access to health insurance coverage, regardless of the health status or claims experience of the group or its workers. The NAIC currently is pursuing two approaches to assuring access, one based on a "reinsurance concept" [4], and another is based on the "assigned risk concept" [5] prevalent in property and casualty insurance.

Further, as part of its effort to assure availability, the working group also will adopt measures which would: (1) require insurers to insure all eligible employees and dependents of a group; (2) require an insurer replacing group coverage to insure all employees and dependents that were previously insured; and (3) prohibit insurers from assessing new waiting periods or pre-existing condition exclusion periods when groups change carriers or when insured individuals change employers. Such provisions are important to prevent lapses in coverage and denial of coverage to certain group members because of their health status. A number of states already have adopted provisions similar to these. The working group will release model language for comment at the NAIC Summer Meeting in June. We anticipate adoption of a final model act—ready for enactment by all of the states—later this year.

The goal of these approaches is to assure that individuals and groups are not denied needed coverage because of health problems. However, these efforts to guarantee availability of coverage will not lower the ultimate cost of health care coverage. Indeed, by providing access to higher risk groups and spreading the costs throughout the marketplace, health insurance premiums may increase. We will be working closely with representatives of small businesses to assure that these reforms fit their needs at a cost that can be borne within the system.

LEGISLATIVE ACTIVITY

The issues of health insurance market reform and access to health care have been widely considered in recent state legislative sessions. States have been active in adopting legislation to improve access to health care, including providing tax incen-

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[3] Adverse selection is the tendency of individuals with higher risk of loss to preferentially seek coverage.

[4] Under a reinsurance approach, insurers can choose to reinsure high-risk individuals or groups (under set rules and premiums) with the reinsurance pool. The group will be charged a premium that is somewhat higher than average, but in most cases substantially lower than the premium needed to cover the group's losses. The extra costs are spread throughout the market through the reinsurance pool.

[5] Under an assigned risk approach, insurers would be required to accept a certain percentage of high risk groups, based on their share of the small group health insurance market.

tives to small business and modifying or eliminating benefit mandates in the small employer marketplace. In addition, more than fifteen states have considered health insurance reforms, and at least six states already have adopted legislation similar to the NAIC Model law on rating and renewability of coverage. The NAIC staff has answered numerous questions from state legislative and regulatory off ices about its initiatives, and we expect many more states to consider and adopt insurance reforms within the near future.

One area where state regulators feel Congress should consider changes involves the federal Employee Retirement Income Security Act ("ERISA"). While ostensibly a pension reform act, ERISA also preempts virtually all state insurance laws as they relate to the health benefit plans of most large employers and collectively-bargained multiple-employer arrangements.[6] The ERISA preemption fundamentally segmented the insurance marketplace and has greatly inhibited states in their ability to design and implement effective market-based reforms. For example, the inability to collect assessments from self-funded plans has substantially impeded the efforts of states to develop effective health risk pools for uninsurable individuals. The NAIC believes that states should have the authority to include all health insurance arrangements, including those that self-fund, in their reform efforts.

CONCLUSION

The NAIC appreciates the opportunity to discuss the issue of access to health insurance. As insurance regulators, we feel that our role is to regulate the insurance marketplace so that it operates fairly and efficiently to provide coverage to the broadest possible group of individuals. The NAIC hopes that its market reforms will produce an insurance market that is fairer, more accessible, easier to understand, and more predictable.

We recognize, however, that most of the uninsured do not have coverage because they or their employers cannot afford it. The costs of insurance primarily reflect the costs of health care services, which continue to soar. The NAIC pledges to work cooperatively with this Committee and other federal and state officials as we search for ways to contain health care cost and enhance affordability of coverage.

Attachment.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS,
Washington, DC, November 11, 1991.

Hon. CHARLES E. GRASSLEY,
SH-135 Hart Senate Office Building,
Washington DC

Dear Senator Grassley: At the Finance Committee hearing on access to health insurance earlier this year, you asked the NAIC to provide estimates of the potential effects on the lowest premium rates currently available to small groups if the reforms discussed by the NAIC in its testimony are enacted. We have been looking closely a this issue over the past several months. Unfortunately, for the reasons discussed below, we are unable to provide any firm answers regarding the potential premium increases. We will however, provide some rough estimates of the range of premium increases that could occur if these reforms are enacted.

There are two areas of reform that have the potential to cause increases in premium rates. The first is the rate compression caused by putting "bands" around the highest and lowest rates charged by insurers to similar groups for similar coverage. This rate compression will increase the lowest rates currently charged to the healthiest groups while decreasing the highest rates charged to the poorer risk groups. The second is the guarantee of insurability that would be provided to all groups, regardless of the health status or claims experience of the group's employees. Many of these groups currently are denied coverage by insurers through medical underwriting practices. By providing a guarantee of availability to these poorer risk groups and absorbing the increased costs into the insured market, rates for all small employers will increase.

Determining the amount of potential increase that could be caused by these reform efforts is difficult for a number of reasons. With respect to the rate compression, the expected increase in the lowest premium rates currently charged will

[6] State insurance laws which are preempted include those addressing: unfair trade and claims practices; adequate notice to applicants and insureds; insurance rating, renewability and continuity of coverage provisions; guarantee fund and insolvency protection; and coverage requirements.

depend in large measure on the "degree" to which any insurer uses experience rating for small groups. If an insurer charges very low rates for new healthy groups, accompanied by significant rate increases for groups with high claims, rate compression will have a fairly dramatic effect on the low initial premiums charged by the insurer. We have seen estimates, from insurers that use experience rating, that rate compression could increase the lowest available rates from between five percent to almost twenty percent. At the same time, we expect the highest rates to be reduced by substantially more.

With respect to the guarantee of availability of coverage, the effects on premium rates are even more difficult to predict. To accurately assess the potential increase, one must predict the number of uninsurable groups that will enter the marketplace because of the new provision, as well as the severity of their illnesses and the associated costs. Also, it is possible that a few groups, probably the healthiest groups with the lowest rates, will—leave the market because of the overall increase in rates caused by the reforms. The NAIC has carefully reviewed information provided by the Health Insurance Association of America and the Blue Cross and Blue Shield Association. Their estimates, which are based on different data and assumptions, range from less than a five percent increase in market premiums to around ten percent. "At this point, it is not possible to determine which of these estimates is more accurate. We will need to closely monitor the experience under the reforms to determine and evaluate the premium effects.

The NAIC would like to be able to provide clearer guidance on the potential increases in premiums that may result from reforms to the small employer marketplace, but at this time it is not possible. Our reform proposals have been aimed at producing a market that is fairer and more accessible to small employers. We hope that these reforms can be achieved at a price that is affordable. We will continue to monitor the marketplace closely and will be prepared to suggest changes if warranted.

I hope this information is helpful as you and other members of the Finance Committee consider the important issue of health insurance reform.

Sincerely yours,

DAVID J. LYONS, *Commissioner of Insurance.*

PREPARED STATEMENT OF JACK A. MEYER, PH.D.

The Forces Driving Health Care Costs

There are three key problems in health care today. First, the real cost of care is rising sharply and continuously. Second, widespread access problems are becoming even more serious as the "free care" system and hidden subsidies dry up. Third, we have not mounted any systematic effort to define and measure the quality of the health care services we are buying, to assess the relative ability of providers to deliver those services, and to use that information to purchase care selectively in consumers' best interests.

There are also powerful forces pushing up health care spending. New medical technology is being introduced into the marketplace at a rapid and accelerating pace. Federal tax subsidies underwrite the overuse of health care services even as many low and moderate-income families are left to fend for themselves. Demographic trends -- most notably the aging of our population -- will drive spending even higher in the future, while public health threats, including AIDS and drug and alcohol abuse, are adding substantially to it now.

Underlying Forces

The debate over the cost of health care has focused on the peculiar structure of the health care financing system. Although this is important, other factors -- some of them external to the system -- are equally critical. The full explanation lies in a complex array of economic, demographic, epidemiological, social, and legal forces, all interacting with the way health care is organized, delivered, and financed.

It is tempting to look for one "villain" that can be held responsible for the growth in health care spending. Employers often blame doctors and hospitals, while providers point to government and the medical malpractice system. Some blame the patient for over-using services, and insurers are criticized for not monitoring the behavior of providers and consumers more closely.

In fact, the problem is the system itself -- and all of the participants in it. The failure to understand this is at the root of many misguided policy prescriptions. By targeting only one "culprit," such remedies are doomed to fail.

The ability of most Americans to pay for health care has increased with their incomes. Real income per capita (in terms of purchasing power) in the United States is the highest in the world. There is a strong relationship between real income and health care spending, and Americans insist on the best health care that money can buy.

Public health trends are also contributing to rising expenditures. Estimates of the cost of the AIDS epidemic alone indicate that federal spending on this disease will reach $4.3 billion in 1992, up from $2.2 billion in 1989. Meanwhile, destructive behaviors such as smoking and alcohol and drug abuse add billions more to the total health care bill. A recent government study determined that smoking leads to $22 billion a year in additional medical costs and another $43 billion in lost productivity.

Changing demographics also will be driving health care expenditures in the years ahead. The growth and aging of our population increased spending by only about one percentage point a year over the 1977-1987 period. Population aging will become a more important factor in the future, however, when the baby-boom generation reaches retirement age, since older people use more, and costlier, health care services. This will be particularly important to the future costs of the Medicare program.

The virtual explosion in the development and diffusion of new medical technology in the U.S. is an increasingly important force, with Americans expecting ready access to these new and expensive technologies. The great flaw in this world of technological advancement is that these medical procedures are not being properly assessed to determine their true effectiveness. The system needs good information on outcomes and quality so that sound decisions can be made about the appropriate use of such procedures.

Medical malpractice has both direct and indirect effects on health care spending. Malpractice insurance premiums directly raise health care costs, but even more important, the threat of litigation and enormous awards contributes to the practice of defensive medicine.

Factors Internal to the Health Care System

While all of the factors noted above contribute significantly to rising health care spending, the way the health care system itself is organized is also of critical importance. In general, it has not contained proper incentives for either consumers or providers to use services cost-effectively. Although this is beginning to change, there is still much more to be done in this area.

The fragmentation of the health care system -- with inadequate emphasis on primary care, prevention, and patient education -- is also raising the levels of health care spending. A lack of early, preventive care often results in greater use of intensive, costly care down the road. Moreover, institutional care and traditional "med-surg" services are over-emphasized, whereas innovative, non-traditional programs such as worker safety and drug and alcohol counseling are proving cost-effective in the long run.

Intensity of care provided -- the resources used per encounter with the health care system -- has become a particularly important cost-driver in the United States. The U.S. hospital industry employs more people per patient than other countries, and has far more high-tech equipment available to treat patients. Intensity will become an even more important determinant of how much is spent on health care in the future.

Of course, more intensity is frequently, though not always, associated with more benefits as well as more costs. New technology can save lives and improve quality of life. It can also be wasteful and redundant. In better technology assessment, we will need to make tough decisions about who gets access to advanced technology, and under what conditions.

Unlike intensity of care, which is demonstrably growing, utilization -- the number and length of encounters with the health care system -- presents a mixed picture. Use of inpatient services has declined, and inpatient hospital utilization is very low in the U.S. compared with other countries. Conversely, the number of outpatient visits has risen significantly, as some services are shifted to ambulatory settings.

Americans have shorter hospital stays than citizens of other nations. Despite shorter stays, however, Americans run up larger bills while in the hospital. The U.S. spends about twice as much per capita as the United Kingdom on health care, even though average hospital stays in the U.K. are twice as long.

Clearly, then, relatively high spending for health care in the U.S. is not the result of Americans going to the doctor more often, entering the hospital more frequently, or staying in the hospital longer than their counterparts in other countries. If anything, the reverse is true.

Another important element of rising health care spending is medical-specific inflation over and above the general economy-wide inflation rate. Between 1977 and 1987, prices of personal health care services increased at a compound average annual rate of 7.3 percent, compared with a 5.7 percent average annual increase in the GNP deflator.

Finally, the United States has higher administrative costs than other nations, reflecting our pluralistic, decentralized payment system. Moving to a one-payer system would reduce such costs, but would bring other problems to the fore (such as the limitations on technology and access to care that inevitably accompany a one-payer system). It remains to be seen whether

Americans would find such limitations to be a price worth paying to achieve the efficiencies associated with a one-payer system.

The Access Problem

Today, at least one of eight Americans has no health insurance, while millions more are under-insured. Our welfare system screens many poor people out of Medicaid coverage, while many lower-wage jobs do not include private insurance coverage. In addition, pre-existing health conditions price (or screen) many people out of affordable coverage. Payers are vying for the good risks and disposing of the bad. Other people are uninsured because they or their employers (mostly smaller firms) simply cannot afford the comprehensive coverage mandated in most states, even if they could afford more basic coverage. The cost and access problems are two sides of the same coin, and should be addressed together.

The Need for Prudent Purchasing

Business, labor, and government need to change the way they purchase health care. To help them do so, we must make greater investments in outcomes research and evaluation, which will help providers determine standards of appropriate care. Otherwise, bill payers are underwriting an unknown mix of appropriate, unnecessary, and even harmful care.

A corresponding investment must be made in getting information about the comparative performance of individual providers in delivering effective care in an efficient manner. This information should be made public, to help educate consumers and purchasers.

The Basic Elements of a New Approach

1) Medicaid Expansion/Tax Credits
   - -- Refundable federal income tax credit could enable all low-income consumers to buy at least basic health coverage
   - -- Alternatively, Medicaid could be expanded to more (or all) of the poor, and the near-poor allowed to "buy in" by making income-related contributions

2) Medicaid Reform
   - -- Medicaid must be reformed as it is expanded
     - o This means greater use of managed care techniques, risk-sharing arrangements with providers, and reimbursement rates that encourage provider participation

3) Tax Reform
   - -- The self-employed and employees of unincorporated businesses should be allowed the same health-related tax preferences as other workers.
   - -- Temporary tax incentives for small employers to offer and finance part of the cost of health insurance also should be considered
   - -- A ceiling should be placed on the amount of employer contributions to health insurance that employees may exclude from taxable income.
   - -- Taxes on tobacco products should be increased to reduce consumption

4) Enhanced Managed Care
   - -- Managed care as practiced by leading private employers incorporates several basic principles of cost control and quality improvement
     - o Measuring and comparing provider quality and per[illegible]ice

- o Purchasing on the basis of value -- quality in relation to cost
- o Giving individuals strong financial incentives to use selected providers
- o Managing the delivery of health care
- o Emphasizing prevention and wellness

-- Medicare and Medicaid should work with private purchasers to build a successful strategy to reform health care markets on the basis of managed care

5) Regulatory Reforms

-- Regulatory barriers to expanding coverage and controlling costs must be removed

- o State mandated benefits should be preempted by the federal government
- o Anti-competitive laws that stifle selective contracting with providers and utilization review should be eliminated
- o New ground rules are needed for the private insurance industry to make coverage more available and affordable to all Americans; such rules would include open enrollment, prohibitions of medical underwriting of individuals, and guaranteed renewability when policies expire

6) Reforms in the Tort System

-- The malpractice system needs to be overhauled

- o This can be accomplished through developing schedules of awards based on age and severity of injury, the use of alternative dispute resolution mechanisms, limits on awards and contingency fees for lawyers

7) Mandate on Consumers

-- Mandate on individuals to have at least basic coverage is needed to eliminate "free riders" from the system

- o This could only be imposed after assuring that tax credits/Medicaid expansion and insurance reforms enfranchise all consumers

8) New Approach to Medicare

-- Structural changes are needed in Medicare to deal with changing demographics

- o Medicare should be made more like a true insurance program, with across-the-board catastrophic coverge and significant cost-sharing scaled to ability to pay
- o Higher-income older Americans should be asked to pay more of the costs of the program
- o The age of eligibility for Medicare may need to be raised in the next century.

PREPARED STATEMENT OF G. ROBERT O'BRIEN

Good morning, Mr. Chairman. My name is Bob O'Brien. I am President of the CIGNA Employee Benefits Division. CIGNA is the largest investor-owned commercial health insurance operation in the country and one of the largest operators of HMOs. Our premium volume now exceeds $16 billion annually. We cover some 13 million people, operate more than 70 managed care networks and have contracts with over 25 thousand physicians. Our managed care plans include staff model HMOs, IPA HMOs and Preferred Provider Plans.

I want to thank you, Mr. Chairman, for holding these hearings and for the leadership in the health field you have demonstrated over the years. I also am pleased that you invited us to appear before your committee today because I believe we can offer first hand insights on the benefits of managed care. Over the past several years we have made a substantial financial and management commitment to managed care and I want to take the opportunity this morning to share with you the positive results we have achieved to date.

OVERVIEW

We all are concerned about increasing health care costs. One reason I would encourage Congressional support for the managed care concept is that it serves as an important means of addressing the continuing escalation of health care costs. I would call for your endorsement of efforts designed to encourage the use of managed care in private and public health care programs at both the federal and state level, and suggest that you take steps to override legislative initiatives at the state level designed to limit the development and effective operation of the managed care concept. It is my understanding that legislation addressing managed care issues will be introduced in the Senate by Senator Chafee and is a part of Senator Rockefeller's bill as well. I would urge that preemption of state anti-managed care laws included in this legislation be given full consideration as an important element in addressing our nation's health care challenge.

Let me say at the outset that CIGNA believes all Americans should have access to necessary health care. We believe that this goal can best be accomplished through a public/private partnership with government providing the necessary assistance for persons who do not have access to privately financed health care services. This system has provided the vast majority of Americans with the best health care in the world for almost eighty years. Expanding access to coverage for employees of small business is an essential element in building on this foundation. Both federal and state governments must act promptly to make basic health care a continuing reality for all of our citizens. Employee benefit plans are already subject to both state and federal regulation in a variety of forms and we would encourage you to negotiate the appropriate division of responsibility with your state counterparts in accomplishing these reforms quickly.

SMALL EMPLOYER MARKET REFORM

We strongly encourage the adoption of consistent insurance underwriting standards and appropriate pooling arrangements to assure an equitable spread of risk for uninsured and excess risk groups and individuals. Underwriting reforms which emphasize the need for insurers to compete on managing risk rather than selecting risk will stabilize the small employer insurance market and assure that small employers can obtain coverage from a large number of insurers and can be assured of continued coverage. The result would be increased access to health insurance for small businesses and their employees, many of whom now make up the bulk of the uninsured. However, these and other reforms cannot be addressed in a vacuum. Anyone who is committed to providing universal access to coverage must recognize that the ultimate success hinges on the ability to control health care cost inflation.

We believe managed care is the best means of effecting permanent cost containment. A recent New York Times editorial supports this belief.

WHAT IS MANAGED CARE?

Managed care is a term that is frequently misunderstood. Managed care is basically a health care delivery system; a way in which people get their health care. As we define it, Mr. Chairman, managed care consists of health benefit programs that deliver quality care at lower cost by establishing a carefully selected network of doctors, hospitals and other providers who are under contract and who agree beforehand to meet predetermined standards of quality and costs for the care they give. It also must include incentives for individuals to use network physicians.

At the heart of the managed care network is a primary care physician—a care manager doing exactly what general practitioners of traditional family medicine were trained to do: diagnose and coordinate treatment while building strong relationships with patients and families. This new generation of physician manages a patient's entire medical care, arranges specialist referrals, authorizes hospital admission and monitors for quality.

To critics who say "managed care doesn't work," let me say they haven't implemented a comprehensive program of managed care yet. They've been flirting with a few of the techniques of managed care. Techniques such as utilization review, second surgical opinion and procedure review can have a positive impact and should be encouraged, but they are only techniques that should be present in all plans. The real potential for savings lies in achieving lasting change in behavior through contractual relations established with a limited number of quality physicians.

Managed care is a market-driven system of controlling costs and ensuring quality. It is the private sector approach to the problem. Others are proposing price controls but a recent Lewin/ICF study confirms what we have known for some time—regulation of prices in whatever form, "single payor," "all payor," or "expenditure caps," won't contain health care spending and will have a negative impact on the quality of our health care system.

Per capita hospital expenditures in those states that regulate health care spending actually increased at a faster rate than in states that encourage competition among health care service providers, according to this new study by Lewin/ICF. Expenditures per capita in six "regulated" states (Maryland, Massachusetts, New Jersey, Washington, Connecticut and New York) rose an average of 9.5% from 1986-1989, while expenditures in five "competitive" states (Minnesota, California, Oregon, Delaware and Colorado) rose 7.1%. The expenditure increase in the regulated states also outpaced that of the nation as a whole (up 8.5%).

In CIGNA's experience managed care has cut the rate of inflation in our health care programs by one-half. Over the past three years, costs under our indemnity programs have been escalating twice as fast as the rate of escalation under our managed care programs. Recent studies by Dr. Jack Meyer who testified earlier today and by the Conference Board speak to this same success. Managed care is demonstrating that it can effectively control costs while delivering quality service in a growing number of individual care situations. It has the potential to do so on a much broader base.

Managed care is designed to encourage both the patient and the provider to effect lasting changes in behavior of both parties through the use of incentives to reduce unnecessary use of the health care system thereby lowering cost, while still delivering quality care. In fact, managed care encourages quality and it's working as a means of constraining costs. A good example of what managed care can do is the program we created and administered for Allied/Signal.

ALLIED/SIGNAL EXPERIENCE

You have already heard testimony to that effect from Edward Hennessy, CEO of Allied/Signal. As the company who helped develop that program, I would like to reiterate a few key statistics. Allied's cost are 27% lower than they would be under an indemnity plan—a savings of almost $1,250 annually per employee. And we are convinced the savings are real, sustainable and will grow as the incentives continue to work. Of course, Allied's benefit plan characteristics are unique to Allied, and other employers may have more difficulty generating savings of this magnitude if they are unwilling to take the same bold steps that Mr. Hennessy was prepared to adopt. But suppose all U.S. employers who finance health care services were to adopt such aggressive cost-management tools. Suppose they could save $125 per employee, just a tenth of Allied-Signal's savings—$1,250 per employee over a year—by adopting well-conceived and well-communicated managed care programs. Even with this very conservative estimate, the private sector could save more than $15 billion. My personal belief is that such savings could approach $45 billion.

To substantiate my belief, I refer you to the recent estimates by Dr. Robert Brook of the Rand Corporation who indicates that approximately $50 billion of unnecessary services are delivered each year. It's very clear to me, based on our experience over the last several years, that the managed care carriers are adding real value to the health care system. We compete vigorously to develop the best networks and to negotiate the best prices for our customers and we've developed the cost containment techniques to meet those price commitments. Just as important, we've introduced measures to monitor quality that do not now exist in the fee-for-service system. Patient satisfaction surveys, development and review of individual physician

practice patterns, physician-to-physician counselling and, when appropriate, removal of physicians from our networks, are integral to managed care.

MANAGED CARE PROGRAMS FOR SMALL EMPLOYERS

While the publicity of the success of managed care has been focused on large employers such as Allied/Signal, I am pleased to report, Mr. Chairman, that small employers are taking advantage of managed care as well. We cover many small employers either directly or through various association programs. For example, in Los Angeles, we have over 25,000 covered lives in our HMOs through one such program and have recently launched a new sales campaign to increase the number substantially. Through our Direct Marketing Division, we recently have completed negotiations with American Express to jointly market a CIGNA managed care product utilizing our HMO networks to small employers in markets where a CIGNA HMO network currently exists. We also are working with additional sponsors to expand this market as well. We expect to be successful and expect other companies to follow suit. Through our new business ventures we are making substantial progress toward offering the small employer health care coverage.

REGULATORY BARRIERS TO COMPETITIVE HEALTH CARE SYSTEMS

A critical role for government to play in health care at both federal and state levels should be to assure that regulation and incentives are carefully balanced—encouraging affordable private insurance plans and effective managed care systems. All too often today, efforts to develop managed care arrangements are severely constrained by ill-conceived state legislation and a lack of flexibility in such federal programs as Medicare and Medicaid. Impractical limits placed on cost containment programs are destructive and inflationary.

Financing entities should be allowed to provide low-cost indemnity benefit programs and a complete range of managed care programs. To accomplish this end, state mandated benefit requirements and unreasonable state restrictions on managed care plans should be eliminated. Here's where Congress can play an important role in establishing a national framework which will allow the private sector to respond to consumer needs.

We have identified a number of laws in the various states which pose a barrier to managed care, including ones that limit the development of effective networks that restrain effective utilization review programs. Examples include laws and regulations that:

- Restrict the ability of third-party payors to negotiate the form and rate of reimbursement with providers and require them to reimburse providers based on customary charges determined by the providers; these laws restrict the ability of managed care plans to develop cost-effective care;
- Require a managed care plan to pay the same fees to providers who are not included in its system as those who are which destroys the incentives necessary to develop a managed care system and undermine its purpose;
- Restrict the rights of sponsors of managed care plans to contract selectively with a limited number of providers. This limitation prevents managed care plans from contracting with providers who meet their practice standards;
- Restrict the right of plans to utilize primary care physicians in a gatekeeper role which limit plans' ability to ensure that appropriate and cost-effective treatment is provided;
- Limit the co-payment that a managed care plan may require a beneficiary to pay when a non-plan provider is used. These limits undermine the ability of a plan to give sufficient incentive to patients to use the network of cost-effective providers;
- Prohibit utilization review of certain treatments or conditions which guts a critical element of managed care; and
- Require utilization review decisions to be made by residents of the state in which the treatment is offered. These requirements make it difficult for national companies to participate in the local market and add unnecessary costs.

The artificial barriers I've described, constrain our ability to meet consumer demand for managed care programs and deprive our customers and the nation of the savings and quality assurance associated with managed care. These activities are not isolated events. Over 219 pieces of anti-managed care legislation have been introduced in 45 states since January 1st of this year alone. These proposals do not come from our customers but from special interests in the health care industry. Cli-

ents/patients are satisfied wit.1 managed care as evidenced by the results of our member surveys.

MANAGED CARE FOR GOVERNMENT PROGRAMS

A second critical role for government is in the area of contracting for its own beneficiaries and employees. We would urge you to set the health policy direction for the country through the use of managed c:re in government programs.

An obvious but major step would be to improve the efficiency of Medicare and Medicaid through managed care. Medicare and Medicaid have employed utilization review techniques for a number of years and have used HMOs in a very limited fashion. The current program of HMO Medicare Risk Contracts doesn't pass muster in the marketplace. It relies on individual sales and enrollments (and we've seen how that may cause problems) and fails to take advantage of the predominant method of providing health benefits through the employer. The employment-based approach offers important consumer protections, lower costs, economy of scale, and has the potential for real dramatic growth. We have a whole generation of "managed care" employees who will edge back into the costly fee-for-service systems unless you take action.

I would urge you to apply the network-based financial incentives and case management techniques that work in the private sector to Medicare and Medicaid as well. Other government programs such as those covering Federal employees, the military and veterans also could make more extensive use of network-based managed care programs. In addition, the various workers' compensation coverage plans would benefit from application of managed care techniques. If some controls aren't applied soon, this historically valuable no-fault system will follow the track of personal auto insurance with availability decreasing and costs increasing. Again, the potential for savings are significant, and we and others in the industry are prepared to work with you in developing legislation that could assist in expanding the use of the managed care concept.

Managed care can only succeed as a means of controlling national health care costs if it is broadly implemented. A few cases or even a few hundred cases of substantial size will have a very modest impact in containing costs and modifying physician behavior. Conversely, if managed care is broadly implemented, it will have a major impact on costs and quality. Almost all of the major health care reform measures as far as we know, include provisions to promote the development of managed care through limitation on state restrictions to managed care. We are very encouraged by this movement and would urge your support for managed care as well.

CONCLUSION

Mr. Chairman, on behalf of myself and my associates from CIGNA Corporation, we thank you for the opportunity to appear before your committee. We believe managed care is an important element in the battle against rising health care costs and related problems of access to care.

PREPARED STATEMENT OF JOHN J. POLK

The Council of Smaller Enterprises (COSE) is part of the Greater Cleveland Growth Association, Cleveland's Chamber of Commerce. With over 10,000 small business members, COSE is the largest local small business group in the country.

COSE operates one of the largest proprietary health plans for small employers in the U.S. Some 8,000 member companies provide coverage to over 60,000 workers and a total of 145,000 Greater Clevelanders. Member companies will invest $165 million in premiums with sponsored carriers in this contract year.

COSE's programs are unusual in a number of ways. While the group itself is very large, the average size of a company participating in the plans is a company with 8 employees; two-thirds of enrolled groups employ fewer than 5 workers. About 20% of enrolled member companies had no group health coverage prior to joining COSE. Groups with coverage prior to joining COSE report their group health premiums are reduced by 35% to 50% when they join COSE. Since 1984, the average annual rate increases for COSE's plans have been less than 7%, less than a third of the average trend factor increases for insurance carriers' small group plans. And COSE's business is profitable for its insurers.

Four factors are critical to the success of COSE's plans. The group's huge size gives COSE significant negotiating power with area insurers and providers and also confers a high level of actuarial credibility upon the group. COSE's philosophy of aggressive management enforces accountability on both its insurers and its members to keep the program a good deal for all parties. COSE's information system enables it to monitor enrollment, utilization, and financial data for all its plans better than its individual carriers can do it. Most importantly, COSE enjoys a uniquely productive and creative partnership with its insurers.

There are many problems in the small group health care market which can be addressed through a program of aggressive, consolidated, purchaser-driven management. The COSE plans demonstrate that the private sector can deal effectively with the dual challenges of access to affordable health care coverage for small employers if its wishes to be creative, businesslike, and relentless in the pursuit of well-articulated goals.

The Council of Smaller Enterprises (COSE) is the small business division of the Greater Cleveland Growth Association, Cleveland's Chamber of Commerce. COSE is the largest organization of its kind in the country, with more than 10,000 member companies.

One of the most important reasons for our membership growth is the opportunity member companies have to participate in what we understand to be the nation's largest proprietary health plan for small employees. Nearly 8,000 of our 10,000 member companies participate in at least one of the dozen group health care plans which we sponsor on behalf of our members. Those 8,000 companies provide coverage through our plans to over 60,000 local employees and, together with their dependents, about 145,000 Greater Clevelanders — about 1 out of every 10 residents of Greater Cleveland.

Lots of local Chambers have sponsored group health care plans for their members, and some of the plans are even pretty good. What elements of the COSE plan are so unusual?

Clearly, the first unusual element is our size. A company with 50,000 employees nationally would be considered a huge purchaser of health care services. With 60,000 employees in a local community, the COSE plan is a monster, with enormous leverage in our local marketplace.

Yet despite our huge size, the COSE program is composed of thousands of small units which, by themselves, would have precisely zero leverage in the same local marketplace. The average size of a company participating in our plans is a company with about eight employees; some two-thirds of our member companies employ fewer than five people. This is very significant in the health care debate because our program is operating quite successfully in a segment of the marketplace which is not viewed as particularly attractive by insurers, and therefore, where the national problem of the working uninsured is particularly intractable. Eighty percent of the business units in this county employ fewer than ten people, and it is among these companies, the smallest of the small, where group health insurance coverage is least available and least affordable.

Another unusual element of our plans is that, based on our monthly surveys of every new member company applying for our plans, about 20% of our new members tell us that prior to joining

COSE they had no group health insurance coverage. There are three major reasons for this: the companies are brand new and have no track record in the marketplace, which makes them risky as customers in the traditional insurance view; they are very small, with only one or two employees, which means they are ineligible for group coverage through most insurance plans; and/or the prices of our plans make them affordable for small employers for whom coverage is generally quite expensive.

And our prices are very good. Of our new members who had health coverage prior to joining our plans, it is routine to hear that joining COSE's plans has reduced their health insurance costs between 35% and 50%. Our current winner is a one-contract group, a barber who's a sole proprietor, for whom joining our health plans meant a savings of $3,200 per year — and better coverage for his family. This little anecdote is particularly relevant to this committee given that, due to the wisdom of the Congress, this sole proprietor's health insurance premiums are paid for largely with after-tax dollars.

Because of these savings, our group is remarkably stable in terms of participation; fewer than 10% of our enrolled member companies will leave our plans in any given year, and half of those who leave will return to the plans within eighteen months. This is also against the prevailing wisdom in the insurance industry, where it is not unusual to see turnover in insurers' small group portfolios of 30% to 50% per year. Insurers tend to encourage this level of turnover since, the theory goes, the benefits of medical underwriting "wear off" after awhile, increasing the theoretical risk to the insurer, thus requiring insurers to find ways for "old" groups to leave and be replaced with freshly-underwritten business. Many insurers' rating practices are designed to reinforce this type of behavior, which is probably one reason that the typical small group sticks with one insurer for an average of two to three years before moving on. It is kind of ironic that insurers' practices encourage this kind of turnover, and then insurers observe that one of the reasons small groups are tough to insure is that they have no long-term loyalty as customers.

Yet despite the contrarian nature of our group with regard to turnover, our prices are very stable. Since 1984, the first year we had reliable data, the prices COSE members pay for their group health coverage have increased a cumulative total of 46.2%. In the same period, the trend-factor renewal increases charged by

commercial insurers to local small groups have increased prices by about 176%, based on our surveys of local insurance trends. Despite those price increases, most commercial insurers will tell you that they can't make money underwriting small groups. Our primary carrier, Blue Cross and Blue Shield of Ohio, makes money on our business, even at rates which are 35% to 50% below market.

At every step along the line, COSE's health care plans flout the prevailing wisdom and customary practice of the insurance industry generally. And yet COSE has gained a national reputation as a model for providing access to affordable health care coverage for small companies in the toughest segment of the market in a way which has produced significant long-term savings for our members and is profitable for our insurer. For the past five years, the experts have been saying this can't be done and have been waiting for our plans to self-destruct. They show no signs of doing so. We believe the experts are wrong.

Of course, we're not an insurance company. COSE is a purchaser, not an insurer. Our objectives are different. And I think COSE's experience demonstrates how vital is the role of an informed, aggressive purchaser-driven model to the achievement of small group health care reform.

What are the key elements of our success? The first, obviously, is our size and the concentration of our population within essentially a single delivery system. Two benefits come from this element. The obvious one is negotiating leverage, both with our insurer and, through our insurer, with the provider community. The other benefit is actuarial credibility. If one looks at COSE's program not as an agglomeration of 8,000 small companies, but as a universe of 145,000 people, it should be absolutely possible for our insurer to know precisely what their possible risk exposure is for problems ranging from normal births to cancer to AIDS. There is simply no reason for the COSE group as a group unexpectedly to "have a bad year." And the size of our group protects our individual member companies from the shock which comes from a single large claim. If a small company is rated on its own, such a problem could be devastating. But, as part of a large group, whose prices are set using a variation on community rating, there really is safety in numbers.

The second key element is aggressive management. We believe that, left to themselves, insurers have very little incentive to manage their small group portfolios efficiently and with the long-term interests of their customers in mind. Especially today, insurers are providing a much-needed commodity in a seller's market; they make the rules, and small companies either buy from them or don't.

COSE's primary role is as an advocate for our members as purchasers. We negotiate hard, and constantly, with our insurers to make certain they keep our members' needs in mind and do business as efficiently and fairly as possible. We negotiate the rules governing eligibility for our plans to keep them flexible. We negotiate our underwriting standards to make them as inclusive as possible. We negotiate our plan design, delivery systems, even marketing, sales and customer service. We negotiate over administrative costs. Without COSE, who negotiates on behalf of the small business owner in Cleveland?

On the other hand, our management philosophy must recognize that, for long-term value, our deal must be a good one both for our members and for our insurers. So we take steps to enforce the rules we negotiate with our insurers to be sure members stick by them. We are very strict about enrollment rules, to be certain our members are enrolling all their full-time employees and only their full-time employees. We audit members' payrolls annually to enforce compliance, help our members solve inadvertent problems, and encourage our insurers to go after those who flagrantly disregard the rules. Generally, insurers find such efforts expensive to conduct for themselves, leaving the effort to their agents, who are generally more highly motivated to make the sale than to enforce the rules. But we believe we owe it to our insurers to operate our program professionally and with our combined long-term interests in mind.

Third, we have a pretty good information system. Try to get comprehensive utilization data on the small group market from most insurers and you won't get it. Mostly that's because insurers don't maintain that data in any meaningful format. We have designed a comprehensive database through which we can assimilate enrollment, utilization and financial information which enables COSE not just to be on top of how our plans are doing are all the time, but also helps us to look back in time using historical information, and predict the future based on our past experience.

Because of this capability, we were able to spot an aberration in our primary insurer's utilization data reports over the past year of which they were unaware which, when it was resolved, saved our members about 10 million dollars at renewal time. If we hadn't caught the error, our insurer would have found itself ten million dollars richer — by mistake.

Fourth, and finally, the most critical element in our success really is the very special and productive partnership we enjoy with our primary insurer, Blue Cross and Blue Shield of Ohio (BCBSO). Usually one does not consider Blue Cross plans when one thinks of revolutionary innovations in small group health care. But, about ten years ago, BCBSO and its CEO, Jack Burry, recognized that, by working together and being willing to do business a little differently, we could achieve the goals of growth, efficiency, and service to our local small group market.

By far the biggest innovation was a qualitative one; our insurer chose ten years ago to regard COSE as a single customer, rather than a bunch of small ones, and to recognize that doing so, while it might pose some problems for BCBSO, would also make them more powerful. It is difficult to overestimate the quantum leap in understanding of the market that really is. Contrary to the current practice of the insurance industry generally, and to the spirit of their proposed small group reforms, which all revolve around a continuing desire to maintain the small group market as a highly fractionated mass of disenfranchised small retail purchasers, our insurer chose to encourage the formation of a healthy tension between COSE as a purchaser and BCBSO as a provider of service. All our size, knowledge, and expertise would have been for naught had not Blue Cross respected us enough to do business with us in a professional way. The results have been excellent, for both our organizations.

Here is another important observation. The COSE plan is a creature of the insurance environment in Ohio. The coverage we purchase for our members includes coverages for 14 providers and procedures mandated by state law. We receive no subsidies, no tax breaks, and no special consideration from anybody. Despite our success, many of our state elected officials, proponents of socialized health care reform, would like to put us out of business. Insurers don't like us much, and agents hate us, because we don't need agents (or their high small group sales commissions) to sell

our plans. Yet despite all these environmental pressures, the COSE plan continues to group and succeed.

You are all very familiar with the many factors which collectively result in diminished access and increasingly unaffordable costs for small employers. State mandates are a problem; Ohio's 14 mandates will cost our members about 20 million dollars this year.

Administrative costs are very high, generally, for small employers. COSE's administrative costs are about 11% of annual premium. In Ohio generally, insurers, including all the ones whose names you recognize, assess administrative costs ranging from 25% to 30% of premium to their small group subscribers. Agency commissions are a big piece of the differential.

Cost shifting is a problem. We're all generally aware of two levels of cost shifting: from the public sector to the private sector and from the uninsured to the insured population. Small companies face a third level of cost shifting: from large corporate purchasers to small businesses, the effect of the increasing aggressiveness with which large self-insured employers are negotiating directly with providers, and the continuing emphasis which insurers place on fee-for-service reimbursement plans in their small group business.

Problems with insurance industry practices have been widely discussed. It is easy to moralize over many practices, especially related to medical underwriting. Insurers are often regarded as evil, and exploiters of small groups. But insurers are behaving as the environment permits them to behave. I believe that by and large they don't know any better. And they have no market-oriented incentive to change fundamentally.

I do not believe our government is capable of micromanaging the implementation of small group health care reform. Irrespective of how Washington may choose to enact policy, reform will only be truly successful if it can be implemented efficiently at the grass roots, in local communities, with the flexibility to respond to unique community priorities.

I believe the COSE program demonstrates the enormous value of consolidated, purchaser-driven small group health care reform. And I believe the COSE program demonstrates that the private sector, when it chooses to behave creatively, can make reform

happen effectively in the voluntary marketplace. And I believe we've earned the right to be considered as a model for more comprehensive, community-based small group health care reform. Because COSE is not a theoretical model. COSE exists, and it works. Our plan is far from perfect. But from our perspective, we may be the best the private sector has to offer.

7

PREPARED STATEMENT OF UWE E. REINHARDT, PH.D.

My name is Uwe E. Reinhardt. I am Professor of Economics and Public Affairs at Princeton University, where I hold the chair of James Madison Professor of Political Economy. Much of my research in the past two decades has been devoted to health economics and health policy.

I would like to thank you, Mr. Chairman, and the members of your Committee for inviting me to testify on the major twin problems now confronting the American health system: the problem of providing *all* Americans, rich and poor, with access to needed health care and the problem of the ever rising cost of providing that access.

A. HEALTH SPENDING AND THE 'RATIONING' OF HEALTH CARE

Figure 1 exhibits the time path of total national health spending as a percentage of the Gross Domestic Product (GDP) during the period from 1960 to 1989 for a number of industrializid countries, including the United States. The growth in that percentage is not perfectly smooth primarily because the denominator--the GDP--has not grown smoothly over time. Health spending per se tends to grow at a much smoother pace, as can be seen in Figure 2, which presents the past and projected growth in *per-capita* health spending in the United States, after adjustment for inflation.

[Figures 1 and 2]

If one abstracts from the short-term wiggles in the growth of GDP (or its allied measure, the Gross National Product or GNP[1]), then one finds that in the United States, *on average*, the average annual compound rate of growth of total national health spending during the past two decades has outpaced the comparable growth-rate in non-health GNP by close to 3 percentage points. Figures 3 and 4 illustrate the projected future time path of that share for the United States, if the past differential between the two growth rates were to persist in the indefinite future. It is seen that we would be spending between 15% and 16% percent of the GNP on health care in the year 2000, close to 20% by the year 2010 and closer to 50% by the mid twenty-first century. Some more recent forecasts, reflecting *currently* observed growth rates, actually put these projections still higher. They forecast health spending for the year 2000 as between 16% and 17% of the GNP and well over 20% by 2010.

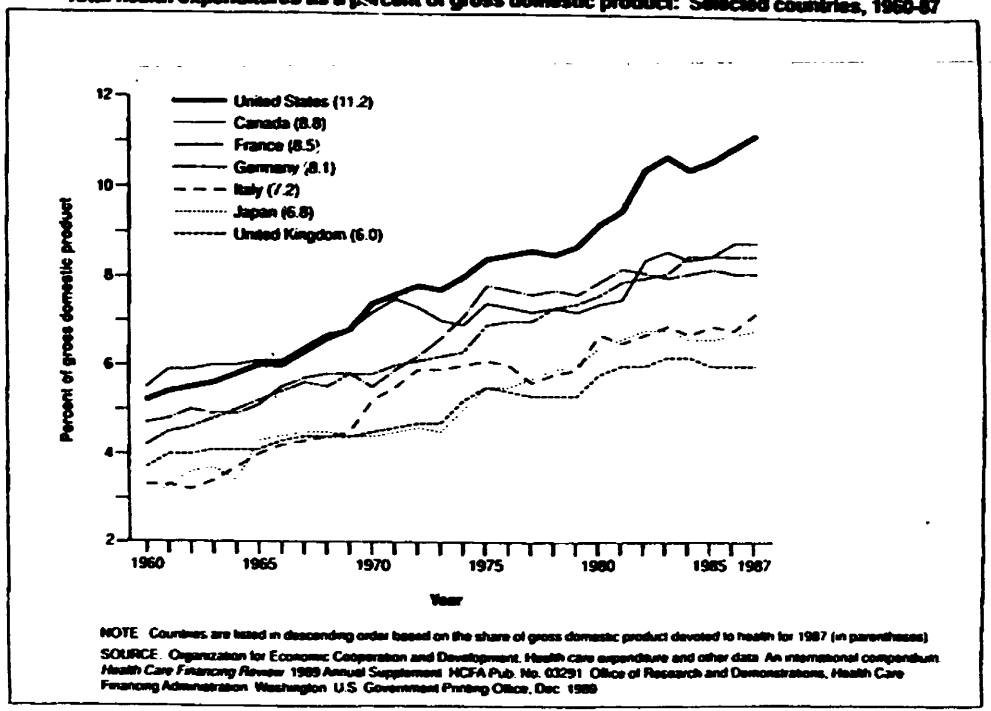
[Figures 3 and 4]

As is shown in Figure 1 other countries have experienced fairly rapid growth in their per-capita health spending as well, but on a much lower growth curve. This can be seen also in Figure 5, which depicts *per-capita* spending on health care in U.S. dollars (after

[1] The GDP includes all output produced in a given year within national boundaries, by whoever resided there; the GNP represents all output produced by a nation's citizens, wherever they may be. The two figures tend to move very similarly over time.

Figure 1

Total health expenditures as a percent of gross domestic product: Selected countries, 1960-87

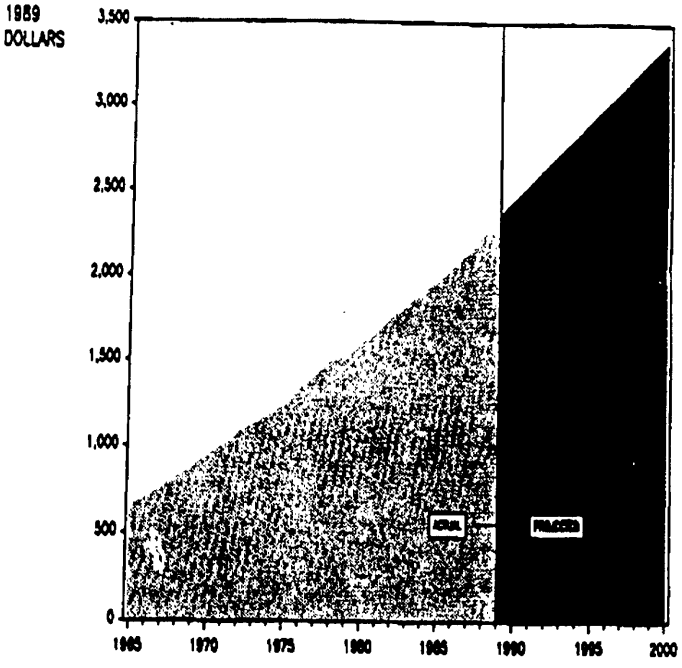


NOTE: Countries are listed in descending order based on the share of gross domestic product devoted to health for 1987 (in parentheses).

SOURCE: Organization for Economic Cooperation and Development. *Health care expenditure and other data: An international compendium.* *Health Care Financing Review* 1989 Annual Supplement. HCFA Pub. No. 03291. Office of Research and Demonstrations, Health Care Financing Administration. Washington: U.S. Government Printing Office, Dec. 1989.

Source: George J. Schieber, "Health Expenditures in Major Industrialized Nations," Health Care Financing Review, Summer 1990; Figure 1.

FIGURE 2. REAL PER CAPITA HEALTH EXPENDITURES, 1965-1989, AND PROJECTED TO 2000



SOURCE: Congressional Budget Office calculations based on data from the Health Care Financing Administration, Office of the Actuary, and Committee on Ways and Means, staff projections for 1990 and 2000. The latter are based on assumed rates of increase in health expenditures from the National Institute of Aging, Macroeconomic-Demographic Model.

NOTES: The projections assume an average annual real rate of growth of 4.0 percent between 1989 and 1990 and of 3.3 percent between 1990 and 2000.

The gross national product fixed-weighted deflator was used to calculate per capita spending in 1989 dollars.

Source: Congressional Budget Office, Trends in Health Expenditures by Medicare and the Nation, January, 1991.

FIGURE 3

HEALTH CARE AS A PERCENTAGE OF THE GNP

UNDER DIFFERENT ASSUMPTIONS

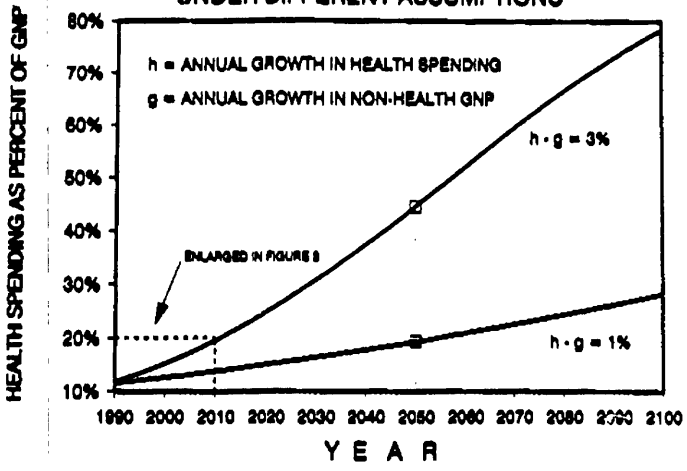
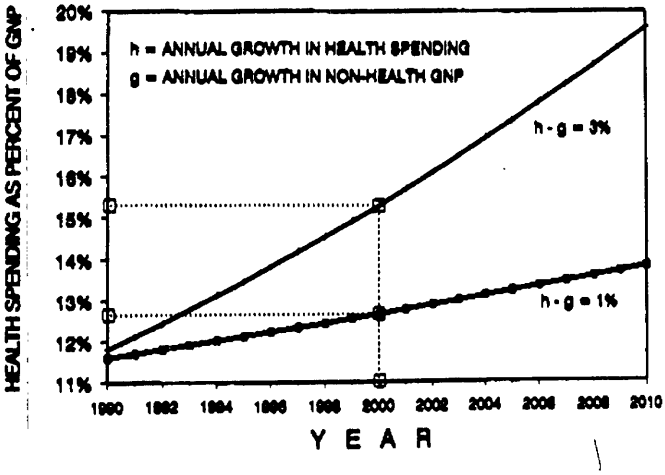


FIGURE 4

HEALTH CARE AS PERCENT OF THE GNP

UNDER DIFFERENT ASSUMPTIONS



adjustment for a purchasing-power parity index). As is seen in Figure 1, these other nations now typically spend between 8 and 9 percent of their GNP on health care. Furthermore, they have generally been able to hold that percentage at that level throughout most of the 1980s, while ours has grown from 9.1% in 1980 to an estimated 12.4% this year.

[Figure 5]

Research has only recently begun to explore precisely what these countries' citizens miss in health care that we Americans do get for our much higher spending. That research can be quite illuminating and merits your continued support. It is well known, of course, what citizens in other countries do get in health care and what millions of Americans do not get: *the peace of mind that comes with stable, comprehensive, rock-bed health insurance.*

At this time, some 35 to 37 million Americans are without health insurance coverage, more than half of them permanently. About two thirds of the uninsured are full-time workers and their dependents. Typically, they work in small, low-wages business firms. About a third of the uninsured are children. It is known that, other things being equal, uninsured Americans with low incomes tend to receive only about 60% of the health services received, on average, by comparably situated insured Americans. It is also known that, other things being equal, uninsured Americans tend to die at higher rates from given illness, presumably because they do not obtain remedial medical intervention earlier on.

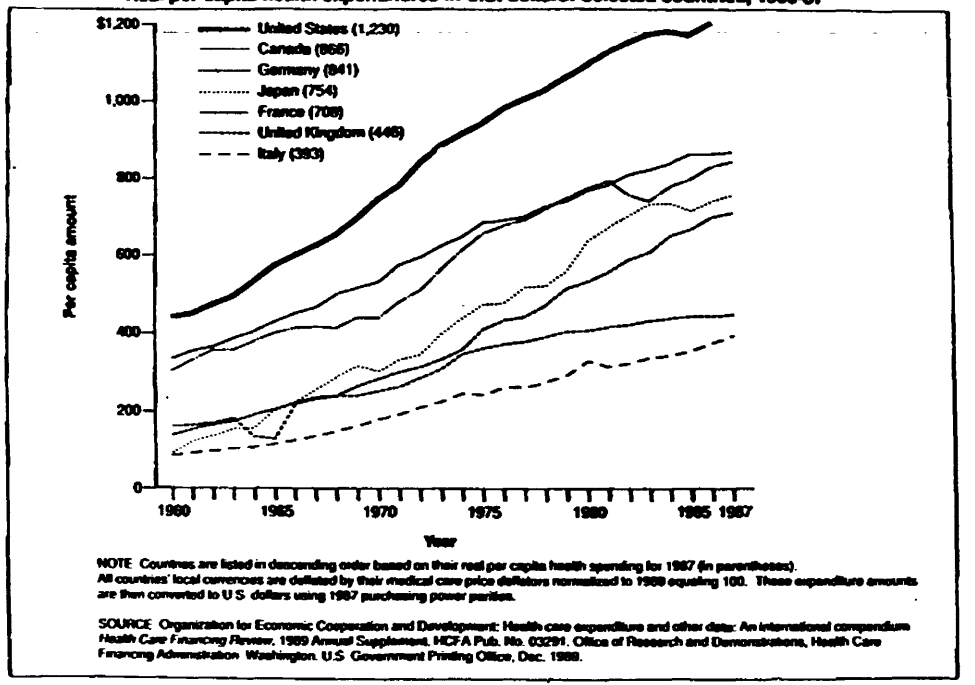
Spokespersons for the American health sector have traditionally accused other nations--particularly neighboring Canada--of "rationing" health care. These spokespersons have warned that some of the health-care reform proposals now before the Congress raise the horrible specter of "rationing" in the United States as well. As a long-time student of American health care, and as an immigrant whose social ethic has been forged elsewhere, I have always been puzzled by that American posture, which strikes me as peculiar. After all, that posture comes in the midst of fairly widespread and quite overt rationing of health care by price and income in this country.

To be sure, most other countries do withhold some high-cost, high-tech health care from all of the people, rich and poor, through formal health-sector planning. By contrast, the United States has traditionally made virtually all imaginable health care easily available to most of its people, but it has withheld a wide number of needed services from millions of its poor and uninsured citizens. To accept that two-class health policy with equanimity, as this country has so far done and is likely to do for some years to come, is to adhere to the ethical principle that rationing of needed care by income and price is morally acceptable, presumably because it is a normal feature of the market place, while withholding something from someone who would be able to pay for it is wicked. In other words, the horror appears to arise not over the specter of witholding from poor citizens needed health care of which this nation actually has a surplus! The horror appears to arise over the erosion of the market ethic in health care.

The ethical precepts implicit in what we Americans actually do in health care may be acceptable to the bulk of us as, apparently, it is. It certainly would not be acceptable to the bulk of the citizens of other industrialzied nations, not even to otherwise politically conservative citizens. It is not for me to render judgements on such differences in social

Figure 5

Real per capita health expenditures in U.S. dollars: Selected countries, 1960-87



NOTE Countries are listed in descending order based on their real per capita health spending for 1987 (in parentheses). All countries' local currencies are deflated by their medical care price deflators normalized to 1989 equaling 100. These expenditure amounts are then converted to U.S. dollars using 1987 purchasing power parities.

SOURCE Organization for Economic Cooperation and Development: Health care expenditure and other data: An international compendium *Health Care Financing Review*, 1989 Annual Supplement. HCFA Pub. No. 03291. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Dec. 1989.

Source: George J. Schieber, "Health Expenditures in Major Industrialized Nations," Health Care Financing Review, Summer 1990; Figure 7.

ethics. At the same time, a detached observer *can* remind Americans that they have no evidently superior moral platform from which to cast aspersions at the quite different approaches to the "rationing" of health care pursued in other countries.

D. MUST UNIVERSAL HEALTH INSURANCE AWAIT BETTER COST CONTROL?

Many Americans argue that, with respect to the poor, their social ethic actually does not at all differ from the dominant ethic shared in Europe and in Canada, but that universal health insurance simply cannot become a reality in this country as long as American health care remains as expensive at it is. Not uncommonly, that remarkable proposition emanates from well-paid, well-heeled and well-insured executives in the private and public sector who believe to be protecting thereby the future of this republic.

To appreciate the moral foundation of this remarkable proposition, it is helpful to imagine such a well-paid, well-heeled and well-insured executive addressing that proposition, *face to face*, to a uninsured mother of three, working full time at some low-income job, and valiantly struggling alone to shape her three youngsters into healthy, productive Americans, some of whom might even become soldiers and fight wars the executive's own offspring might prefer to avoid. It would be an awesome scenario to behold, all the more so because that well-heeled executive will have his or her health insurance purchased, courtesy of the Congress, with *pre-tax* dollars, a tax shelter now showering billions of dollars upon the middle- and upper-income classes who obtain their coverage from their place of work.

The seemingly sensible and politically popular adage "cost-control first, access later" can actually camouflage a hidden intent to postpone forever better access to health care for all Americans, rich and poor. As already noted, at this time American health spending is projected to reach about 16% to 17% by the year 2000. Suppose with much effort the nation succeeded, during the 1990s, to keep that percentage as low as 14. If so, that percentage would still be likely to tower over the percentages spent on health care by other industrialized nations. The actually rather successful cost-containment effort would be decried as a failure. The poor, uninsured would be told to wait just a little longer, until the nation's health-policy thinkers and tinkerers have come up with the ultimate panacea. It will never come.

Ideally, one would want to broaden access in tandem with better cost control. Perhaps that can be done soon, if the Administration and the Congress can muster and concentrate the needed political leadership to that end. In the meantime, however, a nation so proudly claiming for itself a special moral foundation ought to proceed speedily to provide health insurance at *all* Americans, at an average per-capita cost roughly in line with that already being spent by those lucky enough to be insured. That is not a bold and economically reckless proposition; it is one compelled by common decency, and one that is eminently affordable from a strictly economic point of view. At this time, probably only about $ 40 billion or so would be added to the $ 700 billion total national health spending if all of the uninsured were brought up to the average level of health spending enjoyed by

the rest of Americans. It is hard to imagine how that added outlay could break the proverbial "bank," our nation's $ 5 trillion-a-year economy.

Much of the testimony before this Committee so far has dwelt on the theme that current trends in our national health spending will be detrimental to the future growth of our economy. There is something to this argument, although usually it is miscast. In the following section, I would like to offer some observations on this issue.

C. DOES HEALTH SPENDING HINDER ECONOMIC GROWTH?

The argument that health spending harms economic growth comes in two distinct versions.

First, at the macro-economic level it is argued that health spending is consumption and, as such, displaces investment, which includes education and research and development. Because investment is known to enhance longrun economic growth, it may seem to follow that health spending detracts from economic growth.

Second, at the micro-economic level, it is argued that when health spending is funneled through the payroll-expense accounts of business firms, added health spending drives up production costs and thereby the prices of American products. Consequently, it is argued, American exporters are at a competitive disadvantage in world markets and foreign imports gain a competitive edge over American-made products in the United States. Many business executives appearing before this Committee probably have offered that thesis.

Both arguments have enormous intuitive appeal; but both of them are seriously flawed, as I have explained at greater length elsewhere[2].

With respect to the first argument--that health spending displaces investment--one can offer two observations. First, a good part of health spending is, in fact, not consumption, but a *bona fide investment* in the sense that expenditures in one year enhance the individual's productivity and quality of life in future years. Second, even if we arbitrarily declare health spending to represent consumption, *all* forms of consumption detract from investment. It is not clear why health-care per se should be the chief source of a shift of real productive resources from activities that support consumption to those that support investment. Indeed, it is not hard to think of alternative candidates, including the often mindless litigation to which this country devotes its brightest minds, the production and marketing of harmful legal drugs--such as alcohol and tobacco--and the rather exuberant

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[2] See Uwe E. Reinhardt, Health Care Spending and American Competitiveness," *HEALTH AFFAIRS*, Volume 8, No. 4, Winter, 1989; pp. 5 - 21 and testimony before the Joint Economic Committee of the Congress of the United States, Hearing on *Rising Health Care Costs: Are They Really Making it Harder for U.S. Firms to Compete?*, 101st Congress, Second Session; May 23, 1990.

consumption of energy in this country. To single out health care as a source of funding for investment is to argue that a dollar of spending on health care will add less to human happiness in America than would a dollar of health spending on other consumption. While that may well be the case, it needs to be demonstrated. It is a task for cost-benefit analysis.

With respect to the second argument, that health care prices American products out of world markets, we may observe that this nation's employer-provided health insurance is merely one of many fringe benefits that form workers' *total compensation*. Economists remain convinced that fringe-benefits and cash take-home pay tend to be substitutes for one another in the longer run. On that perspective, it is more reasonable to argue that high corporate outlays on health insurance premiums come at the expense of workers' cash take-home pay. Here, too, the question becomes whether through its good offices the business firm procures better value for employees through spending on health care than employees could achieve by having added cash to spend as they see fit. Once again, we are left with a call for better benefit-cost analysis, but not with a call for cost control as a policy target in and of itself.

If health-insurance premiums paid by business do not cause business problems in the product markets (unless business *chooses* to price unwisely there), does it then follow that the level and growth of these premiums are of no concern? Not at all.

First, low-wage industries eventually will find it difficult and impossible to reduce their workers cash wages in step with the growth of the workers' fringe benefits. At some point the cash wages than can be offered will be so low as to drive workers out of the afflicted industries altogether. That plight would be likely to affect mainly the small business firms who employ low-wage workers and who are charged by the insurance industry premiums up to double the premiums comparable policies cost large business firms. That phenomenon, however, is not the result of the level of health spending per se. It is a product of the incredibly awkward manner in which this country has chosen to finance whatever the level of health spending may be--or, which might be a better way to put it, into which this nation has stumbled over the years without much thought about the ultimate consequences of that haphazard approach.

D. PRIVATE HEALTH INSURANCE: THE BRITTLE CORNERSTONE OF THE AMERICAN HEALTH SYSTEM

Suppose members of this Committee were charged with the task of designing, from scratch, a method of financing American health care in a manner that conforms with publicly *professed* principles of social equity and the citizen's desire for an insurance policy that provides peace of mind. Would your Committee be likely to emerge from that effort with a system whose cornerstone--covering the bulk of Americans--is an uncoordinated mosaic of private, unregulated insurance policies each of which is *tied to a particular job in a particular company* and which is priced (ultimately to the insured) by means of a *head tax*? Would that be a sensible approcah for a country embedded in a highly dynamic, global economy that makes every job in Peoria hostage to managerial decisions in Tokyo, Taipei,

Frankfurt or Singapore? Yet, that is precisely the health-care financing system this country has evolved over time, with the active encouragement of the Congress.

Indeed, it can fairly be said most of the problems now faced by American business in connection with health care stem from these awkward design features, rather than from the overall level of national health spending per se. Furthermore, it can also fairly be said that the evident lack of control over spending that this system affords society is an inherent feature of this awkward cornerstone of health-care financing.

At this time, even a well-insured American workers must fear the loss of health-insurance coverage for self and family, should his or her company undergo a so-called restructuring which, in plainer English, typically implies the firing of middle-aged workers and their replacement by cheaper, younger workers. Should that worker be laid off and seek private coverage on an individual basis, he or she would find that coverage enormously expensive, even if all family members were perfectly healthy. Should even one family member be chronically ill, that coverage probably would not be available at all, because our private insurance industry has become ever more adept at judicous underwriting aimed at screeing out high risks.

The industry's current underwriting practices and its so-called *actuarially fair* insurance premiums actually are based on the social ethic that healthy Americans ought not to subsidize with their insurance premiums their sick fellow Americans. As one clever pundit recently put it, the much praised cornerstone of private American health insurance had better be call health-*unsurance*. Inevitably, the private sector's traditional approach enlists the public sector as the private inusrance industry's shovel brigade, as this Congress will appreciate when more and more low-income workers in small business enterprises will find themselves on the street during this decade without employer-provided health insurance.

At this time, the private insurance sector claims to cover about 85% of the American people; yet it accounts for only 32% of health spending. If that industry continues on its current march, it may still enroll as many as 60% of the population by the end of the decade, but pay for less than one fifth of all health care. It is a march to gradual extinction.

To serve this nation better--indeed, to survive at all--our private insurance industry must develop an insurance product that is, at the very least:

1. portable from job to job and into retirement

2. community-rated rather than experience-rated

Portability of insurance coverage would force upon American citizens some badly-needed *life-cycle* planning in health care; it would also remove the inherent brittleness of our current system of health-*unsurance*. Community rating would go a long way to making health insurance more affordable to small business firms one third of whose premiums are now often absorbed by administrative costs of the insurance carrier alone! In the end, however, even a community-rated health-insurance premium, if mandated upon business, remains a simple *head-tax* upon employment that may make it difficult for low-wage industries to survive. As I argue below, in the end such industries will require assistance either in the

form of tax credits or by means of so-called pay-or-play mandates, where payment in lieu of insurance takes the form of a percentage payroll tax, rather than a head tax (see Section E below).

All other industrialized nations now offer their citizens insurance coverage that meets at least the two standards listed above. If the American insurance industry cannot meet these standards on their own, it should either be forced to do so through public regulation, or it should be replaced altogether with a superior alternative. Some policy options to that end will be described in Section E.

E. METHODS OF COST CONTROL

None of my remarks concerning the effects of the nation's overall health spending on the American economy should be taken as a defense of current and projected levels of that spending. On the contrary, there is ample evidence that much of current spending is highly suspect from the viewpoint of benefit-cost analysis[3]. Furthermore, as I have argued at greater length elsewhere and shall argue below, American business, much more so than American government, has been the chief culprit behind this profligacy[4] and, indeed, behind most of the financial woes now besetting our health sector.

My point merely has been to cast doubt on the much mouthed propositions that health spending *per se* detracts from this nation's economic growth (1) because it comes at the expense of capital formation and (2) because it renders American business non-competitive in world markets for industrial products. Those are not the crucial issues at all. The central issue is strictly one of benefits and costs: *do we always get our money's worth in health care?*.

On this question, the U.S. Congress actually deserves praise for having funded, throughout the past two decades, some fundamental health-services research addressed to that very problem, and especially for having established, under OBRA 89, the Department of Health and Human Services' new and better funded Agency for Health Care Policy Research (AHCPR). Furthermore, on this point the much maligned Federal bureaucracy deserves high praise for the vision and the professional expertise with which it has managed the allocation of scarce health-services research dollars to the question of clinical outcomes and appropriateness, research that started as early as the mid 1970s.

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[3] For an easily readable compilation of such evidence, see Robert H. Brook and Mary E. Vania, *Appropriateness of Care: A Chart Book*, Washington, D.C.: National health Policy Forum, George Washington University, June, 1989.

[4] See Uwe E. Reinhardt, *op. cit* and "HEALTH CARE: Business forgets it created the mess. Now it must own up to its mistakes and help find a cure. *Business Month*, October 1990; pp. 56 - 57.

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Remarkably, American business and its ally, the American health-insurance industry, which collectively finance close to a third of all American health spending, have hitherto contributed next to nothing to this fundamental research effort. In fact, until very recently, both the business sector and the insurance industry have passively lavished massive funds upon the health sector with nary a thought ever given to the value they have procured with these expenditures. Although at this time the private sector claims to "manage" the procurement of that care more prudently so as to enhance the benefit-cost ratio of that care--an effort still confined to a very few companies--those efforts proceed almost wholly on the basis of the fundamental research methodology developed with Federal funds, under the auspices of the Federal bureaucracy. It can fairly be said that, without that much maligned bureaucracy, American business today would not even have an inkling that a significant proportion of the health care it procures for its employees is of truly dubious value.

In thinking about better cost control for health care, private and public policymakers should keep in mind a crucial distinction of the term *costs* in this context. Specifically, are we talking about the so-called *opportunity-cost* of health care, or do we have in mind the *transfer cost* of that care. As already noted, the *opportunity cost* of health care is the output society forgoes by having health workers and other real resources active in health care rather than in other worthwhile economic endeavors, such as teaching. The *transfer* cost of health care refers to the slice of the GNP that the rest of society must cede to the direct and indirect providers of health services. Figure 5 illustrates that important distinction.

[Figure 6]

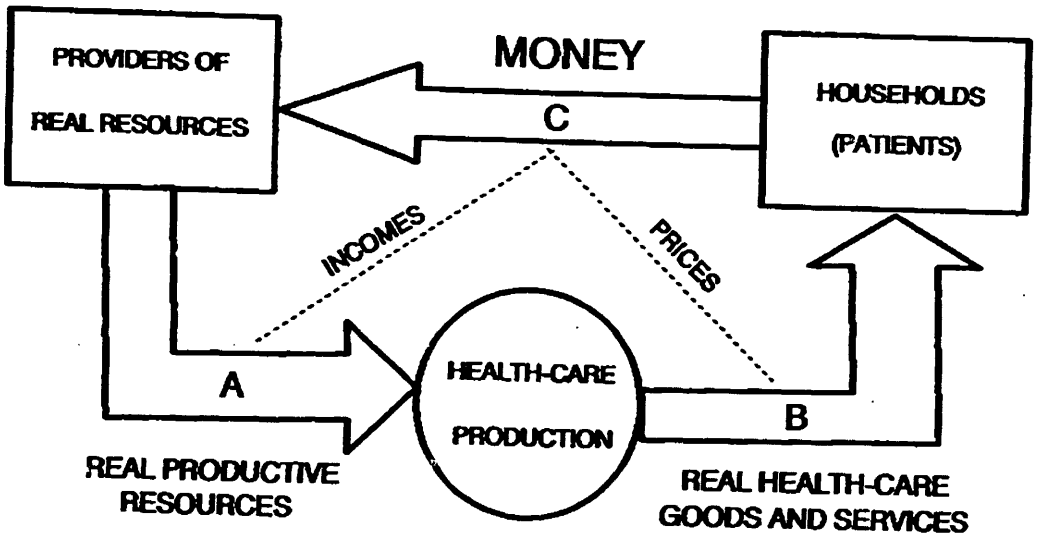
As is shown in Figure 6, two quite distinct resource flows surround the process of health care: the flow of *real resources* (for the most part, human labor) going to patients and the flow of *financial resources* going to the owners of these real resources. The much-cited percentage of the GNP going to health care actually does not at all go to patients; it is the provider's financial reward for whatever they did for patients.

Although Figure 6 illustrates the obvious, it is amazing how little the obvious seems to be understood in our debate on health policy. For example, very often before this Congress it is being argued that any diminution in the flow of *financial resources* to providers will *necessarily* trigger a reduction in the flow of *real resources* to patients. Many members of this body seem sincerely to accept that proposition as they deplore the legendary budget "cuts" (actually, less than hoped-for increases) proposed in the annual Federal budget.

In fact, it is not at all clear why the linkage between money and real resources in health care should be as tight as these arguments suggest, for the intervening variable is the money transfer per unit of real resource--the prices of health services and the hourly monetary rewards earned by the providers of real resources. By international standards, American society has traditionally made very generous money transfers to the owners of these real resources. Relative to average compensation of other Americans, American health workers--including doctors, nurses, hospital administrators, insurance executives, consultants, professional health-services researchers and policy analysts--are all very well paid .

FIGURE 6

THE FLOW OF REAL AND FINANCIAL RESOURCES IN HEALTH CARE



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As they contemplate the future of the American health sector, the Congress and American society at large will have to explore two rather distinct questions related to the issue of cost control:

> **Could the nation's real health-care resources--that is, many bright Americans now devoting their time to health care near patients or in research labs--render more value in other activities?**
>
> **Must the generous money transfers Americans make to the owners of health-care resources, appreciated as they have been by their recipients, really be quite that generous as they have been in the past to attract whatever real resources are truly needed in health care?**

As already noted, by funding fundamental research on the appropriateness of medical treatments, the United States Congress and the executive branch of the Federal government have already taken bold steps to explore the first question. The research so funded will make the United States the unchallenged world leader in this type of inquiry. As noted also, American business has yet to contribute significantly to this fundamental research.

In its arduous attempts at reforming the payment of doctors and hospitals under the Medicare program, Congress and the Federal bureaucracy has for some time now wrestled with the second thorny question listed above, that is, the money transfers (prices) to be paid providers per unit of health service. There has been considerable progress in improving the bases upon which that payment is made. To this end, the Department of Health and Human Services has developed uniform relative-value scales for both hospitals (the so-called Diagnostic Related Groupings or DRG) and for physicians (the so-called Resource-Based Relative Value Scale or RBRVS). With these schedules it ought to be much easier to *negotiate* with providers fair and relatively efficient prices for health services. Yet to be develope, however, is an institutional framework in which such negotiations can take place. In this area the experience of other nations can yield valuable insights for American policymakers.

Once again, the bulk of American business has sat idly on the sidelines as that work on provider compensation has proceeded in the Federal bureaucracy. So far, the bulk of the American business community has continued to transfer passively whatever money transfers the providers of care impose on business, all the while wailing before the Congress over the alleged impact of this fiscal hemorraghe on "American competitiveness." The recent wailing by the business community before this Committee, for example, has been both pitiful and pitiable--pitiable, because it contained so few logically coherent proposals for a solution to the nation's problems in health care.

Probably the best approach for the Federal government, at this time, would be to leave the private sector to its own devices for some time to come, at least until the problems that business leaders will experience in the labor markets there have matured to the point that these

business leaders will literally be forced to develop and to articulate a more coherent health policy they would support. To help the business sector now would impose upon Congress the risk of absorbing the blame for anything that might go awry in the future. As the memebers of this Committee undoubtedly have learned, it seems to be a standard posture among America's business leaders always to blame upon "government" errors of the business community's very own making.

Other industrialized nations have been relatively more successful than has the United States in containing the slice of the GNP allocated to health care. Almost all of them do this through two or three control devices used in combination:

1. **Control over the flow of *real resources* (hospital beds and high-cost, high-tech equipment) into the health system.**

2. **Formally negotiated limits on the prices of health services.**

3. **Formally negotiated overall expenditure caps on parts or all of the health sector.**

One suspects that, ultimately, the United States will embrace such control devices as well. At this time, however, the institutional framework for their implementation--for example, regional bodies that can negotiate binding fee schedules and global budgets--is still lacking. In the meantime, we shall continue to rely upon a mixture of unilaterally set prices established by government and "charges" or "capitation rates" in the private sector, the latter being whatever money transfers the providers of health care manage to extract from private payers. We shall probably remain with that mixture for most of the current decade.

F. OPTIONS FOR PROVIDING UNIVERSAL HEALTH INSURANCE

Very broadly speaking, the millions of currently uninsured--and yet to be uninsured--Americans could be granted access to needed health care either through (A) publicly provided health-insurance, or (B) publicly owned and operated health clinics and hospitals. Figure 7 layout these options schematically.

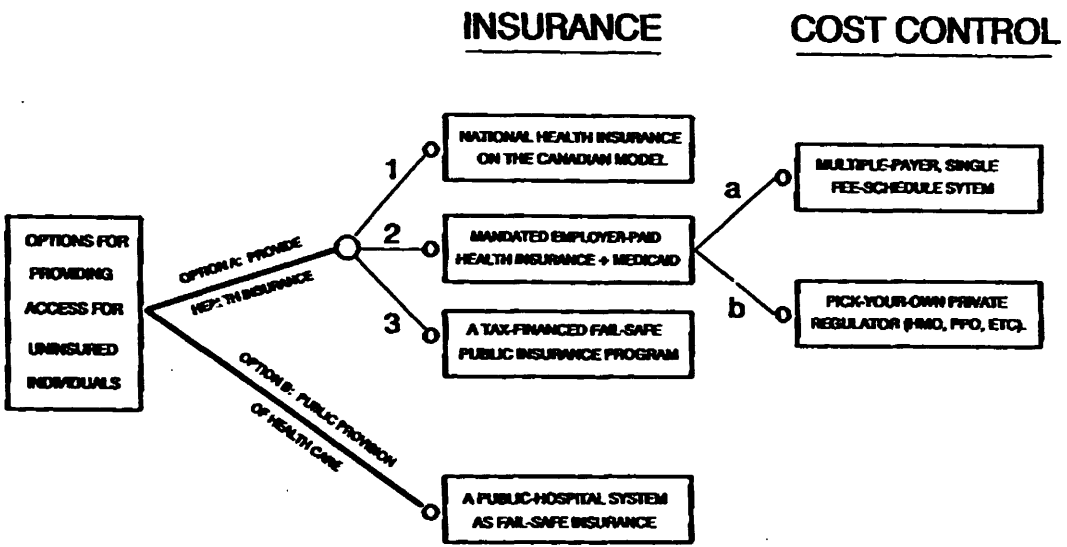
[Figure 7]

1. Option A--Public Provision of Health Insurance

Government at either the federal or the state levels can extend comprehensive health-insurance to all citizens through three broadly distinct approaches.

FIGURE 7

ALTERNATIVE OPTIONS FOR PROVIDING UNIVERSAL HEALTH INSURANCE



National Health Insurance: First they can, as Canada has done, act as the sole provider of basic health insurance and the single payer of providers. As is well known, Canada does appear to have demonstrated its ability to operate such a system to the relatively high satisfaction of its populace, although it spends only about 8.7% of its GNP on health care, compared with our 12.4%. Whether one surveys Canadians about the quality of their *health system* overall or about the quality of their *health care*, they tend to show greater satisfaction with their health sector than do Americans at this time.

It is unlikely, however, that the Canadian approach could easily be grafted onto the United States any time soon, if ever. The strategy implies the virtual dismantling of the private health-insurance sector and, as is well known, would be likely to trigger the staunch opposition of the entire provider community as well. Nation's with parliaments, in which the reigning administration can count on party discipline, may be able to overcome such powerful political obstacles. Canada obviously did. Our Founding Fathers deliberate crafted for us a weak system of governance, one that would have much greater difficulty of producing a coherent and *workable* health insurance plan on the Canadian model, even if the public at large wanted it, as some surveys suggest it does[5]. With all respect due the members of this legislative body, if the ironically titled *Tax Simplification Act of 1986* is any guide, one is not encouraged to believe that this Congress would be able to legislate what a Canadian-style health insurance would require for its implementation.

Mandated, Employer-Provided, Private Insurance: An alternative to the Canadian approach would be to *mandate* all private employers to offer their employees a specified, comprehensive, private health-insurance package. It is the second insurance option shown in Figure 7. Because over two-thirds of all uninsured are full-time workers and their dependents, that approach would sweep the bulk of the currently uninsured into the private health-insurance system, leaving the remainder to be picked up by the public Medicaid program for the poor, or by some other public risk-pool.

Mandated employer-provided insurance is, of course, a pseudo tax upon the private sector, but one that does not flow through public budgets and thus may not be perceived by the general public as a tax increase. Therein lies its considerable political appeal. Its main drawback is that it is a head-tax upon employment, rather than a flat percentage of payroll. As such, the strategy may be burdensome to low-wage industries, unless the strategy took the form of a so-called *pay-or-play* plan allowing a firm either to provide insurance or to pay a tax of X% of payroll.

As is shown in Figure 7, a mandate upon employers to provide their workers health insurance could be coupled with a multiple-payer system under which all payers in a region paid given providers the same fee for the same service. (Branch 2a in Figure 7). That approach would lean on the West German health system, which keeps the great bulk of health spending out of public budgets. To implement it, however, Congress and the states

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[5] See, for example, Robert J. Blendon, "Three Systems: A Comparative Survey," *Health Management Quarterly*, vol. XI, No. 1, First Quarter, 1989; pp. 2-7.

would need to evolve the quasi-public bodies that could negotiate binding fee schedules of this sort. In this respect, the German health-insurance can offer a rich lode of experience.

Alternatively, one could couple a mandate upon employers with the type of managed-care system long advocated by Paul Ellwood and, more recently, by Alain Enthoven. Under that approach, the insured select their own private regulators--for example, competing, private HMOs--and the latter would bargain over fees, utilization and budgets with providers (branch 2b in Figure 7). Remarkably, the managed-care approach has not caught on very well so far, although it has bee proposed to the American public ever since Paul Ellwood first obtained President Nixon's formal support for the idea. Perhaps the recent upward surge of health-care cost will make it easier to implement the system. Congress might show the way by imposing it more forcefully upon Federal employees and upon the Medicare program.

Voluntary Private Insurance with a Public Fail-Safe Program: As a third option, one could leave the matter of employer-based health insurance a private matter to be negotiated *voluntarily* in the labor market and simply mandate the individual to be insured. Those not covered by private insurance would be automatically included in a tax-financed, public Fail-Safe health insurance system--for example, the current Medicare program, or a substantially enlarged and upgraded Medicaid program with uniform national standards and substantial federal financing. Part of the requisite financing could come from a regular payroll tax, part from earmarked income taxes, and part from sales taxes--especially a tax on gasoline.

Coupled with a tax-financed Fail-Safe option could be strong financial inducements (e.g., subsidies or taxes) for private employers to offer their employees health insurance "voluntarily." Such schemes are now known as "Pay-or-Play" plans. Depending upon the strength of the fiscal inducements, a "Pay-or-Play" plan may border either on a purely *mandated* health insurance or on the pure Fail-Safe approach. In Figure 6, these "Pay-or-Play" plans fall somewhere between the second and third insurance branches.

In principle, the third insurance option, a tax-financed Fail-Safe system, ought to have greater political appeal in a country that loathes government *mandates* of any kind. It ought to have appeal particularly to the business community, as it offers the individual firm and its workers the option to free their labor contract from the burden of health-insurance altogether.

In affording the business sector that choice, however, the approach might deprive the private insurance industry of some potential clients. It would thereby evoke that industry's traditionally powerful political opposition. Furthermore, the plan clearly would call for a sizeable increase in the government's health-care budget--perhaps as much as $ 80 billion--as more Americans would gain access to care and as at least some business firms would move their hitherto insured employees into the public Fail-Safe system. It would take strong political leadership of a high order to raise the requisite taxes for the scheme.

2. Option B--Public Clinics and Hospitals

Health-insurance contracts typically represent ill defined, open-ended promises whose costs are not easily controlled *ex ante*. Instead of providing such open-ended contracts, the public sector might simply provide the needed care itself in publicly owned and operated facilities. Although that approach represents the much dreaded "socialized medicine" in its purest form, it does have considerable political appeal and, not surprisingly, has long been used in many places in the United States.

First, a public health system enables legislators to set fixed budgets for their health programs at the beginning of the year, and to avoid the surprises of the open-ended insurance programs, such as Medicaid and Medicare. Second, a public health system allows politicians to delegate to the administrators of the system many morally troubling and politically sensitive chores, such as defining, on the spot, eligibility and benefit packages. It is a perfect device for politicians severely to ration health care without seeming to do so. Indeed, should a financially hard-pressed administrator of a public clinic or hospital evoke a public outcry by withholding needed care, the budget-slashing politicians could have their cake and eat it too: they could demonstrate their concern for the health of the poor by holding public hearings on the administrator's alleged failings.

Finally, of course, like any government-operated institution, a publicly owned health system affords politicians numerous means of granting political favors, either to job seekers, or to contractors and other suppliers of the system.

The shortcomings of a public health system are implicit in its political appeal. First, such systems have not generally been known to be cheap per unit of output. Second, they afford their clients little choice and market power. What the client receives is, in effect, the system's tax-financed *noblesse oblige*, which may range from excellent to awful, depending upon the social ethic of the employees working within the system. Third, publicly owned systems tend to avoid accountability. They seldom produce reliable financial reports, especially reliable statistics on unit costs. Finally, as noted, such systems tend to spare the politician public accountability for a legislating a potentially offensive, second-class health system.

F. A PROBABLE SCENARIO

At this time, probably the politically most viable option would be the second of the insurance options shown in Figure 7, i.e., *government-mandated* employer-provided health insurance, coupled with an enlarged Medicaid program.

Credit for the basic idea goes all the way back to former President Richard Nixon who proposed it in his *Health Message to Congress* on February 18, 1971 and later had it fleshed out as the Community Health Insurance Partnership (CHIP). Numerous close mutants of that proposal now lie before legislative chambers at both the federal and state

levels. The approach has been openly endorsed by the American Medical Association, and it is likely to be endorsed by the American Hospital Association as well.[6]

The option to *mandate* employer-provided health insurance would be feasible at either the federal or the state level. If only some states were to implement it, however, the approach might beget a beggar-my-neighbor policy under which lean and mean states without such a mandate would be able to attract business firms from the more generous states with the mandate and, at the same time, export to the more generous states their sick and poor, many of whom might migrate to the more generous states in search of access to care.

It is easy to imagine a scenario involving the adoption of *mandated*, employer provided insurance, at either the state or the federal level.

In that scenario, the Medicare and Medicaid programs will continue to shift health-care costs to private payers, as the federal deficit mounts in the years ahead. The larger among the private payers will seek to resist these cost-shifts through more vigorous pursuit of Preferred Provider Arrangements and Health Maintenance Organizations, both of which are able to extract price discounts from providers. Thus fiscally besieged, these providers will be even more tenacious than they have hitherto been in seeking revenues from payers with less market power, prominent among them small insurance plans and the small business firms they insure. Unable effectively to resist these higher charges, many small business firms may be driven to cancel their health-insurance programs (if they have one) or not establish one in the first place. A concerned federal or state government is likely to respond to this practice by legislating a mandate upon all employers to provide their employees health insurance.

If that scenario came true, however, the small-business sector probably would acquiesce to the *mandate* only if the underwriting practices of private health insurers were appropriately regulated. Among these new regulations would likely to be mandatory open enrollment and community-rated premiums. Ultimately, these stricture would lead to an *all-payer* reimbursement system, at least within broad regions, such as the state.

There would therefore have to be developed a new mechanism under which regional associations of payers could negotiate *binding* fee schedules with counterpart associations of providers. Associations endowed with such powers do not yet exist in the United States, although they have long functioned in many other countries[7]. Provision of the legislative authorities for such associations would presumably fall to the state governments, perhaps with federal guidance and technical assistance.

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[6] See "McCarthy keeps critics at bay," *Health Week*, September 10, 1990; p. 41.

[7] West Germany operates a system falling into this generic category of health-insurance systems. For more detail on West Germany's system, see the author's "West Germany's Health-Insurance and Health-Delivery System: Providing Access with Cost Control." Paper written for the Bi-Partisan Commission on Health Care, August, 1989.

PREPARED STATEMENT OF BERNARD R. TRESNOWSKI

The Blue Cross and Blue Shield Association (BCBSA) believes the problems of health care cost and access can best be addressed through reforms that build upon our current pluralistic system of health care financing and delivery.

BCBSA offers three steps to improve our health care system:

1. Make Coverage Available for all Americans

BCBSA believes all Americans should be covered under either a private health plan or, for those unable to purchase private insurance, a public program.

2. Make Coverage More Affordable

BCBSA is proud of the system's leadership role in health care quality and cost containment. The Blue Cross and Blue Shield system is constantly developing cost and quality control programs in a broad range of areas—including managed care networks, selective contracting, technology assessment, and changes in payment policy. More needs to be done. We believe all parties involved in health care financing and delivery must participate in developing solutions.

3. Assure a Well-functioning and Competitive Insurance Market

In January of this year, the Board of Directors of the Blue Cross and Blue Shield Association unanimously approved recommendations to reform insurance practices in ways that will help small groups.

At the heart of these reforms is the goal that all small employers should have access to private health insurance at fairly established rates. Because the nature and level of availability of health insurance varies by state, a state should have the flexibility to choose an approach to assuring availability of private coverage that best meets its needs.

BCBSA recognizes that health care cost and access problems are very serious and demand a concerted effort by the private sector and government. We are ready and willing to move ahead with government to develop a series of well-planned, coordinated steps to address these problems.

Mr. Chairman and Members of the Committee, I am Bernard Tresnowski, President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 73 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefit protection for more than 70 million Americans.

Since their inception in the 1930s, Blue Cross and Blue Shield Plans have been committed to developing and improving the nation's pluralistic health financing and delivery system. To that end, we work in partnership with consumers, employers, labor unions, health care providers and government. Our commitment continues today as we address the complex issue of providing access to affordable health care for the nation's uninsured population.

We welcome the opportunity to address the Committee on the important matters of health care access and cost. In my testimony today, I will:

- Offer a historical context for the current access problem;
- Review some of the efforts underway within the Blue Cross and Blue Shield system to hold down health care costs;
- Discuss how we believe this country can build on the employer-based system to assure coverage for all Americans; and
- Provide our recommendations for reforming the small group health insurance market.

COST AND ACCESS ISSUES IN CONTEXT

A number of historical, demographic and economic factors have contributed to our current problems of rising health care costs and decreased access to private insurance. I would like briefly to address some of these, in order to provide a context for our discussion today.

The federal government did not take an active role in civilian health care policy until the middle of this century, when Congress created several programs designed to expand the availability of medical facilities and services. The Hill-Burton Act provided funds for hospital construction; creation of the National Institutes of Health aided in the development of health care technologies; and manpower grants allowed the nation to increase its supply of physicians, nurses and allied health professionals.

After making substantial progress in improving the supply of health care services, Congress accepted a major challenge in health care financing through its enactment

of the Medicare and Medicaid programs in 1965. Medicare and Medicaid offered millions of Americans access to the health care system, and thus dramatically increased the demand for health care services.

The positive effects of these and other programs became apparent quite rapidly: infant mortality rates declined, childhood vaccination became widespread, and elderly people were able to obtain necessary medical treatments. During the 1970s and 1980s, however, some negative effects emerged as well. Federal health programs were enacted at a time when economic growth was in double digits and health care inflation did not exceed 6 or 7 percent—few observers predicted the cost increases that would result as billions of new dollars entered the health care system.

Other factors also contributed to rising health care costs. An aging population and social changes, such as a dramatic rise in drug abuse and violent crime, increased the need for medical services. Advances in medical technology led to high-priced equipment and treatments. Success in treating once-fatal diseases saved lives but increased the demand for renal dialysis, chemotherapy and other long-term treatments. And new diseases, notably AIDS, brought serious illness into the lives of formerly healthy groups of people.

Against this backdrop of increasing costs, the federal government enacted programs to stem capital spending and began to rely heavily on Medicare payment strategies to reduce expenditures and influence provider behavior. Private payers developed new strategies of cost containment, including hospital bill audits and utilization review programs.

American business, faced with increasing foreign competition, turned to HMOs, PPOs and other arrangements that permitted some control over the cost of employee health benefits. An increasing number of large firms abandoned the health insurance system entirely, choosing instead to self-fund their benefit plans. Employers also made greater use of traditional measures, such as deductibles and coinsurance, and new ones, such as coordination of benefits, to help hold down utilization.

Rising costs and changes in the financing and delivery of health benefits brought new gaps in access to health care. The new cost-consciousness of employers made it difficult for health care providers to spread the costs of uncompensated care to insurers and employers. And a growing number of employers and workers, particularly those in small and mid-sized firms, found health coverage unaffordable. Many of the smaller firms, often operating on slim margins, found themselves unable to provide programs with adequate coverage—or to provide any coverage at all.

Access has become a major public policy issue, exacerbated by health care costs that reached $690 billion in 1990—12.2 percent of GNP.

In the mid-1980s, the Blue Cross and Blue Shield Association redoubled its efforts in the areas of health care access and costs. At that time, we identified some underlying concerns and developed the position that these problems would best be addressed by undertaking the following:

- Reforming the Medicaid program to increase eligibility to all those who are below the poverty level and break the link to welfare programs so that low-income working people are eligible;
- Amending ERISA to treat self-funded and insured employers equitably and to provide preemption for state mandated benefits;
- Equalizing the tax treatment for self-funded employers; and
- Creating state high-risk pools, where necessary, for uninsurable individuals.

WHERE DO WE GO FROM HERE?

Developments during the last several years have convinced us that, in addition to the steps we have recommended in the past, more fundamental reform is necessary to address health care access and cost concerns. We have made a commitment to address these problems through the development of recommendations for both governmental and private sector activities.

Among our first steps was the development of a position on assuring access in the most troubled segment of the insurance market—the small group market. In January of this year, the Board of Directors of the Blue Cross and Blue Shield Association unanimously approved recommendations to reform insurance practices in ways that will help small groups.

We now are committed to the broader challenge of assuring affordable coverage for all Americans. We continue to believe very strongly that a pluralistic system is the best way to meet the health care needs of all Americans. Such a framework offers consumers a degree of independence and choice, as well as room for the medical advances and quality care they have come to expect. We believe there are three broad steps that we must take to make our pluralistic approach more effective.

Step One: Make Coverage Available for All Americans

The Blue Cross and Blue Shield Association believes that all Americans and their families should be covered under either a private health plan or, for those unable to purchase private insurance, a public program.

Currently, the vast majority of Americans are insured through the workplace, and more than 80 percent of the uninsured are either workers or dependents of workers. Therefore, we strongly believe that the best way to provide high quality health care is through the employment-based system. This system has served the American public well during the past 50 years, and it has the flexibility to respond to the needs and desires of both employers and employees.

The employment-based system is not perfect, and we are examining how to make it work better. Necessary improvements include greater affordability, continuity of coverage for those changing jobs, and equitable treatment of self-funded and insured benefit plans.

The Blue Cross and Blue Shield Association also is considering how to address the coverage needs of non-working individuals, because some people lack a direct or indirect connection to the workplace. We are particularly interested in broadening the use of tax subsidies in a way that will minimize reliance on public coverage and bring private coverage within the reach of more lower-income individuals.

Step Two: Make Coverage Affordable

Access to health care coverage is illusory unless the coverage is affordable. And with medical costs continuing to outpace general inflation, assuring affordability is a difficult task.

Our system has a long history of undertaking initiatives to limit the cost of medical services, and we have expanded cost containment efforts in recent years. Blue Cross and Blue Shield Plans were founded on the idea of selective contracting with physicians and hospitals. They have a long history of controlling costs through contract arrangements that limit subscribers' liability while assuring that covered services are compensated adequately. Plans also have contract arrangements with physicians that limit payments to reasonable amounts and protect subscribers from "balance billing." The federal government recognized the importance of these strategies when it incorporated them into the Medicare program.

Blue Cross and Blue Shield Plans are proud of their leadership role in health care quality and cost containment through managed care. Our system now operates 164 managed care programs in 47 states. These HMOs, PPOs and point-of-service arrangements cover 17.5 million of our subscribers. The Blue Cross and Blue Shield system operates the largest PPO network and the second-largest HMO network in the country. Overall, close to half of Blue Cross and Blue Shield subscribers participate in HMO, PPO or managed traditional arrangements and the proportion continues to increase.

Utilization management efforts—through precertification, hospital bill audits, case management and other strategies—result in cost savings for Plans and subscribers. They also assure that subscribers receive only necessary medical treatments. A year-long test of a medical review program used by Blue Cross and Blue Shield Plans found that certain common procedures, including hysterectomies and tonsillectomies, were seriously overused by providers. Through this and similar programs, our Plans seek to limit the inappropriate use of medical treatments, with their attendant costs and medical risks.

The Blue Cross and Blue Shield system is constantly developing innovative cost and quality control programs in a broad range of areas. We have learned a great deal from these efforts, and we will continue to improve upon them. Highlights of our current initiatives include:

- **Selective contracting**—Many Blue Cross and Blue Shield Plans are using selective contracting to target certain services with histories of high costs, inconsistent quality or inappropriate use. Such programs are especially common in areas such as mental health and substance abuse treatment, prescription drugs and laboratory services. For example, Blue Cross and Blue Shield of Michigan has begun a clinical laboratory preferred provider organization, Premier PLUS (Prudent Laboratory Use). The Plan has contracted with six clinical laboratory firms, which operate approximately 70 centers in the state. About 50 standard lab procedures will continue to be performed in physicians' offices, but more complex tests will be done by the six firms. Tests done at non-contracting facilities will be reimbursed at lower rates.
- **Prenatal and child health initiatives**—Recognizing that high quality prenatal and child health care saves lives and reduces long-term medical costs, many of our Plans have developed new programs for mothers and children. At least

14 Plans operate Caring Programs for Children, which provide primary health care benefits free of charge to children of low-income families who are not eligible for Medicaid. Blue Cross and Blue Shield of Virginia offers a program called Baby Benefits, a worksite-based program that provides pregnant women with risk assessment, education and intervention.

- **Technology assessment programs**—Blue Cross and Blue Shield Plans devote considerable resources to evaluating the safety and efficacy of new medical technologies and the appropriate use of common treatments. In addition, the Blue Cross and Blue Shield Association's Technology Evaluation and Coverage (TEC) Program has completed more than 200 evaluations of medical equipment and procedures since 1985, making the Association an acknowledged leader in the field of technology assessment.
- **Centers of Excellence for the provision of specialized medical procedures**—The Blue Cross and Blue Shield Association has developed networks of medical centers that will provide high quality organ transplant services to Blue Cross and Blue Shield subscribers, and many of our member Plans have developed their own networks for treatment of other complex conditions. In 1990, for example, Blue Cross and Blue Shield of Arizona designated four rehabilitation centers that will provide its subscribers with high-quality treatment for head trauma at a set fee.
- **Changes in payment policy**—Many Plans have found that innovative provider payment strategies can hold down rising medical costs. For example, Blue Cross and Blue Shield of Minnesota has developed a sophisticated new medical payment system that links hospital reimbursement to patient outcomes. Using a software system, the Plan bases hospital payment on a patient's expected outcomes and medical resource needs. Blue Cross and Blue Shield of Florida has implemented a new prescription drug program, MediScript, which incorporates a pharmacy network, negotiated payment allowances and other cost-saving features.
- **Aggressive anti-fraud measures**—By 1990, approximately 30 Blue Cross and Blue Shield Plans had divisions especially created to uncover and prosecute illegal reimbursement schemes, and another 20 Plans used their internal audit departments to discover fraud and abuse. California Blue Shield's Special Investigative Unit has a full-time staff of five and an annual operating budget of $300,000. The Plan estimates that the unit's work saved subscribers $9.2 million in 1990.

Recently, the issue of insurance administrative costs has received increasing attention. We are proud that our Plans return, on average, 90 cents in services for each premium dollar collected. This figure includes both nongroup and small group business. Profit is not an ingredient of administrative expense in the Blue Cross and Blue Shield system, and all earnings are retained solely for the benefit of our subscribers.

Blue Cross and Blue Shield Plans are devoting increasing levels of resources to cost containment and health care quality initiatives. These efforts contribute to administrative costs but also result in net savings. Information from 27 of our Plans, for example, shows that benefits management programs cost them $73 million in 1989. These efforts resulted in overall savings of $303 million—more than 4 dollars saved for each dollar spent.

Although we have made great progress in assuring that our subscribers receive affordable health care services, certain cost factors are beyond our control. We are limited in our ability to prevent the overabundance of costly medical equipment and devices, which often leads to induced demand. State governments and the courts often order Plans to pay for certain medical services. And we are unable to alter demographic or social changes, such as the crime rate and the aging of the population.

In light of these factors, we recognize our inability to affect major changes in health care costs and assure affordability of coverage on our own. To achieve this goal—and the corresponding objective of increasing access—all of the parties involved must participate in developing solutions.

Step Three: Assure A Well-Functioning And Competitive Insurance Market

The Blue Cross and Blue Shield Association believes that a well-functioning and competitive insurance market is essential to assuring universal access through a pluralistic system.

Eliminating the current imbalances between self-funded and insured benefit plans would be a valuable step toward improving the efficiency of the insurance market. Because ERISA protects self-funded employers from state regulation, these employ-

ers are not required to provide state mandated benefits—nor do they pay state premium taxes or share in the costs of state-run high-risk pools for individuals. Legal imbalances shift these burdens onto insured employers, who tend to be the small and medium-sized companies that are least able to afford the additional costs.

Equal treatment of insured and self-funded plans would serve as an important step toward improved competition. However, we also recognize the need for reform in the health insurance market. To understand the nature of the necessary reforms, it is helpful to understand how the health insurance industry developed.

The nature of private health insurance has changed as the insurance industry has grown. When Blue Cross and Blue Shield Plans began providing insurance coverage in the 1930s, every applicant was accepted for coverage, regardless of health status. In addition, all subscribers in a given area were charged the same price for coverage—a practice known as community rating. In this way, the cost of coverage for enrollees with the poorest health risks was kept at the most affordable level possible, because lower-risk enrollees heavily subsidized the costs of higher-risk enrollees.

However, as competition increased in the health insurance market, underwriting and rating practices similar to those traditionally used in other lines of business began to appear. These practices included denying coverage to high-risk applicants and/or charging such applicants higher rates. These higher rates reflect the fact that only a few high-cost enrollees can generate substantial claims costs. On average, only 4 percent of insured individuals generate 50 percent of claims, while 20 percent of enrollees generate 80 percent of claims.

In this competitive environment, insurers that continued to accept all risks, or had even marginally more liberal enrollment practices, ended up with a worse mix of risks. They consequently were forced to charge higher rates than insurers that had been more selective, causing them to lose their low-risk enrollees, who could find better-priced coverage elsewhere. These carriers were left with higher-risk enrollees, who had nowhere else to go, and risk pools that deteriorated over time.

This phenomenon, known as the "adverse selection spiral," explains why few insurers today can continue to accept high-risk enrollees and remain competitive. It also explains why more people are found to be "uninsurable" or insurable only at high cost.

The competition for the lowest-risk enrollees has led many insurers to price coverage at levels that more closely reflect the risk of a particular group or individual. The cumulative effect is increasing segmentation of the insurance market and a declining ability of Blue Cross and Blue Shield Plans to retain their traditional practices while remaining competitive in the market.

The increasing cost of health care also has diminished our ability to accept all applicants and to community rate coverage. For many years, our Plans were able to continue their early practices, because they were able to offset the cost of high-risk enrollees by controlling overall costs. In addition to the cost management tools described earlier, Plans also had the advantage of provider discounts and preferred federal and state tax treatment. But, as these advantages eroded, so too did Plans' ability to maintain their earlier practices in a competitive market. While a number of Plans continue to provide coverage on an open enrollment, community rated basis in the small group and individual markets, other Plans have had to change their practices in order to compete in their markets.

The Blue Cross and Blue Shield Association believes that reforms are necessary in the small group insurance market to replace competition based on ability to select risks with competition based on ability to control costs. Specifically, the Blue Cross and Blue Shield system supports:

- Assuring that small employers have access to private insurance, regardless of health status, occupation or geographic location;
- Assuring that states have a range of options to choose from in providing for the availability of private insurance to small employers;
- Assuring that small group coverage is provided at fairly established rates;
- Assuring that no small employer is dropped from coverage because of poor claims experience;
- Assuring the adequate effective enforcement of all carrier requirements;
- Assuring the equitable sharing among carriers of both high-risk small employers and the losses associated with covering these high risks; and
- Assuring the availability of lower-cost products.

With respect to assuring small employers access to private insurance, BCBSA believes that states should have the flexibility to choose an approach that meets the needs of their environments. One approach that has received a lot of attention would require all carriers to offer coverage to small employers on a guaranteed

issue basis and is dependent on a private reinsurance mechanism to help carriers spread the costs associated with high-risk groups.

While this approach may be appropriate in some states—where participation in reinsurance is voluntary—we believe it is equally important for states to be able to choose approaches that do *not* rely on guaranteed issue and a reinsurance mechanism. While we believe that this represents one option for states, we also support several alternative approaches.

In general, these other approaches would assure that all small groups had access to private coverage and that all carriers would comply with the requirements noted above.

These approaches would not rely on a reinsurance mechanism to spread the risk of a requirement that all carriers accept all groups. Reinsurance has not been tested in any state. It may prove difficult to regulate, costly to administer and unfair to some insurers. In addition, the losses are unknown and could require additional funding.

These alternatives include those that:

- Assure that coverage is available to all small groups through *at least one insurer* that *voluntarily* provides such coverage and meets all other requirements.

  This approach recognizes that in some states an insurer (or insurers) already offer comprehensive coverage on a guaranteed issue, community rated basis to small employers. For example, in New York and Pennsylvania, Blue Cross and Blue Shield Plans offer year-round "open enrollment" for all their small group products and charge a single rate for all small groups in an area. They are able to offset the costs of these practices through a combination of negotiations with hospitals and physicians, a waiver from certain state taxes and aggressive cost containment activities. In these states, the goal of assuring access has been met, and the introduction of a complex and expensive new program is unnecessary. However, to moderate practices throughout the small group market, it may be appropriate to require all insurers to meet standards such as rating and renewal requirements.
- Require all insurers in the small group market to accept otherwise uninsurable groups through placement of such groups by a state program. Under this approach, groups that have been found to be uninsurable by an insurer would register with a state program. They would be allowed to select coverage under rules set up to assure fair distribution of such groups among all small group carriers in the state.

  This alternative has the advantages of providing incentives for insurers to manage high-risk cases, being easier and less expensive to administer and simpler to enforce than a reinsurance mechanism.

States also could develop other programs for assuring access to private coverage for small employers, as long as the alternatives achieved the objective of assuring access to all small employers at fairly established rates and met the other requirements described earlier.

Assuring Fairly Established Rates. The Blue Cross and Blue Shield Association also supports the rating reforms adopted by the National Association of Insurance Commissioners (NAIC) in December in the model act on Premium Rates and Renewability of Coverage for Health Insurance Sold to Small Groups. These rating reforms address the problem of carriers' pricing small group coverage based on the risk of a specific group which can result in very high rates for some small groups.

The reforms would allow the use of demographic adjustments, that is, actuarial factors that predict health care utilization based on the characteristics of a group, but are not related to the specific claims experience or health status of a group. The reforms would limit the extent to which a group's own experience or health status could be used in setting its rates. In this way, an insurer's ability to set rates that more closely reflect a group's experience would be balanced with the need to subsidize the rates for higher-risk groups.

The reforms also would take the important step of limiting the amount of annual premium increases due to a group's own experience or health status. As a result of these reforms, rates for higher-risk groups would be moderated over time.

However, because the reforms would bring previously uninsurable groups into the insurance system and would redistribute the cost of higher-risk groups throughout the market, rates for lower-risk groups would increase.

It has been suggested that small group insurance reform include a requirement that all insurers offer coverage to small employers at a community rate. We believe such proposals are very problematic, for two key reasons.

First, we believe this approach would actually increase the number of uninsured groups. Uninsured groups tend to be comprised of younger and healthier employees who choose not to spend their wages on health insurance when they do not believe they will need it. If rates are "averaged out," the cost for higher-risk groups would decrease, but the rates for younger. healthier groups would increase As a result more price sensitive groups may well drop their coverage. And the cost barriers that already exist for uninsured small groups will increase for many, making it even more difficult for them to purchase coverage.

And second, insurers that traditionally have had, or continue to have, more liberal enrollment practices can easily be placed at a major competitive disadvantage under a community rating requirement. As discussed earlier, their enrollment of higher-risk, higher-cost groups would result in an average rate that would not be competitive in the marketplace. And perversely, the requirement would reward insurers that have been very selective in the risks they accept.

With respect to access to those who are not part of an employer group, our current position is that states whose Blue Cross and Blue Shield Plans do not provide nongroup coverage on an open enrollment basis should establish high-risk pools to provide access to coverage for uninsurable individuals.

Our efforts to date have focused on necessary reforms in the small group market. We recognize that more comprehensive change also may be needed in the individual market. It is important to understand, however, that reforming the individual market will be much more difficult than reforming the small group market.

Of all the health insurance markets, the individual market has the most severe problem of adverse selection. In this market, individuals make choices about whether they need coverage and which type of coverage to buy based on their perceived or anticipated need. Thus, individuals who need medical care tend to choose the most comprehensive coverage available, while healthy individuals choose either lower-cost coverage or no coverage at all. And in contrast to the small group market, where a group may contain several healthy employees for every high-risk employee, high-risk individuals do not bring along with them other healthy individuals who may help offset their costs.

CONCLUSION

The Blue Cross and Blue Shield Association recognizes that health care cost and access problems are very serious and demand a concerted effort by the private sector and government. At the same time, we need to note that these problems have arisen because of a combination of demographic and societal changes that have created a broad array of other social difficulties as well.

The problem of the uninsured should not be viewed as an indictment of the private, multiple-payer system of health care financing. The private system is meeting the health care financing needs of the overwhelming majority of Americans. Changes must be made, but we believe that the most effective reform will build on the system that currently provides coverage to a majority of Americans. Two-thirds of the nonelderly have health coverage through our employment-based, multiple payer system, and the vast majority are pleased with that coverage.

The Blue Cross and Blue Shield Association is ready and willing to move ahead with government to develop a series of well-planned, coordinated steps to assure access to the uninsured and to control increases in health care costs that have made access the serious problem it is today.

COMMUNICATION

STATEMENT OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS

The Association of Private Pension and Welfare Plans (APPWP) is a non-profit organization founded in 1967 to protect and foster the growth of America's private employer-sponsored employee benefit system. Its more than 400 members include both large and small plan sponsors as well as plan support organizations such as investment firms, banks, insurers, actuarial firms, consulting firms and other professional benefit organizations. APPWP members directly sponsor or administer pension and health benefit plans covering more than 100 million Americans. All of the APPWP members provide health insurance for their employees, and most, but not all, members are self-insured.

My comments today will focus on employer provision of health benefits, employer efforts to manage the costs of these benefits, and the effect that the Employee Retirement Income Security Act of 1974 (ERISA) has on both the provision and management of these health plans.

EMPLOYER SPONSORSHIP OF HEALTH BENEFITS WORKS

Employer-sponsored health plans have evolved over the years to become the most significant source of private health insurance coverage in the United States. Over 188 million Americans—including 80 percent of the civilian full-time workforce—are today covered through an employer plan. As extensive as employer-based coverage is, approximately 34 million Americans are still left without health insurance coverage, largely due to high and rising health care costs. The fact that two-thirds of the uninsured have a direct or indirect employment relationship argues for an expansion of the employer-based system to achieve the goal of universal health care coverage in America.

The substantial role of employer plans in our system is by itself a good argument for continuing to organize health care financing through employers. The costs, dislocations, and redistribution of risk that would result from changing this role are so substantial that it seems hardly practical to consider a complete restructuring of this role in our time.

Our reliance on employers to organize health insurance coverage is not an accident, and there are a number of sound reasons for maintaining this system of health insurance. One is that employers are more able than governments to tailor health plans to the needs of their particular workforces. This capacity to quickly design or modify health benefits also contributes to the employers' unique ability to experiment with new ideas in providing benefits, to modify benefits to meet changing health care delivery patterns, and to discover new ways to manage the cost of health benefits. Over the course of your hearings you have heard considerable testimony from employers reflecting the innovation and energy that is being channeled today into improving the management of health benefits.

Employer provision of health benefits is also an effective way to organize large groups that efficiently distribute risk. When individuals are free to form groups for the purpose of purchasing health insurance, they inevitably organize themselves on the basis of risk—low risk individuals form pools to purchase the lowest cost insurance, and high risk individuals are left with high cost or no insurance. Having individuals acquire health insurance through employment ensures that their participation in health insurance groups is motivated by factors other than the cost of health insurance and thus not an interference with the random assignment of health risk.

Employers also bring a business perspective and a concern about cost-effectiveness to the health care system. Employers can operate as knowledgeable purchasers to gain the greatest value for patients from health services they purchase. While it is also possible for government to act as a knowledgeable purchaser on behalf of pa-

tients, it is a more difficult role for a political entity that must be responsive to a variety of constituencies in addition to the patients themselves. Government's concerns about health care resource limitations may be diluted by conflicting concerns about provider opportunities.

Finally, employer provision of health benefits is a bargain for the federal government. For every dollar of services the government would otherwise finance, the government spends only $0.19 on average if the employer provides the service, according to estimates by Sylvester Schieber in APPWP's study on benefits and taxation titled: *Benefits Bargain: Why We Should Not Tax Employee Benefits.* Thus the government can achieve goals of broad health insurance coverage without having to tax and spend the bulk of the revenue it would need to provide health insurance directly.

In short, we believe the social policy aims of providing affordable financing for high quality health care services can be met most effectively if the government continues to rely on employers to provide health insurance for the preponderance of workers and their families in the United States.

ERISA PROVIDES THE FRAMEWORK FOR EMPLOYEE BENEFITS

Employer responsibilities and employee rights in the provision of employee benefits are governed by the Employee Retirement Income Security Act of 1974 (ERISA). The relationship of ERISA to health benefits is not always well understood, and ERISA has often been credited or blamed for a variety of health care consequences not directly related to this Act.

ERISA is in its essence a broad umbrella of protections for participants in employee benefit plans, including health plans. For health benefits, ERISA requires plans to report and disclose plan provisions to the federal government and to plan participants, sets standards of fiduciary responsibility, provides participants with private rights of action to enforce their claims to benefits, and requires the opportunity for continuation of coverage under group health plans after termination of employment. For pension benefits, ERISA provides additional standards for participation and vesting of benefits and funding of pension plans, as well as a system of pension plan termination insurance.

ERISA's regulatory framework for health plans has not been as specific as its framework for pension plans for a number of reasons. First, the focus of the Congress when ERISA was enacted was largely on the financial solvency of pension funds. Driven by a few significant pension failures, the Congress was intent on setting standards for pension funding and asset investment, and on creating insurance for pension benefits to secure promised retirement income. Not only was health a much smaller obligation at the time, but health benefits were a current and not a future obligation, and thus funding was not a concern.

Second, other pension issues, such as coverage and benefit equity, were less of a concern with health benefits, because health benefits cover a much broader group of employees than pensions, and health benefits tend to be quite uniform for workers at all income levels.

Third, the framers of ERISA recognized that benefit equity was much simpler to determine with regard to pensions, which are monetary payments, than with health benefits which reflect a variety of health services having very different values for persons in different circumstances. To define and measure the value of health benefits is to make judgments about the need and use of various services, and ultimately about health care priorities. It is not a matter to be undertaken solely in a benefit regulation context.

ERISA PREEMPTION OF STATE LAWS PROVIDES CONSISTENCY

In order to maintain consistent treatment for participants of plan sponsors operating in a number of states, ERISA (under section 514) broadly preempts "any and all" state laws related to employee benefit plans. While this section went on to exclude state laws regulating insurance, banking or securities from ERISA preemption, it further specified that employee benefit plans are not to be deemed to be insurance, banking or investment companies for the purpose of state regulation.

The Supreme Court, in *Metropolitan Life Insurance Co.* v. *Massachusetts* (105 S.Ct. at 2389), interpreted section 514 of ERISA to create two separate classes of employee benefit plan: "self-insured" and "insured". Under the court's distinction, ERISA governs self-insured health plans—plans in which a plan sponsor bears the risk for employees' health costs, though they may purchase administrative services only (ASO), stop-loss protection, or minimum premium plans (MPP) from an insurance

company. State insurance laws apply to plans that are entirely purchased from insurance companies.

The single nationwide regulatory framework that is provided through ERISA preemption is a necessity for companies, such as many APPWP members, that operate employee benefit plans in more than one state. ERISA has enabled these multi-state employers to avoid having to separately qualify or meet divergent state requirements with a single plan in a multiplicity of jurisdictions. It has also protected participants by setting uniform standards for the financial operations of employee benefit plans and providing participants with uniform private rights of action to ensure that benefits are paid.

The limitation of ERISA's nationwide regulatory structure to self-insured health plans has left insured plans subject to added costs imposed by state premium taxes and mandated health benefits. The advantage of experience rating a large group and managing its health care costs added to the protection from state taxes and mandated benefits afforded by ERISA preemption has encouraged large numbers of plan sponsors to drop their insured plans and seek ERISA's protection through self-insurance over the last decade. Today, health plans in which an employer has assumed all or part of the risk (e.g. ASO, MPP or stop loss plans) account for 55 percent of total commercial insurance business. While self-insurance is most typical among the largest employers, a recent survey by benefits consultants A. Foster Higgins & Co., Inc. indicates that small employers (those with fewer than 500 workers) are converting to self-insurance at the most rapid rate.

Those plan sponsors that cannot self-insure, for one reason or another, particularly the smallest businesses, are left behind to cope with state regulation, including the increasing burden of state mandated health benefits. State mandates reduce the flexibility that plan sponsors have to meet employee needs and control costs. They impose additional costs by requiring that plans cover specific benefits (such as invitro fertilization, anti-abortion or long term care); pay groups of non-physician providers (such as chiropractors, podiatrists, naturopaths or acupuncturists); or insure specific participants (such as non-custodial children or dependent students).

Although proponents have argued that mandating benefits can reduce costs—for example by substituting lower-paid health professionals for physicians—the experience with most mandated benefits has been that they increase costs by requiring payment to new practitioners for categories of services not previously covered. A study by HIAA of health insurance costs in Maryland in 1986 concluded that, overall, state mandated benefits raised the cost of family coverage by 17 percent.

Despite a growing concern about state benefit mandates, the total number of mandates in force in the fifty states continues to grow rapidly. The number of benefit mandates in effect has risen from fewer than 200 in the mid 1970s to 816 as of 1990, according to the Blue Cross and Blue Shield Association. In fact, the most recent two year period, 1989-90, has seen the largest single enactment of new benefit mandates yet—116 new laws. In all, there now are more than 50 different types of mandated benefits in force, with as many as 35 mandates in effect in the most mandate-prone states. The variability in benefit mandates from State to State itself adds costs. Insurers who market plans in more than one State tend to incorporate the sum of all mandated benefits in the States in which they operate in order to provide uniform plans for their customers.

While the overall trend is still toward more mandates, a few States have begun to respond to concerns about state benefit mandates by enacting a series of "anti-mandate" laws. In the last few years, sixteen states have enacted laws requiring an evaluation of the financial and social impact of additional mandates as a condition for enactment. Three states prevent mandates from applying to insured plans until they also apply to self-insured plans. Nine states have enacted mandated benefit waivers to enable insured plans for small groups (25 to 50 or fewer) to meet a lower minimum state standard and avoid mandated benefits.

We believe that it is an unfortunate result of the limitations placed on ERISA that plan sponsors decisions to self-insure are motivated more by the need to escape burdensome state requirements than by a judgment that self-insurance is the most effective way to bear health risks and manage health insurance costs. Not all employers are large enough or have good enough risks to self-insure.

Small employers should have the same advantages that larger employers can derive from large pools and self-insurance—risk spreading, negotiating discounts with providers, and protection from state benefit mandates. While a variety of pooling arrangements have been tried for small employers, they have often been unable to overcome the adverse selection problems that arise from the voluntary association of separate risk groups.

Employers too small to self insure may have some of the advantages of pooled risk, preemption of State mandated benefits, and managed care by joining multiple employer welfare arrangements (MEWAs). However, an uncertain regulatory environment continues to restrain the use of MEWAs. ERISA section 514(b)(6) places MEWAs under state insurance regulation with regard to the adequacy of reserves and contributions. Some States have used this regulatory authority to set reserve requirements that effectively prevent MEWAs from forming. Other States have left MEWAs unregulated, contending that they are preempted by ERISA. Some uniform approach to defining and regulating these voluntary associations is necessary if small businesses are going to have an effective mechanism to benefit from the risk pooling of large self-insured plans.

APPWP believes a better solution is to extend the protections afforded under ERISA to all employee benefit plans—whether insured or self-insured—and clearly limit the state regulatory involvement to insurance reserve requirements and consumer protections. Preemption of State benefit mandates should apply to the health benefit plans of all employers. If that is not possible, the Congress should at least give small businesses nationwide waivers from state benefit mandates similar to the state-based waivers already in effect in nine states.

LAWS TO RESTRICT ERISA PREEMPTION ARE MISDIRECTED

APPWP is particularly concerned about bills introduced in the House and Senate this year aimed at sheltering a class of State law from ERISA preemption. The proposed legislation is a response to the U.S. Supreme Court's decision in *Pilot Life Insurance Company* v. *Dedeaux* (481 U.S. 41 (1987)) in which the court ruled that ERISA preempted state common law causes of action. Dedeaux's claim against Pilot Life for failure to pay benefits was brought under State general contract law. The Court ruled that these laws did not specifically regulate insurance within the meaning of ERISA's "saving clause" (section 514(b)(2)(A)) and were thus preempted by ERISA, and that ERISA's civil enforcement provisions were the exclusive remedy for insured as well as self-insured plans.

S. 794, introduced by Sen. Metzenbaum (D-OH), would add a new clause to ERISA section 514(b)(2)(A) to "save" from preemption state statute or common law that provides a remedy for their practices in administering plans or processing claims against insurance companies.

APPWP is concerned about bills that would specify additional statutory limits for the application of ERISA preemption. Restrictions in ERISA preemption that would expand State regulatory authority over employee benefit plans would impair the ability of employers to design uniform plans and manage them effectively to meet the needs of their workforces. It would also raise questions about the uniform application of private rights of action now available under ERISA. In particular, S.794 would expand the separate treatment now accorded insured and self-insured plans, and raise the costs of insured plans by exposing their managed care efforts to significantly greater liability under State common law.

RISING HEALTH CARE COSTS THREATEN EMPLOYER ROLE

If there is a threat to the continued involvement of employers in the provision of health care benefits, it results from the lack of control over rising health care costs. The rapid growth in national health expenditures that has continued over the last quarter century has been largely unaffected by public or private efforts to control costs. Business, consumers, and government alike have experienced rising costs driven by a number of factors including the explosion in technology, incentives to overutilize care and to provide unnecessary care, and population aging.

In addition to systemwide increases, there has been a steady shifting of health costs to business that has resulted in the business share of national health spending growing from 19 percent in 1967 to 30 percent in 1989 (according to an article by Katharine Levit and Cathy Cowan in the Winter 1990 issue of *Health Care Financing Review*). As a result, business costs have grown at twice the rate of overall medical inflation, pushing up health insurance premiums by as much as 20 to 50 percent a year in recent years.

The nationwide problems of accelerating corporate health care costs and growing cost shifting to business, in part caused by government policy to underfund Medicare and Medicaid, has not been met with a comparable government effort to develop national cost containment solutions. Employers, applying their own creativity and sensitivity to the needs of their workforces, have focused on controlling the costs of their own health plans through a variety of ingenious strategies. Much of this innovation by large self-insured companies and insurers has focused on manag-

ing the use of services by plan participants, all under the heading of "managed care". These concepts continue to evolve—providing one more example of the adaptability that is inherent in a multiple payor system.

MANAGED CARE CAN EFFECTIVELY CONTROL AN EMPLOYER'S COSTS

The experience of our member companies with managed care initiatives teaches two conclusions. First, managed care can help control a company's soaring costs while enhancing the quality of health care for employees. Second, in an environment where forty percent of health care costs are paid by government programs, individual efforts to control costs cannot overcome the effects of government cost-shifting to private payors, nor can a system of unrelated or competing individual efforts be effective in controlling overall national health care expenditures.

APPWP's recent publication *Second Opinion: Employers Can Make Managed Care Work* provides four examples of member companies whose managed care programs have helped control costs without sacrificing quality. Southwestern Bell Corporation's (SBC's) CustomCare plan was introduced in 1987 in response to a 217 percent increase in its health care costs between 1979 and 1985. CustomCare incorporates networks of qualified health care providers developed by SBC's insurance carrier in 13 metropolitan areas where 65 percent of SBC's employees and retirees live. Employees who use services at the direction of a participating primary physician pay a $10 copayment for the first office visit and no copayment thereafter. Employees have the option of using non-network providers on a service-by-service basis, but must pay a $350 deductible per person (up to 3 persons) and a 20 percent copayment. While CustomCare was effective in reducing aggregate costs 8.9 percent below the trendline expected when it was introduced, SBC continues to monitor and improve the plan. Indeed, continual monitoring and improvement is the essence of "managing" care, rather than simply containing costs.

Allied-Signal implemented its Health Care Connection Plan beginning in 1988 for 113,000 employees and dependents in 26 health care networks across the country. The year before Allied-Signal's plan was introduced, its health care costs increased by 39 percent. The plan Allied-Signal introduced provides financial incentives for participants to choose network providers at the "point-of-service". Participants who choose a network primary care physician pay a $10 copayment for an office visit and a $5 copayment for prescription drugs. Participants choosing non-participating physicians pay a 1 percent of pay deductible (3 percent for a family) and 20 percent coinsurance on remaining bills. Allied-Signal contracted with a major insurance carrier to design a single program nationwide, using 26 networks serving the majority of Allied-Signal employees, dependents, and retirees, and eliminating HMOs and other alternative plans. The insurer has guaranteed Allied-Signal three years of single digit inflation in premiums, and bears the risk for all health care inflation in excess of that amount. Utilization of the networks by Allied-Signal employees has been high—about 75 percent use the networks 95 to 100 percent of the time. Cost increases under the contract will remain will below Allied-Signal's earlier trendline.

First Interstate Bancorp initiated its "point-of-service" Health Span plan with a network of contracted providers in 1989. In the year preceding its implementation, First Interstate's costs increased 35 percent. Health Span began by covering 75 percent of First Interstate's workforce. Participants could choose at the time they need care whether to use its network of contracted physicians and hospitals or use non-participating providers, with the plan paying 70 percent of reasonable and customary covered charges after a deductible of $250 (individual) and $750 (family. Participants using the Health Span network select a personal care physician, and all patient care is subsequently directed by that physician. Since 1989, First Interstate has been steadily expanding its network.

A different approach to managed care is provided to several APPWP members through a insurance carrier program of utilization management known as Healthline. Healthline uses carefully developed physician protocols and active case management to reduce unnecessary medical care and improve the appropriateness of procedures. Healthline blends pre-admission screening for inpatient care, on-site nurse management with reviews of patient records and patient visits, managed mental health care using a preferred provider organization and case management, outpatient pre-reviews with physicians, and protocols for surgery.

At Ameritech, we have kept our average annual increase in health costs to 10.4 percent over the last five years through concerted care management efforts with our local Blue Cross plans. Under the current plan, Blue Cross reviews medical care received by our employees and their dependents. All elective hospital procedures are reviewed prospectively for appropriateness of procedure and for site of service. All admissions, whether urgent or elective, are reviewed for appropriateness of contin-

ued stay. Patients also receive valuable assistance in selecting treatments and providers to ensure a high quality of care. Our plan provides employees the option of using a preferred provider network with financial incentives to use physicians and hospitals who have agreed to participate in the medical management programs and accept negotiated fees. We recently announced that employees will be offered a new "point of service" medical plan that will provide access through a primary physician to a broad package of medical benefits with the option of using a non-network provider at the point of service for a higher out-of-pocket payment.

In all of these instances, employers and insurers are experimenting with alternative approaches to managing employee utilization of health care, selecting qualified providers, and reducing unnecessary medical care to control costs.

Although, APPWP is not prepared to comment on the details of the proposed tax incentives for managed care in H.R. 1565, APPWP supports the effort of the bill's sponsors to encourage broader use by employers of known successful managed care techniques.

STATE ANTI-MANAGED CARE LAWS MAY INTERFERE

Unfortunately, employer and insurer innovations in managed care are increasingly encountering resistance from provider interest groups and growing efforts by State legislatures to limit managed care practices. Several States have passed or are considering laws that would limit utilization review, restrict the formation of provider networks, or require "freedom-of-choice" of pharmacies (preventing use of mail order or formularies) for prescription drug purchases.

Utilization review limitation includes efforts to restrict the use of non-local medical protocols, impose credentialling or residency restrictions on physicians performing utilization review, prohibit utilization review of psychiatric, chemical dependency or chiropractic treatment, or impose stringent appeal requirements. Network restriction and "freedom-of-choice" efforts would limit the use of selective contracting, the exclusion of non-network providers, and the negotiation of reimbursement discounts.

Laws that would prevent payors from holding providers to accepted standards of practice and restrict payor reviews of reimbursement claims interfere with efforts to reduce unnecessary and inappropriate medical care. APPWP believes the continuing enactment of State "anti-managed-care" laws will tie employers' hands in the effort to control their health care costs, and will contribute to an escalating level of health care expenditures in the system as a whole.

APPWP RECOMMENDS A NATIONAL EFFORT TO CONTROL COSTS

APPWP believes that effective control of the growth in national health expenditures requires a national cost management policy. This policy should build upon the existing employer-based, multiple payor system, and encourage a reliance on managed care techniques to eliminate unnecessary medical care and improve the quality of care for patients.

A national program to manage the cost of providing health care should include:

(1) An end to cost shifting from government to private payors and among private payors through an improvement in Medicaid payment rates and through opportunities for private payors to benefit from Medicare methods in the payment of providers;

(2) Efforts to expand the use of managed care techniques to all health plans—particularly to develop methods to extend managed care to small employers—including government plans, and Federal preemption of State anti-managed care laws;

(3) Broad ERISA preemption of State laws affecting benefits and coverage under employee benefit plans, including state benefit mandates;

(4) Efforts to increase the involvement of employees in selecting and paying for health care coverage through greater cost sharing and education;

(5) Additional Federal resources to improve the quality of health care through an expansion of research in medical outcomes, and an effort to improve the use of outcome information in treatment and coverage decisions, including the development of physician protocols and national technology assessment;

(6) Medical malpractice reform, including the development of standards of negligence and treatment practice guidelines, the use of arbitration, limits on punitive damages.

(7) Expansion of health insurance coverage should build upon our employer-based system without resorting to the use of rigid employer mandates or the disincentives of taxes on health benefits.

CONCLUSION

Employer-provided health benefits today meet the needs of most of the working population and their dependents. Employers have the flexibility to tailor benefits to specific needs of their workforces and manage these benefits to insure efficient, high-quality health care. This system works well for 80 percent of the employed population and should expand to meet the needs of as many uninsured Americans as possible through their employment relationship.

ERISA provides the regulatory framework for health benefits. ERISA was intended to uniformly protect the benefits of plan participants and provide national standards for employers through the preemption of varying State insurance regulations and taxes.

The Supreme Court recognized a distinction between self-insured plans and plans that purchased insurance through an insurance company, and that distinction has led to two classes of health plans. Self-insured plans, operated primarily by large employers, can avoid State benefit mandates and have a cost advantages over insured plans, primarily purchased by small employers, which are subject to State benefit mandates and other aspects of insurance regulation. This differential is creating an incentive to self-insure that may lead to arrangements that are harmful for employers or for employees. APPWP believes small business should have access to the same health insurance arrangements to pool risk, manage care, and avoid State benefit mandates that are currently available for large employers.

Managed care provides employers an opportunity to improve the efficiency and quality of health care provided to their employees. The flexibility and pluralism in our existing employer-based multiple payor system has been instrumental in the innovative development of alternative managed care strategies. Efforts to develop new managed care approaches should be encouraged, and small employers should have an equal opportunity to benefit from managed care techniques. In addition, an effort should be made to protect employer plans from State laws that would impair the ability of employers to select providers, review utilization, or otherwise manage health care.

Managed care is not the exclusive answer to rising health care costs in an environment where the government pays nearly half of the bill, and changes in technology, demographics, and utilization influence the growth in health care costs. APPWP urges the Congress to develop a national policy to control health care costs that addresses all dimensions of the problem and applies to all payors in the health care system—public and private alike.

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