PROPOSALS TO STIMULATE HEALTH CARE COMPETITION

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

S. 1968

A BILL TO AMEND THE INTERNAL REVENUE CODE OF 1954 TO ENCOURAGE COMPETITION IN THE HEALTH CARE INDUSTRY, TO ENCOURAGE THE PROVISION OF CATASTROPHIC HEALTH INSURANCE BY EMPLOYERS, AND FOR OTHER PURPOSES

MARCH 18 AND 19, 1980

Printed for the use of the Committee on Finance

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PROPOSALS TO STIMULATE HEALTH CARE COMPETITION

TUESDAY, MARCH 18, 1980

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:30 p.m., Tuesday, March 18, 1980, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Baucus, Boren, Dole, and Durenberger.

[The press release announcing these hearings and the bill S. 1968 follow:]

Press Release #H-10

PRESS RELEASE

FOR IMMEDIATE RELEASE
February 21, 1980

UNITED STATES SENATE
COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
2227 Dirksen Senate Office Bldg.

SUBCOMMITTEE ON HEALTH SCHEDULES HEARING ON
PROPOSALS INTENDED TO STIMULATE HEALTH CARE COMPETITION

The Honorable Herman E. Talmadge (D., Ga.), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the Subcommittee will hold hearings on Tuesday and Wednesday afternoons, March 18 and 19, 1980 to consider the objectives and provisions of S. 1968. This bill is a proposal intended to moderate health care costs by requiring employers to offer a range of health insurance options and limiting the maximum amount of employer tax deductions for health insurance premiums.

Principal Senate sponsors of the proposal are: Senators David Durenberger (R., Minn.); John Heinz (R., Pa.); and David L. Boren (D., Okla.).

The hearings will begin each day at 2:30 P.M. in Room 2221 Dirksen Senate Office Building.

Senator Talmadge noted the consistent and increasing concern with the costs of health care--not only with respect to the Medicare and Medicaid programs, but in terms of the many billions of dollars being spent each year by employers and employees for private health insurance.

The Subcommittee Chairman said, "Dave Durenberger has expressed concern that the expenditure of these tax-deductible billions of dollars without any test of reasonableness or upper limit may well serve to fuel the fires of health cost inflation. Senator Durenberger, as well as others, have expressed the view that limits should be placed upon the tax deductibility of employer-paid premiums and that employers should be required to offer their employees a choice of at least three different insurance plans. The objective here is to stimulate competition among and between different health insurers and to provide economic incentives to employees to select the more efficient insurers." The hearing will explore the potential effects and feasibility of the approach advanced by Senator Durenberger.

Requests to testify. -- The Chairman advised that witnesses desiring to testify during this hearing must submit their requests in writing to Michael Stern, Staff Director, Committee on Finance, 2227 Dirksen Senate Office Building, Washington, D. C. 20510, not later than Friday, March 7, 1980. Witnesses will be notified as soon as possible after this cutoff date as to when they are scheduled to appear. If for some reason the witness is unable to appear, he may file a written statement for the record of the hearing in lieu of a personal appearance.

Consolidated testimony. -- Senator Talmadge also stated that the Committee urges all witnesses who have a common position or with the same general interest to consolidate their testimony and designate a single spokesman to present their common viewpoint orally to the Committee. This procedure will enable the Committee to receive a wider expression of views than it might otherwise obtain. The Chairman urged very strongly that all witnesses exert a maximum effort, taking into account the limited advance notice, to consolidate and coordinate their statements.

Legislative Reorganization Act. -- Senator Talmadge stated that the Legislative Reorganization Act of 1946, as amended, requires that all witnesses appearing before the Committees of Congress must "file in advance written statements of their proposed testimony, and to limit their oral presentations to brief summaries of their argument."

Witnesses scheduled to testify must comply with the following rules:

(1) A copy of the statement must be filed by the close of business the day before the day the witness is scheduled to testify.

(2) All witnesses must include with their written statement a summary of the principal points included in the statement.

(3) The written statement must be typed on letter-size paper (not legal size) and at least 100 copies must be submitted by the close of business the day before the witness is scheduled to testify.

(4) Witnesses are not to read their written statements to the Committee, but are to confine their ten-minute oral presentations to a summary of the points included in the statement.

(5) Not more than ten minutes will be allowed for oral presentation.

Written statements. -- The Chairman stated that the Committee would be pleased to receive written testimony from those persons or organizations who wish to submit statements for the record. Statements submitted for inclusion in the record should be typewritten, not more than 25 double-spaced pages in length, and mailed with five (5) copies by Tuesday, April 1, 1980 to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building, Washington, D. C. 20510.

P.R. #H-10

II

96TH CONGRESS
1ST SESSION

S. 1968

To amend the Internal Revenue Code of 1954 to encourage competition in the health care industry, to encourage the provision of catastrophic health insurance by employers, and for other purposes.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 1 (legislative day, OCTOBER 15), 1979

Mr. DURENBERGER (for himself, Mr. BOREN, and Mr. HEINZ) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To amend the Internal Revenue Code of 1954 to encourage competition in the health care industry, to encourage the provision of catastrophic health insurance by employers, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Health Incentives Reform Act of 1979".

STANDARDS FOR HEALTH BENEFIT PLANS PROVIDED BY EMPLOYERS

SEC. 2. (a) Part II of subchapter B of chapter 1 of subtitle A of the Internal Revenue Code of 1954 (relating to items specifically included in gross income) is amended by adding at the end thereof the following new section:

"SEC. 86. EMPLOYER CONTRIBUTIONS TO HEALTH BENEFIT PLANS.

"(a) IN GENERAL.—

"(1) EXCESS CONTRIBUTIONS.—Notwithstanding section 106, any contribution to or on behalf of a taxpayer by his employer to a health benefit plan, or dental benefit plan, or both, for any month shall be included in such taxpayer's gross income to the extent that such contribution amount exceeds the limitation on contributions under subsection (e) for that month with respect to such taxpayer.

"(2) NON-QUALIFIED CONTRIBUTIONS.—Notwithstanding section 106, any contribution to or on behalf of a taxpayer by his employer to a health benefit plan for any month shall be included in such taxpayer's gross income if such employer fails to comply during that month with any requirement of this section (to the extent that such requirement applies to that employer).

"(b) DEFINITIONS.—For purposes of this section—

"(1) The term 'health benefit plan' means a separate plan of an employer, or a plan to which such employer contributes, for the benefit of his employees or their spouses or dependents to provide such employees, spouses, or dependents with specified hospital or medical services, through prepayment of fees, direct provision of services, payment of insurance premiums, or reimbursement for expenses incurred. For purposes of this section, plans described in this paragraph provided by an employer to two or more distinct categories of employees, which have different employer contribution amounts, shall be considered to be separate health benefit plans if the distinct categories of employees are reasonably differentiated for purposes of determining fringe benefits on a basis other than their choice of, or participation in, a health benefit plan or option thereof.

"(2) The term 'carrier' means an organization (including a self-insured organization or a multiemployer group) which—

"(A) is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar arrangements; and

"(B) offers at least one health benefit plan (or option thereof) meeting the standards of subsections (h) and (i) which individuals entitled to conversion rights under subsection (f) or (g) may purchase, in accordance with the provisions of subsection (f) or (g) at a reasonable premium rate (as determined by the appropriate State agency in accordance with standards prescribed by the Secretary, which standards shall ensure that the rate is reasonable on the basis of the costs involved in providing such coverage).

"(c) MULTIPLE CHOICE OF PLAN OPTIONS.—

"(1) Any employer having a total of more than 100 employees covered under any health benefit plan offered by such employer at any time during a calendar year must provide that such plan offers at least three options for coverage under such plan, each of which meets the requirements of subsections (f), (g), (h), and (i), and each of which is offered by a separate carrier.

"(2) For purposes of determining whether an option is offered by a separate carrier—

"(A) any carriers which are component members of a controlled group of corporations (as determined under section 1563) shall be considered to be a single carrier; and

"5

"(B) any carriers which are under common control (as determined under section 414(c)) shall be considered to be a single carrier.

"(3) For purposes of determining whether an employer has more than 100 employees covered under a plan—

"(A) all employees of all corporations which are members of a controlled group of corporations (as determined under section 1563) shall be treated as employed by a single employer;

"(B) all employees of trades or businesses which are under common control (as determined under section 414(c)) shall be treated as employed by a single employer; and

"(C) in the case of a plan offered by a multiemployer group, each employer of employees covered under the plan shall be considered to have more than 100 covered employees if the total number of covered employees of all member employers exceeds 100.

"(4) For purposes of this subsection, the three option requirement applies to each type of benefit required under subsections (h) and (i), and more than one carrier may be used under each option, provided that there are at least three options available (by three sep-

arate carriers) for each such type of required benefit. The requirements of this subsection shall not apply to benefits offered under a plan which are not such required benefits.

"(d) EQUAL CONTRIBUTION REQUIREMENTS.—

"(1) With respect to any employer offering more than one coverage option under a health benefit plan, the amount of such employer's contribution shall not depend upon which such option an employee chooses.

"(2) If the contribution amount selected by such employer is in excess of the total cost of any option offered, the employer shall contribute, to any employee choosing such option, an amount equal to the difference between the employer contribution amount and the total cost of the option chosen by that employee. Such contribution may be in cash or in any other form of compensation or benefit, but each such employee shall have the option of receiving such contribution in cash.

"(3) For the purposes of this section and section 125 (relating to cafeteria plans)—

"(A) a contribution required by this subsection which consists of additional health benefits shall be treated as a separate health benefit plan option; and

"(B) a contribution required by this subsection which consists of any type of benefit other than cash or health benefits shall be subject to the provisions of section 125.

"(4) No contribution shall be required under this subsection in the case of an employee who chooses not to participate in any option offered under a health benefit plan.

"(e) LIMITATION ON AMOUNT OF EMPLOYER CONTRIBUTION.—

"(1) For purposes of this section, the limitation on employer contribution to a health benefit plan, or to a dental benefit plan, or both, with respect to each month shall be an amount equal to the indexed contribution amount in effect for such month as determined under paragraph (2).

"(2) The indexed contribution amount for each month in a calendar year shall be an amount equal to the indexed contribution amount in effect for the preceding calendar year, increased or decreased (as the case may be) by the percentage increase or decrease in the medical care component of the Consumer Price Index for the third quarter of the preceding calendar year, as compared to such component for the third quarter of the second preceding calendar year.

"(3) For months in the calendar year 1980, the indexed contribution amount shall be—

"(A) $50.00 with respect to coverage provided for the employee only;

"(B) $100.00 with respect to coverage provided for the employee and his spouse; and

"(C) $125.00 with respect to coverage provided for a family group consisting of the employee and his family (other than coverage described in subparagraph (B)).

"(4) The Secretary shall by regulation establish methods for determining the amount of the employer contribution to or on behalf of each employee in the case of a self-insured employer.

"(f) CONTINUITY OF COVERAGE.—In order to be a qualified contribution under subsection (a)(2), the employer contribution must be for a plan (or option thereof) that provides—

"(1) continued group coverage under such plan or option in the event of the death, separation from employment, or divorce, of the employee, for a period of 30 days following such event, for any individual who had such coverage at the time of such event (and the plan shall provide that such employer shall continue his contribution during such period);

"(2) continued group coverage under such plan or option for an additional period of 180 days after the 30-day period referred to in paragraph (1) for any individual referred to in paragraph (1) upon payment of a premium not to exceed the applicable group premium rate for such period (and such payment may be made through the employer); and

"(3) for the right of any individual referred to in paragraph (1) to convert, during the 180-day period described in paragraph (2), to an individual health benefit plan or option that meets the requirements of subsections (h) and (i), without regard to prior medical condition or proof of insurability.

"(g) COVERAGE FOR FAMILY OF EMPLOYEE.—

"(1) In order to be a qualified contribution under subsection (a)(2), the employer contribution must be for a plan (or option thereof) that—

"(A) allows each employee choosing such plan or option to purchase coverage under such group plan or option, for so long as such employee maintains coverage for himself, for his spouse and any of his qualified children;

"(B) allows any such qualified child covered under the plan or option the right to convert, during the period of 180 days following the date on

which he ceases to be a qualified child of the covered employee, to an individual plan or option that meets the requirements of subsections (h) and (i), without regard to prior medical condition or proof of insurability; and

"(C) provides that with respect to any employee who is covered under the plan or option at the time of the birth of any qualified child of his, the coverage under such plan or option shall automatically include such child (and the cost of coverage shall be adjusted accordingly); except that such employee may choose, during the 60-day period following such birth, to waive such coverage for the child.

"(2) A qualified child of an employee is an individual who is a child of the employee (within the meaning of section 151(e)), and who (A) has not attained the age of 19 and resides in the same household as the employee, or (B) is a student (within the meaning of section 151(e)).

"(h) MINIMUM BENEFITS.—

"(1) In order to be a qualified contribution under subsection (a)(2), the employer contribution must be to a plan (or option thereof) that at least provides coverage for the same types of services for which coverage

is provided under title XVIII of the Social Security Act.

"(2) The requirements of paragraph (1) shall not affect any provisions of such plan or option relating to deductibles or copayments, or relating to requirements that covered services be provided by particular persons or facilities.

"(i) CATASTROPHIC EXPENSE PROTECTION.—

"(1) In order to be a qualified contribution under subsection (a)(2), the employer contribution must be to a plan (or option thereof) that provides for payment of 100 percent of the cost of services included under subsection (h)(1) which are provided to an individual covered under such plan or option during a catastrophic benefit period.

"(2) A catastrophic benefit period with respect to any individual—

"(A) shall begin at such time as the individual and his spouse and qualified children, if covered, have incurred, while covered under the plan, out-of-pocket expenses for services included under subsection (h)(1) provided to them during any calendar year in excess of $3,500; and

"(B) shall end at the end of such calendar year.

"(3) For purposes of this section the term 'out-of-pocket expenses' means expenses, the payment for which such individual, or his spouse, or qualified child covered under the plan or option, is responsible, and for which reimbursement cannot be made, or cannot reasonably be expected to be made, under any other form of insurance or benefit plan, or any law or Government program, but does not include expenses incurred to which reimbursement is not made under a health benefit plan or option solely by reason of the fact that the individual or his spouse or qualified child incurred such expenses for services provided by a person or facility, and under such circumstances, such that payment under such plan or option is not authorized.

"(4) For purposes of this subsection the term 'qualified child' has the same meaning as in subsection (g).

"(5) In the case of an employer whose contribution amount to a health benefit plan for his employees is less than the full amount necessary to provide catastrophic expense protection as required by this subsection, one health plan option offered by such employer shall be considered to meet the requirements of this subsection if it meets all such requirements except that the deductible amount is in excess of $3,500.".

(b) The table of contents of part II of subchapter B of chapter 1 of subtitle A of such Code is amended by adding at the end thereof the following item:

"Sec. 86. Employer contributions to health benefit plans.".

EFFECTIVE DATE

SEC. 3. The amendments made by this Act shall become effective on January 1, 1982.

SPECIAL RULE FOR EMPLOYMENT TAXES

(a) GENERAL RULE.—Chapter 25 (relating to general provisions relating to employment taxes) is amended by adding at the end thereof the following new section:

"SEC. 3508. TREATMENT OF EXCESS EMPLOYER CONTRIBUTIONS AND REBATES UNDER SECTION 86 HEALTH PLANS.

"(a) AMOUNT INCLUDED IN GROSS INCOME UNDER SECTION 86(a) TREATED AS REMUNERATION.—For purposes of this subtitle, any amount required to be included in the gross income of an employee under section 86(a) with respect to any month—

"(1) shall be treated as paid in cash to such employee at the close of such month, and

"(2) shall not be treated as paid under a health or similar plan of the employer.

"(b) SPECIAL RULES FOR CASH PAYMENTS.—In the case of any required cash payment under section 86(d)(2)—

"(1) FICA, RR, AND FUTA TREATMENT.—No amount (in addition to that to which subsection (a) of this section applies) shall be subject to tax under chapter 21, 22, or 23.

"(2) WITHHOLDING.—The remainder of the rebate (after the application of subsection (a) of this section) shall be subject to tax under chapter 24."

(b) CLERICAL AMENDMENT.—The table of sections for chapter 25 is amended by adding at the end thereof the following new item:

"Sec. 3508. Treatment of excess employer contributions and rebates under section 86 health plans.".

COORDINATED ADMINISTRATION

SEC. 5. The Secretary of the Treasury, in determining whether health plans or options meet the criteria of subsections (h) and (i) of section 86 of the Internal Revenue Code of 1954 (relating to minimum benefits and catastrophic expense protection) shall coordinate such determinations with the regulations and decisions of the Secretary of Health, Education, and Welfare in carrying out the program established under title XVIII of the Social Security Act.

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Senator TALMADGE. The subcommittee will please come to order.

Today and tomorrow we will hear testimony on proposals which are intended to increase competition in the health care market.

The objective is laudable and one I share.

None of us who are confronted with the frightening increases in the costs of health care programs can afford to ignore alternatives which might moderate those costs.

In fact, I believe the changes in medicare and medicaid hospital reimbursement which I have proposed, and which have been approved by the Finance Committee, will serve to foster efficiency and competition within the hospital field.

We have found that there are no easy answers to the problem of health care costs.

That is why, properly conducted, the legislative process should subject far-reaching proposals to careful and detailed scrutiny.

We want to avoid having the easy answer serve to compound an already difficult problem.

At the same time, careful scrutiny may provide a good basis for appropriate change. The provisions of S. 1968 and related bills are strongly advocated by serious proponents.

At the same time, there are those who have serious reservations about the ramifications and the necessity of those bills.

Hopefully, during the course of these hearings, we will have answers offered to some of the questions which have been raised, including:

Do employers and employees today have incentives to seek out the most efficient and economical insurers?

Does the tax deductibility of an employer's payment for health insurance in fact serve to create relative indifference on their part, as well as on the part of employees, to the costs of health care?

Are employers, unions and others concerned acting to moderate health care costs and premiums?

What effect will these proposals have on the collective bargaining process in the United States?

What are the three different options from three different insurers which would be required of an employer?

What are the effects on the administrative and risk costs of health insurance to employers and employees in terms of having three different plans instead of one?

What are the effects of these proposals on the many self-insured or trusteed plans?

What would be the effect on the economic advantage of a single insurer writing an employer's coverage on a package basis—health insurance, major medical and life insurance—if they were required to be fragmented in the future?

What new administative costs and regulatory burdens would these proposals place upon employers and Taft-Hartley trusts?

What would be the effects of adverse selection on various types of insurers and their costs of providing benefits?

Would a complex federally required plan inhibit an employer from providing benefits or result in his cutting back on benefits?

Would large copayments and deductibles, if selected by the youngest employees with the lowest incomes, aggravate hospital

bad debts and collection problems and create further pressure for coverage by Federal programs such as medicaid?

To what extent would a mandatory three-option program create difficulties in insurance company ratemaking?

Do these approaches allow for legitimate qualitative differences among hospitals and practitioners which may result in greater or lesser costs?

Does the proposed maximum on the deductibility of health insurance premiums fail to acknowledge acceptable differences in costs of providing benefits in one area of the country as opposed to another?

Is low cost care necessarily provided appropriately and at proper levels of quality?

Finally, would legitimate variations in cost and quality of care become subject to arbitrary limits?

That is, is low cost care by definition more efficient, or are there other factors involved?

Obviously, we have a lot of questions, and the committee will certainly look forward to answers.

Because of the large number of witnesses today, I must ask that presentations be as brief as possible, consistent with the making of key points.

Questions and answers, to the extent possible, should also be brief and to the point. With that out of the way, I know we all look forward to an informative hearing.

I would suggest, if it meets with the pleasure of the committee, that witnesses be limited to 10 minutes in presenting their testimony and members of the committee, certainly on the first round, be limited to 5 minutes of questioning.

Is that agreeable, Senator?

Senator DURENBERGER. That is.

Senator TALMADGE. Without objection, so ordered.

Any statement?

Senator DURENBERGER. Yes, Mr. Chairman.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. I want to thank you, Mr. Chairman, for this opportunity and I am indebted to you as all Americans are, for your long-time interest in the subject of health care and we are now indebted to you, as reflected in your opening statement, for a long and probably not totally complete list of very good questions about the approach to health care that we propose here.

I think that it is very appropriate that this subcommittee's first hearing on health care competition comes at a time when national attention is focused on inflation and the economy. The bill we are here to discuss today, S. 1968, the Health Incentives Reform Act, directly addresses the national priorities that have been identified by the President, the Congress and, most important, the public.

Direct Federal Government expenditures on health care continue to increase at alarming and uncontrollable rates. Expenditures on medicare alone are doubling every 4 years, and will total $33 billion in 1980. Total Federal health costs constitute more than 12 percent of the Federal budget. The very fiscal integrity of the Federal budget is jeopardized by these costs: Cost containment strategies are imperative.

The efforts to date have been regulatory. As costs rise, regulations increase, leading to a cycle of more costs and more regulation—all to no avail. Despite considerable investment of Government time and money into regulation, independent studies increasingly acknowledge that the result may be increased costs.

The Health Incentives Reform Act works by providing consumers financial reasons to select the best value in medical care. In turn, this generates incentives among providers to become more cost-conscious and to deliver care as efficiently as is possible.

According to the Congressional Budget Office, the Health Incentives Reform Act will reduce private spending on medical care by an estimated $4 to $6 billion by 1985. Mr. Chairman, I am including the complete CBO report in the record of today's hearings.

Senator TALMADGE. Without objection, the complete CBO report will be included in the record.

Senator DURENBERGER. Thank you, Mr. Chairman.

[The material referred to follows:]

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

Alice M. Rivlin
Director

March 18, 1980

Honorable David Durenberger
United States Senate
Washington, DC 20510

Dear Senator:

The Congressional Budget Office has prepared a cost estimate for the Health Incentives Reform Act of 1979 (S. 1968) at the joint request of Senator Edmund Muskie, Chairman, Senate Budget Committee, and Senator Henry Bellmon, Ranking Minority Member, Senate Budget Committee.

In response to your letter of February 28, 1980, we are sending a copy of this estimate.

Should you desire further details, we would be pleased to provide them.

Sincerely yours,

Alice M. Rivlin
Director

Attachment

CONGRESSIONAL BUDGET OFFICE
Cost Estimate

March 17, 1980

1. BILL NUMBER: S. 1968

2. BILL TITLE:

Health Incentives Reform Act of 1979

3. BILL STATUS:

As introduced and referred to the Senate Finance Committee, November 1, 1979, as clarified in a letter from Senator Durenberger to Dr. Rivlin dated March 6, 1980.

4. BILL PURPOSE:

The purpose of the bill is to encourage competition in the health care industry and to encourage the provision of catastrophic health insurance. The Internal Revenue Code of 1954 would be amended to place a ceiling on the amount of employer contributions to health benefit plans excludable from the employee's gross income. The bill would also require employers providing health benefits to offer a choice of plans with a fixed contribution. Each plan at a minimum would provide protection against catastrophic medical expenses.

5. COST ESTIMATE:

The bill would tax the portion of employer contributions to health benefit plans in excess of a ceiling and would tax rebates paid to employees who choose plans with premiums lower than the employer's contribution. This would be offset to some extent by some employers increasing contributions in response to incentives in the bill. The projected net increases in revenues are shown below.

(by fiscal years, in billions of dollars)

Revenues	1981	1982	1983	1984	1985
Estimated Revenues	0	1.0	1.7	2.0	2.3

These estimates are subject to substantial uncertainty. For example, the 1985 estimate could be as low as $1.5 billion or as high as $3.0 billion.

The bill would reduce private health spending by inducing people to change to insurance plans with more cost-sharing and to prepaid health plans such as Health Maintenance Organizations. By fiscal year 1985, private spending on medical care is projected to be $4 billion to $6 billion lower than under current policies. Most of this reduction would be in nonhospital spending such as physician services, dental services, and mental health services.

The bill would have indirect effects on federal outlays for Medicare and Medicaid, but they would be very small. Physician fees would be lower than under current policies, but most of this effect would show up in average revenues per visit (changes in billing practices, volume of ancillary services ordered) rather than in customary charges for particular procedures. On the other hand, reduced utilization among private patients should free up resources for use by Medicare and Medicaid patients, increasing outlays. The net impact on federal outlays should be close to zero.

6. BASIS OF ESTIMATE:

The estimate assumes passage by July 1981 and implementation on January 1, 1982, the date specified in the bill.

The data base for the analysis is a survey of employment-related health benefit plans conducted by the Bureau of Labor Statistics in 1977. By re-weighting the survey according to national employment patterns, a distribution of monthly family premiums was obtained. Additional data sources were used to adjust for the survey's exclusion of small plans (those with less than 25 participants) and plans in nonprofit organizations. Other sources were also employed to estimate by size of premium the share of the premium contributed by employers.

The premium distribution under current policies was projected to 1985. By extrapolating historical trends, the premium per covered employee was projected to increase at an average annual rate of 14 percent. The share contributed by the employer was projected to increase from 72 percent in 1977 to 80 percent in 1985.

The bill's ceiling on excludable employer contributions is $125 per month for family coverage in 1980, indexed by the Medical Care Component of the Consume Price Index. On the basis of historical relationships, the indexed ceiling was assumed to grow more slowly than premiums per covered employee--by three percentage points per year. Consequently, the ceiling gets tighter over time.

The projected distribution of employer contributions and the projected ceiling were then compared. By 1985, about 34 percent of covered employees should have contributions exceeding the ceiling. (The comparable 1981 projection is 20 percent.)

A substantial number of employees receiving contributions in excess of the ceiling should change insurance plans. For those employees who would be receiving contributions in excess of the ceiling under current policies, the employer contribution was assumed to continue as under current policies.[1] The proposal's effective removal of the tax subsidy for insurance purchased with contributions above the ceiling should result in many employees choosing lower-cost plans. For those employees with employer contributions exceeding the ceiling by more than two-thirds, switching to low-option plans was assumed to reduce the average premium by about 40 percent. For those with employer contributions exceeding the ceiling by less, the estimated reduction in average premium was correspondingly lower.[2]

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1. The estimate is not sensitive to employers reducing contributions in this range.

2. The reduction in average premium was based on an assumption of a 1985 marginal tax rate of 40 percent (income tax and FICA). The elasticity is based on Charles Phelps, Demand for Health Insurance: A Theoretical and Empirical Investigation, prepared for the Office of Economic Opportunity (Rand, R-1054-OEO), July 1973. A larger reduction in average premium is implied by Martin Feldstein and Bernard Friedman, "Tax Subsidies, the Rational Demand for Insurance and the Health Care Crisis," Journal of Public Economics, vol. 7 (1977), pp. 155-178, but the Phelps estimates were judged to be more reasonable.

For those employees whose contributions are projected to be lower than the ceiling, the average premium paid was assumed to be unchanged because the tax subsidy for the purchase of health insurance would not be altered. While significant numbers of employees would probably choose plans with lower premiums, such changes should be balanced by those choosing plans with premiums higher than present plans. The ability of employers to offer cash rebates to employees choosing low-cost plans without jeopardizing the tax-free status of contributions to those selecting high option plans should induce some employers to increase their contributions to health-benefit plans.[3] Those employees who prefer extensive health insurance would wind up with a more extensive plan than before, while others would wind up with the same plan or a less extensive plan plus the rebate. If the single plan under current policies reflects preferences of the average employee, then the average premium under multiple choice would remain the same.

The multiple choice provision of the bill would cause a revenue loss by inducing employers to increase their contributions up to the ceiling. Those with contributions below the ceiling under current policies who choose a more expensive plan will in effect have sheltered more of their compensation from taxes. Those choosing the same plan or a lower cost one will avoid payment of FICA on the portion of the rebate below the ceiling on tax-free benefits.

Some employees would be induced to enroll in Health Maintenance Organizations. Using the 27 percent annual rate of growth of HMO enrollment in the Minneapolis-St. Paul area as an upper bound, S. 1968 was assumed to increase national HMO enrollment growth from 13 percent to 17 percent per year, with half of the additional enrollment occurring in independent practice associations.

Given assumptions about employer contribution shifts and employee choices of plans, calculation of revenue effects and reductions in the premium of the average plan followed

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3. All employers with noncontributory plans were assumed to increase contributions to the ceiling. Smaller percentages of employers with contributory plans were assumed to increase contributions to the ceiling.

directly. Assuming a base of $132 billion in group insurance premiums in 1985, revenues should be approximately $2.3 billion higher in that year than under current policies. The average premium for the chosen plans should be about 11 percent lower than under current policies.

The premium reduction was converted to a reduction in coverage (the proportion of the bill paid by insurance). The factor of a 0.45 percent reduction in coverage for every 1 percent reduction in premiums that was used reflects both a moderate amount of adverse selection (healthier people tending to choose the low option plans) and a reduction in service use roughly equivalent to the reduction in coverage (for example, a 5 percent reduction in coverage causes a 5 percent reduction in use).[4] This translated the premium reduction to a 5 percent coverage reduction. About 85 percent of this coverage reduction was assumed to be for nonhospital services. Assumptions about the effects of health insurance on the use of services are from the low end of the range found in the literature.[5]

Reduced insurance coverage should cause medical fees to increase slower than they would otherwise. Based upon a study by Frank Sloan,[6] medical fees were projected to be about 3 percent lower by 1985 than under current policies. However, Sloan's results predict all of the effect to be in average revenues per visit rather than in customary charges for a visit, so that much of this effect would neither be measured by the Consumer Price Index nor by the "usual, customary, and reasonable" profiles used to determine Medicare reimbursements.

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4. Assuming that most of those employees choosing lower cost plans have relatively extensive coverage now, this utilization assumption is equivalent to a demand elasticity of about -0.2.

5. For hospitals, see Joseph P. Newhouse and Charles E. Phelps, "New Estimates of Price and Income Elasticities of Medical Care Services," in Richard Rosett, editor, The Role of Health Insurance in the Health Services Sector (New York: National Bureau of Economic Research, 1976), pp. 261-312. For physician services, see Anne A. Scitovsky and Nelda McCall, "Coinsurance and the Demand for Physician Services: Four Years Later," Social Security Bulletin, vol 40 (1977), pp. 19-27.

6. Frank A. Sloan, "Physician Fee Inflation: Evidence from the Late 1960s," in Rosett, Role of Health Insurance.

Some offsets were applied to the reduction in private expenditures. First, the fee reduction should induce some increased utilization. Second, the so-called "Roemer effect," or the phenomenon of the availability of resources shifting the demand for services, should result in an increase in use. A one percent increase in resources was assumed to increase hospital use by 0.4 percent, and physician use by 0.2 percent. Netting out all of these offsets leaves an expenditure reduction of about 5 percent.

Finally, savings from additional HMO use were added. On the basis of Harold Luft's research, we assume that a mixture of group practice and independent practice HMOs should reduce expenditures by 15 to 20 percent relative to fee-for-service practice.[7]

7. ESTIMATE COMPARISON:

CBO has estimated the cost of H.R. 5740, a bill with similar provisions. Revenues raised and private medical expenditures saved are projected to be higher under H.R. 5740 than under S. 1968. The major reason for the difference is a tighter limitation on tax-excludable contributions in H.R. 5740.

CBO has also estimated the cost of S. 1590. A revenue loss is projected because the ceiling on tax excludable contributions is much less restrictive, and rebates are not taxed. Private medical expenditure reductions are larger in S. 1590 because the rebates would be tax-free, causing more people to reduce their health insurance coverage.

8. PREVIOUS CBO ESTIMATE:

None.

9. ESTIMATE PREPARED BY: Paul B. Ginsburg (225-9785)
Larry Wilson (225-9785)

10. ESTIMATE APPROVED BY:

James L. Blum
Assistant Director for Budget Analysis

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7. Harold S. Luft, "How Do Health Maintenance Organizations Achieve Their 'Savings'?: Rhetoric and Evidence," New England Journal of Medicine, vol 298 (June 15, 1978), pp. 1336-1343.

Senator DURENBERGER. Unfortunately, the necessary focus on costs has diverted congressional attention away from other worthwhile goals like assuring quality of care and access to health care for all Americans. Until health care costs are brought under control this Congress simply cannot afford to pursue these admirable objectives.

One of the attractions of the competitive approach is that it won't just save our citizens money. It will also result in health providers being more responsive to consumer needs.

As an example, in the Twin Cities of Minneapolis and St. Paul, where competition is flourishing, new clinics and doctors' offices are being built in locations that will best satisfy patients—not doctors—and hours are being structured to best meet patient needs. The true beneficiary of competition is the consumer.

Some critics of the competitive approach argue it will take too long to develop effective market forces in health care. Too long compared to what? How long have we been tinkering with a regulatory solution to our health care concerns, and with what success?

The Health Incentives Reform Act is not meant to be a panacea to all of our health care woes. It is a first step. A first step toward reducing Federal regulation that now costs our country more than $100 billion a year. A first step toward greater cost-effectiveness in health care. A first step toward better quality and more appropriate distribution of health resources. And a first step toward being able to afford adequate health care coverage for all Americans.

The Health Incentives Reform Act successfully melds elements of catastrophic coverage, system reform, and cost containment—all at no cost to the Federal Government and substantial benefit to the consumer. The time for this kind of legislation is now. It demands our serious discussion and consideration.

Thank you.

[The material submitted by Senator Durenberger follows:]

Senator Dave Durenberger

News Release

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HEALTH INCENTIVES REFORM ACT OF 1979

SPONSOR: DAVE DURENBERGER

CO-SPONSORS: DAVID BOREN
JOHN HEINZ

SUMMARY: S. 1968 would amend the Internal Revenue Code in the following ways:

For employers of over 100 people, in order for an employee to claim as tax free the employer's contribution to a health benefit plan that employer must comply with the following:

1) MULTIPLE CHOICE - Each employer shall include in any health benefits program a choice of at least three health insurance or delivery plan options meeting prescribed standards. Each of these options must be offered by a separate carrier.

2) EQUAL EMPLOYER CONTRIBUTION - The amount of an employer's contribution shall not depend upon which option an employee chooses. If an employee chooses a plan whose premium is below the employer contribution level, the employer must give the employee the difference in taxable cash or other benefits.

3) CONTINUITY OF COVERAGE - Coverage for at least 30 days would be required for employees after termination of employment, for dependents after death of an employed family member, and for divorced spouses after divorce. Six months additional continuation of existing coverage upon continued payment of premium by the insured. Following this six month period, conversion to individual coverage would be permitted.

Furthermore, a limit is set on the monthly contribution the employer can offer the employee as tax free:

$50 for one employee coverage;
$100 for employee and spouse;
$125 for family coverage.
These amounts will be indexed to the Consumer Price Index.

In addition, all employers who offer a health plan must include in each offering, coverage of catastrophic medical expenses which exceed $3500 out-of-pocket in any one calendar year. The types of services covered by this catastrophic coverage will be those covered by Medicare.

FOR FURTHER INFORMATION OR DISCUSSION, PLEASE CONTACT AT SENATOR DURENBERGER'S OFFICE, TOM HORNER, 202-224-3244.

WHAT HIRA (S. 1968) WILL DO:

1) HIRA will introduce competition into health care delivery at the time when the employed person chooses a health plan, not when care is needed. Multiple choice is really the converse of high-deductible, cost-sharing plans. The latter induce individuals to avoid seeking care, even when sick; and the fixed deductibles are regressive. Multiple choice promotes objective decisions when the employee is well.

2) HIRA will promote innovative plans - HMOs and others - only to the extent that they can offer efficient, quality health plans. Nothing in the bill favors HMOs or any other particular delivery system except to give them all more of a chance to compete fairly for business.

3) HIRA offers employees the chance to choose the plan which suits them best, rather than having only a single plan chosen by the employer.

4) HIRA limits the tax-free contribution of employers to health plans. The actual figures for this limitation are indexed to the health-cost segment of the Consumer Price Index.

5) HIRA will encourage carriers (insurers, HMOs etc.) to find cost-efficient providers to deliver services.

6) HIRA will maintain the current diversity of medical practice schemes and private insurance plans.

7) HIRA insures that employer-based health insurance will cover the costs of catastrophic illness.

WHAT HIRA WILL NOT DO:

1) HIRA will minimize federal regulation. Compliance will be necessary for employees to claim contributions as tax free.

2) HIRA will not encourage poorly run or inefficient delivery systems.

3) HIRA will minimize federal regulation. Plans offered would only have to cover the same sort of services covered by Medicare, but not at any mandated level of dollar coverage (deductibles, etc.)

4) HIRA will not require new federal expenditures. In fact, these system reforms will generate tax revenue and reduce private sector health expenditures. A CBO analysis of these results is extremely favorable.

5) HIRA will not change the tax structure which taxes all income to employees, whether given as cash rebate or otherwise.

Senator Dave Durenberger

QUESTIONS AND ANSWERS

ON

SENATOR DAVE DURENBERGER'S

HEALTH INCENTIVES REFORM ACT OF 1979

1. WHAT IS THE COST OF YOUR BILL?

ANSWER: The provisions of this bill will cost the Federal Government nothing. In fact, with a cap on the amount an employer can contribute to an employee's health benefit plan that is considered tax free to the employee, the Federal Government should realize some additional tax revenues. The cap assures that the tax subsidy the Federal Government will provide for health insurance does not exceed an amount that should cover the premium cost of a reasonably comprehensive benefit package provided in a cost-effective setting. Precise estimates of these recovered tax revenues do not exist at this time.

Employers will experience an additional administrative burden and expense from complying with the multiple choice and equal employer contribution requirements. These new costs will be countered by decreased health benefit costs resulting from increased competition and the contribution cap. As competition takes hold the rate of health care cost increases should taper off, and employer-based health plans should share in this lowered growth rate. It is extremely difficult to estimate the net effect of these factors on the employer. The experience of the Federal Employees' Health Benefits Plan and many employers who already offer multiple choice suggest that the additional administrative cost would not be excessive.

Consumers will share in the savings of a competitive system. They will realize greater benefits and relatively lower out-of-pocket costs if they select cost-effective plans.

2. HOW MANY AMERICANS WILL BE AFFECTED BY YOUR BILL?

ANSWER: In 1975, about 70 million workers, or 75% of all wage and salary workers, were covered by some type of health insurance financed by employer-paid premiums. Those workers and their dependents, and the employers they work for, would be affected by the provisions in my bill. For the 37.5 million persons with basic hospital insurance and no major medical coverage, the catastrophic provisions in my bill would represent improved coverage.

3. HOW DOES YOUR BILL ADDRESS THE ISSUE OF BETTER HEALTH CARE COVERAGE FOR ALL AMERICANS?

ANSWER: The uncontrolled escalation in health care costs is a major reason the number of Americans without affordable health care coverage is increasing year after year. Before we can extend health coverage,

we need structural changes in the health care system that will make the extended coverage affordable.

The changes that I propose in my bill will stimulate competition and contain costs in a manner consistent with any policy we subsequently adopt to provide health care to low-income, uninsurable, and otherwise uncovered Americans. Project Health in Oregon has demonstrated that low-income people can participate in competitive markets to their advantage and to the advantage of the taxpayers.

We can pursue these pro-competitive structural reforms now at no cost to the Federal Government.

4. WHAT DOES YOUR BILL DO TO HELP PERSONS FROM SMALLER COMMUNITIES?

ANSWER: While the majority of HMOs (the predominant form of competitive model) have developed in relatively large urban areas, there have been a number of innovative competitive plans developed which are successful in smaller communities. The Wisconsin Physicians Service Health Maintenance Program was begun in 1970 and now covers about 150,000 people. A similar system was started in 1974 by the SAFECO Financial Service Company and now has a total of approximately 23,000 members spread over Washington State and Northern California. These plans use innovative incentive mechanisms to make them cost-effective and competitive. SAFECO physicians act as the complete health caretaker for plan enrollees; doctors direct both clinical and financial aspects of care and share in end of year surpluses or deficits. There is no question that it would take some time for all the benefits of competition to spread to smaller communities, but my bill will help speed that process.

Furthermore, there are indirect benefits for these people.

1) Rural physicians refer their serious cases to expensive urban medical centers. Competition in urban areas will result in cost containment, and the benefits will be shared by those rural people referred to the city.

2) Competition in urban areas will result in more appropriate distribution of physicians (especially specialists), and there will be stronger economic incentives for physicians to enter primary practice and move to rural areas. Some claim that there currently exist strong financial rewards for practicing in rural areas (many communities offer lucrative salaries)...and still physicians do not move out of the city. This is true. What we lack now, however, are economic penalties (disincentives) for practicing in over-supplied urban areas. Under a competitive system, there will no longer be the extensive open-ended financing we now have that supports extra and unneeded health services.

5. WHAT EFFECT WILL YOUR BILL HAVE ON HOSPITALS AND HOSPITAL COSTS?

ANSWER: People don't choose hospitals, doctors do. Hospitals are thus accustomed to filling their beds by attracting doctors, not patients. When their costs are paid by third parties, it is not surprising to see vast capacity expansion and unnecessary duplication of expensive technologies. Competitive health plans introduce an acute cost

awareness into the system. Competitive plans are going to be concerned about quality, but they are going to be concerned about costs as well. The hospital that operates cost-effectively and has a relatively lower per diem rate will be more likely to secure a competitive plan's business. As competitive plans garner more and more of an area's available patients, their influence over hospital behavior will become more and more significant.

With the rapid growth of competitive plans in the Twin Cities, hospitals are beginning to face intense competitive pressure to operate more cost-effectively. These plans are shopping around for hospitals that can provide them with the best deal, and in those plans with established hospital relationships, the plans have in some cases negotiated discounts and are applying strong pressure for efficiency reform.

6. COMPETITIVE PLANS HAVE DEVELOPED AND PROVEN EFFECTIVE IN SELECTED AREAS. WHY HAVEN'T THEY HAD MORE SUCCESS? WHY HAVEN'T MORE DEVELOPED ON THEIR OWN?

ANSWER: The reasons are many. My bill is aimed at correcting some of the most important barriers. For example, most people today don't have a choice to have a market. In today's health benefit plan environment, employers offer one plan to cover their employees. Since the plan must satisfy each and every employee and meet his or her particular needs, it must permit participants to use any physician in any hospital in the community. A one-plan offering on the part of employers has meant that insurance plans compete not on the basis of benefit design, but rather on the basis of administrative cost and services.

Until we have a multiple choice environment we cannot expect plans to develop which have a limited number of efficient providers participating in them. The efficient providers in a community cannot form their own plan today because they would not be a viable offering for an employer. A single limited provider plan would not meet the needs of all employees. Only in a multiple choice environment can efficient plans with a limited number of providers begin to develop.

HMOs are the most widespread model of a competitive plan. Drafters of the original HMO legislation recognized the importance of dual choice in assuring the growth of HMOs. The problem is that there are limited provider arrangements which fall short of HMOs which would be competitive if they had access to the market. The dual choice provision in the HMO Act encourages an all or nothing response; innovative and cost-effective arrangements that do not meet federal HMO guidelines are stifled because they don't have access to the market. HMOs are the only existing competitive model because only HMOs are guaranteed access to the market. Multiple choice by employers assures that the environment will at least be conducive to the development of new kinds of cost-effective arrangements.

7. WHY DOES THE PENALTY FOR NON-COMPLIANCE WITH THE PROVISIONS IN HIRA SEEM TO REST WITH THE EMPLOYEE RATHER THAN THE EMPLOYER?

ANSWER: Compliance with HIRA states that any contribution on behalf of a taxpayer by his employer to a health benefit plan shall be included in that taxpayer's gross income if the conditions of the bill

are not met. While it appears that penalty rests with the employee, the effect of this compliance provision will be to hold the employer responsible for the amount that otherwise would have been withheld had the contribution been considered taxable wage. Very large numbers of people in this country work for federal, state and local government agencies and for not-for-profit institutions such as hospitals, churches, schools, and universities. In these cases, the employer has no income tax liability. Consequently, it becomes much more practical to use the exclusion from the employee's taxable income as the lever to achieve change.

8. WHAT ARE THE MINIMUM BENEFIT STANDARDS IN YOUR BILL AND TO WHOM DO THEY APPLY?

ANSWER: Employer-based health benefit plans must meet certain minimum benefit standards. These include continuity of coverage following termination of employment, death of an employee, and divorce, an option to purchase dependent coverage through the employer, and catastrophic coverage. Catastrophic expense protection consists of all health plans limiting consumer out-of-pocket expenses for basic benefits to a maximum annual amount of $3,500. Legitimate expenditures are those covered under Medicare.

9. WHAT COST-SHARING PROVISION ARE INCLUDED IN YOUR BILL?

ANSWER: There are two principal forms of cost-sharing: cost-sharing of premiums and cost-sharing of utilized services. Cost awareness with regard to premiums is essential if the consumer is to have an incentive to seek out cost-effective plans. If we simply pay consumers 100% of whatever their health care costs, we fail to reward those individuals who choose more efficient plans. Cost-sharing of premiums permits consumers to make choices when they are healthy and relatively free of disease. Unlike cost-sharing of utilized services, cost-sharing of premiums does not affect their behavior when sick and in need of care.

Cost-sharing of premiums does not necessarily mean that employees must contribute to the premium, but it does mean that they must recognize the differences in premiums among plans. For example, an employer contribution may pay the entire amount of one plan's premium, but if an employee chooses to use a more expensive plan, then he or she should realize the additional expense. Likewise, if a chosen plan is less than the employer contribution, the employee realizes the savings.

Senator TALMADGE. The first witness today is Karen Davis, Deputy Assistant Secretary for Planning and Evaluation, Health Department of Health, Education, and Welfare.

We are delighted to have you, Ms. Davis, and you may insert your full statement in the record and summarize it as you see fit, please.

Ms. DAVIS. Thank you, Mr. Chairman.

I have with me today Mr. Peter Falk, Director of the Office of Policy Analysis, Health Care Administration; and Mr. Howard Veep, Health Maintenance Organizations.

STATEMENT BY KAREN DAVIS, PH. D., DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION/HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Ms. DAVIS. Mr. Chairman, I am very pleased to have the opportunity to discuss with you the bill you are considering today, the Health Incentives Reform Act of 1979—S. 1968.

This bill is intended to promote efficient methods of financing and provide health care through increasing competition, concepts strongly supported by the administration. It addresses major problems in the health care system.

Despite its many strengths, our health care system also has serious flaws. Today we face three pressing and immediate challenges:

First, we must find ways to control rapidly escalating health care costs. During the 10 years between 1968 and 1978, expenditures of health care services have risen at an average rate of 12 percent per year. If current trends continue, national health spending will be close to $400 billion by 1984, over 10 percent of our gross national product.

Second, we must protect our citizens from financial hardship imposed by medical bills. Today, 22 million Americans have no health insurance coverage; 7 million of the uninsured have incomes below the Federal poverty level, an income of $7,500 for a family of four in 1980. For these individuals, even modest medical expense can be a catastrophe. In addition, 20 million Americans have inadequate coverage for basic medical expenses and another 41 million have inadequate coverage against very large medical expenses. In total, 83 million Americans, more than one-third of our population, are inadequately protected against the devastating costs of medical care.

Third, we must improve access to health care services and assure provision of more appropriate types of care. More than half of our citizens who have incomes below the poverty level are not eligible for medicaid and encounter financial barriers in seeking health services. Millions more poor Americans live in medically underserved areas with few providers, and they may not have easy access to a health care provider. Alternative health delivery systems, such as health maintenance organizations or community health centers, are not present in many parts of the country. Finally, our current financing and delivery systems tend to stress provision of expensive acute care services rather than primary and preventive services. The administration is engaged in numerous efforts to address these problems. The administration's national

health plan takes an overall approach toward these problems, seeking to simultaneously improve coverage and access, provide expanded protection against catastrophic expenses and control overall health care costs.

The legislation which you are considering today, the Health Incentives Reform Act of 1979—S. 1968—focuses primarily on one of these issues, the problem of health care costs. The basic philosophy underlying this legislation is one on which I believe we can all agree. We need and must encourage more efficient delivery of health care services and should promote increased competition in the health care sector.

As I am sure you are aware, the health care sector has many unique features which inhibit the ability of competitive forces to exercise restraint on rising costs.

First, providers dominate the decisionmaking process. Overall, 70 percent of health care expenditures are generated by physician decisions. Physicians determine which tests to order and whether a patient needs hospitalization or surgery. The central role of providers in health care means that physicians can and do create demand for their own services.

Second, patients generally have limited ability to question physician judgments or shop for medical services. This is partly because consumers tend to be unaware of the costs of coverage or care. But it is also because medical care is not like other commodities that consumers purchase. Consumers generally do not have sufficient knowledge to judge the specific types of services they require or the quality of care they receive. The decision to seek medical care is often made at a time of stress, when any consumer is loathe to question a physician's recommendation.

Third, current forms of insurance coverage exacerbate the inherently noncompetitive features of the health care market. Insurance insulates both providers and patients from the immediate impact of health care costs and makes them less concerned about the costs of services they use. Most workers receive coverage through employer-related plans, a system which incorporates tax incentives encouraging purchase of comprehensive, first dollar coverage.

There are numerous ways we could attempt to promote competition in the health care sector. We could provide more information to consumers, encourage providers to participate in cost-efficient prepaid practices, encourage certain alternative modes of delivery such as expanded use of nurse practitioners, and increase review activities to make providers more conscious of the costs associated with the services they provided.

S. 1968 addresses itself to increasing competition in the health selection process. The administration's NHP includes competitive elements as part of a comprehensive strategy for reforming the health system.

While we may all agree on the goal of increasing competition in health care, we should also be aware of its limitations. Competition provides one way of attempting to increase consumer choice and contain costs. However, when we consider procompetitive proposals, we must be sure that they conform with other social goals. We must be sure that the poor do not end up paying the price for greater efficiency and cost containment in health care.

We must also recognize that the proposals designed to increase competition and contain health care costs are largely new and untried. There is little evidence to indicate that these efforts can provide substantial immediate relief from health care inflation or that competitive approaches can effect more than marginal changes in the health care system.

Alternatives to insurance-based, fee-for-service medicine do not exist in many parts of the country. Only 4 percent of the population is now enrolled in HMO's, and even with rapid growth, we expect that no more than 10 percent of the population will be enrolled in an HMO by 1988. Even with strong incentives, it will take time to develop HMO's and IPA's in areas where these systems do not exist.

Other approaches to increase competition, like S.1968, attempt to change consumer purchasing habits. However, we have little practical experience which shows how the majority of consumers would actually behave in such circumstances. Even if consumers do respond to tax incentives in the predicted manner, this change is likely to happen slowly and over a number of years.

I am not trying to suggest that we should not attempt to encourage competition in health care. But I do believe that we must be modest in our expectations. The factors which impede competition and its potential for containing costs are deeply ingrained in the health care system. Our national health plan would be coupled with more direct efforts to contain health care costs, particularly reform of our reimbursement mechanisms, and this approach will be the most effective way of improving the efficiency of our health system.

Let me now turn to the specific proposal which you are discussing today, S. 1968, the Health Incentives Reform Act of 1979. This bill would use tax incentives to promote changes in employer-provided health insurance, thereby encouraging consumers to choose less expensive types of health care coverage.

We strongly support the intent of this proposal, specifically the minimum standards for employer plans, in terms of benefit requirements and out-of-pocket liability, and the equal employer contribution provisions which are similar to those required under the administration's national health plan.

Under the administration's proposal, however, all employers would be required to offer plans conforming to these standards. S. 1968 does not attempt to expand employer-provided health insurance. It imposes these requirements only on those plans an employer voluntarily chooses to offer. We have some concern about establishing minimum standards without mandating coverage by employers. While this may lead to an upgrading of the plans offered by some employers, it could result in other employers completely discontinuing their health coverage or becoming reluctant to initiate it. A similar phenomenon was observed among private pension plans after enactment of ERISA.

Another point of similarity with the administration's proposal is the requirement that employers which offer multiple choice of plans contribute equally to all plans which they offer. Equal contribution, on its own, reduces the likelihood that the employee's choice of plans will be determined by the level of contribution by

the employer. This can encourage the employee to choose more efficient plans like HMO's where they can receive more benefits for their premium contribution.

At the same time, I have some reservations about other provisions in the proposal. In particular, I am concerned about two features, the proposal to limit the subsidy on contribution to premiums and the structure of the multiple choice provisions in S. 1968. These proposals appear to be attractive methods of encouraging competition. Depending upon how they are structured, they may create unintended incentives in health care financing.

Under this bill, the employer's contribution to health insurance premiums that qualify for the tax subsidy would be limited to $125 per month for a family, indexed over time to increases in the medical care component of the CPI. Any excess contribution would be taxable income to the employee.

From the point of view of tax policy, this proposal appears attractive since it limits the amount of tax subsidy provided for any form of health insurance. I can well understand, and sympathize with, concerns about the manner in which current tax treatment of health insurance encourages workers to take additional compensation in nontaxable fringe benefits rather than in taxable wages.

From the perspective of health policy, however, limiting the subsidy for the employer's contribution in this manner appears less advantageous. Most health insurance today is sold on an experience-rated basis, and premiums reflect the anticipated utilization of services by a specific employer group. An employment group which includes a high proportion of older workers or women pays more for the same package of benefits than workers with lower utilization. Premiums also vary among geographic areas, reflecting geographic differences in utilization and health care costs.

The flat national limit proposed in S. 1968 does not take account of these differences in the price of similar health coverage. Some employees will have to pay more for their health insurance, not because they chose a richer package of benefits or a more inefficient plan, but because they work for an employer whose experience-rated premiums are higher. These inequities are of particular concern since those most likely to be affected are the higher risk workers who are most in need of health insurance coverage.

Another problem is that such a proposal may in fact reduce employer concern about health care costs. Employers can be a potent force in combatting health care inflation. They can actively encourage growth of health maintenance organizations and negotiate with insurance carriers for more efficient operation. If the proposal worked as intended, limiting to a fixed dollar amount the employer's contribution that qualifies for the tax exclusion even when indexed according to the increase in overall medical care could reduce the employer's incentive to be concerned about rising health care costs.

The proposal before you requires that the employer offer plans of at least three separate carriers. This differs from the administration's national health plan, which requires multiple choice of HMO's. Multiple choice provisions are intended to encourage competition and contain costs in two ways: first, by providing employees with financial incentives for choosing more efficient methods of

coverage; and second, by attempting to promote competition among health plans by assuring that employees have a choice of plans.

My concern is that the specific structure of the multiple choice provision in S. 1968 may unintentionally lead to an increase in health care costs. In areas where alternative health plans such as HMO's are not available, employers would have to offer three traditional plans in order to conform to the requirements of this proposal. This could lead to three problems.

First, less efficient carriers may be assured a market they do not now have. Currently, many employers offer only one traditional insurance plan and each carrier has strong incentives to offer the best price and benefit structure they can.

Second, the price advantages of group insurance would be reduced if the employment group is split between three plans. Carriers may have to increase premiums in order to budget for potential adverse selection among employees.

Third, employers who self-insure in order to reduce costs may be less likely to do so if they are required to offer two plans from insurance carriers as well.

These problems can have particularly adverse consequences on smaller employees. S. 1968 would apply to firms of 100 or more employees. The negative impact of this multiple choice provision would be ameliorated by increasing the size of firms subject to the requirements.

We note that S.1968 addresses only employer-related health insurance. We encourage expansion of the concept of increasing competition for the private sector to encompassing medicare beneficiaries as well. The administration's proposed Health Maintenance Organization Medicare Reimbursement Act of 1979 (S. 1530) which is also included in the Administration's National Health Plan is consistent with the goals of increasing both competition and comprehensiveness of coverage as expressed in S. 1968.

Our bill has been incorporated into H.R. 4000, the Medicare and Medicaid Amendments of 1979, which has now been reported by both the Ways and Means and the Interstate and Foreign Commerce Committees. We expect favorable House floor action in the next few weeks. On the Senate side, our bill has 26 cosponsors, including 10 members of this committee, and I wish to thank you for this support. A wide spectrum of interest groups have supported this bill and we hope this committee will take action to bring the bill to the Senate floor as quickly as possible.

This proposal is intended to stimulate competition between health care systems while increasing benefits to medicare beneficiaries and yielding long-term savings.

Despite the demonstrated effectiveness of HMO's, few medicare beneficiaries have enrolled. Today medicare has contracts with only 60 of the 225 HMO's and other prepaid group plans now in operation. Only 515,000 medicare beneficiaries, about 2 percent of all beneficiaries, are covered by these contracts, most having enrolled prior to their retirement under an employee group plan. The medicare participation rate is roughly half that of the population as a whole.

While there are a variety of factors which influence this situation, such as the likelihood that medicare beneficiaries have estab-

lished relationships with physicians, Federal reimbursement policies have contributed to low HMO enrollment. We have not rewarded HMO's for their efficiencies nor beneficiaries for their choice of a more efficient delivery system.

Our proposal is intended as a significant step in the right direction and consistent with the provisions of S. 1968. It will use medicare HMO payments to contain costs, generate and stimulate competition among health care systems, while reducing out-of-pocket spending.

It gives providers incentive to be efficient and allows us to pay HMO's in the way that they are accustomed to doing business, on a prepaid capitation basis. This will eliminate a major impediment to HMO participation in the medicare program.

In addition, this proposal expands benefits for medicare beneficiaries who join HMO's while at the same time generating long-term budgetary savings. For the first time in the medicare program, we will be able to reward beneficiaries for seeking out efficient delivery systems. This proposal would assure the quality of care and financial viability of HMO's by contracting only with federally qualified plans.

We propose to pay an HMO 95 percent of what the Federal actuaries estimate would be spent if the beneficiaries enrolled in an HMO were to receive care through the fee-for-service system. The HMO would be allowed the same rate of profit that it makes on its private enrollment, provided total reimbursement did not exceed the 95 percent ceiling. Any savings above the HMO's normal costs and profit would be returned to enrolled beneficiaries in the form of reduced cost sharing, that is, coinsurance and deductibles, or coverage of additional services.

We feel this proposal can have significant competitive impact. In 1978, medicare beneficiaries, who numbered 27 million, accounted for one-third of all personal health care costs in the United States. Channeling some of these moneys through HMO's will promote competition in the health care system generally as well as providing long-term savings to the medicare program.

This effect is particularly notable in that this proposal does not entail special subsidies to HMO's. Special inducements for beneficiaries to join HMO's are available only to the extent the HMO is more efficient than the fee-for-service system. For too long, the Federal Government has missed an opportunity to use the medicare dollar to enhance competition and restrain rising health care costs rather than continuously fueling inflation.

In summary, I have identified some of the questions and concerns which we have about proposals to contain health care costs through encouraging competition. As with any new proposals, they need to be carefully examined to be sure that they will not have harmful effects that may outweigh their benefits We do, however, support efforts to increase competition and assure comprehensive benefits. In the long run, carefully structured proposals to increase competition can be important complements to our overall strategy for containing health care inflation.

Senator BAUCUS. Thank you very much, Ms. Davis.

Senator Boren, do you have any questions?

Senator BOREN. Mr. Chairman, I would first like to ask unanimous consent that an opening statement by me appear in the record at the appropriate place, as if read, and I will conserve the time.

Senator BAUCUS. Without objection.

[The statement of Senator Boren follows:]

OPENING STATEMENT OF SENATOR DAVID BOREN

Senator BOREN. Mr. Chairman, I am very pleased that these hearings have been scheduled on the Health Incentives Reform Act, which I am proud to be cosponsoring with Senator David Durenberger. During the next 2 days, we will receive testimony from a number of leading authorities in the fields of insurance, economics and health care delivery, as well as representatives from business and labor. It is my sincere hope that from this testimony we will gain new insights into the importance of encouraging competition in the health care delivery system.

There is no doubt that we face a serious problem in the area of health care expenditures. During the period from 1965 to 1977, public sector spending for health care skyrocketed from $9 billion to over $68 billion. Medicare costs alone, which in 1976 were $18 billion, will rise to over $50 billion by 1982. It is clearly in the public interest that Congress act to bring these costs under control.

Now as never before we must be willing to explore new solutions to old problems. In the past, we have relied upon governmental regulation as the primary tool for holding down rising health care costs. The time has come, however, to consider whether that approach has worked. Perhaps we will even find that it has been a part of the problem itself.

It is my firm belief that until we tackle the primary cause of excessive health cost increases—the lack of vigorous price competition—we will never succeed in addressing the basic problem. It is an old adage, but in this case it is very applicable: we must attack the root causes of health care inflation, instead of merely treating its symptoms.

The Health Incentives Reform Act proposes a fundamental change in our system of health care financing. The incentives in the present system are exactly opposite of what they should be. Rather than encouraging efficiency and cost-consciousness, they insulate both providers and consumers from the costs of health care.

Mr. Chairman, we hear every day that we are in the midst of an economic crisis. At a time of rampant inflation, when we are beginning to understand that governmental regulation is itself one of the principal causes of our economic ills, we must start looking for new ways to fortify the private sector and encourage free market competition.

The Health Incentives Reform Act is a proposal whose time has clearly come. I look forward to working with my colleagues on the Finance Committee in fashioning a procompetition solution to the problem of rising health care costs.

I would like to ask, first of all, if the Health Incentives Reform Act we are discussing today is compatible with the administration's position on competition.

Ms. DAVIS. There are many elements of it that are compatible with the administration's bill. S. 1968 would mandate choice among alternatives. It would require employers to make equal contributions to premiums for coverage and would provide cash rebates for employees selecting lower cost plans.

There are other areas that are somewhat incompatible with the approach the administration proposes. One is the ceiling on employer tax-free contributions to health insurance. The multiple choice is structured to extend choice to traditional plans where we would extend choice to all qualified HMO's.

We are concerned about that provision and think it raises some problems, providing disincentives for employers to self-insure. It may also pose some administrative problems for some smaller firms.

Senator BOREN. Going back to your comments about the cap on employer contributions, how would removal of the cap, say the $125 set in the bill in employer contributions, how would that affect the competition factor?

Do you think that it would tend to make plans more competitive or do you think it would tend to make them less competitive if we removed the cap?

Ms. DAVIS. I think the proposal without the cap still has strong competitive features. It would require the employers to offer different plans to their employees and to put up the same dollar contribution to alternative plans so that the employee would have an incentive to pick a lower cost plan, or a more efficient plan. There would be strong incentives for efficiency.

In fact, I think competition might be enhanced to a greater degree without the cap because the effect of the cap is to remove any incentive for the employer to care about the cost of health care coverage for their employees.

To the extent that employer concerns also help to promote competition, the cap could have an adverse effect. An employer, for example, would have less incentive to establish a health maintenance organization if his contribution to health insurance for employees was limited to a fixed amount.

So I think, in fact, the proposal might be more competitive without that particular feature.

Senator BOREN. As far as an employee is concerned, if the cap is high enough the employee might not really seek out other plans, do you not think?

If you have a very high option plan as the minimum and you need the cap, is there not a danger you do not have an element of competition there as far as the employee choice is concerned?

Ms. DAVIS. The employee would still have a choice because, with multiple offerings and with the cash rebate for employees picking lower cost options, there is still an incentive for the employee to go into a low-cost plan.

Senator BOREN. Given the present economic situation that we are all having to deal with, do you feel that this act could possibly be enacted, something like a phase I program, with the understanding that as the economy improves and the budget is stabilized that we might be able to then act on some of the other proposals by the administration?

Ms. DAVIS. The administration has proposed many provisions similar to this bill as a part of its national health plan. We do not regard these provisions as a substitute for national health insurance.

We are concerned that if they are not part of a mandatory employer choice, establishing minimum standards on an employee plan which employers voluntarily offer may lead to a deterioration of coverage. We would have some concerns about pursuing such a plan independent of a phased-in national health insurance plan

Senator BOREN. Thank you.

Senator BAUCUS. Senator Durenberger?

Senator DURENBERGER. Thank you.

First, I would like to thank you for your testimony. I think it was very well done and very perceptive.

I have a couple of small questions on the issue of multiple choice. I understand the administration to be basically in favor of the concept of multiple choice. One of the questions you raised is that in areas where there are no HMO's, alternatives, we run the risk of employer and employees choosing between one efficient plan, which has been the traditional carrier and of one or more less efficient plans.

Did I read you correctly?

Ms. DAVIS. That is correct.

Senator DURENBERGER. Does that come from experience in some particular part of the country? I am just curious to know why you would make that statement.

I have assumed even the fee for service system, the conventional insurance system, is fairly competitive. I understand that your concern is with the fragmentation of employee groups so that difficulties would arise when two, three, four, five people choose a traditional group plan.

Am I wrong in that assumption?

Ms. DAVIS. Our concern has to do in part with the incentives that it creates for self-insurance. We have talked with a number of insurance executives—I think you will be getting more information on this through the course of your hearings. We are interested in learning from that as well.

In our discussions with the insurance industry, we found that there has been a very rapid growth in self-insurance by larger employers. Basically they hire or contract with the insurance companies to act as administrative agents to pay claims on their behalf, but large firms have found the most efficient way, the lower cost way, of providing health insurance coverage for their employees is to basically self-insure.

What we are concerned about here, is that if there are no HMO's and the employer must offer three traditional plans, say Aetna, Travellers, other traditional plans, these economies of self-insurance that the larger employers are now enjoying would be undercut.

The employer could still offer his own self-insurance plan and two other alternatives and tell employees that he does not think the other plans are as good a buy, but there is always difficulty in trying to present those alternatives objectively, in actually giving employees accurate information.

That is one concern that has to do with any incentive it might have for the employer not to self-insure if further alternatives have to be offered.

Senator DURENBERGER. On the size of the employee group which should be covered, do you have an opinion on an ideal size?

Ms. DAVIS. Again, this is something where there is no hard and fast answer. I think we would be a little more comfortable with something around 500.

I know you have the 100 in your proposal, but if we are talking about mandating a choice of traditional plans, I think it would be less of a problem in those types of larger firms.

Senator DURENBERGER. We still have the possibility of multi-employer arrangements, even in health care, as much as we do in ERISA and other programs also, I would take it?

Ms. DAVIS. That is correct.

Senator DURENBERGER. Thank you.

Senator BAUCUS. Ms. Davis, you mentioned, as I recall your statement, that there is not much evidence demonstrating the degree to which multiple choice of health care plans actually contain health care costs.

Could you elaborate on that a little bit?

What studies do we have. What evidence do we have that bears on this point, even if it bears only indirectly?

Ms. DAVIS. The best evidence we have comes from the experience with the health maintenance organizations. There have been a number of studies of health maintenance organizations. They have tended to find that hospitalization is reduced 30 to 50 percent for individuals served by such organizations and costs are 10 to 40 percent lower due to provision of choice, inducing employees to enroll in a health maintenance organization. We, therefore, have reason to believe that the costs would be lower for those members of HMO's.

For some of the other provisions, such as trying to change incentives for employees through various indirect tax mechanisms encouraging, for example, buying plans with more coinsurance, I think we have less direct information.

One of the reasons underlying the proposed ceiling on employer contributions is this would discourage some of the first dollar kinds of traditional plans that have absolutely no coinsurance on the part of employees. If that premium were taxable income to the employee, it might change their choice toward plans with more coinsurance.

I think it is fair to say we do not have as much information on how indirect approaches, like working through the tax system, affect different individuals, or why people purchase fairly comprehensive hospital insurance. We do not have enough information on how insurance would change if you change tax incentives or on its impact on health care costs.

There is some evidence that shows that, if there is some coinsurance, it tends to affect utilization, the number of hospital days, the number of physician visits, and so forth. Coinsurance affects the costliness or price per unit of those services.

So the areas where we know the most are around the experience of the health maintenance organizations. We have some evidence

on the effect of coinsurance on utilization. We have less information on the effect of choice or the effect of changing tax incentives on the kind of insurance coverage individuals select.

Senator BAUCUS. If Congress were to adopt S. 1968 or something similar to it, what would your reaction be?

If we were to limit the employer contribution on a regional basis do you think that makes sense, due to different health care costs around the country?

Does it make sense to limit the employer contribution to adjust the limit on a regional basis?

Ms. DAVIS. I think that, adjusting the limit regionally, that would improve one problem with the flat national ceiling, namely that it affects comprehensive plans, those plans that have coinsurance in high cost areas.

So that would be an improvement over the flat national limit. But then you get into the whole business of trying to calculate what is a fair geographic difference.

I think that the other kinds of problems are going to continue, the fact that older workers, the higher health risk workers, employee groups with a number of women, are still going to have high premiums for even plans with some coinsurance.

I think if this provision is trying to get at the problem of not having some coinsurance in traditional plans, then it might be better just to attack that problem directly by mandating some minimum coinsurance provision than with the indirect mechanism, setting a ceiling on the employer contribution.

Senator BAUCUS. I have no further questions.

Thank you very much, Ms. Davis. Thank you for your testimony.

Ms. DAVIS. Thank you.

Senator BAUCUS. Our next witness will be Emil Sunley, Deputy Assistant Secretary for Tax Analysis, Department of Treasury.

I understand that the chairman has set a 10-minute rule and I suggest that we abide by it.

Mr. Sunley, you may proceed in any manner that you wish.

STATEMENT OF EMIL SUNLEY, DEPUTY ASSISTANT SECRETARY OF THE TREASURY FOR TAX POLICY (TAX ANALYSIS)

Mr. SUNLEY. Thank you, Senator Baucus.

I am pleased to appear here today to discuss the role of the tax system in the provision of private health insurance and health care and to examine in particular its effect on competition and cost consciousness.

My full written statement, Mr. Chairman, includes a discussion of three tax expenditures or tax subsidies for health care, namely: the employee exclusion of employer contributions for health insurance plans, the medical deduction and to exemption for hospital bonds.

If I may, in my 10 minutes, I will limit myself to the employee exclusion, which is the primary focus of S. 1968. If you would include in the record my full statement, I would appreciate it.

Senator BAUCUS. Without objection, your full statement will be included.

Mr. SUNLEY. Since the employee exclusion provision reduces the price employees must pay for health insurance, it is also likely to increase the demand for coverage under health insurance. Increased coverage may be reflected in reduction of the deductible amount or the copayment rate or an inclusion of previously uncovered services.

Since tax rates are higher in higher income brackets, the price reduction and the price incentive to increase the quantity of services demanded increases with income.

The quantitative effect of tax subsidies on the overall demand for health services is based, in large part, upon the subsidy rate on marginal expenditures. On average, the Federal income tax expenditures of over $16 billion—including both medical deduction and the employee exclusion—cover approximately 10 percent of total private expenditures for health care. At the margin, however, the reduction in price is much greater than 10 percent. The marginal price reduction is equal to the taxpayer's marginal tax rate, and, for an average employee, the income tax rate alone is 22 percent. If we also take in account State income taxes and social security taxes, the marginal rate rises to 35 percent.

Whether increased demand for medical services will actually lead to an increase in the quantity purchased will depend primarily upon conditions in both the supply and demand sides of the market. In general, the more responsive supply or demand is to price changes, the more likely will the tax subsidy increase the amount of medical care provided in the economy.

While the demand for health care is often viewed as insensitive to price, price effects on demand may be much stronger for controllable expenses or noncatastrophic events than for uncontrollable or catastrophic occurrences. That is, demand for some basic level of health care or insurance may not be responsive to price, but the demand for additional health care or insurance may be much more responsive. This certainly deserves more study.

Insurance complicates considerably the analysis of the demand side of the medical marketplace. Some researchers argue that the demand for health insurance is relatively responsive to price incentives (compared to most estimates of the demand for medical care.) To the extent that demand responds to price incentives, tax subsidies then lead to increased insurance coverage. Increased coverage may take the form of lower deductibles and copayment rates on medical goods actually purchased or it may increase benefits. These researchers then suggest that, once a large proportion of the population pays little or nothing for additional medical services, the demand side of the market ceases to exert an independent restraint on the market, and medical care cost changes, over time, are determined by forces or events not subject to the usual limits of market behavior.

Because tax subsidies tend to increase the demand for medical care, they also tend to increase its market price. A subsidy creates a wedge between the market price received by the seller and the net cost to the buyer. Increases in price result in the tax subsidy (or the wedge) being shared with the providers of medical care; thus, the greater the increase in market price, the less the tax subsidy reduces the net cost of medical care to taxpayers.

To make matters worse, market price increases probably apply fairly uniformly to many types of purchase of medical care, while the value of the tax subsidy increases with the taxpayer's income. Thus, even if the tax subsidy results in a net price, after subsidy, decrease to the average taxpayer, it may still result in a net price increase for low- and moderate-income taxpayers who receive only a small price subsidy. For those who do not receive any subsidy, a net price increase is almost certain.

In issuing industrial development bonds, a State or local government essentially lends its tax exemption to a private business to enable it to finance facilities at the lower interest rates prevailing in the tax-exempt market. This construction subsidy increases the flow of capital into the hospital sector and out of other areas in the economy. The resulting excess hospital capacity in turn increases the cost of hospital stays.

There is sufficient reason to be concerned about the tax and economic policy problem that tax expenditures contribute to high and rising medical care prices. This problem has led some observers, including members of this subcommittee and other Members of the Congress to seek ways to reduce the inflationary properties of medical care subsidies. In fact, they have proposed to redesign existing tax expenditures in a way that will provide leverage for promoting competition and developing consumer cost consciousness—a rare attribute among us eunuchs who waive the responsibility for decisions about medical care to our physicians who are compensated on a fee-for-service basis by third party payers with little if any interest in cost control. Although I would not consider such proposals a panacea, in my opinion this approach can play a significant role in restraining increases in medical care prices.

The Health Incentives Reform Act, sponsored by Senators Durenberger, Boren, and Heinz, would enhance competition among types of medical care delivery systems by granting favorable tax treatment to contributions of employers of over 100 people only if three conditions are met: employers offer a choice of at least three health insurance or delivery plans; employees choosing lesser cost options would receive a cash rebate in lieu of higher health insurance premiums; and all plans must include coverage of catastrophic medical expenses which exceed $3,500 out-of-pocket in any 1 calendar year.

Determining the appropriate tax on the rebate brings forth a dilemma. A legitimate health policy view is that the rebate should be nontaxable and thus play a neutral role; that is, not be a bias for or against money wages versus the employer-paid premium which itself is nontaxable. However, a nontaxable rebate provides an incentive to convert taxable wages into a nontaxable rebate. This could result in a revenue loss of about $2 billion per year even without any increase in health insurance purchases. To avoid this problem, the Health Incentives Reform Act makes the rebate subject to the individual income tax. However, in this plan, the rebate is not subject to employer-paid FICA and FUTA taxes, thus preserving the existing policy of not including most employer-paid fringes in the employer's FICA or FUTA tax base.

The Health Incentives Reform Act would also limit to $125 per month per family the amount of the employer contribution that

qualifies for tax-free treatment. Because of some health policy concerns, the administration's plan did not cap the tax-free amount of the employer contribution. The cap also poses some tax administration issues that deserve examination. As described in S. 1968, the cap would perform several functions. It was proposed in combination with a comprehensive benefit package apparently in an attempt to assure that the plans offered will contain significant deductible and copayment provisions (to keep the premium price within the limit) and thus avoid subsidization of first dollar coverage.

Also, the S. 1968 cap probably is intended to help limit the total amount of the subsidy—the revenue loss to the Federal budget. And, the cap is proposed presumably as part of an attempt to cover a potential loophole. This loophole could emerge when qualified plans are required to offer both a choice of high and low-cost plans with an equal contribution by the employer, and a cash rebate of the difference between the high-cost plan and the option chosen by the employee. Without the cap, an employer could "game" the situation by offering a very high cost plan in an attempt to convert taxable wages into a nontaxable rebate. Making the rebate fully taxable—including income tax, FICA and FUTA—would prevent such gaming and would eliminate this reason for a cap. The cap has some disadvantages from the perspective of health policy—such as using a single national limit for a subsidy that applies to differently situated workers—age, sex and geographic location—and these are discussed in the testimony of my colleagues from HEW.

Mr. Chairman, the last portion of my testimony summarizes the administration's various proposals relating to hospital bonds, medical deduction and national health insurance, but, in view of the red light, I will stop and give you a chance to ask your questions.

Senator BAUCUS. Thank you very much, Mr. Sunley.

Senator Boren, any questions?

Senator BOREN. I gather that you are saying that you do feel that the present method of providing income tax credits creates overconsumption of medical care and increased costs, at least to a degree. Is that correct?

Mr. SUNLEY. I think that is correct. You have a very significant tax subsidy here, at the margin probably 30 to 35 percent of the costs. That has to have an effect on the demand for insurance and an effect on the price of health care.

Senator BOREN. I gather that incentive would even be stronger as you went into the higher tax brackets, is that correct? That effect, ironically, would even be stronger at the higher income levels than the lower income levels?

Mr. SUNLEY. That is true. There is a greater incentive to take compensation in the form of income in kind where possible.

Senator BOREN. I have no further questions. I appreciate your testimony. I found it very interesting.

Senator BAUCUS. Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman. Thank you, Mr. Sunley.

On the question of geographic cost variations, the one that Ms. Davis also addressed, have you any suggestions? Is there some

precedent, in your department, possible solutions for this problem, of moving towards a regionalized cap?

Mr. SUNLEY. I would have to say, Senator Durenberger, that we have always been a little fearful of regional variation in the Internal Revenue Code. I have testified before your committee previously on a higher personal exemption and higher standard deduction for two high-price cost States, both of which have members on this committee.

We have seen a number of proposals to have variations in tax provisions by State or region. The only one of which I am aware is in the Code is the jobs tax credit. If you recall, in the jobs tax credit, the Department of Labor certifies the worker as being eligible. Then the employer sort of collects these certifications and sends them to the IRS; the conditions for being certified eligible vary by region because the poverty level varies by region. At least that does not present problems for the IRS, since we are just collecting certifications. Obviously it does provide problems for the Department of Labor.

With respect to this particular problem, Karen Davis may be right that the variation in costs of various medical plans within regions may be as great as the variation between regions. This variation arises because of difference is the nature of the work, the local environment or the composition of the work force and some of the factors that she described.

I would want to think a long time before I had a regional cap. If we start down that road, I would hate to go through the Internal Revenue Code and see how many other regional variations there are and begin to think what this does to the tax return. It is bad enough to have a different zero bracket amount depending on the type filing unit. If it also varied by region or State and whether you are urban or rural, I do not know where it would stop. That is sort of a watershed issue with us and we have been reluctant to go down that road.

Senator DURENBERGER. There is a little space on page 77 for a schedule for the return, as I recall it.

I would like to clarify one point. The difference between making the rebate nontaxable and taxable, was that $2 million or $2 billion?

Mr. SUNLEY. $2 billion.

The concern that we have today is that there are a number of plans, where the employer, let us say, provides a full plan for the employee, but the employee make a contribution to cover the family. It may be that if you made the rebate nontaxable there is really almost no cost to the employer to extend full coverage to the family. All the employees who have elected family coverage will all of a sudden have taxable wages converted into nontaxable, in-kind benefit. And those single individuals who never elected family coverage would take the cash rebate. You might get very little increase in coverage, yet you would find that in fact we would end up in a shrinkage of the tax base.

Senator DURENBERGER. Are we on the right track here in putting the burden for change on the employee exclusion rather than on the employer exclusion?

We chose that approach because so many employees—of government nonprofit employers and so forth work for employers who do not themselves pay tax. That was the principal reason that we chose to use the employee as the affected party.

Is that a correct choice?

Mr. SUNLEY. I think the employee is conceptually the right place. The employer provided contribution is really compensation to the employee and clearly it ought to be deductible at the employer level, like any other compensation. If there should be a different tax treatment, it should be at the employee level. That is where we should have the differentiation.

Senator DURENBERGER. Thank you very much for your testimony.

Senator BAUCUS. Mr. Sunley, I take it you think there should be limitations not only on cash benefits paid by the employer to the employee under this approach but in all other kinds of nonwage benefits paid, typically fringe benefits.

Is that correct?

Mr. SUNLEY. We have a major problem, as you are well aware, in the whole fringe benefit area. The tax system has an incentive really to provide compensation in-kind rather than in cash.

If you look over time, there has been a tremendous growth in the in-kind compensation, not just due to the tax system. Obviously we have the big ticket items in the employee benefit area, such as group-term life insurance and medical insurance. Then there is a different issue, also one that is of great concern to us, what I might call the smaller fringe benefit issue—the country club dues, the meals and some of the entertainment.

There has been a concern in of tax administration that the American taxpayer perceives that he is being treated unfairly when his neighbor seemingly has much more access to some of these fringe benefits.

I know we have been talking with the Congress in the last several years about the fringe benefit area.

Senator BAUCUS. What is your personal view about that?

Mr. SUNLEY. With respect to the narrow fringe benefit area, I think what is really important is that we get some clear rules.

I find it unacceptable really from a tax administration point of view to continually extend year after year a requirement that the Internal Revenue Service not issue any rulings or regulations in this area. We have an Internal Revenue Code which, in section 61, says all income, all gross income, is subject to tax.

Agents out in the field look at certain employer practices and say this looks like compensation to us.

They then look to see if there is provision in the Internal Revenue Code or in the regulations which says it is not?

And they ask for technical advice from IRS, but IRS really cannot issue rulings or regulations in this area. Trying to administer a tax system without rulings and regulations is really unacceptable.

Maybe what we need is a legislative solution here, but I think we ought to get on to the task and do it.

Senator BAUCUS. Thank you very much, Mr. Sunley. We appreciate your testimony.

[The prepared statement of Mr. Sunley follows:]

STATEMENT OF EMIL M. SUNLEY, DEPUTY ASSISTANT SECRETARY OF THE TREASURY FOR TAX POLICY

Mr. Chairman and Interested Members, I am pleased to appear here today to discuss the role of the tax system in the provision of private health insurance and health care, and to examine in particular its effect on competition and cost consciousness. It is especially beneficial for the national debate that this subcommittee can examine the role of tax expenditures as it reviews the President's National Health Plan, the Health Incentives Reform Act of 1979, and other proposals for national health insurance or for restructuring incentives in the private health care sector.

CURRENT TAX TREATMENT

Over $16 billion of Federal income tax expenditures are provided currently through the exclusion or deduction from the income tax base of payments for certain medical expenses, including premiums for insurance. These tax expenditures are the principal programs of government assistance for the purchase of medical care by the nonaged, nonpoor population, and they exceed the $14 billion of Federal contributions to medical care for the poor.

Specifically, the tax system subsidizes the purchase of medical care by permitting (1) employer contributions for health insurance premiums or other medical payments for employees to be excluded from taxable income and (2) certain medical expenses to be deducted from adjusted gross income on individual income tax returns.

The tax expenditure estimate of $16 billion relates to the Federal income tax alone. There is a further tax expenditure cost of about $3 billion to States with income taxes. In addition, social security tax revenues are reduced by about another $6 billion. In total, Federal and State revenues are reduced by about $25 billion because certain health expenditures are allowed to be excluded or deducted from income and social security tax bases.

In addition, another $0.4 billion dollars of Federal tax revenue is forgone each year because interest income from certain hospital bonds is tax exempt.

As for many tax expenditures, I am not sure that Congress, if starting over, would determine that the existing tax expenditures for health care would be an optimal way of providing either tax relief or assistance for purchasing medical care. Current tax law in this area has resulted more from a maintenance of past practice, or habit, than from a process in which choices were made among means of subsidizing expenditures for health care. The debate on Federal health policy currently being undertaken by the Congress is a convenient and crucial opportunity to reexamine health tax expenditures for health care.

The medical deduction

No deduction for medical expenses existed until 1942. During World War II, substantial numbers of citizens were brought under the income tax and tax burdens were raised significantly; it was felt that some relief from this heavier tax burden should be granted to taxpayers with extraordinary medical expenses. Consequently, deductions were allowed for certain medical expenses exceeding a 5 percent floor. The 1951 Act and subsequent provisions effectively eliminated any floor for medical expenses for the aged, in 1965, however, the Social Security Amendments required that all taxpayers, including the aged, again to be subject to the same floor.

In 1954, another major change was made when the 5 percent floor was lowered to 3 percent, and an additional 1 percent floor was applied to expenses for drugs before those expenses could be counted toward the overall 3 percent floor. A major justification for both actions was that deductions should be allowed for all "extraordinary" expenses. While a 5 percent floor was considered too high to cover all extraordinary expenses, a 1 percent floor was considered necessary to exclude ordinary drug expenses.

Besides the 1 percent floor on drugs, another separate calculation was required when the Social Security Amendments of 1965 allowed a deduction for one-half the cost of medical insurance, up to a maximum deduction of $150, without regard to the 3 percent floor. The remaining half of insurance premiums (including premiums in excess of $300) are subject to the 3 percent floor.

The deduction for medical expenses generally has been justified on the grounds that extraordinary medical expenses reduce ability to pay taxes and that the income tax base should take account of this. However, this argument makes more sense for uncontrollable than it does for controllable or voluntary medical expenses, and also, there is no clear standard for what constitutes extraordinary expenses. In any case, for 1977 (the most recent data available) only 19 percent of taxpayers benefit from

the medical deduction and 43 percent of these only deduct one-half of their insurance premiums.

The tax saving from the itemized deduction rises with income. Of course, the deduction is of no value to the nonitemizer. However, even among returns with itemized medical deductions, the average tax expenditure per return increases as income increases. This increase, in what essentially is a subsidy for the purchase of medical care, is the result of several factors, including higher marginal tax levels. The 3 percent floor does result in a decline in the proportion of taxpayers who can itemize expenses in excess of the floor, especially at income levels in excess of $50,000. However, if the average tax expenditure is calculated across all taxpayers in the income class, rather than just itemizers, the tax expenditure is still of greater average value to taxpayers in higher income classes, rising from $10 for taxpayers with incomes between $5,000 and $10,000 to $501 for taxpayers with incomes of $200,000 or more.

Exclusion of employer-paid premiums for medical insurance

The exclusion from individual income taxation of payments to employer-provided group plans has existed since the adoption of the income tax; only the rationale for the exclusion has varied over time. At first, most fringe benefits of employees were not taxed—tax rates were low and noncash compensation was not widely recognized as income. Of course, before World War II, the income tax did not affect the majority of workers, and taxation of fringe benefits would have served little purpose in the case of nontaxable workers. Moreover, a few decades ago, benefit payments under group health insurance were much smaller relative to income. Later Internal Revenue Service rulings eventually supported the exclusion, and in 1954, the exclusion was written into the Code. However, despite later recognition that fringe benefits indeed are income, and despite rapid growth in amounts spent on group health insurance, no substantial changes have ever been made in the exclusion. Treasury figures show the Federal income tax expenditure cost of the exclusion to have grown form $1.1 billion in 1968 to $13 billion in 1980.

The distribution of benefits from the exclusion—a subsidy for the purchase of medical insurance through an employer, with the subsidy rate increasing with income—is somewhat similar to the deduction; that is, because marginal tax rates increase with income, a dollar of tax-free health insurance is worth more (i.e., the tax expenditure cost is greater) to taxpayers at higher income levels. However, the exclusion is available to all employees, regardless of whether they itemize on their returns or the level of their expenditures. (But approximately 16 percent of all employees do not have group health and, presumably, do not receive employer-paid health insurance premiums.) Below tax-exempt levels of income, of course, there is no employee gain from either the exclusion or the deduction.

Exclusion of interest income from tax-exempt bonds

Prior to 1968, interest on IDB's issued by State and local governments had been exempt from Federal income taxation even though the proceeds were used by private persons. The use of such IDB's had been growing in importance as a mechanism by which State and local governments sought to attract plants to their communities. Through the use of IDB's these governments had been able to extend the tax exemption afforded to interest on their securities issued for public investment to interest on bonds issued for essentially private purposes. Of course, as many States and localities came to utilize this method, the competitive advantage was lost and the increased volume of tax-exempt financing affected the interest cost of public issues. These factors, and fear of increasing revenue losses to Treasury as use of this method of financing long-term private debt expanded, led to the limits on tax-exempt IDB's included in the Revenue and Expenditure Control Act of 1968.

Under present law, the definition of a taxable industrial development bond generally does not include an obligation issued to finance a trade or business carried on by a private, nonprofit charitable organization. Thus, many bonds issued by State and local governments to finance facilities for private, nonprofit hospitals are not considered to be taxable IDB's and are eligible for tax exemption on the gounds that they have been issued directly by States and localities. About $3.5 billion of tax-exempt hospital bonds were issued in 1979.

EFFECT OF TAX EXPENDITURES FOR HEALTH ON THE DEMAND AND PRICE OF MEDICAL CARE

I believe that this subcommittee is especially interested in the effect of the tax expenditures for health on the demand and price of medical care.

Exclusions for medical care, like many other tax expenditures, are mostly open-ended. That is, there are few, if any, budget limits on the amount of the expenditure that can occur. Earners have a substantial and fairly open-ended incentive to convert wage compensation into nontaxable compensation in order to minimize their taxes. For instance, for a taxpayer with a 20 percent marginal tax rate from all sources, $1 in cash compensation is equal to only $0.80 in nontaxable compensation. The tax incentive lowers the price of the nontaxable fringe benefit and thereby creates a demand for more of the fringe benefit—far beyond the demand that would exist in absence of the incentive.

Over the last three decades, these demands have increased enormously, and noncash compensation has become a large part of the compensation package of most workers. As a result, the income tax base has been eroded. To compensate for this, the rate of tax on cash wages effectively must be increased if a given amount of revenue is to be raised; thus, marginal rates of tax on cash wages must go up even if average rates of tax on all compensation remain steady. Workers who receive larger proportions of their compensation in cash—often workers in weak firms or secondary workers—suffer the most from this shift in tax liabilities. Also, the social security tax base has been eroded, slowly forcing other changes in that system of taxation. Moreover, some inflationary pressures can be traded in part to demands of employees for greater increases in payments to nontaxable benefit plans than for increases in cash compensation. It should also be noted that policies to grant equal pay to employees of both sexes are often hindered by the inability of the secondary worker to receive equal value of pay in fringe benefits.

These problems are present with all exclusions of fringe benefits from income subject to tax. The exclusions increase the demand for fringe benefits, which in turn weaken the effort of policies which are based on cash compensation.

In the case of health benefits, income in the form of employer-paid health insurance premiums is exempted from Federal income tax, State income tax and social security tax. Thus, employees may be inclined to accept a larger share of their compensation in the form of health insurance than they would if the income in-kind was taxable. This has contributed to the growth in employer payments to group health plans from 0.8 percent of wages and salaries in 1955 to about 4 percent in 1980.

Since the exclusion provision reduces the price employees must pay for health insurance, it is also likely to increase the demand for coverage under health insurance. Increased coverage may be reflected in a reduction of the deductible amount or the copayment rate, or inclusion of previously uncovered services. Since tax rates are higher in higher income brackets, the price reduction—and the price incentive to increase the quantity of services demanded—increases with income.

The effect of allowing itemized deductions for health care expenses may be analyzed along the same lines. The deduction for health insurance premiums has much the same effect as the exclusion: it reduces the after-tax price of health insurance or health care, and the reduction is of greater value at higher income levels. The major difference is that the exclusion is available regardless of whether the taxpayer itemizes deductions or takes the standard deduction, whereas the personal deduction for health insurance premiums must be itemized. For the majority of taxpayers who do not itemize, there is no price reduction.

The requirement that medical expenses exceed 3 percent of AGI before qualifying as a deduction (except for 50 percent of health insurance premiums up to $150) is somewhat similar to a deductible clause in an insurance policy. Although the evidence is not conclusive, some researchers have found that a small deductible has little effect on the demand for hospitalization, while, for ambulatory and other nonhospital services, a moderate-size deductible is likely to influence demand markedly.

While the 3 percent floor is roughly analogous to a deductible in an insurance policy, the exclusion of employer premiums and the deduction of all expenses above 3 percent are both analogous to a copayment rate. For exmployees in group health plans and for itemizers above the 3 percent floor, then, the marginal tax rate determines the proportion of the last dollar of medical expense or medical insurance paid by the Government; thus, the copayment rate equals one minus the taxpayer's marginal tax rate. Again, the tax incentive for increased use of medical services is greater the higher the taxpayer's taxable income.

The quantitative effect of these tax subsidies on the overall demand for health services is thus based in large part upon the subsidy rate on marginal expenditures. On average, the Federal income tax expenditures of about $16 billion cover approximately 10 percent of total private expenditures for health care. At the margin, however, the reduction in price is much greater than 10 percent. The marginal price

reduction is equal to the taxpayer's marginal tax rate. For an average employee, the income tax rate alone is 22 percent. If we also take into account State income taxes and social security taxes, that marginal rate rises to about 35 percent. For the average itemizer, the marginal rate of income tax is about 25 percent. Since demand is based primarily upon marginal price, the impact of the tax expenditures upon the demand of medical services is greater than the price reduction averaged across all expenditures would indicate.

Whether increased demand for medical services will actually lead to an increase in the quantity purchased will depend primarily upon conditions in both the supply and demand sides of the market. In general, the more responsive supply or demand is to price changes, the more likely will the tax subsidy increase the amount of medical care provided in the economy. While the demand for health care is often viewed to be insensitive to price, price effects on demand may be much stronger for controllable expenses or noncatastrophic events than for uncontrollable or catastrophic occurrences. That is, demand for some basic level of health care or insurance may not be responsive to price, but the demand for additional health care or insurance may be much more responsive. This certainly deserves more study.

Insurance complicates considerably the analysis of the demand side of the medical marketplace. Some researchers argue that the demand for health insurance is relatively responsive to price incentives (compared to most estimates of the demand for medical care). To the extent that demand responds to price incentives tax subsidies then lead to increased insurance coverage. Increased coverage may take the form of lower deductibiles and copayment rates on medical goods actually purchased, or it may increase benefits. These researchers then suggest that, once a large proportion of the population pays little or nothing for additional medical services, the demand side of the market ceases to exert an independent restraint on the market, and medical care cost changes, over time, are determined by forces or events not subject to the usual limits of market behavior.

Because tax subsidies tend to increase the demand for medical care, they also tend to increase its market price. A subsidy creates a wedge between the market price received by the seller and the net cost to the buyer. Increases in price result in the tax subsidy (or the wedge) being shared with the providers of medical care; thus, the greater the increase in market price, the less the tax subsidy reduces the net cost of medical care to taxpayers.

To make matters worse, market price increases probably apply fairly uniformly to many types of purchase of medical care, while the value of the tax subsidy increases with the taxpayer's income. Thus. even if the tax subsidy results in a net price (after subsidy) decrease to the average taxpayer, it may still result in a net price increase for low- and moderate-income taxpayers who receive only a small price subsidy. For those who do not receive any subsidy, a net price increase is almost certain.

In issuing industrial development bonds, a State or local government essentially lends its tax exemption to a private business to enable it to finance facilities at the lower interest rates prevailing in the tax-exempt market. This construction subsidy increases the flow of capital into the hospital sector and out of other areas in the economy. The resulting excess hospital capacity in turn increases the cost of hospital stays.

DEALING WITH THE PROBLEM

There is sufficient reason to be concerned about the tax and economic policy problem that tax expenditures contribute to high and rising medical care prices. This problem has led some observers, including members of this subcommittee and other members of the Congress to seek ways to reduce the inflationary properties of medical care subsidies. In fact, they have proposed to redesign existing tax expenditures in a way that will provide leverage for promoting competition and developing consumer cost consciousness—a rare attribute among us eunuches who waive the responsibility for decisions about medical care to our physicians who are compensated on a fee-for-service basis by third party payers with little if any interest in cost control. Although I would not consider such proposals a panacea, in my opinion this approach can play a significant role in restraining increases in medical care prices.

The Health Incen ives Reform Act, sponsored by Senators Durenberger, Boren and Heinz, would enhance competition among types of medical care delivery systems by granting favorable tax treatment to contributions of employers of over 100 people only if three conditions are met: employers offer a choice of at least three health insurance or delivery plans; employees choosing lesser cost options would receive a cash rebate in lieu of higher health insurance premiums; and all plans must include coverage of catastrophic medical expenses which exceed $3,500 out-of-pocket in any one calendar year.

Determining the appropriate tax on the rebate brings forth a dilemma. A legitimate health policy view is that the rebate should be nontaxable and thus play a neutral role—i.e., not be a bias for or against money wages versus the employer-paid premium which itself is nontaxable. However, a nontaxable rebate provides an incentive to convert taxable wages into a nontaxable rebate. This could result in a revenue loss of about $2 billion per year even without any increase in health insurance purchases. To avoid this problem, the Health Incentives Reform Act makes the rebate subject to the individual income tax. However, in his plan, the rebate is not subject to employer-paid FICA and FUTA taxes, thus preserving the existing policy of not including most employer-paid fringes in the employer's FICA or FUTA tax base.

The Health Incentives Reform Act would also limit to $125 per month per family the amount of the employer contribution that qualifies for taxfree treatment. Because of some health policy concerns, the Administration's plan did not cap the taxfree amount of the employer contribution. The cap also poses some tax administration issues that deserve examination. As described in S. 1968 the cap would perform several functions. It was proposed in combination with a comprehensive benefit package apparently in an attempt to assure that the plans offered will contain significant deductible and copayment provisions (to keep the premium price within the limit) and thus avoid subsidization of first dollar coverage. Also, the S. 1968 cap probably is intended to help limit the total amount of the subsidy—the revenue loss to the Federal budget. And, the cap is proposed presumably as part of an attempt to cover a potential loophole. This loophole could emerge when qualified plans are required to offer both a choice of higher and low-cost plans with an equal contribution by the employer, and a cash rebate of the difference between the high-cost plan and the option chosen by the employee. Without the cap, an employer could "game" the situation by offering a very high-cost plan in an attempt to convert taxable wages into a nontaxable rebate. Making the rebate fully taxable—including income tax, FICA and FUTA—would prevent such gaming and would eliminate this reason for a cap. The cap has some disadvantages from the perspective of health policy—such as using a single national limit for a subsidy that applies to differently situated workers (age, sex, and geographic location)—and these are discussed in the testimony of my colleagues from HEW.

Recent Administration proposals. In 1978, the Carter Administration proposed that medical and casualty losses be deductible only to the extent that, when combined, they exceeded 10 percent of adjusted gross income. All medical expenses, including health insurance premiums and drug expenses would be subject to this same floor. Thus there would be no separate allowance for half of insurance premiums nor would there be a separate 1 percent floor for drugs. The House of Representatives accepted the simplification aspects of this proposal, but the suggested 10 percent floor was kept at 3 percent, and casualty losses were not folded into the medical deduction. The Senate rejected the House provision and no change was made in the Revenue Act of 1978.

Nonetheless, if the itemized deduction is to apply only to extraordinary expenses, then the floor should be raised. While the floor for itemized medical expenditures has remained at 3 percent for 25 years, the proportion of income spent on medical expenditures has risen. From 1950 to 1978, total health expenditures, both public and private have risen from 5.9 percent to 14.7 percent of adjusted gross income, while private expenditures have risen from 4.5 percent to around 8.7 percent. What at one time may have been an extraordinary level of medical expenditures may now be only an ordinary or normal level. To the extent that their is time, the 3 percent floor cannot be justified on either equity or incentive grounds. Substantial simplification would also be possible if fewer taxpayers were required to maintain medical records.

As part of its National Health Plan, the Administration has again proposed that medical expenses be deductible only to the extent that they exceed 10 percent of adjusted gross income. Although we believe that the floor should be raised—for both equity and incentive reasons—even in absence of a National Health Plan, there are additional, compelling reasons why the deduction should be limited in the context of a National Health Plan. Perhaps most importantly, unlike 1978, today a clear choice is given to redirect some of the current Federal expenditures on health care rather than merely reduce those expenditures. Moreover, a National Health Plan means that total Federal experditures for health would increase substantially, leading to subsidies not only of the aged and disabled, but also of those persons in high risk categories and those currently unable to obtain insurance. Indirect subsidies to individuals may also result from subsidies of premium payments made by

employers. Thus, in my judgment, there is sufficient reason to cease allowing deductions for nonextraordinary medical expenses.

In 1978, the President proposed that employer-sponsored medical, disability and group-term life-insurance plans be required to provide nondiscriminatory benefits to a fair cross-section of employees, not merely to a select group of officers or highly compensated employees. Antidiscrimination tests would have been similar to those applied with respect to coverage and benefits under qualified retirement and group legal plans. Congress, however, adopted substantial nondiscrimination tests only for coverage and benefits under medical reimbursement plans which are not funded by insurance, thus allowing discrimination with respect to insured medical plans (as well as disability benefits and group-term life insurance).

As part of the National Health the President has proposed that, effective in 1983, employers be required to provide for all full-time employees a minimum health insurance plan that has a package of basic benefits (including unlimited hospitalization, physician's services, laboratory tests, selected skilled nursing services, home health, mental health, and other benefits, and free-fee maternal and infant care) with annual out-of-pocket expenditures for covered services limited to $2,500 per family. Employers would also be required to make equal dollar contributions to all plans that they offer, including a rebate of the difference between the contribution for the employer's "primary plan" and a lower cost option selected by the employees, thus encouraging employees to seek out lower cost plans (and thus increasing the employer's relative contribution). We believe that this proposal will not only solve some of the problems of discrimination, but also will increase competition in the medical marketplace by giving employees an incentive to choose among cost-efficient plans or health maintenance organizations.

In 1978, the President proposed to limit the use of tax-exempt bonds in financing hospital construction. The Administration is concerned that excess expansion of hospital facilities is increasing costs of medical care and has, therefore, proposed, in its Hospital Cost Containment Act, that the number of certificates of need for hospital construction be drastically reduced. In order further to reduce incentives for construction of excess hospital facilities, the Administration has also proposed to disallow tax-exempt IDB financing for hospitals operated by charitable organizations for which a certificate of need has not been issued. If a need for the facility has been established, interest on the bonds would

As you know, the President has again urged Congress to pass the Hospital Cost Containment Act as part of an overall effort to reduce inflation in the economy.

SUMMARY

In summary, tax expenditures for medical care form a large and growing part of the Federal budget. For 1980, Federal income tax expenditures for medical care will exceed $16 billion and will comprise about 10 percent of total medical expenditures. State income tax and social security tax collections are also reduced by another $9 billion. While not as large as direct expenditure programs such as Medicare and Medicaid, these tax expenditures do have an impact upon the demand and price of medical care. At the margin, these subsidies can reduce price by 29 to 35 percent.

Tax expenditure policy should be explicitly integrated into the current review of national health policies. The design and choice of the exclusion, the deduction and the tax-exempt treatment of hospital bonds should reflect judgments about: the extent to which tax burdens are to be shared between those receiving cash compensation and those receiving compensation in other forms; the extent to which these tax subsidies are to be made equally available to all persons; the design of direct health expenditure programs, and the limits that should be placed on tax-induced increases in demand for health insurance and health care. Even without explicit change in the laws affecting them, the amount of health tax expenditures will be affected by changes in virtually all policies connected with medical care.

Senator BAUCUS. Our next witness will be a panel consisting of Dr. Alain Enthoven, professor of economics, Stanford University and William Schwartz, professor of medicine at Tufts University Medical School.

Gentlemen, we welcome your appearance here this afternoon. I know you have been good advocates of the general proposal, the plan introduced by Senators Durenberger and Boren.

I, as do the rest of us, look forward to your expansion of the bill and concept. You may proceed in any manner that you wish.

STATEMENT BY PROF. ALAIN C. ENTHOVEN, GRADUATE SCHOOL OF BUSINESS, STANFORD UNIVERSITY

Mr. ENTHOVEN. Mr. Chairman, thank you for giving me the opportunity to appear before this committee in support of this important piece of legislation, that is, the Health Incentives Reform Act of 1979—S. 1968. I am appearing here as a private citizen representing my own views. What I have to say bears no necessary relationship to the views of my employer or any of my consulting clients.

The costs of health care in our country are rising at an alarming rate. I am sure that you are all familiar with the figures so that I need not repeat them here. What is new and different now from, say, 6 or 8 years ago is the sheer size of these outlays.

For example, medicare has been approximately doubling every 4 years. The problem for Federal finances created by a doubling of 1972's $9 billion outlay was far less severe than that which would be created by a doubling of the $34 billion projected for 1980.

The growing outlays are on a collision course with other urgent demands on the Federal budget such as for national defense and for tax reductions to spur productive investment needed to reverse the decline in productivity in our economy.

Many factors have contributed to the increase in costs: increased insurance coverage, new technology, an aging population and others. We can do nothing about some of these; others we would not want to reverse even if we could.

But there is one factor of overriding importance that we can correct. Today's dominant health care financing system, the system on which most private insurance, Blue Cross, Blue Shield, medicare, and medicaid are based, rewards providers of care with more revenue for providing more and more costly care, whether or not more is necessary or beneficial to the patient, and it provides insured patients with little or no financial incentive to question the need for or value of services or to seek out and cooperate with less costly providers.

In short, we have a system in which there are many powerful cost-increasing incentives, and no rewards for economy in the use of health care resources. As a consequence, there is a great deal of waste and overutilization of services.

The incentives to which I am referring are those inherent in the system of paying doctors fee-for-service, cost-reimbursement and third-party payment of billed charges for hospitals, and 100 percent Government or employer paid health insurance to protect patients.

Mr. Chairman, my studies have convinced me that it would be possible to cut cost substantially while improving the quality of care, through proper organization and rational economic incentives. By "rational economic incentives" I mean incentives that reward providers of care for finding ways to give better care at less cost and that reward consumers for choosing economical providers.

For the past 10 to 15 years, the main line of public policy regarding health care costs has been to attempt to contain them by direct controls on prices, capacity, and utilization. This policy has failed both economically and politically.

The main reason for the economic failure is that these controls have done nothing to correct the underlying cost-increasing incen-

tives. Indeed, some of the control systems actually intensify the cost-increasing incentives.

If these cost-increasing incentives are such a bad thing, why do they persist? Why doesn't competition from other financing systems replace insured fee-for-service? The answer is that insured fee-for-service is protected from fair competition by law.

Medicare and medicaid are based on fee-for-service and cost reimbursement. Thus, they systematically pay more on behalf of people who choose more costly providers or systems or styles of care. Beneficiaries who are given the choice and choose to join a health maintenance organization receive little or none of any economic savings resulting from that choice.

Under the tax laws, employer contributions to the health insurance or health care of employees and dependents are excluded from the employee's income subject to Federal and State income taxes and social security taxes. These provisions of the tax laws have very powerful economic consequences for the health care system, consequences that were surely not foreseen when they were enacted.

They are, briefly, as follows. First, the tax laws have put health benefits under the control of employers and, where there are unions, under the joint control of labor and management. Thus, health benefits have become a tool employers use in the labor market and that union leaders use as bargaining prizes. This creates continuing pressure for more benefits.

Second, the tax laws motivate employers to take more of their gross compensation in health benefits than they would if health benefits were taxed like other income.

Third, the tax laws make it logical for the employer to pay for 100 percent of all the health insurance the employees want to buy.

Fourth, the tax laws have worked to block fair economic competition of health plans. Most employees are offered a single employer-provided health plan. For those who are offered choices, the employer usually pays more on behalf of those who choose more costly health plans.

In fact, the employer often pays 100 percent of the premium whichever plan the employee chooses. This leaves the employee with little or no reward for making an economical choice.

I have explained these effects of the tax laws in greater detail in my forthcoming book, "Health Plan: Tne Only Practical Solution to the Soaring Cost of Medical Care."

Some employers have told me that they recognize the harmful consequences of their behavior and consider it a serious mistake to have become committed to 100 percent payment of open-ended service benefits. But having done so, they find it hard to change unless everybody else changes too.

That is, they need an external event to force them to make the change to a system that is more rational from an economic point of view.

What is needed is to replace the cost-increasing and anticompetitive provisions of medicare, medicaid, and the tax laws by provisions based on the principles of fair economic competition among health care financing and delivery plans. Briefly stated, these principles are as follows:

First, multiple choice. Each consumer should be offered annually the opportunity to enroll for the coming year in any of several health care financing and delivery plans operating in his or her area meeting certain uniform standards governing all health plans. Traditional insured fee-for-service would be one of the options.

Second, fixed dollar subsidies, equal with respect to choice of plan. Whatever subsidy each consumer gets from medicare, medicaid, an employer or through the tax laws should be the same whichever plan he or she chooses. Thus, the consumer who chooses a less costly plan would save money. The consumer would have a reason, not usually present today, to make an economical choice.

Third, same rules for all. A system of fair economic competition intended to make good quality care affordable to all must be designed with great care. Not every scheme that calls itself competition will produce good results. Carefully drawn rules are needed.

One of the most important and subtle design problems is to set the rules in such a way that health plans will succeed by providing better care at less cost and not by selecting preferred risks. For example, if people were given an annual choice of a low cost insurance plan limited to catastrophic expense protection and a comprehensive plan with first-dollar coverage, those who expected little or no medical expense during the coming year would find it in their interest to pick the low cost plan.

When they planned or expected substantial medical expenses, they would switch to the comprehensive plan until their medical needs were taken care of. Comprehensive plans would not be able to survive in such a competition; they would be destroyed by adverse risk selection.

Experience with multiple choice plans shows that preferred-risk selection can be prevented by such techniques as: (*a*) the employer or government, not the health plans, conducting the enrollment process; and (*b*) reasonable similarity of benefits in all plans.

Rules are also needed to prevent the selling of deceptive or inadequate coverage and to prevent unnecessary complexity in health plan offerings. Such rules should be applied equally to all competitors.

Fourth, doctors in competing economic units. It must be possible for consumers voluntarily to limit their choice of doctors, for a year at a time, to one or another group of doctors, in exchange for better benefits at a lower cost.

Thus, we need some "limited provider plans." In our predominant system of "free choice of doctor" insurance, the consumer's premium is the same whether he goes to the most expensive or economical doctors. Hence, there is no economic competition among doctors, that is, no competition that rewards economy in the use of resources.

For the most part, we do not have fair economic competition today. But in those few places where these principles are being applied, such as Minneapolis-St. Paul, Hawaii, and Clackamas County, Oreg., we see very promising results.

Doctors work hard to improve service while cutting costs. Rates of hospitalization—that is, hospital days per 1,000 people per year—are cut drastically. Economy in the use of health care resources is rewarded. Senator Durenberger has observed this prom-

ising development in his own State and has based his proposal on a careful observation of demonstrated patterns of success there.

The principles of fair economic competition can be applied in various ways. We are dealing here with a complex ecology of incentives. Much judgment and some empirical tuning will be required. Senator Durenberger's Health Incentives Reform Act, S. 1968, represents a most important attempt to apply these principles.

It requires employers of 100 or more to offer choices on an economically fair basis. It involves the consumer in the cost of care in a way that does not threaten serious financial harm. It allows the consumer to benefit from making an economical choice of health care system.

It moves our health care economy toward more equal rules for all health plans. In short, it says: "Let's give people some choices on an economically fair basis." I believe it would be hard to justify opposition to that.

Nobody claims that correcting the incentives and requiring people to be offered choices is a panacea. This legislation will not immediately solve all our medical cost problems. Nor will any other legislation. It is, however, an important and fundamental step in a new direction, a direction in which consumers and providers of care will be rewarded for economical behavior.

Mr. Chairman, this completes my prepared statement. With your kind permission, I would include in the record as an attachment to my statement detailed comments and suggestions relating to S. 1968.

[The material referred to follows:]

STATEMENT OF PROF. ALAIN C. ENTHOVEN, GRADUATE SCHOOL OF BUSINESS, STANFORD UNIVERSITY

Mr. Chairman, thank you for giving me the opportunity to appear before this Committee in support of this important piece of legislation, that is, the Health Incentives Reform Act of 1979 (S. 1968). I am appearing here as a private citizen representing my own views. What I have to say bears no necessary relationship to the views of my employer or any of my consulting clients.

The costs of health care in our country are rising at an alarming rate. I am sure that you are all familiar with the figures, so that I need not repeat them here. What is new and different now from, say, 6 or 8 years ago, is the sheer size of these outlays. For example, Medicare has been approximately doubling every 4 years. The problem for Federal finances created by a doubling of 1972's $9 billion outlay was far less severe than that which would be created by a doubling of the $34 billion projected for 1980. And these growing outlays are on a collision course with other urgent demands on the Federal budget such as for national defense and for tax reductions to spur productive investment needed to reverse the decline in productivity in our economy.

Many factors have contributed to the increase in costs: increased insurance coverage, new technology, an aging population, and others. We can do nothing about some of these; others we would not want to reverse even if we could.

But there is one factor of overriding importance that we can correct. Today's dominant health care financing system, the system on which most private insurance, Blue Cross, Blue Shield, Medicare and Medicaid are based, rewards providers of care with more revenue for providing more and more costly care, whether or not more is necessary or beneficial to the patient, and it provides insured patients with little or no financial incentive to question the need for or value of services or to seek out and cooperate with less costly providers. In short, we have a system in which there are many powerful cost-increasing incentives, and no rewards for economy in the use of health care resources. As a consequence, there is a great deal of waste and overutilization of services.

The incentives to which I am referring are those inherent in the system of paying doctors fee-for-service, cost-reimbursement and third-party payment of billed charges for hospitals, and 100 per cent government- or employer-paid health insurance to protect patients.

Mr. Chairman, my studies have convinced me that it would be possible to cut cost substantially while improving the quality of care, through proper organization and rational economic incentives. By "rational economic incentives" I mean incentives that reward providers of care for finding ways to give better care at less cost and that reward consumers for choosing economical providers.

For the past 10 to 15 years, the main line of public policy regarding health care costs has been to attempt to contain them by direct controls on prices, capacity, and utilization. This policy has failed both economically and politically. The main reason for the economic failure is that these controls have done nothing to correct the underlying cost-increasing incentives. Indeed, some of the control systems actually intensify the cost-increasing incentives.

If these cost-increasing incentives are such a bad thing, why do they persist? Why doesn't competition from other financing systems replace insured fee-for-service? The answer is that insured fee-for-service is protected from fair competition by law.

Medicare and Medicaid are based on fee-for-service and cost reimbursement. Thus, they systematically pay more on behalf of people who choose more costly providers or systems or styles of care. Beneficiaries who are given the choice and choose to join a health maintenance organization receive little or none of any economic savings resulting from that choice.

Under the tax laws, employer contributions to the health insurance or health care of employees and dependents are excluded from the employee's income subject to federal and state income taxes and social security taxes. These provisions of the tax laws have very powerful economic consequences for the health care system, consequences that were surely not foreseen when they were enacted. They are, briefly, as follows:

1. The tax laws have put health benefits under the control of employers and, where there are unions, under the joint control of labor and management. Thus, health benefits have become a tool employers use in the labor market, and that union leaders use as bargaining prizes. This creates continuing pressure for more benefits.

2. The tax laws motivate employees to take more of their gross compensation in health benefits than they would if health benefits were taxed like other income.

3. The tax laws make it logical for the employer to pay for 100 percent of all the health insurance the employees want to buy.

4. The tax laws have worked to block fair economic competition of health plans. Most employees are offered a single employer-provided health plan. For those who are offered choices, the employer usually pays more on behalf of those who choose more costly health plans. In fact, the employer often pays 100 per cent of the premium whichever plan the employee chooses. This leaves the employee with little or no reward for making an economical choice.

I have explained these effects of the tax laws in greater detail in my forthcoming book "Health Plan: The Only Practical Solution to The Soaring Cost of Medical Care."

Some employers have told me that they recognize the harmful consequences of their behavior and consider it a serious mistake to have become committed to 100 percent payment of open-ended service benefits. But having done so, they find it hard to change unless everybody else changes too. That is, they need an external event to force them to make the change to a system that is more rational from an economic point of view.

What is needed is to replace the cost-increasing and anti-competitive provisions of Medicare, Medicaid and the tax laws by provisions based on the principles of fair economic competition among health care financing and delivery plans. Briefly stated, these principles are as follows:

1. *Multiple Choice.* Each consumer should be offered, annually, the opportunity to enroll for the coming year in any of several health care financing and delivery plans operating in his or her area meeting certain uniform standards governing all health plans. (Traditional insured fee-for-service would be one of the options.)

2. *Fixed dollar subsidies,* equal with respect to choice of plan. Whatever subsidy each consumer gets—from Medicare, Medicaid, an employer or through the tax laws, should be the same whichever plan he or she chooses. Thus, the consumer who chooses a less costly plan would save money. The consumer would have a reason—not usually present today—to make an economical choice.

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3. *Same rules for all.* A system of fair economic competition intended to make good quality care affordable to all must be designed with great care. Not every scheme that calls itself "competition" will produce good results. Carefully drawn rules are needed.

One of the most important and subtle design problems is to set the rules in such a way that health plans will succeed by providing better care at less cost and not by selecting preferred risks. For example, if people were given an annual choice of a low cost insurance plan limited to catastrophic expense protection and a comprehensive plan with first-dollar coverage, those who expected little or no medical expense during the coming year would find it in their interest to pick the low cost plan. When they planned or expected substantial medical expenses, they would switch to the comprehensive plan until their medical needs were taken care of. Comprehensive plans would not be able to survive in such a competition; they would be destroyed by adverse risk selection.

Experience with multiple choice plans shows that preferred-risk selection can be prevented by such techniques as:

(a) The employer or government, and not the health plans, conducting the enrollment process; and

(b) Reasonable similarity of benefits in all plans.

Rules are also needed to prevent the selling of deceptive or inadequate coverage and to prevent unnecessary complexity in health plan offerings.

Such rules should be applied equally to all competitors.

4. *Doctors in competing economic units.* It must be possible for consumers voluntarily to limit their choice of doctors, for a year at a time, to one or another group of doctors, in exchange for better benefits at a lower cost. Thus, we need some "limited provider plans." In our predominant system of "free choice of doctor" insurance, the consumer's premium is the same whether he goes to the most expensive or economical doctors. Hence, there is no *economic* competition among doctors, i.e. no competition that rewards economy in the use of resources.

For the most part, we do not have fair economic competition today. But in those few places where these principles are being applied, such as Minneapolis-St. Paul, Hawaii, and Clackamas County, Oregon, we see very promising results. Doctors work hard to improve service while cutting costs. Rates of hospitalization (i.e. hospital days per 1000 people per year) are cut drastically. Economy in the use of health care resources is rewarded. Senator Durenberger has observed this promising development in his own state and has based his proposal on a careful observation of demonstrated patterns of success there.

The principles of fair economic competition can be applied in various ways. We are dealing here with a complex ecology of incentives. Much judgment and some empirical tuning will be required. Senator Durenberger's Health Incentives Reform Act, S. 1968, represents a most important attempt to apply these principles. It requires employers of 100 or more to offer choices on an economically fair basis. It involves the consumer in the cost of care in a way that does not threaten serious financial harm. It allows the consumer to benefit from making an economical choice of health care system. It moves our health care economy toward more equal rules for all health plans. In short, it says: "Let's give people some choices on an economically fair basis." I believe it would be hard to justify opposition to that.

Nobody claims that correcting the incentives and requiring people to be offered choices is a panacea. This legislation will not immediately solve all our medical cost problems. (Nor will any other legislation.) It is, however, an important and fundamental step in a new direction—a direction in which consumers and providers of care will be rewarded for economical behavior.

Mr. Chairman, this completes my prepared statement. With your kind permission, I would include in the record, as an attachment to my statement, detailed comments and suggestions relating to S. 1968.

Detailed Comments on and Suggestions for S. 1968

1. *Multiple Choice:* Any employer having a total of more than 100 employees covered under any health benefit plan must provide at least three options each of which is offered by a separate carrier.

The reason for requiring three choices, instead of two, is in order to "connect the market" and increase the likelihood that particular health care financing and delivery plans will meet each other in direct competition in a significant number of employee groups.

The reason for requiring three separate carriers is to force the development of genuine competition in which the carriers would have to innovate and develop

effective private means of cost control. The mere offering of three options by one carrier, all based on insured fee-for-service, would not have this desirable effect.

The experience of employers who do offer multiple choice, including the Federal government, the State of California, Stanford University, Control Data Corporation, Honeywell, and many others shows that this is a simple and effective way to do business. Allegations that a requirement to offer three choices would lead to a "nightmare of administrative complexity" are shown by these experiences to be false.

2. *Equal Employer Contribution:* The amount of employer's contribution shall not depend on which option an employee chooses. If the employer's contribution amount exceeds the total cost of any option offered, the employer shall conribute the difference to the employee in cash or other benefits.

This requirement is essential to fair economic competition. It assures the employee an appropriate reward for making an economical choice, i.e. the right to keep the savings.

Yet this requirement does not unduly restrict the rights of labor and management to bargain over health benefits. It merely requires that the agreement they reach be compatible with fair economic competition.

It is appropriate to make the required cash rebates taxable income. To make them tax free would be tantamount to abolishing the tax subsidy that supports our private insurance system. The tax subsidy inherent in the exclusion of employer health benefits contributions from the employee's taxable income is an important and necessary support to our private health insurance system. A workable private health insurance system that makes affordable health insurance available to all must include some element of compulsory premium contribution. Without this, the healthy would find it in their interest not to insure, and only those fearing medical costs in excess of their premiums would insure. The premium costs would be driven up and the system would break down. The tax subsidy in the exclusion provides the needed incentive for most employee groups to buy insurance. Making the rebates tax free would create an incentive for employees to demand an extremely cheap "catastrophic only" option, and for the preferred risks to choose it.

For this reason, I would prefer to see the rebates also subject to FICA and FUTA tax on a basis that equalizes the gross cost to the employer of contributing to each alternative (i.e. the employer's share of FICA and FUTA tax on the rebate would be considered a part of his contribution.) However, this issue is a matter of judgment on which it would be hard to find much evidence for either side.

Also for these reasons, I think it appropriate, as S. 1968 does, to require no rebate or contribution in the case of an employee who chooses not to buy health insurance.

3. *Limitation on Employer Contribution That Is Tax Free.* S. 1968 provides a dollar limitation on the amount of the employer's health benefits contribution which is excluded from the employee's taxable income (e.g. $125 per family in 1980 indexed to the medical component of the CPI).

As explained above, the tax subsidy inherent in the exclusion of employer health benefits contributions from the employee's taxable income is an important and necessary support to our private health insurance system. But there is no reason for government to subsidize health insurance purchases above the level at which people can purchase membership in a good quality comprehensive care program. To do so is to encourage waste and to weaken or block economic competition.

Three arguments will be raised against the dollar limit.

First, health care costs per capita are much higher in some areas than in others. Thus, a uniform dollar limit will be too high for some and too low for others. In principle, one could correct this by applying different limits in different market areas, each proportional to health care costs per capita in that area. However, against this one could argue that to do so would be to set a precedent for adjusting the entire tax code for regional cost-of-living differences, an extremely complex task of uncertain outcome. Moreover, the uniform limit focuses the incentives for delivery system reform precisely on those areas that need reform the most, i.e. the high cost areas.

Second, employees now receiving tax-free employer contributions greater than the limit will be subjected to increased taxes, in effect, a "roll back" of existing benefits. This problem could be eased by a transition rule freezing excludable contributions above the limit in 1980 at their 1980 dollar level until inflation causes the general limit to catch up. In any case, the amount of increased tax would not be large.

Third, some groups have high premiums and employer contributions not because they have very generous benefits but because they are experience-rated and have high medical risks. Thus, they would be taxed more because of their poor health status. I believe that the appropriate response to this problem is to use the leverage

of the tax laws to move our whole health insurance system away from experience rating by groups. In Consumer Choice Health Plan, I recommended a combination of community rating by actuarial category for premiums, and tax credits proportional to actuarial cost for premium subsidies. You may wish to consider an actuarial adjustment to the limit on excludable employer contributions available at least on an exceptional basis to high risk groups who can demonstrate that their risk status is substantially above average.

4. *Minimum Benefit Provisions.* The minimum benefit provisions in subsections (h) and (i) are very constructive procompetitive steps. The requirement to cover specified health care services will move health plans toward greater uniformity and comparability. The requirement for catastrophic expense protection will assure that tax-subsidized premium dollars are spent first to prevent insured people from suffering medical bankruptcies or becoming a burden on the public sector after medical expenses have made them poor.

5. *Continuity of Coverage Provisions.* The continuity of coverage provisions are an important step in the direction of remedying one of the worst scandals of our private health insurance system based on employee groups, i.e. that people often lose their health insurance when they need it most, when the breadwinner loses membership in his or her employee group.

NOTE ON PAUL EGGERS DECEMBER 1979 PAPER ON GHC PUGET SOUND RISK DIFFERENTIAL

1. To achieve either fair competition or a fair cost comparison experiment, there must be procedures to assure against preferred risk selection. This is usually done by (a) the employer or government, not the health plan, controlling the enrollment process, and (b) reasonable comparability of benefits. (Obviously if one competitor offers maternity benefits and the other does not, the expectant mothers will tend to choose the former.) In this particular case, from October 1976 until the fall of 1979, HGC did the marketing and enrollment, not HCFA, including pre-enrollment questionnaires and choice of areas of enrollment. As for as I can tell, this was done with the knowledge of HCFA. In the fall of 1979, HCFA agreed to announce the program to all beneficiaries.

It appears that GHC did select preferred risks. I emphasize appears because the evidence is a small sample case study with serious defects in its research design. If there was systematic preferred risk selection, it should not have been allowed. Apparently, the Health Care Financing Administration and GHC mismanaged this aspect of the contract. At least that is an inference I would draw from the Eggers paper.

This small sample case study does not provide evidence either:

(a) That HMOs generally achieve their savings through preferred risk selection; or

(b) That a fair competition cannot be set up.

It does not even prove that GHC open-enrollees in 1978 were better risks that their age-sex counterparts.

2. I believe the research methodology of the Eggers paper is seriously flawed.

The study compares the 1974, 1975, and 1976 utilization of Medicare beneficiaries who subsequently enrolled in GHC, as late as June 1979, with the utilization of the general Medicare population in those years. There is a serious source of bias. The GHC group includes people who survived to enroll on July 1, 1979; the comparison group includes people who died e.g. in January of 1975. Of course, the former were healthier and less costly in 1974 that the latter!

The study acknowledged that on average Medicare beneficiaries use many more services in the last year of life. "The 6 percent of beneficiaries who die during a year account for 23 percent of reimbursements." So the study deleted from the "all other" comparison group those who died during the year. My point is that to make a fair comparison they should have deleted all those who died in any year. If someone who died December 31, 1974 must be removed from the comparison group, surely also someone who died Janury 1, 1975 should be removed.

To get a fair comparison, the study should have looked at cohorts that survived through 1978 or 1979 for both the GHC and the comparison group.

In order to draw the conclusion that GHC selected preferred risks from the Eggers paper one must make the strong implicit assumption that people who were hospitalized less, for example less in 1974, are lower risks in all subsequent years, including 1978, than people who were hospitalized more in 1974. That assumption may or may not be true. I know of no studies that examine this point. My point is simply that the truth of it is not obvious and it should not be accepted without

evidence and careful analysis. For example, many of the people hospitalized in 1974 were presumably hospitalized for such procedures as cataract removal, hip joint replacement, prostatectomy, and other procedures for non-recurring conditions, and hence that would make them lower-risk people for such hospitalization in 1978.

Another serious limitation of the Eggers study is that it is limited to new members or people who have recently switched to the HMO. Such a study cannot hope to provide useful information on HMO members in general. It is as if one attempted to do a study of the health status of members of the Stanford Alumni Association by looking at the health status of those who joined in the past year, most of whom are healthy 21 year olds. If you introduce a new health plan option to people, I would expect that people not presently under the care of a doctor, i.e. the more healthy at the time, would be more likely to switch than those having an established provider relationship. But that tells us nothing about the longer term situation. Do those people soon revert to average status? Who leaves and who stays with the plan, etc.?

I would hope that Mr. Eggers would re-do the study with cohorts of equal survival, with a test of the hypothesis that people who were hospitalized in 1974 are higher risks in 1978 than people who were not hospitalized in 1974, and with other appropriate adjustments, and then publish it in a reputable referred academic journal—so that all the scholars can get a good look at it.

There is considerable quality control inherent in such a procedure that is not present when paper is merely circulated through personal communication.

3. While our data on risk selection by HMOs are fragmentry at best, I believe there is nothing mysterious or sinister about the subject. In a dual or multiple choice situation, which plan gets the worse risks will depend on the balance of a complex ecology of incentives. it could go either way. For example, if the HMO is competing with a "low option plans" with high coinsurance and deductibles, it is likely to be very attractive to people with high expected medical costs. For example, I heard of a case in California in which a family with an annual choice between a "low-option" plan and an HMO learned that four of its children needed open-heart surgery. They switched at the next enrollment and got it all paid by the HMO. If the HMO is competing with a plan that doesn't cover outpatient care, it is likely to be very attractive to people who have chronic illness treatable on an outpatient basis. For example, I recently met a vice president of a large bank in San Francisco who was singing the praises of his HMO. It turned out that he suffers from serious chronic allergy, and the Medical Group of the HMO includes a nationally famous allergist whose services the banker gets with no copayments at all. On the other hand, if you introduce a cost-effective group practice HMO as an option in a group that already has a very comprehensive employee-paid free-for-service plan, I expect you would find that people not presently under the care of a doctor, i.e. the more healthy, would be more likely to switch than those having an established provider relationship. So the balance of risks could go either way, and I would regard it as extremely hazardous to draw far reaching conclusions from one or a few small sample case studies. I also believe that experience shows that this problem can be kept quite manageable by appropriate program design.

4. Under the present Medicare law, there is no requirement that the "savings," if any, be passed on to the beneficiary. The government takes one-half; the HMO can keep the other half. Thus, the potential incentive to a high-risk person to switch to the HMO is seriously attenuated. Moreover, as reported in the Eggers paper, GHC was free to offer only minimum Medicare benefits to high-risk beneficiaries. On the other hand, under the Carter Administration's proposed legislation, all the savings must be passed on to the beneficiary, except for the 5 percent retained by the government, and passed on in the form of reduced copayments and broader benefits. Thus, the enactment of the Administration's proposal would make HMO membership much more attractive, relatively, to high-risk people, than it is today.

The GHC experience was produced under present law which President Carter and many other people would like to see changed.

Senator BAUCUS. Thank you.

Dr. Schwartz?

STATEMENT OF WILLIAM B. SCHWARTZ, M.D., PROFESSOR OF MEDICINE, TUFTS UNIVERSITY MEDICAL SCHOOL, BOSTON, MASS.

Dr. SCHWARTZ. Mr. Chairman, I appreciate the opportunity to appear before the committee to testify on the Senate Health Incentives Reform Act of 1979.

If this bill is passed, it will clearly encourage consumers to consider policies which involve either a health maintenance organization or which require cost-sharing by the consumer.

I would like to talk about the implications of the low-cost programs which individuals are likely to choose under conditions of the bill. Let me start with the considerations of cost-sharing programs. There is no doubt that cost-sharing will significantly reduce the consumption of both ambulatory and hospital services.

Some several years ago, Newhouse, Phelps, and I reviewed the data on this point and found compelling evidence that there is a significant reduction in demand for services in the face of coinsurance and deductible provisions.

This kind of aggregate economic data does not define, however, the interaction between physician and patient which reduces the consumption of services.

Let me first describe how cost-sharing is likely to exert its effect.

Without question, physicians will eliminate a number of useless tests and procedures that are now without concern for cost.

We also know that, at present, patients are inclined to take an extra day or two in the hospital if it is convenient for them, even though there may be no medical justification for that stay. I can look back 20 years ago and recall very well that in an era of little insurance coverage the issue of wasted tests and the extra day in the hospital were matters of great concern to both patient and physician. I anticipate that such an attitude will reappear under cost-sharing provisions. We can expect patients and doctors to begin once again to weigh costs versus benefits in deciding on how much care should be provided.

Let me consider the following scenario.

Take a patient who comes to a physician with a tension headache. The doctor may feel nearly 100 percent confident that there is no organic disease, but he recommends a CAT scan because the test is safe, it is quick and it is painless.

The patient, seeing no cost to himself under an insurance program with first dollar coverage, agrees to go ahead because the potential medical benefit is greater than zero.

Under circumstances in which the patient faces a substantial out-of-pocket payment, his behavior is likely to be quite different. In most instances he will ask, as the patient did 20 years ago, "Well, doctor, what am I getting for my money?" And if he discovers as he would in this case, that the chances are perhaps only 1 in 10,000 or 1 in 50,000 of finding a significant abnormality, he may decide that he wishes to spend his money in some other fashion.

I would expect that we will see a similar change in behavior toward hospitalization as well.

Take, for example, the patient with terminal carcinoma whom we can keep alive in the hospital for an extra few weeks by means of antibiotics, the artificial kidney, sophisticated pulmonary care, and special nutritional programs—all at an enormous cost to society.

In a world of first dollar coverage there is no restraint on provision of such care but in the face of cost sharing, I am certain that family and patient will think long and hard as to whether that

kind of brief extension of poor quality of life is, in fact, cost-justified.

The dilemma that we face stems from the technologic revolution that is driving us into a rising spiral of expenditures. Most of the old diagnostic technology we used had self-regulating characteristics which checked its use. There were risks and pain to the patient. Thus, in medical cost-benefit terms, doctors often decided that these procedures were not worth doing.

Most of the new technology is noninvasive, it is riskless, it is painless, so the only question is, Does it yield any benefits greater than zero? If it does and if the patient is fully insured, we will offer those benefits regardless of the resource costs. That is our responsibility as the system is now configured. Further, as more and more new technology emerges, this dilemma will continually plague us.

There are those who criticize cost sharing on several grounds. First, they argue that a commodity as valuable as life and health is without price and that we should not create a situation in which a patient is forced to put a dollar price on it.

Second, there are those who say that even if a cost-benefit analysis is justified, the individual choosing a cost-sharing program when he is healthy cannot fully understand and foresee the implications of his decisions—of what he will face when he is sick and how he must make decisions on out-of-pocket payment.

Third, they argue that the less affluent face a much heavier burden with cost sharing than do the rest of the population; that is, the low-income worker who will be penalized most seriously.

These arguments deserve consideration and in my written testimony I have considered them in some detail.

One can, of course, go another route. An individual can opt for a health maintenance organization; that is, a prepaid group practice. However, a new problem now arises. The group practice faces the situation in which the usual fee-for-service incentive to do more is replaced by an incentive to do less because of the desire of the HMO to remain competitive.

In consequence, one can expect the physician in the HMO to become sensitive to dollars expended on zero benefit care, to wasted tests, and X-rays and useless hospitalizations. The real question for the patient, however, is whether the tendency to conserve resources will ultimately lead to a reduction in benefits.

There are some recent data in the New England Journal of Medicine (H. S. Luff 298:1336, 1978) which strongly suggest that HMO achieve their cost saving not only through reduction of zero-benefit activity but also through a limitation on care which yields benefits. I hasten to add that even if such is the case, I am not prepared to be critical. I think that HMO's, by and large, probably provide good quality care, despite the fact that they may eliminate some marginal benefits. Both they and we have to face decisions on resource allocation. The technological revolution is producing all kinds of new diagnostic and therapeutic modalities with the result that we can spend an almost infinite amount of money if we intend to provide all benefits greater than zero.

If we wish to control costs, somebody in the system is going to have to make decisions on what kind of care is cost-justified.

As I see it, the physician and patient together will make the decisions under a cost-sharing plan whereas in an HMO, that decisionmaking responsibility is assumed entirely by the physician. He has to decide where on the benefits curve he is going to cut off, where that the care is so costly that it is no longer worth the price.

It is simply a matter, in my view, of who makes the decision, not of the HMO providing something for nothing.

Obviously, what we are trying to do is shift resources which are producing low benefits to a more valued use. The goal, for example, would be to shift expenditures from the hospitalization of a terminally ill patient to care which has a substantial medical benefit.

Someone has to make the decisions as to whether, and how, such shifts should be made.

In summary, then, I do not believe that there is much of a "free lunch" in the health care system. There are some zero benefit activities to be squeezed out of the system, but given current patterns of care, the saving will be relatively small.

If we do not wish to weigh costs and benefits, if we insist on all benefits being provided, regardless of the resources needed to provide them, we inevitably face an endless curve of rising costs. The decision as to whether we are willing to forego some benefits in order to control costs is not an analytic decision. What it really comes down to is a set of value judgments which ultimately are in the hands of the Congress.

Thank you.

Senator BAUCUS. Thank you very much, Dr. Schwartz.

Mr. Enthoven, how many people are now provided health benefits through self-insured or Taft-Hartley plans?

Mr. ENTHOVEN. I am afraid I do not know, Senator. I do not have the data on that.

Senator BAUCUS. The question really is, though, how would this proposal, S. 1968, affect those people in those programs?

Mr. ENTHOVEN. Oh, I think that the way S. 1968 would affect people in those programs would simply be to require the employer or Taft-Hartley trust with 100 or more employees to offer two other choices besides its own, self-insured plan.

Senator BAUCUS. If I understand the potential problem here, a good number of employees who are under the Taft-Hartley plans, are not employees—or 99 others are not working for firms.

Mr. ENTHOVEN I see your point.

I believe the requirement to offer choices would apply to Taft-Hartley trusts.

If the employer is making a tax-exempt contribution, and it goes through a Taft-Hartley trust, then the Taft-Hartley trust would also be required to meet the conditions of the act.

Senator BAUCUS. Why are labor and most businesses opposed to this approach?

Mr. ENTHOVEN. I think in the case of labor that health benefits have proved to be a marvelous source of qualitative benefits, bargaining prizes to be brought home from the bargaining table, and that for a labor leader who wants to get reelected, that is a very desirable thing to have.

So I think that, combined with the open-ended tax treatment, has meant that it has been financially very attractive to get more

and more compensation in the form of health benefits. So it is not surprising that labor unions which have benefits that exceed $125 per family per month would feel that they would be losing something by limiting the tax-excluded contribution to that amount.

In the case of business, I do not think that it is accurate to say that most businesses are opposed. You will find opinions all over the place among businessmen. Of course there are some companies, employers whom I would regard as enlightened, who have adopted the policy already of offering multiple choice on an economically fair basis.

My own employer does that. It is not a business. It is a university. But in Minneapolis, companies like Control Data, Honeywell, Cargill, and others and also IBM and other companies, have decided to offer multiple choice.

They find it attractive, effective, and workable.

In other cases, companies have opposed it simply because they see it as one more burden being imposed on them by the Federal Government.

In my own view, the experience of the companies already voluntarily offering multiple choice shows that the burden is not substantial, the costs are not large.

Senator BAUCUS. My question goes to an assumption. I assume both organized labor and business want to lower costs as much as they possibly can.

Certainly the employees want health benefits, too, the greater the benefits the better, but still they want lower costs. I am curious.

Mr. ENTHOVEN. Organized labor favors the Kennedy plan—in effect, wants to transfer the whole thing to the Government. So they are opposed to any plan based on markets and incentives because of that.

Senator BAUCUS. Your view is labor's opposition is not so much that they are opposed to lowering costs as they are, in favor of the Kennedy approach?

Mr. ENTHOVEN. Also, generally speaking, the thinking of labor leaders does not favor a market approach.

Senator BAUCUS. That is right. My understanding of the basis of the opposition on the part of organized labor is they favor a competitive, collective bargaining approach to establishing payment of premiums and costs and health benefits.

It's not so much because they favor the Kennedy approach; rather is it not true the major objection is that organized labor would like to keep this question on the bargaining table?

Mr. ENTHOVEN. Yes. Of course, S. 1968 does not take it off the bargaining table. It just says the agreement between management and labor will have to fit a new requirement, which is three choices, and an equal contribution.

I might note, Senator, already, of course, many collective bargaining agreements do provide for a choice. So it is not as if it is unheard of. Many Taft-Hartley trusts do offer their employees at least a dual choice.

Senator BAUCUS. Do you know offhand which ones those are, or could you submit it for the record?

Mr. ENTHOVEN. In California the Teamsters, Auto Workers, the Culinary Workers, in fact most large unions offer their employees a choice.

Senator BAUCUS. The point is, still, those are not mandatory. It is not a mandatory requirement that those companies offer a three-way choice. It is still an option.

Mr. ENTHOVEN. That is right. It is optional, except for the requirements of the HMO Act.

Senator BAUCUS. Thank you.

Senator Boren?

Senator BOREN. First of all, I appreciate the testimony given by Dr. Enthoven and Dr. Schwartz. I think they very adequately have shown how the present cost control mechanisms are not working and the fact that the present system is skewing us toward more costly care.

I want to go into a couple of areas which have not yet been covered. Most businesses, of course, have group health policies for their employees. One of the concerns I have heard expressed several times is that a multiple choice plan will result in these businesses losing any premium advantage that they might have in group policies.

I wonder if that concern is a legitimate concern. It might be one of the reasons why some businesses at this point in time are fearful about embarking on this kind of a program?

Mr. ENTHOVEN. Senator Boren, in my view that is a self-serving statement made by insurance companies who want to prevent their customers, the businesses, from offering choices.

First of all, of course, the competition among insurers is just for a small fraction of the total, the retention, roughly, 10 percent of the total. Insurers are able to do nothing about controlling the rest of the costs.

What we are talking about here is trying to create an economic system in which the providers who control most of the costs, and the consumers, are motivated to control costs.

I think one interesting example, to refute the contention that you asked me about is in the Federal employees health benefits program where there is a multiple choice system which has been in effect for years. It includes a Blue Cross-Blue Shield plan and it includes an Aetna Life & Casualty Plan and a lot of HMO's, et cetera. A recent study by Prof. Bill Hsiao of Harvard published in Inquiry magazine compared the claims processing cost, the administrative cost of the Federal employees health benefits program with the current processing costs in medicare, and found that they were, as I recall, on the order of 25 percent lower.

Senator BOREN. What about the rural areas? I represent a largely rural State where we do not have any HMO's in existence at this point in time. How do you believe that increased competition will affect the health care in rural areas and the costs?

Mr. ENTHOVEN. The first thing, Senator, is to recognize the main impact of what we are talking about here, would be in the urban areas. If we are interested in cost control, then we ought to proceed on the basis of the Willie Sutton principle.

When someone asked Willie Sutton, "Why did you become a bank robber?" he said, "That is where the money is."

If we are worried about the costs, the costs are in the big metropolitan areas which are the most suitable to competitive economic systems.

I do believe, however, that this kind of system would be helpful for rural areas in many respects. One is some of the HMO's would be likely to be motivated to put outposts into rural areas.

In Hawaii, for example, Kaiser, under competitive economic pressure put outposts in rural areas. In northern California, the SAFECO Life Insurance Co. has an innovative plan. Doctors participating in this plan serve small towns where there might be one or two doctors in town. This primary care network plan has cost control incentive features in it.

So I think that it could be extended to, and beneficial to, rural areas.

Senator BOREN. What about the areas where we do not have any HMO's, where they are very slow in developing? What effects do you think competition will have on the traditional health insurers?

Mr. ENTHOVEN. I do want to emphasize that this is not an HMO proposal that we are talking about. It is competition in the private sector.

I believe that if we open up this market to real competition in the private sector, then we would see a good deal of very desirable innovation. There are other alternative health care, financing and delivery systems with built-in cost controls and built-in incentives for economy and efficiency other than HMO's.

S. 1968 is not, in any sense, meant to be preferential to HMO's.

Let me explain a little about the primary care network plan, as an example. This was pioneered first by the Wisconsin Physician Service which is a Blue Shield plan in Wisconsin, and by the SAFECO Life Insurance Co. in Seattle.

Essentially the idea is that each beneficiary agrees to select a primary care physician participating in the plan, and then that primary care physician assumes responsibility for the total cost of the patient's care and has a financial incentive to control the cost, to monitor the hospitalization and referral care and so forth.

The SAFECO plan is growing fast. In the State of Washington it is offered to the State employees and it widens their choices. It is doubling every year in membership. It is working well. It is alive and well in northern California.

It is attractive to educated, middle-class consumers. I think many insurers could convert to that kind of a model fairly quickly.

It is not an official HMO.

Senator BOREN. This gives the insurer an incentive to encourage these kinds of programs?

Mr. ENTHOVEN. Yes.

Let me give you another example. Out in Hawaii, which I think of as one of the best examples of competition that we have, most people in the State are covered by one of two health care financing and delivery systems, one of which is the Kaiser Permanente prepaid group practice plan. The other, the Hawaii Medical Service Association, essentially a traditional Blue Shield plan, except that in Hawaii, under competitive economic pressure, HMSA had to control their own costs, so they put in, on a voluntary, private

sector basis, if you like, they put in tight utilization and fee controls of their own.

The executive director of the plan watches very carefully what the doctors are charging. Part of the reason that he can enforce the utilization and fee controls on the doctors is because he says to them, "Look, if I do not hold you fellows down, then we are going to lose the customers to Kaiser."

The very competitive pressure, you might say, not only gives him the motivation, but some of the tools that he can use to do that.

I believe that if we create the competition, even these traditional insurers could start innovating in many ways that would strengthen cost control.

Senator BOREN. Thank you.

Senator BAUCUS. Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman. I just want to start by correcting an assumption that was contained in one of your questions a little earlier. That is, the assumption that labor and most businesses oppose this bill.

I only have been at this 10 months now, 10 rather intensive months, but I have yet to find either totally opposed. I think your summary of labor's position is accurate with regard to national health insurance; but the business people are mostly inquisitive and asking some very good questions about it.

In terms of downright opposition, it is relatively difficult to find.

Dr. Enthoven, some while ago we had a paper distributed to the members of the Finance Committee by the staff, I understand, which questioned one of the HMO group health cooperatives at Puget Sound. The implication was that this group benefits from risk selection, and the question of risk selection has come up here directly. I think it is an important one and one that the chairman of the subcommittee mentioned in his opening statement.

I wonder if you would comment on the accuracy of that study in particular and more importantly whether its conclusions would seem to apply generally to HMO's.

Mr. ENTHOVEN. Yes, I would be happy to.

First of all, I believe that the research methodology of the Eggers paper is seriously flawed. For example, the study compares the 1974 to 1976 utilization of medicare beneficiaries who subsequently enrolled in Group Health Cooperative as late as 1979 with utilization of the general medicare population in those years. There is a serious source of bias. To join the Group Health Cooperative in June of 1979, you had to survive that long, while the comparison group includes people who died in January 1975.

To get a fair comparison, this study should have looked at cohorts that survived through 1979.

Second, in order to draw the conclusion that group health cooperatives selected preferred risks from the Eggers paper, one must make the strong implicit assumption that people who were hospitalized less, for example, 1974 had lower risk in all subsequent years including 1978 than those who were hospitalized more in 1974.

I know of no study that supports this assumption. It may not be true.

Another serious limitation of the Eggers study is it looks only at new joiners of the HMO therefore, it tells us nothing about the comparative risk status of group health cooperative medicare enrollees in general.

I do not believe you can draw any reliable conclusions from such a small sample case study. Nevertheless, I do not doubt that Group Health Cooperative may have selected preferred risks because they, rather than the Health Care Financing Administration, ran the enrollment process. I believe that is the wrong way to run a competitive system or a fair cost comparison. That is, I think the way it ought to be run is for the employer or Federal Government to run the enrollment process so the HMO or other health plans have to take whoever signs up with them.

I do not believe that HMO savings in general can be explained away by preferred risk selection. Generally speaking, it is the employers, not the HMO's, who control the enrollment process. It would be against their interests to allow community rated HMO's to select preferred risks thus leaving the bad risks to their experience rated insurance plans. Employers have been offering these choices for decades now. I do not believe that they would be so foolish as to let that happen on a systematic basis.

Senator DURENBERGER. If you have any other comments, perhaps we could include them in the record.

Mr. ENTHOVEN. I have prepared a longer statement on this and ask that it be included in the record.

Senator BOREN. Without objection.

[The material referred to follows. Oral testimony continues on p. 87.]

GRADUATE SCHOOL OF BUSINESS
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ALAIN C. ENTHOVEN
MARRINER S. ECCLES PROFESSOR
OF PUBLIC AND PRIVATE MANAGEMENT

March 25, 1980

The Honorable David Durenberger
United States Senate
Washington D.C. 20510

Dear Senator Durenberger:

This letter is in response to your request for my comments on a paper entitled "The 'Competition Model' May Be Anti-Competitive" submitted to the Finance Committee during the Health Subcommittee Hearings on March 18 by Mr. Samuel X. Kaplan of U.S. Administrators, Inc. I cannot believe that many people will take Mr. Kaplan seriously. But there may be some concern over some of the issues he raises; so I agree that his charges should not be allowed to pass without comment.

Mr. Kaplan's main contention is that the savings achieved by HMOs are the result of preferred risk selection or "skimming." On page 18, he says, "There is strong evidence to support the theory that HMOs may be less expensive because healthier persons select them and that the costlier ill or illness-prone employees choose indemnity, third-party, or self-insured arrangements." (Emphasis added.)

There is no such evidence. Health services researchers have looked for it for years and haven't found it. The best cost comparison studies generally control or adjust for age and sex and compare people within the same occupational group. Some, such as one by Clifton Gaus, question the beneficiaries about their health status, and find no significant difference between HMO and fee-for-service enrollees.

What is the evidence offered by Mr. Kaplan? On page 11, he offers the following quotation from Professor Harold Luft:

> "Self-selection among HMO enrollees may be critical to lower admission rates; that is, better health or greater aversion to hospital admissions among HMO enrollees may contribute to the differential between HMO and fee-for-service admission rates."

Mr. Kaplan has distorted the meaning of Luft's passage by taking it out of context. The paragraph in which Luft's statement appears begins:

> "Recognizing the complexities of evaluating admissions and assuming a scattering of discretionary cases in all patient categories, we find four possible, but not mutually exclusive, explanations for lower hospital admissions in HMOs:..."

The quotation from Luft, which incidentally is inaccurate, is the fourth possible explanation. The quoted statement is followed by this sentence:

> "Sufficient evidence is not yet available to allow for a comprehensive evaluation of these hypotheses, but some evidence does exist with respect to quality, preventive care, and self-selection."

With respect to quality, Luft concludes:

> "In general, the available data suggest that outcomes in HMOs are much the same as or slightly better than those in conventional practice."

With respect to the self-selection issue, Luft says of the literature:

> "In general these studies have shown few differences between people enrolling in HMOs and in conventional plans."

He then goes on to refer to some new data in one study suggesting that self-selection may be a factor. But he then says:

> "Although these self-selection findings are important, one should use them with care. By design, the studies measure only differences in utilization during the first year or so of membership, when the new enrollees have not yet established a relationship with a physician. Over time, that situation will change, and these relatively low utilizers are likely to become greater consumers of services. Thus, while the selection effect may account for part of the utilization differences, especially among new enrollees, it is unlikely that self-selection explains fully the performance of mature HMOs."

In other words, Luft is saying that it has not been proved that self-selection does or does not contribute to lower HMO admission rates in some cases.

It is a considerable distortion to make the leap from Luft's cautious statement about absence of evidence to Kaplan's bold assertion that "there is strong evidence to support the theory that HMOs may be less expensive because healthier persons select them..."

Mr. Kaplan's citation of the preferred-risk selection practices of the California Medi-Cal Prepaid Health Plans is irrelevant to this issue. The comparison studies on the basis of which it is claimed that HMOs can care for people at a lower cost are mainly based on HMOs that serve employed people, and in which the enrollment process is controlled by the employer or health and welfare fund.

While our data on risk selection by HMOs are fragmentary at best, I believe there is nothing mysterious or sinister about the subject. In a dual or multiple choice situation, which plan gets the worse risks will depend on the balance of a complex ecology of incentives. It could go either way. For example, if the HMO is competing with a "low-option plan" with high coinsurance and deductibles, it is likely to be very attractive to people with high expected medical costs. For example, I heard of a case in California in which a family with an annual choice between a "low-option" plan and an HMO learned that four of its children needed open-heart surgery. They switched at the next enrollment and got it all paid by the HMO. If the HMO is competing with a plan that does not cover outpatient care, it is likely to be very attractive to people who have chronic illness treatable on an outpatient basis. For example, I recently met a vice president of a large bank in San Francisco who was singing the praises of his HMO. It turned out that he suffers from serious chronic allergy, and the Medical Group of the HMO includes a nationally famous allergist whose services the banker gets with no copayments at all. On the other hand, if you introduce a cost-effective group practice HMO as an option in a group that already has a very comprehensive employee-paid fee-for-service plan, I expect you would find that people not presently under the care of a doctor, i.e. the more healthy at the time, would be more likely to switch than those having an established provider relationship. So the balance of risks could go either way. I personally doubt Luft's conjecture that risk selection is a significant contributor to HMO economies on an overall basis. Moreover, I believe that experience shows that this problem can be kept quite manageable by appropriate program design.

By "appropriate program design" I mean primarily:

(a) the employer or government, and not the health plans, conduct the enrollment process. Thus the health plans are informed who their members are for the coming year. They cannot choose them.

(b) Reasonable comparability of benefits so that one health plan is not substantially more attractive than another to the people with high medical risks.

If risk selection were to become a significant factor in a competitive system, it could be corrected for by use of a more refined set of actuarial categories, as I recommended in Consumer Choice Health Plan, and/or by "empirical tuning" of the benefit packages. For example, the SAFECO Company's Northwest Healthcare program uses seven actuarial categories based on age and sex so that doctors who serve older patients get paid more for doing so.

Let me emphasize that I raised and dealt with the risk selection problem in the development of Consumer Choice Health Plan in the summer of 1977. Risk selection is not a new issue that has suddenly emerged.

Mr. Kaplan ignores the fact that we have had decades of experience with millions of employees and their families in dual choice and multiple choice plans and generally speaking preferred or adverse risk selection has not proved to be a significant problem. For example, the Federal Employees Health Benefits Program (FEHBP), an excellent example of the competition model, has been in successful operation since 1960. It now covers about 10 million people. There is no evidence that Mr. Kaplan's speculations about HMO preferred-risk selection have been realized in this program to any significant degree. I have recently been assured by a key OPM official that none of the main participants has claimed that it has suffered from adverse risk selection.

Mr. Kaplan goes on, on page 18, to comment on the evidence of the effectiveness of competition in controlling cost: "Credible, objective analysts such as Howard (sic) Luft of the University of California, San Francisco, Health Policy Program, say practical experiences of several communities in the nation, including the Bay Area, where the Kaiser-Enthoven model has been in place for years, provide supporting evidence that is 'weak' and even 'contradictory'." (The Kaplan paper is so sloppy that its author incorrectly stated the given name of my esteemed colleague and sometime coauthor, Harold Luft.)

The principles of fair economic competition that I am recommending have not been in place in the San Francisco Bay Area for years. They are not in general application today. For example, last summer we did a survey of employers in Santa Clara County. Of a random sample of employers with 500 or more employees, only 22 per cent offered their employees a choice of health plan (two or more choices) and an equal dollar contribution to the plan of their choice. Of employers with 25 to 500 employees, only 3 per cent offered a choice and an equal contribution. Thus, the great majority of employers either offer no choice of health plan, or contribute more on behalf of the more costly plan (which in our sample was the insured fee-for-service plan). Of those offering a choice, one-third of the larger employers and three-quarters of the smaller employers paid 100 per cent of the premium whichever plan the employee chose. Thus, the principles of fair economic competition as exemplified by the Health Incentives Reform Act and the Health Cost Restraint Act are not generally applied in the Bay Area.

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I admit that the evidence in favor of the competitive model's ability to control costs is quite limited. That is because it has been tried in only a few places for a short time. The best examples are Hawaii and Minneapolis-St. Paul. Only in Hawaii is a majority of the population covered by one or another competing alternative delivery system. And even there, the principles of fair economic competition are not fully applied. Yet the cost experience in Hawaii is impressive. Hospital costs per capita are about 68 per cent of the national average despite the fact that there is practically universal comprehensive insurance coverage and the cost of living in Honolulu is 20 per cent above the national average. Of course, one can argue that other factors contribute to health care economy in Hawaii, so it is not possible to identify, on an academically acceptable basis, the relative contribution of competition and other factors. My own personal observation leads me to believe that competition is a significant contributor to health care economy there.

The strength or weakness of the evidence on competition has to be judged in relation to the evidence on the alternatives. The alternative strategy for cost control is direct economic controls on prices, utilization and capacity as in Certificate-of-Need, Hospital Cost Containment, Professional Standards Review Organizations, and controls on physicians' fees. The evidence of the long and broadly-based failure of this strategy is very strong.

Mr. Kaplan does not make clear what national strategy for health care cost control he would recommend. On page 17 of his analysis, he makes some self-serving statements about the self-insurance approach. It is worth noting the sources of the savings he ascribes to this approach. The first is simple tax avoidance which is not a true economic saving. The second and third are the risk, reserve, profit and pension plan charges of the private health plans, and their marketing costs. The costs to which he is referring are, in the case of large groups, typically less than 10 per cent of total premium costs. And all of them are not "saved" in the self-insurance approach. Many are simply absorbed by the employer or claims processor. Thus, shrinking these costs is not a very promising strategy if the goal is substantial reduction in total costs. Recall that Luft found that HMOs reduce the total per capita cost of care by 10 to 40 per cent.

It seems to me fair to say that the "claims review approach" has been tried and has not succeeded. It might be successful if it were motivated by genuine competition.

Mr. Kaplan's characterization of today's situation on page 17 as "the true market, unhindered by government intervention" is totally inaccurate. Today's market for health insurance for employees is strongly influenced by the tax laws. Private health insurance and HMOs are highly regulated by government. The problem is that these laws and regulations block

competition. That is what the Health Incentives Reform Act and the Health Cost Restraint Act are all about.

The rest of Mr. Kaplan's paper is filled with other distortions, confusions and inaccuracies. For example, the Executive Summary begins with the statement, "The 'competition model' under consideration is similar to legislation now before the Congress that would force many corporations and workers to accept health maintenance organizations (HMOs) through tax preferences." This is false. What your Health Incentives Reform Act and Congressman Al Ullman's Health Cost Restraint Act do is to require employers to offer their employees health plan choices on an economically fair basis as a condition for continuing receipt of favorable tax treatment. They do not force workers to accept HMOs. There is a world of difference between requiring employers to offer a fair choice and forcing workers to accept HMOs.

Three paragraphs later, the Executive Summary goes on to say, "The so-called 'competition model' before the Congress would give such preferences to HMOs that self-insured, indemnity and third-party payment plans would be seriously damaged." This too is false. What the bills require is equality of treatment in the offering of choices, not special preferences to HMOs.

Contrarry to what Mr. Kaplan implies, neither the Health Incentives Reform Act, nor the Health Cost Restraint Act, nor Consumer Choice Health Plan rely exclusively or even primarily on HMOs to reduce cost and improve quality of care. I merely cite HMOs as one example to illustrate the possibilities for better care at lower costs. But there are others. One is the Primary Care Network developed by the SAFECO Life Insurance Company of Seattle and by the Wisconsin Physicians Service. This model could be adopted fairly quickly by many insurance companies if the competitive incentives to do so were there. It has a great deal to recommend it. Another is the Health Care Alliance described by Paul Ellwood and Walter McClure. More broadly, I have a great deal of confidence in the ability of the private sector of the American economy to innovate and develop new systems for delivering better care at lower cost if only we can open up the market to competition by assuring that as many citizens as possible have health plan choices on an economically fair basis.

Mr. Kaplan makes biased and selective use of other sources. For example, on page 12, he says: "One recent example of underutilization comes not from some fly-by-night health plan, but from the Health Insurance Plan of Greater New York, which is known as HIP and is the second largest HMO in the nation. According to a report released in December 1979 by the New York State Comptroller, HIP failed to meet its contractual obligations to provide preventive health service to welfare beneficiaries and to the poor children of New York City." An accusation is not the same

thing as guilt. HIP replied: "The report's statement that CHAP services were not provided is simply untrue." It looks like a squabble over data reporting, with a certain amount of posturing by the Comptroller. In any case, Mr. Kaplan presented only one side of an issue that is in dispute.

Moreover, the Comptroller apparently did not conclude that HIP was as bad as Mr. Kaplan's excerpts would suggest. Elsewhere, the same report said: "It is incumbent on HIP and HRA [the City's Human Resources Administration] to study all possible incentives that might induce large numbers of Medicaid clients to enroll in CHP [HIP's Comprehensive Health Plan]. The potential savings are there." Thus, despite his findings, the Comptroller recommended that HRA seek to induce more people to enroll in the HIP plan. If the Comptroller really believed that HIP was fraudulent or had significantly underserved the patients, it is hard to see how in good conscience he could urge "decisive action" to expand the enrollment.

It is tempting to go on and refute more distortions and misrepresentations. But I think these illustrations are enough to make my point. Mr. Kaplan has offered you a thoroughly unreliable analysis.

Finally, why does Mr. Kaplan keep referring to my proposals as "Kaiser-Enthoven?" Does he mean to imply that my proposals are really the joint proposals of the Kaiser Permanente Medical Care Program and myself? That is false. Consumer Choice Health Plan is my own proposal, and not that of the Kaiser-Permanente Medical Care Program. I developed it while serving as a consultant to HEW Secretary Joseph Califano. It received the benefit of the ideas and criticism of many people including government officials, executives of insurance companies and the Blues, health policy analysts and others, only a small minority of whom were associated with the Kaiser Program or any other HMO.

The Kaiser Program has taken no position for or against Consumer Choice Health Plan. They do not endorse any national health insurance proposal.

Moreover, one of the basic principles of Consumer Choice Health Plan and my subsequent "incremental proposals" is fair economic competition, that is equality of treatment for all types of health care financing and delivery plans and for their beneficiaries. My proposals contain no special preferences for HMOs, only equal rules for all. For example, in my March 1978 article on Consumer Choice Health Plan (CCHP) in the New England Journal of Medicine, I wrote, "I would not place much confidence in proposals for special grants and subsidies for HMOs. ...Given a truly fair market test as proposed in CCHP, health plans demonstrating the economic superiority of many HMOs will prosper without help." Mr. Kaplan's analysis is in error in implying that my proposals are for special preferences for HMOs. It is apparent that Mr. Kaplan has not understood my writings.

Does he mean to suggest that he has exposed a big secret, that is that the Kaiser Program is one of my consulting clients? That would be ridiculous. In the interests of "truth in advertising," I have always been very "up front" about that relationship, especially when consulting for Kaiser competitors! I even list it on my résumé so that no one will feel surprised or deceived. While the Kaiser Program is indeed one of my consulting clients, neither my analysis of the Health Incentives Reform Act nor of any of the other pro-competition proposals, nor of any national health insurance proposal, has fallen within the scope of my consulting assignments with them. (My consulting assignments have been in such areas as long-range capital financing policy, strategic planning, and cost-effectiveness evaluation of investment alternatives.) I have also done consultations for numerous other organizations in the health care field.

Is this meant to be a subtle attack on my integrity and professional independence, an attempt to discredit my proposals through innuendo and insinuation? Is he implying that I am representing as my own something that is really someone else's? If so, I categorically deny the implication. It is both false and absurd. It would make no sense for me to do such a thing. My proposal was first published in the New England Journal of Medicine, the nation's leading medical journal. It is ridiculous to suggest that the Journal's editorial board, composed of some of the nation's leading medical minds, could be fooled into thinking that what was really a "Kaiser-Enthoven-HMO proposal" was an Enthoven proposal for fair competition in the private sector.

I defend my proposals and criticize others on the merits, and not on the basis of the professional associations of the authors. I think it would improve the quality of the dialogue greatly if Mr. Kaplan were to do the same.

There may be another reason why Mr. Kaplan refers to me as "Kaiser-Enthoven." On page 20 of his diatribe, he states: "It is fair to theorize about Kaiser-Enthoven because it is a theory, itself." Then he goes on to conjure up a fantastic scenario that ends in "a massive HMO medical monopoly." I wonder if Mr. Kaplan is trying to suggest, in his fantasy, that I will become a German-style monarch who presides over the HMO medical monopoly, not a "health czar" but a "health Kaiser!" The dream is exhilirating; it sounds like a lot more fun than being a mere Stanford professor. Let me assure you, then, that my ambitions are limited to making a modest contribution to improving the equity and efficiency of our health care economy.

Seriously though, the proposals to create competition are not as "theoretical" as Mr. Kaplan implies. On the contrary, they are based on such demonstrated practical successes as health plan competition in Minnesota and Hawaii, the

Federal Employees Health Benefits Program, and Project Health in Multnomah County, Oregon. And, as you well know from your own observation, the results of these experiences are encouraging, though not conclusive proof of efficacy in a scientific sense. And they do not support Mr. Kaplan's theories.

It is ironic that Mr. Kaplan thinks that proposals that would create competition and break up the present noncompetitive situation would create a massive monopoly. It should make one wonder about everything else in his paper.

Yours sincerely,

Alain Enthoven

Alain Enthoven

GRADUATE SCHOOL OF BUSINESS
STANFORD UNIVERSITY, STANFORD, CALIFORNIA 94305

April 3, 1980

The Honorable Herman E. Talmadge
Chairman, Subcommittee on Health
Committee on Finance
United States Senate
Washington D.C. 20510

Dear Senator Talmadge:

Thank you for your letter of March 24 and for the opportunity to respond to questions concerning my testimony. I appreciate very much this indication of your interest in proposals to create incentives for economy in health care financing.

My answers to your questions are as follows.

The main answer to your first question is the plain fact that most employers do not offer their employees a choice of health plan or if they do, they do not make an equal contribution regardless of choice of plan. Thus, the existing incentives to employers to offer their employees a fa. choice are not strong enough. The reasons for this are somewhat complex. I have explained them in my forthcoming book Health Plan: The Only Practical Solution To The Soaring Cost of Medical Care. Among the contributory factors are these. First, employers see health benefits as a tool to use in the labor market or in collective bargaining. Labor leaders see health benefits as a prize to be won at the bargaining table. Both emphasize benefits particular to their company or union, rather than using their medical purchasing power to contribute to the development of a fair competitive market serving the whole community. Second, the tax laws provide an incentive for the employer to pay for 100% of comprehensive benefits with his pre-tax dollars. Where choices are offered, this often means the employer pays 100% of the premium for either alternative, thus more on behalf of those choosing the more costly alternative. Third, the incentive for the individual employer to offer fair multiple choice is weak; the main benefits of competition accrue only if most employers in an area offer fair multiple choice. A minority of employers offering fair choice by themselves cannot expect to transform the health care market.

While most employers want to contain health insurance costs, they also want to do other things, and the incentives to act to control health care costs may not be strong. The incentive depends on the extent to which they perceive they can gain a competitive advantage. One employer may not see that he would gain a competitive advantage from something that benefits all employers about equally.

With respect to your second question, the study to which I referred documenting the fact that Medicare claims administration costs 26% more than FEHBP claims administration is "Public versus Private Administration of Health Insurance: A Study in Relative Economic Efficiency" by William Hsiao, published in Inquiry, December 1978.

As to the GAO report, I do not find the criticism of the FEHBP to be very substantial. As you know, in this imperfect world, there is always room for improvement in any program. So if you turn the GAO auditors loose on the FEHBP or any other program, they are sure to come up with some criticisms and suggestions. What they have to say does not diminish the fact that the FEHBP is a model of administrative effectiveness and simplicity.

On the other hand, in 1978 the Inspector General of DHEW reported over $4.5 billion a year in waste, fraud and abuse in Medicare and Medicaid. That is very substantial. It illustrates the inherent unmanageability of these programs as presently configured.

With respect to your third question, the Health Incentives Reform Act would not restrict collective bargaining directly. However, it would have an important indirect effect. That is, if management and labor want to continue the tax-favored status of employer-paid health benefits, the agreement they reach would have to comply with the terms of the Act. This is not an unprecedented idea. Collective bargaining is already influenced in important ways by the tax laws. And it is regulated directly and in detail by the NLRB. So what we have today is hardly a pure state of "free collective bargaining" or a "free market."

The requirement that choices be offered to workers would shift some of the power over health benefits from management and labor leaders to workers. I regard that as a desirable result. I have great confidence that American workers, if provided with accurate information about health plan alternatives, will be able to choose wisely what is in their own best interest.

Finally, at the same hearing at which I testified, there also appeared Mr. Samuel Kaplan of U.S. Administrators, Inc. Mr. Kaplan, who opposes multiple choice of health plans on an economically fair basis, used the work of Dr. Harold Luft of the University of California as one of his main sources. I am enclosing, for your information, and for the record, a copy of a letter from Dr. Luft to Mr. Kaplan protesting Mr. Kaplan's misrepresentation of Luft's views by quoting his statements out of context.

Sincerely,

Alain Enthoven

Enclosure
cc. The Honorable David Durenberger

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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SCHOOL OF MEDICINE
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March 26, 1980

Mr. Samuel Kaplan
U.S. Administrators, Inc.
3540 Wilshire Boulevard
Los Angeles, CA 90010

Dear Mr. Kaplan:

It has recently come to my attention that you have been quoting some of my research on HMOs in your paper entitled "The 'Competition Model' May Be Anti-Competitive." While I am pleased you have decided to disseminate my paper on "HMOs, Competition, Cost Containment, and NHI," I am rather concerned about the way you used some of the material in your paper. There are two issues I would like to raise--(1) quoting out of context and (2) the applicability of my research findings on self-selection and competition to the current policy debate.

Your quote on pp. 10-11 reproduces only the self-selection explanation of lower admission rates in HMOs. I purposely included four explanations. ((1) careful triage, (2) quality differences, (3) prevention, and (4) self-selection) in the same paragraph to avoid such misplaced emphasis. Furthermore, there is no evidence that active "skimming" by HMOs has occurred anywhere but in the unique situation of the MediCal Prepaid Health Plans in southern California during the early 1970's.

On page 19 you say "[t]here is strong evidence to support the theory that HMOs may be less expensive because healthier persons select them and that the costlier ill or illness-prone employees choose indemnity, third party or self-insured arrangements." While not a quote in your paper, you mention me immediately before and after it, so there may be attribution by association. Let me reiterate one point that should be clear from my work--there are relatively few aspects of HMO performance on which there is strong, unambiguous evidence and self-selection is definitely not one of them. In fact, the self-selection issue is one for which the evidence is most scanty. If you have any evidence on the self-selection question, I would be most interested in examining it.

On page 7 of your paper you lump together San Francisco, Rochester, New York, and Minneapolis-St. Paul as places "where the kind of competition envisioned by the 'competitive model' has been in place for many years." In fact, competition in the latter two areas has been notable in only the last few years. Thus, the "weak and contradictory" evidence on competition is to be expected. It takes quite a while for the medical care system to respond to changes in financing and organization, and several more years for researchers to perform enough studies to develop solid evidence in any direction. The first pieces of research on a fluid situation are almost always "weak and contradictory."

Finally, I must emphasize that competition between HMOs and conventional plans under the current tax system is quite different from that which might ensue under proposed changes to the laws regarding employer contributions to health insurance. Thus, the presence or absence of a measurable "competitive impact" in the current environment has only limited relevance for the policy debate.

If you have any other questions concerning my paper or other research, I would be happy to discuss them with you.

Sincerely,

Harold S. Luft, Ph.D.
Associate Professor of Health Economics

HSL/co

cc: Scott Fleming
Alain Enthoven

Senator DURENBERGER. I would like to ask a question of Dr. Schwartz, if I might. I found interesting your comment on changes over the last 20 years. I would like you to reflect on the attitude both of doctors and of consumers of health care today toward the free lunch concept, the dulling of cost consciousness.

My question, basically, is whether or not it is possible to change the idea that health is too dear, life is too dear, attitude on the part of consumers. Is it possible to change the cost unconsciousness, if you will, of doctors in this country?

Dr. SCHWARTZ. I think that if physicians face resource constraints—for example—an HMO that has a fixed amount of money available to spend—they do become cost conscious. They worry about wasteful procedures and also are very likely to eliminate some activities which have marginal value.

My own view is that there is so much we do which has a very small benefit relative to the cost that probably we could wipe out a good deal of "beneficial care" without any notable effect on the overall quality of care. In other words I suspect that the HMO's do a pretty good job even while being cost conscious.

So I do not think that this is an intractable problem. I think that if, as in HMO's there were ways of creating incentives—for physicians to become cost conscious, for patients to become cost conscious—that something very useful can be accomplished.

The difficulty is that, at present, when I talk to interns and residents about costs they look at me blankly because they do not view anything as having a cost. All they see are the benefits that may flow from what they do.

And because they are totally indifferent to costs and have no incentive to be concerned about costs, they are bored with any discussion of the problem.

I think what we have to do is create an environment in which a concern for costs becomes something that is in a physician's everyday life and I see no reason why we cannot, as a profession, deal with that problem in a perfectly acceptable fashion.

Senator DURENBERGER. Thank you.

Senator BOREN. Thank you.

Senator Dole, do you have any questions?

Senator DOLE. No; I am sorry I am late.

I have no questions, but I do have an opening statement and that of Senator Heinz which I would like to have made a part of the record.

Senator BOREN. Without objection.

[The prepared statements of Senators Dole and Heinz follow:]

PREPARED STATEMENT OF SENATOR DOLE

I join with the chairman in welcoming our witnesses. I am looking very much forward to hearing from each of you on the important subject before us today, incentives and reform in the health system.

The philosophy espoused by my distinguished colleagues, Senators Durenberger and Schweiker, that of encouraging competition in the health care market, is perceived as a far more politically attractive solution than regulating hospital prices.

Certainly we view competition, and support of private enterprise initiatives as postive alternatives to the Government's heavy hand.

As we see today, a number of proposals have been introduced which support these philosophies. Many of them contain these similar principles: consumer choice; limits

on tax-free employer contributions; and same rules for all competitiors and doctors in competing economic units.

In summary, these principles appear to embody three basic elements:

(1) Motivating consumers to put pressure on insurers;

(2) Regulating insurers so that they must compete to design competitive, low cost health care delivery systems which in turn

(3) Place pressure on providers to be more cost conscious.

What I expect to hear today is differing opinions on whether or not these principles, if placed into law, will work, and the long term effects of the changes. Certainly the tax provisions must be carefully examined for the potential effect on employees and their labor-management agreements.

Competition is an idea that many will grasp on to and support, but few may truly understand.

Clearly, the goal is to make all parties more sensitive to prices and thereby increase competition and efficiency.

This pro market approach deals specifically with the perverse incentives that work to reduce efficiency and increase costs. But we must remember that in devising any solution to solve any specific problem, we must beware of an inclination to look to one answer as meeting all our needs. To choose one solution is to underestimate and under mine the basic tenents of our health care industry. The many aspects of the system are different, yet the same. There are perverse incentives which have led to intolerable increases in health care costs and the economic situation will certainly force us to again consider methods of reduction in all areas, including health care. I believe we must be ready with rational and responsible answers.

Competition is a fine concept and the provisions in the bills before us, which support this concept, deserve our serious attention.

But we must remember that implementing or stimulating an effective, competitive proposal will be equally as complex as any regulatory approach.

So let's proceed with caution, lest we create more chaos.

OPENING STATEMENT BY SENATOR JOHN HEINZ

Mr. Chairman, I would like to commend your subcommittee for holding these hearings on the issue of reforming our health care system. This is welcome recognition of the critical need to restructure the incentives for coverage under employer health plans.

As members of the committee know, I am a cosponsor of Senator Durenberger's Health Incentives Reform Act (S. 1968), which calls for the introduction of competition into our health care system, as opposed to the current situation where incentives discourage competitive market place activities. Allow me to take a moment to elaborate briefly on the very fundamental problems of the current system, which merit our immediate attention:

Current tax treatment of employer contributions and employee benefits has created inefficiency within the health care industry.

Employees, in most cases, currently lack the opportunity to choose health insurance plans, and therefore cannot select health care coverage most suited to individual needs.

There is currently no financial incentive to the employee to choose a health insurance plan that is less expensive but provides adequate and reasonable benefits.

I would like to briefly develop these points. Mr. Chairman, we have been told repeatedly over the years that health care benefits and health care costs simply do not operate according to conventional economic laws. Of course, it is neither possible nor desirable for an emergency appendecitis victim, for example, to negotiate with hospital personnel for the cost of surgery as he is being wheeled into the emergency room. However, it is possible that within at least one critical sector of the health care system—the insurance industry—the market place principles of competition can operate, and can operate effectively. In this area, employees can behave as rational consumers, if presented with competitive choices. And further, such competition would go a long way towards arresting the spiraling growth of health costs and medical spending.

The current tax structure is a primary contributor to health system inefficiency and inflated costs. Currently, all employer contributions to employee health benefit plans are treated as tax-free income to the employee. Thus, workers, behaving as rational consumers, have preferred additional tax-exempt health care coverage to additional taxable wages. We have, therefore, witnessed a remarkable increase in first-dollar insurance coverage. When costs are not met by the buyer—the patient—

nor the seller—the provider—but rather by a third party, the inevitable result is an absence of incentive to hold costs down.

A second, related inefficiency in the health care system is created by the current tax structure. If an employer offered a variety of health care plans under present tax law, and made an equal contribution to each of those options, the tax liability of his employees would be increased. For example, if an employer currently pays the entire cost of an expensive health plan, and decides to offer a choice of an equal amount of compensation for a low-cost health plan plus cash, any employee who continues to choose the expensive option would have to pay tax on the cash foregone. This has the effect of limiting available options to one, or having an unequal contribution made, thus distorting the choice made by the employee.

Therefore, low-cost plans are put at a competitive disadvantage, and because of limited available options, many employees have more insurance than they would otherwise purchase.

It is for these reasons that I have cosponsored legislation intended to change the tax structure to stimulate competition and innovative, alternative health care delivery mechanisms. The three basic features of an employment-based competitive approach to system reform, that I advocate, along with an increasing number of others with an interest in health care policies, are:

Employers shall offer to their employees a choice of a minimum of three health benefit plans;

Employers shall contribute equally to whichever plan an employee chooses, thereby assuring that the employee is aware of the cost of his or her plan; and

If the employee chooses a plan less costly than the employer's contribution, he (she) will receive a tax-exempt rebate; if he or she chooses a more costly plan, he or she will pay the difference out of taxable income.

The reduction in favorable tax treatment for employers and employees for noncompliance with any of these principles should increase the incentive for employees to look for better buys in the insurance market, and consequently to turn to more efficient health care providers.

If we encourage incentives for employees to choose the most economical plan—best benefits for least cost—I believe we will also create an environment for insurance companies and providers to develop innovative approaches, such as prepaid group practice plans, which will provide quality health care coverage for our citizens while, at the same time, reduce costs.

I strongly believe that the ills of our current health care delivery system can be cured, and the competitive principles embodied in HIRA and Sen. Schweiker's and Congressman Ullman's bills constitute the fundamental ingredients to the critically needed prescription. I look forward to studying the testimony offered by the distinguished witnesses over the next two days and to working with all interested parties to develop workable legislation to stimulate health care competition.

Senator BOREN. I have one additional question to Dr. Schwartz.

You mentioned the argument that cost sharing is a much more onerous requirement for those in the lower income groups. That is a concern that I have.

I wonder how you respond to that argument?

Dr. SCHWARTZ. I do not think that there is any simple response because one first has to ask if the person who chose the cost-sharing policy was well-informed at the time that he made the decision.

If you believe that it is possible for a consumer to make an informed decision at the time that he chooses a policy, then one might logically argue that, as with any other risk in life, he should take the responsibility for that decision when, at a later point, he faces the cost.

But a critic might take the point of view that we as a society should simply not allow a low-income person to be put in that situation. We could decide, as a matter of morality and ethical judgment, to limit the use of cost sharing.

The HMO has the advantage that it does not selectively affect the poor. Once someone has chosen to become a member of an HMO, even though there may be some rationing of services going

on, it is not in terms of the dollars that the person has available at the time that he is seeking care.

Senator BOREN. Is there any concern that the deductibles and copayments might cause people not to have early diagnosis and preventive care they might otherwise have. We know—preventive care and early diagnosis are cost effective, yet if we require copayments we might discourage that.

Is there any danger of that?

Dr. SCHWARTZ. I think the evidence in support of any significant effect of that sort is very small. I believe also that it is important to distinguish between kinds of preventive care.

The kinds of preventive care which are likely to be most cost-effective are those which involve problems such as hypertension, glaucoma or carcinoma of the cervix and it would be feasible to exclude from the cost-sharing provisions of any plan a few such high yield preventive activities. Such preventive care can probably be delivered in store fronts without a physician—blood pressure measurement, a Pap smear, whatever.

So I think, to the extent that the issue of prevention is of concern, it could be dealt with explicitly by the proposed legislation.

Senator BOREN. We could mandate it within the plans with all the options being provided?

Dr. SCHWARTZ. I think so. It seems to me that it would be possible legislatively to mandate cost-free screening for those common situations such as hypertension which have a payoff.

General preventive care is a different matter. Multiphasic screening and the annual physical are really of dubious value and it is unclear whether they are worth the costs. I certainly would not worry much about cost-saving for such services.

Senator BOREN. Senator Durenberger, do you have any questions? Senator Dole?

If not, thank you both very much.

[The prepared statement of Dr. Schwartz follows. Oral testimony continues on p. 102.]

STATEMENT BY WILLIAM B. SCHWARTZ, M.D.

VANNEVAR BUSH UNIVERSITY PROFESSOR AND PROFESSOR OF MEDICINE

TUFTS UNIVERSITY SCHOOL OF MEDICINE

before the

SENATE FINANCE COMMITTEE

on

THE HEALTH INCENTIVES REFORM ACT OF 1979

MARCH 18, 1980

For many years our society has acted as though a nearly endless supply of resources were available for health care. Each year an ever-larger share of the national pie has been served to hospitals and the health-care system. We seem, however, to be approaching the limit of our willingness to allocate funds this way and must shortly find a way to limit costs.

Virtually all analysts agree that the current form of health insurance is a major reason that the price of health care has become uncoupled from the cost of illness. At present, most policies require the insured to contribute little or nothing to whatever hospital bills he may incur. Consequently, neither the patient, the physician, nor the hospital has any direct incentive to reduce expenditures.

The bill introduced by Mr. Durenberger would partially restore the link between the price of health care and the resources required to provide it. It promises to create an environment that encourages employees to reconsider expensive policies providing "first-dollar" coverage and perhaps choose less costly programs which either provide HMO coverage or require substantial cost-sharing on the part of the patient.

What will be the impact of more extensive cost-sharing? Can we expect a change in behavior among patients who take sick and then face a coinsurance or deductible payment? Will physicians respond by providing the same services as when coverage was more complete? The answer is "no." Newhouse, Phelps and I (New England Journal of Medicine 290:1345-1359, 1974), from a detailed analysis of the available data, have shown that cost-sharing

requirements significantly reduce the amount of services, both ambulatory and hospital, that consumers use. Faced with out-of-pocket payments, patients demand less care. But statistics such as these do not reveal the process by which costs influence the decisions of patients and doctors, nor do they illuminate what, if any, social losses are being incurred.

Let me first describe how patients and physicians make decisions under circumstances in which the patient has full or nearly full insurance coverage. As you well know, fully insured patients and their physicians are indifferent to the cost of services. The patient knows that his individual costs will be spread over the premium paid by all policyholders, so that the care he receives is essentially "free" to him. He responds with two attitudes -- and both are wholly rational given the situation. First, he doesn't care whether a procedure or other activity is in fact useless to him, provided the procedure involves no pain or risk. Second, he wants and expects the best of everything, regardless of its cost. In this the physician is the patient's ally. In my experience on ward rounds, physicians are reluctant even to discuss matters of cost. They consider it a distraction from the "really important" issues, the medical matters at hand. The response, like the patient's, is rational. Given the lack of fiscal incentive it is unlikely that any effort to raise cost-consciousness will have much effect, and appeal to social conscience, I have found, is likely to be unavailing.

This attitude permeates the way physicians practice. For example, little consideration is given to whether a laboratory test or x-ray will really yield useful information. As a result, large numbers of tests are

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requested and, in many instances, repeated one or several times, without justification. Indifference to expenditures also extends to other aspects of patient care, for instance the length of a patient's stay in the hospital. Not infrequently, patient or family may find it more convenient to delay discharge for a day or two after it is medically appropriate. Full benefits of the hospitalization have been achieved, but the patient, as a matter of convenience, asks to stay an extra day. Unless the hospital is full and patients are awaiting admission, the physician tends to acquiesce. In consequence the patient is happier, the physician is no worse off, and the hospital has kept a bed full for another day. Only society, through its pocket book, suffers. Please bear in mind that I have just described common examples of money spent ostensibly for "health" care that is in fact spent only for convenience.

If the patient were paying part of the bill, his or her attitude toward care which yields no medical benefits would have to change. I say this not based on speculation but on experience. Fifteen or twenty years ago, when many people were uninsured and when "first-dollar" coverage among the insured was far less common, the typical patient was reluctant to stay in the hospital simply for the sake of convenience. Because each extra day meant a further out-of-pocket expenditure, the patient wanted to be discharged at the very earliest moment after his treatment was completed. Cost-sharing should tend to revive such patterns of behavior.

What about care that is not medically useless but does yield some benefits, though perhaps at a very high price? Are patients willing to

weigh benefits against the costs in deciding on how much care they want? Do they demand that care be cost-justified or do they leave all these decisions to the physician? Consider, for example, a patient with headaches that appear to be the result of tension and anxiety. The physician is quite confident that there is no physical abnormality to account for the patient's complaint but, "just to be on the safe side," suggests a CAT scan. The patient asks the right questions. He discovers that the procedure can be done in an hour, that it is safe and painless, and that his health insurance covers the costs. For him, it makes sense to have the scan performed, because the costs to him, except for his time, are zero and the expected benefits, however small, are greater than zero. He accepts the physician's recommendation.

Consider now the patient who faces a $200-or $300 deductible portion of his insurance, which has yet to be paid this year. Once again he asks about the time required, the risk and the pain, but he will, in addition, usually ask how likely is it that the test will reveal an abnormality. The doctor is almost certain the patient has tension headaches, and so tells the patient that the likelihood of finding significant pathology is extremely small, although the possibility cannot be absolutely dismissed. The patient must now decide whether a remote chance of obtaining useful diagnostic information is worth $200 or $300. For many patients the answer is "no." Cost-sharing has worked its effect.

In the days of little insurance coverage, it was common to see patients respond to analogous situations in just the above fashion. Many who faced out-of-pocket payment for a routine chest x-ray or a barium enema decided

not to go ahead with the procedure when confronted with the cost. In each instance, there was a small probability of losing benefits, but the patient, when given adequate information, decided that the expected benefits were not large enough to justify the costs. Such behavior is still encountered in the occasional patient with little or no insurance, and there is little reason to doubt that it would appear in a new group of consumers whose insurance coverage included a provision for a coinsurance or a deductible payment.

Decisions on hospitalization will respond similarly. In past years, many patients with little or no insurance chose to have their pneumonia or their congestive heart failure treated at home rather than in the hospital. The slight extra risk, they felt, was more than offset by the dollars saved. Human nature today is not likely to be very different if cost-sharing again becomes common. Consider the case of a patient with terminal cancer. Hospitalization, let us say, offers the prospect of extending life for a few days or a few weeks. Through the use of antibiotics, the artificial kidney, and a special nutritional regimen, there is some chance that the patient can survive a little longer in the hospital than at home. In many cases, the marginal benefits will be viewed by patient or family as small, and we can expect to see fewer decisions to intervene and fewer dollars expended.

Similar considerations of costs and benefits will also enter into decisions on various types of elective surgery, an operation for a torn cartilage or a hysterectomy for menopausal bleeding.

Cost-consciousness assumes a particular importance given the nature of the technologic revolution which is taking place in medicine. In the past, the bulk of expensive diagnostic procedures also involved some significant risk to the patient or caused appreciable discomfort or pain. The physician was thus forced to weigh risks versus the potential gain in information and, in many instances, found that, on medical grounds alone, the procedure could not be justified. As a result, many diagnostic techniques were used to only a limited extent. In recent years all this has changed. Most new tests entail no risk and produce no discomfort, and many of them replace older procedures which were hazardous or painful. As a result, risk-benefit analysis is no longer necessary, so that a key restraint on their use, and therefore on expenditures, has been removed. Now, any non-invasive test which promises to yield even the slightest benefit is freely used--so long as it presents no significant dollar cost to the patient.

There seems little doubt that the legislation, as envisaged, will change this state of affairs if, as is likely, many consumers decide to choose a plan with cost-sharing features. As I have pointed out, under such circumstances, some care which yields relatively low benefits will be forgone. In other words, dollars will be saved but another kind of price will be paid.

Many argue that this price is unacceptable, that creating a cost-conscious environment is undesirable as a matter of public policy. The grounds for this position are several.

First, health care is said to be so valuable that to put a dollar price on it is improper, perhaps even immoral. But individuals and society are, in fact, constantly making choices concerning their health, balancing dollars

or pleasure against the risk of injury or illness. Take, for example, the decision to buy a premium tire that slightly reduces the risk of an accident. Most individuals select the lower priced tire, trading off the extra risk against the availability of extra money to spend on other goods or services. The individual who fails to use his safety belt, or who continues to smoke cigarettes or to eat excessively, is also balancing risks and benefits, the risks to his health against the pleasures that he would otherwise have to forgo. Society makes similar decisions in determining how much to invest in radar equipment at an airport or eliminating environmental hazards to health. In sum, applying cost-benefit analysis to health is not a novelty tactic in a world in which resource limitations often have life and death implications.

Another criticism of cost-sharing is not that cost-benefit analyses are inherently undesirable but that most people are not in a position to make sound decisions in choosing between expensive and cheap policies. While healthy, they may not appreciate how they will feel when confronted with illness. They may, therefore, choose a cost-saving policy, the implications of which they will not understand until they eventually become ill. By the time they realize their error, the financial barrier will deter them from obtaining care that they really want and should have. Those troubled over this possibility feel that encouraging the choice of a cost-sharing insurance program, therefore, represents undesirable social policy. They emphasize the potential impact on low-income employees, who may be especially inclined to go the low-cost route. Obviously the lower the income of the worker, the greater the relative penalty for having made the "wrong" choice o plan. On these grounds, some feel that no financial barriers

to obtaining care should exist.

This problem of financial barriers could be dealt with, at least in part, by mandating that some commonly used and high-yield procedures be excluded from the coinsurance or deductible provisions. For example, screening for genetic defects or hypertension could be fully covered at relatively low cost to the insurance scheme. Papanicolaou smears for carcinoma of the cervix or pressure tests for glaucoma could be exempted in the same fashion. There would, of course, still be circumstances in which cost-sharing would deter provision of care that could yield some appreciable benefits. If, as a society, we feel that such an outcome is unacceptable, then cost-sharing must be viewed as unacceptable.

The employee choosing a low-cost insurance plan might, of course, prefer to avoid the problems of cost sharing and instead opt for a prepaid group practice. HMO's are cost-conscious and have an incentive to operate efficiently in order to remain competitive. As a consequence, and in contrast to fee-for-service practice, the fiscal incentive is to do less rather than more. One can reasonably assume, for example, that physicians in prepaid group practice try to avoid ordering useless (i.e., zero-benefit) tests and procedures. How often this tendency to do less extends to real benefits we do not know. But the possibility that such reductions do occur merits serious consideration.

The study by Luft recently reported in the New England Journal of Medicine gives some credibility to the argument that HMO's limit some health benefits. In his examination of Health Maintenance Organizations, he found that most of the cost-saving is attributable to hospitalization rates about thirty percent lower than those of conventionally insured

populations. This reduced rate was, however, not the result of fewer discretionary or "unnecessary" admissions but was the result of lower admission rates across the board. In other words, both surgical and medical admissions were lower and discretionary procedures, such as hernia and hysterectomy were reduced no more than other types of surgical procedures (the only exception among discretionary procedures was tonsillectomy which was reduced to a very low rate). These findings may simply reflect the elimination of useless care across the full range of medical and surgical illnesses, but it seems far more likely that the reductions resulted, at least in part, from eliminating care that would have provided some benefits.

I should perhaps also say that in many years of clinical practice, I have been struck by the fact that much of what we as physicians do consists of activities which yield benefits that are small relative to costs. I am, therefore, quite ready to believe that in an enyironment that encourages cost-consciousness a substantial reduction in marginal care could occur without any very obvious change in quality of care.

I have no criticism of a prepaid group practice which, in fact, forgoes some benefits in order to save dollars. If costs are to be controlled, someone has to make decisions on whether the benefits being provided are worth the expenditures. Under plans in which there is cost-sharing, the patient, in association with his physician, makes the judgment. In the HMO, the decision is simply shifted to the physician who, more or less independently, decides what is and is not worth doing. Under these latter conditions, of course, the ability of the individual patient to pay does not enter into the decision as it would if a coinsurance or deductible payment were involved.

In my view there can be no "free lunch." Given current patterns of care, it seems highly unlikely that we can provide all benefits to everyone and at the same time control costs. The rapid change in technology which is characteristic of the health-care system will, as I have pointed out, continually aggravate the cost spiral if we are not willing to make choices. The question is not of cost-sharing versus prepaid group practice, but of what mechanisms for controlling costs seems most efficient and equitable.

To summarize: Our nation can, if it chooses, continue to let health expenditures rise at a rapid rate. If we value the benefits sufficiently and are willing to forgo alternatives, both societal and personal, this course is the proper one. But if we believe that the rise in expenditures is yielding diminishing or trivial benefits, we can try to limit what we spend. To do this we can create incentives for a more prudent regard of costs by physician and provider alike. The only other option is to place a budget ceiling on health care. The problems, dislocations, and stresses that would be created by this strategy are many and, in my opinion, of a magnitude that should give us pause.

If the goal of the Committee is to contain costs by placing more responsibility for decisions in the hands of the consumers and encouraging providers to be cognizant of expense, the present bill is clearly a step in that direction.

Senator BOREN. Our next witness is Samuel Kaplan, the president of U.S. Administrators, Inc.

Again, I would repeat we are operating under a 10 minute time limitation and are endeavoring to move around as quickly as we can.

STATEMENT BY SAMUEL X. KAPLAN, U.S. ADMINISTRATORS, INC.

Mr. KAPLAN. Mr. Chairman and members of the committee, my name is Sam Kaplan. I am president of U.S. Administrators, Inc., a Los Angeles firm that administers insured and self-funded benefit plans for employees of participating employers. Our clients are single employers and labor-management trusts. Benefits include medical and other health-related plans, pension and workers' compensation.

The plans we administer cover more than 1 million persons, which represents a growth of 40 percent compounded annually over the last 5 years. Although I would like to believe that this growth is attributable entirely to the quality of our production, another factor probably is the increasing interest in self-funding by the employers who foot the bills. They have found out that self-funding saves dollars.

At the outset I would like to express my gratitude to Senator Herman Talmadge for accepting my request to testify. In addition, I would like to thank Senators John Heinz, David Boren, and especially Senator David Durenberger for raising the issue of competition so that it could be discussed openly in this hearing.

Although S. 1968 is the announced subject of this hearing, another bill, S. 1485, also has been referred to this committee. I must confess, therefore, that it appeared more logical for me to consider both bills since both measures seek to encourage competition in the marketplace.

My testimony at this time will address both the specificity of each bill and the concept itself.

I would like to start by relating an event which took place in California on February 12, 1980. The California Chamber of Commerce Health Care Costs Committee, a panel of some 60 corporate health benefits officers, met to consider a number of health care cost containment proposals to recommend to the full state chamber membership.

Among these proposals was one offered by the Kaiser Foundation Health Plan and its consultant, Prof. Alain Enthoven. The Kaiser-Enthoven proposal was very similar to S. 1485, which has been referred to this committee.

After a spirited debate, the chamber health care costs committee rejected the Kaiser-Enthoven proposal with only one dissenting vote, that dissenting vote cast by an official of Kaiser.

One would assume that corporate executives would endorse the favorable consideration of these bills because they would place a lid on corporate health benefits costs per employee based upon some formula, perhaps the national average capitation payment of federally qualified HMO's as suggested in S. 1485.

Corporate executives are searching for ways to contain and even reduce their health benefits costs, which are approaching 10 per-

cent of gross revenues in some companies and industries. Nevertheless, these very practical individuals are too sophisticated, technically competent and concerned with the welfare of their employees to grasp for panaceas.

Therefore, I suggest that you consider the significance of this decision by corporate health benefits officials in the Nation's most populous State, a State known as the land of the health maintenance organizations, as part of your deliberations over the so-called competition legislation before you.

I was an active participant in the debate, and I would like to present to you some of the evidence considered by the scores of corporate executives before they arrived at their decision to reject the so-called competition model.

First, I would like to outline what is contained in the "competition" legislation. Second, I would like to discuss the situation with regard to HMO's, structures upon which these bills appear to rely. Third, I would like to suggest that the committee consider the real impact of this legislation on true competition.

The primary "competition" bill before this committee is S. 1485, the Health Incentives Reform Act of 1979, introduced on July 12, 1979. I would respectfully request the chairman to include in the record of these hearings at the conclusion of my prepared testimony a paper I prepared entitled, "The Competition Model May be Anti-Competitive." This paper contains the description of the Health Incentives Reform Act published in the Congressional Record by its sponsors on the day it was introduced.

In the interest of time, however, let me summarize what S. 1485 would do. The tax laws would be rewritten to provide that as a condition of tax deductibility of health plan contributions, employers would be required to contribute the same amount of money in behalf of each employee, regardless of the health plan selected by each.

Each qualifying employer would be required to offer a minimum of three plans, two of which would have to be State or federally qualified HMO's, if available.

Employees could choose from among the plans offered, but the employer's contribution would be limited for tax deductibility purposes to the national average capitation payment of federally qualified HMO's.

If an employee elected a plan carrying a lower price tag than the employer's contribution, that employee could keep the cash difference tax-free.

On the other hand, if an employee chose a plan whose cost was greater than the employer's contribution, the employee or the employer must pay the difference with after-tax dollars.

The basic theory behind S. 1485 and S. 1968 is that health care providers can be forced to join together to offer low cost health care. This can be accomplished by offering tax-free bonuses to employees selecting the lower cost plans.

Therefore, any provider not presently involved with lower cost plans would be forced by market pressures to join together with others offering low cost plans or be forced out of business. The lower cost plans would exert additional competitive pressures by

expanding benefits and services while still remaining competitive with any higher cost plans.

Clearly, the specified preference of HMO's in S. 1485 and the implied preference in S. 1968 are the dominant mechanical features of these bills.

The American Enterprise Institute for Public Policy Research considered competition and the role of HMO's last October during a conference on national health insurance here in Washington. At that conference Harold S. Luft, a health economist with the University of California, San Francisco, health policy program, delivered a paper on the issue.

He cited the experiences of San Francisco, Rochester, N.Y., and Minneapolis-St. Paul where the kind of competition envisioned by this legislation has been operating for many years. Based upon the experiences of these cities, Dr. Luft said, the evidence in support of so-called competition on health care costs is "weak and contradictory."

Dr. Luft and others cite strong and compelling evidence that the per-unit cost of services provided by HMO's is the same as that of the fee-for-service sector. HMO efficiency and economy are realized in reduced utilization and hospital admissions.

Furthermore, Dr. Luft states that empirical evidence indicates that HMO's may be the beneficiaries of promotional statements to the effect that they are less costly than other systems, which may be true not because of their efficiencies and economies but simply because the people who join them tend to be younger and healthier. This is known as self-selection.

In support of this, I submit that the Department of Health, Education, and Welfare Health Care Financing Administration (HCFA) studied the historical health status of medicare beneficiaries who joined the Group Health Cooperative of Puget Sound.

The study found that the specific individuals who joined the Co-op used less than half the average hospital care of the general medicare population in the Seattle area. HCFA states that it is not sure whether this phenomenon was the result of voluntary self-selection or whether the HMO encouraged the healthy to join and discouraged the less healthy from joining.

There is further evidence of selection of healthy and younger individuals in prepayment systems. In California, the State turned in 1972 to prepaid plans in an effort to control the spiraling costs of its Medi-Cal program. Government audits, including those requested by this committee, revealed selection of healthy medicaid beneficiaries by preenrollment physical examinations and other practices, such as enrolling only young people, who of course are the healthiest segment of our general population. This practice is known as skimming.

While the issues of self-selection and skimming are serious, the problem of underutilization becomes critical. Just as overutilization—providing more medical services than a patient needs—may be endemic to the fee-for-service sector because providers profit from the services they deliver, underutilization may be endemic to HMO's which can profit from the services they do not provide. An HMO receives its monthly payments whether or not its members request or utilize any services.

Underutilization was evident in the California medicaid program contracting with prepaid plans. Frequently, people who needed care did not get it, yet the plans received their regular, stipulated monthly payments from the State.

One recent example of underutilization comes not from some fly-by-night health plan but from the Health Insurance Plan of Greater New York, the second largest HMO in the Nation. The comptroller of the State of New York found that although the city of New York contracted and paid for the physical examinations of children of the poor, the HMO did not provide the examinations for which it got paid to do.

There is a lesson for business in the microeconomic impact on overall health care costs in the cities of San Francisco, Rochester, and Minneapolis-St. Paul. There is still another lesson in the experience of self-selection, skimming, and underutilization by prepaid systems in Seattle, New York, and California.

It is possible that under this legislation, an HMO could skim a corporate work force through an advertising and promotional effort that could induce self-selection of the young and healthier workers, who are usually paid lower wages and salaries than older workers.

For these younger workers with growing families, the incentive to opt for the cheapest plan is great, particularly if it means putting some tax-free dollars in their pockets.

This self-selection of the cheaper options by the young and healthy workers would leave other health benefit plans within a corporate work force with an actuarial time bomb, a risk pool of ill and illness-prone older workers, forced to pay for higher benefits with after-tax dollars because of their need for a more expensive plan with greater benefits.

In other words, the normal statistical curve of distribution of the young and the old, of the sick and the healthy, could become so skewed that the allocation of cost of the fee-for-service indemnity plans would necessarily be destined to constant escalation, regardless of the status of the national economy.

This skewing of the normal distribution of the young and the old, the sick and the healthy were reviewed by the GAO in its study of California medicaid costs.

The GAO reported that because the prepaid plans sought the young and the healthy, California medicaid's stipulated payments to the prepaid groups were considerably in excess of the services required or delivered to the enrolled population. GAO's conclusion was that California medicaid costs probably were greater with prepayment than would have been the case if the State had not contracted with prepaid plans.

However, it would be a tragic mistake to tar all HMO's based upon the unsatisfactory experiences of the States of New York and California and the medicare experiences in Seattle. Many experts believe government program experiences have only limited applicability to a private sector setting.

Nevertheless, it would be a serious error for this committee or any corporate health benefits official and labor organization leader to underestimate the inflationary impact of prepayment through self-selection, and skimming and the human suffering of underutilization.

It is most reasonable to conclude that serious damage would be done by this legislation to such HMO alternatives as self-funded coverage, Blue Cross-Blue Shield and well-administered indemnity plans. The reason for this is that HMO's, based upon historical evidence, will end up with young, healthy family members who now give balance to the risk pool. Other plans would be left largely with an older, higher-risk population. This is exactly what happened in the California medicaid program.

I am sure each of you is familiar with the Blues and insured indemnity plans, but self-funded health plans are relatively new so I will explain their operation briefly, if I may.

Self-funding is especially practical for employee groups of more than 1,000 persons. While there are many forms, self-funding basically means that the corporate or the labor-management trust, through an administrator, pays the medical provider directly for services provided to the beneficiaries of the self-funded plans.

Sometimes such plans cover up to a specified level of benefits or costs for individual procedures or covered services, and then insurance is purchased to cover defined catastrophic cases.

Here are some of the advantages. There is an avoidance of the premium tax imposed by the States on insured plans, which may amount to as much as 4 percent of the premium. There is elimination of the risk and profit charges of insured plans and elimination of the risk and surplus charges of Blue Cross-Blue Shield plans and health maintenance organizations.

There is elimination of the insured plans, Blues, and HMO's cost allocations for advertising, entertainment, promotion, sales and other marketing and nonessential expenses. There is elimination or drastic reduction of moneys assigned to contingency or similar reserves.

The greatest advantage of self-funding for the larger groups for which it is best suited is simply that it is less expensive. This is perhaps the greatest reason for the relatively recent proliferation of this alternative to the Blues, insurance, and HMO plans.

Another significant benefit of self-funding, aside from the front-end savings of no premium taxes, and eliminating the cost allocations of the Blues, insured and HMO plans, is the ability to maintain an effective cost containment program. Either through internal corporate or trust plan management or through the contracting for administrative services with companies such as U.S. Administrators, unions, and employers are able to scrutinize the charges of providers and negotiate differences over fees and services.

Self-funded plans can establish their own medical policies. Those policies should and generally do include standards not only related to fees for services but also to the quality of care provided.

I assure this committee that corporate executives are engaged in a most serious search to reduce their health care benefit costs. It is in their own self-interest to do so. If this legislation were to provide these concerned employers with a way out of their health care benefits costs dilemma, they would certainly endorse it. But it does not.

In fact, it could not only compound the cost factors but also could increase administrative costs and possibly disrupt the very delicate balance usually found in labor-management relations. Injury could

be done to older workers or retired employees who are much more susceptible to serious and long-term illness and disabilities and who have so little time or opportunity to recover from ruinous medical expenses.

One of the strongest positive elements of this legislation is the obvious necessity to further investigate, debate, and discuss the continuing problem of containing health care cost escalation.

In addition, however, I would hope for a return to respect for the integrity of our language in the committee's further discussion. The legislation searches for alternatives to reduce costs, but would it foster competition?

At each critical point, the bills call for Government intervention in support of HMO's. Consider two of the proposals major structural underpinnings: employer contributions limited under the proposed law to a Federal yardstick pegged to government-qualified HMO charges, in the case of S. 1485; and require employers under Federal law to offer at least three plans in S. 1485, two of which must be government-qualified HMO's if available.

Certainly this reliance on governmental mandate belies the use of the word "competition." In a true open market, enterprises compete on an equal basis for capital as well as sales, providing services and goods to the marketplace where consumers can make free selections on the basis of quality and cost.

Consumer choices are most difficult in the health care marketplace, but there are methods other than those proposed to educate the public to whatever choices may be available.

HMO's already enjoy extraordinary competitive advantages. In the capital formation area, they may dip into a large barrel of Federal grants—free money—and loans. In the marketplace area, a federally subsidized and qualified HMO can invoke Federal law and require specific employers to offer its prepaid health package to employees.

HMO's are now being encouraged, favored, pampered, and proliferated by our health planning laws, and many of them are announcing plans to construct hospitals around the country in areas designated by local health systems agencies as being already overbedded.

In May, the GAO said that even after receiving millions of dollars in Federal grants and subsidies and even with their federally mandated marketing edge, some HMO's cannot survive. Bruce Spitz, in an article appearing in a recent edition of the Duke University Journal of Health Policy, wrote:

> HMO advocates contend that one of an HMO's strongest advantages is its incentive for efficiency and potential ability to reintroduce competition into the medical marketplace. The catch words of "efficiency" and "competition" conjure up the image of rugged individualism and free enterprise.
>
> It is reassuring and very American. But is it appropriate to the medical delivery sector or any other sector characterized by consumer ignorance, provider-generated demand and highly differentiated services which may or may not produce the desired results?

Mr. Spitz notes in his article that language is sometimes distorted in order to reach an ideologically acceptable solution. "It is a process," he wrote, "where we ask the wrong question and then exaggerate the answers."

Finally, I would like to suggest with due respect to the members of the committee that in their subsequent deliberations regarding the subject bills, they be guided by the testimony they have heard and have yet to hear. The importance of the subject matter cannot be overemphasized in its impact on all of the residents of our country and the way in which this proposed legislation will affect the health resources and facilities available to our people.

I feel confident that the best interests of the people who rely upon your judgment will be uppermost in your minds as you enter your deliberations.

Finally, I would like to pose a few questions that the committee might consider answering before taking further action on this proposal or any others that would so radically transform the private sector's health benefit plan financing arrangements.

Under Senator Herman Talmadge's proposal for determining the cost impact of new programs on government, how much would it cost the Department of Health, Education, and Welfare and the Internal Revenue Service to administer and monitor this program?

In fairness to labor organizations and corporations, what would be their administrative cost? How would equity be maintained in establishing the amount of tax deductibility to employers in high cost areas as compared with low cost areas?

If "competition" is appropriate for the private sector, why would it not be as appropriate for Government financing arrangements? However, if Government programs beneficiaries are encouraged to join HMO's, what does the committee propose to offer to insure against self-selection, skimming and underutilization that would inevitably result in a waste of taxpayers' funds and abuse of people, as the historical evidence so pointedly shows?

In the event of personal financial losses by older workers, forced to pay for richer benefit plans with after-tax dollars and copayments, what relief would be provided to them?

What cities and communities have HMO's sufficiently strong to consider offering their plans to employee groups?

What systems are in place in government to ensure against underutilization and other abuses evidenced in HMO's? Are there any penalties for such abuse?

Would the committee consider protecting corporations and labor organizations from abusive HMO's by providing grants to conduct labor-management inspections of HMO's to certify their efficiency, economy and integrity in the absence of such a Federal program?

In the interest of consumer information, would the committee consider requiring that each HMO offering itself to an employee group provide monthly reports on each patient encounter, so that the labor-management group can determine whether their group is being underutilized?

Mr. Chairman, I want to thank the committee for this opportunity to testify on these proposals. It is a privilege for me to appear before the Finance Committee and I would be happy to answer any questions which you may have now or later, in writing.

Senator BOREN. Thank you, Mr. Kaplan.

I would like to ask two questions on behalf of Senator Talmadge.

First, what is the impact of these proposals with respect to coverage of seasonal workers in agriculture and construction?

Mr. KAPLAN. In agriculture in 1978, the number of seasonal workers varied from a low of 169,000 in February to a high of 679,000 in July. How are these people going to be covered?

I look back at one of our clients, Hunt Foods in Fulton, Calif., basically a packer of tomato products, basically an employer of a large number of seasonal employees. They have been approached over the last 2 years by nine different HMO's, some federally qualified, some State qualified.

The question Hunt Foods asked, as a discerning employer, is, Will you cover a seasonal employee? The answer of nine was no.

The question was, Why not? The answers were twofold.

No. 1, it is too much of an administrative burden. We do not know how we could conceivably handle seasonal employees.

No. 2, we cannot make any money on seasonal employees.

Senator BOREN. The second question of Senator Talmadge, do you know of any employers that have tried the approach of getting additional cash benefits, both employees electing lower cost insurance, and what have been the results?

Mr. KAPLAN. There have been a number of them. Professor Enthoven mentioned Control Data Corp., IBM, TRW, and so forth. All nonunion employers.

It is a lot easier in a nonunion environment because you have one plan nationwide. You do not have to go through a multitude of bargaining sessions with different unions and it is very simple in that type of environment.

Let's talk about TRW as an example. TRW does not have three options, they have four options. They have a core plan, a basic indemnity plan, in which TRW pays all the costs and the employee has to pay nothing.

They have a high-cost option in the indemnity area. They have an HMO option and then they have a low-cost option.

Any employee opting for the low-cost option receives, in cash, the difference between the core plan and the low-cost option.

What has been the results at TRW? At TRW 39.5 percent of the employee population nationwide selects the core plan where the company picks up the total amount of the cost; 18.2 percent of the employees have picked up the high indemnity option in which they have to pay the difference between the company basic plan and the high option; 37.2 percent picked up the high option and indemnity section; 18.2 percent picked up the HMO option, which is the highest option they have; 5 percent picked up the low option in which TRW rebated some dollars. Out of that 5 percent most of those people were in their professional group were single people without any health problems or women employees whose husbands were working someplace else and they already had the coverage.

In TRW's experience, 39.5 percent took the core plan; 37.3 percent took the high option core plan with money out of pocket; 18.2 percent took the HMO option, the highest of all; and only 5 percent took the low option program in the core situation.

By the way, TRW for the year 1980 with HMO's across the country have been notified that their increase in cost ratio was approximately 25 percent this year over 1979.

You have another example right here in Washington, right across the country, with your Federal employee health benefits

program. Under the Federal employee health benefit program the two big providers of the service are Blue Cross, with 55 percent of the population and Aetna with roughly 19 percent of the population I believe it is. Anyway, you have 70 percent of your Federal employees who have opted for Blue Cross or Aetna. Both of those plans have a high option program.

Of your Federal employees, 83 percent or 1.9 million of them out of the 2.3 million covered by the Blue Cross and Aetna have opted for the high option although they ended up paying 40 percent of the premium costs out of their own pocket with after-tax dollars.

Those are two examples. There are many more.

Senator BOREN. Senator Dole, do you have any questions?

Senator DOLE. Well, I am checking here to see.

As I understand it, most of the pro-HMO provisions have been taken out of the Durenberger bill. If that is the case, what is your position on the elements that remain?

Mr. KAPLAN. My position is what is the competition going to be?

Enthoven says we have got some primary care networks, but in today's world and what is happening down there in the trenches it is a fact that the only other alternative today are HMO's. The Federal Government is committed to financing HMO's.

What other alternative is there? You talk about SAFECO in Seattle, the Wisconsin plan and the one in northern California. You are talking about a minute portion of the population. It will take you years to effect any kind of primary network function.

If you face HMO's, you face nothing in the case of competition.

Senator DOLE. Do you have any solution to the problem of adverse selection?

Mr. KAPLAN. As long as you are going to offer an incentive toward adverse selection, you are doing so by making it possible for the young, healthy employee who does not need today, who sees no need for medical care today, he is going to opt for the low-cost option.

He is going to opt for the option that is going to put money in his pocket.

Senator DOLE. Thank you.

Senator BOREN. Senator Durenberger?

Senator DURENBERGER. Yes.

I am concerned specifically about which sections of 1968 you believe would require or force low-cost options or an HMO. Is it as simple as the concept of multiple choice or something else in the bill that you believe forces low option?

Mr. KAPLAN. That forces what?

Senator DURENBERGER. Most of your testimony, it seems, has been to the point that we are either forcing low option or forcing HMO's on the system. And I am curious to know whether it is just the concept of multiple choice that does that or something else in 1968 that you believe will force low-option selection and HMO's on the system.

Mr. KAPLAN. There is available today, as Enthoven says and as I have related here, there are many forms offering more than one option, many Taft-Hartley trusts offering more than one option, but it has been done in the private sector without anybody's trying

to tax somebody, without anybody looking at what may be an antiunion bill that really may force people to do certain things.

What is going to happen—Enthoven went off a little bit on the Taft-Hartley aspect of it. You are talking about a $125 cap. I do not think that anybody in this room is naive enough to believe that the strong unions like the Auto Workers and the Teamsters are going to live with a $125 cap. They may well go with a $125 cap if the UAW is negotiating with Chrysler and Chrysler is paying $221 for health benefits per month, they are going to negotiate in addition $76 in after-tax dollars for that employee. You are going to have the greatest push-cost inflation factor you ever saw in your life with this type of concept.

The strong unions are not going to buy this. They are going to negotiate additional sums of moneys to enable them to have their members pay for the benefits they have got today that they negotiated through the years without any out-of-pocket expense.

That is what it is going to be like in the real world.

Senator DURENBERGER. Is self-insurance as profitable way for a large employer to go compared to the traditional insurance system or any other insurance system?

Mr. KAPLAN. I am a great believer in self-funding. I think any employer with 1,000 employees or more is being remiss if they do not self-fund. I think you will find most of your Taft-Hartley trusts have gone to self-funding, mandating fiduciary responsibility on those trustees.

It is difficult to justify any other way than self-funding. It will save a great deal of money. Self-funding with proper administration will save a great deal of money.

You are talking about containing the costs of health care, if I may digress a minute, we have clients out there because of total utilization review administration have seen the health care costs reduced by as much as 26 percent to 30 percent in face of escalating costs of 10 percent to 15 percent in the general areas.

And it is done in the private sector. It is done in the fee-for-service environment. It is done without denying the employee access to benefits. It is done without reducing the quality of care, and it has been very, very effective.

The FTC has done some studies on it. GAO has done some studies on it and you can get this information to do it in the private sector with total utilization review.

It works.

Senator DURENBERGER. Thank you.

Senator BOREN. Would an experience rating be a possibility in terms of preventing what you are talking about? In terms of skimming and moving into the low options and having the discrimination between those healthy groups and others?

Mr. KAPLAN. You say an experience rating?

Senator BOREN. Experience rating; yes.

Mr. KAPLAN. You do have an experience rating to a degree today, anyway. When you offer that individual at a lower salary an incentive to opt out of that particular system into some low option he is going to take that at this particular point in time. When he gets sick and the year comes up, he is going to opt for the fee-for-service area and for HMO and the higher area.

Senator BOREN. I can see what you are saying there, but in terms of offering it for the person, if you brought an experience rating into it you may affect the distribution a little differently, do you not think?

Mr. KAPLAN. I do not know. You have self-funded programs where the employer is contributing into a trust, the trust is self-funded on its benefits. There are many self-funded trusts, for example, that offer an HMO option if they want to.

Senator BOREN. How do you explain it that we have had, in some areas of the country, what you would call skimming, some examples of it and in other areas we do not seem to have had it. How do you explain the difference?

Mr. KAPLAN. I do not know if there are other areas where we have not had it. I can only site the most populous areas where it has happened. I cannot tell you it has not happened.

My concern is, underutilization in the HMO area and the fee-for-service area. Our big concern is overutilization, the doctor performing more services than necessary because the dollars are there.

Our concern in the HMO area, the prepaid area, is underutilization. The doctors in question, he is only going to get so much money. He is not going to do it out of the kindness of his heart and he wants to make sure he makes a profit out of what he receives.

Senator BOREN. When an employer is given an option, given multiple choice plans, are you assuming that quality of care is completely out of the window, that the employee is going to completely disregard the quality of care and if some of the options become notorious for providing bad care that is not going to have any impact?

Mr. KAPLAN. The employee is in no condition to evaluate the quality of care.

Senator BOREN. The person receiving the care is in no position to evaluate the quality of care? Would you repeat that please?

Mr. KAPLAN. Yes.

I say the lay person is in no position to evaluate the quality of care.

Senator BOREN. The lay person is in no position?

Mr. KAPLAN. The lay person.

Senator BOREN. You and I, as lay people, are not able at all to tell about the quality of care we are getting from the doctor, the hospital, the clinic?

Mr. KAPLAN. No; we are not, unfortunately.

Senator BOREN. I think that is an absurd statement, I would have to say.

Mr. KAPLAN. Senator, we have an interpersonal relationship with a physician. We may like some physician. We may not like some physician. We may not like the guy who is the greatest expert in this particular area in the world. But we do not relate with him.

What I am saying, you cannot really tell yourself, nor can I, that we are not physicians ourselves, that our treatment is really advised.

Senator BOREN. I would say, Mr. Kaplan, I do not pick my doctor on the basis of how well I like their personalities. I do try to weigh a few other characteristics.

Are there any other questions?

No other questions. Thank you very much.

[The response of Mr. Kaplan to letters from Professors Luft and Enthoven follow:]

U.S. ADMINISTRATORS INC.,
Los Angeles, Calif.

Hon. HERMAN E. TALMADGE,
Chairman, Finance Subcommittee on Health,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: At the end of March, 1980, I received a letter from Professor Harold Luft suggesting that I had quoted his writings out of context in materials that I submitted as a witness before the Senate Finance Subcommittee on Health on March 19, 1980. In an effort to ensure a complete testimony, I immediately informed the printing clerk of the Committee that I intended to ask that Professor Luft's letter to me and my response be included in the permanent record.

Subsequently, I learned that another witness at the hearing, Professor Alain Enthoven, was asked to comment for the committee record on my testimony. Although he did not share his remarks with me directly or invite my response, his letter has become generally available through his wide dissemination. In the interest of a thorough, complete and impartial hearing record, I respectfully request that my analysis of Professor Enthoven's letter be included. I am also enclosing a copy of Professor Luft's letter to me and my subsequent response to him. I have not received a response from Professor Luft to my reply to him. I also request that this correspondence be included in the hearing record.

Mr. Chairman, I would again like to express my gratitude to you and the Subcommittee for providing the opportunity to fully debate an issue which, if adopted, could have such a major impact on our health care financing arrangements.

Sincerely,

SAMUEL X. KAPLAN.

Enclosures.

SUMMARY OF A RESPONSE BY SAMUEL X. KAPLAN TO LETTER OF PROF. ALAIN ENTHOVEN TO U.S. SENATOR DAVID DURENBERGER

Professor Alain Enthoven of Stanford University wrote to U.S. Senator David Durenberger on March 25, 1980, commenting on a paper entitled, "The Competition Model May be Anti-Competitive," prepared and submitted to the Senate Finance Committee by Samuel X. Kaplan, President of U.S. Administrators, Inc., of Los Angeles.

Professor Enthoven was highly critical of Mr. Kaplan's paper and in his letter, he seeks to respond to Mr. Kaplan's analysis of the Enthoven "competition" model and Senator Durenberger's legislative counterparts which would limit the amount of tax deductible contributions by employers and employees for health benefits.

One of Professor Enthoven's major allegations is that Mr. Kaplan quoted out of context the writings of Professor Harold Luft of the University of California, San Francisco, when Mr. Kaplan said that they contained evidence that health maintenance organizations (HMOs) may be less costly because persons enroll in them, thereby creating economies. Mr. Kaplan, in reply, simply notes Professor Enthoven's own statement in which he agrees with Mr. Kaplan's analysis of Professor Luft.

Professor Enthoven also charged that Mr. Kaplan is in error when he stated that the Enthoven model and the Durenberger bills would benefit HMOs, to the detriment of our health financing arrangements. Mr. Kaplan, in reply, simply quotes the Congressional Record remarks of Senator Durenberger on the day he introduced one of his "competition" measures. The Record is rife with references to HMOs.

Professor Enthoven makes numerous other allegations, to which Mr. Kaplan replies. The exchange is attached, with Professor Enthoven's letter presented in block quotations, followed by Mr. Kaplan's replies to each section.

Enthoven:

Hon. DAVID DURENBERGER,
U.S. Senate,
Washington, D.C.

DEAR SENATOR DURENBERGER: This letter is in response to your request for my comments on a paper entitled "The Competition Model May Be Anti-Competitive" submitted to the Finance Committee during the Health Subcommittee Hearings on March 18 by Mr. Samuel X. Kaplan of U.S. Administrators, Inc. I cannot believe

that many people will take Mr. Kaplan seriously. But there may be some concern over some of the issues he raises; so I agree that his charges should not be allowed to pass without comment.

Mr. Kaplan's main contention is that the savings achieved by HMOs are the result of preferred risk selection or "skimming." On page 18, he says, "There is *strong evidence* to support the theory that HMOs may be less expensive because healthier persons select them and that the costlier ill or illness-prone employees choose indemnity, third-party, or self-insured arrangements." (Emphasis added.)

There is no such evidence. Health services researchers have looked for it for years and haven't found it. The best cost comparison studies generally control or adjust for age and sex and compare people within the same occupational group. Some, such as one by Clifton Gaus, question the beneficiaries about their health status, and find no significant difference between HMO and fee-for-service enrollees.

Kaplan response:

His statement is untrue that there is *no evidence* to support the preferred risk selection theory (emphasis added). The evidence not only exists, but it is found in the very authority—Professor Harold Luft— whom Enthoven cites. The issue is not whether the evidence is there but rather what use policymakers in Congress and elsewhere should make of it.

Enthoven:

What is the evidence offered by Mr. Kaplan? On Page 11, he offers the following quotation from Professor Harold Luft:

"Self-selection among HMO enrollees may be critical to lower admission rates; that is, better health or greater aversion to hospital admissions among HMO enrollees may contribute to the differential between HMO and fee-for-service admission rates."

Mr. Kaplan has distorted the meaning of Luft's passage by taking it out of context. The paragraph in which Luft's statement appears begins:

"Recognizing the complexities of evaluating admissions and assuming a scattering of discretionary cases in all patient categories, we find four possible, but not mutually exclusive, explanations for lower hospital admissions in HMOs: . . ."

The quotation from Luft, which incidentally is inaccurate, is the fourth *possible* explanation. The quoted statement is followed by this sentence:

"Sufficient evidence is not yet available to allow for a comprehensive evaluation of these hypotheses, but some evidence does exist with respect to quality, preventive care, and self-selection."

With respect to quality, Luft concludes:

"In general, the available data suggest that outcomes in HMOs are much the same as or slightly better than those in conventional practice."

With respect to the self-selection issue, Luft says of the literature:

"In general these studies have shown few differences between people enrolling in HMOs and in conventional plans."

He then goes on to refer to some new data in *one* study suggesting that self-selection *may* be a factor. But he then says:

"Although these self-selection findings are important, one should use them with care. By design, the studies measure only differences in utilization during the first year or so of membership, when the new enrollees have not yet established a relationship with a physician. Over time, that situation will change, and these relatively low utilizers are likely to become greater consumers of services. Thus, while the selection effect may account for part of the utilization differences, especially among new enrollees, it is unlikely that self-selection explains fully the performance of mature HMOs."

In other words, Luft is saying that it has not been proved that self-selection does or does not contribute to lower HMO admission rates in some cases.

It is a considerable distortion to make the leap from Luft's cautious statement about absence of evidence to Kaplan's bold assertion that "there is *strong evidence* to support the theory that HMOs may be less expensive because healthier persons select them. . ."

Kaplan response:

Enthoven criticizes the way in which my paper quotes Professor Luft, charging that I have distorted Luft's meaning by taking his words out of context. I suggest the reader consult page 10 of Professor Luft's paper, to judge the question of context. The central point—whether Luft did or did not raise questions about selective enrollment—is apparent regardless of Enthoven's editing or mine and the answer is found by a wider reading of Luft, beginning on page 14 of the Luft paper.

The discussion starting with the subheading *The Impact of Self-Selection* says that there is, indeed, evidence of self-selection; and that Luft himself studied the matter and found that

". . .self-selection can be an important factor and, furthermore, the type of selection depands crucially upon the type of HMO being offered and the net premium cost to the potential enrollee." (Luft, page 15)

Professor Luft is not, of course, the only student of these matters. The General Accounting Office has looked into a Medicare contract with the Group Health Cooperative of Puget Sound, a widely admired HMO model, and found clear evidence of selective enrollment among Medicare beneficiaries. For several years, the Kaiser Foundation Health Plan contract to serve Medi-Cal enrollees contained a provision on allowing no enrollment or causing immediate disenrollment of persons with long term neurological disabilities. In the Department of Health, Education and Welfare technical assistance manuals written to help developing HMOs prepare marketing plans, heavy emphasis was placed on enrollment of working groups, if not individuals. At present, HMO outpatient facilities are expanding in middle income areas across the country, avoiding areas where risks are predictably higher. Few HMOs in the country have enrolled any significant numbers of identifiably high risk groups and none has specialized in the poor, with the exception of the troubled California prepaid health plans.

A fair summary, I think, is that some (not all) HMOs do have lower costs, although no one has actually identified why, and there is evidence that preferred risk enrollment is one of the reasons. However, for Professor Enthoven's theory, the issue is critical: inconclusive evidence is as good as no evidence, he says, so let's get going. Meanwhile, he ignores the clear, unambiguous evidence that while HMO starting costs are lower, the rate of inflation in their premiums is as high as the free-for-service sector (Luft, page 6).

The lower hospitalization rates in HMOs raise significant further doubts about the Enthoven plan (Luft, page 10). Luft says that lower hospital admission rates have one of two primary explanations: (1) that HMOs identify and screen out cases that really do not require hospitalization—the discretionary or "unecessary cases;" and (2) that HMOs achieve a lower hospitalization rate without any apparent discrimination among cases according to obvious "necessity."

If the first explanation holds, HMO desirability is confirmed on both cost and quality grounds. If the second explanation holds, HMO experience must be assessed cautiously to make sure that lower costs are not the result of lower quality or a different patient mix, and then investigate further other factors that may potentially explain the lower hospitalization rates in HMOs.

The next sentence, which follows in the Luft text, is important:

"A survey of the best available data from a broad range of HMOs tends to support the second explanation rather than the first."

Now according to Luft, studies are clouding the most cherished of all the HMO articles of faith: that unnecessary surgery is screened out and both patient care and financial conditions benefit. Not clearly so, according to Luft.

If we discussed each of the criteria by which we judge health care systems—cost, utilization, accessibility of disadvantaged groups, timeliness and appropriateness of care, etc.—and if we discussed each of these at length and with all the evidence before use, there would still be room for dispute over the merits of HMOs versus fee-for-service. There is no dobut that prepaid, disciplined, and organized delivery systems are *potentially* superior to fee-for-service, solo and single speciality group practices, but obviously not in every case. Nor is the current Department of Health and Human Services' (DHHS) administration of the HMO program certain that HMO qualification is a guarantee that consumers may buy with confidence. (Refer to GAO and Senate Investigations Committee reports).

Enthoven:

Mr. Kaplan's citation of the preferred-risk selection practices of the California Medi-Cal Prepaid Health Plans is irrelevant to this issue. The comparison studies on the basis of which it is claimed that HMOs can care for people at a lower cost are mainly based on HMOs that serve employed people, and in which the enrollment process is controlled by the employer or health and welfare fund.

Kaplan response:

Professor Enthoven dismisses the California experience with prepaid health plans as irrelevant to his model, saying that he is basing his strategy on plans serving employed persons in which the enrollment process is controlled by employer or health and welfare funds. He evidently does not know that three of the earliest prepaid contracts signed by the State of California were with plans that had long

been serving union members and families in Los Angeles and Orange Counties (Innovative Health Systems, Family Health Program of Long Beach, and the California Medical Group). Disregarding California's experience—which cried out for regulation and led to federal funding to develop a sophisticated cost and quality monitoring and evaluation system, now just completed—is like navigating the North Atlantic and ignoring the icebergs. The lessons- learned were not lost on Congress which adopted tougher requirements for HMOs after surveying the situation and should not be lost now when contemplating national health initiatives. California's prepaid health plan program was launched by the Reagan administration with high hopes that it would reduce costs, that it would sharpen competition with the fee-for-service sector, and that it would be regulated by allowing enrollees to vote with their feet. None of those objectives was achieved on more than a modest scale, but financial abuse and patient neglect were commonplace, according to the April 20, 1978, report of the U.S. Senate Permanent Subcommittee on Investigations.

Enthoven:

While our data on risk selection by HMOs are fragmentary at best, I believe there is nothing mysterious or sinister about the subject. In a dual or multiple choice situation, which plan gets the worse risks will depend on the balance of a complex ecology of incentives. It could go either way. For example, if the HMO is competing with a "low-option plan" with high coinsurance and deductibles, it is likely to be very attractive to people with high expected medical costs. For example, I heard of a case in California in which a family with an annual choice between a "low-option" plan and an HMO learned that four of its children needed open-heart surgery. They switched at the next enrollment and got it all paid by the HMO. If the HMO is competing with a plan that does not cover outpatient care, it is likely to be very attractive to people who have chronic illness treatable on an outpatient basis. For example, I recently met a vice president of a large bank in San Francisco who was singing the praises of his HMO. It turned out that he suffers from serious chronic allergy, and the Medical Group of the HMO includes a nationally famous allergist whose services the banker gets with no copayments at all. On the other hand, if you introduce a cost-effective group practice HMO as an option in a group that already has a very comprehensive employee-paid fee-for-service plan, I expect you would find that people not presently under the care of a doctor, i.e. the more healthy at the time, would be more likely to switch than those having an established provider relationship. So the balance of risks can go either way. I personally doubt Luft's conjecture that risk selection is a significant contributor to HMO economies on an overall basis. Moreover, I believe that experience shows that this problem can be kept quite manageable by appropriate program design.

Kaplan response:

Professor Enthoven now concedes what he characterizes as "Luft's conjecture that risk selection is a significant contributor to HMO economies on an overall basis." But he "personally" doubts it. Why all the criticism of me for quoting Luft out of context when Professor Enthoven now agrees that this is Luft's conclusion?

Is it not curious that Professor Enthoven must dip into his repertoire of personal experiences to refute the empirical research and throughtful analysis of Professor Luft?

A major point in the paper I prepared and with which Professor Enthoven so strongly objects is that HMOs are the beneficiaries of preferred risk selection—that the healthy persons would buy the cheapest option. Consider his own more complete discussion of adverse risk selection contained in his March 18, 1980, testimony before the Committee on Finance.

"One of the most important and subtle design problems is to set the rules in such a way that health plans will succeed by providing better care at less cost and not by selecting preferred risks. For example, if people were given an annual choice of a low cost insurance plan limited to catastrophic expense protection and a comprehensive plan with first-dollar coverage, those who expected little or no medical expense during the coming year would find it in their interest to pick the low cost plan. When they planned or expected substantial medical expenses, they would switch to the comprehensive plan until their medical needs were taken care of. Comprehensive plans would not be able to survive in such a competition; they would be destroyed by adverse risk selection."

Professor Enthoven in his letter that "experience shows that this problem (risk selection) can be kept quite manageable by appropriate program design." He then describes his "appropriate design." The trouble is that his design does not exist anywhere, leaving us without the experience necessary to show that it will work.

Enthoven:

By "appropriate program design" I mean primarily: (a) the employer or government, and not the health plans, conduct the enrollment process. Thus, the health plans are informed who their members are for the coming year. They cannot choose them; and (b) Reasonable comparability of benefits so that one health plan is not substantially more attractive than another to the people with high medical risks.

Kaplan response:

Professor Enthoven tells us, on the one hand, that there should be "competition" among plans and that consumers must be free to choose from among these plans. On the other hand, he says there must be "appropriate program design" to ensure "reasonable comparability of benefits so that one health plan is not substantially more attractice then another to people with high medical risks."

Who would be responsible for ensuring "reasonable comparability of benefits" in health plans? The government? If the Federal Government directs similarity of plans, how can we have "competition" among these plans?

Finally, if a part of his program design means that the employer or government conducts the enrollment process, what has happened to the freedom of the consumer to choose; and to choose what? Government-closed health plans?

In my view, it is a contradiction to use terms such as "consumer choice", and "competition" in describing the Enthoven plan. Wherever cracks appear in the logic of his plan, Professor Enthoven glues it together with government regulation or control, which he alleges to be a major cause of the health cost problem.

Enthoven:

If risk selection were to become a significant factor in a competitive system, it could be corrected by use of a more refined set of actuarial categories, as I recommended in Consumer Choice Health Plan, and/or by "empirical tuning" of the benefit packages. For example, the SAFECO Company's Northwest Healthcare program uses seven actuarial categories based on age and sex so that doctors who serve older patients get paid more for doing so.

Kaplan response:

Professor Enthoven seems now ready to abandon community rating—long held to be one of the chief advantages of HMOs—in favor of a modified form of experience rating—that is, adjusting premiums to compensate for the costs of enrollee groups with identifiable or expected utilization patterns. There is some merit to the idea, but I am surprised that the sacred cow of community rating has been so quickly let out of the barn. Surely, if differential rates are to be paid by government and private purchasers, then rate review and utilization monitoring cannot be far behind. The idea that physicians serving older patients should be paid more without justifying the additional expense is nonsense. About 10 percent of the elderly account for more than 50 percent of Medicare costs. No health plan should be excessively reimbursed for serving healthy elderly anymore than one should be penalized for serving the chronically ill. I support the requirement that prepaid rates under Medicaid be based on actuarial evidence, and I would expand that to include actual health status and utilization, not conjecture. That would end any uncertainty about advantageous or adverse risk selection.

Enthoven:

Let me emphasize that I raised and dealt with the risk selection problem in the development of Consumer Choice Health Plan in the summer of 1977. *Risk selection is not a new issue that has suddenly emerged.*

Mr. Kaplan ignores the fact that we have had decades of experience with millions of employees and their families in dual choice and multiple choice plans and generally speaking preferred or adverse risk selection has not proved to be a significant problem. For example, the Federal Employees Health Benefits Plan (FEHBP), an excellent example of the competition model, has been in successful operation since 1960. It now covers about 10 million people. There is no evidence that Mr. Kaplan's speculations about HMO preferred-risk selection have been realized in this program to any significant degree. I have recently been assured by a key OPM official that none of the main participants has claimed that it has suffered from adverse risk selection.

Mr. Kaplan goes on, on Page 18, to comment on the evidence of the effectiveness of competition in controlling costs: "Credible, objective analysts such as Howard (sic) Luft of the University of California, San Francisco, Health Policy Program, say practical experiences of several communities in the nation, including the Bay Area, where the Kaiser-Enthoven model has been in place for years, provide supporting

evidence that is 'weak' and even 'contradictory'." (The Kaplan paper is so sloppy that its author incorrectly stated the given name of my esteemed colleague and sometime coauthor, Harold Luft.)

Kaplan response:

He is quite right when he says that risk selection concerns are not new, but he also cites the Federal Employee Health Benefits Program (FEHBP) as evidence that the problem is not significant and that the competition model really works. There are several problems with these assertions. First, as already noted, the FEHBP studies suffer from the flaws Luft describes on Page 15 of his paper. Next, while there may have been some marketing competition in the FEHBP, it bears little resemblance to the "appropriate program design" he advocates. In fact, California unions, supported by public employees, began organizing statewide in the late sixties and early seventies to protest both rate increases and conditions at Kaiser facilities, only to be told by Kaiser representatives that if the unions did not like what they were buying, they could take their business and enrollees elsewhere according to union officials with whom I talked. But, of course, there was nowhere else to go except into a disorderly fee-for-service market where out-of-pocket costs to families were increasing each year. They had no risk capital and insufficient numbers of medical personnel to start up new plans and the emerging prepaid health plans were, for the most part, so shabbily run they were not acceptable. In one sense, this history supports, at least in theory, the Enthoven argument that enrollees would have left if the opportunity had been available, but it certainly points out that for those federal employees enrolled under FEHBP, the options went from bad to worse. The market, as Enthoven wants to create it, simply did not exist.

Enthoven:

The principles of fair economic competition that I am recommending have *not* been in place in the San Francisco Bay Area for years. They are *not* in general application today. For example, last summer we did a survey of employers in Santa Clara County. Of a random sample of employers with 500 or more employees, only 22 per cent offered their employees a choice of health plan (two or more choices) and an equal dollar contribution to the plan of their choice. Of employers with 25 to 500 employees, only 3 percent offered a choice and an equal contribution. Thus, the great majority of employers either offer no choice of health plan, or contribute more on behalf of the more costly plan (which in our sample was the insured fee-for-service plan). Of those offering a choice, one-third of the larger employers and three-quarters of the smaller employers paid 100 per cent of the premium whichever plan the employee chose. Thus, the principles of fair economic competition as exemplified by the Health Incentives Reform Act and the Health Cost Restraint Act are not generally applied in the Bay Area.

Kaplan response:

But where a wide open health market does exist, Enthoven chooses to ignore it because it has not resulted in lower costs. In San Francisco, a city with a declining population, there is a staggering surplus of hospital beds, 3500, distributed among 17 hospitals, all located in a city smaller than Washington, D.C. In addition, there are more physicians (480 per 100,000) than in any similar city. Kaiser has a large and busy hospital and outpatient service in the city and a smaller prepaid plan has started at one of the community hospitals. The result: the highest priced medical care in America. True, Kaiser has been closed to new groups for some time so the full impact of the option has not been felt, but then, why have no new HMOs come into this rich market? More than $300,000 in federal development funds were spent attempting to bring physicians and hospitals into a city-wide Independent Practice Association, but in spite of a good design and strong buyer interest, the plan was stillborn for lack of provider support. Blue Cross has attempted to find a physician group for a base in San Francisco, but without success. Physicians are less busy than they could be and some are working outside their specialities, yet prices do not come down. Clearly, the usual market forces do not work in San Francisco, nor do they work elsewhere in the health industry as has long been demonstrated. Enthoven's proposal is not a free market proposal at all. It would limit health organizations on one side and put great economic pressure on consumers on the other.

Enthoven:

I admit that the evidence in favor of the competitive model's ability to control cost is quite limited. That is because it has been tried in only a few places for a short time. The best examples are Hawaii and Minneapolis-St. Paul. Only in Hawaii is a majority of the population covered by one or another competing alternative

delivery system. And even there, the principles of fair economic competition are not fully applied. Yet the cost experience in Hawaii is impressive. Hospital costs per capita are about 68 per cent of the national average despite the fact that there is practically universal comprehensive insurance coverage and the cost of living in Honolulu is 20 per cent above the national average. Of course, one can argue that other factors contribute to health care economy in Hawaii, so it is not possible to identify, on an academically acceptable basis, the relative contribution of competition and other factors. My own personal observation leads me to believe that competition is a significant contributor to health care economy there.

Kaplan response:

And all to promote a theory that he admits is supported by limited evidence. Such evidence as there is includes Hawaii and Minneapolis-St. Paul, but he discards the latter and concentrates on Hawaii, citing impressively lower hospitals costs (68 percent of the national average in spite of high costs of living in Oahu). He then notes that other factors might contribute to health care economies in Hawaii. Although he does not cite them, these factors include: low wages (in spite of the cost of living), cultural attitudes resisting the use of health services, communal social traditions offering support and maintenance of health outside institutions, not to mention the vigorous and well informed demands of island unions which have, through contracts, exacted the kind of regulatory conditions that are left to government in other States. All of these factors have been identified by students of Hawaii's unique cultural and economic life as reasons hospital costs are low. Competition, so far as I can find, has not been cited in any study. "My own personal observation leads me to believe," says Professor Enthoven, "that competition is a significant contributor to health care economy there."

For purposes of emphasis, I would like to discuss what Professor Enthoven has written in this section. First, he says, "I admit that evidence in favor of the competitive model's ability to control costs is quite limited." But he means the evidence is limited to a few geographic areas and although he mentions two areas, he focuses on Hawaii. Clearly, he says that Hawaii offers "evidence" to support his theory.

Then, he says, "My own personal observation leads me to believe that competition is a significant contributor to health care economy there." Notice how the "evidence" of Hawaii has dissolved into a "personal observation" which leads him to believe. . .

Here we have the most forceful advocate of a major change in tax law that would restructure the financing of health benefits saying the evidence in support of these major changes, geographically, "is quite limited" and even where it can be found, the so-called "evidence" is really the result of his "personal observation" that leads him to believe what he has observed constitutes evidence.

Enthoven:

The strength or weakness of the evidence on competition has to be judged in relation to the evidence on the alternatives. The alternative strategy for cost control is direct economic controls on prices, utilization and capacity as in Certificate-of-Need, Hospital Cost Containment, Professional Standards Review Organizations, and controls on physicians' fees. The evidence of the long and broadly-based failure of this strategy is very strong.

Kaplan response:

The reader must appreciate this statement and its effort to further slide around facts to justify professorial theories. He speaks of economic controls and he refers to Certificates-of-Need, which are obtained from Health Systems Agencies (HSAs) created by the National Health Planning and Resources Development Act, enacted in 1975 and implemented in 1976. Many of the HSAs, which rule on Certificates of Need, were not really in business until 1978 and 1979 and some still are getting organized.

He refers to PSROs, which are local panels of physicians responsible for reviewing the utilization and charges of their peers. This, too, is a relatively new program and as for hospital cost containment, the Congress has failed to enact such a program.

Nevertheless, Professor Enthoven says of these systems that "the evidence of the long and broadly-based failure of this strategy is very strong."

Where is the "evidence of the long and broadly-based failure" of hospital cost containment? Where is similar evidence of the failure of health planning? We can suggest that Professor Enthoven travel up the road from his university to San Francisco to visit the West Bay HSA, covering Marin, San Mateo and San Francisco counties, for vivid evidence of one of the most successful HSAs in the nation. Where

is the evidence that PSROs have failed. We can direct Professor Enthoven to the Los Angeles PSRO 23 so that he may obtain some "personal observations" which may lead him to believe there is evidence contradicting his views.

In general, Professor Enthoven dismisses the possible value of economic controls, PSROs, Certificate-of-Need and controls of physicians' fees. I am inclined to agree that these efforts as presently handicapped by law are having a limited national effect, but there are areas of the country where their impact is great. In fact, there are more areas where these controls are working than there are areas where the so-called "competition" model can be claimed to be operative.

I would point out that in his original *Consumer Choice Health Plan* (Executive summary, page 12, para C.8.) he cites compatibility with health planning, hospital cost containment and physician fee controls as a virtue of his proposal. He goes on to suggest that compliance with those controls could be made a condition of plan qualification. I suspect the change of heart comes not from new learning by Professor Enthoven, but by a change in audience. His CCHP was originally written for former DHEW Secretary Joseph Califano whose interest in government control of health costs was lively and well-known. Professor Enthoven's advocacy of controls has cooled with the departure of Secretary Califano.

Enthoven:

Mr. Kaplan does not make clear what national strategy for health care cost control he would recommend. On page 17 of his analysis, he makes some self-serving statements about the self-insurance approach. It is worth noting the sources of the savings he ascribes to this approach. The first is simple tax avoidance which is not a true economic saving. The second and third are the risk, reserve, profit and pension plan charges of the private health plans, and their marketing costs. The costs to which he is referring are, in the case of large groups, typically less than 10 per cent of total premium costs. And all of them are not "saved" in the self-insurance approach. Many are simply absorbed by the employer or claims processor. Thus, shrinking these costs is not a very promising strategy if the goal is substantial reduction in total costs. Recall that Luft found that HMOs reduce the total per capita cost of care by 10 to 40 per cent.

It seems to me fair to say that the "claims review approach" has been tried and has not succeeded. It might be successful if it were motivated by genuine competition.

Kaplan response:

The issue before the Finance Committee is not my national strategy for health care cost control, but Professor Enthoven's "competition" proposals. My claims for self-insurance were modest, based, after all, on actual experience while his proposals are not. Administrative cost savings are not to be ignored when they add up to hundreds of thousands of dollars or, in the case of public programs, in the millions. A significant point here is that close monitoring of claims in self-funded health benefits arrangements can reduce unnecessary utilization and, therefore, costs (and it is demonstrable which utilization is being reduced, unlike HMOs). Furthermore, self-funding *does* result in reduced overhead costs. Without a coordinated pricing policy, the overall costs of health care cannot be reduced simply because no one controls the price except the provider.

But how will things change under Enthoven's plan? What is to prevent providers from forming a workable consensus—as they do now—as to what income they expect and then seeing that they get it? When payroll costs and productivity are put together, physicians in prepaid group practices do not make much less than their professional counterparts in fee-for-service. Nothing in Enthoven's proposal will affect in any way the ability of physicians to set their own income goals and reach them.

My alleged "self-serving" statements aside, I would like to direct attention to the open marketplace which both Professor Enthoven and I cherish. The Library of Congress estimates that as much as 30 percent of the nation's employees receive health benefits through self-funded arrangements and that this represents a substantial growth from 7 percent of just ten years before. On the other hand, HMOs now cover only 4 percent of the U.S. population in spite of a massive Federal grant and loan program. Self-funding is growing because it is less expensive and through cost savings enables employees to receive richer benefits. This may not be "economical" or "competitive" in Professor Enthoven's parlance, but to corporations, unions and employees, it means they receive more health benefits for less money.

Professor Enthoven, citing no authority, states that "it seems fair to say that the 'claims review approach' has been tried and has not succeeded." It is neither fair to say, nor is it accurate. I direct Professor Enthoven to his own university's medical

center where "claims review" has resulted in identifying extraordinary overcharges by Stanford of the California Medi-Cal Program; and I would suggest that he travel the few miles from his own campus to the San Francisco offices of Blue Shield of California to see one of the most sophisticated service plan claims review processes in the nation. Where is his evidence that claims review has not succeeded? Sophisticated claims review procedures are the backbone of any cost saving health benefits plan administration.

Enthoven:

Mr. Kaplan's characterization of today's situation on page 17 as the "true market, unhindered by government intervention" is totally inaccurate. Today's market for health insurance for employees is strongly influenced by the tax laws. Private health insurance and HMOs are highly regulated by government. The problem is that these laws and regulations block competition. That is what the Health Incentives Reform Act and the Health Cost Restraint Act are all about.

Kaplan response:

As for regulation hindering true competition, in contrast with the Enthoven model, it may be so, but I would not accept it without evidence. Deregulation of the airlines may have decreased rates, but it has also so limited flights in the interior California valleys that residents of these areas feel that they are being ignored. Similarly, small groups of employers and employees will have little impact on a health plan market where enrolled numbers run into tens or hundreds of thousands. Only a public process—which may involve regulation in the form of accountability—can assure responsiveness to small buyers in the market.

Enthoven:

The rest of Mr. Kaplan's paper is filled with other distortions, confusions and inaccuracies. For example, the *Executive Summary* begins with the statement, "The 'competition model' under consideration is similar to legislation now before the Congress that would force many corporations and workers to accept health maintenance organizations (HMOs) through tax preferences." This is false. What your Health Incentives Reform Act and Congressman Ullman's Health Cost Restraint Act do is to require employers to offer their employees health plan choices on an economically fair basis as a condition for continuing receipt of favorable tax treatment. They do not *force* workers to accept HMOs. There is a world of difference between requiring employers to offer a fair choice and forcing workers to accept HMOs.

Kalpan response:

As for the question of force versus choice, I would only point out that there is a world of difference between a choice without pressure and one that involves possible tax penalties. To repeat what I pointed our earlier, if the only plan geographically usable to an employee group is the highest priced plan, then the employees in that plan, through no fault of their own, will be penalized. That is hardly a hypothetical case. The Northern California Laborer's Health and Welfare Trust Fund covers laborers and hod carriers throughout northern California and southwestern Nevada. What HMO will the laborers in the rural areas of Chico, Redding, Red Bluff or Eureka join? Obviously, they will not join one. None exists nor is one likely to exist for years, if ever. Meanwhile, they will join a higher priced Blue Cross or Blue Shield or indemnity plan and pay a penalty for it. How is that fair?

Enthoven:

Three paragraphs later, the *Executive Summary* goes on to say, "The so-called 'competition model' before the Congress would give such preferences to HMOs that self-insured, indemnity and third-party payment plans would be seriously damaged." This too is false. What the bills require is equality of treatment in the offering of choices, not special preferences to HMOs.

Kaplan response:

In his July 12, 1979, statement on the introduction of S. 1485, the Health Incentives Reform Act of 1979, Senator Durenberger included a "section description and analysis" which included the following (emphasis added below):

1. "Proposal. Each employer subject to the Fair Labor Standards Act, having 25 or more employees, shall include in any health benefits program offered to employees a choice of no less than three health insurance or delivery plans meeting the standards described below. . . . *Two of the three must be state or federally qualified health maintenance organizations, if available.*" (Page S. 9257 of the Congressional Record, July 12, 1979)

2. "Proposal: *The tax-free employer contribution would be limited to the average premium cost for federally qualified HMOs across the country.*" (Page S. 9258 of the Congressional Record, July 12, 1979)

3. "In effect, the federal government is subsidizing people's choices of the most costly health plan options. It is appropriate for the federal government to subsidize health insurance purchases up to the level required for good quality comprehensive health care (*as provided by the HMOs*). If people want to buy or negotiate for their employers to buy, more costly health insurance, that should be their right, but not at taxpayer expense." (Page S. 9258 of the Congressional Record, July 12, 1979)

4. "*Any health benefits plans must cover, as a minimum uniform set of benefits, the Basic Benefits defined in the HMO Act.*" (Page S. 9258 of the Congressional Record, July 12, 1979)

5. "Proposal: *Change Section 1856 of the Social Security Act to permit any Medicare beneficiary to direct the 95 percent of the 'Adjusted Average Per Capita Cost' (AAPCC) to the Medicare program for people in his actuarial category who are not members of an HMO, be paid, as a premium contribution on his behalf, to the HMO of his choice in the form of a fixed prospective periodic payment.*" (Page S. 9259 of the Congressional Record, July 12, 1979).

At the conclusion of his description, Senator Durenberger inserts a series of articles in support of the "competition model" and HMOs, including "HMOS: The Road to Good Health Care" by James F. Doherty, the Executive Director of the Group Health Association of America; "Competitive HMOs are Bringing Changes to Area Medical-Care System" by Peter Vanderpoel; two articles about the HMO experience in Minneapolis-St. Paul; and a series of articles by Professor Enthoven which extoll the virtues of health maintenance organizations. (Pages S. 9259 through S. 9282 of the Congressional Record, July 12, 1979)

Although I am aware that Senator Durenberger has since introduced another bill which is less direct in its endorsement of HMOs, the above described bill has never been withdrawn and is still pending in the Senate Finance Committee. Professor Enthoven may not like to use the term "force" for the "encouragement" for individuals to participate in HMOs. However, with the type of built-in advantages described above, employees may have little "choice" left but to join an HMO.

Enthoven:

Contrary to what Mr. Kaplan implies, neither the Health Incentives Reform Act, nor the Health Cost Restraint Act, nor Consumer Choice Health Plan rely exclusively or even primarily on HMOs to reduce cost and improve quality of care. I merely cite HMOs as one example to illustate the possibilities for better care at lower costs. But there are others. One is the Primary Care Network developed by the SAFECO Life Insurance Company of Seattle and by the Wisconsin Physicians Service. This model could be adopted fairly quickly by many insurance companies if the competitive incentives to do so were there. It has a great deal to recommend it. Another is the Health Care Alliance described by Paul Ellwood and Walter McClure. More broadly, I have a great deal of confidence in the ability of the private sector of the American economy to innovate and develop new systems for delivering better care at lower cost if only we can open up the market to competition by assuring that as many citizens as possible have health plan choices on an economically fair basis.

Kaplan response:

Again I question the economic theory that underlies the premise that innovative programs would spring up if the economic incentives were there. Right now, a Teamsters Local in San Francisco receives a total of $170 per member per month in health benefits, excluding pensions, based on 80 hours of work per month. Their enrollment in Kaiser is up to 45 per cent. Surely $170 per month is enough incentive for another plan to seek their business, but apparently it is not. The members who live too far away from Kaiser to use it must continue the very costly, higher priced indemnity plan.

Enthoven:

Mr. Kaplan makes biased and selective use of other sources. For example, on page 12, he says, "One recent example of underutilization comes not from some fly-by-night health plan, but from the Health Insurance Plan of Greater New York, which is known as HIP and is the second largest HMO in the nation. According to a report released in December 1979 by the New York State Comptroller, HIP failed to meet its contractual obligation to provide to the poor children of New York City." An accusation is not the same thing as guilt. HIP replied: "The report's statement that CHAP services *were not* provided is simply untrue." It looks like a squabble over

data reporting, with a certain amount of posturing by the Comptroller. In any case, Mr. Kaplan presented only *one side* of an issue that is in dispute.

Kaplan response:

It is true that accusation is not the same as guilt, but the Controller's evidence and argument are convincing, in my view, and since that study is about the only kind of information we would ever have available for judging a plan, even under Enthoven's proposal, some kind of consumer decision is in order. Otherwise administrative courts to resolve disputes between public agencies and HMOs would need to be created unless we were to end public agency review. And, if so, what would take its place?

Enthoven:

Moreover, the Comptroller apparently did not conclude that HIP was as bad as Mr. Kaplan's excerpts would suggest. Elsewhere, the same report said: "It is incumbent on HIP and HRA (the City's Human Resources Administration) to study all possible incentives that might induce large numbers of Medicaid clients to enroll in CHP (HIP's Comprehensive Health Plan). The potential savings are there." Thus, despite his findings, the Comptroller recommended that HRA seek to induce more people to enroll in the HIP plan. If the Comptroller *really* believed that HIP was fraudulent or had significantly underserved the patients, it is hard to see how in good conscience he could urge "decisive action" to expand the enrollment.

It is tempting to go on and refute more distortions and misrepresentations. But I think these illustrations are enough to make my point. Mr. Kaplan has offered you a thoroughly unreliable analysis.

Kaplan response:

The documentation by the Comptroller regarding HIP illustrates the consumer dilemma that Professor Enthoven ignores: namely, that choices and options inherent in his proposal are unworkable. The answer is not to suggest that consumers float from plan to plan, but to develop rational surveillance and enforcement systems that guarantee performance, because of the evidence reported by the U.S. General Accounting Office and the Senate Permanent Subcommittee on Investigations of inappropriate financial and patient care practices in prepayment settings.

After taking all of the time and energy to criticize my writing, it would have been quite a contribution to our exchange if Professor Enthoven had discussed my other points with which he disagrees. Certainly, to summarily dismiss these as "more distortions and misrepresentations" raises questions about his sincerity in wanting to have a full and complete exchange of views. This is of particular concern in light of the professor's own concession that he is asking the United States Congress to change tax laws based upon "personal observation," not evidence.

Enthoven:

Finally, why does Mr. Kaplan keep referring to my proposal as "Kaiser-Enthoven?" Does he mean to imply that my proposals are really the joint proposals of the Kaiser Permanente Medical Care Program and myself? That is false. Consumer Choice Health Plan is my own proposal, and not that of the Kaiser-Permanente Medical Care Program. I developed it while serving as a consultant to HEW Secretary Joseph Califano. It received the benefit of the ideas and criticism of many people including government officials, executives of insurance companies and the Blues, health policy analysts and others, only a small majority of whom were associated with the Kaiser Program or any other HMO.

The Kaiser Program has taken no position for or against Consumer Choice Health Plan. They do not endorse any national health insurance proposal.

Moreover, one of the basic principles of Consumer Choice Health Plan and my subsequent "incremental proposals" is *fair* economic competition, that is equality of treatment for all types of health care financing and delivery plans and for their beneficiaries. My proposals contain no special preferences for HMOs, only equal rules for all. For example, in my March 1978 article on Consumer Choice Health Plan (CCHP) in the *New England Journal of Medicine,* I wrote, "I would not place much confidence in proposals for special grants and subsidies for HMOs. . . . Given a truly fair market test as proposed in CCHP, health plans demonstrating the economic superiority of many HMOs will prosper without help." Mr. Kaplan's analysis is in error in implying that my proposals are for special preferences for HMOs. It is apparent that Mr. Kaplan has not understood my writings.

Does he mean to suggest that he has exposed a big secret, that is that the Kaiser Program is one of my consulting clients? That would be ridiculous. In the interests of "truth in advertising," I have always been very "up front" about that relation-

ship, especially when consulting for Kaiser competitors! I even list it on my resume so that no one will feel surprised or deceived. While the Kaiser program is indeed one of my consulting clients, neither my analysis of the Health Incentives Reform Act nor of any of the other pro-competition proposals, nor of any national health insurance proposal, has fallen within the scope of my consulting assignments with them. (My consulting assignments have been in such areas as long-range capital financing policy, strategic planning, and cost-effectiveness evaluation of investment alternatives.) I have also done consultation for numerous other organizations in the health care field.

Is this meant to be a subtle attack on my integrity and professional independence, an attempt to discredit my proposals through innuendo and insinuation? Is he implying that I am representing as my own something that is really someone else's? If so, I categorically deny the implication. It is both false and absurd. It would make no sense for me to do such a thing. My proposal was first published in the *New England Journal of Medicine*, the nation's leading medical journal. It is ridiculous to suggest that the *Journal's* editorial board, composed of some of the nation's leading medical minds, could be fooled into thinking that what was really a "Kaiser-Enthoven-HMO proposal" was an Enthoven proposal for fair competition in the private sector.

I defend my proposals and criticize others on the merits, and not on the basis of the professional assocations of the authors. I think it would improve the quality of the dialogue greatly if Mr. Kaplan were to do the same.

There may be another reason why Mr. Kaplan refers to me as "Kaiser-Enthoven." On page 20 of his diatribe, he states: "It is fair to theorize about Kaiser-Enthoven because it is a theory, itself." Then he goes on to conjure up a fantastic scenario that ends in "a massive HMO medical monopoly." I wonder if Mr. Kaplan is trying to suggest, in his fantasy, that I will become a German-style monarch who presides over the HMO medical monopoly, not a "health czar" but a "health Kaiser!" The dream is exhilarating; it sounds like a lot more fun than being a mere Stanford professor. Let me assure you, then, that my ambitions are limited to making a modest contribution to improving the equity and efficiency of our health care economy.

Seriously though, the proposals to create competition are not as "theoretical" as Mr. Kaplan implies. On the contrary, they are based on such demonstrated practical successes as health plan competition in Minnesota and Hawaii, the Federal Employees Health Benefits Program, and Project Health in Multnomah County, Oregon. And, as you well know from your own observation, the results of these experiences *are* encouraging, though not conclusive proof of efficiency in a scientific sense. And they do not support Mr. Kaplan's theories.

It is ironic that Mr. Kaplan thinks that proposals that would create competition and break up the present noncompetitive situation would create a massive monopoly. It should make one wonder about everything else in his paper.

Yours sincerely,

ALAIN ENTHOVEN.

Kaplan response:

Professor Enthoven states that it is erroneous to imply that his proposals provide special preferences for HMOs. If such an implication is erroneous it is curious as to why he has expanded such energy in his writing defending them against findings of Professor Luft and the paper I prepared.

Certainly this is a curiosity in itself, but his implication that the evolution of his CCHP proposal into whole-hearted support of the "competition" proposals before the Finance Committee does not constitute a preference for HMOs is not only misleading but also it is false.

He accurately states that Kaiser neither has taken a position for or against his plan nor has it endorsed any national health insurance plan. By implication, he postures Kaiser in a stance of silence on various "competition" proposals, which is misleading.

On February 12, the California Chamber of Commerce Health Care Costs Committee met to consider various proposals to contain health costs, which ultimately were to be submitted to the full Chamber membership. One of the proposals before the Chamber Committee was submitted by Professor Enthoven, according to the Chamber staff. I was present at the meeting of some 60 California health benefits and health financing officials. The debate over Professor Enthoven's plan was between me and Scot Fleming, Senior Vice President of Kaiser Foundation Health Plan, and when the vote was taken, the only vote cast in favor of Professor Enthoven's proposal was cast by Mr. Fleming.

There is a further coincidence of issues advocated by Professor Luft and beneficial to Kaiser. Contained in Professor Enthoven's CCHP is a recommendation that HMOs receive 95 percent of the area fee-for-service per capita cost for providing services to Medicare beneficiaries. This has been a position of Kaiser since 1972 as evidenced by a Kaiser memorandum made a part of a Senate Finance Committee record on May 18, 1978.

There is yet another coincidence between the position of Professor Enthoven and that of Kaiser. The strategy of providing "choice" as a substitute for clear accountability for real Kaiser costs, quality and satisfaction is a fundamental and long-standing tenent of all Kaiser development plans. In short, Kaiser seems to be asking that it be "chosen" and once chosen that the consumers accept its determinations of cost and quality.

But certainly the most convincing evidence of the relationship between Kaiser interests and Professor Enthoven's proposals is his acknowledgment that he is a consultant to Kaiser and perhaps this is one reason why there is a coincidence in his positions and those issues benefitting or advocated by his client.

I do not believe that this is sinister nor do I believe that this relationship impugns the integrity of his work, as Professor Enthoven suggests. Professor Enthoven's personal advocacy in Washington of matters beneficial to his client simply shows that Professor Enthoven is a good businessman.

U.S. ADMINISTRATORS INC.,
Los Angeles, Calif., April 3, 1980.

HAROLD S. LUFT, Ph. D.,
Associate Professor of Health Economics, School of Medicine, University of California, San Francisco, Health Policy Program, San Francisco, Calif.

DEAR PROFESSOR LUFT: Thank you for your March 26 letter in which you raised some concerns about our use of certain of your materials in our paper entitled, "The Competition Model May Be Anti-Competitive." First, I want you to know that I join others in regarding you as perhaps the most objective of those analyzing today's situation with regard to health care financing, and I believe your work will ultimately be cited as most significant in the field.

The paper we prepared was a summary of various materials and was not intended to be a definitive writing. Its sole purpose was to raise questions as part of a debate by those considering the so-called "competition" alternative to present health care financing systems. I must admit that your paper, "HMOs, Competition, Cost Containment, and NHI," does a much better job of questioning the wisdom of institutionalization in law of so-called "consumer choice" and "competition" alternatives. Frankly, I am surprised and disappointed that more currency is not being given to your work on Capitol Hill. Although I disagree with the present thrust of various "competition" proposals, I do believe that there is contained in them the elements essential to a long-overdue and much needed debate.

I am sorry you feel we quoted your work out of context. I do not believe we did. Moreover, the paper was submitted to the most severe scrutiny by lawyers, health care financing specialists and by professional writers who were asked to review the writing for just this type of concern.

First, in an effort to avoid any claim of misquotation or quotation out of context, we included your paper as an attachment to every paper we distributed. Moreover, each significant document cited in our writing was likewise attached.

Secondly, we introduced the reference to your writing on page ten of our paper by calling to the readers' attention that these were "Summary" remarks and the entire paper was appended. We did this with the following introductory sentence: "Luft, in his above cited paper which appears in Appendix II, states in a summary section of his writing on HMO costs that:"

Thirdly, we called to the attention of the reader on page 11 that your comments on self-selection were one of your several theories when we introduced the quotation from your paper with the following sentence: "Luft discusses this suggestion in his paper and offers several alternative theories, including the following:"

With all due respect, I do not believe that your material was quoted out of context, but I do appreciate the desire of any author, particularly scholarly writers, to see as much of their materials presented in as complete a context as possible. Your suggestion that we quoted your writing out of context implies that we willfully used portions of your work in an effort to mislead. Such a suggestion is wrong.

In your letter, you also call attention to a statement on page 18 of our paper, which was actually contained on page 20. This was a summary section of my paper, and I am sorry you feel that "there may be attribution by association" to you because your work is referenced elsewhere on the page. The more important issue you raise is on the point of self-selection, and you invite me to provide you with

evidence on the self-selection question. I would like to refer you to Appendix IV of my paper, entitled, "Risk Differential Between GHC Medicare Open Enrollees and Other Medicare Beneficiaries" by Paul Eggers. The self-selection question is also raised in Appendix VI, "When a Solution is Not a Solution: Medicaid and Health Maintenance Organization," by Bruce Spitz. Perhaps the best overall discussion of self-selection, however, is contained in the section of your paper entitled, "The Impact of Self-Selection," (a title that implies the practice exists). Your writing raises very serious issues for consideration by any reasonable legislator, any responsible health benefits officer and any group of trustees who take seriously their fiduciary role.

In our discussion of the experiences of San Francisco, Rochester, NY, and Minneapolis-St. Paul, I fail to see that we have a quarrel; but, once again, I direct your attention to your own paper and the section entitled, "The Competitive Impact of HMOs." Once again, you raise most serious questions for consideration by legislators, health benefit officials and trustees.

I want to make it quite clear that I absolutely do not believe that your paper was quoted out of concern, and I would like to pledge to you my support for your most important work. Indeed, in a world where the clarity of debate is clouded by the misuse of our language and where the marketing strategies of self-interested groups are cloaked by university-based representations and public interest buzz-words, your work stands as the effective expression of honest, forthright research based on obvious deep, personal integrity.

Although I have never met you, I deeply respect you and your work and this is why I am so sorry you feel my own effort may have done a disservice to you. I am grateful that you indicated the names of persons being copied with your letter to me and that you included a copy of your letter to Dr. Chris Saudek of Senator David Durenberger's staff. Certainly, your paper and your testimony before the Senate Committee on Finance last month would have been a most important contribution to the hearing record and it is unfortunate this did not take place.

Finally, I noted that you sent on the same day letters to me and to Dr. Saudek in which you made the allegations against me. I want you to know that I feel you were most unfair to me because you did not give me a chance to discuss directly with you the concerns that you had. Furthermore, in writing to Dr. Saudek you effectively sought, perhaps unintentionally, to undermine my testimony before the Committee on Finance.

I would be most pleased to meet with you at any time to discuss your point of view, and I certainly would be honored to hear of your continuing, important research. I want to repeat that it was most unfortunate that you did not testify at the Finance Committee hearings on the Durenberger proposal because I know of no other analyst who has better set forth the evidence and theory behind what should be the concerns of the American family, the labor movement and the business community with Senator Durenberger's proposal and the predecessor offerings of Professor Alain Enthoven. You, more than anyone else, appear to have thought these matters through and it is for this reason I am sorry you did not testify before the Finance Committee.

Your charges against me to a member of the staff of a United States Senator are very serious. Testimony before the Congress must be truthful and accurate. Therefore, I am asking Senator Herman Talmadge, Chairman of the Finance Health Subcommittee, to include in the printed record of the March hearing a copy of your letter to me, noting courtesy copies to Mr. Scot Fleming and Professor Alain Enthoven of the Kaiser Foundation Health Plan, a copy of your letter to Dr. Saudek, and a copy of this letter to you.

I hope that you will give serious consideration to my views and that you will review your own conduct of this matter.

SAMUEL X. KAPLAN,
President.

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO,
SCHOOL OF MEDICINE, HEALTH POLICY PROGRAM,
San Francisco, Calif., March 26, 1980.

Mr. SAMUEL KAPLAN,
U.S. Administrators, Inc.,
Los Angeles, Calif.

DEAR MR. KAPLAN: It has recently come to my attention that you have been quoting some of my research on HMOs in your paper entitled "The 'Competition Model' May Be Anti-Competitive." While I am pleased you have decided to disseminate my paper on "HMOs, Competition, Cost Containment, and NHI," I am rather concerned about the way you used some of the material in your paper. There are

two issues I would like to raise—(1) quoting out of context and (2) the applicability of my research findings on self-selection and competition to the current policy debate.

Your quote on pp. 10-11 reproduces only the self-selection explanation of lower admission rates in HMOs. I purposely included four explanations. ((1) careful triage, (2) quality differences, (3) prevention, and (4) self-selection) in the same paragraph to avoid such misplaced emphasis. Furthermore, there is no evidence that active "skimming" by HMOs has occurred anywhere but in the unique situation of the MediCal Prepaid Health Plans in southern California during the early 1970's.

On page 18 you say "[t]here is strong evidence to support the theory that HMOs may be less expensive because healthier persons select them and that the costlier ill or illness-prone employees choose indemnity, third party or self-insured arrangements." While not a quote in your paper, you mention me immediately before and after it, so there may be attribution by association. Let me reiterate one point that should be clear from my work—there are relatively few aspects of HMO performance on which there is strong, unambiguous evidence and self-selection is definitely not one of them. In fact, the self-selection issue is one for which the evidence is *most scanty.* If you have any evidence on the self-selection question, I would be most interested in examining it.

On page 7 of your paper you lump together San Francisco, Rochester, New York, and Minneapolis-St. Paul as places "where the kind of competition envisioned by the 'competitive model' has been in place for many years." In fact, competition in the latter two areas has been notable in only the last few years. Thus, the "weak and contradictory" evidence on competition is to be expected. It takes quite a while for the medical care system to respond to changes in financing and organization, and several more years for researchers to perform enough studies to develop solid evidence in any direction. The first pieces of research on a fluid situation are almost always "weak and contradictory."

Finally, I must emphasize that competition between HMOs and conventional plans under the current tax system is quite different from that which might ensue under proposed changes to the laws regarding employer contributions to health insurance. Thus, the presence or absence of a measurable "competitive impact" in the current environment has only limited relevance for the policy debate.

If you have any other questions concerning my paper or other research, I would be happy to discuss them with you.

Sincerely,

HAROLD S. LUFT, Ph. D.,
Associate Professor of Health Economics.

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO,
SCHOOL OF MEDICINE, HEALTH POLICY PROGRAM,
San Francisco, Calif., March 26, 1980.

CHRIS SAUDEK, M.D.,
Senate Finance Committee,
Dirksen Senate Office Building, Washington, D.C.

DEAR DR. SAUDEK: Alain Enthoven mentioned to me that Mr. Samuel Kaplan of U.S. Administrators recently testifed before the Senate Finance Committee. I have not seen his testimony, but I have seen a paper he presented to the California State Chamber of Commerce Health Care Costs Committee. In that paper he uses some of my findings out of context.

I have recently written him pointing out some of the misinterpretations in his paper. Since he testified before receiving my comments, some of the same problems may have been present in his testimony to the Finance Committee. To help put the question in perspective, I am enclosing a copy of my letter to Mr. Kaplan.

Sincerely,

HAROLD S. LUFT, Ph. D.,
Associate Professor of Health Economics.

Senator BOREN. Our next witness is Mr. Michael Bromberg, executive director, Federation of American Hospitals, accompanied by Dwight Hood, president.

Mr. Bromberg, we are happy to have you.

STATEMENT BY MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, AND DWIGHT E. HOOD, PRESIDENT, FEDERATION OF AMERICAN HOSPITALS

Mr. BROMBERG. Mr. Chairman and members of the subcommittee, my name is Michael D. Bromberg, executive director of the Federation of American Hospitals. With me is Dwight E. Hood, president of the federation and vice president of Lifemark Corp. of Houston, Tex.

The Federation of American Hospitals is the national association of investor-owned hospitals representing approximately 1,000 hospitals with over 111,000 beds. Our member hospital management companies also manage under contract more than 350 hospitals owned by others.

Investor-owned hospitals in the United States represent approximately 25 percent of all nongovernmental hospitals. In many communities, investor-owned facilities represent the only hospitals serving the population.

In light of the current state of the Nation's economy, and our past experience with the inflationary impact of new Federal programs, any health insurance measure should be phased into being over a number of years to cushion the economy from sudden increases in demand for services.

The initial phase should target protection for low-income families and catastrophic coverage for all Americans. Any new insurance plan should minimize public sector financing and Government administration and should maximize private sector financing and administration through the use of private insurance and alternative delivery systems.

The following principles should, in our opinion, be adopted to achieve these objectives.

One, competition among health plans and providers must be stimulated by applying market-oriented economics to health care delivery. This kind of competition can bring about greater efficiency in the utilization of health services, encourage diversity and innovation in providing services, and give consumers the maximum freedom of choice among delivery systems.

Two, federally financed programs should reward efficient providers and plans.

Three, patients must have some financial stake in the system, through some cost sharing of premiums and copayment of incurred costs, in order to bring some market-oriented restraint to decisions on utilization and choice of plans.

Four, the amount of Government subsidies or employer contributions to various health plans should be the same fixed dollar amount. Higher premium costs should be borne by the party selecting the plan. This would encourage consumers to select efficient plans or elect to purchase higher cost plans at higher out-of-pocket cost.

Most of these principles have been utilized by the Federal employees health benefits program which has been in effect since 1960 and now provides coverage to over 10 million Federal employees. These principles could be incorporated into a national health insurance bill in the following manner.

One, mandate or encourage through tax incentives the offering of multiple health insurance plans to all employed persons by employers.

Two, require the medicare and medicaid programs to offer similar private health plan options—HMO's, private insurance, and other delivery systems—to Federal program beneficiaries at a fixed equal dollar contribution rate.

Three, extend Federal funds to purchase private insurance in lieu of receiving care under federally administered programs. For the near poor, the Federal contribution or subsidy should be geared to family income.

Four, revise medicare and medicaid institutional reimbursement for services to beneficiaries who do not opt into a private plan. Cost reimbursement should be replaced by target rates calculated by comparing similar facilities in order to reward efficiency and penalize inefficiency.

Unless these basic changes in approach are incorporated in any health insurance bill, we will aggravate existing disincentives for cost effectiveness and expand the underlying causes of inflation and increasing demand.

Those underlying causes are cost reimbursement which discourages efficiency, third party payment with little patient financial participation which discourages restraint, and lack of competition among health plans and providers which discourages both efficiency and restraint.

S. 1968, the Health Incentives Reform Act, sponsored by Senator Durenberger and cosponsored by Senators Boren and Heinz, contains many of the basic reforms which we have discussed. We would urge the subcommittee to expand the multiple choice and equal contribution features of the bill to include the medicare-medicaid programs.

Other proposals pending in Congress would allow beneficiaries the option of enrolling in HMO's but not other private insurance plans. That amounts to limited and unfair competition and we urge that any such provision be broadened to any private plan which provides benefits equal to those recognized by the medicare and medicaid programs.

S. 1968 addresses one of the critical factors influencing increasing utilization of health care services and the resultant increase in expenditures, our Federal tax policy concerning health insurance and expenses.

We support a change in the tax code encouraging employers to offer and employees to select low cost insurance plans. According to a recent Congressional Budget Office report, the Federal Government subsidizes health care through various tax provisions in the amount of $14.5 billion a year. These tax subsidies fuel the demand for insurance, utilization, and unrestrained spending in the health field.

Current tax laws allow the exclusion from employees' taxable income of contributions made by employers for employees' health benefits. Consequently, employees have a great financial incentive to bargain for broad, employer-financed health benefit packages.

Such coverage stimulates more frequent utilization of health care services and drives up health care expenditures. It removes

any cost consciousness on the part of consumers and provider. Employees are not encouraged to seek benefit packages more specifically tailored to meet their health care needs, especially in light of the prevalence of group health coverage.

Changing tax provisions to eliminate open-ended employer contributions as proposed in S. 1968 and encouraging the offering of several health plans would do much to increase consumer awareness. Today the system of medical insurance insulates consumers through use of first dollar coverage and low deductibles from the direct cost of health care.

Those whose health care is financed with Federal funds also have been desensitized to the cost. This type of legislation addresses the problem of lack of consumer participation in health care financing.

Employer plans, in order to qualify for tax deductions or exclusions, should ultimately provide the medicare package of benefits such as in S. 1968, but should include sufficient copayments and deductibles to increase consumer awareness of medical care costs and their participation in utilization decisions.

Those participating in public health programs, medicare and medicaid, should also have the choice of alternative private health care plans. Through use of Government voucher or other participatory system, these beneficiaries and recipients should be given the option of selecting their health care coverage from among qualified health insurance plans and delivery systems.

The offering of alternative plans required in S. 1968, with the standardized benefits package, will simplify for consumers the process of comparison shopping among various health insurance plans. The bill promotes consumer choice and awareness and rewards judicious consumer action.

The multiple choice proposals increase competition in the third party payment system. Health insurance companies will know the exact dollar amount that qualifies for the employer exclusion. They will be competing for the same dollars on the basis of price.

Providers of health care will also play a role in reducing health care expenditures. They will be able to negotiate with health insurers for financial incentives for the delivery of cost-effective quality health care.

Teaching institutions must be assured that education costs will be recognized in such negotiations. Increased consumer sensitivity in participation in health care decisions will decrease the overutilization of and demand for excess services.

Imposing a limit on the amount employers may contribute to a health plan without any part of the contribution treated as taxable income to the employee would force consumers to at least consider exercising restraint in selecting benefit packages as well as health plans.

The Congressional Budget Office, in testimony presented to the House Ways and Means Subcommittee on Health, viewed the limiting of tax-free employer contributions to and the offering of alternative health plans as "ways to reduce the use of insurance and contain medical expenditures."

S. 1968, by requiring multiple choice and equal contributions regardless of plan selection, would increase consumer involvement

in decisions about the health delivery system at the time of health plan selection rather than when entering the health care system. This in turn would stimulate the development of alternative plans.

We support S. 1968 with the following recommended amendments. One, the amount of excluded income for employer contributions to a health plan on behalf of employees should be limited to an actual national experience adjusted for regional differences.

Two, the rebate from selection of a lower cost health plan should be split equally between employer and employee and between the Government and beneficiary. This will provide an incentive for employers and the Government to encourage the offering of plans priced below the expenditure limit helping to stimulate development of alternative health care delivery systems.

Three, allow self-insurance by employers unless more than 10 percent of employees choose alternative plans offered. Such plans should be viewed as alternatives and part of any competition approach.

Four, permit multiple plans to be offered by the same carrier in order to ease the administrative burden on employers.

Five, grandfather existing contracts. Employers should not have to come into compliance until expiration of existing contracts.

Six, plans offered by employers should provide 60 to 120 days continuation of coverage after termination of employment.

Mr. Chairman, we believe that the principles we have outlined here today are not only desirable but would save the Government millions of dollars, if not billions, in administrative costs. A recent study by William Hsiao, Harvard professor of economics, indicates that the Federal employee program, which relies on private administration, has a unit cost of administration which is 26 percent lower than medicare.

Savings from a market-oriented approach such as the one proposed by the Health Incentives Reform Act could be used to extend coverage to the near poor and others who are not protected. Those savings could also be used to cover mental health and long-term care needs which are presently inadequately covered by most Federal programs and private insurance plans.

Mr. Chairman, for the past few years there has been a climate of confrontation between health care providers and the administration. The confrontation has overshadowed areas of agreement between the industry and Government on the underlying causes of increasing health costs. We urge Congress to look at those causes or disincentives and to act on legislation designed to correct these disincentives.

We have lost more than 3 years by engaging in political rhetoric over the administration's proposals to ration care. During those several years, we could have been reforming the medicare-medicaid payment system. That needs to be done immediately.

Now we also have an opportunity to increase competition and restrain spending by fashioning legislation similar to S. 1968. We urge the subcommittee to act favorably on that legislation with the suggested revisions incorporated in our testimony today.

Mr. HOOD. Mr. Chairman, we believe that there is a consensus emerging among the majority of interested parties that a competition, consumer-choice approach to health delivery is a more effec-

tive and sounder choice than the regulatory, Government-choice approach. While some witnesses will undoubtedly raise objections to certain features or provisions of S. 1968, few will oppose the general intent and thrust of the proposal.

While S. 1968 and similar proposals may be viewed as an outgrowth of the current pressure to curb health expenditures, they do not rely on substantial new Federal regulations. Nor do they focus on providers as the sole cause for rapidly increasing health care costs. Most importantly, they rely on the private sector to achieve significant change.

Congress should, under any national health insurance plan, preserve a strong role for the private sector, thus injecting much-needed competition into the health care delivery system. Similar programs offering choice in Minneapolis and on a more comprehensive basis in the Federal employees health benefits plan have shown that competition can prove effective in curbing health care costs while meeting health care needs.

For these reasons, we believe that S. 1968 with modifications provides the basis for a politically acceptable as well as effective strategy to achieve cost containment through appropriate provider and consumer restraint in utilizing the health delivery system.

The increased demand for health services has been in large part a result of the erroneous belief that health care is not only a right but that somehow it is free. Third party payment, and particularly federally financed programs, have fueled increased health care expenditures by insulating beneficiaries from the real costs of health care. The tax laws have also shielded most employed consumers from those same real costs.

The competition strategy of S. 1968 addresses those elements which hide the costs of health care from providers, consumers, insurers, business, labor, and others who participate in decisions affecting the quantity or volume of health services demanded in the United States.

S. 1968 addresses those basic elements by encouraging restraint while protecting freedom of choice. The regulatory strategy relies on Government to impose restraint by controlling the system and rationing services.

While the status quo would obviously benefit, or at least be less risky for, providers, we believe a choice between the market and regulatory policies should be made now. We have chosen the market policy because we believe it is a more equitable policy for all involved in health care, less apt to endanger quality of care, and more efficient than a Government regulated system.

The competition strategy of the Health Incentives Reform Act is also consistent with the voluntary effort to contain costs and consistent with the antiregulatory viewpoint of the general public and the Congress.

The legitimate concerns about specific provisions of S. 1968 are correctable through the amendment process, but the legitimate concerns about regulations as the answer to increased health costs are not correctable within a regulatory framework.

We urge the committee to act favorably on S. 1968 with the modifications we have recommended.

We thank the chairman and the subcommittee for this opportunity to present our views on the Health Incentives Reform Act.

Senator DURENBERGER. Thank you very much.

I wonder if either of you would describe for me the impact on hospitals in this country of competition and do it as briefly as you can. You have a wide variety of institutions under the definition of hospital.

You have some very large hospitals, the ones equipped to deliver acute care, the neonatal intensive care units, the open heart surgery, all your tertiary care facilities.

Then you have an even greater variety of much smaller hospitals. I am concerned with whether or not in a competitive setting certain types of hospitals, particularly the larger ones, might suffer. Second, to the extent that there has been a concern expressed here this afternoon by at least one witness about the impact of the HMO's on the health care system, I would appreciate your observations as to the impact of health maintenance organizations on hospitals.

Mr. BROMBERG. Let me try to tackle the first one. Obviously I cannot speak for all the hospitals. Particularly I cannot speak for the larger ones. Future witnesses may be able to.

But my opinion on the matter—we did put in a statement here that we are concerned about the research and education costs of large institutions and that would have to be protected, but my own personal opinion, the impact on hospitals gets back to the question of marketability of the option.

If there are several options being marketed by insurance companies it seems to me that any option that either treated a teaching facility unfairly or left it out of the coverage would not sell very well. Most of us would not want to buy an insurance policy that says you can go to any small hospital but you cannot go to the teaching hospital in Minnesota, or you cannot go to the Mayo Clinic.

I think it would be in the best interests of both sides to have a good faith negotiation, which is what the market is, on the one hand.

On the other hand, I think it would give the insurance companies a stimulus or solid incentive to negotiate rates with hospitals of all kinds, not just big teaching hospitals, but also small investor-owned hospitals and get away from the present system of cost reimbursement which is inflationary and has no incentives.

That step in and of itself would be worth the passage of this bill. As a matter of fact, we gave some thought to recommending that in order to qualify for Federal tax deductions, insurance plans should not have cost reimbursement.

People agree it is a bad way to go but people do not agree on how it should be done. I do not think we are experts, the Congress or the Government or anyone else is expert enough to know what kind of prospective rate is perfect for hospital X. To force the market to do it is what this bill would do, and we think that would be healthy.

I would hope that in teaching hospitals and small hospitals, the impact would be equal across the board. It would not be inequitable on anyone.

In terms of the impact in general on hospitals both from this and HMO's, I would say it is obviously going to vary from area to area but we just went through a situation in Washington, D.C., where the biggest HMO 1 year ago in effect went out bidding for the hospital subcontract work and there was real competition for the first time among hospitals to get that business

The teaching hospitals got some of it here. Not as much as they had before. They got the ones for the esoteric test diagnosis and the smaller hospitals got more work for the routine cases. I think that is healthy, to some extent, as long as all the hospitals are covered.

We are not here to testify in favor of your previous bill. I want to make that clear.

We are not here to say that HMO's should be forced on anyone, but we think the mere presence of an HMO as an additional option forces the other providers to stay on their toes. It becomes a yardstick, just as I think to have three or four hospitals in a town, provided it is not overbedded, is probably better than to have one hospital in town because somebody is there to keep you honest, somebody is going to compare your rates.

What we have to do is get to a situation where we have rates instead of cost reimbursement, which is tough to compare. I do not see the HMO as a threat except in the sense that it has been carried too far in terms of favoratism. One of the prior witnesses mentioned exemptions from health planning. I think that is unfair competition.

I think it can get carried too far, but just the concept is fine with us.

Senator DURENBERGER. Thank you.

Senator BOREN. Mr. Bromberg, since you represent the proprietary hospitals you presumably have to be interested in profit and loss issues. I wonder what additional suggestions you may have how your hospitals could be more competitive than they now are?

Mr. BROMBERG. The No. 1 recommendation we have been making for years, and we endorsed the Talmadge-Dole bill for 6 years, would be to first start with the medicare-medicaid program. I think that the real cause of the problem is cost reimbursement which takes away incentives and I think the Talmadge-Dole bill is a very good step in the right direction to get away from that toward a target rate and we would like to see that part of the bill, at least, enacted soon. That is 40 percent of the business, and if you can correct that, you have gone a long way. If hospitals have an incentive to reduce costs for medicare, they will automatically be reducing costs for everyone.

You cannot reduce one-third of your costs without reducing the other two-thirds. That would be step one.

Another step would be to put into place a system that encourages insurance companies to also get away from cost reimbursement. Many of them use it. I think this competition bill would do that, because to market a plan, it would benefit the marketer of the plan to be able to negotiate a fixed rate.

I think all of these things are preferable to the Government doing it. If we get a system that stimulates the private sector, do it.

Mr. HOOD. One other thing I would add to that. By adding incentives now—I am speaking primarily from the patient's point

of view—to get out of the hospital faster, it is common knowledge that the faster turnaround generally will produce a better return.

Senator BOREN. You think a deductible or competing policies will help that?

Mr. HOOD. I think there will be some pressure which will add to the encouragement of moving the length of stay to a shorter length of stay, which would save money and moving—perhaps those cases to outpatient where it can be done on the outpatient basis, which obviously would be less expensive.

Mr. BROMBERG. If I can go back to the question for a second, the implication—and I think it is correct—that we are interested in the ability or opportunity of a hospital to make a profit, regardless of its ownership, it should be able to make a profit so it can keep going.

You get to a point of whether you want to choose the protection of a system that lets all hospitals make a little profit, or a risk-based market system that allows some hospitals to make a good profit and others to go bankrupt because they fail, which is what we do not have now.

I think we are saying we would like to take a step toward the latter. Cost reimbursement is safe. If this bill did not pass, it would probably be better in the short run for our members. Clearly we would be better off with no legislation.

But in the long range, I think we would be a lot better off if there was a way, not for the Government to close hospitals through indirect reimbursement freezes, but a good way for hospitals, some of them, to go under, the way other businesses go under because they have not made it and have not been able to compete in the same climate and other hospitals not to have a limit on how much profit it could make, as long as they were competing effectively.

Senator BOREN. You are saying there is room for competition even in this field, which has the same effect, at least in some degree, that it has in other fields, in terms of greater efficiency based upon the need to become more efficient to continue to do business.

Mr. BROMBERG. Exactly.

Senator BOREN. Thank you very much.

We will proceed with the next witness, Mr. Alexander McMahon, president, American Hospital Association, accompanied by Michael Hash, acting director, Washington office.

STATEMENT OF J. ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY MICHAEL M. HASH, ACTING DIRECTOR, WASHINGTON OFFICE

Mr. McMAHON. Thank you, Mr. Chairman.

I am Alex McMahon. As you noted, I am accompanied by Mike Hash, the acting director of our Washington office. We represent over 6,000 hospitals and health care institutions and over 30,000 personal members.

I would like my statement to be put in the record. I am just going to make a couple of comments, Mr. Chairman. You and the other members have been very patient this afternoon, and there is no need for me to repeat any of the other arguments in favor of the bill or any descriptions of it.

We understand the cost concerns that the Senate has, that the House has, that the administration has. We have those cost concerns, too, because we don't feel any more comfortable under the spotlight than anybody else. They led us to create the voluntary effort to control health care costs in a coalition of doctors and suppliers and carriers.

As I am sure you and the other members know, the VE is succeeding. We have been reporting to you about it.

But, Mr. Chairman, controls, whether they are mandatory or voluntary, aren't really going to work over the long run if the incentives don't encourage cost containment activity. And the present incentives, as some of these other witnesses have been telling you today, are still expansionist.

Government programs and private programs continue to encourage greater use; and hospitals and doctors are hard pressed not to respond to provide more services to more people.

As we noted in our testimony, the Health Incentives Reform Act is a plan to reduce health care costs by promoting competition among health insurers and providers, encouraging structural change in the delivery system, and enhancing the cost awareness of the consumer.

As we see it, Mr. Chairman, it begins to modify the incentives in the right direction.

On page 4 and 5 of our testimony we describe the plan. I am not going to repeat any of that description, but I do want to emphasize that we have noted the two different kinds of cost containing involvement that the bill tries to bring about.

In some cases through a low option plan, it would bring about cost sharing. This would, at the time of illness, make an individual or the family more concerned about and thus more ready to discourse about the procedures that are to be undertaken.

The other incentive is through the choice of plans on an annual or periodic basis. This may over time, we are convinced, as it has in the Federal employees program, bring about a greater cost awareness.

Another concern we have is about the insensitivity of a single figure cap, to regional economic variations. We know that to modify that in some way, to switch from $125 flat to some kind of regional variation, adds a complexity. But we are studying that to see if we can't offer to the subcommittee and to others studying it a way to make some adjustments so that the $125 will have the same impact in New York as it does in Minnesota and in Oklahoma, Mr. Chairman.

And finally, another issue that we have noted is the complexity that arises because of dual coverage of two working people in the same family, husband and wife. We deal with that now better than we used to, with coordination of benefits.

But we are not certain about what the implications would be in this kind of situation. That is a matter that we will to study and are ready to provide the fruits of those studies.

In conclusion, Mr. Chairman, any mechanism that has the potential of maintaining the quality of this Nation's health care at a cost we can afford, while at the same time reducing or eliminating

inappropriate governmental regulation, warrants the best and most thorough study.

We are pleased that this committee is doing it. We think Senator Durenberger has made a real contribution to the debate about where we take our next steps, and we stand ready to be of assistance to this committee in any way we can, Mr. Chairman.

Senator TALMADGE. Thank you very much, Mr. McMahon. I appreciate your good statement and I think you have raised some excellent points.

Following up earlier discussion or exchange that I had a minute ago with one of the witnesses, from your experience would you say that consumers do or do not evaluate the quality of care that they get at hospitals, clinics, and from phys cians?

Mr. MCMAHON. I think they evaluate a lot of things, Mr. Chairman. On occasion they certainly are concerned about price, particularly if there is a cost sharing or some limitation on it. And they evaluate quality, and not quality always in the measurable sense because we don't know how to measure quality precisely. I wish we had a better output measure than we do.

So the kinds of things that patients—I like that word better than consumers, frankly—measure are the kind of care they got at the bedside, the kind of treatment they got from the physician by way of explaining what was going on, what the risks were, and his treatment. Finally, of course, they evaluate whether they are better and back at work, or whether the family member is, at the conclusion at treatment.

So yes, they are concerned and they can be motivated, Mr. Chairman. Otherwise we wouldn't have taken the position we have on this bill.

Senator BOREN. Senator Durenberger?

Senator DURENBERGER. Thank you.

I would not want to let the occasion pass without expressing my gratitude to the association, not only for the testimony here and the analysis of the bill, but I think particularly for the voluntary effort process over the last few years.

I think in effect, without being crass, that it bought us all time. We have some ideas, Senator Boren and I have, before the committee. We do not want to fall into the trap of more regulation and artificial cost containment, either in the form of the cost containment proposals that have been before us or those that are contained in other kinds of national health insurance legislation.

I wonder if I could ask you, Mr. McMahon, a question similar to that I addressed to Mr. Bromberg, about the future of hospitals and how the various kinds of hospitals in this country would behave in a competitive environment. We now have some examples. The Twin Cities is obviously the one I know best, and there are others. There are examples of competition at work, the presence of either federally or State-qualified HMO's, using the HMO in the generic sense of a limited provider, prepaid form of practice.

I wonder if you would comment briefly on where you see the hospital industry going in this competitive environment.

Mr. MCMAHON. Senator Durenberger, I wish I could. But I have got to be honest with you. I can't. There is a lot of competition there today. What we have been doing is making sure that this

competitive concept and the implications in it are broadly discussed across the hospital field.

Obviously, anything that cuts back on cost is going to be painful. I guess the further away I get from age 50, the more I understand resistance to change. I try not to succumb to it. But you have heard some resistance to change this afternoon.

Some of the answers that I have given grow out of some discussions hospital people have to understand competition. They do understand that people are measuring quality. And they are ready to take some risks. Perhaps I tilted the cards a little bit by saying something was going to happen one way or another.

The economists, it seems to me, from other areas have taught us for a long period of time that there is no way you can impose control solely on the supply side of the equation, encourage demand, and expect to have any kind of reasonable, civilized, balanced result.

I think the great contribution that is being made by these discussions is an understanding that incentives focusing on cost containment rather than penalities and regulations are a much sounder way to encourage a look at costs and what we are doing and measure quality along with it.

So I can't tell you what will happen, but I can tell you that most of the hospitals that we have talked to prefer to see incentives on both sides of the equation than solely on the supply side.

Senator DURENBERGER. Do you have any concern, then, about the system that will change gradually, I suppose, from a cost reimbursement system to a rate negotiation system?

Mr. MCMAHON. I am worried a little bit about that rate negotiation. Rate concentration, yes, this would do. I think that under this approach, there are going to be different discussions going on between doctors and hospitals and patients and employers and probably insurers, and a greater focus on it, a focus that we trust will replace regulation, a focus that in lieu of regulation can bring about a cost consciouness because all of a sudden we have brought the consumer, or the patient, into the equation.

Senator DURENBERGER. Thank you very much.

Senator BOREN. Thank you very much.

[The prepared statement of Mr. McMahon and answers by AHA to questions submitted by Senator Talmadge follow. Oral testimony continues on p. 148.]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH
OF THE
SENATE COMMITTEE ON FINANCE
ON S.1968, THE HEALTH INCENTIVES REFORM ACT

March 18, 1980

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me is Michael M. Nash, Acting Director of the Association's Washington Office. Our Association represents more than 6,100 member hospitals and health care institutions, as well as over 30,000 personal members.

We appreciate this opportunity to present our views on S.1968, the Health Incentives Reform Act, and commend this Subcommittee for its continued attention to the issues of health insurance and health care costs.

INTRODUCTION

The Health Incentives Reform Act, introduced by Senator Durenberger and cosponsored by Senators Boren and Heinz, is a plan to reduce health care costs by promoting competition among health insurers, encouraging structural changes in the health delivery system, and enhancing the cost awareness of the consumer. We welcome the Subcommittee's interest in this new and innovative approach to reducing health care expenditures. We hope that efforts aimed at controlling costs can be accomplished in a manner that is consistent with the goal of improving access to comprehensive health services for all our citizens. In fact, S.1968 would improve health care coverage among the working population by mandating that employers who offer health insurance to their employees provide a minimum benefit package, including catastrophic protection.

AHA POSITION ON HEALTH INSURANCE ISSUES

Before proceeding with a discussion of the bill, I would like to place our views in perspective by outlining our Association's position on health insurance

coverage. It has long been our policy that all Americans should have access to comprehensive health benefit coverage, consistent with economic constraints in our nation. In our view, such a program should be built upon the existing pluralistic system of financing and delivering health services and should be extended on an incremental basis related to available resources and system capacity. The method of financing the system should include the use of such sources as private premium payments, employer-mandated payments, general tax revenues, and payroll taxes, thus allowing for maximum flexibility, innovation, and recognition of differences in local conditions. We believe that a plan structured along these principles would best serve both the health care needs of our nation and the realities of our economy.

On the other hand, we believe a federally-centralized program would be detrimental to the quality and accessibility of health care and would result in a costly, top-heavy bureaucratic system. The federal government's role should be primarily one of coordination and standard-setting, in addition to its continuing obligation to the aged, poor, and medically indigent. In view of existing fiscal limitations, the development of such a program should be phased, so that the government does not raise expectations unrealistically and promise benefits that are not affordable.

We realize, however, that immediate attention must be given to developing both short- and long-term solutions to the problem of rising health care expenditures. As you are aware, Mr. Chairman, the AHA has undertaken, in conjunction with other provider, consumer, and business groups, the Voluntary Effort (VE), a program designed to restrain the rate of increases in health care costs.

The VE has made significant progress toward this goal, and we are proud of its accomplishments. These accomplishments have proven that it is not necessary to impose a mandatory cost containment program on the nation's hospitals. As we have repeatedly stated, such an approach would do nothing about the underlying causes of rising hospital costs. We are pleased that the House of Representatives and the Finance Committee have rejected this approach in favor of continued voluntary commitments. However, we also believe that a long-run solution to current health care cost concerns will require broader action than

can be provided by the VE. We believe that we must reinforce the VE by examining the incentives underlying medical care cost behavior, and it is for this reason that we welcome your interest in this legislation.

THE REGULATION OF HEALTH CARE COSTS

Many regulatory initiatives have been undertaken in recent years in attempts to control health care costs, yet solutions have been incomplete and often counterproductive. This fact can be attributed to the highly complex nature of the medical care sector and the numerous and often conflicting incentives that affect both the supply of and the demand for medical services. Further, governmental regulatory policy itself has often been uncoordinated, inconsistent, and contradictory.

This Subcommittee is familiar with the recent history of federal involvement in the regulation of our health care system. It is a history of payment and capacity restraints on hospitals, while each year private and government programs have broadened the access of individuals to health services. In addition, extension of health insurance coverage to the employed population has provided "first dollar" benefits for a greater number of people. As access has improved, expenditures for services have risen, creating pressures for even greater regulatory activity.

A proliferation of regulations, sometimes highly specialized and frequently not coordinated with other relevant regulations, has also driven up the cost of delivering health care. The costs of compliance that must be borne by the private sector are staggering. Some of these costs are easily identified, such as increases in paperwork, time, and effort. More important, yet difficult to isolate and quantify, are other costs to society in the form of reductions in innovative incentives and shifts to less efficient, but more expensive, modes of activity.

S.1968 is reflective of the growing consensus in this country that, just as we cannot continue to create an unlimited supply of health professionals and facilities, neither can we afford to increase indefinitely the demand for health care services. We are pleased that the concept of using marketplace incentives to modify current patterns of demand for health care has been brought into the

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legislative forum, because, in our view, if this approach is to be successful, changes will have to be made in present regulatory policies to make them consistent with marketplace incentives. By attempting to restructure incentives on the demand side of the equation, the Health Incentives Reform Act focuses attention on an important factor in health care cost increases.

INTENDED EFFECTS OF THE HEALTH INCENTIVES REFORM ACT

The Health Incentives Reform Act is a proposal designed to strengthen the marketplace forces in the health insurance industry and the health delivery system. The measure seeks to modify--through changes in the tax law--the incentives which affect demand. The AHA believes that such changes could contribute to curtailing excessive demand for health services.

The bill would add a new section 86 to the Internal Revenue Code. This section would regulate the tax status of employer contributions to health benefit plans. Under current law (section 106 of the Code), employer contributions to health insurance plans on behalf of employees are excludable from employees' gross income.

Section 86 would require, first, that such contributions be included in employees' gross income to the extent they exceed a specified limitation (e.g., $125 per month for family coverage, indexed according to the medical care component of the Consumer Price Index). This section also would require that employer contributions be included in gross income if the insurance coverage provided by the employer did not comply with certain specific requirements:

- Multiple choice of plan options: employers with 100 or more employees would be required to offer three options for health insurance coverage from three separate carriers. Each of these options would have to provide continuity of coverage, coverage for the family of the employee, and certain minimum benefits, including catastrophic expense protection.

- Equal contribution requirements: The amount of the employer contribution would not depend on the option selected by the employee. If the contribution level selected by the employer exceeded the cost of the option chosen by the employee, the difference would be paid to the employee either in cash or in other benefits. (Under a new section 3508 added by the bill, this cash rebate would be taxable.)

The requirements of a choice of insurance options and equal employer contributions, combined with the limitation on such contributions and the change in the employee's financial responsibility, is designed to increase consumer cost awareness at the time of obtaining health insurance or enrolling in a prepayment plan. The employee would have the choice of selecting "low option" or "high option" coverage, but would bear from taxable income some of the cost if a more expensive "high option" plan were chosen. It is expected that, as a result, many consumers would consider their insurance needs more carefully and select "lower option" qualified plans at a lower premium. Such decisions, we assume, would be based on adequate information about the plans.

The changes in the tax structure would also have two indirect effects which could influence consumer choices:

- Increased cost sharing: To the extent that the above incentives would lead consumers to choose less expensive "low option" plans, the consumers could be required to pay larger deductibles and copayments when services are provided.

- Competition based on price: It is expected that, as consumers and employers became more sensitive to the costs both of insurance and services, health care providers would be encouraged to compete with each other in the provision of services to defined groups on the basis of price. Providers and insurers would be prompted to develop alternative health care delivery modes or establish and negotiate other cost-saving arrangements.

AHA COMMENTS ON AND CONCERNS ABOUT THE MEASURE

The AHA believes that the competitive approach embodied in the Health Incentives Reform Act could well serve to increase the cost consciousness of both consumers and providers, and promote desirable structural changes in health care delivery. The bill addresses cost concerns in a manner that is consistent with our policies on the provision of health services. Since this approach builds on the employment relationship by mandating minimum insurance benefits, it provides a potential framework for the improvement of health insurance coverage. It also has the significant advantage of working within existing private insurance mechanisms. Further, this legislation, through direct competition, could encourage innovation in the financing and delivery of health services and promote the development of varied types of organizational and sponsorship arrangements for providers--consistent with the AHA's basic goals for health services delivery.

In addition, as we have noted, the bill's approach is consistent with the need to address directly the causal factors which underlie the cost behavior of both providers and consumers. If we are to achieve a long-term solution to the problem of controlling the cost of medical care, it is essential that we strive to correct inappropriate incentives and strike a balance between demand and supply.

We note, however, that there are some specific unresolved issues relating to the consumer choice approach which are of particular interest to hospitals. We believe these issues should be addressed early and carefully in deliberations on this legislation. Specifically:

- We are concerned about the effect of price competition on institutions with major commitments to medical education and research, which usually are financed substantially through patient care revenues. Such institutions necessarily incur higher costs in the provision of services related to these essential activities. Therefore, unless and until other sources of support are available, special provision must be made for these institutions in a competitive environment.

- Similarly, many hospitals which are providing services to large numbers of indigent patients must finance this care through additional charges to paying patients. Because of this cross-subsidization for such undercompensated care, special answers to the survival of these institutions in a competitive environment must be found.

- We also are concerned about the insensitivity to regional economic variations of setting a nationally-fixed level for employer contributions toward health insurance premiums. Such a level would result in residents of high-cost service areas finding that each premium dollar buys less health care, potentially increasing the financial burdens for both consumers and providers. Realizing that adjustments for regional variations are complex, we nonetheless believe that a solution to this problem must be found.

- Another issue that warrants further evaluation is the administrative complexity in the health insurance system arising from the large number of American families in which both spouses are employed and have employment-based health insurance coverage. Under existing procedures for the coordination of benefits in such circumstances, the package of benefits of one spouse is often used to fill gaps in the coverage of the other. This practice will have an adverse influence on efforts to constrain demand through consumer choice approaches.

- Finally, we have a broad concern related to the impact of competition for health care dollars on the scope, quality, and accessibility of services, and on those institutions which provide leadership in health care delivery, often involving expensive equipment and personnel. The introduction and diffusion of advancements in medical practice and technology are sometimes important factors in variations in the cost of hospital care. In view of the unparalleled progress and quality of health delivery in our nation, we urge a careful evaluation of the effect of marketplace incentives on the continued ability of hospitals to make needed improvements widely available to the American public.

Despite the existence of these specific concerns, we believe that we can and should proceed to explore the potential of marketplace forces as a rational and equitable approach to dealing with increases in health care expenditures and as an alternative to regulatory approaches. The Health Incentives Reform Act is a significant step toward a workable adaptation of the consumer choice approach and it therefore merits the serious attention of providers, consumers, and the Congress.

The AHA is currently studying the effects of alternative health insurance arrangements and the potential effects of consumer choice insurance programs on the financing and delivery of health care. We are interested in evaluating the effects on insurance coverage and utilization of medical services of increases in out-of-pocket costs. We are hopeful that our work, in cooperation and conjunction with other efforts that may be undertaken, will provide a basis for more definitive evaluation of the assumptions which underlie the Health Incentives Reform Act.

CONCLUSION

Mr. Chairman, any mechanism with the potential of maintaining the quality of this nation's health care at a cost we can afford, while at the same time reducing or eliminating inappropriate government regulation, warrants the very best and most thorough study that the private and public sectors can undertake.

Mr. Chairman, I thank you for the opportunity to present our views on this proposal. I will be pleased to respond to any questions that you and other members of this Subcommittee may have.

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April 2, 1980

Honorable Herman Talmadge, Chairman
Subcommittee on Health
Senate Finance Committee
2227 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman

At your request we are submitting responses for the hearing record on S.1968 in regard to additional questions which you asked subsequent to our oral testimony on March 18, 1980.

Question: HMOs are now proposing or building hospitals without planning agency approval, for example, construction is proposed in D.C. and in Detroit, Michigan. Do you believe this kind of preferential treatment spurs competition and reduces health care costs? Does AHA support the exemption for HMO hospitals?

It has been the position of the American Hospital Association that the facilities and services subject to review under state certificate of need statutes mandated by the National Health Planning and Resources Development Act should include all comparable facilities and services regardless of ownership, control, or location. Arbitrary exemptions make it impossible to realize the goals of comprehensive health planning regarding access, appropriate utilization, high quality and control of health care costs.

Competitors receiving special advantages can divert utilization from approved projects and equipment, pushing regulated competitors below the economic break-even point. Competition, as contemplated by proposals for improved marketplace incentives, is distorted under such circumstances. Marketplace incentives affecting resource allocation are unfairly affected by uneven and inequitable regulation. Consumer decisions, both in terms of costs and accessibility, will not, therefore, reflect true preferences as long as one group of providers is given special benefits by the regulatory process.

AHA has advocated that all construction of inpatient facilities be subject to certificate-of-need review and approval. We vigorously opposed the provisions in P.L.96-79 that exempt the inpatient facilities of health maintenance organizations from state certificate-of-need statutes. The plans for new inpatient facilities in certain cities to which you make reference should receive the same review and approval that is required for all other proposals of a similar nature.

Question: We keep hearing talk of using large copayments and deductibles to discourage people from going into hospitals or staying there. Based on the experience of your member hospitals, what proportion of patients go to the hospital and receive unnecessary care solely because it is paid for?

Control of inappropriate utilization is a priority concern for the AHA and its member hospitals, both to assure the appropriateness and quality of medical care and to contain hospital expenditures. Recently, the activities of the Voluntary Effort (a cooperative program of the private sector to restrain the rate of increase in health care costs) have focused additional attention on the need to assure that medical care is rendered in the appropriate setting and in a cost-effective manner. Inpatient utilization has been affected by two distinct factors during this period: utilization review programs and the encouragement of outpatient services.

The AHA and its members have cooperated with the Professional Standards Review program, which has made significant advances in assuring that hospital care is of high quality and rendered in an appropriate setting. In addition to recognizing that hospitals are required by law to conduct utilization review and medical audit programs with respect to patients whose care is financed from Medicare and Medicaid funds, the AHA supports the principle that hospitals should conduct these programs for all patients, regardless of the source of payment, as part of their corporate responsibility to ensure high quality health care in their communities.

While some insurance mechanisms through coverage and reimbursement policies may have created incentives to use inpatient facilities in circumstances in which other modes of treatment might also be appropriate, increasingly insurers (including the federal government) have improved their coverage of outpatient services, and hospitals have expanded outpatient programs to provide more services in this setting, where medically appropriate.

Importantly, the decision to hospitalize patients is, of course, made by the responsible physician, taking into consideration the many different factors affecting individual patients. We are not aware of any evidence or experiences that indicate that patients go to hospitals and receive unnecessary care solely because it is paid for. The PSRO and other utilization reviews described above provide assurance that decisions to hospitalize are appropriate and necessary.

Several so-called competition proposals now before the Congress are also relevant to the points raised in your question. Two distinct approaches are being emphasized. The first aims to increase the cost-awareness of individuals at the time they select health insurance coverage; the other seeks to increase the cost-awareness of individuals at the time they obtain health services through higher deductibles and copayments.

S.1968, sponsored by Sen. Durenberger, relies primarily on the former approach. It is expected that, as a result of requiring that individuals be given a choice among health plans and by limiting the amount of the employer contribution that can be excluded from taxable personal income, consumers will consider more carefully their need for coverage, perhaps selecting "lower-option" qualified plans at a lower premium.

It is true that, to the extent consumers elect these low option plans, they could be required to pay higher deductibles and copayments when services are provided. On the other hand, consumers could participate in low-option plans without increases in out-of-pocket expenditures. That is, as consumers and employers become more sensitive to the cost of insurance, health care providers would be encouraged to compete with each other, on the basis of price, in the provision of services to defined groups. Providers and insurers would be prompted to develop alternative health care delivery modes or to negotiate other cost-saving arrangements, resulting in lower insurance premiums.

Thank you again for the opportunity to participate in these hearings. We are anxious to continue our assistance to you and your staff in the further refinement of this legislation.

Sincerely

Michael M. Hash
Acting Director

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Senator BOREN. Our next witness is Mr. Walter J. McNerney, president of the Blue Cross-Blue Shield Association.

Mr. McNerney, we are happy to have you.

STATEMENT BY WALTER J. McNERNEY, PRESIDENT, BLUE CROSS-BLUE SHIELD ASSOCIATION

Mr. MCNERNEY. Thank you, Mr. Chairman.

I appear here in behalf of the Blue Cross and Blue Shield plans around the country. I would like to submit a longer statement for the record and at this point simply highpoint a few considerations.

The first point I would like to make is that we are used to being in a competitive market. We go head to head against several hundred good competitors every day across this country. I think an important point to make is that the variety and the depth of our competition is improving.

That is to say that today there is a larger number of diverse financing schemes in the market than there was 10 years ago, whether in the form of ASO's, HMO's. Those of us who are involved in more traditional methods in addition have a wider scope of benefits, new and innovative features.

So that the consumer, even though it may be dual choice instead of multichoice, can exercise through his option now a greater innovative force on the field than he could previously.

A word about competition versus regulation in a generalized sense. We have listed some observations. I would like to highpoint three. The field fell in love with regulation about 5 or 6 or 7 years ago and expected that through public utility application, that the problems of cost, quality, access, distribution and so forth could be solved.

Now I think we are beginning to recognize that the market forces need much greater accent. I would stress that the orthodoxy of either extreme isn't right. We have got to be careful as we move to the market that we undergird it with requisite regulations so that the choices are defensible.

The second general comment that I would make is that in any large-scale program, even the FEP program which has been re-

ferred to several times, there is a sore temptation by the administrator of the program to begin to move more and more into regulation and standards and administrative fiat, if you will, which tends to smother the innovative and market forces of the program.

When one contemplates going nationwide with a choice program, I am simply going to, that the Congress is going to have to be especially sensitive to the fact that there will be an even sorer temptation when hundreds of millions of people are involved than when 10 million people are involved.

The third thing we say about competition and regulation, is that in the debate it is terribly important to understand that a No. 1 agenda item is the low income groups marginal to medicaid, and medicaid itself. In the debate, one mustn't lose sight of the applicability of this scheme to the low-income group or some alternative scheme that suits that group, so that we don't come through this legislative period or the one subsequent to it without resolving what is a very tough problem.

In our testimony we go on to talk about some problems that are intrinsic in implementing choice or procompetitive legislation, not just confined to S. 1968. I won't get into those again. I think our testimony raises a fair number. As an example, in any procompetitive legislation, the question arises at what level you peg the employer's contribution.

Mr. McMahon has already mentioned that. Should it vary by section of the country? If so, how do you classify? If the amount exceeds the ability of small employers to afford the freight, what do you do about that? How does one protect against adverse selection? What provisions should be made to protect against currently negotiated health benefits?

I raise these questions only to make the point that they have got to be taken into account if the marketing of this idea is to be successful. There are vested interests that are there that have to be contended with, labor, management, providers, carriers, et cetera.

In my opinion, these forces are going to have to be compromised; the trick is how to compromise them. In that regard, I think we come back to the fact that regulation should be designed to the extent possible to make the competitive environment more effective rather than as a substitute for regulation itself.

As an example, one could contemplate laying down minimum standards for benefits and for carriers without prejudicing the choice beyond a limited point. But again, I will not get into that in detail.

A word more about the competition model. The theory behind the model is that by getting people to take money out of their pocket at the time of the transaction first and to shop among alternatives when buying care through a carrier, that they will be more interested in the transaction and will give incentive to the carrier to produce more at a more efficient price.

I want to make mention of the fact that the out-of-pocket payment can be important, but its use, to me, has to be selective. That is to say, the problem is partly demand, but the demand problem isn't all how we prepay or insure. There are also the problems of inflation, rising expectations toward health, higher incomes. Those are also part of the demand picture.

And importantly on the supply side, the excess beds, excess doctors in some parts of the country, burgeoning technology, et cetera, are also contributing. The point is that one can't solve the cost problem or the quality problem by bearing down on one side of the equation without considering the other.

This brings me to the second point. If the incentive is to shop for less expensive coverage, presuming that that will be worthwhile coverage, one has to recognize that there is an underlying assumption that by putting pressure on the carrier, the carrier will transmit that pressure to the provider.

I have to be very sympathetic to that theory, because Blue Cross-Blue Shield does turn around in a market under extreme competitive pressure and contract with doctors and hospitals and others to produce services. In that contract process, we try to negotiate prices. HMO's do the same thing.

But I think it should be pointed out that not everybody in the competitive market does that. Some simply trade the dollars. So a lower price, instead of impacting the basic productivity, efficiency, and effectiveness aspects of the delivery process, may simply ignore them, and the question is, if you exacerbate that problem with schemes such as ASO's, which you heard about, or experience rating in the extreme, you jeopardize the insurance pool and its ability to provide continuity of coverage when a person leaves a group and goes to a single coverage.

You jeopardize the ability of the carrier to subsidize to some limited extent the high risk small groups, or groups who fortuitously have bad selection.

Now to come to the question of S. 1968. We have made some specific suggestions about it. I will simply say that as we have looked at it, it has got a lot of provocative ideas in it and we think we have made some useful suggestions that would perhaps improve its current structure.

One further question I will raise here and then let it go at that. There is a dilemma. You want three separate carriers involved in fulfilling the prescription of three options.

The fact is in some sections of the country there won't be three carriers able to produce three discrete and defensible options. The question arises of what compromises you make under those circumstances.

I would hope under any conditions that you would permit any given carrier to offer more than one option. For example, under the Federal employee program, we offer three or four. We offer a high option, we offer a low option program, we offer an HMO network, and some of our plans have individual HMO options.

We are one of the precious few that have the capital, the marketing expertise and background to be able to do that. So the principle of tripartite choice is sound, but perhaps it would be well to encourage those of us who have been in the field a long time to promote a greater variety within our ranks, to provide the choice in those places where it wouldn't otherwise be available.

In sum, we think that the ideas in the act have a great deal of merit. The trick is to come to a way of implementation that judiciously balances the regulatory and the market forces and, in the process, on the one hand protects security and social justice as it

attacks, on the other hand, the problems of efficiency and effectiveness.

In any event, we applaud you for your efforts and we stand ready to be of specific assistance well beyond these generalities that I have stated if we can be of any help.

Senator BOREN. Mr. McNerney, you have expressed the concern about people going into the low cost plans when they are well, shifting to the higher cost options when they are sick or when there is likelihood to think they are going to have an illness or health problem.

Do you have any suggestions for how we might combat that problem in general?

Mr. MCNERNEY. First of all, in a very interesting way it shows that the consumers aren't dumb, doesn't it? I think that, yes, I would, for example, not allow movement from one scheme to another too rapidly, so that however you design your program, it would be impossible to skip and jump based on an illness.

In order to qualify for movement, you might have to have a certain tenure. Then, of course, there is the whole question of how you design your system. My plea would be that it be designed in such a way that you couldn't develop cells that were too small, where the adverse selection was too severe.

Precisely how you would subsidize some of the poorer risks with resources from some of the better risks is something we could talk about in greater detail. It is a very complex subject. But suffice it to say, some provision should be made.

Senator BOREN. You seem to be saying that there is a great deal of competition among the carriers themselves. Do you see the provider as the main barrier to competition in the current situation, under the current system?

Mr. MCNERNEY. A barrier?

Senator BOREN. Yes.

Mr. MCNERNEY. I don't see the provider as a major barrier to competition. Let me give you an example. Under Blue Cross-Blue Shield, if you will forgive me for a personal example, we have had an overall strategy stimulated by the competition of HMO's—which we also offer, incidentally—to pay for less care in hospitals and more outside, to get patients out of the most expensive site into more cost-effective alternatives.

In the last 10 years, through a series of interventions, the number of patient days per 1,000 subscribers across the country for which we pay has gone down 18 to 19 percent. Our target over the next few years is to move from where we are now at 720 patient days per 1,000 subscribers toward 500 days.

The HMO average, including our own HMO's, is down around 300 or 400. We have, however, a larger slice of the American population by age and occupation than our competition has. We can't aspire to get all the way down. But much has been done which could not have been done under service contracts—and we do contract directly with the hospital—unless the cooperation were there.

The hospitals aren't comfortable with rapid change any more than you or I are, but on the other hand, they are changing. They are accepting this challenge by developing more ambulatory care.

Quite importantly, the multihospital system—shared services, ingenious holding company forms—are beginning to move into the picture, demonstrating that those who are effective are searching for a response.

The sum and substance of the response they seek is alternatives to the old inpatient way of doing business.

Senator BOREN. The competition, then, that you are experiencing from other carriers and sometimes within the same company with various carrier forms does have an effect and filters down into the provider sector in terms of their increased willingness to make adjustments to it also.

Mr. MCNERNEY. Yes, sir. And I think to that extent it is good. I would come back to one point, using today's market as an example. I am concerned with the growth of ASO's and with insurance that doesn't substantively involve itself with the provision of care and leave the selection process unfettered. While these good things that I talked about are going on, it is true that poised delicately above the parameters of medicaid is a population variously estimated at from 5 million to 20 million people with either no coverage or inadequate coverage.

Clearly, even with a solid medicaid program, their problem isn't going to be addressed, leaving the market to play exactly the way it plays at the moment.

Senator BOREN. Senator Durenburger.

Senator DURENBERGER. Thank you.

I thank you, Mr. McNerney, for sharing your many years of experience with us.

I have a wide variety of questions that I would love to ask you, but let me concentrate not on the provider or the insurer, but on the employer. You have alluded to the employer's role a couple of times, and I think it is apparent that the emphasis here is on the employer.

There has been testimony earlier today about the alleged advantages of self-insurance, or self-funding, as I think it was referred to. I would assume that since Blue Cross is the largest or close to the largest writer of group coverage in the country, there are certain advantages that you have over others.

I wonder if you would speak to the nature of the advantages of self-funding, the advantages that your companies may have in a competitive environment, if you believe that there are those advantages.

Mr. MCNERNEY. I would say up front that I am prejudiced on this issue. Clearly the average self-funded program is a competitive idea. But the problem with self-funding, it seems to me, is that, number one, the self-fund would tend to be popular where the risks were good. If I were an intelligent employer and I have a high risk business, or particularly aged employees or handicapped employees, I would be a little foolish to go on my own when I could merge my experience through other devices such as Blue Cross and Blue Shield.

So there is a selectivity factor inherent here and this begins to feed off into the society-wide problems we talked about a moment ago.

No. 2, I don't think very many employers are inclined to interfere much with the delivery system when the chips are down. After all, if you have employee relations at stake, and there is a question of more or less care, or whether the hospital should close a wing, and you are on the board, the demonstrated experience is that when you have got the risk, there is apt to be reluctance to move aggressively.

You haven't enough leverage in the market even if you have a lot of desire. If you have 1,000 employees and it is a city of 1 million, what is your leverage? The leverage, in fact, through self-funding is fragmented among a series of separate and disparate parts.

So I have the feeling both from the point of view of community-wide application and in terms of leverage over the system, that it isn't a particularly good thing to do.

I would add one more thought. It tends to be more popular where labor is weak, and sometimes an employer can take advantage of an employed population through these funds to an extent that I don't like to see, in terms of quality of benefits.

What we have to offer, and let me hasten to add that we still have a lot to learn, is that we do take on groups, and to a certain extent we do pool them, depending on their size, so that they share in the experiences of others. We have never canceled anybody. So if you leave Blue Cross or Blue Shield as a group member, you can become a single member.

Our underwriting restrictions with regard to what degree family members are covered and at what age they are still considered dependents are quite liberal. I just pointed out to you that we are trying to intervene with the delivery system, I referred particularly to what has happened to the patient days for which we have paid.

We don't always do a good job. We make mistakes in how we pay bills, and our computers at times are apt to do embarrassing things, like recently they canceled me for my own protection when my wife went to the hospital. But on a very basic level, think those are the distinctions I would draw.

Senator DURENBERGER. You, I think, are the second witness today who commented on the problems that might exist in certain areas of the country relative to the availability of three carriers as prescribed in this bill. I think your suggestion was some kind of an alternative for three options from the same carrier.

I think you used the words "discrete" and "defensible"to describe the carriers. I am not sure whether you used those words deliberately or for some other reason. I would be curious to know what areas of the country, in your opinion, are devoid of three discrete or defensible options.

[The following was subsequently supplied for the record:]

Response. Recognizing that S.1968 does not impose such a requirement, I use the phrase "discrete and defensible" to mean a range of substantially differing options; for example, a choice among Blue Cross and Blue Shield service benefits, a commercial insurer's indemnity program and a health mantenance organization. We are not aware of any area of the country in which an employer would not be able to satisfy two options by purchasing a quality health care program from a Blue Cross and Blue Shield Plan and from a reputable first-line insurance company. Most of the health care programs sold by the Blue Cross and Blue Shield Plans and the commercial insurance companies are designed around the fee-for-service concept.

The Blue Cross and Blue Shield Plans in most cases pay for services in full, while the commercial insurance industry tends generally to sell a variation of that concept which introduces deductibles and coinsurance. But on the point of a third discrete option, the HMO concept and its several variations is the only one which comes to mind, and there will clearly be a problem of access to this option for many employers. To date, the development of the existing 225 HMO's has come about only in those areas where there tend to be high concentrations of people. In certain areas of the country, for example the South and Great Plains states where there are relatively few HMO's, it may be difficult to make three discrete plans available to a single employer.

Mr. McNERNEY. I would like to answer that responsibly by offering to make a statement for the record, but I will simply say that there are some rural and semirural areas, near west, south, southwest, near northwest, where clearly you would be fortunate to get much more choice than fee-for-service, like Blue Cross-Blue Shield, and often a weak indemnity scheme.

Under those circumstances, I would like to see anybody who can come up with some alternatives encouraged to do it, whether they are a third choice or a multiple of the second.

Beyond that, I would like to impress on you that the pressure on carriers these days is to be efficient and effective. We have no conflict of interest when we move in that direction. It is a matter of survival and success.

I would like you to look at the Federal employee record, where we offer four options. I am glad we have them and I think they are all being run well. The point is that the Federal employee is not disserviced by having access to four options.

Senator DURENBERGER. Can we narrow the problem of lack of defensible choices down at all if we raise the qualifying limit here to something greater than 100, or would you have some thoughts on that 100-employee limit that you would share with us?

Mr. McNERNEY. You know, I suspected I might get asked that question. Groups have interesting characteristics. I am not prepared to answer whether that is a good point of distinction or not, but I would like to address it. I will go to our marketing people and see if we can offer something not only in terms of size, including actuarial experience, but in terms of the dynamics of the employer-employee relationship and whether there is a better natural breakpoint.

If you wouldn't mind me submitting that statement, I would be glad to do it.

Senator DURENBERGER. I would appreciate it if you would on each of these questions, if you would like.

Mr. McNERNEY. All right.

[The following was subsequently supplied for the record:]

In preceding testimony, Senator Durenberger asked Mr. McNerney if we can narrow the problem of lack of defensible choices if we raise the qualifying limits to something greater than 100 employees.

Response. Without clearly and precisely identifying some specific objectives, it would be difficult to determine the optimum number of employees the employer must have before he must begin offering three choices of health insurance programs. We do believe that there are certain problems inherent in requiring an employer of any size to offer three distinct health insurance options to his employees:

Under any situation, the three options would create additional administrative expense, not only to the employer, but also to the insurance carrier. This increased administrative expense ultimately winds up as an increased cost to the health care program.

Fragmenting an employer's total employee population into a number of different programs adversely affects the ability of the insurance carrier to experience rate those groups. The choices give the employees opportunities to switch between the high and low cost program, depending upon the level of care they want or need at any given point in time. This adverse selection distorts utilization of the program and can cause a greater fluctuation of premium charges.

In addition to the questions contained in the transcript, the Committee submitted two additional questions:

Has Blue Cross suffered from adverse selection during annual open enrollment periods under the Federal Employee Plan? That is, do people shift from lower cost plans to high option Blue Cross when illness occurs? And what do you believe would occur if people in good health could receive a cash rebate if they switched to a low option plan?

Response. In recent years, we at Blue Cross and Blue Shield have begun to look more closely at the results of the Federal Employees Program Open Season. Our analysis has focused on those employees who shift coverage between the various options available through Blue Cross and Blue Shield, and there are strong indications that adverse selection is taking place.

As an example, our analysis for the 1975–76 Open Season shows that those people who enrolled for High Option individual coverage used services at a rate 45 percent higher than the overall program utilization for that category for the same period of time, while those who enrolled for High Option family coverage used services at a rate 55 percent higher than the overall program utilization for that category for the same period of time. Moreover, our analysis shows that those persons who dropped our High Option coverage had a utilization of 55 percent for individual coverage and 65 percent for family coverage lower than the overall utilization of the entire population enrolled in the same categories. We have been unable to pinpoint precisely what alternate plan was selected by those Federal Employees leaving the High Option plan, but we feel certain that they enrolled either in our Low Option or other federal options providing a low level of benefits.

For the same 1975–76 period, our study shows that those Federal Employees leaving our Low Option plan had utilization higher than the overall pool for their category. These people had utilization of 55 percent for individual and 35 percent for family greater than the remainder of the same pool. Although we are not certain as to the plan chosen by those federal employees, we suspect they chose the Blue Cross and Blue Shield High Option or other comprehensive plans.

We believe that a cash rebate would only exaggerate the adverse selection that we have observed. Furthermore, a cash rebate may cause some individuals who would normally require and choose high option coverage to select low option coverage and collect the cash rebate which, in another sense, is again adverse selection.

Contention is made that Labor and Management have no incentives to seek moderated health care premiums because employers' premiums are tax deductible without limit. Is that true in your experience? Are Labor and Management relatively indifferent to health care premiums and costs?

Response. Management is, indeed sensitive to the cost of health care premiums. A recent study of decisionmakers that we conducted found cost to be a significant factor in Management's selection of carriers. We found that there were 30 criteria considered in selecting a carrier for group health insurance. Of the eight most important criteria, four were cost related—Nos. 3, 6, 7, and 8.

1. Pays claims accurately.
2. Pays claims on timely basis.
3. Competitive retention charges.
4. Provides explanation of all claims paid or rejected.
5. Answers questions promptly.
6. Program to hold down health care costs.
7. Program to reduce duplicate benefit payments.
8. Competitive premium charges.

These were characteristics considered extremely important or very important.

These findings definitely indicate that employers and Management look at costs very carefully.

As to Labor, we can only say that Labor may be less concerned with costs and more concerned with level of benefits than Management, but is not indifferent to costs.

Senator DURENBERGER. One other issue relates to the size of the cell, as either you or someone has referred to it. The problem always comes up, particularly with small businesses, suppose you

have one carrier that gets 60 employees to sign up and another that gets 35 to sign up, and you are left with 5? Do you share that concern? Do you think that is realistic? And do you have some recommendations for us as to how this might be handled?

Mr. MCNERNEY. I am concerned. I think what you want to concern yourself with is that the carrier that gets the five can join those five with another five and another five and another five, which is a form of community rating.

The way things go in our industry, and I am speaking just for Blue Cross and Blue Shield, is that if a group is beyond a certain size, it stands on its own bottom. If it is between, let's say, 100 and 1,000, it would go in a pool with a lesser subsidy than it would if it were a smaller group, which would get the greater subsidy from the insurance pool.

Now, that varies by plan and the techniques used, but some provision has to be made to merge that group of five in the example you cited with others.

Senator DURENBERGER. With regard to FEHBP here, or all around the country, have you experienced the severe adverse selection problems?

Mr. MCNERNEY. Not severe, although we are on the verge of it as the program matures, I think. There is a tendency for those of higher age without family to act differently from those who have different characteristics. At this point it is not a severe problem, but the signs of it are beginning to show.

Apropos of that point, if you don't mind me elaborating on that, I made mention that there is a sore temptation on the contractor's part to get into the market, in this case the Federal Government. We are beginning to see signs in that program, as the number of participating carriers goes from 30-some odd to over 100—signs that there are some political aspects involved in who comes in as a carrier.

Under what conditions you can advertise or not advertise is variously interpreted. So again, I urge you to look at it with the thought that in the design of the bill you would take special steps to avoid some of these problems.

Senator DURENBERGER. Thank you very much.

Mr. MCNERNEY. Thank you.

[The prepared statement of Mr. McNerney follows. Oral testimony continues on p. 171.]

STATEMENT OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATIONS

on

S. 1968

THE HEALTH INCENTIVES REFORM ACT OF 1979

presented to

SUBCOMMITTEE ON HEALTH

of the

COMMITTEE ON FINANCE

UNITED STATES SENATE

by

WALTER J. MCNERNEY

PRESIDENT

March 18, 1980

62-511 0 - 80 - 11

Mr. Chairman and Members of the Subcommittee:

I am Walter J. McNerney, President of the Blue Cross and Blue Shield Associations. On behalf of the Associations, I appreciate this opportunity to share with you our thoughts on the subjects of cost sharing, employee option and the tax aspects of health insurance. The Blue Cross and Blue Shield Associations are the national coordinating agencies for the 69 Blue Cross and 69 Blue Shield Plans in the United States. The Plans operate as non-profit organizations, each with its own Board of Directors and each subject to state regulation pursuant, in most cases, to special enabling legislation.

Our experience in providing coverage for the private market includes eight of the ten largest industries, and many medium and small groups and individuals. We are involved in every state. In the government market we are involved to a significant extent in Medicare, Medicaid and CHAMPUS.

We have also been a major part of the Federal Employee Health Benefit Programs since its inception, and currently we have 53% of the enrollment in a marketplace of 106 options offered by approximately 100 competitors. In that context we offer high and low option traditional service benefits and Health Maintenance Organization options, including an HMO network.

Competition is not new to the Blue Cross and Blue Shield organizations. Across the country we face a variety of competitive financing mechanisms, and the number as well as the variety is increasing. In order to maintain or

acquire enrollment we must continually meet the tests of quality, price and service. None can be ignored. As a result we, like some others, have moved beyond simple risk sharing to cost containment and service strategies that blur considerably the traditional and false distinction between financing and delivery of care.

During the last twenty years, the number of people covered for health expenses has increased dramatically. Specifically, about 8 out of 10 Americans now have coverage for hospital expenses compared to 6 out of 10 two decades ago. Medical-surgical coverage grew during this period from over 3 in 10 to over 7 in 10 persons and major medical coverage has grown from 2 in 10 persons to a point where now 6 in 10 persons have that protection.

During the same period, our industry has seen increased competition in benefit designs as well, e.g., major medical innovations, medical necessity provisions, and important new benefit programs such as second surgical opinion.

Additionally, different financial arrangements such as "administrative services only" and "minimum premium programs" have emerged as alternatives to the traditional financing mechanisms.

Another alternative to traditional financing mechanisms are trusts under section 501 (c) (9) of the Internal Revenue Code. In 1978, 11 percent of the employers said they utilized a 501 (c) (9) Trust. This trust may elect to purchase health insurance from carriers or it can self-insure.

HMO's provide another competitive alternative to traditional fee-for-service benefit programs. In 1970, there were 30 HMO's in the country enrolling between 2 and 3 million persons. In 1978, there were 203 HMO's -- 100 qualified by the federal government -- with an enrollment of about 7.4 million persons. The Blue Cross and Blue Shield Plans and some of the commercial insurers have been active supporters of these HMO's and the competition they represent.

Also emerging as important factors in the health insurance market are third party administrators and "software houses" which provide system support services and have expanded to include claims processing capabilities.

Even credit card organizations have entered the field by providing reimbursement for health care services.

Although the number and variety of choices vary considerably by area, the elements of choice are expanding and groups themselves have become more active and discriminating in their search for effective benefits, thus further encouraging innovation and greater choice.

Competition v. Regulation

Based on our experience, we should like to offer a few general observations about regulation and competition before commenting more definitively about the Health Incentives Reform Act of 1979. Certainly both competition and regulation are needed in the health field. Human services should not be determined entirely by a market nor should they be deadened and dispirited by excessive regulation.

In the late 1960's and early 1970's, many health industry observors and even some participants became uncritically supportive of regulation. We have tried it and find that it has definable limits. It is therefore appropriate to examine ways to energize the market both to help contain costs and to foster innovation. Regulation, to the extent it is used, should support those market mechanisms rather than substitute for them.

Certainly in any large scale program there is an abiding temptation to regulate and to resort to administrative rules. The FEHBP has resisted the temptation better than Medicare. But, even in FEHBP, with a smaller staff and involving far less paperwork, the government is drawn toward resolving by regulation or administrative fiat, the various pressures from the public, Congress, carriers, and providers.

Any program promulgated by the Congress, applicable to the country as a whole, will be especially vulnerable in this respect. It will therefore be particularly important for the program to focus on goals and objectives and standards of performance and avoid the temptation to "run things."

When things are "run" from afar, the forces of the market are blunted and become ineffective. A critical issue is whether the Congress can face up to the realization that in complex human services administered at the neighborhood level, it is best to concentrate on clarity of goals and flexibility of means. Can national policy be seen in the context of a series of inter-related local initiatives?

For the past decade or more the debate over regulation and competition has obscured the need to solve the problems of our low income groups. When we thought we could provide comprehensive care for all, the low income groups were put in line with everyone else, in the name of "universality." Whatever one might think of this policy, we now know that resources are severely limited and comprehensive NHI as envisioned in the mid-1970's is impractible. It is time instead, on a priority basis, to face the access problem of the low income groups irrespective of the results from the debate over competition and regulation.

Improving Medicaid, strengthening Medicare and providing reasonably affordable options to the near poor must be in the center of our concerns.

Otherwise, we believe that providing options to persons as a major market force is worth serious consideration. Whether the program will be effective comes down to how it is implemented. In this regard, the following issues, among others, must be addressed by any pro-competition bill:

- If the employer contribution is pegged, at what level is it pegged? If too low, poor financing schemes are encouraged. If too high, innovative delivery systems may be discouraged. Should the limit be uniform across the country or vary? If it varies, with what factors should it vary, e.g., age, sex, geographic location? In small businesses, what is done if the limit causes economic problems?

- How are persons protected against bad choices, without excessive regulation of choice?
- How does one protect against adverse selection, i.e., the aggregation of good risks at the expense of poor risks or switching coverage when more comprehensive services are needed?
- How is the individual protected against discontinuity of coverage?
- How does one overcome the reservations of management and labor and the potential complication of the whole fringe benefit structure?
- Should the number as well as the quality of choices be controlled?
- Should the employer be free to coordinate the administration of an entire range of choices through a single agent?
- What provision should be made to protect currently negotiated health benefits?
- Does option extend to the poor and near poor and, if so, how is it achieved? What has been our experience with such means as vouchers or tax credits varied by income and risk categories?
- Will addressing tax deduction questions at the same time that options are being introduced complicate or facilitate the transition?

These and other issues are important. They are very real to organized labor, management, providers, carriers, and to the public, many of whom will want to see how it works.

In essence, the various forces at play will have to be compromised. For example:

- While trying, to save money we must address the access problem of the low income groups.
- It may be necessary to limit the employer's expense to a given percent of payroll.
- Minimum benefit standards and carrier eligibility will be needed to protect against bad choices.
- Some form of community rating will be necessary to protect against adverse selection.
- The exact options should be bargainable by group.

- o Continuity of coverage must be protected through transfer privileges between both group and individual coverage, grace periods of coverage following termination of employment, availability of high risk pools, etc.

- o A minimum number of options should be available above minimum standard. The only way this can be achieved across the country is to encourage major carriers to offer more than one option, as under the FEHBP.

- o Features such as vouchers, tax credits, and other tax changes should be incorporated, if at all, on an evolutionary basis based on initial experiences with the program.

As one examines the compromises that are necessary to balance social justice and efficiency or cost and benefit, it becomes apparent, as it has to the FEHBP on a smaller scale, that market and regulatory forces are both needed -- one is ineffective without the other.

The Competition Model

"Pro-competitive" legislative proposals such as the Health Incentives Reform Act of 1979 include two basic approaches to reform. First, they aim to encourage consumers to be more discriminating in the use of health care by requiring them to pay more of the cost of care out-of-pocket at the time care is given. Some propose to do this by changing the tax laws to encourage employers and employees to buy insurance that includes major deductibles or coinsurance. Second, they would seek to encourage consumers to shop around for less costly health care and health insurance systems -- such as some HMO's. They would do this by requiring equal employer premium contributions to several alternative health insurance plans and rebating all o. part of the savings to employees who choose the less costly form of coverage.

Deductibles and Coinsurance

I have dealt with these mechanisms in the past; in essence, they must be used selectively.

It would be unwise to assume that prepayment and insurance are the only factors in rising costs. They do increase demand, but so do rising incomes, increasing public expectations regarding the worth of health services, and higher prices for goods and services. On the supply side, we see the impact on cost of unused bed supply, excess manpower in some areas, the upward thrust of science and technology, and the difficulty human service institutions, such as hospitals, have in improving productivity through the substitution of technology for human resources.

Shopping for Less Costly Insurance

I would like to spend a few moments on the incentives in competitive choice proposals for consumers to shop for less costly health insurance and health care delivery systems. The theory is that by getting employees to shop harder for good deals in health insurance, health insurers will be forced to design less expensive insurance arrangements or offer new delivery systems such as HMO's. In fact, the ultimate purpose of "pro-competitive" proposals is to motivate doctors, hospitals and other providers to compete with each other to offer health care in less costly ways. The proposals would do this indirectly by inducing consumers to shop harder for lower cost health insurance--and theorizing that insurers will transfer this pressure on to doctors and hospitals.

Mr. Chairman, there is merit in this theory. Blue Cross and Blue Shield

Plans have a long history of negotiating "participating provider" arrangements under which participating providers accept our fee as payment in full. We also negotiate contracts with hospitals for special rates. We pass along the savings gained from the practices to our subscribers through lower premiums or additional benefits. These savings also help most Plans to offer open enrollment and to offer affordable premiums to individual enrollees and small groups.

In addition, Blue Cross and Blue Shield Plans are among the major initiators of HMO's in the nation.

The fact is that we have long believed that competition among insurers should be based on their efforts to negotiate or organize less costly health care from providers. If it seems possible to change the tax laws or enact regulations to encourage this, we would favor cautious exploration and would work to evolve such legislation.

But, it will not be easy to design such laws. History shows that competitive pressures on insurers don't always give rise to negotiations with providers for more favorable prices or arrangements to create new delivery systems. Competitive pressure on insurers can be diverted before it reaches the provider. Some insurers find other ways to compete that stop short of the provider. Some forms of competition have raised problems. For example, extreme forms of experience rating and the next step, administrative service only arrangements, can badly fragment the insurance pool at the expense

of high risk groups and continuity of coverage. It is easier to compete using these practices than it is to negotiate with providers or work with them to develop new delivery systems and we must recognize this fact in designing the incentives under the program.

Our attack must be on all of these elements. Among others, the carrier as a financing mechanism, has an important role to play, but in deciding its dimensions, we must keep in mind that there are two sides to prepayment and insurance. There is no question that insurance increases demand. But, while prepayment and insurance create demand beyond the composite of individual market decisions, they also afford protection against the unknown and unpredictable. Further, some of the demand created produces better quality of care. In this regard, the improving health status of the American population should be noted.

We must face the question of how much we put responsibility for cost increases on the individual as opposed to attacking the source of the problem through concerted effort. The public is being told to take on more responsibility with respect to exercise, nutrition, smoking and other lifestyle factors, as well as to be judicious in their use of hospitals and doctors. The public's question is "What leverage does an individual have, particularly a sick individual?" Also, where in this process are the government and entrusted private institutions who know, presumably, how to reconcile those tough cost/benefit problems?

The Blue Cross and Blue Shield Associations believe that, although the individual must accept responsibility for his or her own welfare, there are limits to what is reasonably acceptable. We feel that we and other institutions, public or private, have a major responsibility on behalf of the subscriber for cost containment. In past years, we have become increasingly active in such programs as incentive reimbursement, pre-admisssion testing, utilization review, medical necessity of services, and areawide planning. We have expanded our benefits to embrace a wide variety of services, e.g., ambulatory surgery, home care, and drugs, to take the heat off the most expensive modes of treatment.

The Health Incentives Reform Act of 1979

These lessons teach us, Mr. Chairman, that competition can be constructive or not—depending on its provisions. Increased competition will have beneficial results for health care if it is guided by thoughtful regulation. In particular, there are a number of areas of regulation that I feel need to be further developed in the Health Incentives Reform Act and similar bills.

Rating. Some mechanism should be included for requiring all subscriber groups to contribute to the costs of the total insurance pool, in order to lower premium costs for higher risk and small groups.

Enrollment. Mechanisms for assuring open enrollment by all insurers should be designed to guarantee that all individuals and groups have access to coverage. Otherwise, we could force more lower income Americans into publicly supported programs. Also, we must take steps to assure that the self-employed and other individual subscribers aren't priced out of the market.

In addition to these general concerns with this proposal, I should like to add these specific comments.

o The penalty for non-qualified contributions appears to be inequitable. If the employer fails to comply with certain provisions, the employee is penalized by having the non-qualified contribution counted as gross, taxable income. Is this fair or logical? Should not the penalty apply to the employer?

o The states' roles in determining a "reasonable premium rate" for carrier conversion policies are unclear. Does this reference a role which states now play in regulating insurance? If not, does this mean states will, in effect, start setting premiums for conversion coverage? Greater clarity is needed.

o Requiring employers of 100 or more employees to offer three coverage options will present problems. This will fragment the employee population and could produce small groups which, due to actuarial requirements, will necessitate relatively higher premiums.

o The required three options by three separate carriers will generate increased administrative work for carriers and employers. More importantly, by requiring that the three options be offered by different carriers, the bill may force carriers to specialize. A carrier would not risk its established, strong line of coverage to experiment in new lines of coverage if it is restricted to providing only one of the multiple options. Thus, the provision will probably inhibit competition and the development of new forms of coverage and reduce the availability of options in many sections of the country.

o In order to be actuarially sound, the 180 day conversion right from group to individual coverage would have to be limited to people who had

maintained continuous coverage from the group. Otherwise, people could pick up individual coverage only when they might need expensive care during that six month period. This should be made explicit.

o Some employers could offer catastrophic coverage by raising the basic coverage deductible up to $3,500. Then, because insurance premiums are not counted toward meeting the catastrophic deductible, employees would face a disincentive to securing basic coverage on their own. Is this what is intended and is it desirable?

Summary

As this Subcommittee addresses the implementation of competitive models, it would be well to involve a generous cross-section of interests through testimony and consultation and to tap the experience we have had to date. Successful implementation of the basic concepts will require the balancing of complex forces and some vested interests. Without safeguards, implementation could be counterproductive.

In net, your concerns are timely and the Blue Cross and Blue Shield organizations offer their assistance in working with you on these proposals.

I'll be happy to try to answer any questions you may have.

Senator BOREN. Our last witness today is Mr. John Graff, chairman of the Health Committee of the National Association of Life Underwriters.

Mr. Graff, we are happy to have you. If you would like to introduce the others that are with you.

Mr. GRAFF. Thank you, Mr. Chairman. I am accompanied this afternoon by Mr. William M. Bartlett, the director of health insurance activities for NALU, and Mr. William R. Anderson, NALU counsel.

Senator BOREN. Glad to have all of you.

STATEMENT BY JOHN F. GRAFF, CLU, CHAIRMAN, HEALTH COMMITTEE OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

Mr. GRAFF. Mr. Chairman, members of the committee, my name is John F. Graff. I am from Chicago and I am an independent broker representing a number of different insurance companies that market life and health insurance.

I am currently health insurance chairman for the National Association of Life Underwriters on whose behalf I appear here today. I am accompanied by William M. Bartlett, director of health insurance activities for NALU, and William R. Anderson, NALU counsel.

The National Association of Life Underwriters is a Washington-based trade association representing associations made up of approximately 140,000 life and health insurance agents, general agents, and managers who live and work in virtually every community in the United States and who, as individual businessmen, have been in the health insurance business from its very inception.

We appear here today to discuss the Health Incentives Reform Act of 1979—S. 1968. We applaud the efforts of Senator Durenberger for introducing S. 1968 and its attempt to meet the health crisis in this country today while retaining and utilizing the private insurance industry.

We further commend S. 1968 for its attempt to encourage competition in the health insurance industry and to involve the individual more directly in the choice of his own health care.

We strongly advocate individual responsibility in this area. For example, we produced an audiovisual presentation—cassette tape and slides—on the subject of the individual's responsibility for his/her own health care. The audiovisual describes the problem of the high cost of health care; what some of the solutions may be and how the individual can favorably affect the system.

Too often, people are insulated from the actual cost of their own health care because they are not individually paying the bills.

This audiovisual entitled "Your Risk and Mine" is a 13-minute cassette tape with 80 color slides, to illustrate some of the points we are making. A copy of the script is attached to this testimony.

[The material referred to follows:]

YOUR RISK -- AND MINE (Revised "Risk Worth Sharing")

VIDEO	AUDIO
1. Title Slide.	1. Music Up.
2. ilan in Hospital	2. Medical care . . . a vital, expected and expensive commodity in today's world --
3. World map w/Inflation" burnt through	3. And, like most things in our inflation-riddled economy,
4. Doctor treating patient	4. the life-prolonging miracle of modern medicine is becoming increasingly expensive.
5. Graph	5. In 1976, we Americans spent over $140 billion, or $522 per person, on health care.
6. Graph	6. But by 1978, the total tab had risen to more than $192 billion, or $863 per individual.
7. Crowd shot	7. Yet most of us are shielded from the continually-increasing cost of health care
8. Hospital bill	8. because we think someone else -- insurance or government -- is paying our medical bills.
9. Man tossing bill aside	9. As a result, we tend to forget the small economies that can have such a significant effect on that total,
10. Man looking at bill	10. and then complain when the cost of third-party payment --

VIDEO	AUDIO
11. Copy: Premiums Taxes	11. insurance premiums or taxes for such programs as Medicare or Medicaid --
12. Newspaper Head: Health Care Cost Rises; Medicare Budget Increased	12. rise to reflect the higher costs paid by private insurers and government.
	(PAUSE, Music Down)
13. People walking	13. There is much that we as individuals can do to control spiralling health care costs,
14. Individuals, w/Understand burnt through	14. but first, it's important to understand why individual actions are so important,
15. Health Care puzzle	15. and how they affect the big picture.
	(PAUSE)
16. Copy: Risk-Sharing	16. The foundation of our private and government insurance systems is the principle of risk-sharing.
17. 4-way split: people	17. This means that many individuals pool a small portion of their resources to create a large fund
18. Same as #4, w/arrow pointing to dollar sign	18. from which to pay the expenses of those pool members who become sick or injured.
19. Woman in hospital bed	19. Thus, in the short run, a few benefit financially from the collective efforts of many...
20. Family w/Security burnt through	20. while each pool member is secure in knowing that his or her medical bills will be met should ill health occur.
21. Crowd w/Protection burnt through	21. And in the long run, all pool members will

VIDEO	AUDIO
	in terms of both claims paid and on-going security.
22. Copy: Individual Contributions = Premiums	22. The individual contributions are the premiums paid for private health insurance
23. Copy: Individual Contributions = Premiums and/or Taxes	23. and/or the taxes paid for government-sponsored health care programs.
24. Man writing check	24. Viewed this way, it becomes obvious that it isn't someone else who is paying the tab -- it's us.
25. Copy: Risk-Sharing ~~Risk-Shifting~~	25. It is, indeed, a risk-sharing, not a risk-shifting, system.
	(PAUSE)
26. Magnifying glass w/Control to one side	26. Now, let's examine how we can control the size of claims paid,
27. Pile of money, w/Control burnt through	27. and thus control the amount we each need to contribute to create a fund large enough to meet those claims.
28. Copy: Providers Government Insurance Individuals	28. To begin, consider the component parts of the system.
29. 4-way split: Doctor, nurse, clinic, hospital	29. Health care in this country involves providers -- doctors, nurses, hospitals, clinics, etc.,
30. Liberty bell/ins. co. logos	30. government and the insurance industry as primary financers of the cost of medical care,
31. Man/Woman	31. and individuals, as consumers and as those ultimately responsible for pro-

VIDEO	AUDIO
	viding the money to pay health care bills.
32. 3-way split: worker, executive, health pro	32. This partnership works most efficiently when each member cooperates with the others' needs.
33. Board of Directors meeting w/Organizations ARE People burnt through	33. And, because individuals, in the final analysis, are responsible for industry and government policies and programs,
34. Man at blackboard	34. it is individual input and concern that actually determines the effectiveness of the entire system.
35. Man handing another man a check	35. In addition, it is the individual who benefits from this careful control.
36. Copy: What Can We Do?	36. But, just what is it that each of us can do?
37. Hand reaching for bill	37. In general, each individual can demand and carefully review itemized hospital bills;
38. Woman at phone	38. Each can use, when appropriate, alternative, less expensive forms of care
39. 3-way split: clinic, mother, appointment	39. such as clinics, nurse practitioners, or scheduled doctors' appointments
40. Hospital emergency room	40. instead of relying totally on the more costly hospital emergency room.
41. Kids going to YMCA	41. We can also make or renew a commitment to taking good care of ourselves,
42. 2-way split: Kid w/apple racquetball	42. for good diet, proper exercise, sufficient rest and regular check-ups

VIDEO	AUDIO
43. Hospital	43. will not only make us feel better, but will also lower our medical bills.
44. Town meeting	44. More specifically, as persons involved and as persons affected, we should encourage each other, industry and government in cost-containment efforts.
45. Person checking bills	45. We can urge the insurance industry to continue its careful review of bills,
46. Company logos w/ coinsurance, initial deductible provisions burnt through	46. and its cost-efficient co-insurance and initial deductible provisions.
47. Hospital bill, w/ ins., individual portions shown	47. These provisions not only encourage us, as consumers, to keep our bills as low as possible,
48. Clerk in accounting office	48. but also, they minimize the administrative cost of paying claims by reducing a potentially huge number of small claims.
49. Car on scenic highway	49. As with car insurance, the co-insurance and deductible provisions keep the total premium far lower than would be possible without them.
50. Doctor's waiting room	50. We can also encourage the private insurance industry to continue its development of such product innovations as coverage of regular check-ups,
51. Jogger	51. policy discounts for those who take good care of themselves,

VIDEO	AUDIO
52. One person consulting doctor	52. or payment for second opinions before deciding on elective surgery. (PAUSE)
53. Man writing to legislator	53. Government, through contact with legislators, should be encouraged
54. Capitol w/Programs, Tax Incentives, burnt thru	54. to limit its role to aiding those who can't provide for themselves, designing tax and other incentives for wise planning,
55. American flags, w/"Guaranteed Access" burnt thru	55. and to establishing motivation and/or programs to make sure all Americans have access to quality, affordable health care. (PAUSE)
56. Individual, highlighted	56. Individual effort within the health care provider sector is important, too.
57. Meeting w/Planning Boards burnt through	57. Community representatives serve on hospital and clinic planning boards,
58. US map w/HSA burnt thru	58. and on Health Systems Agencies -- HSAs-- which oversee the geographic and population-based distribution of equipment and facilities.
59. Doctors' meeting	59. Individuals can support practitioners who form Professional Standards Review Organizations, or PSROs.
60. Copy: Standard of Care, Price Guidelines	60. PSROs try to assure uniform standards of quality of care, and, in addition, they try to establish price guidelines for routine medical services.
61. Blind liberty, scales of Justice	61. And, as jurors, individuals should remem-

VIDEO	AUDIO
	ber that we, consumers, ultimately pay those huge damage awards,
62. Secretary w/Bills Reflect Premium Costs burnt thru	62. because we share in the high cost of medical malpractice insurance, for it is reflected in bills that we pay.
63. 2-Way split: technician, Hospital w/Budget Review burnt through	63. Hospitals and other health care facilities should continue doing prospective budget reviews;
64. Hospital annual report	64. they should continue to emphasize sound fiscal management;
65. 2-Way split: Nursing center, lab shot	65. and they should continue to cooperate with other area facilities in planning for enough, but not too much, capacity and equipment.
	(PAUSE)
66. Money w/ Quality of Care, Affordable Price burnt through	66. We all want and need quality health care at an affordable price.
67. Many individuals	67. We all agree that medical care should be available to all.
68. Man w/foot on desk	68. And now we must make the personal, individual commitment necessary
69. US map w/100% Covered, Costs Controlled burnt thru	69. to make sure our collective goal is reached.
70. Crowd w/Reward Worth Effort burnt through	70. The reward will certainly equal or even exceed the effort required--
71. Graph	71. A lower total health care tab means smaller individual shares in the cost of sharing risks.
72. Copy: Lower Premiums and/or Smaller Tax Bills	72. And that means lower premiums and/or smaller tax bills.

VIDEO	AUDIO
73. Group plan brochure	73. And since, for many, insurance coverage is at least partially paid for by employers,
74. Paycheck	74. it could mean bigger paychecks because less employer money spent on insurance
75. Bigger paycheck	75. translates into more to spend on salaries or on more competitively-priced products, which also contribute to higher incomes.
	(PAUSE, MUSIC UP)
76. Graphic: Win-Win	76. Quite simply, individual efforts to control health care costs create a win-win situation.
77. Copy: Quality Access Flexibility Costs	77. Quality goes up; access improves; regional flexibility is maintained; costs are controlled.
78. Copy: Risk-Sharing	78. All it takes is an awareness of and a commitment to the basic concept of risk-sharing,
79. Several individuals	79. and individual efforts toward meeting our collective goal.
80. Produced as a public service by the National Association of Life Underwriters/NALU Seal	

# # #

Mr. GRAFF. Our organization has about 1,000 local and State associations and we have encouraged these associations to show this audiovisual to local chambers of commerce, labor groups, civic organizations and any other groups that might benefit by seeing it. An educated consumer is the best weapon against rising health care costs.

As we stated, we are in favor of S. 1968's avowed purpose to encourage competition in the health care industry; however, we question whether S. 1968, as it is presently written, will do so.

S. 1968 requires employers with more than 100 employees covered under a health plan to offer at least three options among which an employee might choose. This provision severely limits the employer's ability to purchase the best coverage available for his employees at the best price.

If he is able to insure his entire work force with one policy he will generally be in a better bargaining position in the insurance market than if he must provide a number of different plans. In other words, he has at hand an economy of scale when he has only one plan to purchase because a greater number will be included in that plan, thus reducing its cost. He loses this economy when he must provide more than one plan.

For example, many group insurance contracts offer size discounts. If an employer has 117 employees enrolled in a plan and a discount is offered for plans with 100 or more participants, this discount will be lost if the employer is forced to offer alternative plans, with one plan perhaps having 40 employees in it, the other 77.

Furthermore, the cost to the employer of establishing and administering three plans as opposed to one may discourage employers from offering any health insurance plan at all to their employees, thus defeating the avowed purpose of the bill.

The "indexed contribution amount" in S. 1968 appears to be arbitrary and does not take into account geographical differences in health costs. As S. 1968 is presently worded, an employer may contribute a specific amount to an employee's health care plan, which amount will not be included in the employee's gross income.

The amount will be determined for each month in a calendar year according to the Consumer Price Index and is fixed for 1980 as $50 for an employee only; $100 for an employee and spouse; and $125 for family coverage.

Health costs vary widely throughout the country. While this set amount may be equitable in some areas, it will work a hardship on some employers in areas where the costs of medical care are considerably higher. Significant differences in health care costs can be experienced even within a community. Right here in Washington, D.C., for example, the difference between the cost of a semiprivate room in Sibley and George Washington hospitals is $111.

S. 1968 appears to put the burden of enforcement on the employee. If an employer does not comply with the provisions of this bill, it is not the employer who stands to lose his tax exemption or deduction or be fined; rather, the employee would lose the right to exclude from adjusted gross income the employer contribution to a health benefit plan.

We find this to be an inequitable way to enforce this bill. We feel that the sanction should be invoked against the employer rather than the innocent beneficiary of the contribution.

We find the "equal contribution requirement" of S. 1968 to be somewhat troublesome. Under this provision, any employer offering more than one coverage option must contribute an equal amount to each option regardless of which option the employee chooses.

If the employer's contribution exceeds the actual cost of the particular option selected by the employee, then the employee is entitled to receive a rebate equal to the difference and, at his option, may receive this rebate in cash. We see this as a dangerous means by which an employee could be induced to choose the health plan of the poorest quality in order to receive a cash rebate. This would have the effect of decreasing rather than increasing the quality of health care in the United States.

S. 1968 also appears to infringe upon the State regulation of insurance. The bill provides that the Secretary—whether of the Treasury or HEW, the bill is not clear—shall establish certain standards to insure that premium rates on conversion of group policies are reasonable. Although the bill provides that the determination of the premium rates shall reside with the appropriate State agency, the establishment of standards which would govern that determination would be an unwarranted intrusion into the power of States to regulate insurance.

The bill appears to further violate the prerogatives of State regulation by mandating continuation of coverage for employees and dependents in the event of discontinuance of the group plan. Group health insurance is the subject of legislation and regulation throughout the States and the provisions concerning continuation after the group coverage terminates are covered by these laws and regulations. For S. 1968 to superimpose particular provisions in this area would certainly interfere with State prerogatives that have already been the law of the States for some time.

S. 1968 mandates the inclusion of a catastrophic expense protection. We support the theory of catastrophic health insurance and we are in favor of the $3,500 deductible in S. 1968. However, we do suggest that it be indexed to keep pace with inflation so as to prevent the deductible amount from being rendered meaningless by rising inflation. We understand the Senate Finance Committee is studying how best to develop complete catastrophic health protection and is specifically being asked to consider this aspect of the problem.

In conclusion, we endorse the purpose of S. 1968—to encourage competition in the health care marketplace and to encourage individual participation in the choice of health care plans. However, we feel that the bill as presently drafted, by limiting the tax-free employer contribution and mandating that the employer provide three distinct and separate health insurance programs, will not achieve these purposes, but rather will inadvertently result in a lower level of health care being provided to the American public. This will be a result to the extent that employers cease to provide health care programs at all due to the added administrative burdens and additional expense in providing three plans rather than

one, coupled with some employees opting for the least expensive plan—to realize the rebate—and therefore the plan with the poorest coverage.

The enforcement provision of S. 1968 by which the employee loses the exclusion from his gross income for employer contributions that do not comply with the provisions of the bill is unfair to the consumer of insurance who has little or no control over whether or not his employer will comply.

Competition may not be promoted in the health care industry by S. 1968 but rather might be stifled by forcing the employer to offer three plans, which will severely limit the marketing possibilities of the one plan he may prefer. The fewer employees electing to enter into a plan, the fewer desirable features the employer may be able to include in it.

We are aware of the great problems facing the health care industry today and are constantly working within our associations to increase the level of awareness on the part of the consumer-insured concerning all aspects and provisions of his health care. Playing an essential role, as we do, in providing health care, we constantly strive to educate the consumer and provide him with the best health care possible to meet his needs today. We feel that much has to be done to improve health care in this country.

We thank the committee for allowing us to appear here today and if we can be of any further assistance to the committee we stand ready to assist in any way possible.

Senator BOREN. Thank you very much, Mr. Graff.

Do you really think that very many companies or employers will opt to not provide health insurance in the future if this kind of plan goes into effect? Don't you think there are very substantial pressures within the labor market that, in order for an employer to remain competitive, would lead them to continue to offer this kind of coverage?

Mr. GRAFF. That is a difficult question to answer. Although there are a substantial number of small employers—and when you are addressing employers of 100 employees and less, you are dealing with the small employers, there are a substantial number who do not offer individual or group health insurance benefits to their employees.

They may offer a very elaborate and expensive pension, profit sharing and retirement plan and let the employees buy with after-tax dollars whatever health coverage they so desire. Granted, they are in the minority, but they definitely do exist.

Senator BOREN. You talked about your agreement with the aim of trying to focus more individual responsibility for holding down the costs of health care. We go back to the individual patient, individual consumer or citizen, however you want to phrase it. You said that you think there should be a stronger sense of responsibility on the part of the individual.

What suggestions would you make for making the individual feel more responsibility? With all due respect, if it is not costing me anything out of my own pocket, I wonder how much I am going to be swayed by seeing a film to the effect that I ought to be really interested and it is my duty to be interested in holding down the costs of my care.

If I feel no direct effect of that, how effective is that really going to be, or is that going to be a little bit like some of the preachments on energy conservation that don't seem to have been too effective in terms of getting something done?

Mr. GRAFF. I think, Senator, it depends on who sees it. Now, this audiovisual has been shown to every conceivable type of group you can think of in the country. Its impact on a private citizen, other than impressing on him that the use of deductibles and copayments is not a bad thing, is that it reinforces the fact that we all know that first dollar coverage programs are very expensive.

The latest figure I saw was that it cost $58 to issue and process a $10 claim check. Now, this is the type of message we want to bring to the individuals.

Then we have a different type of message. We can show them that yes, deductibles and copayments were good things, not only for the employee but it's also a better bottom line situation for the farm. Then I think we've accomplished something there.

Our companies that are in the property and casualty business have the same problem with the homeowner's policy, and they just simply mandated a $50 or $100 deductible under that homeowners policy; they did the same thing under the automobile policies, and there was no freedom of choice left. They just eliminated the small claim.

Senator BOREN. So the deductibles and copayments are the main things, the main areas where you put emphasis in terms of——

Mr. GRAFF. We as an association and I as a practitioner definitely have discouraged first dollar plans for years.

Senator BOREN. What about the question I asked earlier. There does seem to be some lack of competition, I think we'd have to say price competition in the health field. Do you think it's primarily a failure of the providers themselves where we're talking about physicians? Is it primarily a failure of competition in that sector, since I gather the carrier sector itself is very competitive from what you've said.

Mr. GRAFF. I think at this stage in time at least the experience that I have had personally with the 20 some odd companies we involve ourselves with, and the 500 employers that we deal with, that the smaller employer does not have the time really to be concerned with cost containment, and whether that hospital room rate or whether that physician's charge is excessive.

Basically these small employers are spending 24 hours a day, 7 days a week trying to survive in their business and they install an employee benefit plan, and it pays what it pays and unfortunately, that small employer unit does not have the time and the availability to get involved perhaps on a hospital board and try and find out whether he's getting 100 cents on the dollar for his claim or not.

I think in the larger groups, I know in the larger groups, and in the non-huge metropolitan markets, the larger employers in those communities are a very significant factor in what goes on, and they do serve on the hospital boards and on HSA's, and they really understand what's going on.

Unfortunately, the smaller employer unit, as I said before, not only does he not know; he doesn't have the time to get involved

and he puts in the medical benefit plan that he thinks is the best for his particular group.

Senator BOREN. What about the situation where you have a very strong bargaining unit for the employees and they pretty well rule out health care which contains large deductibles and copayments, and certainly that's something that happens. The stronger the bargaining organization is, the less likely it is that the employee is going to be contributing.

Mr. GRAFF. That's absolutely correct. At least it is in the Midwest. Negotiated plans have a tendency to be almost mandatory first dollar, and I don't know what the solution is.

Senator BOREN. You've talked about the fact that this cost-sharing is an important part of making an individual feel a sense of responsibility. Do you think that we'd have better luck in mandating some kind of cost-sharing by the employee, or do you think that that would be better achieved by offering multiple plans where you had the possibility of rebates and other things, dealing with it practically?

Mr. GRAFF. I have trouble with the word "mandate," and I think the small employer, as I mentioned in my testimony, is going to have great difficulty with more than one carrier. The young, the healthy are going to opt for the low plan, the low premium plan if you will. You have your innate problem, too, in certain group cases, and I don't believe it was mentioned in your testimony today, that superannuated groups, groups of older employees, groups with very high female content, are going to by nature have a very high premium rate. And there's really nothing we can do to change that because the morbidity costs for superannuated groups and high female content groups are greatly higher than those in the normal cross-section employee group. And that is a severe problem with this type of proposed legislation.

Senator BOREN. Do you know what the trend is in the country? Is it toward the issuance of more policies that have cost sharing, deductions, et cetera, or is it away from that? Is it toward more first-dollar coverage?

Mr. GRAFF. I think today we have a choice, and once again let me gear my comments to the smaller employer unit to which this bill really addresses itself to, 100 and over, but there is a substantial number of small employer units around the country who 15 to 20 years ago if they had less than 10 employees, had no group insurance available to them at all. So they were just excluded from that coverage.

We can now write group insurance with groups of one via this multiple employer trust.

Senator BOREN. But I wonder about the volume nationwide. Do you have any idea what that is, whether or not we're moving toward greater percentage of the coverage being first dollar coverage or a smaller?

Mr. GRAFF. The companies, the participating companies who insure these muliple employer trusts really are dictating the benefits, and as we get down under 10 lives and under 5 lives and down to the 1-man corporation, if you will, the dollar coverage to 1, 2, and 3 life groups. But the companies are dictating, rather than the multiple employer trusts.

We're finding the tendency on the part of the employers to be much more aware in the last 5 years of the costs of medical insurance.

Senator BOREN. Senator Durenberger, questions?

Senator DURENBERGER. Yes; thank you.

Mr. Graff, just to put your testimony in perspective without being critical of it, which I am not, would you describe for us either a typical life underwriter or describe yourself, since you're chairman of the health committee of the National Association. Describe your own business for us so we can put both your experience and your advice to us in some perspective in terms of the kind of insurance that you write——

Mr. GRAFF. Seventy-five percent of our business is written to and with employer groups involving life and health insurance. The other 25 percent involves individual policies and pension and profit-sharing plans.

So the vast majority of our business is group medical, and sometimes group life piggybacked on it, for employer groups running anywhere from 1 to 250. We do have 3 groups in excess of 500.

Senator DURENBERGER. So you are selling, in addition to health insurance, you're selling life or a pension plan or whatever the case may be.

Mr. GRAFF. Pension and profit-sharing plans are a very small component of our business, with the vast majority of our business being group health.

Senator DURENBERGER. And as you described it, mainly to smaller employee groups, smaller employers?

Mr. GRAFF. That's correct, and our national association, our members are agents on the vast majority of group insurance plans that are written in this country involving less than 1,000 lives. Most of the jumbo cases are written by consultants with insurance companies, for whom no commissions are paid.

So when you exclude General Motors and Chrysler and what not, our national association probably represents the agents who are writing 95 percent of the group business in the country.

Senator DURENBERGER. Does your problem with fragmentation in the small employee group come from the standpoint of the overhead costs, if you will, to the employer or does it come from the fact that you don't agree with Mr. McNerney's testimony that the smallest of the fragmented group cannot get adequately covered by being combined with other small numbers from other employment units?

Mr. GRAFF. I disagree with what he said there. I can conceive of no State in the country, and in fact Mr. Anderson and Mr. Bartlett and I kind of compared notes for a minute when that statement was made—I can think of no State in the United States where you could not get three companies to bid on a given group plan.

Now you may not get the low option that you're after, but then again you might.

What concerns me is that most States in the country today have group statutes that mandate that 75 percent of your employees must enroll in the group insurance plan or you do not have a valid group insurance plan.

Now with the dual choice option, there has been a specific exception made as far as State law is concerned, but that still does not mandate that the insurance carrier who had 100 percent of the employees to begin with is prohibited from canceling that risk.

So we've had more than a little bit of problem with the dual choice with the HMO's.

Now if we go to three separate carriers, I think you've definitely violated the State law in every State, which mandates that 75 percent of your employees must enroll in the plan. And I don't know how you solve that problem without changing State law in 50 States.

Senator DURENBERGER. That and one other issue is relatively new to me, and that's the issue you raised of continuity. That's a subject that's been discussed in the Finance Committee for a year now in connection with catastrophic and some other programs, and perhaps you might clarify for us the problem that we're running into when we mandate continuity of coverage in terms of either the violation of specific State laws or be in violation of some prerogative of the State insurance commission when we mandate continuity.

Mr. GRAFF. I am a firm believer in State regulation, and most States have adequate group legislation. Most States have inadequate group conversion legislation, to which your bill addresses itself, and we've expressed concern a number of times that State laws, and the NAIC has an excellent model and so does HIAA, on group extension and conversion, how it would take care of short-term unemployed, strikes, widows, divorces, and run it out to 180 days with the employee paying 100 percent of that premium during that 6-month period and then mandating a decent minimum standard plan. And I think that can be accomplished. I would hate to see the Federal Government take over the regulation of the insurance industry.

Senator DURENBERGER. So would I, obviously, and I think I've had occasion to vote against that sort of thing several times in the last few months, but——

Mr. GRAFF. I think you have two components in this particular legislation that you may have missed, and that is how do you treat group dental, which is fast becoming available not only to the big groups but to the medium-sized groups and in a few instances are available to the small groups, and now that we've provided group dental to everybody, how do you treat group prepaid legal?

Now do we aggregate all of those benefits for your 5100, 125 cap, or do we have separate caps or do we ignore them? We have a lot of pressure from our employers today for group dental, and it's coming very, very fast and I would suspect by at least the end of 1981 practically any size employer group in the country will be able to have a reasonable group dental plan.

I think this type of legislation has to either specifically put it in or take it out, and if you're going to address yourself to the dental situation, then I guess the next thing you'd better look at is group prepaid legal because that's coming down the track now for the jumbo groups. And as you well know, anything that starts with the biggies works its way down.

Senator DURENBERGER. Does your written statement contain any specific recommendations to make this legislation the kind of bill that would get your wholehearted enthusiastic endorsement?

Mr. GRAFF. No, sir, it does not.

Senator DURENBERGER. Your statement does not?

Mr. GRAFF. We comment on certain portions of the bill. We appreciate your concern in trying to create more competition, but we have addressed our testimony, I believe, to the problems that are innate, at least to the smaller employers, and in general to all employers. The State statutes or the 75 percent requirement.

Senator DURENBERGER. Just one more thing, Mr. Chairman, to clarify your response to a previous question in which I made reference to Mr. McNerney. I understood that you did not agree with his statement that there were areas of the country in which three defensible, discrete, carrier options might not be available to employers. In your judgment——

Mr. GRAFF. With 100 and more employees, yes, I would take exception to his statement.

Senator DURENBERGER. You don't know any State in which there would not be at least three available——

Mr. GRAFF. Ten lives maybe, but not 100.

Senator DURENBERGER. Thank you very much.

Senator BOREN. Thank you very much, Mr. Graff. We appreciate the testimony of all the witnesses today. There have been some excellent statements given and I think in every case, each witness contributed something useful and to some degree a new insight for consideration of the committee.

Senator Durenberger?

Senator DURENBERGER. If I might, Mr. Chairman, on one point I have a request to make. The point concerning whether employees are unfairly given the burden of compliance.

There is, accepted in tax law, the approach that in areas such as pensions and legal services, that kind of burden already exists. And I would request that the Joint Tax Committee explain this particular provision in a couple or three paragraphs, whatever it takes, and that that particular discussion could be made a part of this record.

Senator BOREN. Without objection their response will be made a part of the record.

[The joint committee response follows:]

CONGRESS OF THE UNITED STATES,
JOINT COMMITTEE ON TAXATION,
Washington, D.C., March 31, 1980.

Hon. DAVID DURENBERGER,
U.S. Senate, Washington, D.C.

DEAR SENATOR DURENBERGER: This letter is in response to your request for an analysis of the effect on employees of the enforcement of the employer health plan provisions of S. 1968.

S. 1968 would subject employer health plan contributions to employee income taxes and employer and employee payroll taxes if the plan did not meet the various conditions specified in the bill. While the employer would be liable for unemployment insurance taxes (FUTA) and social security taxes (FICA) on these contributions, the employee bears most of the increase in tax liability which would result when employer contributions were made to a nonqualified health plan.

There are several administrative and policy considerations which may have make this penalty less harsh than it may appear. First, if the Internal Revenue Service, in

conducting an audit of an employer health plan, were to find that the plan did not meet the specified requirements, it is likely that liability would be assessed only against the employer for withholding and payroll taxes. The employer's withholding liability, which arises because the contributions are includible in the employee's income, would be used to offset the employee's liability for additional income taxes; in fact, the IRS may not find worthwhile the effort required to determine liability for individual employees.

Second, using the employee exclusion as the means to promote the objectives of the bill is consistent with the policy to encourage (but not absolutely require) employers to comply with the bill's requirements, Thus, a firm could make contributions to a nonqualified health plan; these contributions would be treated no more harshly (for tax purposes) than if they had simply been paid in cash. Using a stronger penalty, such as disallowing businesses a deduction for these contributions or imposing civil penalties, could lead nonconforming employers to eliminate their contributions to their health plans or cancel them, so that workers could be forced to pay the entire cost of the plan or to purchase health insurance under individual policies. In addition, such penalties may not affect State and local governments, nonprofit organizations, or businesses showing a loss.

Third, several other Internal Revenue Code provisions impose requirements on employee benefit plans, including pension plans and group legal services plans, through the use of a similar mechanism—denying the employee exclusion for contributions to plans which do not conform to the statutory requirements. This mechanism generally has been effective in encouraging employers to offer plans which meet the requirements. The rules, as enforced, have resulted in few disqualifications of employer retirement plans.

Sincerely yours,

BERNARD M. SHAPIRO.

Senator BOREN. These hearings will continue tomorrow afternoon at 2:30 and the hearings will now stand in recess until that time.

[Whereupon, at 6 p.m., the hearing recessed, to reconvene at 2:20 p.m., Wednesday, March 19, 1980.]

PROPOSALS TO STIMULATE HEALTH CARE COMPETITION

WEDNESDAY, MARCH 19, 1980

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2:30 p.m., in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Durenberger, and Matsunaga.

Senator TALMADGE. The committee will please come to order. Due to a conflict in my schedule yesterday I was unable to be present to hear all of the witnesses. I have questions for some of those witnesses. Without objection I would ask the staff to present those questions to the witnesses and have their responses included in the record at the end of their testimony.

Is there any objection?

[No response.]

Senator TALMADGE. Without objection it is so ordered.

Our first witness today is Mr. Alfred E. Kahn, adviser to the President on inflation. We are happy to have you, Mr. Kahn. We will insert your prepared statement in the record. You may summarize.

STATEMENT OF ALFRED E. KAHN, ADVISER TO THE PRESIDENT ON INFLATION, ACCOMPANIED BY DENNIS A. RAPP, DEPUTY TO MR. KAHN, AND ARTHUR J. CORAZZINI, COUNCIL ON WAGE AND PRICE STABILITY

Mr. KAHN. Thank you, Mr. Chairman.

I would like to introduce my deputy, Dennis Rapp and Art Corazzini who is with the Council on Wage and Price Stability.

Senator TALMADGE. We are delighted to have you, gentlemen.

Mr. KAHN. My statement is really quite brief, Mr. Chairman. It should not take more than a few minutes because it is about as long as my knowledge of the subject.

I appear before you to comment on the Health Incentives Reform Act only with considerable diffidence. I am not an expert in the economics of health care and I have not had an opportunity to acquaint myself in any kind of detail with many of the specific issues presented by the bill let alone to have reached settled conclusions about them.

All I can do and I am happy to do is to endorse the underlying assumptions of the bill about the defects of our present system of

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providing and paying for health care and express my general agreement with the bill's general approach to remedying those defects.

As the President's adviser on inflation I am powerfully influenced by two considerations to support your efforts. The first is the unacceptably high rate of inflation in the costs of medical care. This component of the Consumer Price Index has lagged slightly behind the entire CPI only because the latter has been so heavily influenced during the last year or so by the soaring costs of energy.

The medical care industry is less energy intensive than the economy as a whole on the average and of home purchase.

Still the acceleration of inflation of medical care costs to a 12-percent annual rate in the fourth quarter of 1979 and 17.7 percent in January of 1980 is ample reason for my office to concentrate attention on the medical area.

I observe also that the rates of increase in hospital expenditures as measured by the industry's own sample of community hospitals accelerated similarly in October and November of 1979 producing an average annual rate of increase of 13.5 percent for the first 11 months of that year as compared to 12.9 percent in 1978 despite the continuing voluntary cost containment effort.

The second direct association between my present position and this bill is the regulatory reform plank in the President's anti-inflation program with its strong commitment to the encouragement of competitive market forces in preference to direct regulation wherever feasible.

The President is an ardent proponent of competition and so am I.

In my testimony last year supporting the administration's hospital cost containment bill I emphasized the structural defects of our present system of providing and paying for medical care. I can think of no area of American life that affects every citizen as much and that needs structural reform as urgently as our health care industry.

Specifically I pointed out unlike other sectors of the economy there are few incentives for hospitals to hold down costs on their own and what is true of hospitals is true to a lesser extent of all medical care. In fact inflationary pressures are built right into the system.

More than 90 percent of all hospital bills are paid for by third parties; insurance companies, medicaid or medicare. This means that neither the consumer, that is the patient, nor the provider, the doctor and the hospital, nor the agency that decides what costs will be incurred and that is the doctor feels the pinch of rising costs in deciding what kind of facilities and care are to be provided.

Moreover reimbursement is on a cost-plus basis; hospitals receive about 60 percent of their revenues on the principle of the more they spend, the more they get. The rest of the payments are made on the basis of hospital established prices; the hospitals are paid what they ask.

Neither of these kinds of charges is subjected to the test of a competitive marketplace. Consumers do not make comparisons. They do not shop around. Most of the decisions are made not by them but by physicians whose earnings may be directly affected by those decisions.

In other words this is not like any other industry. The reasonableness of whose charges and services can safely be left to the competitive marketplace; the effective checks present elsewhere in the free enterprise system are simply not present here.

There are in general two basic approaches to the control of performance of markets that are not working well; direct regulation and competition.

Hospital cost containment itself is a regulatory approach. I supported it only as an interim measure while we attempted to introduce structural corrections that would automatically insure the introduction of economic calculations into the decision of how much health care should be provided and at what costs.

What combination of direct regulation on the one hand and encouragement of price competition on the other would be the optimum way in the long run of improving the efficiency with which we deliver health care I do not know.

It seems to me clear that to the extent we can provide for informed choices among competing delivery systems and can provide the usual economic incentives that will force whoever makes those decisions to weigh costs against benefits without distortion we should do so.

It is the attempt of your bill to move along this path as well as the general methods that it selects for accomplishing these results that I am happy to endorse.

The bill would do these things as I understand it by requiring all employers above a certain size as a condition for exemption of their contribution to employee health protection plans from the employees' income taxes to offer a choice of health plans to which they would make equal premium contributions regardless of the plan selected with the employees receiving any of the savings generated by their choosing less expensive plans.

While I am not in a position to assess all the implications and consequences of such a provision it does seem to me to establish the basic prerequisite for competition; equal contributions by employers to all plans rather than large contributions to more expensive and smaller contributions to less expensive plans and multiple offerings and free choice by employees and the chooser pocketing the savings from subscribing to a less expensive plan.

So far as I can see the proposed cap of $125 per family per month on tax-free employer contributions is not in itself relevant to the encouragement of competition for that it would suffice merely to have equal employer contributions along with rebates to employees.

On the other hand the cap seems an elementary necessity in a period of inflation for two closely related reasons. First, inflation quite properly imposes extreme pressure on all of us to limit governmental expenditures to revenues. This comes at a particularly opportune time for me to say that in view of the President's announcement of last Friday and the days and days many of us have spent working over how we are in fact going to restrain Government expenditures.

In the longer run inflation puts pressure on us to reduce general tax rates.

According to the study in January of 1980 by the Congressional Budget Office the Treasury loses about $9.6 billion annually because of this exclusion from taxable income.

At a time when we are being forced because of the intensity of our inflation problem to contemplate cuts in outlays for food stamps; welfare reform; youth training and employment and countercyclical fiscal assistance to hard pressed cities and feel obliged to put off tax incentives to encourage investment and absorption of the structurally unemployed into productive employment, at such a time this unlimited exemption seems to me totally indefensible.

The other side of the coin is that the unlimited tax exemption for employer contributions to employee health plans is directly inflationary because it inflates demand. It attenuates the incentive of employers to hold in check the rising costs of health insurance and the offering of increasingly expensive coverage.

The Federal Government should not be subsidizing inflation in health care costs through its tax policies.

I must confess that I have some uncertainty about the provision in your bill that would set minimum requirements for any plan. I know some people argue that employees should be saved from the consequences of selecting inadequate plans, attracted by the larger rebates such a choice would occasion.

I know of the fear that if you offer a very inexpensive plan consisting only let's say of catastrophic coverage with a large deductible that it will attract all the low risk employees attracted by the large rebates leaving only the high risk employees to bear the costs of the fuller plans, costs which would be increased by the desertion from the plans of the younger and healthier and therefore it would deny the higher cost employees the benefits of cross subsidization by the low risk group.

I also realize there is an argument for this that you have to have some standardization of policies if people are going to be able to make informed choices. I am not arguing against that provision.

My own preference for the competitive solution inclines me to be somewhat hesitant about regulatory prescriptions of the minimum characteristics of the plans to be offered and necessarily it makes me hesitant about endorsing governmentally enforced cross subsidizations. It leads me to want to see the market free to offer consumers the widest range of choices they are willing to select.

I emphasize I am merely setting forth the pros and cons. I have not made a judgment. My understanding is in the administration's national health insurance bill, there is in fact a requirement of certain minimum prescriptions about characteristics of plans to be offered and obviously I am not in a position to contradict the administration's policy.

On the other hand I can see the case for prescribing the cap on tax exempt contributions that it be set at the cost of providing some specified minimum benefit plan essentially on fiscal grounds.

On the one side such a cap would put a stop on the inflationary unlimited escape from taxes of employer contributions to plans no matter how rich. If you set the cap near the cost of an efficient health maintenance organization or a more conventional insurance policy with substantial cost sharing that would impose a salutary pressure on all providers to hold costs down.

On the other side such a cap would insure a tax subsidy since it would be tied to a minimum acceptable plan and it would insure that the tax subsidy was ample enough to encourage some desired minimum level of coverage.

The possible prescription of a minimum benefits package is related to another arrangement the committee might consider and this is a purely personal suggestion. That is the possibility that employers might share in the rebates. This again is personal. Rebate sharing some observers believe will increase the incentive of employers to offer a range of low cost choices because they will share in the savings.

I confess that I do not have a sense of how important that might be. Some people argue it would be great. It raises the danger that an employer might offer only some very high and some very low option plans in order to try to push his employees in the direction of selecting inadequate low-option plans because the others are so expensive and then will enable the employer to earn large rebates.

If at least one of the plans offered must be a reasonable prescribed minimum package then this danger would be substantially reduced.

This all goes to the question of whether one should have minimum packages or not.

There is one other prerequisite for the offer of a fuller range of choice than we have today that is not confronted in the bill and once again I offer you the pros and cons. I have not formed a judgment on it.

As I understand it, in situations in which employers do offer employees a choice with rebates to the employees who choose less expensive plans, in such situations the additional costs of plans with fuller coverage become subject to income tax on the ground that the employees who are protected by those higher cost plans could instead have opted for less expensive plans and obtained a rebate.

This tax treatment, that is the taxing of the additional cost of the better plans in terms of their coverage could be justified on the ground that the Treasury ought to be subsidizing, that is exempting from tax only the coverage provided by some minimum stipulated plan and should not exempt the additional costs of more rich plans.

It could be justified on the grounds also that since the rebates would be subject to tax so should the incremental costs of more generous plans so the taxes would not distort the choice between higher cost plans and lower cost plans.

On the other hand I know some people argue that if you subject that incremental cost to tax it will clearly discourage companies who already have medical plans from introducing multiple choices for their employees since the moment any number of their employees select the less expensive plan all their other employees will be subject to income tax for the difference and they are not subject to it now. There would be enormous resistance on the part of employers to offer these lower cost options. I have heard that argument.

I am aware that this brief appraisal of your bill in a sense barely scratches the surface and for that I am sorry.

I would like to think instead that it might be characterized as getting at the fundamentals. Establishing the necessary conditions for free and unbiased choices under incentives to make those choices economic is the essential condition for introducing more effective competition in the provision and financing of medical care.

I feel strongly that we must as vigorously as possible explore the extent to which competition rather than detailed prescriptive regulation can do the job of subjecting our health expenditure decisions to economic tests.

Doing that latter job that is seeing to it that some economic calculus is introduced into our decision about how much to spend on health, doing that job is absolutely essential if we are to control inflation in health care costs and subject those expenditures to exactly the same kind of inescapable economic calculus as we now apply in our society to the purchase of food, shelter and police protection.

Thank you very much for this opportunity to talk in rather general terms about the plans. I would be glad to try to answer your questions if you will understand that I am not an expert in this field but I am an expert on competition.

Senator TALMADGE. Thank you very much, Mr. Kahn, for a very fine statement.

If this competitive approach is adopted, would you no longer press for a hospital cost containment program with a flat cap on it?

Mr. KAHN. No. I would continue to press for hospital cost containment because I do not know to what extent it would suffice. I do not know to what extent you can rely simply on competition. It will clearly take time. The mere development in different localities of alternative plans, the construction of HMO's or other prepaid plans that have incentives to hold down costs, it is going to take a long time.

In the interim I think hospital cost containment is indispensible as a means of putting the cap and forcing people to make some economic decisions.

Senator TALMADGE. Would the approach in S. 1968 create any new administrative cost, paperwork or regulatory compliance burdens on business?

Mr. KAHN. Yes. I think there would be some additional paperwork costs because employers, even if you confine the plan to large employers, would have to develop mechanisms for offering their workers the choice Federal workers have. There would undoubtedly be some additional cost.

It seems to me the cost of offering people competitive choices and subjecting providers of medical care to efficiency pressures that the cost of doing that can only be small compared with the probable benefits.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman.

Thank you, Mr. Kahn, for your testimony. You indicated in response to the chairman's question that you would continue to press for cost containment.

Let me ask you a related but not identical question. On the basis of what I heard you say here today I see a preference on your part

for competition over a regulatory process. I also see a wise recognition of the fact that you cannot put one in and drop the other immediately. It is sort of a phased process.

There is an additional issue that we have been facing here for the last year or year and a half and that is the issue of continuing the expansion of subsidized fee for service programs.

I just wondered if, today, given the inflationary pressures on the budget and the inflationary pressures on the economy as a whole, would you discourage this committee from substantial expansion of the subsidized fee for service health care system in this country until we reform the system with some kind of informed choice and competition?

Mr. KAHN. I can answer only very generally. Certainly the expansion of subsidized fee for service medical care ought to be accompanied by adequate measures to hold the costs at check. That is to say I cannot see one introducing large-scale subsidies without trying to accompany that with some means in advance of containing what would otherwise be an inescapable ballooning of the costs.

Senator DURENBERGER. This committee has been, in a sense, rejecting broad scale universal coverage, subsidized fee for service, and concentrating on the area of catastrophic coverage.

It has been my concern that a catastrophic plan, covering all expenses over $3,500, without some kind of system reform, would be the most inflationary kind of expansion of fee for service system we could imagine. When we cover everything over a certain dollar, there is no constraint whatsoever.

Specifically with regard to major expansions of catastrophic in either a subsidized system or an employer based system, would you recommend we put that off for a while or at least accompany it with some kind of a competitive reform?

Mr. KAHN. I am not sure I can say anything more than I have already said. It seems to me important that we make every effort as we introduce these subsidized expanded possibilities of service and we accompany it with such cost control mechanisms as we possibly can devise and with that response I think you have already penetrated beneath the thin veneer of my knowledge in this field.

Senator DURENBERGER. Thank you.

I have one last question which relates to the voluntary guidelines on wages and the presumed pressure that adherence to those guidelines brings to bear on fringe benefits and particularly health benefits. I am not familiar today with exactly where the OCWA strike against the refineries stands, but as I read it they are remaining within the guidelines on wages, but the big pressure is on fully paid health care.

I would appreciate your comments on the appropriateness of fully paid benefits while we are trying to hold wages to our guideline percentage.

Mr. KAHN. I hope I am not jumping in making too large a logical jump but it seems to me that is exactly the virtue of this bill, that it extracts the incentive that we now have to pay wage increases in this form, an incentive that is provided at the expense of the U.S. taxpayer.

I do not really want to comment on the OCWA settlement. We have not seen the results.

I cannot be any more indifferent to increases in cost that are imposed on employers because they carry the name of health benefits than any other kind of increase in costs. I am worried about cost inflation and cost inflation is cost inflation no matter what box it happens to fit into.

Senator DURENBERGER. Thank you very much.

Senator TALMADGE. Senator Matsunaga?

Senator MATSUNAGA. Thank you very much, Mr. Chairman.

As you have so well expressed, Mr. Kahn, we are all concerned about the escalating costs of health care. Yet we do not want to rush into any new programs or so-called reforms that might bring about even greater costs, especially in the Government bureaucracy which may offset the savings of the tax-based health insurance reform proposals before this committee.

I do not know whether you have given any real thought to this because as you say you are not an expert in this area, but in your view, do employers and employees under existing laws have sufficient incentives to seek out the most effective and the most economical health insurance coverage?

Mr. KAHN. They clearly do not have sufficient incentive.

Senator MATSUNAGA. As you know, there is quite a bit of opposition to the proposal before us now. If you have looked at all of the proposals, do you or the administration have a proposal which may combine the underlying assumptions of the bills proposed and of the answer you just gave?

Mr. KAHN. I think the administration may well. The proper provider of that proposal would be the HEW and not me. I spend the better part of my life, Senator, trying to walk a tightrope between expressing my own opinions and speaking for the administration. On this one I am expressing my own opinions except that I know I can speak for the President when I say he is an ardent exponent of pursuing the competitive possibility wherever it is even remotely possible it will work. He kicked me into deregulation of the airlines faster than I was prepared to go but in a perfectly proper way.

Senator MATSUNAGA. Do you think HEW will soon be coming forth with such a proposal? I believe the "E" was recently taken out of HEW.

Mr. KAHN. That is correct. It is Department of Health and Human Services.

Senator MATSUNAGA. The "E" does not stand for efficiency, does it?

Mr. KAHN. You will not get me to rise to that one, Senator.

Senator MATSUNAGA. We will wait for the proposal of the administration.

Thank you, Mr. Chairman. I must excuse myself. I have to go to the synfuels conference committee meeting.

Senator TALMADGE. I have one other question, Mr. Kahn. Do you think we should get Government further into regulation of fringe benefits? If we decided we could improve productivity in the country by reducing the number of paid holidays eligible for tax deduction from 10 or 15 to 6, you support such a proposal?

Mr. KAHN. I hesitate to respond to an idea that has been presented to me for the first time. I think I would be disinclined to use the tax laws to try to influence in what form workers obtain improvements in their standard of living, whether they obtain them through paid vacations or through higher wages.

As an economist I tend to believe if you try by law to handicap one way of doing it then the balance of bargaining power or the balance of market considerations will push them to getting the benefits in some other way.

That reflects a kind of fundamental attitude of mine. I would also like to think about that. I think I would be disinclined for the Government to get into that degree of pervasive dictation of how wages should be paid.

Senator TALMADGE. Thank you very much, Mr. Kahn.

Our next witness is Mr. Bert Seidman, director of the Social Security Department, AFL-CIO who is accompanied by Mr. Robert McGlotten, associate director, Department of Legislation.

Mr. Seidman, you may insert your full statement and summarize it, sir.

STATEMENT OF BERT SEIDMAN, DIRECTOR, SOCIAL SECURITY DEPARTMENT, AFL-CIO, ACCOMPANIED BY ROBERT McGLOTTEN, ASSOCIATE DIRECTOR, DEPARTMENT OF LEGISLATION; STEPHEN KOPLAN; AND RICHARD SHOEMAKER, ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT, AFL-CIO

Mr. SEIDMAN. Thank you, Mr. Chairman.

With me is Robert McGlotten, the associate director of our Department of Legislation as well as Steve Koplan of that department and Dick Shoemaker, an assistant director of the Department of Social Security of the AFL-CIO.

Mr. Chairman and members of the subcommittee, the AFL-CIO welcomes this opportunity to present its views with respect to S. 1968. While we recognize the good intentions of the bill's sponsors, our major criticism of this bill is that it attempts to meet the rising costs of health care by penalizing through the Tax Code millions of employees.

The bill creates strong incentives for employees to select traditional health insurance plans heavily loaded with deductibles and coinsurance provisions. Such plans appear to be cheap and therefore might appeal to young and healthy employees but high deductibles and coinsurance do not lower the total cost of health care. They only shift the cost of paying for health services from premiums which are prepaid to out-of-pocket expenses that are paid by the consumer at the time health services are rendered.

The penalty for providing a plan that does not meet these and other standards would be that the expenditures could not be treated as a business expense under the tax laws but the penalty does not fall upon the employer. It would fall upon employees who must include employer payments for unqualified health insurance plans as an addition to their gross income subject to income taxes.

The bill would require employers to give rebates to employees as an inducement for them to choose the plan with the lowest premium cost. These rebates would also be considered additional taxable income to the employee.

The bill, although perhaps unintentionally would discriminate against health maintenance organizations because health benefits provided by HMO's are comprehensive with no or minimal copayments. This may make their premiums but not their total costs relatively high as compared with cheap traditional insurance policies providing no benefits for preventive care or for the routine doctor visits which minimize high cost catastrophic health expenses.

In our view this bill is conceptually faulty. It assumes unrealistically that patient-consumers have sufficient information prior to their need for health services to make a rational decision as to what insurance policy would be the best buy for them.

It assumes consumers have enough medical knowledge and the will to challenge their doctor's evaluation of their need for hospitalization and for other health services on the basis of the patient's judgment as to both their quality and cost.

This is simply not the way the medical care system works. It is the doctor who makes these decisions. Doctors and not patients control the demand for health services. The patient decides only on his or her first contact with the doctor. After that the doctor makes all the decisions from prescription of a simple drug to major surgery.

Patients know that doctors do and should make the medical decisions. When patients go to a physician with symptoms or perhaps for a physical examination, they place themselves under the doctor's direction. Physicians control from 70 to 75 percent of all health care expenditures.

It should be clear if any progress is to be made in controlling health care costs, fiscal controls must be placed on the physician and not the patient.

S. 1968 may reduce taxes and premiums for health insurance in the short run. These savings would only be achieved by transferring costs from taxes and premiums to out-of-pocket expenditures by consumers. Total costs, which include taxes, premiums and out-of-pocket payments, would be increased because of the lack of first dollar coverage for physician out-patient services. This lack of first dollar coverage would discourage preventive care and early diagnosis and treatment and result in more expensive surgery and hospitalization.

Catastrophic insurance to pay for acute illness and longer hospital stays would underwrite these high costs and stimulate the expansion of high cost technological care both in health education and in hospitals.

Human and capital resources would be channeled into catastrophic illness and away from primary care.

The long run cost implications of such a program are horrendous. Catastrophic insurance would benefit only 5 persons out of 100, unless it was an integral part of a universal comprehensive national health insurance program. Catastrophic insurance would not help the poor pay their routine medical bills but would help the well-to-do pay the large bills that resulted from the catastrophic illness.

It would be another program to help the rich without addressing the medical needs of the poor and would make medical care more expensive for everybody.

The insurance manual rate for a catastrophic insurance policy with a $3,500 deductible is about $3.50 a month for a single person or $8.80 a month for a family. Middle- and high-income citizens can easily purchase such policies although depending on such factors as physical condition and whether it is a group or individual policy, the premiums would be somewhat higher than the manual rates.

S. 1968 would not help to extend health insurance protection to the 25 million persons presently having no private or public health insurance. Neither would it do anything to improve the very inadequate health insurance protection which many millions of additional persons in this country now have.

S. 1968 would tax working people; benefit the rich more than the poor; increase health care costs and undermine efforts to organize more efficient health delivery systems such as HMO's.

We in the AFL-CIO will continue to support the only approach which will make good health care available to all Americans at an affordable cost—universal and comprehensive national health insurance.

Canada has such a program. Its health care costs as a percentage of its gross national product have declined since 1971 while our costs have increased. In 1977 Canada spent 7.2 percent of its GNP on health care for all Canadians. In that year the United States spent 9 percent of its GNP for health services leaving 25 million uninsured.

Under ordinary circumstances the AFL-CIO makes an effort in hearings such as this to suggest ways of improving proposed legislation. Unfortunately because we find S. 1968 to be conceptually wrong, in our opinion no amount of tinkering will make it acceptable.

We will strongly oppose the so-called consumer choice health plan or any variation of it. We will also strongly oppose catastropic insurance or any variation of it, whether it stands alone or in combination with the consumer choice health plan approach.

We will continue to support the only approach which will make good health care available to all Americans at an affordable cost, universal and comprehensive national health insurance.

Thank you, Mr. Chairman. We will be glad to answer any questions.

Senator TALMADGE. Thank you, Mr. Seidman, for a very good statement.

It is contended that because of the deductibility by the employer of health insurance premiums, employers are relatively indifferent to the cost of the health insurance for their employees.

Have your member unions found that to be a fact as they engage in collective bargaining?

Mr. SEIDMAN. If it ever was a fact and it may have been some years ago, it is certainly not true today. We see this in two different ways. First, we see it in the tremendous resistance of employers in collective bargaining against any improvement of health care plans and their efforts to cut back on the health care plans that unions have already negotiated.

We find that to be a very unwelcome development but we also find a welcome development and that is, we find that employers to a greater extent than ever before are looking for what we consider to be very legitimate ways of reducing health care costs.

Just a relatively short time ago a top level labor-management committee looked at this whole question of health care costs. Much to our surprise and pleasure, we found when we put aside some rather controversial issues such as national health insurance, we were able to agree on the labor side and the management side on many specific ways of dealing with the health care costs problem either through the collective bargaining approach, that is labor-management cooperation in effect, or through legislation.

I would say increasingly and by now I think this is true of almost all employers, they are very much concerned with health care costs but they would have to speak for themselves.

Senator TALMADGE. Yesterday Mr. Enthoven alleged that the reason labor leaders were opposed to S. 1968 was because if enacted it would effectively put an end to their hopes for the Kennedy national health insurance proposal. Is Mr. Enthoven's analysis correct?

Mr. SEIDMAN. I think Mr. Enthoven is entirely wrong. As a matter of fact if I were to put my crystal ball in front of me I would say if it is enacted it will help our chances for getting universal and comprehensive national health insurance but only after disastrous increases in costs and cutbacks in health benefits for millions and millions of workers and their families. That we do not want to do.

We are opposing the bill for the reasons I have outlined in summary form orally and which we have spelled out in much more detail in our prepared statement which the members of the committee may wish to study.

We are opposing it not for the reason that we think it is going to hold back enactment of a universal and comprehensive national insurance system.

Senator TALMADGE. It is alleged union members such as steelworkers are not concerned as individuals with the cost of health care because those benefits are paid for them by third parties insurers whose premiums are paid by the employer and not by the worker.

It is alleged this insulation creates indifference. Would you comment?

Mr. SEIDMAN. I do not think that is at all true. The fact of the matter is workers know when they negotiate for health care benefits, it means they are foregoing wages or reduction of hours or paid vacations or other elements of the collective bargaining package.

Workers know there is a tremendous escalation of health care costs and that is why they support their unions in the efforts unions have made to restrain health care costs and to seek enactment of the kind of legislation which will make health care available on a universal basis but which also contains built in elements for cost constraint.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman.

Mr. Seidman, I would like to believe the statement you made here is the accurate one, rather than the statement you made in your testimony, and that you do like this general support but you are afraid of what is going to happen between now and the time the competitive approach can be blended with universal coverage. That is the response I heard to the chairman's question when he asked you about the Enthoven statement.

As I recall your reply it was you were not opposed to this but it is——

Mr. SEIDMAN. We are opposed to it.

Senator DURENBERGER. Why are you opposed to it?

Mr. SEIDMAN. I can give you the reasons but I have specified them in my testimony. We think in the first place it is based on assumptions which we find entirely unrealistic and that is first of all, that employers and employees are responsible for the tremendous escalation in health care costs——

Senator DURENBERGER. Excuse me, let me get back to my question because I only have a few minutes.

I want to get back to the allegation about what Dr. Enthoven said or did not say. On page 5 of your statement, it is said, "We will continue to support the only approach which will make good health care available to all Americans at an affordable cost, universal and comprehensive national health insurance."

That has been the position of your organization for many years. I have heard it myself 20 times since I came here a year and a quarter ago. You oppose catastrophic. You oppose this. You oppose anything that comes through this committee if it is not universal and comprehensive national health insurance.

Is that your position?

Mr. SEIDMAN. That is not our position. We support those programs which we think will provide benefits to people short of national health insurance. I can state two which are coming through your committee right now; hospital cost containment and the child health assurance plan, the CHAP legislation. We support both of those. They fall far short of national health insurance. We support them because we think they will improve health care for people and we think they will have at least some effect on the cost of medical care.

We oppose programs which we think will not achieve those objectives.

Senator DURENBERGER. You have four specifics at the top of page 5; the bill attacks working people; the bill would benefit the rich more than the poor; it would increase health care costs and would undermine efforts to organize a more efficient delivery system.

The CBO report addresses the health care cost issue. If in your printed statement you can prove that health care costs would increase, I would be surprised. Your second point—that it benefits the rich more than the poor—as I understand your testimony, relates primarily to the catastrophic aspects of the bill.

Mr. SEIDMAN. That is correct. We do not think it would benefit anybody except through the catastrophic route and then it would only benefit those people who can afford it.

Senator DURENBERGER. The failure in the bill, in your opinion is its mandate for coverage stops at catastrophic and continuity of coverage.

The last point I am most interested in is that the bill undermines efforts to organize more efficient health delivery systems such as HMO's.

If you can demonstrate for me this bill does that, I will be glad to change this bill.

Mr. SEIDMAN. We do go into that in some length in the detailed statement. The point we wish to make is particularly in the early stages, the cost of the monthly premiums of HMO's may be higher than the amounts you have set in the bill but the total cost of health care to the people who join those HMO's may be lower than in the traditional plan.

The bill would discriminate against those HMO's which are just getting underway and therefore help to discourage the development of alternative health delivery systems.

Senator DURENBERGER. One of the points you made earlier in your testimony related to something called skimming or preferred selection or adverse selection. I think you objected to this because the young would take the lowest coverage and stick everybody else such as the families and the older with the bill.

I take it because your organization and some of your member organizations have been very involved with HMO's that you could tell us what your experience has been with regard to skimming or adverse selection in HMO's.

Mr. SEIDMAN. I do not know of any adverse selection in HMO's. We have dual choice arrangements and people have the choice of the HMO or the traditional arrangement, whichever they wish to choose. The HMO is required to take in anybody who chooses the HMO. I do not know that there has been any particular skimming.

Senator DURENBERGER. Does that experience include non-Federally qualified HMO's, just various forms of prepaid limited provider arrangements?

Mr. SEIDMAN. There was a disastrous experience in California some years ago with nonqualified organizations which purported to be HMO's. Other than that I do not know of any problems which have arisen along the line you are suggesting.

Senator DURENBERGER. Thank you very much.

Senator TALMADGE. Thank you very much, gentlemen. We appreciate your contribution.

[The prepared statement of Mr. Seidman follows. Oral testimony continues on p. 256.]

SUMMARY OF THE STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. Chairman and members of the subcommittee, the AFL-CIO welcomes this opportunity to present its views with respect to S. 1968. While we recognize the good intentions of the bill's sponsors, our major criticism of this bill is that it attempts to meet the rising costs of health care by penalizing, through the tax code, millions of employees.

This bill, would rewrite the tax laws so that, as a condition of tax deductibility as a business expense, employers would have to make the same dollar contribution to more than one health insurance plan for their employees. S. 1968 would require that each employer offer at least three different health insurance plans one of

which must be a low cost option. In addition any employer contributions to a health plan in excess of $125 a month for a family with children, $100 for a husband and wife and $50 for a single person would have to be included for tax purposes in the gross income of the employee and would, therefore, increase the tax burdens on working people.

Under the bill any qualified employer-employee health benefit plan would be required to provide protection against the high cost of a catastrophic illness. The ceilings established under the bill would preclude an employer from providing a comprehensive health plan without substantial deductibles and coinsurance to his employees.

A traditional health insurance plan heavily loaded with deductibles and coinsurance provisions to make it "cheap" might appeal to young and healthy employees, but high deductibles and coinsurance do not lower the total cost of health care. They only shift the cost of paying for health services from premiums which are prepaid to out-of-pocket expenses that are paid by the consumer at the time health services are rendered.

The penalty for providing a plan that does not meet these and other standards would be that the expenditures could not be treated as a business expense under the tax laws. But the penalty does not fall upon the employer. It would fall upon the employee who must include employer payments for unqualified health insurance plans at an addition to his gross income subject to income taxes.

The bill would require employers to give rebates to employees as an inducement for them to choose the plan with the lowest premium cost. These rebates would also be considered additional taxable income to the employee.

The bill would discriminate against Health Maintenance Organizations (HMOs) because health benefits provided by HMOs are comprehensive with no or minimal copayments making their premiums but not their total costs relatively high as compared with cheap traditional insurance policies providing no benefits for preventive care nor for routine doctor visits which minimize high cost catastrophic health expenses.

In our view this bill is conceptually faulty. It assumes unrealistically that patient-consumers have sufficient information prior to their need for health services to make a rational decision as to what insurance policy would be the "best buy" for them. It assumes consumers have enough medical knowledge to evaluate their need for hospitalization and for other health services on the basis of both their quality and their cost.

This is not the way the medical care system works. It is the doctor who makes these decisions. Doctors—not patients—control the demand for health services.

It is the doctor who decides whether a patient goes to a hospital or receives much less expensive treatment on an outpatient basis.

It is the doctor who decides when a patient can be transferred to an extended care facility. It is the doctor who decides when the patient can be discharged from a hospital or nursing home

It is the doctor who decides how often the patient should come to the office for treatment and the number of hospital visits that need to be made by the doctor.

It is the doctor who prescribes drugs, either by brand name or less costly but equally effective generic equivalents.

It is the patient's physician who leaves instruction with the house staff or the nurse.

It is the doctor who schedules the patient for revisits for treatment.

Patients know this. When patients go to a physician with symptoms—or perhaps for a physical examination—they place themselves under the doctor's direction. Physicians control from 70-75 percent of all health care expenditures.

It should be clear, then, if any progress is to be made in controlling health care costs, fiscal controls must be placed on the physician and not the patient.

S. 1968 may reduce taxes and premiums for health insurance in the short run. These savings would only be achieved, however, by transferring costs from taxes and premiums to out-of-pocket expenditures by consumers. Total costs, which include taxes, premiums and out-of-pocket payments, would be increased because of the lack of first dollar coverage for physician outpatient services. This would discourage preventive care and early diagnosis and treatment and result in more expensive surgery and hospitalization.

Catastrophic insurance to pay for acute illness and longer hospital stays would underwrite these high costs and stimulate the expansion of high-cost technological care in health education and in hospitals. Human and capital resources would be channeled into catastrophic illness and away from primary care. The long run cost implications of such a program are horrendous.

Catastrophic insurance would benefit only five persons out of a hundred. Unless it was an integral part of a universal comprenhensive national health insurance program, it would not help the poor pay their routine medical bills but would help the well-to-do pay the large bills that resulted from a catastrophic illness. It would be another program to help the rich without addressing the medical needs of the poor and would make medical care more expensive for everybody. Middle and high income citizens can easily purchase a catastrophic insurance policy for $3.50 a month for a single person or $8.80 a month for a family.

S. 1968 would not help to extend health insurance protection to the 25 million persons presently having no private or public health insurance.

However, S. 1968 would—

Tax working people;

Benefit the rich more than the poor;

Increase health care costs;

Undermine efforts to organize more efficient health delivery systems such as HMOs.

We in the AFL-CIO will continue to support the only approach which will make good health care available to all Americans at an affordable cost—universal and comprehensive national health insurance. Canada has such a program. Their health care costs, as a percentage of their Gross National Product, have declined since 1971 while our costs have increased. In 1977, Canada spent 7.2 percent of their GNP on health care for all Canadians. In that year, the United States spent 9.0 of its GNP for health services leaving 25 million uninsured.

Under ordinary circumstances, the AFL-CIO tries to suggest ways of improving proposed legislation. Unfortunately because we find S. 1968 to be conceptually wrong, no amount of tinkering will make it acceptable to us. We will strongly oppose the so-called "Consumer Choice Health Plan" or any variation of it. We will strongly oppose catastrophic insurance or any variation of it whether it stands alone or in combination with a Consumer Choice Health Plan approach. We will continue to support the only approach which will make good health care available to all Americans at an affordable cost—universal and comprehensive national health insurance.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE HEALTH SUBCOMMITTEE
SENATE FINANCE COMMITTEE
ON S. 1968
A BILL TO ENCOURAGE COMPETITION AND CATASTROPHIC HEALTH INSURANCE

March 19, 1980

Mr. Chairman and members of the subcommittee, the AFL-CIO welcomes this opportunity to present its views with respect to S. 1968. While we recognize the good intentions of the bill's sponsors, our major criticism of this bill is that it attempts to meet the rising costs of health care by penalizing, through the tax code, millions of employees.

This bill, and others like it that have been introduced in the House of Representatives, would rewrite the tax laws so that, as a condition of tax deductibility as a business expense, employers would have to make the same dollar contribution if they offered more than one health insurance plan to their employees. S. 1968 would require that each employer offer at least three health insurance plans. In addition, any employer contribution to a health plan in excess of $125 a month for a family with children, $100 for a husband and wife and $50 for a single person would have to be included for tax purposes in the gross income of the employee and would, therefore, increase the tax burdens on working people.

A traditional health insurance plan heavily loaded with deductible and coinsurance provisions to make it "cheap" might appeal to young and healthy employees, but high deductibles and coinsurance do not lower the total cost of health care. They only shift the cost of paying for health services from premiums which are prepaid to out-of-pocket expenses that are paid by the consumer at the time health services are rendered. Each plan offered by an employer to his employees would have to provide the same benefits as Medicare as well as meet

certain other standards, the most important of which is that all plans would have to provide protection against the high-cost of a catastrophic illness. Because S. 1968 mandates broad benefits for qualified plans, any plan costing no more than the ceilings established by the bill would necessarily have to be loaded with deductibles and copayments.

The method of enforcement of these provisions and standards is strange to say the least. No penalty would fall upon employers who failed to offer at least three plans that conformed with the requirements of the bill. Rather the premium payments made by the employer for a plan that did not qualify for tax exemption would be counted as taxable income for his employees. It would be the employees who would have to pay the penalty in the form of higher taxes because of the employer's failure to adopt a qualified plan.

S. 1968 would require rebates to employees who choose a very low-cost health insurance plan costing even less than the ceilings imposed by the bill on employer contributions. The inevitable effect would be adverse selection against the more comprehensive plan because only the young and healthy who anticipate and hope they will not get sick would elect the low-cost option. This would increase the cost of insurance for elderly employees, unhealthy employees and those with large families. This would also discriminate against Health Maintenance Organizations (HMOs) whose rates are about the same as, or above, the ceiling of $125 a month for family coverage. A table, "Monthly Premium for Federal Employees for a Family, Copayments and Doctor/Office Visits per Beneficiary for Fifteen Prepaid Group Practice Plans" shows these rates and is included as Appendix A attached to this statement.

Mr. Chairman, this bill follows a conceptual framework that assumes consumers have the economic power and the information to achieve the best insurance buy and to exert sufficient pressure on the producers to reduce the cost of medical services. But consumers have neither the information nor the power to exert such pressure. One reason is that there are intermediaries between the providers and the consumer.

These intermediaries are Blue Cross, Blue Shield and insurance companies. Nevertheless, a member of academic theorists have tried to sell the idea that if consumers will shop around for less expensive health insurance policies, insurance companies, in turn, will exert pressure on the providers of health services to be more efficient. One critic of the scheme has referred to it as the domino theory of cost containment. Pressure is exerted on the first domino, the consumer, to fall upon the next one, the insurer. The second domino pressures the third, physicians and hospitals. The main problem is that the first domino may not fall in the direction of the second and the second may not fall against the third.

Low-cost insurance policies are not the best buys for consumers. Cheap health policies have limited benefits and are loaded with deductibles, coinsurance, limitations and exclusions. They erect financial barriers to utilization of physician visits necessary to avoid acute illness. Such policies, therefore, tend to channel money into hospitalization, surgery and high-cost technological care making medical care and, therefore, health insurance more expensive for everybody.

The multiplicity of insurance policies, each with different deductibles ($50, $100, $1,000, etc.), coinsurance rates (10%, 20%, 25%, etc.), limitations (30, 60, 90 days, etc. of hospitalization or 10, 20 or 50 etc. doctor visits), and exclusions (no coverage for newborns for a week or 10 days or for prenatal care or for pre-existing conditions) make it impossible for the consumer to make a rational decision as to which insurance policy is a best buy. Nor can consumers make a rational choice unless they know in advance the disease with which they will be afflicted. Will it be an acute disease such as cancer or a chronic disease such as arthritis? It is even worse for consumers when a newborn has a birth defect since birth defects are not covered by most insurance policies for the first week or 10 days after birth.

The conclusion must be that the first or consumer domino can fall in any direction.

If it does, by chance, fall upon the second domino the relationship between Blue Cross and the hospitals can be described as cozy and physicians control most Blue Shield plans as the Federal Trade Commission has documented.

Until Congress passed the Health Maintenance Organization Act of 1976, the insurers performed no function other than the mechanical processing of claims and mailing out checks to providers. To be fair to the insurers, they are now sponsoring HMOs and other innovative organizational arrangements for delivering health services. However, this activity, which the AFL-CIO welcomes resulted from a fear of losing business to prepaid group practice plans such as the Kaiser Foundation health plans, Group Health of Puget Sound, the Health Insurance Plan of Greater New York and others. It was, therefore, the competition of other providers and not the pressure of consumers that was the stimulus for the insurers to develop alternatives to the fee-for-service system.

The theoreticians who developed the so-called "Consumer Choice Health Plan" (CCHP) ignore the realities of the medical care system. Consumers, given a choice, choose plans that provide first dollar coverage even when they may have to pay part of the higher premium themselves. As union representatives, we know this, but you need not take our word for it. The prototype CCHP is the Federal Employees Health Benefits Plan (FEP). FEP has over 3.4 million subscribers who represent over 10 million people including dependents. Annually, federal employees are given a choice of four benefit programs: Blue Cross, Aetna, an HMO and a union sponsored plan if the employee is a union member. The government's contribution cannot exceed 75 percent of any plan's premium. Employees who select a more expensive benefit package have to pay more for it. Alternatively, they can select less expensive coverage with a lower personal contribution. Both Blue Cross, Blue Shield and Aetna offer a high option and low option plan. Only 7.5 percent of federal employees choose the low option plans. The State of Maryland has a program patterned after FEP. The state's experience is that 95 percent of the employees choose the high option plan. Most of the elderly population has chosen to have their Medicare deductibles and coinsurance provisions met with supplementary insurance. The premiums for this supplementary coverage are paid for entirely from their meager incomes. The popularity of first-dollar coverage persisting as it does over time and in the face of alternatives involving lower premiums and escalating medical care costs is a phenomenon which Congress ought not to ignore. Consumers have clearly indicated their choice. It is a plan with comprehensive benefits and first dollar coverage particularly for physician office visits. When given the choice, consumers select the plan with the most comprehensive coverage and the least financial barriers to health care.

It is claimed by the advocates of the so-called Consumer Choice Health Plan that health plans with deductibles and copayments requiring out-of-pocket payments at the time service is rendered will stimulate consumers to shop around

in the medical marketplace for doctors who charge lower fees and for low-cost hospitals. They even claim that such plans will give consumers the incentive to challenge their doctor with respect to the diagnostic tests the doctor orders or the location of treatment the physician may recommend. We doubt if there is anyone in this room, unless he or she is a physician, who have ever challenged the clinical judgment of his or her doctor.

According to the CCHP advocates, deductibles will reduce the effective demand or utilization of health services and, therefore, reduce costs. This is the economic theory that price is determined by supply and demand. These economists think health care is like other goods and services and that if provided on a prepaid basis without charge, this will result in people swarming into doctor's offices to receive what they inaccurate call at the time the service is given their "free care."

Mr. Chairman, what is conspicuously absent from these misguided notions is a rudimentary understanding of the basic economics of the health care industry. The laws of supply and demand are skewed beyond recognition in this industry.

Doctors -- not patients -- control the demand for medical services.

It is the doctor who decides whether a patient goes to a hospital or receives much less expensive treatment on an outpatient basis.

It is the doctor who decides when a patient can be transferred to an extended care facility. It is the doctor who decides when the patient can be discharged from a hospital or nursing home.

It is the doctor who decides how often the patient should come to the office for treatment and the number of hospital visits that need to be made by the doctor.

It is the doctor who decides what laboratory tests or diagnostic procedures need to be performed.

It is the doctor who prescribes drugs, either by brand name or less costly but equally effective generic equivalents.

It is the patient's physician who leaves instructions with the house staff or the nurse.

It is the doctor who schedules the patient for revisits for treatment.

Patients know this. When patients go to a physician with symptoms or perhaps for a routine physical examination, they place themselves under the doctor's direction. Physicians control from 70-75 percent of all health care expenditures.

It should be clear, then if any progress is to be made in controlling health care costs in the public interest, fiscal controls must be placed on the physician and not the patient.

In Canada, a country with a social, political and economic system very similar to that of the United States, health care is virtually all prepaid in one way or another. Deductibles are forbidden under its national health insurance program although their law does allow the provinces to charge some copayments. There are no copayments for doctor visits. You might think the doctors would be swamped. The facts are that in Canada there are 5.0 outpatient visits to doctors per-person per-year and in the United States there are 4.2 visits per-person per-year. Canada has more doctor visits per-person than the United States to be sure, but if consideration is given to the fact that 20-25 million Americans have no health insurance at all -- public or private -- and millions more have to pay for their visits out-of-pocket, it can hardly be claimed, as these economists do, that prepaid care results in swamped doctors' offices or results in abuse. It should be pointed out that Canadians not only have better financial

access to care than Americans but the distribution of physicians as between rural and urban areas is more equitable. In some areas of the United States there are no doctors and, therefore, no visits.

Closer to home, the experience of prepaid group practice in the U. S. lends no support to the theory that prepaid care results in a rush by consumers to doctors' offices.

Most of the plans have no copayment for a doctor visit. With the exception of one plan which, is at the national average, all of the plans have fewer doctor or clinic visits per-person per-year than traditional insurance with deductibles and some have considerably fewer visits. (See Appendix A)

The economic theoreticians trained in the "law of supply and demand" refuse to believe in the reality of consumer behavior. If the reality does not conform to theory, they discard reality -- not the theory. The fact is, whether prepaid or not, people do not like to go to doctors, especially when it involves time off from work and docked pay as it does for many workers. If they experience only minor discomfort, they tend to put off an office visit hoping they will feel better later. Or, sometimes fear of the unknown deters them from seeking help. Going to the doctor is inconvenient, time consuming and, if pay is reduced, costly.

Only 16 percent of the visits to doctor offices are first visits initiated by the patient. All of the rest are initiated by the doctor or made by previously treated patients.

Medical care is not like refrigerators or television sets. Prepaid care does not result in a queuing at the doctor's doorstop to get something for nothing as the experience in Canada has amply demonstrated. But it does deter necessary and early diagnosis and treatment that results in more expensive hospitalization and acute illness. The result is more tax dollars being spent for Medicare and Medicaid and higher costs for everybody.

The State of California received permission from the Department of Health, Education and Welfare to conduct an experimental study to evaluate the effect on Medicaid beneficiaries of a $1.00 copayment for the first two visits to a doctor and fifty cents for the first two drug prescriptions each month. A matched sample of Medicaid beneficiaries received their care without any copayments as a control group.

The study showed that following the start of copayment, utilization of ambulatory visits to doctors' office and other outpatient services went down for the copayment group as compared with the control group. However, hospitalization rates for the copayment group rose faster than for the group with no copayment. The study concluded that because of the modest $1.00 copayment, early medical care was deferred, and due to the neglect of early medical care, usage rates of more costly hospitalization increased. The increased cost of hospitalization for the copayment group more than offset the saving to the state of reduced utilization of physician services.

Mr. Chairman, we ask that this study "Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish," be incorporated into the record as Appendix B.

We would also like to cite the experience of the Province of Saskatchewan, Canada. The Canadian national health insurance program forbids deductibles, but does allow copayments. In order to "save" money, the Province instituted a $1.50 copayment for doctors' visits which resulted in an overall reduction in outpatient services to the poor of 18 percent. At the same time, services to the non-poor increased. There was also an increase in the number of physical examinations provided by the doctors for the non-poor population.

Dr. R. A. Armstrong, Director General for the Canadian health insurance plan, commented on the copayment experience:

> ". . . while these lower income people were hit with utilization decreases, after the first year there was an increase in utilization by young single males and females. In other words, the doctors were not going to sit twiddling their thumbs, particularly when they only got paid if they worked."

Saskatchewan dropped the copayment provision in 1973. The important point is that copayments did not even result in a reduction in the utilization of physician services, because doctors determined the demand for their services.

One final point with respect to the "consumer choice" provisions of S. 1968 is that it would not help the working poor because it is voluntary and small employers who cannot now afford a health benefit plan for their employees, even with the employees contributing, receive no help toward the cost of a plan and still would not be able to afford one if the bill passed. The working poor are generally employed by small businesses. The bill, therefore, would not extend health insurance coverage for the 25 million persons presently uninsured.

Catastrophic Insurance

In order for an employee health benefit plan to be qualified for tax exclusion, S. 1968 requires coverage for catastrophic illness costing more than $3500 in uninsured out-of-pocket expenses. Only upper income families could afford to make such payments and most of them are already well insured. For all other families the $3500 would, in itself, be catastrophic.

Congress is considering other catastrophic insurance bills without the "consumer choice" provisions. All catastrophic insurance bills would greatly accelerate the already unacceptably high inflation in health care costs. The American people would be saddled with higher taxes, higher insurance premiums and higher out-of-pocket payments if any catastrophic health insurance bill were enacted unless it is part of a universal comprehensive national health program.

Catastrophic insurance would only perpetuate the factors most authorities consider responsible for the breakdown in the delivery of health services -- that is, the lack of organization of the system compounded by a distorted specialty and geographic distribution of health professionals and an inadequate supply and inefficient use of trained personnel in certain allied health professions. There is virtually no teamwork among the many specialties and subspecialties in medicine, except in such organized settings as prepaid group practice plans.

Medical care in the United States is oriented to the unusual, interesting or medically-challenging types of treatment. As a result, health care in the U. S. is notably weak in the area of preventive care and routine medical treatment for commonplace illness. The commonplace sickness of today often becomes the catastrophic illness of tomorrow because of the lack of access to preventive and health maintenance services for millions of Americans. Because catastrophic insurance is aimed at the more "dramatic" and most expensive areas of medicine, such as open heart surgery and organ transplantation, an even greater disproportion of physicians will specialize in these areas because that is where the more money can be made.

The extension of catastrophic insurance contradicts the purposes of the health education legislation now before Congress and would undermine the efforts now under way to give emphasis to primary care and ambulatory services. The long time growth in the number of specialists and superspecialists in relation to the number of family and primary physicians has only recently been reversed. This new trend will not last long if catastrophic insurance is enacted.

Catastrophic insurance with a $3500 deductible would be of benefit to only five persons out of a hundred. Ninety-five percent of the population would receive no benefit from the program. Because catastrophic health insurance helps very few people, the cost of a catastrophic health insurance policy is very cheap -- about $3.50 a month for a single person and $8.80 per month for a family.

Catastrophic health insurance has had a trial run in the United States, and that experience demonstrates the high cost of such a program. When the end-stage renal disease program under Medicare became operational in July 1973, the Department of Health, Education and Welfare estimated the cost at $250 million for the first year. Actual costs were $1 billion in 1979.

Japan has instituted catastrophic insurance with unfortunate results. We certainly should not repeat its mistakes. In 1973, Japan instituted a catastrophic health insurance program to cover dependents of employees and others not covered by employer-employee benefit plans. Japan's health plan was a catastrophic insurance plan similar to what is proposed in this bill and other bills. It provided a ceiling of 30,000 yen a month or about $951 a year on co-payments.

As a result, the Japanese discovered that the number of high cost cases -- those costing more than $35] doubled in just two years, and the average charge for a high-cost illness case increased 21 percent.

Appended to this testimony (Appendix C) is a reprint of the article, "Japan's High Cost Illness Insurance Program, A Study of its First Three Years 1974-76," published in the March-April 1978 issue of Public Health Reports. We respectfully request that it be incorporated into the record as part of our testimony.

Mr. Chairman, the AFL-CIO has indicated its opposition to catastrophic insurance at some length in its testimony before this subcommittee on March 28, 1979 and we respectfully request that our complete testimony be included in the record of these hearings as Appendix D.

The sponsors of S. 1968 claim the bill would stimulate the development of more HMOs. The opposite is true. The bill would impede their development. There is nothing in the bill that would prevent an employer from offering a high-cost traditional insurance plan, an HMO and a low-cost indemnity plan as well. The low-cost plan with its rebates would have the most appeal to the young and healthy thereby resulting in adverse selection for the HMO. In most of the country HMOs are not available as an option.

Catastrophic insurance would inhibit the development of prepaid group practice plans which offer the greatest potential for containing health care costs, reversing the perverse incentives of the fee-for-service system and reducing hospitalization. As with Medicare, retrospective reimbursement would not allow Health Maintenance Organizations full reimbursement for the hospital days they save. It would not compensate HMOs one penny for the catastrophic illnesses they prevent. And, unless HMOs can utilize the funds saved from

reduced hospitalization and catastrophic illness for outpatient care, which accounts for about two-thirds of their total budget, HMOs probably could not survive.

The great majority of Americans would only have a choice of three traditional health insurance fee-for-service plans differing only in premiums, deductibles, coinsurance, limitations and exclusions. Under the fee-for-service system of paying doctors and the cost-plus method of paying hospitals, the basic provider costs of any traditional health insurance plan are the same. Basically, all traditional health insurance policies are the same product with different brand names and with different packaging: some simple, some fancy.

Most damaging to HMOs would be that catastrophic insurance, with its deductibles, would not pay for preventive care nor routine health maintenance office visits. HMOs are highly competitive because they are able to transfer the savings from lower hospital utilization and fewer catastrophic illnesses to outpatient care expenses.

Outpatient care is included in the HMO premium. Catastrophic insurance and other cheap health insurance policies with their deductibles transfer this cost to out-of-pocket payments by patients.

S. 1968 would not help the poor meet the high deductible of $3500 required before the catastrophic insurance stopped further loss. It would, therefore, help the rich more than families with less than average incomes.

S. 1968 would reduce taxes and premiums for health insurance only in the short run. These temporary savings would only be achieved, however, by transferring costs from taxes and premiums to direct out-of-pocket expenditures by consumers of health care services. Workers' total costs, which include taxes, premiums and out-of-pocket payments, would be increased because of the lack of first dollar coverage for physician outpatient services.

This would discourage preventive care, early diagnosis and treatment on an outpatient basis and result in more acute illness and more expensive hospitalization.

Catastrophic insurance to pay for high-cost technological care would underwrite these high costs and stimulate their expansion. Manpower and capital resources would be channelled into catastrophic illness and away from primary care. The long run cost implications of such a program are horrendous.

The root causes of inflation in this industry are cost-plus reimbursement of hospitals and the fee-for-service method of reimbursing physicians. Fee-for-service payments reward the physician for more expensive services and a greater volume of services. Why not reverse the incentive and pay physicians on the basis of capitation as HMOs do? Then physicians would be encouraged to prescribe the less expensive forms of treatment as, for example, home health care in lieu of hospitalization or outpatient surgery in lieu of in-patient surgery. Such capitation payments should cover not only the physician's own services but all services he or she orders as well as hospitalization, diagnostic tests, etc.

As a start, capitation should be an optional method of payment under Medicare, Medicaid and other federal programs. The AFL-CIO, therefore, supports the Medicare-Medicaid Amendment in H. R. 3990 which would permit capitation payment to HMOs for their over-65 members as a major step forward. More and more physicians are accepting capitation payments and some like it because it eliminates almost all paperwork.

The most effective way to achieve cost control is by enacting a comprehensive and universal national health insurance program such as the Health Care for All Americans Act. Even with comprehensive services, the top-to-bottom cost controls incorporated in this proposal would soon make the nation's health care bill lower than it would be without national health insurance.

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Canada has had a comprehensive and universal national health insurance program since 1970. A comparison of the percentages of the Gross National Product of the two countries spent on health care is illuminating.

Health Expenditures as a Percentage of the Gross National Product
Canada and the United States

	Canada	United States
1960	5.5	5.3
1965	6.0	6.2
1970	7.0	7.6
1971	7.3	7.8
1972	7.2	7.9
1973	6.9	7.9
1974	6.7	8.2
1975	7.1	8.6
1976	7.1	8.8
1977	7.2	9.0
1978	N.A.	9.1

Source: USA - HCFA - Office of Research, Demonstrations and Statistics
Canada - Health and Welfare, Health Economics and Statistics Division

It should be noted that Canada spent more, as a percent of its GNP, in 1960 than the United States. Beginning in about 1963, Canada has been spending less and after 1971 health expenditures declined in relation to its GNP. Canada spent slightly less in 1977 than it spent in 1971. In the United States, except for 1973 when the wage-price stabilization program was in effect, health expenditures have steadily risen in relation to the U.S. GNP.

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How the Canadians control costs is of interest. The provincial governments are the single and only source of payment for health services. The providers have to be paid and the provinces have to provide services for the population. Both the providers and the provinces need each other so the framework for negotiation is established. A prospective budget is negotiated for each hospital. There is almost no regulation. It is up to the hospitals to govern their internal affairs and allocate resources and operate efficiently in order to stay within their budget.

Likewise, the provincial governments negotiate a fee schedule with the provincial medical society. Doctors are generally allowed to bill their patients directly in which case the patient has to be reimbursed by the provincial authority. However, the great majority of doctors bill the authority directly as they receive payment more promptly. In such cases, the fee schedule has to be accepted in full payment for the service rendered.

Fee schedules alone do not control expenditures for physician services. Utilization control is also necessary. Canada accomplishes utilization control by making a physician profile for each physician. This is easy to do because every claim of every physician must go to the provincial authority. Where a physician profile indicates overutilization or abuse, the matter is taken up with the medical society. Since the errant physician is in effect robbing other doctors, the medical society is also interested in controlling abuse and peer pressure is exerted on the errant physicians to mend their ways. It is most unusual for a doctor to be expelled from the program. Canadians recognize that the key to controlling health care costs is to place restraints on reimbursement of doctors and hospitals -- not on consumers.

There is much rhetoric in this country about the inefficiency of government, government bureaucracy and the efficiency of private enterprise. Government health insurance in Canada operates about 4 times more efficiently than does private health insurance in the United States. The overhead cost of the Canadian national health insurance program is 3 percent of expenditures for benefits. In the United States, the overhead cost of private insurance was 11.7 percent in 1977. And the 11.7 percent does not include the extra administrative costs that the providers must incur. For example, physicians from Canada visiting in the United States are astounded to find 10 times as many employees in the business and accounting offices of American hospitals in comparison with Canadian hospitals of comparable size providing comparable services. No wonder! The Canadian hospital receives a periodic check, usually monthly, from the provincial authority. There is little or no billing of patients after they are discharged, no dunning letters and no bad debts. And, detailed regulations, therefore, are almost nonexistent.

Hospitals in Canada are concerned only with the needs of the patient.

Mr. Chairman, 85 percent of the Canadian people approve of their national health insurance program. It is by far the most popular Canadian social program.

Unfortunately, we do not have such a program before this subcommittee at this time. Instead, we have a bill that would:

1. Tax working people.
2. Help the rich more than the poor.
3. Increase health care costs.
4. Undermine efforts to organize more efficient health care delivery systems.

If S. 1968 is enacted, health care resources will be focused even more than in the past on the curative treatment type of medical care. Its approach would encourage the costly growth of highly technical and extremely costly hospital oriented treatment. It is impossible to control the costs of an industry that can determine the need for its services and set prices. The attempt in this bill to enlist consumers to police the monopolistic powers of the providers avoids coming to grips with the key problem, that of securing a handle on provider reimbursement.

Ordinarily, the AFL-CIO tries to suggest ways of improving proposed legislation. But we find S. 1968 to be conceptually wrong. No amount of tinkering will make it acceptable to us. We will strongly oppose catastrophic insurance or any variation of it whether it stands alone or in combination with this bill. We will continue to support the only approach which will make good health care available to all Americans at an affordable cost -- universal and comprehensive national health insurance.

Appendix A

Monthly Premium for Federal Employees for a Family,

Copayments & Doctor/Office Visits Per Beneficiary

for

Fifteen Prepaid Group Practice Plans

State	Prepaid Group Practice Prepayment Plan	Monthly Premium 1980	Copayment for Doctor/Office Visit (1979)	Doctor/Office Visits Per Member (1978)
California	Family Health Program	$111.54	None	4.2
	Kaiser-N. Calif (S.F.)	99.26	$1.00	3.6
	Kaiser-S. Calif (L.A.)	120.73	None	3.3
	Ross-Loss Medical Group (L.A.)	138.49	None	3.2
Colorado	Kaiser-Denver	115.64	$2.00	2.1
District of Columbia	Group Health Association	145.95	None	3.7
Illinois	Michael Reese Health Plan	140.12	None	2.8
Massachusetts	Harvard Community Health Plan	136.85	$1.00/day	2.1
Michigan	Metro Health Plan	141.46	$3.00	2.7
Minnesota	Group Health Plan	104.59	None	2.1
New York	Community Health Plan of Greater New York	110.58	None	3.9
Ohio	Kaiser-Cleveland	126.25	None	2.8
Oregon	Kaiser-Portland	101.75	$1.00	3.1
Rhode Island	Rhode Island Group Health Assoc.(Providence)	117 11	None	2.5
Washington	Group Health of Puget Sound	111.37	None	3.3

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Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish

MILTON I. ROEMER, M.D., CARL E. HOPKINS, PH.D., LOCKWOOD CARR, B.S., AND FOLINE CARTSIDE, M.A.

The California "copayment experiment" imposed a charge of $1 on certain Medicaid beneficiaries for the first two visits to a doctor and 50 cents for the first two drug prescriptions each month, effective January 1, 1972. Data on utilization rates were gathered for six months before this date and for 12 months after it. While other administrative requirements, like prior authorization of certain services, doubtless also played a part, it was found that, following the start of copayment, utilization of ambulatory doctor's office visits and other services associated with them showed a decline, relative to that of the non-copayment cohort. After a brief lag, however, hospitalization rates in the copay cohort rose to levels higher than those of the non-copayment cohort—more than offsetting the savings to the state from the reduction of ambulatory service use rates. Due presumably to the neglect of early medical care because of the inhibiting effect of the copayments, these higher use rates of costly hospitalizations suggest that financial deterrents on access to ambulatory service by poor people are penny-wise and pound-foolish, not to mention their effects on health and well-being.

Note: The following paper was prepared and submitted before the publication of "California's Medi-Cal Copayment Experiment" by Earl W. Brian and Stephen F. Gibbens as a special Supplement to the December 1974 issue of this journal. Although examining the same medical care program, our study is based on a cohort analysis over time—before and after the imposition of copayment requirements—and applies statistical techniques which adjust for the critical differences in "test" and "control" populations, not done in the previous report. Moreover, it examines hospitalization experience not only because of its costliness but especially because of its value as a reflection of the long-term effects of the demonstrated reduction in ambulatory services. As a result, our conclusions on the ultimate consequences of copayment fees for ambulatory services in a low-income population are very different from those of Brian and Gibbens.

ONE OF THE persistent subjects of debate in planning health insurance or other financial support programs for medical care is the effect of copayment or deductible requirements. Applied in many programs, both private and governmental, the general assumption has been that these cost-sharing charges would inhibit "unnecessary" or "frivolous" demands for medical care, and therefore reduce the burden on the fiscal source and available health manpower.[1]

Copayment as a Deterrent to Use of Medical Care

Much research has been done on the question of copayment as deterrent, with conflicting findings. Obviously the effects of cost-sharing on utilization or demand depend on the amount of money involved—either in fixed dollars or percentage of charges, on the income level of the insured, on whether the copayment applies to a service ordered by the doctor (like hospitalization) or to one initiated by the patient (like an ambulatory visit), and on other factors. The weight of evidence seems to

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suggest that for services decided upon by the doctor, if the cost-sharing requirement is small, the effects are transitory or virtually nil.[5] For patient-initiated services, on the other hand, the inhibiting effect of copayments on utilization may be substantial, but especially so for lower income families.[1]

A depressing effect of copayments on consumer demand obviously reduces medical care expenditures in the short run, even if one counts both personal outlays and payments from a social (insurance or revenue-derived) fund. For the social fund, moreover, the saving results from two mechanisms: 1) the reduction in numbers of medical claims, and 2) the nonpayment by the fund of the copayment amount itself. These fiscal effects, however, tell us nothing about the medical or health consequences of the copayments. It certainly cannot be inferred that a patient's failure to see or delay in seeing a doctor for a symptom means that the ambulatory visit was unnecessary or frivolous. It means only that the copayment obligation effectively inhibited the procurement of care, whether it was medically advisable or not. A recent review paper by researchers from the Rand Corporation, for example, draws the conclusion that copayments reduce ambulatory care demand, thereby saving health insurance funds; it does not consider, however, the possible effects on health.[6] Nor does it consider the later demands for care that these health effects might generate, perhaps more than offsetting any initial savings.

An investigation of the so-called "California Copayment Experiment" (hereafter called COPE) which operated under the Medicaid program from January 1972 until July 1973 provided us with an opportunity to probe this question—that is, the longer term effects on health and costs of a small copayment obligation imposed on Medicaid beneficiaries as a condition for visiting a doctor and for having a prescription filled. Examining the experience of the California COPE program before its start and for 12 months after permitted some inferences on both these matters.

The California "Experiment" and Its Assessment

In brief, the California State Department of Health Care Services imposed a copayment charge of $1 on certain Medicaid beneficiaries for the first two visits to a doctor each month after January 1, 1972. The doctor or his assistant was expected to collect the dollar and, whether he did or not, the State deducted one dollar from the fee payable under the program. Similarly, a 50 cent copayment was imposed for the first two drug prescriptions each month, this amount to be collected by the pharmacist. A survey of providers showed that over 80 per cent of the doctors and 90 per cent of the pharmacists did, in fact, collect the COPE charges.

Under the original Medicaid law (which barred states from imposing any payment obligations on the indigent beneficiary for statutorily required medical services), this California measure could be approved by the federal Department of Health, Education, and Welfare, only if it was considered an "experiment." Our research group at UCLA, which was called upon by the federal Department to evaluate the results, was not involved in the experimental design. Had we been, we would have much preferred to establish two randomly chosen or matched populations of Medicaid beneficiaries, one of which was required to copay while the other was not. Instead, the State—perhaps in the interests of compassion—decided to impose the copayment obligation only on those Medicaid beneficiaries who had some additional financial resources outside their statutory cash benefits, while not imposing it on the rest of the eligible persons.

Thus the two populations, with respect to "copay" or "no-pay" status, were not

basically alike. The copay group, constituting families with some resources, tended to be a decidely older-age population. Even though our evaluative study was confined to AFDC (Aid to Families with Dependent Children) beneficiaries, the children in the copay families tended to be older. Moreover, the very existence of some extra resources in these families meant that their standard of living and perhaps other cultural characteristics were likely to differ from those in the more impoverished no-pay AFDC population. These differing sociodemographic characteristics would inevitably influence tendencies to seek medical care and meant, unfortunately, that our evaluative research could not be based on a simple comparison of the trend lines of the medical care demand rates of the two populations.

Instead, it was necessary to establish two cohorts of copay and no pay populations, to follow their demand rates for a reasonable length of time both *before* and *after* the imposition of the copayment charge, and then to compare not the absolute rates but the *relative* levels of utilization of various types of medical care by the two populations. This could be achieved by establishing a base period, prior to copayment, at which the actual utilization rates of the two populations were converted to a common *index* figure of 100. Then one could follow the trend lines for the indices of the two cohorts to determine whether, after the imposition of copayment in one cohort, a difference was observable in the demand or utilization trends followed by each.

Since California is a large state, and our research funds were limited, we could not examine the total experience of the State's over 2,000,000 Medicaid beneficiaries. We chose instead the AFDC universe within three counties (San Francisco, Tulare, and Ventura) believed to be fairly representative of the State as a whole, both in urban-rural distribution and in ethnic or racial composition of Medicaid persons.* In these three counties, the copay cohort population throughout the observations numbered 10,687 and the no-pay cohort numbered 29,975, or a ratio of roughly 1:3. This ratio was also characteristic of the Medicaid population in the State as a whole.

TABLE 1. Service Data Collection Quarters

Quarter	Time-Period	Status
1	July-September 1971	Before copayment
2	October-December 1971	Before copayment
3	January-March 1972	Copayment started (Jan. 1)
4	April-June 1972	Copayment in effect
5	July-September 1972	Copayment in effect
6	October-December 1972	Copayment in effect

To establish the basis for these two trend lines, as noted above, a time span was studied beginning six months before the copayment charge was imposed and ending 12 months after. Computerized data were examined for medical and related claims paid for services actually rendered during six quarterly (three-month) periods over this 18-month span. The exact quarters for which service data (from paid claims data tapes) were collected are shown in Table 1.

Findings

In Table 2 are presented the actual rates of doctor's office visits per 100 eligible AFDC Medicaid beneficiaries over the 18-month study period. Also presented in this table are the same rates, adjusted to an index figure of 100 for the first quarter, as

* Origionally, information had been obtained on seven counties, but examination showed so many serious gaps and problems in the claims and eligibility data in four of the counties that we felt compelled to reduce the sample to three counties, in these, the data were satisfactory for analysis.

TABLE 2. Doctor's Office Visit Rates for AFDC Families, by Copayment Status in California Medicaid Program, July 1971-December 1972: Number per 100 Eligibles per Quarter-Year, and Indices of Rates Based on Quarter 1 = 100

Quarter	Doctor's Office Visits per 100 Eligibles		Index of Office Visit Rates (Quarter 1 = 100)	
	No-pay	Copay	No-pay	Copay
1	79.54	75.47	100	100
2	66.79	59.98	84	79
Copayment Started				
3	79.09	69.13	99	92
4	71.24	64.77	90	86
5	67.46	59.55	85	79
6	73.18	66.31	92	88

Note: Illustrated graphically in Figure 1.

explained above. Graphic presentation of the index figures from Table 2 appear in Figure 1.

Interpretation of this table (and subsequent tables and figures) requires further explanation about the course of events in California's Medicaid program over this 18-month period. In October 1971, at the start of Quarter 2, a number of administrative changes were introduced in the program; most important among these was a requirement of prior authorization from a State

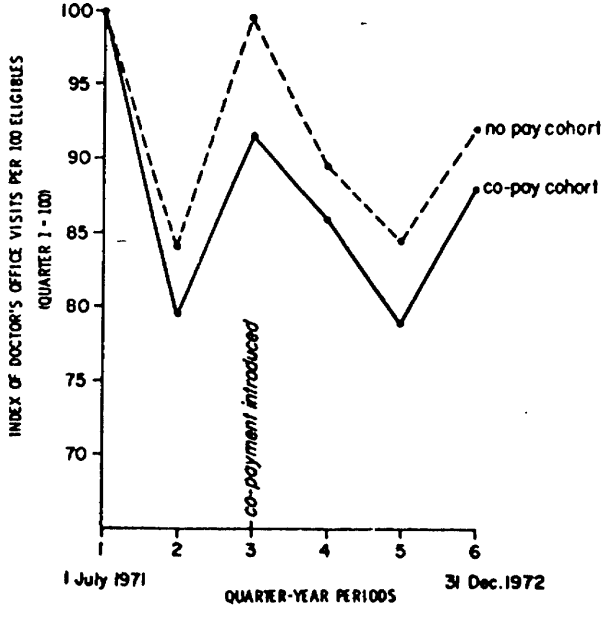

FIG. 1. Doctor's office visit rates for AFDC families, by copayment status in California Medicaid program, July 1971-December 1972; indices of rates based on Quarter 1 = 100.

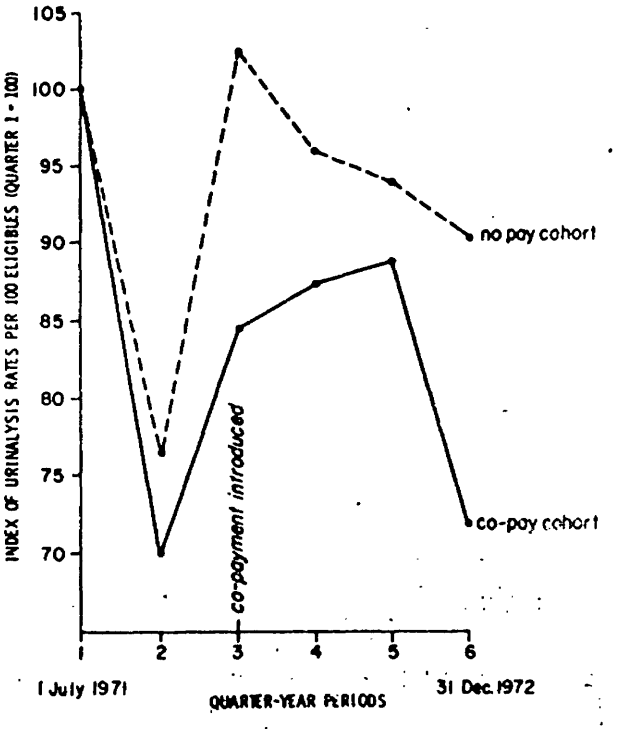

FIG. 2. Urinalysis rates for AFDC families, by copayment status in California Medicaid program, July 1971 – December 1972: indices of rates based on Quarter 1 = 100.

Medicaid Consultant for more than two ambulatory services or more than two prescriptions in any month. It is evident that this requirement was associated with a sharp decline in utilization rates of *both* the no-pay and copay cohorts for Quarter 2, even before copayment was introduced.[†] Prior authorization for ambulatory services beyond two per month, for nonemergency hospital admissions,† and for certain other services was a continuous requirement for both cohorts throughout the remainder of these observations. It is not possible to disentangle the inhibitory effect of this requirement from the copayment obligation in the copay cohort, but its substantial effect may be estimated from the trend line for the no-pay cohort. Probably seasonality also had some effect on both trend curves—for example, the rise in doctor's office visits and drug prescriptions in the sixth quarter for both groups was very likely associated with fall-winter (October-December) respiratory disease.

Keeping in mind the combined effect of the prior authorization requirement, as well as the different sociodemographic composition of the two cohorts, it would appear from these data that the prior authorization requirement, after its introduction at the

† This restriction had, in fact, been operative since April 1968. Such prior authorizations, of course, have been used to restrict medical care use in welfare program for centuries.

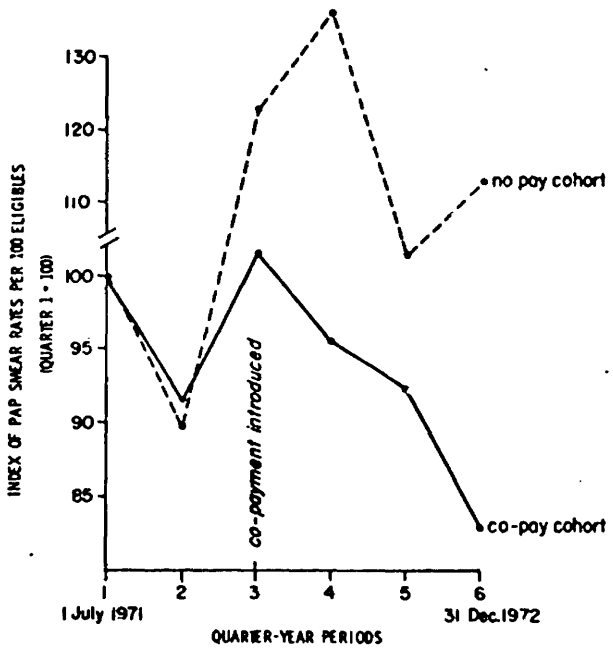

FIG. 3. Pap smear rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

start of Quarter 2, led to a sharp reduction in the rate of ambulatory doctor visits. Then for subsequent quarters, while seasonality and disease incidence associated with it may have been exerting an influence, the copay cohort had a rate of doctor's office visits—relative to the base period for the index—substantially below that of the no-pay cohort throughout the study span. There would seem to be little doubt that this differential was due to the copayment requirement.

Continuing, for the sake of simplicity, with the data simply in graphic form, we can consider a common diagnostic laboratory test, urinalysis, in Figure 2, and a common preventive screening test, the Pap smear, in Figure 3. By both of these trend lines, it is apparent that the copay cohort had substantially lower utilization indices than the no-pay cohort. In Figure 4, the use of prescription drugs, with a 50-cent copay requirement, shows similar relationships. All three of these types of service were associated with ambulatory doctor's visits, for which copayments were usually required.

Table 3, however, presents data for the two cohorts, with an important distinction. It applies to the hospital patients, and—while showing rates and indices separately for both cohorts—no actual copayment was required from either population, and the decision on hospitalization was made by the doctor.** The same data are shown in graphic form in Figure 5. The data in Table

** Our data are based on an unduplicated count of hospital *patients*, rather than admissions, which may have amounted to more than one for some patients.

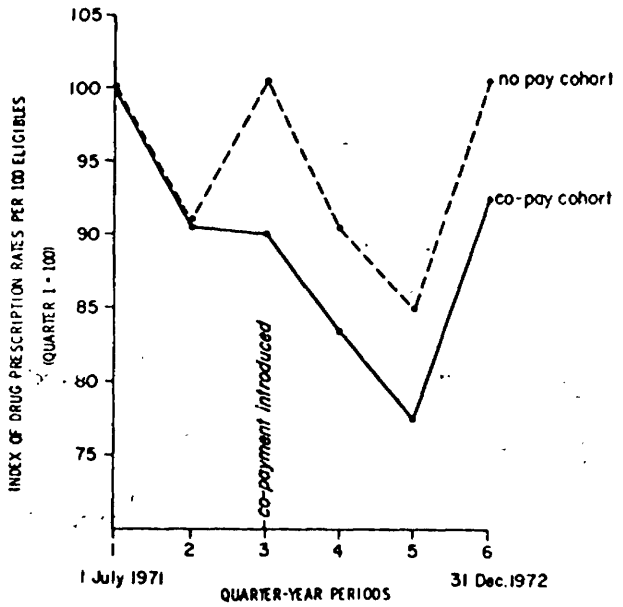

FIG. 4. Drug prescription rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

3 and Figure 5, in sharp contrast to trends in all previous tables, show that after introduction of copayment in January 1972 the index figures for the copay cohort leaped up to a *higher* level than those for the no-pay cohort. They remained at a higher level for three of the four copayment quarters. The drop in the final quarter may

TABLE 3. Hospital Patient Rates* for AFDC Families, by Copayment Status in California Medicaid Program, July 1971-December 1972: Number Hospitalized per 100 Eligibles per Quarter-Year, and Indices of Rates Based on Quarter 1 = 100

Quarter	Hospital Patients per 100 Eligibles		Index of Hospitalization Rates (Quarter 1 = 100)	
	No-pay	Copay	No-pay	Copay
1	3.56	2.54	100	100
2	3.07	2.09	86	82
Copayment Started				
3	3.12	2.37	88	93
4	2.88	2.14	81	84
5	3.05	2.29	86	90
6	2.70	1.71	76	67

* Data are based on an unduplicated count of hospital *patients* during a quarter year, rather than admissions, which may have been more than one for some patients.

Note: Illustrated graphically in Figure 5.

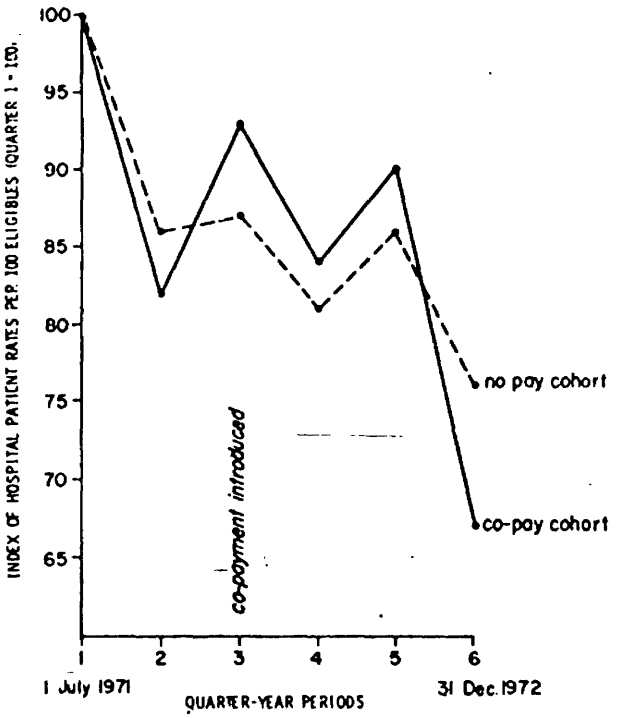

FIG. 5. Hospital patient rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

simply reflect the completion of hospitalizations in the previous three quarters for persons needing such care, as well as the usual overall drop in hospital use around the Christmas holiday season.

Figure 6 presents the hospitalization rates on another basis. It shows the trend of indices for all diagnoses except those related to pregnancy. The latter may be regarded as "nature-generated" and relatively independent of a doctor's judgment in modern American society. With these cases removed, it is apparent that the differentially higher indices of hospital use for the copay cohort are even greater in three out of the four copayment quarters than for the total of hospital patients shown in Figure 5.

Discussion

These findings suggest that the effects of copayment requirements for ambulatory services (and prescriptions) in a medical care program for low-income families were to exert a deterrent effect on demand or utilization. The inhibiting effect applied to office visits—the bedrock of general medical care—and also to typical diagnostic tests (urinalyses), to preventive procedures (Pap smears), and to drug prescriptions. Easy access to and use of general ambulatory doctors' services are widely considered to have preventive value, by permitting prompt diagnosis and treatment of an illness before it becomes more serious.

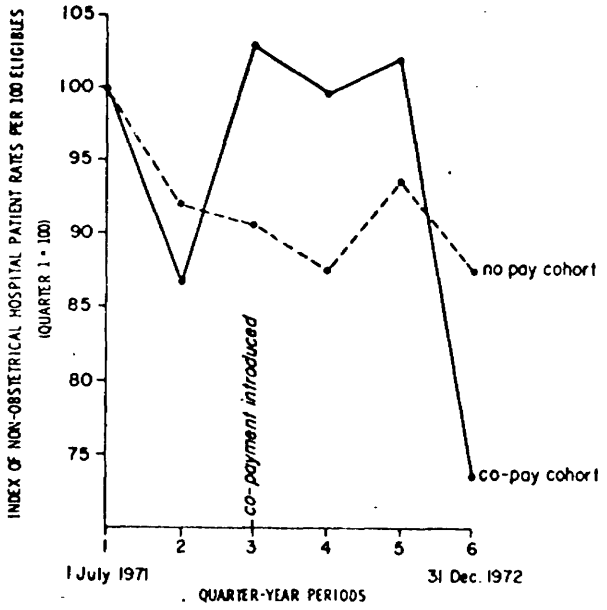

FIG. 6. Hospital patient rates for all non-obstetrical admissions in AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

When such ambulatory services are inhibited, it would seem that a price is paid—namely, a rise in the relative rate of hospitalization. It is likely that this elevated hospitalization rate is due to the postponement of ambulatory care, so that when the patient is finally driven to seek assistance, his case is more advanced and requires inpatient care. This interpretation is supported by the general observation in the U.S. National Health Survey of longer hospital stays among low-income persons, even for the same diagnosis, in the nation as a whole.[8] This is likewise associated with lesser rates of ambulatory doctor's care by the poor generally and is usually interpreted along the lines offered above.

A clear-cut reduction in diagnostic tests (urinalyses, Pap smears, and others) as well as ambulatory treatment (doctor visits and prescriptions)—as found in our study—could hardly be expected to benefit health status. This is quite aside from the pain and suffering involved for the low-income patient, who postpones seeking medical care at early stages of his illness.

These findings also have serious financial implications. Hospitalization is by far the costliest sector of medical care. A reduced rate of ambulatory care may yield short-term financial savings, but a subsequent increase in the rate of hospital use could more than outweigh these amounts.

To determine the net financial effect within the copayment cohort, we may estimate an expected cost to the State, based on the rate of office visits in the quarter preceding the initiation of copayment, which was on an annual basis 2,400 visits per 1,000 (much lower, incidentally, than the rate in the general population, and hardly justifying the State government's

assertion of "overutilization"). Multiplying this by the cost-per-visit of $8.79 in that quarter yields an "expected" cost of $21,096 per 1,000 eligibles. After copayment was initiated, the actual cost for the year was $21,008 or a theoretical net saving to the state of just $88 per 1,000.‡

Turning to the hospitalization experience, the "expected" expenditure would be based on the base-period rate of 83.6 patients per 1,000 per year at a cost of $623 per patient (the annual cost per patient in the copayment period) or a total of $52,082 per 1,000. Actually, the expenditure in the copayment period was $53,017 or a net excess of $935 per 1,000. (It should be noted that this excess was due entirely to the increased hospitalization rate; if one took account of actual inflation of hospital costs over the precopayment period, the difference would be much greater.) Substracting the estimated saving for ambulatory services of $88 per 1,000, the net excess cost to the state was $847 per 1,000 eligibles. Thus, for the approximately 1,450,000 AFDC beneficiaries in California, the overall *excess cost* to the State was $1,228,150. (It is noteworthy that California discontinued the entire copayment procedure June 30, 1973, even though federal P.L. 92-603, effective January 1, 1973, officially permitted such copayment under certain circumstances.)

‡ In spite of the lower indices of office visit rates for the copay cohort, compared with the no-pay cohort (shown in Table 2 and Figure 1), it may be noted that the actual rate of visits of both cohorts (for epidemiological or other possible reasons) exceeded the precopayment rate during three out of the four copayment quarters. Thus, despite the $1 saving to the State for most visits, this explains the small differential in total expenditures.

In a word, it would appear from this study of the California Copayment Experiment with Medicaid beneficiaries that the State government's strategy was penny-wise and pound-foolish. Short-term savings for lower ambulatory care use were followed by definite increases in costly hospital use. It is of interest to note that this general course of events was predicted in a legal brief submitted in opposition to the copay program before it was instituted.[4] As the experience of many "health maintenance organizations" has repeatedly demonstrated, comprehensive medical care, without cost-sharing deterrents, is probably not only the best way to maintain a person's health, but is also most economical in the long run.[7]

References

1. Beck, R. G.: The effects of copayment on the poor. J. Human Resources, publication pending.

2. Brian, Earl W.: The Medi-Cal Reform law. California's Health, April 1972, p. 3.

3. ———. Government control of hospital utilization: a California experience. N. Engl. J. Med. 286:1340, 1972.

4. Butler, Patricia, *et al*: Attorneys for California Welfare Rights Organization. California's Copayment Waiver Proposal. Los Angeles, August 17, 1971.

5. Hall, Charles P., Jr.: Deductibles in health insurance: an evaluation. J. Risk Insurance 23:253, 1960.

6. Newhouse, Joseph P., Phelps, Charles E., and Schwartz, William B.: Policy options and the impact of national health insurance. N. Engl. J. Med. 290:1345, 1974.

7. Roemer, Milton I., and Shonick, William: HMO performance: the recent evidence. Health and Society, Summer 1973, p. 271.

8. U.S. National Center for Health Statistics: Medical Care, Health Status, and Family Income. Public Health Service, Washington, 1964.

Japan's High-Cost Illness Insurance Program
A Study of its First Three Years, 1974-76

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JAPAN RECENTLY INSTITUTED a new, specialized health insurance program in recognition of a need to relieve its citizens of the high costs of health care resulting from serious illness (Health Insurance Law, Japan, 1922 (22), revised 1938, 1958, Amendment 89, September 26, 1973) Japan therefore became one of the few countries in the industrial or postindustrial phase of development that have moved to alleviate this problem Thus, its experience is a valuable subject for study

Communicable diseases are no longer the major causes of high mortality and morbidity rates. In Japan today, cerebrovascular disease, cancer, heart disease, and other long-term chronic illnesses are the major causes of disease, disability, and death. These long-term illnesses require complex diagnostic and treatment modalities, potent drugs, specialized facilities, and the use of highly trained medical personnel. Since the introduction of new technologies for these illnesses, annual expenditures for medical care have increased rapidly.

In the past, health (sickness) insurance in Japan

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covered only a portion of the total charges for care. Recently, the majority of medical care costs have been paid by insurance funds derived from premiums, and the uncovered remainder came from out-of-pocket payment by the patient to the provider or institution.

The 1973 amendment to the Health Insurance Law made medical care benefits, *Kogaku Ryoyohi*, for high-cost illness available to nearly 70 percent of the population not previously covered adequately by their health insurance. Workers enrolled in the employer-employee health insurance plans and all persons age 70 and over already had comprehensive health insurance coverage. However, dependents of insured persons and all beneficiaries in the national health insurance plan (Kokuho) were required to pay 50 percent of all medical care charges out of pocket, with no stated maximum liability. When the new benefit was instituted, dependents were still required to pay the 50 percent co-insurance, but a maximum limit of out-of-pocket liability was stipulated by law (30,000 yen within a calendar month).

High-cost illness expenditures usually stem from illnesses that require in-hospital care. For example, if a patient were hospitalized and the total charges incurred within a calendar month were 150,000 yen ($526 if U.S. $1 = 285 yen), the following would occur: (*a*) the insurance initially would cover 105,000 yen or 70 percent of the charges, (*b*) the patient would have to pay 45,000 yen out of pocket, and (*c*) the patient would be reimbursed 15,000 yen after submitting a high-cost illness claim to the insurer because the maximum personal liability is 30,000 yen. Under the new catastrophic illness coverage, the total charges must exceed 100,000 yen ($350) in a calendar month before reimbursement can be claimed.

It was important to study this new program in Japan for two reasons. First, the early experience of the program could be used for future planning that could benefit Japan's providers, insurers, and consumers. Certain questions could be asked about the initial operational phases of the program. That is, have use patterns, case frequencies, and expenditures for care changed as a result of the institution of this new insurance benefit? If so, in what ways? And should the program be changed in any way or is it satisfactory to all parties? The early research effort may create more questions than answers. But the questions will be answered eventually, and the answers will help to improve the program. If sufficient

Table 1. Health insurance plans,[1] beneficiaries, and study population at risk, Japan

Plan and year established	Beneficiaries	Study population at risk[2]	Sampling ratio
Employer-employees' health insurance:			
1. Seikan Kempo, 1926	Employees of firms having 5–1,000 persons	14,412,000	1:20
2. Kumiai Kempo, 1926	Employees of firms having more than 1,000 persons	14,611,000	[3] 1:10, 1:15
3. Hiyatoi Kempo, 1953	Day laborers	282,000	1:2
4. Senin Hoken, 1940	Seamen	497,000	1:2
5. Kyosai Kumiai, 1962	National and local government employees; public corporation employees; private school teachers and staff	[4] 4,193	[4] All cases
National health insurance:			
6. Kokuho, 1938	Employees of firms having fewer than 5 persons; persons who are self-employed, retired, aged, and others not covered by employees' insurance	43,853,000	[3] 1:40, 1:50

[1] All plans were provided for under the Health Insurance Law of 1922 and as amended in recent years.

[2] Includes the number of dependents in plans 1–4 and all persons in plan 6 eligible for high-cost illness insurance benefit; excludes insured workers.

[3] Sampling ratios were changed to lower rates for 2 plans for second and third study years.

[4] Study population for plan 5 included only 1 segment of a single mutual-aid society; this subgroup represented 0.058 percent of the parent group which has a population of 7,181,000.

[5] All appropriate cases were included.

and timely information from a series of research projects is made available to planners and administrators for review and consideration, they should be able to make more objective decisions for future programing. Second, the experience in Japan may provide valuable information for the United States or any other nation contemplating the addition of a high-cost illness benefit to its social program (*1–3*).

Study Purpose

This study was made to examine the first 3 years' experience of *Kogaku Ryoyohi*, the high-cost illness benefit, and to determine:

- whether the addition of a new benefit changed access to care;
- whether different patterns of use occurred among the six major health insurance plans;
- whether expenditure and length of hospital stay changed significantly over a short time;
- the distribution of high-cost illnesses in different insurance plan populations at risk; and
- which illnesses, among 10 selected diagnostic categories, generated high-frequency use, high costs, and longer hospital stays.

The primary objective of the new insurance benefit in Japan was to lighten the financial burden of persons with high-cost illnesses. However, it is difficult to know in advance how much dormant, unmet need exists in a population. Under the new benefit, it was possible that numerous persons previously unknown to have high-cost illnesses would seek hospital care. Only educated guesses, based on bits of historical information, could be made as to the percentage of this population. Therefore, we attempted to obtain answers to at least some of the questions from the early experience of the new program.

Study Methods

The first step of the study was to locate agencies that had information about the populations at risk and use patterns of beneficiaries in each of the insurance plans. Next, visits were made to these agencies to determine the availability and accessibility of, as well as the feasibility of collecting, hospital case information, specifically by diagnosis, insurance plan, expenditure, length of stay, and year of service.

Information and assistance for the conduct of this study was provided by the following sources:

All Japan Federation of National Health Insurance Organization (Kokuho Chuokai)

National Federation of Health Insurance Societies (Kenporan)

Ministry of Health and Welfare (Koseisho): Bureau of Information and Statistics; Bureau of Health Insurance; and Bureau of Medical Affairs

The Institute of Public Health (Kokuritsu Koshu Eisei In): Department of Public Health Practice; Department of Public Health Demography; and Department of Public Health Statistics

The information acquired for the study consisted of summary frequency distributions only; neither age-specific nor sex-specific data were readily available in the appropriate cross tabulations from all 6 plans (table 1) by 10 selected diagnostic categories (table 2). The time and cost required to gain this additional information was beyond the scope of this

Table 2. Diagnostic categories selected for study of high-cost illness insurance, by subcategory and index No.[1]

Diagnostic category and subcategory	Index No.
Tuberculosis	
Respiratory tuberculosis	4
Other tuberculosis	5
Cancer:	
Malignant neoplasm of the stomach	21
Malignant neoplasm of the mammary glands	22, 23
Other malignant neoplasms	24
Mental illness:	
Psychosis, mental deficiency, neurosis, abnormal personality, other mental disease	32–34
Nervous system disease:	
Diseases of the nervous system	40
Hypertension:	
Hypertensive disease	43
Heart disease:	
Active rheumatic fever and chronic rheumatic heart disease	41, 42
Ischemic heart disease	44
Cerebrovascular disease:	
Cerebrovascular disease	45
Bronchitis:	
Bronchitis and pulmonary emphysema	52
Gastric and duodenal ulcer:	
Ulcer of the digestive system	58
Other gastric and colon disease	59
Accidents; poisoning; other:	
Trauma and fracture	84
Intracranial and organic injuries	85
Heat injury	86
Injuries by chemical substances	87
Other injuries or trauma	88

[1] From Eighth Revision, International Classification of Diseases Adapted for Use in Japan, 1963

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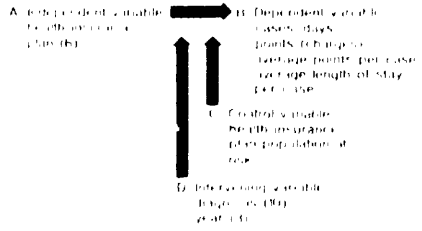
project. The information collected is characterized by the following variable sets:



Analysis

Initially, cross tabulations of cases, total charges, and total days were reviewed by insurance plan, diagnosis, and year of service for high-cost cases. In addition, crude (unadjusted) rates of average charges per case and average length of hospital stay were tabulated.

Differences in the means within and between plans were tested by analysis of variance methods for the following variable sets: (*a*) average charge per high-cost case by diagnosis for each study year separately (between insurance plan comparisons), (*b*) average length of hospital stay per high-cost case by diagnosis for each study year separately (between insurance plan comparisons), (*c*) average charge per high-cost case by diagnosis during 3 years (within insurance plan comparisons), and (*d*) average length of hospital stay per high-cost case by diagnosis during 3 years (within insurance plan comparisons).

Projected monthly and annual incidences of high-cost illness cases, by insurance plan and for the total population at risk, were estimated from a 1-month sample of cases from each of five plans. For the sixth plan, Kyosai Kumiai, the estimates were made by use of information from the Kumiai Kempo experience. Case frequencies and information available about the population at risk were considered in calculating the projected incidence. The monthly projections were far more reliable and valid than the annualized rates because they were derived from insurance agency samples for a single month. Annualizing these rates has its hazards, however, they were calculated to obtain at least a crude estimate of the annual incidence of high-cost illness in Japan. More refined methods should be developed by other researchers in Japan to improve the estimates for future planning.

The following real and potential statistical biases should be kept in mind in evaluating the findings of this study:

- Some insurance plans instituted the high-cost illness benefit from the beginning, while others phased this benefit in during 2 years. Information was collected about all cases of high-cost illness as previously defined, regardless of whether or not a particular plan offered the benefit, based on the criterion of expenditure (cases that had total monthly charges of more than 100,000 yen). The case frequencies may have been higher by insurance plan if all the beneficiaries had been entitled to the new benefit from the beginning of its availability.
- In this study, Kyosai Kumiai cases were represented by only one small group (0.058 percent) of public employees, who may not have been representative of their parent population at risk or may not have reflected the illness experience of Kyosai Kumiai as a whole. The data for this subgroup represent the total experience for each study year, not a sample as for the other five plans.
- The samples for the five plans were drawn during different months, four in April and May and one in September, of each year, the climate during these months is similar. Although the different sampling

months introduce potential seasonal variation, most of the diagnostic categories in the study represent chronic diseases rather than acute infectious ones that tend to be affected by season.

• Kumiai Kempo drew its sample in September, but in August 1976 the maximum liability had been raised from ¥30,000 to ¥39,000 yen (Ordinance 201 approved by the Diet, Tokyo, August 1, 1975). The sample was drawn as if the rate were still ¥30,000 yen, the cutoff for inclusion as high-cost cases. It is possible, but not likely, that persons who could afford ¥30,000 but not ¥39,000 yen might have deferred hospital care because of the additional 9,000 out-of-pocket yen now required. But it is more probable that Kumiai Kempo beneficiaries were not yet aware of the change in charges at that early time. Thus, they were expected to have sought hospital care as if the upper limit of out-of-pocket expenditures was still ¥30,000 yen.

• The data available from Kumiai Kempo for this study for 1976 were based on 91 percent of the edited and checked sample cases. The remaining 9 percent of the cases were being checked during the data collection period and were not included in the tabulations presented here. There is little reason to believe that inclusion of this 9 percent would have changed the findings significantly because the available data were consistent with the information collected about the beneficiaries of this plan for 1974 and 1975.

• The sampling rates differed between insurance plans and changed in two plans during the study period. Kumiai Kempo went from a 1:10 to a 1:15 sampling rate, and Kokuho changed its sampling rate from 1:10 to 1:50. There is always the potential of sampling error; however, the sampling frames and subsequent sample sizes appear to be of sufficient magnitude that the occurrence of sampling error was considered negligible.

• All case information was taken from a special study of selected single calendar months; therefore, the average length of stay could not exceed 31 days.

These potential biases were not expected to have a significant effect on the reported findings.

Findings

The high-cost illness insurance benefit was designed for dependents of insured persons covered by the five employer-employee insurance plans and all persons covered under Kokuho. The eligibility criteria for beneficiaries by insurance plan and the study population at risk are shown in table 1. The enrollee population in Hiyatoi Kempo and Kokuho plans had fewer children in the 0-14 age group and more elderly persons in the 70 and over group than in the other four insurance plans. These are two examples of differences by age groups between insurance plan populations at risk. The age distributions of the other four plans were similar. Unfortunately, age-specific information was not available on the case material used in this study. Therefore, all of the material presented consists of unadjusted frequency distributions and rates.

The frequency distributions of high-cost cases (more than 10,000 points or more than 100,000 yen; 1 point equals 10 yen) for each of the 6 health insurance plans, by year, were as follows:

Plan	1974	1975	1976
Seikan Kempo	1,042	2,029	2,417
Kumiai Kempo	1,665	2,108	2,218
Hiyatoi Kempo	401	749	768
Senin Hoken	581	788	897
Kyosai Kumiai	15	178	257
Kokuho	2,477	3,478	3,948
Total	6,097	9,330	10,475

Case frequencies increased annually for each of the six plans. As expected, the largest plan, Kokuho, had the most cases. Kyosai Kumiai had the fewest cases because information was available from only one mutual-aid society. The distributions were similar to the proportions they represented of the totals at risk.

A pattern by diagnostic categories for beneficiaries was seen in certain health insurance plans. Hiyatoi Kempo had higher proportions of patients with psychiatric illness, cerebrovascular disease, and heart disease; Senin Hoken, tuberculosis and nervous system disease; a Kyosai Kumiai subgroup, bronchitis and the accident-poisoning-trauma category; and Kokuho, gastric and duodenal ulcer. These were 2- and 3-year trends that require further investigation. The diagnoses for beneficiaries of Seikan Kempo and Kumiai Kempo did not show a noticeable pattern.

Psychiatric illness, cancer, and cerebrovascular disease accounted for approximately 50 percent of the high-cost illnesses. The remaining seven illnesses made up the other half of the cases. The increase in high-cost psychiatric illness demonstrated the most profound change between the first and second year of the program (1974, 12.9 percent and 1975, 25.9 percent of the high-cost cases). Psychiatric illness maintained its same position in 1976, accounting for 26 percent of the cases. No other diagnostic category showed this degree of change. The proportions of high-cost illness cases by diagnostic category and insurance plan varied somewhat, but the observed variation by year within each plan and across plans

can not be explained fully on the basis of available information.

Without exception, average charge (points) per high-cost illness case increased by year for all six plans, as shown in the following table:

Plan	Points[1] 1974	1975	1976
Seikan Kempo	15,772.7	16,552.4	18,749.5
Kumiai Kempo	15,648.6	16,391.1	19,154.4
Hiyatoi Kempo	14,464.8	15,308.2	16,981.4
Senin Hoken	15,569.8	15,785.0	18,604.4
Kyosai Kumiai	17,349.4	22,127.5	21,514.6
Kokuho	15,669.2	16,753.4	19,260.7
Overall average	15,657.0	16,532.6	18,949.5

[1] 1 point = 10 yen

Cancer patients consistently had the highest average charge per case (1974, 21,997.9 points; 1975, 25,725.6 points; and 1976, 30,060.3 points), followed by patients with gastric and duodenal ulcer and cerebrovascular disease. Patients with psychiatric illness had the lowest average charge per case (1974, 11,453.4 points; 1975, 12,476.0 points; and 1976, 13,980.3 points). These diagnostic categories demonstrate the extremes from the grand means (1974, 15,657.0 points; 1975, 16,532.6 points; and 1976, 18,949.5 points). The other diagnoses were spread within these extremes. The diagnostic-specific average charges are not presented in tabular form here; they are available from Broida.

The average length of hospital stay is shown in table 3 by diagnostic category. Patients with psychiatric illness had the longest average stay (1974, 30.2 days; 1975, 30.1 days; and 1976, 30.0 days), while cancer patients had the shortest stays (1974, 25.7 days; 1975, 24.8 days; and 1976, 23.2 days). These same trends were also found across insurance plans by diagnosis. The details documenting these overall cross trends are available, but not presented here. When the data from the preceding text table and table 3 are combined, certain factors emerge. Cancer patients had the highest average charge and at the same time the shortest hospital stays, whereas the opposite was true for persons with psychiatric illness. It must be assumed that cancer patients required the use of specialized personnel and high levels of surgery, medication, and other expensive management over a relatively short time. In contrast, psychiatric patients required lengthy stays and less intensive services. The patients in the other eight diagnostic categories required different combinations of these two factors.

Estimates of the incidence of high-cost (catastrophic) illness in the population are shown in table

Table 3. Average length of hospital stay (days) for high cost cases, by diagnostic category and year

Diagnostic category	1974	1975	1976
Tuberculosis	29.7	29.5	29.4
Cancer	25.7	24.8	23.2
Psychiatric illness	30.2	30.1	30.0
Nervous system disease	29.8	29.1	29.0
Hypertension	28.5	28.3	28.6
Heart disease	28.4	27.9	27.3
Cerebrovascular disease	28.5	28.1	27.8
Bronchitis	27.7	27.4	26.1
Gastric and duodenal ulcer	28.2	25.9	25.2
Accidents, poisoning, other trauma	26.1	26.1	25.0
Overall average	28.0	28.1	27.6

1. Annualized rates were projected from single month data derived from each insurance plan. Overall rates were calculated from a summary of the information from all plans. The estimated incidence for Japan (99.4 percent of the population is insured) was as follows: 1974, 2.17 percent; 1975, 3.39 percent; and 1976, 4.44 percent.

Finally, average monthly and annualized charges per case by study year were estimated in yen and converted to dollar equivalents based on the Japanese experience. If the dollar equivalent is based on the current exchange rate (October 25, 1977, U.S. $1 = 252 yen), the average annual charge per case from the 1976 experience would be equal to $8,594.90. It is interesting that these figures are similar to those projected by some researchers in the United States (*2, 3*). We recognize that both the estimated annualized incidence and charges per case are crude. However, they are provided as points of reference for future

Table 4. National estimates of the incidence (annualized) of high-cost illness cases in Japan, by health insurance plan and year,[1] in percentages

Insurance plan	1974	1975	1976
Seikan Kempo	1.74	3.38	4.02
Kumiai Kempo	1.35	2.60	2.73
Hiyatoi Kempo	3.41	6.34	6.49
Senin Hoken	1.84	3.81	4.33
Kyosai Kumiai	1.37	2.64	2.77
Kokuho	2.71	4.76	5.40
Overall average	2.17	3.39	4.44

[1] Population at risk as of March 1975 from "Health Insurance and Health Insurance Societies in Japan 1976," National Federation of Health Insurance Societies (Kemporan), Tokyo, 1976

research. In the next section we describe some implications and limitations of the findings from this study for public policy in the United States.

Comments

The findings of this study indicate that high-cost illness increased markedly in frequency and expenditure per case, regardless of diagnostic category, during the first 5 years of Japan's new insurance program. These increases probably can be attributed to a series of interacting factors:

- increased access to care because of the availability of the new insurance benefit,
- unmet need transformed into effective demand,
- physician and patient knowledge of maximum patient financial liability,
- increases in the intensity of services because of the availability of new and improved technology,
- two increases in the rates of reimbursement for physician care during the study period, and
- general inflation of medical care costs.

At the same time, there was little change in the average length of hospital stay per high-cost case. For persons with low-cost illness, however, there was a marked reduction in the number of cases, average charge per case, and average length of stay. The low-cost case frequency decreased by more than 50 percent during the 5 years, average charges were reduced 20 percent, and length of stay declined from 17.9 to 8.1 days (detailed data available from Broida).

It appears that a shift from low-cost to high-cost illnesses occurred at the cut point; that is, illnesses formerly classified as low cost subsequently incurred expenditures that were high enough to be classified as high cost. Some evidence to support this hypothesis was observed from documented information provided by Kemporan about the beneficiaries of Kumiai Kempo. The implication is that when a benefit was offered, patients and the medical care system (providers and institutions, for example) took advantage of the benefit. This is not to say that there was wrongdoing by any of the parties, but rather it indicates that when people become aware of a benefit their need turns into an effective demand. In addition, new technology and the introduction of expensive drugs also tended to increase costs and expenditures for medical care and thereby converted low-cost to high-cost illness.

In Japan, particularly since the offering of the new benefit, there was no incentive for the provider or the patient to reduce the intensity of services or the length of hospital stays. The reason for the lack of incentive was that, in the short run, neither party was at risk for the increased expenditures above the maximum liability level. However, the Government has been called upon to provide increasing subsidies to some health insurance plans, and this is causing concern for the future of the program. The only way to make up this deficit was to raise the insurance premiums or raise the maximum liability level, or a combination of both. At present, the combination of increasing both the premium and the maximum liability is being tried. This approach may not completely solve the problem, and it might reduce access to care for those persons in greatest financial need.

In the future, stronger forms of cost containment will be instituted in an attempt to control inflation and some of the other factors that affect the costs of the medical care. At the same time, it will also be necessary to assure adequate levels of access and quality of care, a balance that is difficult to sustain. Many of the same factors that had an impact on the increases in costs, and subsequently expenditures for care incurred by patients in this high-cost illness program in Japan, are currently being discussed as potential problems that could occur in the United States should "catastrophic illness insurance" become available to the U.S. population at large.

Reflections

What lessons can we learn from this experience in Japan? First, Japan has had a comprehensive, compulsory sickness insurance program in place for many years. Its history and development were complex, but it has been able to meet a societal need—"assure all of our people health and welfare" (*4*). The insurance was first developed for the working population in 1922 and later included dependents, but with lesser coverage than was offered to workers.

To reduce this inequity between insured persons and dependents, the out-of-pocket payment for dependents was reduced from 50 to 30 percent. Recently, dependents' coverage was expanded to include a high-cost illness insurance benefit with a monthly maximum liability level; that is, the 30 percent deductible remained in effect. However, when the cumulative deductible reaches a specified maximum, 100 percent of the additional expenditures are covered. The maximum liability level has been increased once since the institution of the benefit in 1973 and probably will be raised again soon (Legislative Proposal, Diet Session, Tokyo, spring 1977). The major reasons for these program changes are (*a*) more illnesses have been classified as high

cost and (*b*) the cost per case has exceeded the projected estimates for meeting the needs of a particular segment of the population.

The real situation was almost like that postulated by Roemer's law (5). Physicians, hospital beds, and funds for the payment of services were readily available, therefore, they were used. In this situation, the patients and providers expanded the utilization rates, costs, and expenditures to meet the criteria of the benefit. Without appropriate controls in the form of cost containment and without a built-in incentive system for both providers and consumers of care, the program will undoubtedly continue to be open ended. That is, rising utilization, costs, and financial deficits will become the rule rather than the exception.

It is difficult to anticipate the impact and effects of a new program. The task of changing an operating program is usually more difficult than the initial task of establishing it. Nevertheless, in a crisis situation all parties, regardless of their affiliations, are forced to come to terms with the problems and to make decisions for change. In most cases, they must make compromises and give up some rewards for the good of the majority. After all, the primary purpose of this particular program was to benefit a segment of the population inflicted with serious, expensive, and in many cases, terminal illness.

The Ministry of Health and Welfare of Japan, the Japanese Medical Association, and leaders in the health insurance field have developed this program as a joint venture. We are confident that they will continue to improve the program by reviewing their initial experiences and by instituting appropriate revisions. Planners and policy makers in the United States and other nations can learn from the positive, as well as the negative, experiences of this special program that has been available to a significant segment of the population in Japan since the fall of 1973.

References

1. Congressional Budget Office, Congress of the United States. Budget issue paper—catastrophic health insurance. U.S. Government Printing Office, Washington, D.C., January 1977.
2. Health Resources Administration. Financing of catastrophically expensive health care, Vol. I. Final report. Vol. 2. Appendices. Arthur D. Little, Inc., Cambridge, Mass. Report of a contract (No. HSM 110-71-197). Department of Health, Education, and Welfare, January 1975.
3. Falk, I. S. Proposal for national health insurance in the U.S.A.—origins and evolution, and some perceptions for the future. Milbank Mem. Fund Q. 55: 161-193, spring 1977.
4. Ohtani, F. One hundred years of health progress in Japan. International Medical Foundation of Japan, Tokyo, 1971, p. 114.
5. Roemer, M. Hospital utilization and the supply of physicians. JAMA 178: 989-993, Dec. 9, 1961.

SYNOPSIS

BROIDA, JOEL H. (National Center for Health Services Research, Hyattsville, Md.) and MAEDA, NOBUO. *Japan's high-cost illness insurance program: A study of its first three years, 1974–76. Public Health Reports, Vol. 93, March-April 1978, pp. 153–160.*

In October 1973, Japan's basic Health Insurance Law of 1922 was amended to provide catastrophic illness coverage for dependents of insured workers enrolled in the employer-employee insurance plans and for all persons under the so-called national health insurance plan. Before this time, dependents were required to pay 30 percent of physician, hospital, and related charges out of pocket. Now, although they are still required to pay 30 percent out of pocket, they have a maximum liability level of 30,000 yen ($120) during any calendar month. Health insurance covers 100 percent of the excess charges above the personal liability level.

From 1974 to 1976, the first 3 years of the high-cost (catastrophic) illness benefit, an increase of more than 70 percent occurred in the frequency of high-cost cases. This general trend was observed for all of the six major health insurance plans studied. The average expenditure per case increased 5.7 percent from 1974 to 1975 and 14.6 percent from 1975 to 1976, regardless of plan. However, there were marked differences by diagnosis. Although inflation explains part of these increases, the intensity of services certainly played a part. The average length of hospital stay for high-cost cases remained relatively stable, with an overall minimal decrease of 0.6 day—1974, 28.0 days; 1975, 28.1 days; and 1976, 27.6 days. Cancer patients had the highest average charge and the shortest hospital stays; whereas patients with psychiatric illness had the lowest average charge and the longest hospital stays. The authors recommend that micro studies be carried out that include other variables—such as age, sex, severity of illness, education, income, and occupation—for a better understanding of the unexplained variations.

National estimates of the incidence of high-cost illness cases were 2.17 percent in 1974, 3.39 percent in 1975, and 4.44 percent in 1976.

These preliminary findings should be of interest to health planners and administrators in Japan, as well as to those in the United States because of the pending proposals for catastrophic illness insurance.

Appendix D

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONTRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE HEALTH SUBCOMMITTEE,
SENATE FINANCE COMMITTEE ON
CATASTROPHIC HEALTH INSURANCE AND
MEDICAL ASSISTANCE REFORM LEGISLATION OF 1979 (S. 350, S. 351)

March 28, 1979

The AFL-CIO welcomes this opportunity to present its views with respect to S. 350 and S. 351.

We strongly oppose Title I in both bills which would establish a catastrophic health insurance plan.

However, we strongly support the concept behind Title III in the proposals which would establish federal standards for private health insurance plans. Title III, in our opinion, should be divorced from the catastrophic provisions and the minimum benefits specified provided without deductibles and coinsurance. We also strongly support Title II of S. 350, which is not a part of S. 351. We also believe that federalization of Medicaid should be separated from catastrophic insurance.

The AFL-CIO does have suggestions to improve both of these sections, but both should be temporary until such time as Congress enacts a comprehensive and universal health insurance program.

While still paying lip service to comprehensive national health insurance, the Administration's so-called Phase I, for all practical purposes, abandons the President's commitment to that goal.

Although the details of its provisions have not been spelled out, what has been released indicates the Administration's proposal will not be very different from S. 350. If this turns out to be the fact, this testimony would be applicable to the Administration's plan as well as to this bill.

Catastrophic Insurance (Title I of S. 350, S. 351)

Medical care costs continue to escalate at about twice the rate of all goods and services, as measured by the Consumer Price Index, and these costs are nearly doubling every five years. The impact of these rising costs on the federal budget is substantial - more than 40 percent of health expenditures now come from public funds. Federal payments for Medicare, Medicaid and other health programs total about $57 billion and will rise to $102 billion by 1983. The combination

of direct and indirect federal, state and local government payments to the health industry makes it one of the most heavily subsidized industries in the country - a $76 billion subsidy in 1978 alone.

We believe that catastrophic insurance would greatly accelerate the already unacceptably high inflation in health care costs. For the American people this means higher taxes, higher insurance premiums and higher out-of-pocket payments if catastrophic insurance is enacted. Indeed, medical care costs could easily double in three years, rather than the current five years, if this open-ended catastrophic proposal is enacted - and that, Mr. Chairman, would be the catastrophe of catastrophic insurance.

Catastrophic insurance would only perpetuate the factors most authorities consider responsible for the breakdown in the delivery of health services - that is, the lack of organization of the system, compounded by a distorted specialty and geographic distribution of health professionals, and an inadequate supply and inefficient use of trained personnel in certain allied health professions. There is virtually no teamwork among the many specialties and subspecialties in medicine, except in such organized settings as prepaid group practice plans. In most voluntary hospitals, there is little or no teamwork among attending physicians. This leads to medical care cost inflation, which catastrophic insurance would not correct.

Medical care in the United States is oriented to the unusual, interesting or medically-challenging types of treatment. As a result, health care in the U.S. is notably weak in the area of preventive care and routine medical treatment for commonplace illness. The commonplace sickness of today often becomes the catastrophic illness of tomorrow because of the lack of access to preventive and health maintenance services for millions of Americans. Because catastrophic insurance is aimed at the more "dramatic" and most expensive areas of medicine, such as open heart surgery and organ transplantation, it is logical to conclude that an even greater disproportion of physicians will specialize in these areas, because that is where the more money can be made.

Catastrophic insurance would undermine the efforts now under way to give emphasis to primary care and ambulatory services. The long-time growth in the number of specialists and superspecialists in relation to the number of family and primary physicians has only recently been reversed. This new trend will not last long if catastrophic insurance is enacted.

Most catastrophic illnesses are treated in hospitals, and the vast majority of the estimated $5 to $7 billion cost of a catastrophic program - which we believe would be a substantial underestimate by 1981 - would go to hospitals. This would distort the allocation of national health care resources to hospitals or other institutional treatment and take resources away from prevention, health maintenance, home care, outpatient surgicenters and hospices.

Many areas of the country are already plagued by an excess of hospital beds. By channelling billions more dollars into hospitals, catastrophic insurance would encourage hospitals to keep patients longer than necessary because it would only pay for longer hospital stays. Professional Standards Review Organizations (PSROs) cannot be relied upon to control utilization in the face of such strong financial incentives to the contrary.

Most medical care is good for people, but too much care can be harmful at worst or superfluous at best. We frankly believe that S. 350 and S. 351, would make it too financially attractive to some unscrupulous doctors and hospitals to provide hospital care surgery and laboratory work that is not needed. Since the only quality controls in these bills are the inadequate Medicare standards, both the taxpayers and the patients could be big losers.

Catastrophic insurance would underwrite the expansion and proliferation of high-cost medical technology. According to the Council on Wage and Price Stability, most of the increase in hospital cost inflation is due to the intensity of care - or, in other words, the use of more and more expensive diagnostic and therapeutic equipment While the use of this new technology does save lives, but the rampant proliferation of inappropriate use and the lack of any assessment of the diagnostic or therapeutic value of this technology versus risk greatly increases costs.

The efficiency and effectiveness of new medical technology is usually unknown before it is widely diffused into the medical care system. Machines often proliferate so quickly that there are not enough patients to make use of all the available capacity. This has been true of open heart surgery units, auto-analyzers, x-ray machines, patient monitors and CAT (computerized axial tomography) scanners. CAT scans are less painful and risky than the procedures they replaced, but the United States now has the capacity to do nearly three million scans a year while the procedures replaced never accounted for more than 400,000 a year. In fact, there are more CAT scanners in Massachusetts than in all of England, where the machine was first invented.

The reasons for the diffusion and overutilization of expensive technology are well known:

* Doctors have almost unrestricted controls over decisions to buy and use equipment. Doctors, not patients, are the customers of hospitals, because doctors fill the hospital beds with their patients.

* Patients are seldom told about the costs, risks and benefit of various therapies. They simply follow their doctor's instructions, because the doctor is the expert.

* Doctors have incentives for more intensive use of technology, because the equipment and medical technicians to operate it are provided to doctors rent free. After all, the patient or the insurance company or the government pays for the "rent" of the equipment. The use of hospital-based procedures are profitable for the doctor, because they do not have to make an investment in the equipment. As a result, medical education emphasizes technological, hospital-oriented specialties.

* Professional prestige and rewards are proportional to the intensity and specialization of the technology used by physicians. It is, without doubt, the most glamorous facet of the profession.

* Hospitals have similar incentives to buy and use this new technology. Hospitals attract and retain physicians by catering to their professional desires. A hospital's prestige is enhanced by having the best and newest equipment, which in turn attracts the better

doctors, who are a hospital's real customers. Again, third-party payers, including Medicare and Medicaid reimburse hospitals on a cost basis for the technology.

Title I of S. 350 and S. 351 would just pour billions of dollars into this extravagant and wasteful system without providing for better planning or more efficient utilization of this high-cost technology.

Mr. Chairman, catastrophic health insurance has had a trial run in the United States, and that experience demonstrates the high-cost factor of such a program. When the end-stage renal disease programs under Medicare became operational in July 1973, the Department of Health, Education and Welfare estimated the cost at $250 million for the first year and close to $1 billion annually by 1978. Actual costs are now over $1 billion and are expected to rise to $2.3 billion by 1982.

Why costs have increased is symptomatic of the problems associated with gearing programs to the more costly forms of care.

After the law passed, the proportion of patients on home dialysis -- which costs between $7,000 and $14,000 a year -- declined from 37 percent to 25 percent, while the percentage of patients treated in dialysis centers increased. Treatment in these centers costs about $25,000 a year. The number of dialysis centers has doubled between 1972 and 1977, and there are now more than 860 approved to receive Medicare funds and many are operated on a for-profit basis.

There is also evidence from other countries that a program like catastrophic insurance increases costs. Japan instituted a catastrophic health insurance program in 1973 to cover dependents of employees and others not covered by employer-employee benefit plans. Japan's health plan was a catastrophic insurance plan similar to what is proposed in these two bills. It reduced the copayment of such persons from 50 to 30 percent and provided a ceiling of 30,000 yen a month or about $1263 a year on such copayments. Prior to the 1973 law, there was no ceiling on copayments.

As a result, the Japanese discovered that the number of high-cost cases -- those costing more than $351-doubled in just two years, and the average charge for a high-cost illness case increased 21 percent. Moreover, a shift from low-cost to high-cost illnesses occurred at the

cut-off point of $351. Illnesses which previously had been classified as "low-cost" subsequently incurred expenditures that moved them into the "high-cost" category.

Appended to this testimony (Appendix A) is a reprint of the article, "Japan's High Cost Illness Insurance Program, A Study of its First Three Years, 1974-76", published in the March-April 1978 issue of Public Health Reports. We respectfully request that it be incorporated into the record as part of our testimony.

Catastrophic insurance would also inhibit the development of prepaid group practice plans which offer the greatest potential for containing health care costs, reversing the perverse incentives of the fee-for-service system and reducing hospitalization. As with Medicare, the retrospective reimbursement formulas in Title I would not allow Health Maintenance Organizations full reimbursement for the hospital days they save. It would not compensate HMOs one penny for the catastrophic illnesses they prevent. And unless HMOs can utilize the funds saved from reduced hospitalization and catastrophic illness in outpatient care, which accounts for about two-thirds of their total budget, HMOs probably cannot survive.

We fear that Title I would freeze into place the fragmented, inefficient fee-for-service system for all time, with continuing cost escalation the inevitable result. HMOs have the incentive to control cost because they are paid prospectively. They receive a fixed annual amount for comprehensive services and reimburse their doctors by capitation or by salary. HMOs, therefore, have an incentive to control unnecessary utilization and make more rational use of medical technology.

Catastrophic Insurance - Program for the Rich

Upper middle class and rich people are relatively unconcerned about small bills which they can readily meet out-of-pocket or through insurance. They do, however, desire protection against large medical bills. Middle class people often fear bankruptcy more than becoming ill.

As a matter of fact, for the period 1963-70, total medical expenses of the top one percent of the population increased 17.2 percent per year compared with 11.2 percent for the total population.

For the poor and many working people, unless catastrophic health insurance is built on top of a foundation of comprehensive national health insurance program, it would not pay for needed care until after they had incurred initial high expenditures they cannot afford.

The Medicare experience points up the need for a comprehensive insurance program as a base. Medicare does not provide benefits for preventive care, and, therefore, discourages early diagnosis and treatment because of its deductibles on physician services. Medicare, therefore, places emphasis on coverage for acute illness, rather than preventing sickness in the first place.

The Health Care for All Americans Act, soon to be introduced by Senator Edward Kennedy, will provide for physician and hospitalization without limit, and, therefore, includes catastrophic insurance as an integral part of a total health care program. We, therefore, wish to make it clear that we favor catastrophic protection for all Americans, part of a comprehensive program with a foundation of basic coverage which includes preventive and health maintenance benefits without financial deterrents. The statement by the AFL-CIO Executive Council on the "Health Care for All Americans Act of 1979" is also appended to our testimony (Appendix B).

In conclusion, catastrophic insurance standing alone is a program for the rich, hospitals and doctors. For the American people, it would be a catastrophe.

TITLE II (S. 350) -- Federalizing Medicare

The proposed federalization of the Medicaid program would provide comprehensive benefits for the very poor (i.e., coverage for a family of four with an income of $5400 or less), but such benefits would be subject to a copayment of $3 for patient initiated doctor visits up to a maximum of $30.

Experience proves that a $3 charge for the first patient-

initiated visit would deter necessary utilization of health care services and would not discourage unnecessary utilization. The state of California received permission from the Department of Health, Education and Welfare to conduct an experimental study to evaluate the effect on Medicaid beneficiaries of a $1 copayment for the first two visits to a doctor and fifty cents for the first two drug prescriptions each month. A matched sample of Medicaid beneficiaries received their care without any copayments as a control group.

The study showed that following the start of copayment, utilization of ambulatory visits to doctors' office and other outpatient services went down for the copayment group as compared with the control group. However, hospitalization rates for the copayment group rose faster than for the group with no copayment. The study concluded that because of the modest $1 copayment, early medical care was deferred; and due to the neglect of early medical care, usage rates of more costly hospitalization increased. The increased cost of hospitalization for the copayment group studied more than offset the saving to the state of reduced utilization of physician services.

Mr. Chairman, we ask that this study "Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish," be incorporated into the record as Appendix C.

We would also like to cite the experience of the Province of Saskatchewan, Canada. The Canadian national health insurance program forbids deductibles, but does allow copayments. In order to "save" money, the Province instituted a $1.50 copayment for doctors' visits, which resulted in an overall reduction in outpatient services to the poor of 18 percent. At the same time, services to the non-poor increased. There was also an increase in the number of physical examinations provided by the doctors for the non-poor population.

Dr. R. A. Armstrong, Director General for the Canadian health insurance plan, commented on the copayment experience:

". . . while these lower income people were hit

> with utilization decreases, after the first year there was an increase in utilization by young single males and females. In other words, the doctors were not going to sit twiddling their thumbs, particularly when they only got paid if they worked. Presumably, these younger people found it easier to get an appointment when they weren't competing with the elderly or with the lower income people."

Saskatchewan dropped the copayment provision in 1973. The important point is that copayments did not even result in a reduction in the utilization of physician services, because doctors determined the demand for their services.

As written, Title II of S. 350 would provide virtually no protection for the working poor. Working poor families can be defined as those with an annual income of less than $10,000. According to 1977 data, there are a total of 15.7 million or 27.5 percent of all families with incomes of less than $10,000. Of this, about five million families would be eligible for Medicaid. This means that about 10 million poor working families would have incomes too high to be eligible for Medicaid, but would not earn enough to meet the out-of-pocket expense of the $2000 medical deductible or the 60-day hospital deductible under catastrophic insurance. They would also be too poor to afford a basic insurance policy to cover these deductibles.

It should be emphasized that the first $2000 of medical expenses and the first 60 days of hospitalization plus other health expenditures constitute over 99 percent of total expenses for personal health services. A reasonably comprehensive private insurance policy to cover these deductibles would cost more than $1300 a year.

The spend-down provision of Title II would not, therefore, help the working poor except in exceptional cases.

Spend-down for a Family of Four
at
Various Income Levels To
Meet Eligibility Requirements for Medicaid

Income	Under S. 350 Income Ceiling for Medicaid	Spend-down Required
$10,000	$5,400	$4,600
9,000	5,400	3,600
8,000	5,400	2,600
7,000	5,400	1,600

For low-income working families, the spend-down required for Medicaid eligibility would, in itself, be catastrophic. The cost of an adequate health insurance policy would be beyond their means.

There is also a notch effect. A family of four with an income of $5300 that receives a $200 raise in wages would become ineligible for Medicaid. Such a family is worse off because the potential value of Medicaid exceeds the $200 raise.

The cost of applying varying means tests for families of different sizes, plus adding and removing beneficiaries as their income moves up or down, would be a substantial percentage of benefit payouts. The cost of administering the spend-down provision of S. 350 would also be very high.

Moreover, catastrophic insurance with its emphasis on high cost hospital care, plus the incentives to hospitals to purchase expensive equipment whether needed or not, would raise the cost of medical care for everybody. It would affect the poor most adversely.

Title III (S. 350 and S. 351) -- Private Basic Health Insurance Protection

Certification of health insurance companies by government authority is a concept whose time has come.

The AFL-CIO does not believe that the health of the American people is a legitimate area for exploitation by unscrupulous profiteers from either the providers of care or financial interests. Minimum standards that third parties must meet in order to be qualified by the Secretary of HEW would be a major advance in the public interest. However, we are concerned about the adequacy of the standards.

The standards would allow a deductible of $100 for hospital care and coinsurance payments of 20 percent. They would also allow a deductible of $50 for insurance against the cost of medical expense and 20 percent coinsurance. Copayments deter patients from contacting their doctors early to maintain their health and avoid acute illness. Deductibles, in particular, are a serious barrier to early diagnosis and treatment. As a result, they increase total health care costs.

Mr. Chairman, what is conspicuously absent from both bills is a rudimentary understanding of the basic economics of the health care industry. The laws of supply and demand are skewed beyond recognition in this industry.

Doctors -- not patients -- control the demand for medical services.

It is the doctor who decides whether a patient goes to a hospital or receives much less expensive treatment on an outpatient basis.

It is the doctor who decides when a patient can be transferred to an extended care facility. It is the doctor who decides when the patient can be discharged from a hospital or nursing home.

It is the doctor who decides how often the patient should come to the office for treatment and the number of hospital visits that need to be made by the doctor.

It is the doctor who decides what laboratory tests or diagnostic procedures need to be performed.

It is the doctor who prescribes drugs, either by brand name or less costly but equally effective generic equivalents.

It is the patient's physician who leaves instructions with the house staff or the nurse.

Patients know this. When patients go to a physician with symptoms -- perhaps for a physical examination -- they place themselves under the doctor's direction.

It should be clear, then, if any progress is to be made in controlling health care costs in the public interest, fiscal controls must be placed on the physician and not the patient.

In other words, doctors not only supply the services, but actually create 70 percent of the demand for health services -- including their own services.

Another misconception on which these bills are based is that health insurance follows the principles of casualty insurance. Effective and efficient health services cannot be compared with casualty insurance principles of insuring against low frequency but potentially catastrophic expenses beyond the control of the insured.

S. 350 and S. 351 are an attempt to make health care fit into the principles of insurance, rather than adapting financing to the realities of the health care industry. The result is a massive misallocation of resources to acute illness and relatively few resources for prevention and health maintenance.

One analogy would be if a person never bothered to put oil into the engine or water into the radiator of his or her car, but simply drove the car until it broke down. In this case the person would pay a large repair bill which could have been prevented by the cost of a few quarts of oil.

Health insurance -- as presently constructed -- can never pay for preventive care, because seeking preventive care is under the control of the insured and a violation of insurance principles. Yet, preventive care is less costly than acute care -- as prepaid group practice plans have repeatedly demonstrated.

The copayment provisions of the minimum benefit package of benefits an insurance company must provide for certification under Title III would, therefore, increase total health care costs, because it ignores preventive care.

The minimum benefit package outlined in Title III would not cover drugs, home health services, extended care, intermediate care services, mental health services, prenatal and well-baby care, family planning or early and periodic screening, diagnosis and treatment of children. Each of which benefits has proven cost effective over concentrating on acute care.

The standards of certification under Section 1504 do not include any requirement that insurance policies be community-related. The result would be substantial competition between insurers for low-risk groups, and a competitive waste of marketing dollars.

The bills permit states to establish statewide health insurance facilitation programs, one function would be to encourage and facilitate the marketing of certified private insurance policies. We must, therefore, conclude the primary purpose of Title III is the promotion of private health insurance, which we believe is an improper role for government at any level. Lastly, all employers should be required to purchase a certified policy because many small employers would not even be able to afford the minimal benefit package stipulated in this Title.

Conclusion

Title I of S. 350 and S. 351 would cover less than one percent of total expenditures for personal health services. It would accelerate the inflation in health care costs by channeling more dollars into intensive high-cost care, rather than financing prevention and health maintenance to avoid catastrophic illness.

Federalizing Medicaid as provided by Title II of S. 350 would be a major advance, but the $3 copayment for the first patient-initiated visit should be eliminated.

Certification of insurance policies as provided by Title III, and establishment of federal standards for such certification is also a step forward, but the standards should include a requirement of community rating, and copayments should not be allowed if a policy is to be certified.

The AFL-CIO would support Title II and III, as amended along the lines we have suggested, and if they are totally divorced from Title I.

# # # #

Senator DURENBERGER. We will alter the agenda a little to accommodate some witnesses who must leave for the airport. We will hear the panel consisting of Dr. Gary Appel, president of the Council of Community Hospitals; Dr. Richard J. Frey, immediate task chairman of the board of trustees, Minnesota Medical Association, and Paul L. Parker, executive vice president and chief administrative officer, General Mills, Inc.

Gentlemen, you may divide your time in any manner you see fit. You may insert your full statement in the record and summarize it.

STATEMENT OF PAUL L. PARKER, EXECUTIVE VICE PRESIDENT AND CHIEF ADMINISTRATIVE OFFICER, GENERAL MILLS, INC.

Mr. PARKER. Thank you, Mr. Chairman.

My name is Paul Parker. I am executive vice president of General Mills which is a large diversified food company located in Minneapolis. We are engaged in five basic business areas and worldwide have some 65,000 employees. Today I will simply comment about our General Mills' experience with competitive health plans for employees working in our headquarters city of Minneapolis.

We are talking about 3,000 salaried individuals. The thrust of my comments based on our experience is that in health care as in so much else in life competition is both useful and important in helping to provide the best of a product or service to the customer.

We hope our experience might be of use and value to others in the corporate world throughout the Nation. We think the Twin Cities does have an unique background in group health competition but that does not mean our experience is not transferrable.

HMO membership in the Twin Cities increased almost 30 percent in 1979 over 1978 and the number of HMO members has increased from 246,000 to 319,000 people. This is about 16.5 percent of our total seven county metropolitan area.

These developments have not taken place behind closed doors and in our community it is almost as common to hear a message or advertisement extolling the virtues of a particular health plan as it is to see or hear or read about the virtues of wallpaper or hot dogs or used cars.

We offered our first HMO option to our employees in 1973. It was more expensive than our traditional plan with Prudential Insurance Co. We charged employees from $6 to $9. We signed up 20 percent.

The indemnity plan of Prudential and the HMO plan cost lines have since crossed and our employees today with HMO are not required to make any contribution to their health care.

Since that time we have added two more HMO's.

I am not here today to argue the merits of one health plan versus another, simply to say that from our experience there is evidence that when you offer people the opportunity to choose, that is when you provide competition, you enhance your ability to give better health service and reduce cost.

We know from experience that just making the choices available is not enough. You have to have careful preselection and screening; make certain you are offering your people good sound health plans

and then you have to communicate very carefully and on a sustained basis so individuals and families make the right choice.

We do not leave this to the PR department. We start with our medical people and with our employee relations people and our benefits people to make certain that anything we offer our people is indeed worthy of their attention.

We talk about accessibility and availability and acceptability and appropriateness and accountability. We take a neutral position as to which plan an employee should participate in. He certainly is going to have to have a lot of facts and figures at his disposal.

We use employee meetings during working hours. That is the only way to make certain your people are going to take the time to sit down and study the situation.

We are absolutely convinced from our experience and our experience is all I can go on, that the principle of offering optional health plans to individual employees and reduce costs can provide the best of service and we would submit that any legislation which moves us further down the road to competition and choice is therefore socially responsible.

Thank you.

STATEMENT OF GARY APPEL, PRESIDENT, COUNCIL OF COMMUNITY HOSPITALS

Mr. APPEL. Mr. Chairman, my name is Gary Appel. I am here representing the hospitals of the State of Minnesota. I have submitted written testimony and I would like to offer that for the record so I can summarize.

Senator TALMADGE. Without objection it will be inserted into the record at this point.

Mr. APPEL. I would like to talk a bit more informally for the 5 minutes I have.

I attended the hearing yesterday afternoon. I thought the testimony was supportive of the bill. I was left with one main impression and that is the concept of competition in the minds of many seemed unreal, almost academic as if we were talking about something that could occur at some future date.

In the brief time I have I would like to give some insight and some ideas and understanding of what is already going on in the Twin Cities of Minneapolis and St. Paul.

It is our feeling that competition does exist at the present time. It is keen. It is strong. It is for keeps. The medical care providing community in the Twin Cities is as competitive as we think exists anyplace in the country.

It is our feeling that the delivery of medical care as an industry is going through a period of enormous transition. I think without any doubt that those of us who will study health care in the 1990's will look back at the period of the 1980's and find that we were going through a major industrial revolution within the health care industry; multihospital corporations are springing up at a rapid rate, linkages and ties to HMO's are springing up, shared services are becoming rampant. Mergers of hospitals are commonplace in our area, new services are being delivered and price competition is just beginning to take place in a substantial degree in places like the Twin Cities area.

I think there is a reason for this. The hospital industry and I speak for hospitals in particular today, is in what could be considered to be a mature stage. In the Minneapolis and St. Paul area the number of hospital days is falling fairly sharply over the 1976 to 1978 period. There are 175,000 fewer days of total hospitalizations in the Twin Cities area than there were in 1976.

Expenditures of hospitals have increased only 9.5 percent in the 1978 to 1979 period, far less than inflation a good deal less fast than elsewhere in the country in the medical sector.

We have excess beds. We recognize that. The hospitals in our area are adjusting to that.

Hospitals in the area are beginning to discount prices in particular to HMO's. At this point in time it is mainly because HMO's are the only insurers that can concentrate patients. Hospitals are beginning to bargain in the marketplace using price as a competitive tool.

I would like to point out that price competition is often the last aspect of competition that develops in any industry. It is not only health care. If you look at surveys of private businesses, price competition normally fits into sixth place or lower as a viable competitive tool and the health care industry is no different. We need the proper stimulus and response to be able to adjust in a price competitive way.

It is becoming commonplace for hospitals to charge on a flat per diem basis. The importance of that is it provides an opportunity for experimentation and demonstration in competing in the marketplace and setting per diem rates.

I could go on with satellite clinics and hospitals moving into rural areas and providing care and supportive services in order to compete effectively for patients but I want to make one additional point in the short time remaining.

The competitive force which exists, is a life and death struggle in communities like ours. Those competitive energies can and are being siphoned off increasingly through the regulatory process. Regulations do not hurt all hospitals equally. What happens is the regulatory process pits hospital against hospital and provider against provider using the same competitive force that could be positively directed for consumer well being but is generated more into the politics of survival using the regulatory approach which helps no one in our judgment.

In summary: Strong competitive pressures do exist today. We think they are enormous. We think they have not yet been channeled properly. We support Senator Durenberger's bill as a first step in the direction of making those competitive forces most useful to patients and consumers.

Thank you.

STATEMENT OF RICHARD J. FREY, IMMEDIATE TASK CHAIRMAN, BOARD OF TRUSTEES, MINNESOTA MEDICAL ASSOCIATION

Dr. FREY. Mr. Chairman and members of the subcommittee, I am Dr. Richard Frey, past chairman of the Minnesota Medical Association and also chairman of the cost commission in Minnesota

which was initiated by the Minnesota Medical Association but which very clearly operated independent of that association.

I will only capsule some of our thoughts which I have put forth in my report.

The commission with the full endorsement of the association looked carefully at the rising cost of medical care and these have been espoused here by many before and there is no need to repeat them.

I should point out we should be quick as physicians particularly to recognize the difference in the product, that the intensity of the service is far different than it was years ago. It is not like comparing apples and oranges. We have had remarkable advances in technology that for all practical purposes completely changed the nature of the care that is delivered and this cost a great deal of money.

We also looked at the tremendous demands that are evident in the community for medical care; how we have responded with the medical manpower pool so we now have the people and the technology to deliver just an unlimited amount of medical care.

From this background it seemed clear that without something happening that there would be just an unending escalation of medical costs, particularly when we looked at the incentives that were guiding the current program. These two have been alluded to by other speakers.

I think physicians have done an excellent job in giving the most in quality of medical care but there has been no great incentive even in the physician community to look at the cost of medical care intensively. They have not had a great incentive to make cost conscious decisions.

Certainly the consumer has had no great incentive particularly as we get farther and farther down the road to what we heard a short time ago and that is dollar one coverage for medical care, to remove that essential element of cost sensitivity from the consumer I think is very frustrating and flys in the face of our efforts of cost containment.

Institutions have not had good incentives to overserve. Third parties certainly have been rewarded for selling more and more insurance. As an example even insuring the supplemental coverage in part A which removes in all essence the last vestige of cost sensitivity from that group. I think this is wrong.

We have created really a spare no expense cost insensitive society at the present time. That is not going to change if we do not change the system or at least change many of the incentives that direct the system.

The cost commission felt very strongly that we had one or two directions to go in and that was either further regulation or promote competitive forces in health care. I will say very clearly that the Minnesota Medical Association and the cost commission felt very strongly in support of promoting competitive forces and creating as much as possible a free market in medicine and the fundamental recommendations made are put forth in my remarks.

I would again say as Gary Appel did that the experience in the metropolitan area I think is not necessarily unique but it is refreshing to see how without regulation we now have seven operat-

ing alternatives. You can call them HMO's or prepaid plans if you will.

I must say I am a fee for service physician. I do not even belong to an HMO. I believe in the free choice and the pluralism this brings to our community as they stand side by side with the fee for service medicine in a more competitive environment then we have ever seen before.

Something is definitely happening and it is showing up on the bottom line as reduced hospital days. Some of the reductions in hospital days from the plans have been remarkable. There has been an overall reduction in the use of our excess capacity because of the impact of this competitive system as Dr. Appel has alluded to.

We are going on with a cost care coalition in Minnesota which will be a coalition of forces led in large part by industry who has a real stake as purchasers of medical care and a very interested medical community. I have great aspirations for what they can accomplish with the roadwork that has already been laid down.

I believe that the greatest threat to the competitive marketplace in medicine is not resistance from patients or from physicians but it is the further governmental regulation that will destroy the flexibility we need to promote the free marketplace in medicine.

I think the opportunities that are alluded to in the Health Incentive Reform Act really relate to the promotion of competition and requiring consumer selection of plans.

We also strongly endorse the quality of contribution regardless of delivery system choice; to subsidize one plan or one system to the disadvantage of another denies objective evaluation and frustrates our search for the best possible form of health care delivery.

We certainly endorse the concepts of this bill but we do not comment on the logistics of implementation since this will be addressed by other speakers who have more expertise in this area.

Thank you.

Senator TALMADGE. Dr. Frey, Minneapolis' experience has been highly publicized as an example of how HMO's reduce hospital use. According to Prof. Harold Luft of the health policy program of the University of California who has studied this matter extensively, hospitalization in the Minneapolis-St. Paul area by HMO enrollees was 38 percent less than the Blue Cross group average.

Between 1975 and 1977 while HMO enrollment doubled in the Minneapolis-St. Paul area, overall hospital utilization stayed constant or increased slightly.

Dr. Luft suggests that this result is consistent with among other things a selective enrollment of low utilization in HMO's.

How would you explain the fact that overall hospital utilization did not decrease?

Dr. FREY. During those years between 1975 and 1977, it is difficult to come up with conclusions because the penetration of the market was relatively small. It is growing at a rate of about 30 percent per year but even at the present time there are only 316,000 people enrolled in prepaid plans in the seven prepaid plans available.

I do not think there is any question that the experience in the HMO's and the cost savings we have seen in the local area are

directly related to decreased utilization of hospital facilities. There is a direct proportion. The reduction of hospital days in some of the plans have gone from as much as 750 days to 460 days per thousand from 1977 to 1979.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman.

Dr. Appel, you mentioned that to some, competition has a sense of unreality. One of the "unrealisms" I have sensed at least from a couple of the objectors to competition is their doubting that people are able to play any a role at all in determining their health care. I wondered if you or any of the other panelists would comment on whether it is impossible for the patient or the consumer or the individual to play a role in the choice of health?

Mr. APPEL. It is my view the consumer together with the physician can and indeed does play a significant role in the expenditures and the services received in health care. I think that could be certainly encouraged into the future.

There is no question there are things happening in our Twin Cities area that in part are due to the fact that there are consumers through their buyers, HMO's and the like, that are genuinely out in the field and making adjustments. The number of patient days per thousand and the total number of patient days in the Twin Cities has fallen off quite dramatically.

As Senator Talmadge has questioned earlier, the problem in looking at some of those national figures is the fact that somebody like Dr. Luft has not netted out some of the increase in chemical dependency in patient acute care. There have been significant changes legislatively within the State of Minnesota that have driven those up. With 175,000 patient-days fewer in acute care and an increase of 120,000 days in chemical dependency, those figures look as though they are offsetting but consumers together with HMO's are making a major impact.

Senator DURENBERGER. Dr. Frey, let me ask you about the cost consciousness of physicians. There is one whole page in the AFL-CIO testimony which describes the many ways in which doctors and not patients control the demand for health services. It ends up with the conclusion, "It should be clear that if any progress is to be made in controlling health care cost, fiscal controls must be placed on the physicians."

Would you compare the current role of the physician in practicing cost effective medicine and the role he might play under a competitive environment?

Dr. FREY. I am sure we have all heard that before. It is true. I would submit the physician is responsible in large part as he acts as a purchaser of health care for his patients. He is purchasing technological services and the like. In our present system of reimbursement there has been to a degree a lack of cost conscienous in spending those dollars.

The patient with the physician enters in part into the medical judgment of the course of action but also has a tremendous impact on the cost that is spent for that medical care particularly as you relieve him of these sensitivities.

I think a good example is part A in medicare where once the front end load is passed that we see as a practicing physician how

patients stay in the hospital for an inordinate amount of time for reasons that are nonmedical and yet there is no incentive on the part of the patient and really no incentive on the part of the physician other than to police his patient to terminate this hospital stay.

It is very expensive and this type of philosophy has tremendous impact on the cost of an individual's illness.

I do think cost conscious decisions by physicians will evolve from more competition. It must or they will not survive.

We are currently, including the Government, rewarding expensive services. It is really rewards inefficiency in our health care system. As that stops and we see competition and we see the appropriate set of incentives and reward for cost conscious behavior that is precisely what we will see from the physician community.

Senator DURENBERGER. One of the objections of the AFL–CIO, and if it is true it is a good objection, is that competition would undermine efforts to organize more efficient health delivery systems such as HMO's. When I asked Mr. Seidman about that he said it is because it costs HMO's more to get started so their charges in a competitive environment are higher and therefore what we are trying to do with competition discriminates against HMO's.

Would you agree with him in that position?

Dr. FREY. I would say there are some startup costs for an HMO. There is no question about that. I think those are costs that should be borne out by their experience if they are going to be more efficient. If they cannot compete with fee for service physicians on a purely nonsubsidized or equal subsidy basis then they do not belong in the marketplace.

Senator DURENBERGER. In the Twin Cities' experience you do have HMO's competing with higher costs, and they are getting enrollees, are they not?

Dr. FREY. There is no question about it. They have done it in the Twin Cities. They have not been subsidized. They are now in the black. The first year might be a little bit tantalizing but so is it for anybody else that goes into the private practice of medicine.

In a very short time this will wash out if they are an efficient type of delivery system.

Senator DURENBERGER. Thank you.

Senator TALMADGE. Thank you very much, gentlemen, for your excellent contribution.

[The prepared statements of the preceding panel follow. Oral testimony continues on p. 232.]

Testimony of Paul L. Parker, Executive Vice President and Chief Administrative Officer, General Mills, Inc., Before the Subcommittee on Health, Committee on Finance of the United States Senate.

Mr. Chairman and Members of the Subcommittee, my name is Paul L. Parker. I am Executive Vice President and Chief Administrative Officer for General Mills, a large, diversified food company whose headquarters are in Minneapolis, Minnesota. General Mills is engaged in five basic business areas - foods at home, restaurants, toys and games, apparel and fashion items, and specialty retailing. We have some 64,000 employees worldwide.

My remarks today will focus on the General Mills experience with competitive health plans for our salaried employees working in our headquarter city of Minneapolis. We are talking then about close to 3,000 salaried individuals and the experience which they and we as a corporation have experienced in the past several years. The thrust of my argument, based on our experience, is that in health care as in so much else in life, competition is both useful and important in helping to provide the best of a product or service to the customer or consumer.

While we would hope that the General Mills experience might have value to others in the corporate world throughout the nation, we must point out that for one reason or another, Minneapolis/St. Paul have a background and record of group health competition which are unusual, and therefore not transferable to other cities.

There are seven operational health maintenance organizations, in the Twin Cities. Only one of these is federally qualified; all seven are state certified. Of these seven HMO's, two are individual practice association models, one is a staff model, and four are group models.

HMO membership in the Twin Cities increased almost 30% in 1979 over 1978 with the number of HMO members increasing from 246,000 persons to 319,000 people. This new membership represents 16 1/2% of the total seven-county metropolitan area, and this is a membership rise from a '78 figure of some 12.3%.

These developments have not taken place behind closed doors and, in fact, today in our community, it is almost as common to hear, see or read a commercial

message or advertisement extolling the virtues of a particular group health plan as it is to hear, see or read about the virtues of wallpaper, hot dogs, or used cars.

We offered the MedCenter Health Plan group model HMO option to our Minneapolis employees in 1973. It was more expensive than our traditional group health indemnity plan, and employees were required to pay monthly $6.00 charges for single coverage and $9.00 for family coverage. We originally signed up some 20% of our eligible people. The indemnity plan and the HMO plan cost lines have since crossed, and our employees are not required to make any contribution to their health care.

In January of 1976 we added a second group model HMO option and in January of this year, a third. This new plan, the Physicians Health Plan, is an individual practice association HMO model, and its cost is higher than our group health indemnity plan. Members contribute $4.80 for single and $7.70 for family coverage.

And as of this time, almost 75% of our Minneapolis salaried employees are HMO members.

I am not here today to argue the merits of a particular medical plan vis-a-vis another. The points I do wish to make are these:

1. We believe that from our experience, at least, there is evidence that offering people the opportunity to choose, that is, providing competition, enhances one's ability to provide better health service and at reduced cost.
2. Simply to make choices available is not enough. There must be careful pre-selection and screening to make certain that the choices offered are indeed worthy of an employee's attention, and beyond this, there must be careful and continued communication so that individuals and families can make the right choice and are, indeed, to spend the necessary time evaluating the cafeteria selection before them.

Typically, then, before we would submit a new group health plan to our employees for their consideration, we become involved through our Benefits Department and our Medical Department to make certain that what is proposed is indeed in the best interests of the individual and the corporation. We

are concerned with what we call the five A's - accessibility, availability, acceptability, appropriateness and accountability. We provide ourselves with a long list of specifics which must be checked and checked out before we feel comfortable with taking the next step which is to propose the group health plan to our people as an option for their investment.

There is no doubt but that communications between the company and the individual are critical. We take a neutral position as to which plan an employee should participate in, feeling that it is the individual's right and, indeed, responsibility to make the choice. But how can he or she make the choice without material and facts and figures as provided by us?

We use employee meetings, benefit comparison pamphlets, personal contact, and do this on an ongoing basis. We hold our meetings during regular business hours in order to get higher attendance and our Benefits and Medical people are always available to counsel with an individual who has doubts or questions or problems.

Last year, General Mills as a part of its public service program retained the firm of Yankelovich to do a national study of families on the general subject, "Family Health in an Era of Stress." We were interested in confirming what we suspected - that today perhaps more than ever before, the American family is concerned with its health, not simply the cost of health care but beyond that a concern for all facets of good health, whether physical or emotional. The findings of that study showed dramatically how important this whole matter of health is to the American family, and particularly so in these times which are troublesome not simply from an economic point of view but from factors which relate to such matters as working mothers, broken homes, drug and alcohol abuse, and mental health. Given this situation and the importance of what is at stake for society, we think it imperative that a corporation, and particularly a large one, go far beyond the traditional one group health approach. It is not enough to present to our people a single plan and to offer it with no alternatives or options available. In health care, as in most other aspects of the marketplace, there seems no reason to doubt but that competition will spawn improvement and new ideas and, in many cases, better service at reduced cost. Any legislation which moves us further down that road is socially responsible.

STATEMENT

OF THE

MINNESOTA MEDICAL ASSOCIATION

TO THE

SUBCOMMITTEE ON HEALTH OF THE

U.S. SENATE FINANCE COMMITTEE

ON S. 1968

THE HEALTH INCENTIVES REFORM ACT

by

RICHARD J. FREY, M.D.

Wednesday, March 19, 1980

SUMMARY STATEMENT

A position paper representing Minnesota Medical Association views on causes of escalating health care costs and proposed remedial action. Primary emphasis is placed on changing incentives and behavior patterns through promotion of pluralistic delivery systems and creating cost sensitivity in both provider and consumer segments through cost sharing mechanisms. Conceptual support for the Health Incentives Reform Act is proposed with emphasis on the multiple choice and equal contribution features.

I am Dr. Richard J. Frey, a practicing internist in Minneapolis, Minnesota representing the Minnesota Medical Association, Immediate Past-Chairman of the Board of Trustees of the Minnesota Medical Association, and Chairman of the Minnesota Medical Association's Commission on Health Care Costs. The Commission was initiated by the Minnesota Medical Association in May of 1977 to study and discuss the now well rehearsed problems of rapidly escalating health care costs. Though sponsored by the Minnesota Medical Association, the Commission acted independently of the Association, concluding its charge early in 1979. This 21 person Commission representing business and industry, labor, government, communications, insurance carriers, hospital administration, health planning, and physicians was charged with the task of identifying major causes of escalating health care costs and recommending a remedial course of action. The Commission's report, "New Directions for Health Care" will be made available for your review. It contains 41 recommendations the majority of which have been endorsed by the Minnesota Medical Association's House of Delegates either per se or in principle. Minnesota Medical Association's action on the Commission report is also available for your review.

As you know, two alternative strategies are available that could potentially control costs in the health care system:

* expansion of government regulation to all areas contributing to cost rises, or
* the stimulation of competitive forces through creation of a pluralistic delivery system.

The Commission on Health Care Costs and the Minnesota Medical Association decisively adopted the latter alternative as the more desirable direction to take, particularly in view of the failure of government regulations to contain costs and the lack of cost effective documentation to support the regulatory approach.

The actions considered fundamental by the Commission and the Minnesota Medical Association to actualize this pluralistic, market-oriented system were to:

1. Organize new health care plans which vie with the traditional delivery system for consumers (HMOs are the most common type of health care plan now in operation, but the plans could take a variety of forms).
2. Promote market forces through making health care plans widely available to employees, Medicare/Medicaid recipients, and the self-employed.
3. Eliminate barriers, legal and otherwise, to a competitive health care marketplace.
4. Include cost-sharing in insurance plans and health care plans (if included in the price of premiums, cost-sharing could be used to encourage employees to enroll in cost-effective plans; if included in the costs of actual services, it should serve to reduce unnecessary use of these services).

It is with this background that the Minnesota Medical Association supports the concepts embodied in S. 1968, the Health Incentives Reform Act of 1979, as sponsored by Senator Durenberger.

The rising costs of medical care are a product of multiple factors. Inflation accounts for a very significant portion of the escalation in costs as it does in all sectors of our economy. Equally important, however, is the change in the intensity of service available. Advances in technology have all but completely changed the nature of the service to a point at which an unacceptable percentage of our resources can be spent on therapeutic and diagnostic modalities, if this technology is not appropriately applied. Yet, the technology of today represents only the tip of the iceberg in terms of ultimate potential.

On this background and in response to an ever increasing demand for medical services, the medical manpower pool, physicians and trained para-medical personnel, has increased dramatically and beyond proportionate increases in the general population. Third party coverage, both public and private, has fueled the unprecedented demand for services and has led the way in creating a "spare no expense" mentality that pervades our health care system. Projecting these existing realities on our excesses in medical facilities and capacities leaves no alternative apart from continuing rapid escalation of health care costs at an unacceptable rate.

Fundamental to this scenario is the current set of incentives now operating within the system. None of the groups making up the health care system -- providers, consumers, institutions, and third party payers -- have the incentives to make cost conscious decisions. Providers traditionally are trained to do everything possible in their diagnostic and therapeutic approaches. Cost considerations have not been a significant barrier under our present system of reimbursement. Particularly in the area of expensive

institutional care. Consumers have the incentive to seek the ultimate in care without due concern for cost, since the third party covers most or all of the costs. Dollar one coverage has been the goal of many labor, management negotiations. Institutions are rewarded for providing expensive and sophisticated services. Third party insurers are rewarded for more extensive coverage and have extended this coverage to the deductibles in such as Part A Medicare to remove the last vestige of cost sensitivity of this segment of our society.

None of these groups can be faulted for malicious behavior. They are acting rationally, given the current set of incentives. The controversy should not lie in whether we must seek changes, but rather in the selection of alternative strategies to bring about appropriate change. Very simply, we have but two choices -- the expansion of government regulation and control or the stimulation of true competitive forces through promotion or creation of a pluralistic delivery system. The former must evolve into a system of control through a rationing of medical care and forced compliance. Fiscal control can be achieved only by setting limits on total expenditures and allowing those operating within the system to apportion the resources to the best of their abilities and interests. The second choice -- the stimulation of competitive forces -- promotes a free market in health care, changes the incentives and thus the behavior of those operating in the system.

The Minnesota Commission on Health Care Costs and the Minnesota Medical Association currently and over whelmingly support the promotion of competition in health care delivery and creation of a free market. We strongly support pluralism in delivery systems that create a choice for

both patients and physicians. This competitive environment with competing forms of health care plans standing side-by-side with traditional fee-for-service practice will promote incentives to guide cost and quality conscious behavior by both providers and consumers. We further support those measures that return cost sensitivity to the consumer, particularly some form of cost sharing in insurance plans and health care plans included in the price of premiums or in the cost of actual services.

The metropolitan area of Minneapolis, St. Paul, Minnesota already has seven operating pre-paid plans with an enrollment of approximately 316,000 - 16% of the population, and has been growing at an annual rate of approximately 30%. These represent a variety of arrangements with both hospitals and physicians. Physicians may be salaried; they may continue fee-for-service practice under a corporate structure; hospitals may enter into a variety of risk sharing contractual arrangements or per diem contracts. The flexibility in provider and consumer contracts promotes tailoring of benefit packages and price competition as well as quality competition.

We are seeing dramatic changes in our area. We have multiple choice; we have vigorous competition that must address access, cost and quality. Hospital rate increases are down. Hospital days are down dramatically in some plans and overall across the community. The cost savings realized are at this point clearly related to the ability to promote conservative hospital practices and policies. Something refreshing is happening in this metropolitan area and notably without regulation from the outside. And this is only the beginning of changes in patterns of medical practice. New

challenges and problems will surface as more competitive plans become available to other segments of society such as the Medicaid and Medicare populations. Experience to date supports the belief that these problems can best be handled in the competitive marketplace with a minimum of regulation.

In accord with the recommendations of the Commission on Health Care Costs, Minnesota has now formed a Health Care Coalition charged with an ongoing effort to implement as appropriate, the recommendations of the Commission on Health Care Costs. This is an independent non-profit Coalition with strong representation from the purchasers and providers of health care. This Coalition will facilitate implementation through promotion of coordinated efforts and stimulation of innovative changes in patterns of practice, lifestyles, health and medical education, reimbursement policies and regulatory policies, all with an ongoing process of evaluation of impact on cost and quality of medical care. It will promote the free market concept recommended in the Commission on Health Care Costs report.

The greatest threat to the competitive marketplace in medicine is not consumer or physician resistence, but rather further governmental regulation that destroys the flexibility essential to competition. The Minnesota Medical Association finds in the Health Incentives Reform Act of 1979 the multiple choice of health care delivery systems providing a choice for all participants. This opportunity and requirement for the consumer to select a plan and participate in a form of cost sharing for his care will promote a cost sensitivity that is essential to cost

containment. The Minnesota Medical Association strongly endorses the equality of contribution regardless of delivery system choice. To subsidize one plan or one system to the disadvantage of another denies objective evaluation and frustrates our search for the most efficient form of health care delivery. The leadership of the Minnesota Medical Association supports the concepts embraced in this bill. The logistics of implementation and details of coverage, however, were not addressed by the Association.

I am grateful for the opportunity to submit this testimony and representation on behalf of the Minnesota Medical Association.

COUNCIL OF COMMUNITY HOSPITALS
SERVING THE SEVEN COUNTY METROPOLITAN AREA

STATEMENT OF THE COUNCIL OF COMMUNITY HOSPITALS AND

THE MINNESOTA HOSPITAL ASSOCIATION ON THE

HEALTH INCENTIVES REFORM ACT

BEFORE THE SENATE FINANCE COMMITTEE

MARCH 19, 1980

INTRODUCTION

My name is Gary Appel. I'm a health economist and the President of the Council of Community Hospitals, which represents thirty-five hospitals in the Twin Cities area of Minneapolis and St. Paul. I'm here today to speak both for these hospitals and the Minnesota Hospital Association whose membership includes 178 of Minnesota's hospitals as members.

I have four areas to cover in this testimony. First, to provide strong support for what we believe to be the purpose of the Health Incentives Reform Act. Second, to express the views of Minnesota's hospitals regarding competition. Third, to explain why we support the rapid implementation of Senator Durenberger's concept of competition. Fourth, to provide some evidence and insight into the present competitive environment in the greater metropolitan areas of Minneapolis-St. Paul.

OVERVIEW OF THE MEDICAL CARE INDUSTRY TODAY

To begin, let me say that those who know the Twin City area unanimously share the view that the medical care industry is in the middle of a remarkable transformation - HMOs continue to grow and influence the change, but that's only a part of the process. On the hospital side there is equal or even more dramatic change.

Multi-hospital corporations continue to expand. Mergers of hospitals are commonplace. A wide range of multiple corporate organizational arrangements are being tried. Hospitals are beginning to bargain in the marketplace for patient business, vice-presidents for corporate strategy and marketing are being hired, and in general,

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hospitals have dramatically changed their thinking toward a competitive enterprise.

It is this sense of dramatic change that Senator Durenberger preceptively understood early in his first term in office as providing the potential for improving the health delivery system - not only at home but nationally as well - through internal market forces rather than more government intervention.

Senator Durenberger is right, there are forces at work in the Twin City area which only now are beginning to provide substantial gains to consumers. These gains will increase, if we continue to creatively and positively develop these forces more effectively for our area. Furthermore, if these pressures are generated elsewhere throughout the country, gains to the American public will be substantial.

I. SUPPORT FOR CONCEPT OF HIRA

The hospitals of Minnesota support the purpose of the Health Incentives Reform Act, as a significant and positive first step toward stressing market forces rather than regulation. The purpose of this bill which we support is threefold.

- Encourage more consumer involvement in making decisions regarding the benefits and costs of medical care.
- Decrease cost of care by rewarding efficient providers and encouraging the inefficient to change through market forces.
- Provide proper incentives which will allow significant deregulation of the medical care industry, including the hospital sector, as competitive forces develop.

The bill, as we see it, is an attempt to build market forces two ways. One is to encourage cost sensitive buyers of care who will be interested in and benefit from selecting more efficient providers of care. The second is to encourage group purchasers of care (e.g. HMOs and certain insurers) to selectively seek the more efficient providers, thereby rewarding them by influencing patients to seek their services.

Simply stated, we see the bill building consumer incentives which are transferred through insurers and in turn provide additional financial reasons for medical care providers to reduce costs.

The concept of the bill is based upon the same presumption that advocates of more regulation subscribe to. That is, some providers are efficient and others are less so. That, with proper economic incentives, the less efficient can be encouraged to find ways to cut costs.

The critical difference, in our minds, is that competition builds upon the creative energies within the medical care industry, whereas regulations increasingly require intervention by outside forces. We therefore support the competitive approach proposed by Senator Durenberger.

II. THE HOSPITAL VIEW OF COMPETITION

For obvious reasons, Minnesota's hospitals do not view competition solely as the development of HMOs. HMOs are, at times, only purchasers of hospital care. At other times, they are partners in the delivery of that care and in some instances they are in competition with hospitals.

We view a competitive care industry as one which fits this definition:

> A competitive medical care industry is one in which all its components respond automatically over time to the diverse wishes of the consumer, producing high quality services efficiently and innovatively. Market forces exist to the extent that only those members of the industry which best serve the public will prosper and grow.

Using this definition a competitive strategy will encourage competition among hospitals, between HMOs and hospitals, among HMO and other insurers and so forth. No one segment of the industry has an advantage established in law, all must succeed based upon their capacity to serve the public interest. It is our experience that laws such as Certificate-of-Need, which tend to concentrate on hospitals, significantly reduce competition, even among hospitals themselves, and should undergo reconsideration as competition becomes more firmly established.

III. WHY WE SUPPORT RAPID IMPLEMENTATION OF SENATOR DURENBERGER'S CONCEPT OF COMPETITION

Our support for competition may be viewed by some as premature because we are not yet able to clearly articulate its total direct and indirect impact on a health delivery system - a system which despite some problems continues to function very well. We don't know, for example, how competition might generate serious financial problems for teaching hospitals or

those which are forced by social concern to subsidize care to the poor. Nevertheless, we still support the competitive concept given the belief that these and other unresolved issues can and will be solved.

Minnesota's hospitals believe that properly designed competition will prove to be the most acceptable long-range option for the medical care industry.

For years we have not only cooperated with, but encouraged, the non-competitive alternative. We established health planning years before legislation mandated it, and we continue to cooperate with the planning agencies created by federal law. We assisted our physicians in the development of utilization review well ahead of federal legislation and continue to support its successful efforts. We began a Hospital Rate Review Program in the early 1970's without government pressure to do so, and we continue to support its efforts to cut costs. And today we seriously participate in the American Hospital Association's voluntary effort to contain health costs through extensive joint purchasing arrangements, sharing of services, staffing only beds in use and in many other cost cutting efforts.

In spite of our success (the medical care component of the CPI in the Twin Cities continues to climb at least one full percentage point or more under inflation generally), we believe that in time, strenuous efforts to regulate the hospitals even more will once again surface. We want to show strong support for the competitive alternative now so as not to provide a false impression that our support for regulatory alternatives exists only when the pressure is the greatest. We believe that now is the time to rationally develop the competitive strategy during a successful period of cost cutting.

We firmly believe that future significant cost savings must rely on the creative energies and knowledge within our industry. They cannot rely on the good intentions of those who manipulate the industry through external forces.

There is yet another even more important reason why we believe Senator Durenberger's competition proposal should be quickly implemented. We see emerging a health planning process which increasingly is diverting positive competitive tendencies from socially useful efforts into political competition which health planning inevitably encourages. The hospitals in a highly competitive community, such as the Twin Cities,

cannot ignore the fact that the planning/regulatory process does not hurt all hospitals equally. Rather, it helps some hospitals at the expense of others providing a powerful competitive tool.

Therefore, in order to survive, our hospitals are forced to compete through the various health planning agencies. This generates a deep concern in their own minds because such political competition does not benefit the public.

We recognize that acute hospital care is a mature business, and that as actions continue to reduce hospital use, some facilities will have to change roles or leave the medical care business entirely. We believe, however, that those who survive and prosper should do so because they best served the public needs and not because they are merely more skilled in the politics of health planning and regulation.

We applaud Senator Durenberger for recognizing that the longer we pursue the planning/regulatory path, the harder it will be to obtain significant consumer control through the market. And we are very close to losing this opportunity even in areas of advanced competition such as the Twin Cities.

For example, health planners generally do not accept the critical importance of excess capacity in an industry as a major factor causing price competiton. Once excess beds are removed and the planning process has finished its present efforts to establish medical care franchises, the ability to generate effective market forces through efforts such as HIRA will be significantly reduced. If we continue down the road toward a planned industry much further, we fear that the security which inevitably comes from franchising may be embraced by providers of medical care, thereby closing the door on a truly competitive environment.

The HMOs and Hospital Competition

While national attention has concentrated on the HMO development in the Twin Cities as the competitive force (and there is no doubt that HMO growth has been a significant contributor to the competitive milieu), competition among hospitals has paralleled that growth, in part stimulated by it, but in many ways developing as a distinct phenomenon.

HMOs in our area have stimulated a hospital competitive response. In, and of itself, the drop in hospital use due to HMOs is indistinguishable from the drop caused by

the PSRO, changing style of medical practice generated by heightened cost awareness, or by the efforts of the hospital staff themselves. And the drop in days leading to excess capacity is a necessary, but not sufficient, condition for effective competition.

The critical added element is a group of price sensitive buyers which are only now beginning to emerge in the Twin Cities. HMOs have taken the lead in this regard, but as yet their strength as group buyers of care is only partly exercised. Total pressure could increase greatly through a broader range of insurers who direct the flow of patients, and thus, develop market power by selecting hospitals which provide the best value. The HIRA Bill encourages the evolution of more cost sensitive buyers, in addition to HMOs, and that's vital.

IV. INSIGHTS INTO HOSPITAL COMPETITION IN THE TWIN CITIES

It is extremely difficult to adequately describe our hospitals' competitive environment. Data on patient days, cost, use rates, and the like only begin to tell the story, but provide a thought-provoking beginning.

Here are some numbers from the Twin Cities which are worthy of consideration. Patient days (excluding chemical dependency and psychiatric care) dropped almost 9.0% or 175,000 days between 1976 and 1978 alone, while patient days per 1000 population dropped by 231 days or 17.8% over the years between 1970 and 1978.

The increase in total hospital expenditures was 9.5% between 1978 and 1979 versus 12.6% nationally and was down from over 17.6% in the 1975-76 period. The average length of stay in hospitals continues to decline despite more intense inpatient care. If the patients had stayed in hospitals as long in 1978 as they did in 1970, there would have been 250,000 more days of care provided by Twin City hospitals.

These figures are an indication that something significant and positive is going on in the Twin Cities, but they neither prove competition is working, nor do they reveal future potential benefits from more competition. Also, these figures do not provide any insight into structural changes, as hospitals attempt to adjust and build a competitive environment.

The hard data on hospitals tell only a small portion of the competition story. Some examples and impressions from our actual experiences provide more useful insight into the broad range of competitive activities which are happening today.

Examples of Hospital Competition in the Twin Cities

- Some hospitals have negotiated price discounts with HMOs which direct patients to their facilities. The hospitals constrain the size of the discounts so as to eliminate any subsidization of HMOs by non-HMO patients. This is done through commitment to charge non-HMO patients less than they would have been had not the patients moved to the facility and shared in paying the hospital's fixed costs. These discounts establish the precedent of price competition in the hospital sector.

- Some hospitals and HMOs have negotiated flat rates or standard per diem charges. The exciting aspect of this, is that it provides an opportunity to work under a simplified reimbursement mechanism which might eventually be applied to Medicare and Medicaid patients. It's a forerunner of a whole new generation of reimbursement mechanisms.

- It is increasingly common knowledge that HMOs are shopping for the "best buy" in hospital care, thereby increasing the cost consciousness of hospitals and other suppliers of care.

- There is a marked increase in open dialogue within hospitals regarding competitive strategy and marketing.

- Group practices, hospitals and HMOs are actively beginning to establish satelite clinics. The fact that these link patients to certain hospitals is disturbing "normal" referral patterns, this in turn is eliciting a competitive response from hospitals associating themselves with other HMOs, etc. This whole process provides an excellent example of an industry changes to better respond to consumers demands.

- Hospitals are beginning to market directly to employers providing a range of services from first aid to emergency care and employee physical exams. This gives another good example of competition induced positive responses.

- Hospital ties to other hospitals are varied and numerous. The day when a smaller hospital operates in total independence is quickly fading. Multi-hospital corporations and management contracts are a highly significant change in the competitive environment.

- Minnesota's hospitals are now constructing data bases (with financial assistance from HEW) which will provide information for future innovative hospital reimbursement demonstrations involving all patients, not just those in HMOs. Historical data is being analyzed today to find trends in hospital usage to improve marketing capability and assess the results of competition.

  The forces caused by excess hospital capacity, which could be used so positively, are being siphoned off into efforts to use the health planning process as a competitive factor. As health planners strive to carve up the market or franchise providers, individual hospitals have no choice other than to help mold the plans in ways which hurt them least. Ever increasing amounts of time and energy are being devoted to convincing agency health planners of the merit of individual hospital's perspectives.

- Some Twin City area hospitals are reaching out into rural areas to link their physicians and hospitals. They provide education, support and consultation in return for added patient referrals. This is another example of how the needs of people can be met by industry innovation in response to market forces.

This list could continue. The point is that hospital competition is alive and takes various positive and some negative forms. Passage of Senator Durenberger's competition inducements, together with appropriate deregulation of hospitals as competition develops, can move the range of industry responses more extensively toward the socially useful and also increase the intensity of the response.

CONCLUSION

Minnesota's hospitals support Senator Durenberger's efforts to encourage competition in the medical care industry. We support the purpose of the Health Incentives Reform Act with the belief that it is a significant first step, but only a first step, in the right direction.

We recognize that not all direct and indirect effects of competition or legislative inducements for competition are as yet known. We support competition now with the belief that unresolved issues, such as appropriate deregulation of all providers including hospitals, at the proper time, and the funding of medical education under a competitive environment, will be addressed in due course.

Minnesota's hospitals are encouraged that Senator Durenberger had the vision to see the potential of competition as it develops in his home state. We are pleased to be able to support the purpose of the Senator's HIRA bill based on our increasingly rich experience with competition.

We feel that if only a fraction of the energy now devoted to regulating the medical care industry is devoted to implementing better ways to encourage creative energies it contains, and to provide sufficient flexibility for these forces for positive innovation to flourish, it would have a dramatic and positive effect on medical care for years to come.

We ask the members of the Senate Finance Committee to continue its efforts toward competitive reform.

Thank you for this opportunity to speak today.

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Senator TALMADGE. We will vary the agenda slightly to accommodate another witness who must leave for the airport. Our next witness is Mr. O. H. Delchamps, Jr., president and chief executive officer of Delchamps, Inc., on behalf of the Chamber of Commerce of the United States who is accompanied by Jan Peter Ozga, associate director, health care, Chamber of Commerce of the United States.

You may insert your full statement into the record and proceed as you see fit, sir.

STATEMENT OF O. H. DELCHAMPS, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, DELCHAMPS, INC., ON BEHALF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES, ACCOMPANIED BY JAN PETER OZGA, ASSOCIATE DIRECTOR, HEALTH CARE

Mr. DELCHAMPS. Thank you, Chairman Talmadge and members of this distinguished committee.

As you have stated I am Oliver Delchamps, Jr., chairman of the board of Delchamps, Inc. We operate a regional supermarket chain in a four-State area in the South operating out of Mobile, Ala.

Today I am representing the Chamber of Commerce of the United States where I serve on its board of directors and as chairman of its Special Committee on the Nation's Health Care Needs.

Jan Ozga is the chamber's health specialist.

Like Dr. Kahn, I am not an expert in this field. I am a food peddler by trade.

The full text of our comments are on S. 1968 and other so-called competition bills and national health care in general.

I would like to summarize those remarks. The U.S. chamber is the Nation's largest business federation with over 94,000 members; 85 percent of our business members employ 100 or fewer employees.

Business is concerned about the rising cost of health care because it is the largest buyer of health services in the country.

In 1979 employers paid about $48 billion for group health insurance premiums; 90 percent of all group health insurance is bought

through the workplace with employers paying 70 percent of the costs.

Perhaps another $50 billion was paid by business if you factor in such items as taxes to support medicare and medicaid; medical benefits portion of workmen's compensation; paid sick leave; in-plant health services; corporate philanthropy for health projects and compliance with safety and health regulations.

Table 1 in our statement compares employee benefit costs for the years 1967 and 1968. Please note while wages doubled for an increase of actually 115 percent, total employee benefits nearly tripled or a 190-percent increase.

Health insurance costs increased 275 percent or you might say health costs almost quadrupled the cost of 1967.

Clearly business has a right and responsibility to speak out on health care issues especially on legislation which creates programs requiring most of their financing from employers.

If proposals to improve the Nation's health care and its system of delivering and financing this care are viewed as solutions to problems, it is important to understand what the problems are. Right now 95 percent of all Americans have some form of health insurance either from private sources such as commercial insurance or Blue Cross or public sources such as medicare and medicaid.

As we have stated, business plays a major role in providing this protection either through direct contributions or taxes. The obvious problem in the Nation's health care is the 5 percent of the population without health insurance. This was reported by the Congressional Budget Office.

These needy persons can be covered by slightly modifying existing public and private programs without creating an entirely new system of national health insurance or imposing a catastrophic health insurance scheme or by changing the tax code which, as constructed, has contributed to the ever widespread of health care coverage.

Part of the uncovered population are small employers or employees who work for such employers and part-time and seasonal workers. For the most part their cost for health insurance because of their size or because of their marginal operations striving to survive has been prohibitive.

Over 25 percent of local chambers of commerce help provide health insurance to that small business member. To help these and other chambers and trade associations in this effort we plan to publish a manual for small and medium sized firms on how to shop for and provide cost effective health care benefits.

You can design health insurance policies which cover employees for a reasonable period after they are terminated. The cost of this continuous coverage can be negotiated between employers and employees.

With respect to medicaid, this program's eligibility and services could be expanded to provide even more protection against health care costs after improvements in accountability and efficiency are implemented.

State administered pools and private health insurance could cover for slightly higher premiums persons not eligible for private

or public insurance because of their type of work or health conditions. Several States already have such pools.

This combination of private efforts to extend and improve health insurance coverage and modest changes to existing public health care programs would provide most of the needed improvements and do so without impinging on economic freedom or increasing the current health care cost inflation.

Currently there are three types of health insurance proposals before the Congress. The first type is a comprehensive plan as advocated by President Carter and Senator Kennedy which would create or lead to a massive national health insurance scheme. We oppose these costly and unneeded health insurance proposals.

The second type of health insurance proposal deals with catastrophic health insurance. Because of the growing widespread availability of catastrophic health insurance through private sources, especially the workplace, a Government mandated employer paid catastrophic health insurance plan is not necessary and could lead to higher inflation in health care and ultimately to national health insurance.

Table 2 in our statement documents the growth of employer provided catastrophic health insurance which now covers over 90 percent of the workforce. Table 3 reveals just how costly a catastrophic only plan might be. Essentially it shows some small employers would have to spend $800 per year per employee for such coverage.

The third and potentially more desirable type of plan are the competition health insurance proposals such as S. 1968 advocated by Senator Durenberger and S. 1590 advocated by Senator Schweiker. Similar bills are being debated in the House of Representatives.

These bills share certain common features. They all mandate that most employers offer a catastrophic health insurance plan. This requirement interferes with employer-employee bargained health plans which develop the kind of health benefits which employees want and can afford.

As stated earlier, mandating such protection also is unnecessary since it is already being provided on a wide scale voluntarily.

Competition bills also require employers offer a choice of three different health plans from three different health insurance companies or organizations actually providing care. The intent of such a mandate is that offering such choices will promote more competition within our health care industry.

Although this is an admirable goal and one which the chamber has long supported, again options in health care protection are already being offered by many employers either voluntarily or because of Federal law.

This part of the legislation appears unnecessary. In some cases competition bills place a limit on the amount employers can pay for health care costs. S. 1968's limit is $125 per family per month. By most standards this is a fairly generous amount and such a limit could easily become the minimum amount to be contributed given the trend of previously mandated programs. Such limits also do not take into account variations in health care prices by regions of the country and would interfere with self insured programs.

In order to motivate employees to become more cost conscious, competition plans offer rebates to employees choosing lower cost health insurance plans. These rebates are taxed differently depending on the specific proposal.

All savings in this arrangement go to the employee. Employers and employees should share in these savings thus motivating employers to seek ever more cost effective health care plans.

The chamber does support uniform payment by each employer for all health plans offered to its employees.

So there is no misunderstanding, the national chamber supports instilling more competition into the health care industry and employers contributing to such efforts through their health benefits program. This is a clear message in our health action program which also lists several other important actions employers can take to improve health and contain costs in their companies and their communities.

These other actions include designing more cost effective health insurance plans; instituting health education programs in the workplace and participating in local health planning.

Our basic objection to S. 1968 and other competition type health insurance proposals is they are not needed given the trend of coverage provided through voluntary negotiations or required by existing statutes.

Competition legislation as written places burdens on employers to offer multiple choices where they are already doing so or where this may not be practical or cost effective. Savings under S. 1968's multiple offerings requirement accrue only to employees, thus eliminating the incentive for employers to seek cost effective alternatives.

For all of these reasons the U.S. chamber requests that you defer action on S. 1968 and similar proposals and concentrate instead on providing ways to provide the 5 percent of the population without any health insurance with access to such protection.

We thank you very much.

Senator TALMADGE. Thank you very much for an excellent statement.

I read all of your testimony. I noticed on page 5 that you state 88.5 percent of the employees in the United States in 1978 had catastrophic benefits of $100,000 or more.

Does that figure include the small farmers and the small filling station operators and the small barbers, people of that nature?

Mr. OZGA. Not entirely.

Senator TALMADGE. Of the total population of the United States and I assume it is on the order of 220 million now, how many persons have catastrophic coverage of $100,000 or more?

Mr. OZGA. Some sort of catastrophic protection, I believe it is somewhere in the area of 60 to 70 percent.

Senator TALMADGE. I think it may be higher than that.

Like you, I am opposed to a "cradle to the grave" national health insurance program. I have a good deal of sympathy for an individual whether he is a barber or filling station operator or employee, who is confronted with health costs beyond the scope of his insurance. Suppose that breadwinner takes cancer and lingers on for a year or a year and a half and dies and it cost that family $100,000

to $150,000. This could bankrupt a family of very substantial means.

How would you recommend we handle that?

Mr. DELCHAMPS. Senator, as I stated, not only chambers of commerce at the local and State level but many associations—and I know in our State retail associations through the Farm Bureau—provide several plans if anyone just wants to have a minimum membership in an association. I think this is one way to reach a lot of individuals and small businessmen, the farmers. Every college fraternity has some sort of group plan.

We plan to promote this through local chambers of more group plans available to more people. There are not many people who cannot qualify for some sort of group benefits. Louisiana is in the process of setting up workmens' comp self-insured program for small retailers.

I think there are ways of tackling this through the private sector and our chamber plans to do this and I know NAM and others are promoting this particular thing.

Senator TALMADGE. I know these policies are available to anyone who has the resources to buy them. Some of these people, however, may not have the resources.

I think the greatest unmet health need in America today is the sort of case that I have outlined to you. I get annually hundreds of pitiful letters similar to what I described. They frequently have some coverage either provided by an employer or by themselves. However, they have exhausted their benefits and still the problem remains.

Mr. DELCHAMPS. I have talked to a number of businessmen. We are not a big business. Our total payments under our major medical in our company, we have major medical for every employee of $50,000. We plan on raising it to $100,000.

Our total last year was less than $100,000 for over 2,000 employees.

Senator TALMADGE. I know your coverage is good. Unfortunately, in some areas, it is not.

Mr. DELCHAMPS. In business to be competitive you have to have competitive wages and employee benefits to get good people and to keep them regardless of the size of the business.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. I would like to deal with the one sentence summary on page 10 of the health action study and that is "America's health care system can best be improved by promoting more competition among health care providers and insurers, cost consciousness among providers and consumers and individual responsibility among consumers." Is that a fair statement?

The question now is how we go about achieving those objectives. I would like to ask a couple of questions to clarify the chamber's position.

The first objection the chamber has is this law would set a limit on how much employers and employees could spend on health care coverage. Would either of you indicate how you believe this law sets that limit?

Mr. DELCHAMPS. We are concerned as we stated that the $125 a month as I understand it is a maximum and it would soon become

a minimum. In our particular company we think we have a great plan and I know a lot of others who are paying $500 or less per employee.

Senator DURENBERGER. Is that the part of the bill that is objectionable, the $50, $100, and $125 cap?

Mr. OZGA. Setting a limit; yes.

Senator DURENBERGER. Is there an inconsistency later on when you say the competitive type plans also encourage consumer cost sharing which the chamber supports? Do you object to our form of cost sharing?

Mr. OZGA. You can have cost sharing without setting a limit no matter what the contribution level turns out to be. You can still share in the cost of that.

Senator DURENBERGER. How would you get cost sharing into a competitive piece of legislation without putting in a dollar amount for the employer contribution?

Obviously we do not tell the employer he cannot pay more than $50, $100, or $125. We merely say anything over that is taxable income to the employee.

Mr. OZGA. For example, whatever the premium is, it could include 25 percent copayment on that.

Senator DURENBERGER. Your objection is that if we put actual dollar figures in here as an upper limit, the employee will insist the employer contribution be at that level?

Mr. OZGA. It could lead to that; yes.

Senator DURENBERGER. The other observation you make is that employers have found that providing HMO's as a health insurance option to employees does not increase their administrative costs significantly. Is that an analysis of a number of employers 'experiences?

Mr. OZGA. Yes.

Senator DURENBERGER. I ask you that because a number of individual employers and some employer organizations have indicated their major concern about this legislation is that it is going to substantially increase their administrative costs.

I understand your testimony to be there are at least 10,000 employers in America today that offer at least two choices of a standard fee for service plan and an HMO and none of them have experienced significant administrative costs.

Is that correct?

Mr. OZGA. We have a difference of opinion on this. I guess it is a relative term depending on how much you want to say is the difficulty for you. I think on balance after some experience with these plans, this tends to level out. That is the reason we are voluntarily promoting this kind of solution.

Senator DURENBERGER. If you had your choice on the catastrophic coverage bill with a minimum mandate as part of a competitive bill or catastrophic without a competitive component, separate from a competitive system reform, which would you choose?

Mr. OZGA. I think either choice is unacceptable.

Senator DURENBERGER. It is the chamber's position that it opposes catastrophic mandate?

Mr. OZGA. Yes.

Mr. DELCHAMPS. That is our big problem, mandated. We think business in general is doing a good job. We are not there yet. The trend is good.

Senator DURENBERGER. Thank you very much.

Senator TALMADGE. Thank you very much. We appreciate your contribution, gentlemen.

[The prepared statement of Mr. Delchamps follows. Oral testimony continues on p. 300.]

STATEMENT

on

S. 1968 and RELATED HEALTH INSURANCE PROPOSALS

before the

SUBCOMMITTEE ON HEALTH

of the

SENATE FINANCE COMMITTEE

for the

CHAMBER OF COMMERCE OF THE UNITED STATES

by

D. H. Delchamps, Jr.

March 14, 1980

My name is Oliver H. Delchamps, Jr., Chairman of the Board of Delchamps, Inc. in Mobile, Alabama. I am a member of the Board of Directors of the Chamber of Commerce of the United States and Chairman of its Special Committee on the Nation's Health Care Needs. I am accompanied today by Jan Peter Loga, the Chamber's Associate Director for Health Care.

The U.S. Chamber is the nation's largest business federation, with over 94,000 members, consisting of business firms, trade and professional associations, and state and local chambers of commerce. Within our business membership, 85 percent employ 100 or fewer workers. This statement is presented on behalf of our membership.

We appreciate the opportunity to comment on S. 1968, related competitive health insurance legislation, and national health care issues in general. The direction of the debate on national health care has changed dramatically during the past decade and requires fresh thinking as we begin the 1980's. These hearings provide an excellent forum for such a re-appraisal.

U.S. Chamber Position on National Health Care

Our position on national health care is that all Americans should have access to quality care through an essentially private, voluntary system of providers and insurers. Only when an important health care need is not being met is government intervention justified. Legislation which does not conform to this position is not acceptable to the U.S. Chamber. This would include bills which require employers to offer health insurance which they are already providing voluntarily or which would go beyond the scope of the primary problem in our nation's health care system -- the estimated five percent of the population without any type of health insurance.

For these reasons, the U.S. Chamber opposes the comprehensive health insurance plans proposed by Senator Ribicoff (S. 1812) and Senator Kennedy (S. 1720). Similarly, we oppose the catastrophic-only plans proposed by Senators Long (S. 760) and Dole (S. 748). Finally, the Chamber cannot support the so-called competition plans proposed by Senators Durenberger (S. 1968) and Schweiker (S. 1590). However, the competitive-type proposals are clearly more, if not entirely, acceptable to the business community than the comprehensive or castastropic plans. Certain modifications could improve this legislation.

The State of the Nation's Health

Americans are living longer and healthier lives than ever before. Infant mortality and other peri-natal death rates -- long a source of concern in our otherwise healthy country -- are now on the decline. The type of health care provided by our hospitals and doctors is unparalleled anywhere in the world. Advances in technology, such as sophisticated diagnostic and treatment equipment, along with the continued high quality of medical education, are a tribute to the American economic and health systems which combine private initiative with social concerns. Even our severest critics, in times of crisis, seek American health care because of its reputation for high standards. In short, our nation's health care system should be a source of pride among its citizens.

America's system for protecting its citizens against the cost of health care is equally impressive. Over 95 percent of all Americans have some form of health insurance, either from private plans such as commercial insurance and Blue Cross/Blue Shield or from public programs such as Medicare and Medicaid.

Business has played a major role in making this kind of protection available. An estimated $48 billion in 1979 was spent by employers for group health insurance premiums to cover employees and their dependents. Indeed, 90 percent of all group health insurance is bought through the workplace, with employers paying 70 percent of the cost. Health related costs paid by business also include taxes to support Medicare and Medicaid, as well as outlays for the medical benefits part of Workers' Compensation, paid sick leave, in-plant health services, compliance with safety and health regulations, and corporate philanthropy for health related projects.

As a result of these costs, companies such as General Motors now spend more for health insurance than to any single supplier of steel, and the Ford Motor Company estimates its total health bill per employee is now over $2,100 per year. Not surprisingly, much of this cost is passed along to consumers in higher prices.

Employee Benefit Costs

The U.S. Chamber's survey, Employee Benefits, 1978, reveals how much benfit costs have soared over the past ten years. Table 1 below compares average weekly costs per employee for selected benefits for the years 1967 and 1978, with the percentage change during that decade. Note that employers spent an average of $98.21 per week per employee for benefits in 1978, compared with $33.06 in 1967. Benefits grew almost twice as fast as wages during this period: between 1967 and 1968 benefits rose nearly 200 percent, while wages increased 115 percent. Based on this trend, employee benefits are estimated to cost American employers over $400 billion in 1981.

TABLE 1

WEEKLY COST OF BENEFIT COVERAGE PER EMPLOYEE *

	1978	1967	Percent Change
Old-age, survivors, disability and health insurance (FICA taxes)	$ 15.06	$ 4.88	+209
Pensions (nongovernment)	14.98	5.02	+198
Insurance (life, hospital, surgical, medical, etc.)	14.88	4.02	+270
Paid vacations	13.15	5.21	+152
Paid rest periods, coffee breaks, lunch periods, etc.	9.69	3.44	+182
Paid holidays	8.69	3.25	+167
Unemployment compensation taxes	4.46	1.25	+257
Workers' compensation	4.33	1.00	+333
Profit-sharing payments	3.63	1.48	+145
Paid sick leave	3.35	1.00	+235
Christmas or other special bonuses, suggestion awards, etc.	1.00	0.63	+ 59
Thrift plans	0.83	0.15	+453
Salary continuation or long-term disability	0.79	N.A.	N.A.
Dental insurance	0.58	N.A.	N.A.
Employee meals furnished free	0.46	0.23	+100
Employee education expenditures	0.38	0.08	+375
Discounts on goods and services purchased from company by employees	0.29	0.25	+ 16
Other employee benefits	2.26	1 17	+ 93
Total employee benefits	$98.81	$33.06	+199
Average weekly earnings	$267.77	$124.33	+115

N.A. Data not available.

* Several of these benefits were reported by only a small proportion of employers, and these costs were substantially higher than the above amounts for those companies paying these benefits. For example, profit-sharing payments averaged $3 63 per employee per week for all companies in the survey, but were $17 29 for companies having profit-sharing.

Source: Employee Benefits 1978, Chamber of Commerce of the United States

These figures clearly show why employers, especially small employers, are concerned about any form of legislation that increases benefit costs. This is particularly true in the insurance area, where costs rise 271 percent from 1967 to 1978.

Hence, business has the right and responsibility to speak out on health-related matters, especially legislative programs which derive a major part of their financing from employers. Business needs to be assured that programs which it pays for are actually needed, and, if they are, that they operate efficiently and effectively.

Proposals for National Health Insurance

There are basically three types of proposals for national health insurance: comprehensive, catastrophic and competitive.

Comprehensive Health Insurance. The Administration proposal, (S.1812) would cost $25 billion for the first year alone. The Kennedy plan (S.1720) would cost $60 billion when fully implemented. Through a combination of controls and regulations placed on hospitals, doctors, and insurers, both plans would lead to a national health insurance system with the federal government in firm control. Other countries which have tried this approach have experienced a number of undesirable and counter-productive results, including an increase in the cost of care, a decrease in the quality of care, long waits for health service, deteriorating equipment and facilities, decreasing numbers of health personnel, and an eventual rationing of health services. There is no reason to believe that the United States would not suffer similar experiences.

Thus, because they are too expensive, go way beyond dealing with those persons without any health care coverage, and would lead to a system of costly yet substandard health service, the Chamber opposes S.1720 and S.1812.

Catastrophic Health Insurance. This approach is advocated by Senators Long (S.760) and Dole (S.748) and is included in nearly all of the major health insurance proposals. Basically, these plans require most employers to provide, and employees to accept, insurance which would pay for most of the cost of health care after a certain level of health cost was reached. Protecting all Americans against financial ruin due to health care costs is a laudable goal. However, such protection is already being provided--mostly by employers — making a government mandated program unnecessary.

From 1973 to 1978, the proportion of employees covered for catastrophic health costs of $100,000 or more rose from 24 percent to 88 percent. One-half of these have $1 million protection and one-third have unlimited benefits. Overall, 85 percent of all Americans have some type of catastrophic health insurance. Table 2 shows a recent five year trend for this type of coverage.

TABLE 2

PERCENTAGE OF SURVEYED EMPLOYEES COVERED FOR CATASTROPHIC HEALTH INSURANCE BENEFITS, 1973-1978

CATASTROPHIC BENEFITS	PERCENT OF EMPLOYEES	
	1973	1978
$ 5,000	1.7	--
10,000	7.5	1.9
15,000	4.8	0.6
20,000	9.5	1.9
25,000	14.8	1.7
25,001-49,999	9.1	--
50,000	21.6	2.8
50,001-99,999	1.8	--
100,000	5.9	2.6
100,000 or more	24.2	88.5

Source: Health Insurance Institute

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A government mandated program of catastrophic health insurance interferes with the right of employers and employees to decide the type of health care benefit package they want and can afford. A catastrophic insurance program also would be costly and inflationary. For example, according to data compiled by the Health Insurance Institute, many small businesses may have to pay an additional $600 per year per employee for a government mandated catastrophic health insurance program. Table 3 compares HEW and HII estimates on how this cost would vary depending on the deductible and types of dependents covered.

Table 3

ANNUAL PREMIUM COST PER EMPLOYEE
FOR CATASTROPHIC HEALTH INSURANCE (FY 1981) 1/

MAXIMUM FAMILY RESPONSIBILITY	INDUSTRY ESTIMATE	HEW ESTIMATE
$5,000	$392 ($445) 2/	$141 2/
3,500	551 (625) 2/	370 3/
2,500	726 (823) 2/	[illegible] 3/

1/ Total premium cost for employees with no group coverage. Assumes no employee share of cost, no coverage for collateral dependents or for drugs.
2/ Figures in parentheses include coverage of collateral dependents.
3/ HEW estimates are based on all employees. Industry estimates are based on those employees selecting coverage.

Source: Health Insurance Institute

A third possible problem with a catastrophic-only program is that it could cause the health care system to concentrate on delivering more and more expensive health care, when, in fact, more emphasis needs to be placed on preventive and outpatient primary care.

Finally, a catastrophic health insurance program could be the first step toward national health insurance, with the deductible level for eligibility being gradually lowered and more and more budgetable services being covered through a government-mandated program.

For all of these reasons, the Chamber opposes a government-mandated catastrophic health insurance program as embodied in S.760, S.748, the Finance Committee conceptual plan outlined last year, and other proposals with similar provisions.

Competitive Health Insurance. These proposals, sponsored by Senators Schweiker (S.1590) and Durenberger (S.1968), would attempt to promote more competition among health care providers and insurers by requiring employers to offer several choices of qualified health care plans and setting limits on how much employers could pay for health insurance. This would be accomplished by revising the tax code to allow business to deduct the cost of such plans only up to a certain dollar limit and only when several plans -- which meet certain standards -- are offered.

Competition in health care is best exemplified by prepaid health care plans, also known as health maintenance organizations (HMO). HMOs have demonstrated a unique ability to contain costs while providing high quality care. One of the reasons is that the plans are at risk to keep patients healthy as well as treat them when they are sick or injured. In HMOs, emphasis is placed on preventive and outpatient care, resulting in only one-half the number of admissions to hospitals (the most expensive settings in which to receive health care) as occur with conventional health plans. As a result total health care costs -- premiums plus out-of-pocket -- tend to be lower than those associated with traditional health insurance.

Employers have found that providing HMOs as a health insurance option to employees does not increase their administrative costs significantly and frees them from processing claims and reconciling grievances that sometimes arise in doctor-patient insurer arrangements. Consequently, over 10,000 employers are offering HMOs as an option to health insurance.

Thus, offering choices of health care plans, including HMOs, already is occurring to a large degree. Another federal law for this purpose, one which would set a limit on how much employers and employees could spend on health care coverage, is unnecessary and could inhibit the growth of HMOs because of their association with the heavy hand of government.

Setting a limit on how much employers can contribute to health care plans might appear to be a cost containment device. However, such arbitrary limits do not reflect regional differences in health prices, interfere with self insured plans, and could establish a high level floor rather than a ceiling on such contributions. At the same time, the Chamber supports the notion of a uniform payment by employers for all types of health plans.

The competitive-type plans also encourage consumer cost sharing, which the Chamber supports as a necessary way to bring more cost consciousness into the health care system. Competitive-type legislation requires that high and low options be made available. Employees choosing lower priced plans would receive a rebate, which would be taxable under some bills and non-taxable under others. All savings then would go to the employee and none to the employers. Greater cost savings could result if employers were able to share in the savings.

Another problem associated with the competitive-type plans is their requirement that employers continue to provide catastrophic-only protection to employees for up to three months after they have been terminated. Although such a requirement would help to fill in the gaps in health insurance coverage, such a mandate would be particularly costly to businesses with seasonal and high labor turnover. Some retailers could have more people off than on the payroll coverage for health insurance. Continuous coverage provisions should be linked to an appropriate length of service.

Thus, although the competitive-type bills are less undesirable than the comprehensive or catastrophic proposals, the U.S. Chamber cannot support them because they, too, infringe on the employers' right to negotiate health benefits with employees. They also force employers to provide choices when such choices are already voluntarily offered by employers.

With certain modifications, such as more flexible guidelines on offering choices and premium contributions, the elimination of the catastrophic requirement, and a sharing of cost savings between employees and employers, competition legislation may become more acceptable to the business community.

Summary

As I said at the beginning, over 95 percent of the American population has some form of health insurance. The real challenge is to provide the remaining five percent with access to protection against health care costs, while, at the same time, continuing to contain these costs.

Creating comprehensive or catastrophic-only programs may help solve this coverage problem but will most assuredly worsen health care cost inflation.

A better approach is to provide assistance and incentives to small business to offer cost effective group health insurance. Business organizations,

including trade associations and state and local chambers of commerce, are already providing access to such plans to their members, especially small business members. Such efforts are largely responsible for the significant increase in employer provided health insurance coverage. Also, state-administered pools of private health insurers should be created to cover persons who are not insurable because of their health status, lack of employment or unavailability of employment based health insurance. Such pools are already in operation in several states. Finally, improvements need to be made in Medicare and Medicaid, such as increasing the eligibility and services -- including catastrophic benefits. However, before such improvements are made in these programs, more efficiency and accountability are needed in their operations.

The U.S. Chamber has made a major commitment to improving the health care system, through the implementation of its widely acclaimed Health Action program. This nationwide, community oriented effort is based on a two year study sponsored by the National Chamber's Foundation, an affiliate of the U.S. Chamber.

This study found that America's health care system can be best improved by promoting more competition among health care providers and insurers, cost consciousness among providers and consumers, and individual responsibility among consumers. One of the ways to achieve these objectives is to have business and other community leaders use their clout and expertise to contain costs and improve health in their companies and communities. Specifically, the Chamber's Health Action program recommends that employers begin designing health insurance policies which encourage more outpatient care, promoting the growth and development of prepaid health care, instituting

health education programs in the workplace, and encouraging more participation in health planning. Thus far, about 25 communities have implemented their own action plans on health.

The recommendations in our Health Action program and those listed above represent an effective strategy to improve health and contain costs, without mandating government programs of comprehensive, catastrophic or competition health insurance. The improvements made in coverage and reduced cost inflation over the last five years are a testimonial to the effectiveness of this alternative.

Senator TALMADGE. Our next witness is Mr. Harold O. Buzzell, president of Health Industry Manufacturers Association accompanied by Kenneth Marshall, chairman of the board and also Mr. Karl D. Bays, chairman of the board and chief executive officer of American Hospital Supply Corp.

Gentlemen, you may insert your full statements in the record and divide your time in any way you see fit.

STATEMENT OF KARL D. BAYS, CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER, AMERICAN HOSPITAL SUPPLY CORP.

Mr. BAYS. Thank you, Mr. Chairman.

I am Karl Bays, chairman and chief executive officer of American Hospital Supply Corp. Our company is a manufacturer and distributor of health care products worldwide. We have 30,700 employees.

I have been a member of the industry for 22 years and my involvement has included service on the Cost of Living Council's Health Advisory Committee in the early 1970's and I work today serving on the boards of two large medical centers and the hospital in my home community.

My concern about health care consumers includes 250,000 employees at corporations where I am a director.

I view health care as a manager; a consumer; a citizen and a competitor. I also view the field as one who is convinced we must get at some basic issues affecting the cost of the excellent health care that our nation provides.

I welcome this committee's focus on these issues.

Certainly one of the most basic health cost issues is demand including accelerated demand created by the overwhelming success of medicare, medicaid and private insurance programs.

During the debate on mandatory hospital cost containment, it never made much sense to me to blame hospitals for meeting that demand, for doing what was asked of them by doctors and their well insured patients.

S. 1968 suggests a productive approach to creation of incentives and encouraging new competition and cost awareness among health care providers and consumers.

Our corporation has actively supported the voluntary effort to contain hospital costs. For example in 1977 and 1978 our prices were up only 3 percent and in 1979 our prices were up less than 5 percent.

We cannot put all our hopes for reduced health spending on any one program. My opinion is that would be unrealistic. The voluntary effort has produced results but we must also deal with the most basic issues affecting demand and ultimately costs.

There are two things I believe we must do. First of all, we must move quickly to extend health care to those who still lack adequate care and specifically to people lacking protection against catastrophic costs. I realize I differ here with my colleagues from the U.S. chamber.

I believe we can afford to do this and I do not believe we can afford not to.

Second, the industry and Congress must work together if we are to succeed in developing cost effectiveness among health care providers serving both privately-insured and Government insured employees.

I am convinced that increased competition is the only way to extend care and manage costs without potentially counterproductive regulation. I do not see any reason why competition cannot be beneficially increased in health care. In its pure form, competition simply means concern about consumer needs and innovation in serving those needs.

It means consumers deciding what is best for them. As a supplier, American Hospital Supply Corp. specializes in developing and providing systems that help hospitals operate efficiently. We do this because it benefits our hospital customers but we also do it because it benefits us in a highly competitive market.

As an employer our commitment to cost saving systems for hospitals must be matched by a commitment to managing the costs of employee health benefits. Medical and dental benefits for our employees cost almost twice as much per covered employee today as it did in 1975. That is a worthwhile investment and one we are happy to make.

We are also obliged to make sure it is a productive investment and an investment in the best possible health care at the lowest possible cost.

Our experience in this area may be instructive. During this past year we have changed carriers for our self insured health plan. We have done this to take advantage of more cost effective and responsive administration. We have expanded our home health care coverage for employees and their families. We are paying for surgical second opinions. We are discouraging unnecessary use of the emergency room. We are encouraging preventive care through immunization and health promotion programs we sponsor.

We offer one basic health benefit plan to most U.S. employees. A third of our employees live in areas that have health maintenance organizations. In some locations there are more than one HMO.

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American's contribution to an employee's health coverage is standard whether the individual chooses to enroll in an HMO or not.

To date 10 percent of our employees with available HMO coverage have enrolled. That is up from 5 percent last year. In some of our locations the enrollment is 30 percent. Employees tell us they welcome the choice.

We have experienced no added administrative costs in offering HMO coverage. We have experienced no undue shifting back and forth from one plan to another to take advantage of specific benefits.

In many of our locations HMO coverage is currently not available or feasible. We still want to offer choices to these people. We are studying the feasibility of other alternatives including a low cost insurance option.

I can assure you, Mr. Chairman, that our employees are highly interested in and knowledgeable about health care benefits. Even the slightest change in our health benefits package is well scrutinized by these consumers.

In summary, I would like to recommend that the committee keep several points in mind. We must avoid regulation even regulation in the name of competition that further complicates, confuses and raises the costs of operating the health care system. Any final legislation should truly promote competition. This should be done through development of the broadest possible variety of delivery options and it should not favor one form of health care delivery over another.

Careful consideration must be given to the special contributions that teaching hospitals make to the Nation's health care system. I am afraid that legislation designed to increase competition might do so at the expense of the vital research and educational functions of these institutions. I would encourage you to look at them separately.

Mr. Chairman, I thank you.

Senator TALMADGE. Thank you. Mr. Marshall?

STATEMENT OF KENNETH MARSHALL, CHAIRMAN OF THE BOARD, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION, ACCOMPANIED BY HAROLD O. BUZZELL, PRESIDENT

Mr. MARSHALL. Mr. Chairman and committee members, I'm Ken Marshall, chairman of the board of the Health Industry Manufacturers Association (HIMA), a trade association representing more than 260 manufacturers of medical devices and diagnostic products. I am accompanied by Hal Buzzell, president of HIMA. The association offers its comments on S. 1968 both as the representative of a highly competitive group of health care producers, and as employers with a strong interest in maintaining the good health of their employees.

Being in the medical care business, it is natural that we believe all Americans should have access to, and an adequate level of, high quality health care. Furthermore, these goals can be achieved most efficiently by relying on the private sector to finance and deliver the majority of care with minimal Federal involvement.

This is not to deny the Government a legitimate role within the health care system. For example:

We recognize the requirement of the Food and Drug Administration (FDA) to inform and protect the public from hazardous health care services and products. To that end, we worked closely with Congress and FDA in developing medical device legislation.

Much of the biomedical research conducted within the United States is supported by the Government through the National Institutes of Health (NIH). Without NIH initiatives to assume the risks of basic R. & D., the quality of American medical care would suffer dramatically.

Federal entitlement programs like medicare, medicaid, and ESRD provide health insurance benefits to a significant portion of the population. Without these income transfers many citizens would be unable to purchase basic medical services, and the distribution of health care resources would be highly inequitable.

On the other hand, we do not believe that Federal intervention geared to rationing health care—as the Carter administration attempted to do with its hospital cost containment proposal—is either effective or warranted. As a consequence, we joined most of the other witnesses appearing yesterday and today in opposing this legislation. We congratulate this committee for its efforts to focus attention on medicare-medicaid reform, and on legislation such as Senator Durenberger's proposal to encourage competition which is the subject of today's hearings.

From our perspective, S. 1968 addresses three perceived problems within the health care system. They are: One, a lack of consumer and provider concern with the cost of medical care. Clearly, high option fee-for-service health insurance plans give consumers and providers little incentive to consider the cost of the health services they use. During the past two decades the trend has been for employers to provide their employees with exactly this type of health insurance.

Two, excessive health insurance coverage in some private industries, and for many Federal employees. Specifically, selected employee groups, for example, automotive workers, have been encouraged by open-ended Federal tax subsidies to bargain for comprehensive first-dollar insurance packages provided by their employers. Monthly premiums for such extensive health benefits may exceed $200—all tax free. Also, Federal employees are encouraged to buy high-cost health insurance through the Federal employees health benefit program. On an average, Government workers choosing high option health insurance receive $300 more in annual premium contributions than those who enroll in low option plans. It should come as no surprise that 90 percent choose high option.

Three, the absence of incentives that would cause carriers to offer, and consumers to choose from, different health insurance benefit plans. The vast majority of businesses within our own and other industries do not offer their employees a choice of health insurance options. It is our observation, however, that when employers voluntarily provide such choices, employees react by selecting plans that best suit their needs. It is important to recognize, however, that increasing choices will entail costs that must be weighed against expected benefits.

We support many of the principles embodied in S. 1968. Specifically, we agree that:

One, existing Federal tax policy encourages employers and employees to overinsure.

Two, existing Federal and some private sector company policy and practice encourages employees to overinsure.

Three, the system for financing and delivering health care in America would benefit from more competition. Increased competition will introduce copayments, deductibles, and prepaid plans that produce greater consumer and provider awareness of medical cost and necessity.

Although we support these principles, we do have reservations about the methodology employed in S. 1968 to implement them. Our major concerns surface in three areas:

One, S. 1968 requires that social security benefits be provided in each option of an employers health plan. This poses a significant problem, since most employees demand a mix of health care services far different from the average medicare patient. A truly competitive health insurance system would allow consumers to choose from an array of different benefit packages the one that best suits their needs. By mandating benefits this bill will limit the flexibility of insurers and constrain consumer choice.

Two, the legislation avoids any reference to HMO's or prepaid health care systems recognized as controlling utilization and providing cost-effective health care. The implicit assumption may be that such alternative delivery systems will be fostered in a world of free competition and multiple choice. Whether this will happen is unclear, however. By creating an insurance system with rebates for low option coverage and inflexible benefit packages, this bill could stifle innovation in the delivery of health care.

Three, we believe that substantial research needs to be done regarding the costs of implementing this bill. Specifically: (a) The costs of negotiating with three separate carriers and keeping workers informed about their choices must be justified through health care cost savings; and (b) For those employers that presently offer multiple options and contribute different amounts to each, the equal contribution-rebate requirement in this bill could prove quite costly. This provision could force firms to provide increased compensation to employees who previously elected lower cost options.

For example, the Federal employee health benefit program presently provides multiple choice and variable contributions to its employees. Approximately 300,000 Federal employees choosing low-cost options receive contributions to their monthly premiums that average $40—much less than the legal maximum of $66 contributed to high option plans. The enactment of S. 1968 could increase Federal outlays for employee compensation by $90 million—300,000 times $300 a year—in the form of windfall rebates to selected workers.

Generally, we do not believe that the movement to a more competitive health care system need be overly burdensome to either firms or their employees. We strongly advise the committee to scrutinize those responsibilities for promoting competition assigned to Federal agencies by this law. In light of past experience, we urge

you to seek alternative mechanisms whereby the private sector can accomplish the same tasks without centralized direction.

Clearly, the process of refining this legislation will require close scrutiny and careful analysis of its expected impacts. During this gestation period, we will be happy to provide industry guidance on this important legislative pathway.

Thank you for the opportunity to present HIMA's views before you today.

Senator TALMADGE. Thank you very much. Both statements are very good.

Mr. Bays, the contention is made that labor and management have no incentive to seek moderated health insurance premiums because the employers premiums are tax deductible without limit. Is that true at your corporation?

Mr. BAYS. No; it is not, Mr. Chairman.

As I pointed out, we have done a number of things in the last year to try and reduce the cost of our health care coverage. Our costs have been going up approximately 23 percent a year, compounded until last year, and through some of the measures that I mentioned in my statement, we were able to bring that increase down to 16 percent, or lower than 16 percent.

So, I think that is clear evidence that we are certainly trying to keep control of those costs.

Senator TALMADGE. We received a report from the Comptroller General describing unusual and significant differences in prices paid by losses for the same or similar supplies. For example, GAO reported in Atlanta the lowest price paid by a hospital for an oxygen cylinder was $2.65 and the highest price paid was $5. Fluorescent lamps in Atlanta ranged from a high of $1.22 to a low of 59 cents. Also in hospitals in Atlanta, 500 milligram penicillin tablets ranged from a high of $18.52 per 100 to a low of $3.92

GAO reported similar problems in five other cities throughout the United States.

It seems to me that we may well have a problem of inadequate information and inadequate competition in the hospital supply business.

Following up on the approach in S. 1968, we might want to require that for identical or comparable supplies hospital must secure at least three bids from three different independent supplier, and that regardless of the low bid we would not recognize as reasonable any costs which exceed the average price paid throughout the country for that item.

What is the difference between the purchase and provision of hospital supplies and the purchase and provision of health care insurance?

Mr. BAYS. Mr. Chairman, I am familiar with the GAO study that you referred to. I am not familiar with the methodology used in it. It is my understanding that the survey did about one-half of 1 percent of U.S. hospitals, so it is a very limited survey. I don't know what comparisons were made in these particular studies as it relates to products, the service, the quality and other variables such as quantity, volume purchases, the quantity purchased, freight charges, discounts for volume orders, and a number of other

things that go into the purchasing and selling of hospital supplies in our business.

As a matter of fact, I did read that in claiming these wide variances in pricing, the total report said that there was a cumulative differential of only about 10 percent over all, although it did point out, as you suggested it did, a number of wide variances with individual products.

So, it seems to me that there would have to be a lot more study done before you jump into something as far reaching as what you just proposed.

Let me add two other points in answer to that:

First, I can assure you it is a very competitive business. If you talk to the financial communities who monitor our industry, I think you will find they find it to be very competitive, and certainly our company does, and I know the cost represented by the Health Industry Manufacturers Association does.

Also, let me point out to you that bidding on products is probably, in my opinion, the worst way to get the best purchasing because it does not take into effect the cost of carrying inventory; it does not take into effect any of the systems being required today which are doing a great deal to reduce the cost of health care.

I would be delighted to talk with you further on this subject, because I think the GAO study deserves a lot more study before you jump to anything like you are proposing.

Senator TALMADGE. I was not proposing it. I was merely asking a question.

Mr. BAYS. I thought you did say you were proposing it.

Senator TALMADGE. I said, what is the difference between mandating average cost price purchase of supplies and mandating a particular system of health care? That is the question I asked.

Mr. BAYS. I misunderstood you. Your question is that——

Senator TALMADGE. If you are going to mandate health coverage, why should we mandate cost of vendors' products, is the question I asked.

Mr. BAYS. To mandate health coverage is a social question, Mr. Chairman.

Senator TALMADGE. Health premiums. The question was this: If we are going to mandate cost of health insurance premiums, wouldn't it make just as much sense to mandate the cost of products vendors would sell?

Mr. BAYS. No; because the reason that you are talking about mandating coverage of insurance, Mr. Chairman, is because it is the opinion of the committee and others, or some members of this committee, that you don't have the competition inherent that you have in other aspects of the economy, and I am trying to state that you do, in fact, have that competition going into the sale and purchase of hospital supplies.

So, I see a great difference in the two, Mr. Chairman.

Mr. MARSHALL. To respond to your question, the implication in the GAO report is that if one person is paying $2 and that is the lowest price, everybody should pay $2. I don't believe that is the kind of mandating you are talking about in health insurance. We are talking about competition among different groups that can

provide a total package of service. There is not a minimum benefit package, so suppliers can provide what the consumer wants.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman.

Thank you for your presentation and your responses to that question.

The statement that you presented brings forth a point I don't think anyone has brought up before, and I think it is very well made. We often use the Federal employees health benefits program as an example of multiple choice, and it is an example only of multiple choice, but it does not have equal employer contribution.

You make the point well about the failure of the Federal Government to provide for equal employer contribution. The result is an oversubsidizing of a lot of us.

I think the other part—and I speak from the experience of one who has been presented with the 20 small-print books and having to make up my mind—it is impossible to make a choice under the Federal system unless you hire an adviser to guide you through the process.

One of the neat things about what I have seen in private industry is the way in which employers do provide for easing into employee choice with both materials and other kinds of opportunity to guide them in making a choice. We don't have the Federal employees. We get these books slapped on us, with fine print, and there is no way you can make a choice.

So, I think that is an important contribution.

Mr. MARSHALL. The comment was made by the representative of the chamber that companies to a degree compete for employees by providing good benefits programs. I think that is true in varying degrees. If you are going to provide the programs, then you try and present them in a way that people can find them useful for them.

When we take on multiple choice, we try to take on the responsibility to make sure people understand the choice they are going to make. They are going to blame us if they make bad choices, because they did not have good information. We don't want to be in that position with people who are important to our company.

Senator DURENBERGER. Following on that point, Mr. Bays, you said either no additional cost increase or a minimal amount of administrative cost increase. I guess there must be a lot of employers in this country that find that hard to believe. If you would describe the kind of cost increase that is required to move from a single plan to multiple, it might be helpful.

Mr. BAYS. I think the point that Mr. Marshall and that you made earlier, Senator, about the communications, is the key to our success in this area. We work very hard in preparing materials and include a film strip that we provide to all of our employees, all U.S. employees, and we insisted that that be shown at each of our locations. We had training meetings of our personnel people, to come in, to be sure that they were fully informed on the multiple choice.

I am not particularly happy with the HMO, the job we have done in the MMO area, although we have doubled it. We have some locations like south Florida where we have over 30 percent enrollment, and other areas where we have not done so well.

But I would say the majority of the cost now has been in this area, and in the training area and preparation of materials. This also came about at a time when we were making our programs, as I mentioned earlier, to get our cost down, so it is difficult for me to give you a precise increase because our costs over all did not go down last year.

Senator DURENBERGER. One of the things we talked about here today is the higher cost of HMO's, at least initially. Maybe one of you has experience to comment on that.

The federally qualified HMO, of course, is under certain requirements which many State qualified and other HMO's are not. This adds substantially to the expense of a federally qualified HMO in doing business.

Do any of you, based on your experience, have thoughts about the future of competition without Federal HMO mandate?

Mr. MARSHALL. In my experience, the fastest growing HMO's are not federally qualified. In St. Louis, a new one formed in late 1978; they finished their first 12 months on January 31. It is the IPA St. Louis Metro. We are now investing in it because we are considering offering it to our people. They recruited 27,000 members and finished the first 12 months in the black.

That is quite an accomplishment. They received no subsidy; they raised their money through subscriptions of doctors at $10,000 a head. We think from what we see that is a fast growing area.

One of their advantages that they explained to us is the ability to experience rate rather than community rate. That lets them go out initially and target on large employers and large groups of employees to offer them a good, competitive plan that creates good signup.

Senator TALMADGE. Thank you, gentlemen. We appreciate your fine contribution which you have made.

[The prepared statements of the preceding panel follow. Oral testimony continues on p. 331.]

Karl D. Bays
American Hospital Supply Corporation

Summary of Recommendations on S.1968

American Hospital Supply Corporation has actively supported the Voluntary Effort to contain hospital costs. But we can't put all our hopes for reduced health spending on any one program. That would be unrealistic. The Voluntary Effort has produced results. But we must now deal with the more basic issues affecting demand and, ultimately, costs.

Competition is the only way to extend care and manage costs without potentially counter-productive regulation.

As a supplier, American Hospital Supply Corporation specializes in developing and providing systems that help hospitals operate efficiently.

As an employer, American believes its commitment to cost-saving systems for hospitals should be matched by a commitment to managing the costs of employee health benefits.

5. Maximum employer flexibility should be required to use more than one carrier or to offer more than two options.

6. Provisions such as coverage for terminated employees do not promote the intent of the bill and should be excluded.

7. The progress of this legislation toward its goal should be reported on annually by the Secretary of Health and Human Resources.

S.1968 holds great promise. It recognizes the wisdom of the choices that consumers collectively make. Consumers, given the opportunity, can make informed and correct choices about health care, as they do about other purchases.

American's experience with employee-choice plans and fixed contributions has been positive.

The committee is cautioned against acting hastily amid the current enthusiasm about the idea of competition. We should guard against well-intentioned measures that don't produce desired results, or do produce undesired results.

1. Regulation that further complicates the operations of business and of the health-care system must be avoided.

2. Final legislation shouldn't favor one form of health-care delivery over another.

3. The special needs of teaching hospitals must be taken into acount.

4. The multiple-choice and equal-contribution requirements of S.1968 should be extended to Medicare and Medicaid as soon as possible.

Statement of

Karl D. Bays

Chairman of the Board

American Hospital Supply Corporation

Before the

Subcommittee on Health

of the

Senate Committee on Finance

on

S.1968

The Health Incentives Reform Act

Mr. Chairman, I'm Karl D. Bays, chairman and chief executive officer of American Hospital Supply Corporation. American is a manufacturer and distributor of health-care products. We have 30,700 employees.

I've been a consumer of health care for 46 years and a member of the industry for 22 years. My involvement has included service on the Cost of Living Council's health advisory committee in the early 1970s. My work today includes serving on the boards of two large medical centers and the hospital in my home community. My concern about health-care consumers includes 250,000 employees at seven corporations where I'm a director.

So I view health care as a manager, a consumer, a concerned citizen and a competitor. I also view the field as one who's convinced that we must get at some basic issues affecting the cost of the excellent health care our nation provides. I appreciate the focus that Senator Durenberger and his co-sponsors, Senators Heinz and Boren, have brought to bear on some of those issues in S.1968, the Health Incentives Reform Act.

Certainly one of the most basic health-cost issues is demand, including accelerated demand created by the overwhelming success of Medicare, Medicaid and private insurance programs. During the debate on mandatory hospital cost-containment, it never made sense to me to blame hospitals for meeting that demand--for doing what was asked of them by doctors and their well insured patients.

S.1968 suggests a more productive approach, through creation of incentives that encourage new competition and cost-awareness among health-care providers and consumers.

American Hospital Supply Corporation has actively supported the Voluntary Effort to contain hospital costs. But we can't put all our hopes for reduced health spending on any one program. That would be unrealistic. The Voluntary Effort has produced results. But we must now deal with the more basic issues affecting demand and, ultimately, costs.

There are two things I believe we must do:

1. We must move quickly to extend health care to those who still lack adequate care, and specifically to people lacking protection against catastrophic costs. I believe we can afford to do this. I don't believe we can afford not to.

2. The industry and Congress must work together if we're to succeed in developing cost-effectiveness among health-care providers serving both privately insured and government-insured consumers.

I'm convinced that increased competition is the only way to extend care and manage costs without potentially counter-productive regulation. And I don't see any reason why competition can't be beneficially increased in health care. In its pure form, competition simply means concern about consumer needs and innovation in serving those needs.

As a supplier, American Hospital Supply Corporation specializes in developing and providing systems that help hospitals operate efficiently. We do this because it benefits our hospital customers, but also because it benefits us in a highly competitive market.

As an employer, American believes its commitment to cost-saving systems for hospitals should be matched by a commitment to managing the costs of employee health benefits.

Medical and dental benefits for our employees cost almost twice as much per covered employee today as they did in 1975. That's a worthwhile investment and

one we're happy to make. But we're also obliged to make sure it's a productive investment--an investment in the best possible health care at the lowest possible cost.

Our experience in this area may be instructive. During just the past year, we've changed carriers for our self-insured health plan, to take advantage of more cost-effective administration. We've expanded our home health-care coverage for employees and their families. We're paying for surgical second opinions. We're discouraging unnecessary use of the emergency room. We're encouraging preventive care through immunization and health-promotion programs we sponsor.

We offer one basic health-benefit plan to most U.S. employees. A third of our employees live in areas that have Health Maintenance Organizations. In some locations, more than one HMO is available. American's contribution to an employee's health coverage is standard, whether the individual chooses to enroll in an HMO or not.

To date, 10 percent of our employees with available HMO coverage have enrolled. That's up from 5 percent last year. In some of our locations, the enrollment is 30 percent. Employees tell us they welcome the choice.

We haven't experienced any added administrative costs in offering HMO coverage, or any undue shifting back and forth from one plan to another to take advantage of specific benefits.

In many of our locations, HMO coverage is currently not feasible. We still want to offer choices to these people, however. We're studying the feasibility of alternatives, including a lower-cost insurance option.

I can assure you that our employees are highly interested in, and knowledgeable about, health-care benefits. Even the slightest change in our health-benefits package is well scrutinized by these consumers.

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American's experience with employee-choice plans and fixed contributions has been positive. And I don't believe our experience has been unique among corporations that have tried these programs.

I must add a caution, however, against acting hastily amid the current enthusiasm about the idea of competition. I urge the committee to be deliberate in exploring the full impact of each step taken in this area. We should guard against well-intentioned measures that don't produce desired results, or do produce undesired results.

I hope the committee will keep several points in mind:

1. We must avoid regulation--even regulation in the name of competition--that further complicates and confuses the operations of the health-care system.

2. Any final legislation should truly promote competition, through development of the broadest possible variety of delivery options. It shouldn't favor one form of health-care delivery over another.

3. Careful consideration must be given to the special contributions that teaching hospitals make to the nation's health-care system. Legislation designed to increase competition must not do so at the expense of vital research and education functions.

4. The multiple-choice and equal-contribution requirements of S.1968 should be extended to the Medicare and Medicaid programs as soon as possible. These consumers should have options, too. And hospitals should be able to treat government-insured patients on the same incentive basis as private patients.

5. Maximum flexibility must be maintained in any legislation that is enacted. Employers, for instance, should not be required to use a separate carrier for each health plan option. Multiple carriers could unnecessarily increase an employer's administrative costs. Employers who offer health insurance should not be required to offer more than two health plan options. A minimum requirement of two plans would guarantee choice for employees without imposing undue burdens on the employers. Furthermore, a multi-location company, such as American, would probably choose to offer two nationwide options in addition to local HMOs, thereby giving some employee groups three or four choices.

6. Further, in the area of flexibility, I believe the committee should guard carefully against including detailed provisions that really don't serve to increase competition or promote the basic intent of this bill.

An example is the proposal regarding insurance coverage for terminated employees.

7. A date, perhaps five years after enactment, should be set for the Secretary of Health and Human Resources to report on the effects of this legislation and its progress toward its goals. Annual reports should be required in the interim. Businesses are constantly required to change plans, programs and products as a result of changing events and conditions. Government, to be effective, must do the same.

In summary, I believe that S.1968 holds great promise. It recognizes the wisdom of the choices that consumers collectively make. Consumers, given the opportunity, can make informed and correct choices about health care, as they do about other purchases.

We need to increase competition, consumer-choice and cost-awareness among health-care providers and consumers. New incentives, designed wisely and well, could help make that happen.

Thank you very much.

TESTIMONY

OF THE

HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

PRESENTED BY

KENNETH A. MARSHALL
CHAIRMAN OF THE BOARD

AND

HAROLD O. BUZZELL
PRESIDENT

BEFORE THE

SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

ON

THE HEALTH INCENTIVES REFORM ACT
S. 1968

MARCH 19, 1980

SUMMARY

The Health Industry Manufacturers Association (HIMA), representing more than 260 manufacturers of medical devices and diagnostic products, believes that all Americans should have access to, and an adequate level of, high quality health care. Futhermore, these goals can be achieved most efficiently by relying on the private sector to finance and deliver the majority of care unencumbered by excessive Federal involvement.

We do not believe that Federal intervention geared to rationing health care - as the Carter Administration attempted to do with its Hospital Cost Containment Act - is either effective or warranted. As a consequence, we joined most of the other witnesses appearing yesterday and today in opposing this legislation. We congratulate this Committee in its efforts to focus attention on Medicare-Medicaid reform, and on legislation such as S. 1968 proposed by Senator Durenberger.

From our perspective, S. 1968 addresses three perceived problems within the health care system. They are:

- A lack of consumer awareness and concern with the cost of medical care.
- Excessive health insurance coverage in some private industries, for many Federal employees, and for the beneficiaries of entitlement programs.
- The absence of vigorous price competition among health insurance carriers for the premium dollars of consumers.

Although we support these principles, we do have reservations about the methodology employed in S. 1968 to implement them. Our major concerns surface in five areas:

(1) Medicare, Medicaid, and other public beneficiaries should be included in this program.

(2) If the intent of this bill is to encourage a trend towards lower levels of insurance coverage, this would be best accomplished by making the rebates tax-free.

(3) Tailoring a benefit package after the Social Security benefits is a significant problem.

(4) We believe that substantial research needs to be done regarding the costs of implementing this bill.

(5) It appears that this legislation will not be conducive to HMO development.

Mr. Chairman and Committee Members:

I'm Ken Marshall, Chairman of the Board of the Health Industry Manufacturers Association (HIMA), a trade association representing more than 260 manufacturers of medical devices and diagnostic products. I am accompanied by Hal Buzzell, President of HIMA. The Association offers its comments on S. 1968 both as the representative of a highly competitive group of health care producers, and as employers with a strong interest in maintaining the good health of their employees.

Being in the medical care business, it is natural that we believe all Americans should have access to, and an adequate level of, high quality health care. Furthermore, these goals can be achieved most efficiently by relying on the private sector to finance and deliver the majority of care unencumbered by excessive Federal involvement.

This is not to deny the government a legitimate role within the health care system. For example:

- We recognize the right of the Food and Drug Administration (FDA) to inform and protect the public from hazardous health care services and products. To that end, we worked closely with Congress and FDA in developing medical device legislation.

- Much of the biomedical research conducted within the United States is supported by the government through the National Institutes of Health (NIH). Without NIH initiatives to assume

the risks of basic R&D, the quality of American medical care would suffer dramatically.

- Federal entitlement programs like Medicare, Medicaid, and ESRD provide health insurance benefits to a significant portion of the population. Without these income transfers many citizens would be unable to purchase basic medical services, and the distribution of health care resources would be highly inequitable.

On the other hand, we do not believe that Federal intervention geared to rationing health care - as the Carter Administration attempted to do with its hospital cost containment proposal - is either effective or warranted. As a consequence, we joined most of the other witnesses appearing yesterday and today in opposing this legislation. We congratulate this Committee for its efforts to focus attention on Medicare-Medicaid reform, and on legislation such as S. 1968 proposed by Senator Durenberger.

From our perspective, S. 1968 addresses three perceived problems within the health care system. They are:

- A lack of consumer awareness and concern with the cost of medical care. Clearly, many consumers of health care are both unaware of and uninterested in the cost of the health services they use. In large part this behavior results from an insurance system that insulates the patient from the bulk of his medical bills. For example, the beneficiaries of most Federal health care programs (VA, DOD, Medicare/Medicaid) have virtually no stake in the cost of their care. To the extent that the Medicare and Medicaid programs involve some cost sharing, this can be eliminated through

the private insurance market.

- Excessive health insurance coverage in some private industries, for many Federal employees, and for the beneficiaries of entitlement programs. Specifically, selected employee groups (e.g., automotive workers) have been encouraged by open-ended Federal subsidies to bargain for comprehensive first-dollar insurance packages provided by their employers. Monthly premiums for such extensive health benefits may exceed $200 - all tax-free. Also, Federal employees are encouraged to buy high-cost health insurance through the Federal Employees Health Benefit Program. On an average, government workers choosing high-option health insurance receive $300 more in annual premium contributions than those who enroll in low-option plans. It should come as no surprise that 90% choose high-option. Finally, VA, DOD, and Medicare/Medicaid beneficiaries are provided with very liberal benefits at little or no cost.

- The absence of vigorous price competition among health insurance carriers for the premium dollars of consumers. Major employers in the private sector and their employees may benefit from lower premium increases due to carrier competition. Although substantial competition may already exist, especially where HMOs are offered, there has been little incentive to offer a range of options at varying prices. Certainly it will be important to weigh the administrative costs of fostering carrier competition against the expected benefits. Perhaps more can be done, but if such a move is desirable, it is unclear why many Federal programs haven't adopted it.

We support many of the principles embodied in S. 1968. Specifically, we agree that:

(1) Existing Federal tax policy encourages employers and employees to overinsure.

(2) Existing Federal policy and practice encourages government empoyees to overinsure, and provides excessive health insurance coverage for the VA, DOD, and Medicare/Medicaid populations.

(3) We support the principle of fostering a climate for increased competition among insurance carriers, especially if linked to consumer participation. Increased competition among insurers will introduce copayments, deductibles, and prepaid plans that produce greater consumer and provider awareness of medical cost and necessity.

Although we support these principles, we do have reservations about the methodology employed in S. 1968 to implement them. Our major concerns surface in five areas:

(1) Achieving the purposes of greater consumer awareness of medical costs, a shift towards lower levels of insurance coverage, and increased competition among insurance carriers will not occur unless Medicare, Medicaid and other public beneficiaries are included in the program. These groups consume over 40% of health care in America, and it is hard to imagine a health care system that excludes them ever being truly competitive.

(2) If the intent of this bill is to encourage a trend towards lower levels of insurance coverage, this would be best accomplished by making the rebates tax-free.

(3) Tailoring a benefit package after the Social Security benefits is a significant problem. Todays employees have far different needs than the Medicare patient.

(4) We believe that substantial research needs to be done regarding the costs of implementing this bill. Specifically:

(a) The costs of negotiating with three separate carriers and keeping workers informed about their choices could well exceed any insurance premium savings. We believe that in order to foster competition only two plans are necessary.

(b) For those employers that presently offer multiple options and contribute different amounts to each, the equal contribution-rebate requirement in this bill could prove quite costly. This provision could force firms to provide increased compensation to employees who previously elected lower cost options.

For example, the Federal Employee Health Benefit Program presently provides multiple choice and variable contributions to its employees. Approximately 300,000 Federal employees choosing low cost options receive contributions to their monthly premiums that average $40 - much less than the legal maximum of $66 contributed to high-option plans. The enactment of S. 1968 could increase Federal outlays for employee

compensation by $90 million (300,000 x $300/year) in the form of windfall rebates to selected workers.

(c) In light of the potential administrative costs previously discussed, we recommend that only employers with over 5,000 employees be covered by the multiple choice requirement.

(5) It appears that this legislation will not be conducive to HMO development. Our observation is that HMOs are priced at or above "high-option" indemnity plans. We feel that with contribution limits and rebates employees will tend toward the low cost option.

Generally, we do not believe that the movement to a more competitive health care system need be overly burdensome to either firms or their employees. We strongly advise the Committee to scrutinize those responsibilities for promoting competition assigned to Federal agencies by this law. In light of past experience, we urge you to seek alternative mechanisms whereby the private sector can accomplish the same tasks without centralized direction.

Clearly, the process of refining this legislation will require close scrutiny and careful analysis of its expected impacts. During this gestation period, we will be happy to provide industry guidance on this important legislative pathway.

Thank you for the opportunity to present HIMA's views before you today.

Senator TALMADGE. The next witness is Dr. Lowell H. Steen, chairman of the board of trustees, American Medical Association.

Dr. Steen, you may insert your full statement in the record and summarize it in any manner you see fit.

STATEMENT OF LOWELL H. STEEN, M.D., CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY WAYNE W. BRADLEY, GROUP VICE PRESIDENT, AMA; AND HARRY N. PETERSON, DIRECTOR, DIVISION OF LEGISLATIVE ACTIVITIES

Dr. STEEN. Thank you, Mr. Chairman, and members of the committee.

With me today here are Mr. Wayne Bradley, who is one of our group vice presidents, and Harry N. Peterson, director of the Division of Legislative Activities. We are pleased to present the views of the American Medical Association on S. 1968, a bill intended to promote economies in health care and expenditures through increased competition in health insurance and the delivery of care.

Mr. Chairman, for more than a decade the American Medical Association has been a major participant in the intensive debate on the subject of expanding availability and access to high quality medical care.

Procompetition proposals now before this committee bring new considerations to this debate. The goal of this legislation is to lower national expenditures for health care by assuring options of coverage to employees under employer health plans and thereby to generate competition in health care.

Mr. Chairman, the vast majority of the American people are protected by health insurance but there are some who through no fault of their own cannot obtain the coverage they need.

There are a number of changes that should be made in the private insurance system that would go a long way to close the gaps in health insurance coverage while building upon the strengths of the existing system of health care delivery.

For instance, minimum standards of adequate benefits should be contained in health insurance policies, with appropriate deductible and coinsurance.

A simple system of uniform benefits should be provided by Federal, State, and local governments for those unable to provide for their own medical care. Government might purchase private health insurance where possible in providing for the poor. Medical coverage would be improved through the purchase of private catastrophic coverage.

A nationwide program could be instituted by the private insurance industry—and Government, if necessary, for reinsurance—to make available catastrophic coverage to protect against the impact of a costly illness that could be economically devastating.

We call upon the committee to consider these points when reviewing any health insurance proposal.

Mr. Chairman, I shall now comment on some of the specifics of S. 1968, the Health Care Incentives Reform Act of 1979.

If you will now turn to the bottom of page 5 of our printed testimony—freedom of choice by the patient is a cornerstone of our American pluralistic system of health care delivery. The patient

chooses the method by which he will receive treatment, whether by a solo practitioner, a medical group, or a prepayment plan.

The consumer also decides whether to be insured under an insurance policy, a benefit plan, or an HMO. It is in this setting that American medicine has progressed to unchallenged world leadership and is unsurpassed in the quality of care it delivers.

S. 1968 would support this pluralism, as it calls upon employers to give added choices of coverage to their employees through private insurance or plans. It also assures that each of the various coverage options will contain certain benefits, including catastrophic coverage. It contemplates varying deductible and copayment levels depending on the coverage selected.

Participation of the employee in any plan would be voluntary on the part of the employee. While the bill is silent on who pays the premium, the premium would normally be shared with employer and employee according to terms agreed upon between the employer and his employees, or a bargaining agent for the employees. All of these elements are appropriate and should be supported.

The AMA supports competition in the delivery of medical services. Competition at its best can raise the quality of care and reduce costs of providing that care. Such competition is promoted in S. 1968 in the requirement of multiplan options.

But there are also limiting conditions to be considered. The bill requires that an employer with more than 100 employees who offers a health plan must offer three plan options to employees, with no specification as to the extent of the benefits to be provided. As one, and perhaps two, of the plan options, title XIII of the Public Health Service Act could operate to require that the employer offer membership in a health maintenance organization, HMO.

The AMA supports the use of HMO's as a method of delivering medical services in a pluralistic delivery system; however, under certain circumstances the law requires that two HMO plans be included as options in the employer's health benefits plan. Thus, the interrelationship between the HMO Act and S. 1968 does, in fact, produce a limitation on offer and choice of plans, which appears to be incompatible with the rationale of S. 1968 as the basis of competition.

Since the law already requires the furnishing of comprehensive benefits provided by an HMO, and there would be no corresponding broad coverage requirement for conventional insurance, competiton could suffer.

We are also concerned about the lack of specificity in the proposal which could cause inadequate coverage.

Any employee relying entirely on employment insurance for coverage could be lacking in protection under the proposal. In mandating minimum benefits, the bill requires simply that the employer health benefit plan cover the "same type of services" as are now provided in medicare.

No benefit plan except the mandated HMO option has to provide coverage adequate to meet the employee's needs. No limitation is placed on deductible or copayment, except in the context of the ceiling on health care expense.

Within the bare terms of the minimum standards of benefits, therefore, the employee would be assured only of catastrophic coverage, with a $3,500 out-of-pocket loss limit, or an even higher loss limit if the employer contribution did not cover the premium for a $3,500 deductible.

The main thrust of the bill is contained in the provisions changing the present exemption from income tax enjoyed by employees with respect to employer contributions to health insurance premiums. There is a provision for a system of cash rebates to employees designed to encourage employees to select a lower cost plan, and this is intended to shift to the employee a greater part of the cost of his overall health care and generates added cost awareness and restraint in spending.

We have reservations about a program that might encourage the individual to acquire less coverage than is desirable. Experience has shown generally that individuals, given the choice, will seek broad coverage. For example, medicare is a program designed to provide for coinsurance and cost sharing as a mechanism to restrain demand for health services; yet millions of medicare patients choose to pay additional premiums out of their limited income for supplemental insurance to assure broader coverage.

Savings under S. 1968 would come about gradually over a period of years, but during that interval certain changes would have to occur. Buying habits would have to change so that more Americans are willing to buy less-expensive, lower-option coverage, entailing more out-of-pocket costs, and employed persons would have to learn to make sophisticated economic choices in plan selection.

Against the prospect of gradual savings, however, the general public would be faced with an immediate change in the tax laws for added tax. Those who continued to opt for high-option coverage would become subject to tax on excess employer contribution to their insurance, without any compensatory reduction in premium.

There is a likelihood of increased premium for some individuals attributable to reduced group sizes and adverse selections, since younger, healthier employees would be expected to choose a low-benefit option until such time as the individual expects increased family medical costs.

In general, we believe that long-term advantages can be derived for all Americans through increased competition in the health industry. S. 1968 contains concepts aimed toward this goal.

In conclusion, Mr. Chairman, we support the principle of increased competition through multiple-choice insurance options for employees. Any legislation embodying such principles must also carry sufficient safeguards to protect the purchaser. Participation by the employee in the cost of his health care can be beneficial in reducing overall costs, but his level of participation must be realistic so that adequate coverage can be acquired by the individual.

We must never let quality be sacrificed to cost considerations.

Thank you.

Senator TALMADGE. Thank you for your fine statement.

Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman.

Thank you for the very specific statement. I have just a couple of questions:

One, over the period of the months I have been working on this, one valuable tool has been the study that the AMA sponsored, and the National Commission on the Cost of Medical Care. Though I know it is not official policy, if you would not mind, I would like the chairman to make it a part of the record.

Dr. STEEN. We would be delighted to have you do so.

[The information follows. Oral testimony continues on p. 350.]

NATIONAL COMMISSION ON THE COST OF MEDICAL CARE

Summary Report

DECEMBER 1977

CHAIRMAN'S MESSAGE

The problem of escalating health care costs does not lack for attention. Health care providers, government agencies, the media, social scientists, consumer groups, business, labor organizations, and other concerned persons have made numerous statements and asked many questions on the subject. Answers have been more difficult to come by. The need for answers, however, has not lessened. The Board of Trustees of the American Medical Association established an independent Commission on the Cost of Medical Care mandated to provide a comprehensive overview of health care costs and possible approaches toward solutions.

The 27 members, drawn from a broad base of expertise, accepted the responsibility of fulfilling the assignments designated in the Charge to the Commission. Those six points were:

- A description of the health care delivery system;
- Identification of the factors underlying the rising costs of health care;
- A review and evaluation of existing research on the causes of health care cost inflation;
- An evaluation of the impact of pending or future health care programs on the health care delivery system and health care costs;
- Recommendations on policies designed to contribute to containment of health care expenditures while providing quality care to the public; and
- Recommendations and directions for future research programs, including detailed description of existing data bases.

The three volumes of the full Commission Report contain the work of the Commission. Without the time and attention of the members, this task could not have been completed. In appreciation for their efforts, I would like to thank the members.

Of course, without adequate support staff the project would have been equally difficult to accomplish. On behalf of the Commission, I would like to acknowledge the staff of the American Medical Association's Center for Health Services Research and Development for their participation in the Commission work. In particular, the members would like to name the following individuals who have made the journey with us: Joel Bobula, Norbert Budde, Toba Cohen, Philip Cotterill, Louis Goodman, Lynn Jensen, Jacqueline Leopold, and Edward Meeker.

Max H. Parrott, M.D.
Chairman

Members of the Commission

Max H. Parrott, M.D., Chairman
Past President,
American Medical Association
Mr. Brooks Chandler
Vice Chairman of the Board,
Provident Life and Accident
Insurance Company
Michael DeBakey, M.D.
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Founder, Kaiser Permanente
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Mr. Dudley Towne
Watson Clinic
Stanley S. Wallack, Ph.D.
Congressional Budget Office (to 7-77)
Brandeis University
Advanced Studies of Social Welfare
L. Emmerson Ward, M.D.
Chairman, Mayo Foundation
Mr. Victor M. Zink
Director, Employee Benefits
and Services
General Motors Corporation
Toba J. Cohen
Executive Secretary

*Dr. Klar chose not to vote in order to emphasize that the Dept. of Health, Education, and Welfare had already promulgated its positions, policies, and initiatives regarding cost containment.

INTRODUCTION

Health care—a most fundamental and personal need—is being examined in a new light. After years of emphasizing access to and quality of care, society is calling to question the cost of delivering this service.

Health care costs have escalated over the decade from 1966 to 1976 with annual expenditures climbing from $42 billion to $137 billion. Expenditures on health care have grown at an average annual rate of 11 percent. While a little over half of this growth is attributable to a general rise in prices, this escalation rate is faster than for the rest of the economy. The health care share of the Gross National Product, now 8.6 percent, could, at present rates of growth, rise to 10 percent, or more, before the next three years pass.

The question is not whether 8 or 10 percent is too much, the question is one of benefits and priorities. As society perceives the need to support other social programs, it becomes increasingly clear that change is necessary. After years of consumers wanting unlimited care; government promoting growth in the production of both providers and facilities; and physicians providing service based solely on quality, it is necessary to instill alternative behavior patterns for everyone. Changes of the magnitude necessary are best developed through the combined efforts of decision makers from the areas where health care is purchased, delivered, and used.

An awareness of the need to provide guidelines for these changes, and an acute desire to tap resources outside the profession, led the Board of Trustees of the American Medical Association to establish a Commission on the Cost of Medical Care. The 27 members were recruited from business, labor, the health care delivery sector, academia, the consumer area, and government, and charged with delivering innovative solutions to health care cost problems. They were asked to engage in the kind of interchange that would deliver recommendations.

At the first Commission meeting, in March 1976, the members reviewed the trends in health care prices over the last decade and set to work defining specific areas in the delivery of health care that impact on costs. The resultant list was divided into four major areas to facilitate further analysis: 1) the system within which care is delivered, 2) the factors affecting demand for care, 3) the supply and distribution of providers, and 4) the technological innovations that are impacting on health care delivery. The Commission members then divided into task forces for each of the four areas.

Each task force was charged with producing recommendations for change in its area and preparing a task force report for consideration by the Commission. Each approached this charge in its own way.

The Commission, as a unit, worked through a format by which it: 1) assessed the problem by reviewing the background material provided by the task force reports; 2) listened to presentations on selected topics and conducted discussions in plenary sessions; 3) made recommendations in the Summary Commission Report; 4) listed gaps in information in a future research agenda; and 5) provided allied information through a listing of available data bases and a collection of papers containing materials presented at plenary sessions or solicited from the selected authors

The recommendations, contained in this section of the report, were agreed upon by a simple majority of the members. Any member wishing to express a formal dissent has done so. These reports are contained in appendix A of the full Commission Report.

Certain characteristics inherent in the health care delivery system affected all areas under consideration. The following discussion of this system, necessary to any analysis of costs, centers on the system's divergence from an economist's notion of an ideal market. Among the most important differences are the structure of health insurance and the associated subsidy effect; the lack of consumer and provider knowledge regarding the cost, efficacy, or necessity of specific medical procedures; and the potential ability of the provider to affect demand.

The current arrangements, while providing quality care to a wide range of consumers, have come under attack because of the rapidly increasing cost. The Commission defined two alternative approaches to the issue of cost containment: 1) strengthening consumer and provider price consciousness, and 2) expanding regulatory measures in an effort to exert widespread control over costs.

Strengthening price consciousness requires substantial restructuring of the incentives facing consumers and providers of health care. Some forms of regulation, especially public-utility type regulation tend to distort incentives for price consciousness. However, there is a useful role for some specific regulatory measures such as those designed to provide information to consumers and providers. A process of strengthening price consciousness combined with complementary regulatory schemes will lead, in terms of cost, quality, and access, to an optimal program of health care delivery.

In view of the ongoing discussions, in both the public and private sector, of the need to control health care costs, the Commission recognizes that it is advisable to effect changes in the current system. The report that follows represents the Commission's recommendations on what providers, consumers, insurers, and regulators should do to make the delivery of health care more cost effective.

STRENGTHENING PRICE CONSCIOUSNESS

The Commission examined two approaches for containing health care costs: strengthening price consciousness, and increased use of public-utility type regulation (e.g., controls on rates, revenues, and capital acquisitions). Both approaches have potential benefits. Reliance on market mechanisms can lead to cost-effective production of output, and permit consumer preferences to play a key role in determining what goods and services are produced.

Regulation, as a mechanism, can serve to avoid needless duplication of equipment in industries with significant economies of scale. In industries where well-functioning markets do not exist, regulation can provide a method for controlling price and/or revenues. Such control will determine the amount of resources in an industry and the distribution of output among consumers.

Both market-strengthening and public-utility type regulation have disadvantages. Sole reliance on price as a mechanism for determining access to care obviously has an adverse impact on the poor. Further, for a market to function well, consumers must be adequately informed about the prices, qualities, and efficacy of the alternatives (e.g., providers, treatments, and health plans) before them. Owing to the complexity of medicine, there is some doubt whether this condition can be sufficiently satisfied.

The disadvantages of regulation are seen in both practice and theory. Public-utility regulation has not usually been effective in reducing prices in other industries. It has been demonstrated that such regulation is a costly process that has often resulted in higher prices, less competition, and reduced levels of innovation. A fundamental problem with public-utility regulation, as it would manifest itself in health care delivery (in such terms as certificate-of-need legislation, regional budgets, and revenue limits), is that the regulator cannot possibly take the wide variety of consumer preferences into account when formulating policy.

In its debates on strengthening price consciousness and increasing public-utility regulation, the Commission recognized that each scheme had significant benefits and genuine drawbacks. After weighing each, it was decided that the most promising approach to cost containment, in the presence of insurance, is strengthening price consciousness. However, it is obvious that no market, especially one as complex as health care delivery, can operate completely free of regulation. Further, some mechanisms must be put in place to assure that no group of consumers is denied quality care due to inability to pay. A strategy combining elements of price consciousness and some regulation would remove many of the problems inherent in strict public-utility regulation. An important improvement is that total expenditures would be determined on the basis of individual decisions rather than by administrative fiat that would restrict individual choice. The greatest possible number of decisions about health care should remain with the individual consumer and provider as they best know what is required in each case.

Further, while the management of health care institutions should reflect an awareness of cost, it is necessary to emphasize that cost containment is not a goal in itself. The objective should not be to keep resources devoted to health care from growing, but rather to give those whose decisions affect health resources reason to take cognizance of costs.

Consumers would become more price conscious when choosing health insurance and health plans if, in the case of employer-provided plans, they were offered a wide range of alternatives, and if employer and government contributions for such alternatives were independent of total premium costs. This consumer price consciousness would encourage insurers and health plans to develop and implement more explicit incentives to hold down costs, because they would want to hold down the prices they charge for their plans.

Recommendation 1: Economic Incentives in Purchasing Insurance and Health Plans

A. New employees of firms that provide health care benefits should be allowed, whenever feasible, to choose among a number of health care programs offered to them by their employers, through certified carriers, including Health Maintenance Organizations. (Certification is discussed in Recommendation 7.) At periodic intervals, both old and new employees may change their health care program—choosing among the same options made available to new employees. In firms with employees represented by unions, the range of programs can be established through the collective bargaining process.

B. To give employees an economic incentive to shop for cost-effective health care coverage, employers who contribute to their employees' insurance premiums should do so through contributions that are the same for competing plans. In the case of plans, including public programs, whose premium cost is less than the contribution, the difference should be paid to the subscriber as a rebate or in the form of additional benefits. In firms represented by unions, the amount of contribution or the form of the rebate could be determined through collective bargaining.

C. In order to increase consumer price consciousness at the time of purchase of health plans or health care insurance, the current exclusion from taxable income of employer paid health insurance premiums and the current tax deduction for consumer payments for insurance premiums should be replaced with either a fixed dollar tax credit or deduction. The tax treatment

of payments for health plans and health care insurance should be identical for employer-provided and self-purchased programs.
D. Individuals who purchase health plans and health care insurance on their own should have plans made available to them for the same price, adjusted for actuarial and administrative differences, as that paid for employer-provided plans.

Consumer price consciousness should also be strengthened at the point where care is sought or delivered. An established approach is to have the patient share selectively, at the time of delivery, in the cost of utilized services. Because this encourages the patient and the provider to become more aware of actual costs, the type, quantity, and quality of health care used could be more selectively planned. To be effective, such a system must have an appreciable impact on out-of-pocket costs, be flexible enough to encourage early identification and treatment of illness, and be reasonably economical to administer. It is important that care be taken to provide a proper balance between price disincentives designed to discourage unneeded or unnecessarily expensive care and insurance incentives designed to encourage the use of needed and appropriate care. Further, cost sharing should be tailored to meet the needs of low income families.

Recommendation 2: Consumer Cost Sharing

Insurance policies should include provisions through which the consumer shares in the cost of care received, at the time of service, for selected benefits and for selected groups, and in which employees share in group premium costs. In firms with employees represented by unions, the range can be established through the collective bargaining process.

Price consciousness can also be raised by offering the consumer a choice among competing health care delivery arrangements. The Commission considered a number of schemes including Health Maintenance Organizations (HMOs), Health Care Alliances (HCAs), Variable Cost Insurance (VCI), and Health Maintenance Plans (HMPs). HMOs rely on prepaid capitation financing, that is, providers contract to deliver all health care services to subscribers for a fixed monthly charge. Capitation affects utilization of health care services primarily through the incentives it presents to providers. Those who have contracted to deliver services are at risk, consequently they have an incentive to deliver only necessary services. Moreover, HMOs must compete for patients partially on the basis of price, and so must be aware of costs. Considerable evidence exists to indicate that capitation systems can result in less costly treatment regimes, fewer cases of elective surgery, and lower hospitalization rates. Unfortunately, public policy has not been neutral between HMOs and fee-for-service practice.

However desirable, expansion of HMOs requires a large scale restructuring of the health care delivery system that cannot occur rapidly. Two experimental proposals, HCAs and VCI, are designed to achieve the beneficial effects of competition without requiring extensive reorganization of practice patterns. Both programs require little change in the way physicians practice, but would require changes in the way insurance is written. Providers would be experience-rated so that insurance premiums would reflect the costliness of the providers consumers choose.

Under Variable Cost Insurance (VCI), health insurers would offer policies that would be tied to specific groups of hospitals based on their specific cost experience. Those policies that provide coverage for the more expensive hospitals would have the more expensive premiums. Consumers, on consultation with their physicians, would be free to choose hospitals from those where their physician has staff privileges, however, the amount of their expenses that is reimbursed would depend upon their coverage. Because consumers would benefit from purchasing lower-priced plans, they would have an incentive to choose physicians associated with cost-effective hospitals. Accordingly, hospitals would have an incentive to contain their expenses in order to gain more attractive ratings. Physicians could, therefore, seek to alter their staff privilege arrangements and/or bring pressure upon hospitals to keep their costs down. Finally, even if consumers did not choose lower priced plans, the subsidy of those who use high-cost providers by those who use low-cost providers would end.

Under Health Care Alliances (HCAs), groups of physicians would be collectively experience-rated according to their adjusted annual expense per patient. All covered patient-related expenses, including hospitalization, would be considered in arriving at an HCA's rating, adjustments for the sickliness of patients would be included. Because consumers could benefit financially by choosing the less expensive plans, physicians in HCAs would have an incentive to deliver care cost effectively and thus hold down their ratings.

A Health Maintenance Plan is also designed to provide financial incentives for cost-effective delivery of care. The HMP was instituted in Wisconsin in 1972 under the auspices of Blue Shield. The Wisconsin Health Maintenance Plan is designed to collect and channel practice pattern and cost information back to participating providers. In addition, the program is set up to place the participating physicians at risk for part of the cost resulting from their recommendations.

Based on the potential these alternative arrangements have for providing incentives for price consciousness, the Commission believes in the importance of pursuing the following:

Recommendation 3: Fair Market Health Plan Competition

HMOs have the potential to strengthen consumer and provider price consciousness by competing on the basis of services delivered and price. Policy should be neutral between HMOs and fee-for-service practices, and there should be fair market competition between HMOs and other provider and insurance systems.

Recommendation 4: Alternative Financing Arrangements

Experiments should be conducted to test the effectiveness of health care financing arrangements such as: Variable Cost Insurance (VCI), Health Care Alliances (HCAs), and Health Maintenance Plans (HMPs).

In order for consumers to exercise informed choice, conditioned by price consciousness, it is necessary that they be able to obtain information on alternative providers and health plans. To the extent HMOs, VCI, or HMPs are adopted, information on price will be available. However, if cost sharing is relied upon as a cost-containment strategy, a special effort must be made to make information on price readily accessible. The Commission recognizes that it is considerably more difficult to provide information on quality than on price and, accordingly, recommends a major research program on this subject as well as the institution of certification, and periodic recertification, programs. These programs are designed to assure consumers that the certified providers, carriers, and health plans meet certain quality standards.

Recommendation 5: Regional Physician and Hospital Directories

On a voluntary basis, physicians should make available, in a regional directory, such information as prices for rather well-defined procedures, length of time required to obtain an appointment, willingness to accept new patients (or Medicare/Medicaid patients), institutional affiliations, and whether they are board-certified in their specialty. Hospital directories should also be available and include information on services offered and other information relevant to consumer choice.

Recommendation 6: Information on Alternative Health Care Plan Benefits

A. In order for consumers to understand the benefits provided by the alternative health care plans that they may buy, employers and unions should attempt to provide, in a format that facilitates comparison of services covered and exclusions, information on the alternative plans they offer. This should include the fraction of total premiums the insurer anticipates will be paid out in benefits and dividends for each plan.

B. In order to guard against abuses that may occur in the market, the concept of "Truth in Insurance," especially in the context of individual insurance, should be followed. Companies selling individual health insurance should be required to provide clear and concise disclosure material to consumers, setting forth the essential features of the coverage, including the fraction of total premiums the insurer anticipates will be paid out in benefits and dividends for each plan. They should further be required to provide policy benefits that are reasonable in relationship to premiums charged. If states do not enforce the advertising rules recommended by the National Association of Insurance Commissioners, federal legislation may be necessary.

Recommendation 7: Regulation of Insurance Carriers and Health Plans

Organizations financing health care services (e.g., insurance companies, Blue Cross, Blue Shield, HMOs, health and welfare trusts) should be certified at the state level on the basis of financial soundness, and plans should be routinely monitored by the same agency to guard against misrepresentation of cost or benefits. All carriers in a given regulatory jurisdiction should be subject to the same standards.

Information on quality assurance is required for meaningful competition among providers. The consumer must be in a position to appraise how various providers can benefit him and his family.

Recommendation 8: Assessment and Assurance of Quality

A. Recognizing that the quality of care given by a provider is difficult to measure, a major research effort, concentrating upon patient outcomes or upon process measures known to be associated with outcomes, should be undertaken to improve this ability.

B. Once a reliable method for measuring quality of care is available, the results should be communicated to consumers. A further research effort should concentrate on how this may most effectively be done.

C. Voluntary recertification programs can make information on provider quality available to consumers. Medical associations should promote voluntary recertification programs from which descriptions of the criteria for recertification, as well as information on on individual physician's participation in the programs, could be made available to consumers.

PRIVATE SECTOR COST CONTAINMENT INITIATIVES

The Commission discussed payment or reimbursement systems designed to stimulate cost-effective delivery of health care. These plans are based primarily on private-sector initiatives. They encourage organizations of providers and third-party payers to become more innovative in developing and implementing explicit incentive structures—such as programs to identify providers whose fees are outside specified norms—for containing health care costs.

Recommendation 9: Reimbursement Levels for Providers

Local groups of physicians, hospital people, third-party payers, and other appropriate parties should work together to reach agreement on the reasonableness of levels of reimbursement for providers.

Recommendation 10: Voluntary Cost Containment Program

With participation from outside the industry and the full involvement of the medical staff, the hospital industry is urged to put in place a structured voluntary cost-constraint program, based on periodic review and public notice of all hospital expenditures exceeding a predetermined acceptable limit.

The Commission also believes that reimbursement mechanisms are useful in providing incentives for hospitals to restrain, voluntarily, additions to capacity and to deliver care cost effectively.

Recommendation 11: Reimbursement Restrictions

Third-party payers, including government, should be encouraged to conduct experiments designed to reduce expenditures for inappropriate care, to reimburse only services performed on equipment approved by placement review, and to insure that charges for ancillary services are based on appropriate standards of utilization.

Recommendation 12: Prospective Rate Setting for Hospitals

Payment to institutions on the basis of prospectively determined rates, and other payment systems which also create incentives for facilities to be more cost conscious, should be explored and implemented as their effectiveness becomes clear.

Recommendation 13: Incentives to Limit Bed Capacity

Programs should be designed to provide incentives to hospitals to limit bed capacity according to the needs of the population served by the hospitals.

Peer review is a potentially important method of identifying appropriate care patterns To be effective, such review must consider cost-benefit implications as well as quality of care and medical necessity. The Commission believes that physicians should, and can, engage in peer review.

Recommendation 14: Incentives to Provide Appropriate Care

A On the basis of peer review criteria and findings, the medical profession, working through specialty societies and others, should develop and disseminate guidelines for appropriate care based on criteria of medical necessity, quality, and cost benefit These criteria should be sufficiently detailed and explicit so as to identify departures from them and allow independent consideration of the medical appropriateness of such departures

B The medical profession, working with third-party payers, should explore ways to put providers at risk for at least part of the inappropriate care resulting from provider utilization decisions as indicated by unacceptable departures from the established guidelines relevant in a particular instance Neither the patient nor third-party payer should bear the costs of decisions which result in inappropriate care

Current insurance mechanisms often offer extensive coverage for high-cost, low-volume forms of care, and high-visibility, high-risk conditions, as in inpatient care and acute illnesses They do not, however, generally cover low-cost, high-volume, low-visibility forms of care such as in outpatient care or preventive care to the same degree Consumer preferences and provider decisions regarding what services are used, when, and how often, are conditioned by the benefit structure, and this may be contributing to inefficient and cost-increasing patterns of utilization. Studies of minimal levels of benefits and catastrophic benefits would be useful to any analysis

Recommendation 15: Utilization in Appropriate Settings

Private and government insurance benefit packages should be adjusted to provide balanced coverage of alternative services and settings in the provision of health care. These benefit packages should also restrict reimbursement for health services provided in inappropriate settings (Utilization review also has the potential to play an important role in this regard) The Commission recognizes that, in the short-run, such an adjustment may exert upward pressure on the rate of growth of health care expenditures However, the modification of the health insurance benefit structure is expected to create incentives for more efficient utilization decisions by consumers and providers, and a more efficient distribution of inpatient and outpatient facilities.

GUIDELINES FOR REGULATION

The Commission believes that the greatest hope for cost containment in the provision of health care lies in strengthening price consciousness in the health care marketplace. Before such a solution can be achieved, however, a greatly enhanced decision-making role must be provided for the consumer. Developing mechanisms to effect this change in the complex—and necessarily provider-dominated—area of health care delivery is no small task Indeed, the Commission believes that it cannot be expected to occur in the absence of some regulation Thus, there is a clear role for public regulation in several areas of health care delivery, indeed, many such regulations are already in place. Among the oldest and most clearly established are protecting the consumer by providing information on the qualifications of those allowed to practice medicine (state licensure), the safety of drugs (Food and Drug Administration), and the financial security of insurance institutions (state insurance commissions) Beyond these, some regulatory efforts are required to establish a delivery system that reflects professional and social concern about appropriate levels of care

Controls on the delivery of health care are now a fact of life As the government's role in financing health care has expanded, many of these controls have been targeted at costs Certificate-of-Need, Professional Standards Review

Organizations and Medicare reimbursement restrictions are among the most prominent. While the commission is aware that there are well known disadvantages to instituting regulatory measures as cost-containment vehicles, the limitations of market oriented policies are likely to mean that realistic approaches will combine the elements of stronger market incentives with complementary regulatory controls.

In the absence of efforts to strengthen consumer and provider price consciousness, some forms of public-utility regulation, such as controls on rates and revenues, are likely to become necessary to achieve cost containment. However, to embark on a course of specific regulation of revenues could produce a health care delivery system that neither patients nor providers would find satisfactory. Some major reasons for this conclusion are: 1) To make a substantial impact on costs, the regulator would have to affect many decisions having to do with individual patient management—a difficult task in the presence of insurance or prepayment wherein incentives to want more are left in place for both provider and patient. 2) The information available to the regulator in assessing the aggregate impact of regulatory decisions would, because of the broad-range of such decisions, be meager. Conversely, to form an opinion about the appropriateness of individual treatment, the regulator would have to review individual cases. Thus, the alternatives are either poorly informed decisions or expensive review that still admits the possibility of error. 3) Patients differ in the types of therapies they want and would be willing to purchase. Medicine deals with an individual's innermost values; every regulatory decision would impact upon them. Because a centralized regulator could not possibly know these values, such as satisfaction or security, they could not be incorporated into the decision-making process.

Therefore, a careful study of public-utility regulation, as it would apply to health care delivery, should be made prior to any widespread adoption. Moreover, such regulation should not undercut strategies designed to strengthen price consciousness.

Recommendation 16: Evaluating Public Utility Regulation and Exemptions From It

A. If controls on revenues, capital acquisition, prices, etc. are expanded, attempts using carefully controlled experiments (e.g., introduction of regulation only in a few areas) should be made to evaluate the effects. In light of the problems with public-utility regulation in other industries, evaluation of regulatory options should take into account provider capture of the rate setting process and the effect of the regulation on competition between providers, including its impact on entry and innovation.

B. Regulation whose rationale is cost containment should exempt organizations or areas where innovations are being tested for the purpose of cost containment, or where strategies to increase price consciousness are being successfully pursued.

Another factor that merits further study is the cost of implementing and adhering to the various regulations affecting providers. The Commission believes that the regulatory process impacts on health care costs.

Recommendation 17: Review of Regulatory Process

The costs of regulations of all kinds, both governmental and voluntary, have significant impact on the total costs of health care. Government, as well as providers of care, must give attention to the simplification of the regulatory process and to consolidating and reducing the number of inspections, audits, surveys, reports, and other mechanisms of enforcement.

The Commission supports the concept of areawide planning and review of capital expenditures, such as the establishment of multi-hospital systems, sharing of services among hospitals, and contracting-out of certain services, and believes that efforts should be made to reduce the social costs due to duplication and underutilization of expensive capital.

Regional efforts to improve planning for the cost effective provision of health care may require both the expansion of certificate-of need legislation to some nonhospital settings and the decertification of some existing hospital services.

Recommendation 18: Planning

The concept of planning is supported. There should be continued monitoring of existing certificate-of-need legislation as to costs, benefits, and effectiveness, and establishment of equitable techniques for its administration. It is recognized that certificate of-need programs have the potential for assuring that hospital additions and capital acquisitions are appropriate for community needs. Coverage should be restricted to large capital expenditures of $150,000 or more.

Recommendation 19: Certificate-Of-Need

If certificate of-need (CON) legislation proves to be effective as a cost-containment technique for inpatient institutions, then for the sake of consistency:

Expand CON to provider settings outside the hospital, including private physician's offices, in order to provide coverage for a new facility or service that is being proposed for a noninstitutional setting and one that substantially duplicates the facilities or services offered in the institutional setting. This certificate-of-need expansion should not include expenditures for replacement equipment.

Recommendation 20: Decertification

Programs to achieve "decertification" or conversion to other use of facilities found to be excessive to community needs should be implemented if certificate-of-need proves successful. Financial assistance for the modification of inpatient hospital facilities to other health purposes may result in less cost in the long run than continued maintenance of underused acute care facilities.

Guidelines regarding local and regional needs for health personnel and facilities would provide useful information for any health planning process. Local health planners face special difficulties in making decisions regarding complex capital equipment and its related technologies. The national guidelines recently issued for comment by the Department of Health, Education, and Welfare could have been a step in the right direction, but the guidelines were

developed without adequate involvement of professional groups. Since there is no clear assurance that these guidelines can be modified to meet local needs, such shortcomings must be remedied if future guidelines are to make a useful contribution to the planning process.

Recommendation 21: Supply Guidelines

Encourage development of guidelines other than on a national basis, to determine what health personnel and facilities are needed in various geographic areas to meet the expected demand for health services.

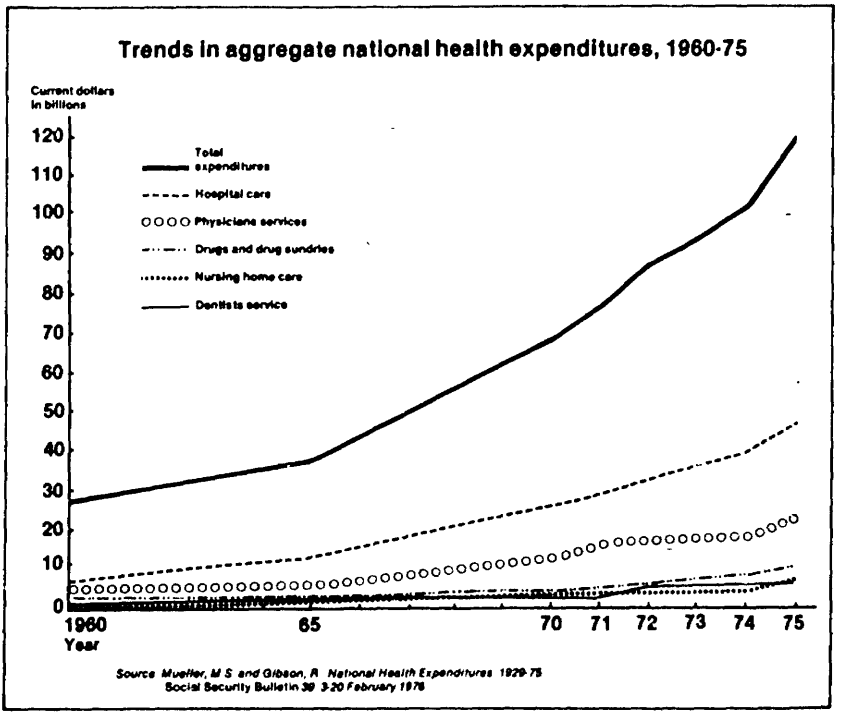
Recommendation 22: Placement Review Criteria

Develop consensus criteria for the placement of expensive facilities and capital equipment, such as computed tomography (CT) scanners and open heart surgery units, for use by state and local health planning agencies in making placement decisions of this type. The criteria should be developed at the national level with the cooperation of expert health professionals, including providers and government, and should be flexible enough to meet specific needs of individual states and localities. The criteria should take into account factors such as medical need, operating as well as capital costs, and other expected benefits and costs of the specific technology. States might be given the option of exceeding the national criteria within established limits.

The concept of regional centers to provide high technology care in a cost-effective manner was discussed as a way to consolidate services.

Recommendation 23: Regional Centers

Where cost-saving opportunities exist, regional centers should be established for high-cost specialized technologies. The number of such opportunities may be limited. Separate planning systems which would fragment and overlap with CON review should not be allowed to proliferate.



Capital expenditure restrictions are another method that could be employed to control resources. Under the proposed Hospital Cost Containment Act of 1977, each year the Department of Health, Education, and Welfare would limit total national hospital capital expenditures for resource development and/or renewal. Each state would be allocated a share of the total, based largely on the state's population. Planning agencies, using the CON mechanism, would determine how their state's share would be spent.

It is argued that the advantage of this approach, in contrast to other possible financing restrictions, is that it would effectively put a lid on capital spending while maintaining flexibility in terms of specific investment choices. Furthermore, it is argued that a capital expenditure limit might strengthen CON agencies in their decision-making roles by increasing their resistance to political pressure.

The proponents of capital expenditure limits have, however, failed to develop a valid methodology or reliable process to determine the appropriate level and distribution of capital expenditures. Moreover, the practical difficulties of determining the appropriate level of the limit make it very likely that, if enacted, its impact would be arbitrary and uneven.

Recommendation 24: Capital Expenditure Limits

Capital expenditure limits, such as those proposed in the Hospital Cost Containment Act of 1977, should not be enacted.

The discussion of regulatory proposals for controlling health care costs has, so far in this report, dealt almost exclusively with the capital expenditures of hospitals. Those decisions are made by the hospital administrator and the board of trustees as well as by physicians. However, decisions about the utilization of hospital facilities are made principally by the physician in consultation with his patient. The great expansion of public and private health insurance has brought with it a variety of review programs with the twin objectives of cost containment and quality control. In many instances, physicians have opposed these programs because they intrude on the physician-patient relationship and/or abridge the physician's freedom in making medical decisions. The degree of physician cooperation with review programs will, in large part, determine their success or failure.

Practice evaluation techniques have the potential to provide insights on the relationship between structure, process, and medical outcomes. In order to evaluate this potential, routine review of existing programs is necessary. Since even unofficial guidelines can in effect become rigid standards that reduce flexibility for experimentation and innovation, guidelines should be regionally, not nationally, generated. It is thought that practice evaluation techniques can be helpful in cost containment efforts.

Recommendation 25: Criteria and Use of Practice Evaluation Techniques

A. The reviewing boards associated with PSRO, medical audit, and the like should:

1. Develop workable local guidelines of appropriate care whenever possible.
2. Emphasize diagnostic tests and surgical procedures in retrospective medical audits.
3. Encourage increased use of prospective assessment of selected conditions prior to hospitalization, and
4. Utilize more selective methods of concurrent evaluation.

B. The appropriate boards should also see that results gathered through review techniques are more widely utilized through a mechanism that would:

1. Extend review to both institutional and office based ambulatory care settings.
2. Develop a mechanism for channeling to providers the review information on the efficacy and cost efficiency of various treatment modalities.
3. Use review results as a medical education device, and
4. Insure linkage of review results with planning activities.

COST CONTAINMENT MEASURES WITHIN MEDICAL PRACTICE

In the past, providers have considered primarily the medical needs of their patients. The Commission believes that providers must now take steps to make cost-effective utilization recommendations without sacrificing the quality of care. There are a number of programs that can be undertaken within the health care system that are not dependent on major changes in the delivery system.

It is argued that there is often duplication of diagnostic tests for a given patient among providers. One way to reduce this practice is to establish effective quality standards for ambulatory laboratory or X-ray facilities that would enable providers to rely on previous diagnostic findings when they come to use them in a new setting. It should be remembered that some highly complex procedures must be repeated in order to assure that the patient receives the appropriate treatment.

Recommendation 26: Diagnostic Findings

Providers, working at the local level, should develop mechanisms for the sharing of diagnostic findings for a given patient in order to avoid duplication of expensive diagnostic tests and procedures.

Another area of interest is the result of recent experiments concerning second opinions prior to elective surgery. Studies have shown that the second opinions do not always recommend surgery. However, because there is no evidence to believe that second opinions are more valid than first opinions, these results do not constitute sufficient evidence to conclude that there is excess surgery. But if some surgery is indeed inappropriate, the practice of encouraging patients to obtain an additional opinion may have the potential for reducing unnecessary elective surgery with some resultant cost savings. The long-range effect of such programs has not yet been measured. Second opinion surgical study projects should continue to be conducted.

Recommendation 27: Second Opinions Prior to Surgery

Third-party payers, working with providers, should undertake conscientious evaluation of the methodologies and the results of current experimentation with coverage of second opinions prior to elective surgery. The long-term results and general adaptability of such programs should be evaluated in terms of medical care quality, cost effectiveness, the cost and quality of alternative care provided in place of surgery, and the long-range medical implications for the patients who did not have surgery.

In a broader sense, physicians are demanders of health care as they make decisions on behalf of patients. In this role, physicians may recommend care that is considered inappropriate because it is not medically necessary or consists of expensive amenities. The decision to prescribe such care can result from patient preference, the form of payment, or physician attitudes regarding current and acceptable medical practices.

Recommendation 28: Inappropriate Medical Care

The medical profession and others, working together, should examine those factors associated with medical practice that lead to utilization of inappropriate care, and assume responsibility for informing providers and consumers of their existence and impact.

There are physicians who act in an unacceptable fashion with patients and their insurers as has been amply demonstrated by the experience of the Medicaid and Medicare programs as well as the private insurance industry. Because of a lack of disciplinary power, the medical profession has been virtually powerless to apply remedies.

Recommendation 29: Disciplinary Measures for Physicians

The medical profession should strongly encourage increased efforts to develop effective means for dealing with those providers of medical services who are found to be abusing or defrauding the health care financing or delivery system.

Some medically unnecessary procedures, such as duplication of diagnostic tests or greater hospitalization are performed due to provider concern about professional liability. Such defensive measures contribute to the increase in health care costs. An authoritative body of professional opinion might indicate to providers and courts alike that good diagnosis and treatment does not always mean that more tests and procedures should be performed. Cost-benefit criteria, as well as medical-necessity and quality-criteria standards can, and should, be applied to the care and treatment delivered by all providers.

The Commission is aware of the presence of malpractice and negligence on the part of certain providers, and does not advocate that barriers be placed in the way of legitimate malpractice claims.

Recommendation 30: Defensive Medicine

A Providers and courts should utilize guidelines of appropriate care—based on considerations of quality, medical necessity, cost effectiveness, and allowing for the varying circumstances of individual cases—for guidance as to what constitutes acceptable levels of performance on the parts of physicians and other providers.

B The medical and legal professions, working together with third-party payers, should examine the feasibility and desirability of having the resolution of professional liability claims placed outside the traditional courtroom-jury setting.

In order for consumers and providers to utilize care cost effectively, a variety of services must be available to them. For example, consumers can be encouraged to utilize preventive-care services only if such services are readily available.

To be cost effective, early-detection screening should be made available only to those populations who are at risk. The availability of a regular source of primary care, allowing coordination and continuity of care, is also necessary if consumers are to be encouraged to become cost-effective utilizers of care.

Recommendation 31: Preventive Services

Encourage the development of policies and mechanisms that lead to continuity, coordination, and continuous availability of patient care including professional preventive care and early-detection screening services.

In the Kaiser-Permanente system, where the plan's design rules out the use of significant cost sharing, trials are being conducted using multiphasic health evaluation (MPHE) as a way of allocating resources among patients. The multiphasic health evaluation program provides a mechanism for screening all presenting patients in order to establish need for care. The accounts of the success at Kaiser-Permanente of multiphasic health evaluation and resultant educational efforts, in terms of the potential for reducing patient anxiety and more efficiently utilizing physician time, have been noted.

Recommendation 32: Multiphasic Health Evaluations

Carefully controlled experiments should continue to be conducted to determine the cost effectiveness of multiphasic testing programs in diverse environments.

SUPPLY AND DISTRIBUTION OF HEALTH CARE PROVIDERS

The Commission discussed the effect of the current rate of growth of the supply of physicians and the implications of their geographic and specialty distribution on health care costs. Research shows that physicians have tended to locate disproportionately in the large urban centers of this country and not necessarily where the need for their services is most acute.

One solution often offered to the problem of access and rising health care costs is to increase the supply of physicians. Resulting competition, it is argued, could temper increased physician fees and cause some physicians to move to a less crowded specialty or to an underserved area. The Commission, however, is unconvinced that either would occur given present institutions. Furthermore, there are arguments that increases in the supply of providers may lead to concomitant increases in demand. The Commission believes that the current rate of production of physicians is adequate to meet expected demand.

Recommendation 33: Physician Supply

There should be no new efforts to increase the number of medical school graduates until such time as necessity for change is clearly evident.

It is essential to reduce the geographic disparity in the availability of physicians' services. There are a variety of programs, either currently in effect or in the planning stage, designed to encourage physicians to establish practice in certain geographic areas. Public policy in this area should be designed with a clear understanding of the factors which influence physician location choices. In addition, programs should be directed at different targets, such as the medical student, the medical school, graduate programs, or the practicing physician. Some examples include: 1) reducing fee differentials that exist between well-served and underserved areas; 2) developing group practice opportunities in communities large enough to support such practices; 3) assisting in the financing of appropriate health and medical equipment and facilities in medically underserved communities; 4) developing additional continuing medical education workshops, and other support services for physicians practicing in shortage areas; and 5) continuing the development and expansion of area health education centers that have the potential to provide a considerable part of the clinical training and continuing medical education of primary care physicians, dentists, and other health personnel.

Recommendation 34: Professional Attractiveness

More effort must be devoted to improving the professional attractiveness of service in shortage areas. The development of preceptorship and other rural and inner-city training programs would be instrumental in acquainting physicians with medical practice in shortage areas. However, the potential impact of any programs would be limited without an effort to provide an environment and resources that would increase the number of physicians who remain in an underserved community after such training.

Recommendation 35: Loan Forgiveness and Scholarships

There should be less reliance on current loan-forgiveness and scholarship programs as a means to affect physician location decisions. For such a policy to be effective, recipients of government loans and scholarships who default on their service commitment must be required to pay back a substantial portion of the cost of a medical education, rather than just the cost of tuition.

Recommendation 36: Recruitment from Underserved Areas

If state loan forgiveness programs are established, they should be coupled with admission programs which actively recruit students from rural and other underserved areas. The financial lever alone is insufficient to have a permanent influence on physician distribution. However, the joint effect of admissions and loan policies hold more promise of being successful since students who were raised in a rural environment are most likely to return there to practice.

The specialty choices of physicians play an important role in any redistribution program. Increased specialization in non-primary specialties has the effect of discouraging physicians from locating in those underserved places that are likely to be some distance from centers of learning and related support facilities. It has been shown that family practitioners tend to respond differently than other physicians to various location forces. Therefore, a significant increase in the proportion of family practice physicians might lead to a more equal geographic distribution of physicians. An increase in family practitioners could be expected to result in lower unit costs of medical care and a more appropriate balance between primary and secondary-tertiary care.

Recommendation 37: Family Practice

There should be an increase in the proportion of family practice physicians. Such an increase could

be expected to contribute to the moderation of rising health care costs in two ways:

A. Through the substitution of physicians trained to the delivery of primary care for more specialized physicians who are likely to provide more expensive primary medical services, and
B. Through lower training costs for a given supply of physician manpower or, conversely, a larger supply for the same level of costs.

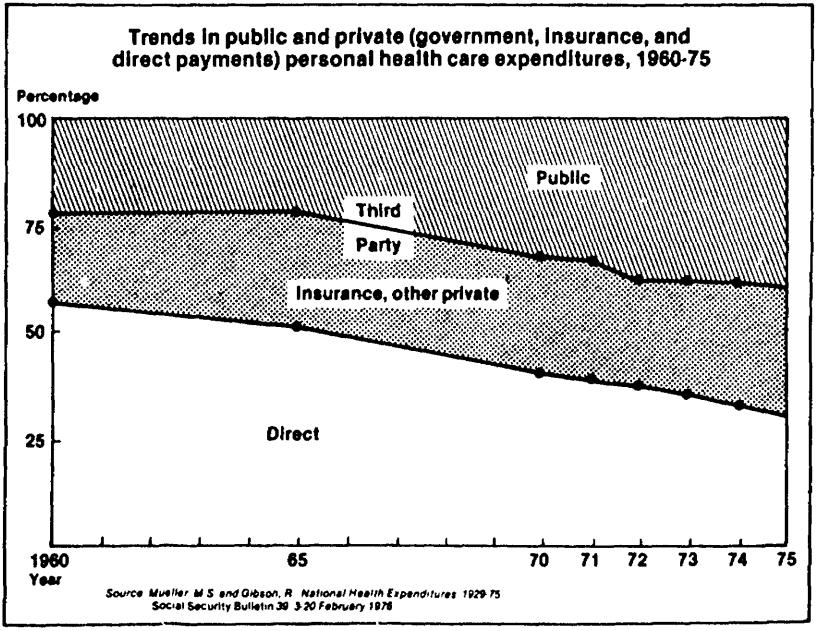
In order to achieve this objective:
A. Federal and state support for the establishment of departments of family medicine, particularly for the recruitment of faculty, should increase in order to increase the proportion of practitioners in family practice, and
B. Federal capitation grants contingent upon meeting primary care residency percentage requirements should continue. However, it is recommended that voluntary efforts be made to develop and expand both undergraduate and graduate programs to educate primary care physicians in numbers that will exceed such requirements.

The physician is the principal decision maker in the treatment of a patient's medical condition. This role is of critical importance with respect to the cost of health care. In order to foster an acceptance of cost effective clinical decision making among physicians, the Commission believes that certain changes in the nature of the physician's education and training are required.

Recommendation 38: Curricula on Economics of Health Care

A. Medical, dental, and osteopathic schools should develop curricula designed to expose students to the economics of the care they deliver, the nature of resource scarcity, and a variety of health care settings.
B. With the sponsorship of appropriate professional societies, and with the use of a good textbook, the economics of care should be incorporated in courses as a part of professional training. The material should be mandatory and subject to examinati n.

The hospital setting provides an ongoing opportunity to reinforce the physician's price consciousness. The forms on which the physician orders services for his patients can be used to focus his attention on the costs of treatment alternatives.



Recommendation 39: Price Consciousness in the Hospital Setting

Physicians should be encouraged to enter or acknowledge the cost or charge for hospital based services

The Commission also discussed modifications in the organization of the health care delivery system as it affects the physician's practice. Physicians have always employed and, in varying degrees, delegated patient care services to allied health personnel. However, new and expanding roles for health workers have been established within the last decade. Formal education and training programs for allied health professionals have been developed on the basis that nonphysician personnel can assume a larger role in the delivery of preventive, acute, and restorative patient care. Thereby, physicians would be freed to care for more seriously ill patients.

There is widespread opinion within the medical profession that physicians could delegate, without harm to their patients, a number of the tasks they frequently perform. However, some physicians tend to hire fewer support personnel, such as nurse practitioners, physician assistants, and clinical psychologists, than is technically and economically feasible. The Commission believes that means to facilitate the delegation of additional responsibilities to allied health personnel should be implemented.

Recommendation 40: Modify Restrictions on Allied Health Personnel

Legislative restrictions should be modified regarding the use of allied health professionals under the supervision and direction of a licensed physician who is responsible for the performance of that assistant. There is a wide discrepancy between the number of tasks physicians believe could be delegated to support personnel and the number of tasks physicians actually would delegate. The real or perceived barriers of state medical practice acts contribute to this discrepancy and should be modified.

Recommendation 41: Reimbursement for Allied Health Personnel

Reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel. These professionals should be under the supervision of practicing physicians.

RESEARCH GUIDELINES

In recent years, technological innovations have attracted increased attention as a cause of rising health care costs. While new technologies are generated by research and development, it is the willingness of the health care delivery system to finance their use that primarily determines their impact on total health care costs. Accordingly, many of the efforts toward cost consciousness proposed in this report involve the impact of technological innovations. In addition, the timely dissemination of accurate research information can contribute to more appropriate use of health care technologies, thereby lowering the cost of health care and improving quality.

Recommendation 42: Technology Assessment and Information Dissemination

A. There should be a substantial expansion of efforts to assess health care technologies and to collect and disseminate the resulting information.

B. A national center should be established to serve as a central depository and clearinghouse for information on health care technologies. The center would be an important source of information for physicians, patients, and all others concerned with medical technologies, including governmental and other third-party payers.

Limitations of current evaluation techniques, limited information about the major chronic diseases, and ethical constraints regarding human experimentation make technology assessment a difficult, tentative process. These problems imply that there are substantial risks associated with attempting to link technology assessment to controls on the acquisition and utilization of these technologies. Technology assessment, costly in itself, could lengthen the time between discovery and diffusion of a technological advance. This would reduce patients' access to unproven, but possibly efficacious treatment modalities. If technology assessment interferes with the incentive to conduct research and development, it could, in the long run, reduce the number of technological advances. It is important that technology assessment not inhibit major beneficial and cost-saving advances.

Recommendation 43: Limit Restrictions on Diffusion of New Technologies

A. Existing restrictions on the diffusion of new drugs and devices, including the Food and Drug Administration's market clearance tests, should not be expanded. Safety assessments should be carried out promptly, and new drugs and devices should not be withheld from the public while lengthy efficacy tests and cost effectiveness investigations are conducted.

B. The government has the responsibility for assessing the safety of new technology, and disseminating the findings. While there should be no expansion of the statutes making the diffusion of technology contingent on technological assessment, the government and private carriers may, quite legitimately, decide to deny reimbursement for technologies classified as experimental.

In the long run, progress depends on the research and development of new health care technologies. Better scientific understanding of the underlying disease mech-

anisms is needed in curing or coping with such problems as heart disease, cancer, stroke, schizophrenia, arthritis, and diabetes.

Recommendation 44: Basic Research

There should be increased funding for research toward basic scientific understanding of disease mechanisms.

While basic research is conducted, both biomedical and health services research can contribute toward identifying and coping with technology-related cost problems

Recommendation 45: Research Toward Cost-Saving Innovations

Public and private organizations should direct more research toward solving technology-related cost problems. For example, more research might be directed toward diseases which are especially expensive to treat with current technologies. Or more research might be done in designing methods to utilize potentially cost-saving technologies.

CONSUMER AND PATIENT EDUCATION

Educational programs are important in providing knowledge and assistance to consumers and patients if they are to make cost-effective utilization decisions. Such educational endeavors thus become an integral part of any plan to contain health care costs.

Recommendation 46: Health and Patient Education

Consumers and patients should be encouraged and assisted to become more active and knowledgeable participants in making health care utilization decisions by:

A. Developing health and patient education programs that inform consumers and patients about the costs and benefits associated with potential and alternative courses of treatment, and

B. Emphasizing self-help education programs directed at well and worried-well individuals and groups to provide consumers with the information necessary to make the initial decision as to whether or not provider care is necessary, or whether there are other alternatives open to them such as self-care, bed rest, or use of nonprescription drugs or first aid.

One of the major problems inherent in the desire to educate consumers and patients is developing and initiating effective education programs. Due to the cost and difficulty of implementing such programs, they are not usually assigned a high priority by community organizations, hospitals, or professional providers. The Commission believes in the importance of such programs, and encourages their development and implementation.

Recommendation 47: Private Sector Involvement in Education

Voluntary health agencies and other private sector organizations should be encouraged to experiment with various types of health and patient education programs, develop evaluation mechanisms to assess education efforts against specific and realistic success criteria, and implement programs designed to encourage employee groups and large employer firms to act as vehicles for these health education programs. A national clearinghouse to make information and prepackaged program materials available to groups seeking assistance in setting up health and patient education programs should be developed.

Cost containment in health care may also be accomplished through the reduction of need for service by: 1) the prevention and reduction of the incidence of illness through the development of more healthful lifestyles; and 2) the early detection of incipient conditions permitting treatment through lower cost therapy. Health education programs, in addition to other courses of action, can provide a variety of informational techniques, one or more of which may act to motivate a consumer to achieve the dual goal of healthful lifestyle and reduced cost.

Recommendation 48: Healthful Lifestyles

Consumers should be encouraged and assisted to learn healthful practices by:

A. Educating and motivating the consumers to adopt more healthful lifestyles.

B. Exploring methods of utilizing public communication more effectively in health education efforts directed towards motivating consumers to adopt healthful lifestyles.

C. Encouraging consumers, in appropriate risk groups, to utilize professional preventive health care services which would permit the early detection and treatment, or the prevention, of illness.

Note: This Commission's recommendations were put in final form less than one week before this printing. The text of this report may vary slightly from the version published in the full Commission Report

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Senator DURENBERGER. The other relates to the current mandated offering of a federally qualified HMO when accessible to employers. While I recognize that that is a potential problem, I wonder if it is a problem as you see it in the statement.

Again, going on the basis of some of the testimony here today and the experience of Minnesota, I think we have one federally qualified HMO and seven or eight other HMO's.

We also heard testimony on the additional cost for Federal qualification. I wonder if, given that, you could elaborate on your concern or your objection to the existence of this law side by side with S. 1968?

Dr. STEEN. I think our concern has to do with what might be offered as the only other option.

In a given area where two qualified HMO's exist, those might constitute two of the options, and then the employer might conceivably elect to offer as the third option some very low-level coverage that is quite inadequate, and this is really our concern, Senator Durenberger, the potential of the inadequacy of the third benefit.

Senator DURENBERGER. That probably comes in a couple of forms. Yesterday, again, I recall hearing some testimony that there are areas of the country where there simply are not three good carriers.

There was also some testimony to refute that. One way to look at it is, there are only two or three options out there, one of which is the federally qualified HMO.

The other point I think is important is that we don't limit the options to three.

Obviously, as in the Federal plan, you can have a wide variety of plans. So you are not closing the door to nonfederally qualified HMO's, IPA's, and so forth, as long as they can be price and quality competitive and so forth.

Mr. PETERSON. The point on that is, it is not too practical to expect an employer of 100 employees to offer a great number of plans to its employees. So, if two of three plans have to be HMO plans, then the options for the conventional insurance, as Dr. Steen said, would be very limited—unless you contemplate there may be, say, five plans offered. We recognize this could be done under the bill, but we view that to be highly impractical for employers.

Senator DURENBERGER. I expect we are going to find that once this system goes into effect, some of the kinds of things we will see will be multiemployer approaches to this, so the same program will be accessible to employers of fewer than 100 and more than three options will be made available, particularly where you are in a large enough community for those options to be exercised.

Mr. PETERSON. Much of the testimony has centered on the employer with 100 employees. As we look at the bill, however, we see the tax consequences applying to all employers and all employees with respect to the transfer of the taxable amount over the $125 employer contribution. That effect under the bill occurs, even though the employer does not have 100 employees.

[The prepared statement of Dr. Steen follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Senate Finance Committee
United States Senate

by

Lowell H. Steen, M.D.

Re: Health Care Competition Legislation

March 19, 1980

Mr. Chairman and Members of the Committee:

My name is Lowell H. Steen, M.D. I am a physician in the practice of internal medicine in Hammond, Indiana, and I am Chairman of the Board of Trustees of the American Medical Association. With me today are Wayne W. Bradley, Group Vice-President of the AMA, and Harry N. Peterson, Director of the Division of Legislative Activities. We are pleased to present the views of the American Medical Association on S 1968, a bill intended to promote economics in health care expenditures through increased competition in health insurance and the delivery of care.

Mr. Chairman, for more than a decade the American Medical Association has been a major participant in the intensive debate on the subject of expanding availability and access to high quality medical care. In the course of this debate we have appeared frequently before the several Committees of Congress dealing with this important subject, giving testimony concerning the needs that must be met to assure access to quality health care for all Americans regardless of income. We have presented our views on alternative approaches offered to meet these needs. We have offered our own program to Congress, and suggested changes in others.

"Pro-competition" proposals now before this Committee bring new considerations to this debate. They do not undertake to furnish health care directly or to make such care available through expanded insurance coverage. The goal of this legislation is to lower national expenditures for health care by assuring options of coverage to employees under employer health plans, and thereby to generate competition in health care.

Mr. Chairman, the vast majority of the American people are protected by health insurance, but there are some who through no fault of their own cannot obtain the coverage they need. There are gaps in protection that cannot be ignored. The new legislation is not designed to deal with this problem, and in some ways that we shall discuss may even exacerbate it.

Currently, most of the population is brought into the mainstream of health care by insurance through employment. In this regard, the present tax provisions concerning employee health insurance benefits have been spectacularly successful in encouraging employers to offer their employees health benefit plans. In addition, the aged, disabled and disadvantaged now have

coverage through Medicare, Medicaid and supplemental health insurance policies. Estimates of the number of people covered vary. According to some studies, only about 7% of the population are without some form of medical care coverage.

Those without insurance generally are people who do not qualify for Medicare or Medicaid; are unable to obtain insurance because of pre-existing illness; are unable to afford available coverage; or choose to self-insure. Although the percentage of the population who are without insurance is small, this constitutes a significant insurance gap. There is also a concern about adequacy of coverage for some, including catastrophic coverage.

There are a number of changes that should be made in the private insurance system that would go a long way to close the gaps in health insurance coverage while building upon the strengths of the existing system of health care delivery. Minimum standards of adequate benefits should be contained in health insurance policies, with appropriate deductible and coinsurance. A simple system of uniform benefits should be provided by federal, state and local governments for those unable to provide for their own medical care. Government might purchase private health insurance where possible in providing for the poor. Medical coverage would be improved through the purchase of private catastrophic coverage. A nationwide program could be instituted by the private industry (and government if necessary for reinsurance) to make available catastrophic coverage to protect against the impact of a costly illness that could be economically devastating. We call upon the Committee to consider these points when reviewing any health insurance proposal.

Mr. Chairman, I shall now comment on some of the specifics of S 1968, the "Health Care Incentives Reform Act of 1979."

Comment

S 1968, introduced by Senator Durenberger, is intended to create an incentive for employers to make available multiple health benefit plan options to employees and thereby to promote competition in delivery of health care and containment of health care costs.

Employers providing health insurance coverage for more than 100 employees would be required, in order to maintain for their employees the tax-free status of their premium contributions, to offer their employees at least three coverage options, each such option to be provided through a separate carrier. Each of the options would provide a range of benefits--basically those of the type covered under the Medicare program--but benefits and copayments could vary among the plans. Catastrophic insurance coverage to limit out-of-pocket expense that a family might have to pay during any year would be mandated. The employer plan would have to provide a catastrophic expense ceiling of $3,500, but this ceiling could be raised to more than that amount in one of the plan options and still be in compliance with the bill requirements, if the employer contribution were insufficient to pay for a plan with the $3,500 ceiling protection.

Under S 1968 the employer would be required to contribute the same dollar amount towards the premium of all options offered. An employee selecting an option with a lower cost premium would be entitled to payment from his employer of the difference between the fixed contribution and the cost of the plan selected.

In current tax law, employees receiving health insurance through their employment do not pay income tax on amounts paid by their employer toward

their insurance premium. S 1968 would change this law to limit the tax exemption, and this would apply to employed persons generally, regardless of the size of the employer. An employee would be required to include an employer contribution as income to the extent that the contribution exceeded $125 a month (adjusted annually for inflation) when contributed for family coverage. The tax-free limit would be $100 if the contribution were for coverage of the employee and his wife only, and $50 if for the employee only. Qualified policies under the proposal would have to offer, in addition to Medicare-type benefits and catastrophic coverage, some continuity of coverage for employees leaving an employer and conversion privileges.

The bill contains no mandate that the employer provide any insurance, and the employee's participation in any plan would be voluntary. Nor are there any obligations created by the bill for employers who do not have more than 100 employees. There is no requirement that an employer contribute to any premium--only that, if a contribution is made, it must be equal for each of the options provided.

Freedom of choice by the patient is a cornerstone of our American pluralistic system of health care delivery. The patient chooses the method by which he will receive treatment--whether by a solo practitioner, a medical group, or a prepayment plan. The consumer also decides whether to be insured under an insurance policy, a benefit plan, or an HMO. It is in this setting that American medicine has progressed to unchalleneged world leadership and is unsurpassed in the quality of care it delivers.

S 1968 would support this pluralism as it calls upon employers to give added choices of coverage to their employees through private insurance or

plans. It also assures that each of the various coverage options will contain certain benefits, including catastrophic coverage. It contemplates varying deductible and copayment levels depending on the coverage selected. Participation of the employee in any plan would be voluntary on the part of the employee. While the bill is silent on who pays the premium, the premium would normally be shared between employer and employee according to terms agreed upon between the employer and his employees (or a bargaining agent for the employees). All of these elements are appropriate and should be supported.

The AMA supports competition in the delivery of medical services. Competition at its best can raise the quality of care and reduce the costs of providing that care. Such competition is promoted in S 1968 in the requirement of multi-plan options, but there are also limiting conditions to be considered.

The bill requires that an employer (with more than 100 employees) who offers a health plan must offer three plan options to employees, with no specification as to the extent of the benefits to be provided. As one-- and perhaps two-- of the plan options, title 13 of the Public Health Service Act could operate to require that the employer offer membership in a Health Maintenance Organization (HMO). The AMA supports the use of HMO's as a method of delivering medical services in a pluralistic delivery system. Under that Act, employer plans, when there are 25-or more employees and an HMO in the area in which they reside, must presently include an HMO option that provides comprehensive benefits and otherwise meets special conditions of qualification. In areas in which there are more than one HMO, using different methods of delivery of services, at least two of the three options in the employer's health benefit plan might have to be options of membership in

a qualified HMO organization. For example, if there are two qualified HMO's in the area, and one--but not the other--uses an independent practice association (IPA) or contracts with health professionals for the provision of basic health services, the law requires that each of the plans be included as options in the employer's health benefits plan. Thus, the interrelationship between the HMO Act and S 1968 does in fact produce a limitation on offer and choice of plans which appears to be incompatible with the rationale of S 1968 as the basis of competition. Since the law already requires the furnishing of comprehensive benefits provided by an HMO and there would be no corresponding broad coverage requirement for conventional insurance competition could suffer. The proposal could militate against available choices for those who might want conventional coverage with less expensive yet adequate coverage or full-coverage conventional insurance.

We are also concerned about a lack of specificity in the proposal as a cause of inadequate coverage.

Any employee relying entirely on employment insurance for coverage could be lacking in protection under the proposal. In mandating "minimum benefits," the bill requires simply that the employer health benefit plan cover the "same types of services" as are now provided in Medicare. No benefit plan (except the mandated HMO option) need provide coverage adequate to meet the employees' needs. For example, while plans would be required to pay for hospitalization, an employer concerned about premium costs could offer two plans, one with ten days for hospitalization, the other with 20 days. Neither program may be sufficient to cover an employee's insurance needs. No limitation is placed on deductible or copayment, except in the context of the ceiling on

health care expense. Within the bare terms of the minimum standards of benefits, therefore, the employee would be assured only of catastrophic coverage with a $3,500 out-of-pocket loss limit (or an even higher loss limit, if the employer contribution did not cover the premium for a $3,500 deductible). Moreover, if the employee should buy basic coverage on his own, he could still be faced with risk of the full amount of the catastrophic deductible for the year over and above expense insured and reimbursed under his basic coverage. Expenses reimbursed by other insurance would not count as out-of-pocket loss.

The main thrust of the bill is contained in the provisions changing the present exemption from income tax enjoyed by employees with respect to employer contributions to health insurance premium, and in the provision for a system of cash rebates to employees designed to encourage employees to select a lower-cost plan thereby shifting to an insured employee a greater part of the cost of his overall health care and generating added cost awareness and restraint in spending.

The concept of increased competition through limitation on the tax exclusion by employees with respect to employer-paid premium and a system of cash rebates for low-cost plan selection was contained in a recommendation of the National Commission on the Cost of Medical Care over two years ago, and this recommendation of the Commission for reducing health care expenditures received AMA approval.

However, we have reservations about a program that might encourage the individual to acquire less coverage than is desirable. Experience has shown generally that individuals, given the choice, will seek broad coverage. For

example, Medicare is a program designed to provide for coinsurance and cost-sharing as a mechanism to restrain demand for health services. Yet millions of Medicare patients choose to pay additional premiums out of their limited income for supplemental insurance to assure broader coverage. For those individuals, the assurance of fuller coverage has justified the cost of supplemental policies. Such action by patients dramatically decreases the expected reduction in total system costs that the copayment mechanism was designed to provide.

Assuming the success of the competition approach, the Congressional Budget Office estimates a significant increase in tax revenues, and a greater amount of savings through reduced health expenditures. The actual amounts would vary with each plan. These results are expected to come about gradually over a period of years, but during that interval certain changes would have to occur. Buying habits would have to change so that more Americans are willing to buy less expensive lower-option coverage entailing more out-of-pocket costs, and employed persons would have to learn to make sophisticated economic choices in plan selection.

Against the prospect of gradual savings, however, the general public would be faced with an immediate change in the tax laws for added tax. Those who continued to opt for high-option coverage would become subject to tax on "excess" employer contribution to their insurance without any compensatory reduction in premium. There is a likelihood of increased premium for some individuals attributable to reduced group sizes and adverse selections since younger, healthier employees would be expected to choose a low-benefit option until such time as the individual expects increased family medical costs.

On balance, we believe that long-term advantages can be derived for all Americans through increased competition in the health industry. S 1968 contains concepts aimed toward this goal.

Conclusion

Mr. Chairman, we support the principle of increased competition through multiple insurance options for employees. Any legislation embodying such principles must also carry sufficient safeguards to protect the purchaser. Participation by the employee in the costs of his health care can be beneficial in reducing overall costs, but his level of participation must be realistic in that adequate coverage can be acquired by the individual. Also, we must never let quality be sacrificed to cost considerations.

Senator TALMADGE. Next we have Mr. Burton E. Burton, senior vice president, Aetna Life and Casualty, on behalf of the Health Insurance Association of America.

Mr. Burton, you may insert your full statement in the record and summarize it, sir.

STATEMENT OF BURTON E. BURTON, SENIOR VICE PRESIDENT, AETNA LIFE AND CASUALTY, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY JACK AHEARN, ESQ., COUNSEL, AETNA LIFE AND CASUALTY

Mr. BURTON. Thank you, Mr. Chairman.

My name is Gene Burton, senior vice president of Aetna Life and Casualty and also appearing with me today is Jack Ahearn, counsel, also of Aetna Life and Casualty. I appear on behalf of the Health Insurance Association of America, which includes more than 300 health insurers writing about 85 percent of the private commercial health insurance in the United States.

The bill before us, S. 1968, seeks to stimulate competition in a business which is already one of the most competitive in our Nation today. Commercial insurers compete not only with each other but also with Blue Cross plans, prepayment plans like HMO's, and with a wide variety of other insuring and self-insuring arrangements.

Even the Nation's largest commercial health insurer writes less than 2 percent of the total business. This competition has spurred a vast assortment of available coverages and innovative approaches, including sponsorship of a variety of alternative delivery systems.

Employers seeking health coverage today may select plans ranging from high-deductible, high-copayment coverages to plans placing greater emphasis on first-dollar coverage. Our industry has long emphasized deductibles and copayment as cost containment incentives of some value, and virtually all the plans we sell contain these features to some extent.

We recognize the value of competition and it is from this perspective that we address S. 1968.

We appreciate the creative suggestions in Senator Durenberger's bill and applaud his imaginative attempt to find innovative ways to contain health care costs. We are not persuaded, however, that S. 1968 will deliver its promises. In our view, the bill does not take adequate account of marketplace realities.

In order to conserve the committee's time, we will focus our remarks on the main features of the bill.

The premise of the bill is that more competition among carriers and other financing mechanisms will contain the cost of health care.

First, with regard to the multiple-choice feature, there is a phenomenon known to the insurance business as adverse selection. Our extensive insurance experience indicates that given a choice, most employees, including virtually all those who anticipate sizeable family medical expenses, will choose the most comprehensive option available. In fact, this is exactly what we at Aetna have observed while insuring FEHBA, where relatively few employees have chosen the lower cost option and where the difference in cost between the high- and low-option plans is much greater than the difference in plan benefit levels.

To the extent that this selection occurs, employer costs for the more comprehensive plan will usually be higher than they would have been in the absence of a choice. We believe this selection, together with a required equal employer contribution to each plan, will have a net result of increased total employer plan cost.

Administration of multiple plans would increase employer costs in other ways as well. Economies of scale would be significantly diminished and an employer's bargaining power with respect to any single carrier would be reduced accordingly.

Furthermore, the added costs and complexities of the bill, in our judgment, will discourage employers from offering a benefit plan to their employees and may create an ERISA-type disincentive for some employers to cease offering any health benefit plan.

In addition, there may well be other incentives in the bill for an employer seeking to avoid added cost and inconvenience.

For example, an employer may choose to offer three very similar plans that represent no real choice for employees; or he may advise employees to select one particular plan which is favored by the employer; or an employer of fewer than 100 employees may withdraw from a multiple-employer trust in order to avoid the requirements of the bill.

These are some of the direct consequences of the bill for employers. There would also be increased expenses for carriers which would have to be borne by the financing system.

The bill calls for an entirely new and much more expensive approach to group insurance marketing which will diminish substantially the administrative effectiveness of group insurance. Each existing group plan would effectively be split into three smaller plans, with an attendant loss in economy of scale.

The requirement that each plan be offered by a different carrier would further increase expense and further reduce the economy of scale. No carrier would know at the time it prices its plan how

many employees would enroll. This loss of control over the size of insured groups will not only result in insurer and employer uncertainty about rates and contributions to be charged for the benefit plan, but might also mean that carriers would find it necessary to begin imposing restrictions like medical underwriting.

Such restrictions are not normally applied today to groups of over 100 employees and would not be in the best interest of these groups.

A multiple carrier requirement would also be a real disincentive for insurers to develop and support alternative delivery systems, such as HMO's, whih could then never be offered to that carrier's own customers; nor would a three-carrier requirement be reasonable in the case of the self-insured employer or the employer with employees in several locations, some with HMO's available and some without.

Consider, for example, the case of a self-insured employer today with 5 plant locations of over 100 employees each. If there were federally qualified HMO's available at only two of these locations, under this bill the employer would probably find it necessary to administer a self-insured plan and two insured plans at three locations, and those three choices in addition to the two different HMO's at the other two locations. The administrative complexities are self-evident.

Another feature of the bill would impute taxable income to an employee if his employer's contribution to a benefit plan exceeds a certain dollar amount which would vary by the number of dependents. The purpose of this provision is to enhance cost consciousness through awareness of the cost effects of plan design.

The problem is that plan design is only one element that affects premium levels. In fact, demographic variations among groups of employees have a dramatic impact on premiums.

To use geographic variations as an example, a typical comprehensive medical care package for a 200 life group would cost under $100 per family per month in Jackson, Miss., and over $200 in Los Angeles. A uniform national tax limit would have vastly different consequences for differently situated employers and their employees. If this disparity were corrected by means of a variable limit that took account of geographic differences, the plan would be more equitable but extremely complex.

Given the largely conjectural effectiveness of this kind of tax cap and the difficulty of administering it equitably, we are not able to support this key feature of the plan.

All of these points lead to the conclusion that this cost containment approach would not work in today's marketplace. There is ample competition among carriers today. We are aware of no evidence that multiple-plan options would stimulate alternative delivery systems or would bring about behavioral changes among providers of care.

On the other hand, there is considerable evidence that this bill would increase the costs of the health care financing system and would not significantly reduce claim costs under group benefit plans.

For these reasons, we cannot support enactment of S. 1968. Nevertheless, the Health Insurance Association of America would be

pleased to work with the committee and staff in thinking through the cost containment problem as a whole, as we have tried to do with the committee's catastrophic national health insurance proposal.

Thank you.

Senator DURENBERGER. Thank you very much.

In the second to last paragraph, I would either offer you the evidence that you heard here today or suggest that perhaps you may have analyzed it already and come to different conclusions.

For example, about the people in the Twin Cities relative to competition, I am referring specifically to the statement, there "is no evidence that multiple-plan options would stimulate alternative delivery systems" and so forth.

You are obviously aware—because you, as an individual company, Aetna, write a lot of insurance in the Twin Cities—you are at least aware of that kind of experience with multiple-plan offering, are you not?

Mr. BURTON. Yes, we are. There seems to be a good result developing in that particular community.

Senator DURENBERGER. The problem you point out regarding the difference between Jackson, Miss., and Los Angeles is the problem I think we are all aware of, and we are all concerned about and trying to find some way to deal with it.

When you say the complexity would result from making the plan more equitable, are you referring to using the tax system or the IRS to design, say, a different schedule in different regions of the country?

Mr. BURTON. Yes, I was, different tax limits for different areas of the country.

Senator DURENBERGER. Let me ask you about the Federal Employees Health Benefit Plan. I think you were probably here when Mr. Marshall from the Health Industries Manufacturers Association talked about the fact that many Federal employees are choosing the high-option insurance and pointed out that—I think he used the figure $300—the fact of the unequal employer contribution means that if I chose Aetna with a high option, I am also receiving $300 more in annual premium contributions than someone who takes a different plan.

Do you believe that is one of the reasons why many Federal employees have not chosen a lower cost option, or could it be?

Mr. BURTON. There is not much question in my mind if the employer contribution to the low-option plan were made equivalent to the high-option plan, there would be some increase in enrollment in the low-option programs.

I tend to question whether it would be significant; however, our experience seems to point overwhelmingly in the direction of employees wanting liberal coverage and choosing that coverage when it is available.

Senator DURENBERGER. On the issue then of adverse selection, is there evidence in Aetna's participation in the Federal Employees Health Benefit Plan of adverse selection, and if so, in what communities do you see the evidence of it?

Mr. BURTON. One has to call this evidence very indirect. The relationship and the difference between the low-option plan and

the high-option plan is really not very great. The additional copayment features in the low-option plan are not significant. As a result, if one were to actuarially relate the low-option plan and the high-option plan, you arrive at something like a 10 or 11 percent expected benefit cost difference between the two programs; yet the actual cost difference between the low-option plan and the high-option plan is something like 40 percent.

So, something very real is going on.

Senator DURENBERGER. Your experience with that plan would indicate to you there is not much adverse selection, preferred risk or whatever. In other words, there are not a lot of people loading the high-cost part of the system with the burden for their low-cost selection?

Mr. BURTON. We would interpret these statistics as suggesting clearly there is a significant amount of antiselection.

Senator DURENBERGER. Despite the fact people are overinsuring, taking the high option?

Mr. BURTON. I am sorry. People are overinsured, did you say?

Senator DURENBERGER. I thought that was your observation, that few employees have chosen the low-cost option.

People apparently under FEHBA are.

Mr. BURTON. There are two things at work. People will tend normally to select the most liberal plan they can, even if it costs them money. People who are in poor health will almost always use their native intelligence to select the most liberal plan they can. We think that is what happened under the Federal Employees Plan.

Senator DURENBERGER. Thank you very much.

Senator TALMADGE. Our next witness is our distinguished colleague, Senator Bellmon.

We are happy to have you with us, Senator Bellmon.

My apologies to the previous witness for having to temporarily go out and answer the phone, but that happens around the Senate. We can't be in one place continuously.

We are honored to have you.

STATEMENT OF HON. HENRY BELLMON, U.S. SENATOR FROM THE STATE OF OKLAHOMA

Senator BELLMON. Thank you, Mr. Chairman.

With me at the witness table is Tom Sullivan, a member of the staff of the Budget Committee.

I have a statement I prepared and I ask unanimous consent——

Senator TALMADGE. Your entire statement will be inserted in the record, and you may proceed in any manner you see fit.

Senator BELLMON. I will short it, Mr. Chairman, in the interest of time.

Mr. Chairman, members of the committee, the health care system in the United States is under constant criticism because it is too expensive and renders inadequate or inappropriate care to many people. Government spending for medicare and medicaid programs is growing rapidly. Government spending for medicare and medicaid has doubled every 5 years since the programs began in 1966 and will reach $65 billion in fiscal year 1981.

Clearly, these programs have helped many low-income, elderly and disabled people to obtain needed health care they would otherwise have been unable to afford; but it is also clear that pumping out huge amounts of Federal dollars on essentially an open-ended basis has helped cause rapid inflation in health care prices.

Prior to the initiation of medicare and medicaid in the mid-1960's, inflation in the medical care sector was consistently less than in the rest of the economy. During the past 5 years inflation in medical services has exceeded the general price rise by an average of nearly 2 percentage points per year.

Despite years of hand-wringing about inflation in health care costs, there has as yet been no effective large-scale action to control health care expenditures. Current Federal policies and regulations encourage the use of high-cost institutional care rather than prevention, low-cost in-home care and outpatient care.

In short, our track record with the regulatory approach raises serious doubts that we can ever hope to rely on increased regulations or on improved Federal management of medicare and medicaid as our primary approaches for controlling costs and encouraging appropriate care in the field of health.

Instead, we need a clear break with the past and new Federal policies in both the tax and health program fields that will help assure adequate care for all our citizens at reasonable cost.

Considering the problems both in our economy and in the Federal budget, we need a bill which will begin to change the manner in which the health system works, slow the cost of increases and decrease the regulatory burden of Government intervention in the health care system.

The Schweiker bill, S. 1590; the Durenberger bill, S. 1968; the Ullman bill, H.R. 5740; and the Martin bill, H.R. 6405, are legislative initiatives which offer substantial progress toward these objectives. All of these bills are characterized as procompetitive; that is, they stimulate competition in the health care system.

The four proposals are characterized by several common elements, even though the details vary and each proposal does not contain every element. These common elements are:

One, employers with a minimum number of employees would be required to offer a choice of health insurance plans, one of which would be a low-cost option.

Two, employees who chose the low-cost option would receive, in direct payments or in some other fringe benefit, a percentage of the difference between the cost of that option and of the high-cost option.

Three, only payments made to health insurance plans which conform with the standards set by the legislation would be tax-deductible business expenses for the employer.

Mr. Chairman, there are other elements in the bills which seek to introduce greater competitive forces into the medicare and medicaid programs and to expand the utilization of health maintenance organizations. More enlightened Federal policies in these areas are also urgently needed.

If the Federal Government is to encourage, through changes in tax policies, greater competition among insurers and health-care providers, and more reliance in low-cost forms of care, it certainly

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must do the same thing in the medicare and medicaid programs which are directly funded with Federal dollars.

I am a cosponsor of the Schweiker bill, but I urge the Finance Committee to put together a bill which adopts the best features of all four proposals and bring it to the Senate floor.

The adoption this year of such a bill would at last put us on the road to a sensible national policy on health care financing. I recognize that 1981 will be a tight budgetary year, but I believe the problems in our health care system are so severe that we must proceed as rapidly as we can to institute fundamental reforms of the types proposed in these bills.

I am very encouraged that all of these bills would apparently save substantial sums over the long run if we were to drop the catastrophic benefit features.

In my view, it would be a serious error to enact, in advance of fundamental reforms in the health care financing stystem, a so-called catastrophic benefits program. The introduction of such a program would undoubtedly fuel a new surge of inflation in health care costs; it would certainly shift increased numbers of patients into high-cost hospital beds and out of nursing homes and home care.

Before we adopt a catastrophic benefits plan, we simply must introduce stronger competitive forces and greater incentives for low-cost alternatives and other protections against unnecessary use of high-technology services.

In other words, I would personally oppose a catastrophic benefits plan this year unless it is packaged with changes of the type proposed in the Schweiker, Ullman, Durenberger, and Martin bills and unless all the changes were phased in gradually over a period of several years so as to minimize inflationary effects.

Mr. Chairman, I am submitting in addition to my statement some other comments for the record describing some basic aspects of the health care system and the fact of competition in two geographical areas.

This experience suggests better ways to structure the health care system and Federal intervention in that system. There are, of course, no guarantees that such an approach will work effectively on a national scale. We do know, however, that our traditional methods of financing and regulating in the health care area have not been very successful.

The Durenberger, Schweiker, Ullman, and Martin bills represent a good beginning. I look forward to the opportunity to help the Finance Committee and our Budget Committee to secure Senate enactment of an appropriate health care financing bill.

Senator TALMADGE. Thank you very much, Senator, for a very fine statement.

Any questions?

Senator Durenberger?

Senator DURENBERGER. I want to express my appreciation to Senator Bellmon because he puts it in both the right policy perspective and the right timing perspective. I am indebted to you for your contribution.

Senator BELLMON. Thank you.

[The prepared statement of Senator Bellmon follows. Oral testimony continues on p. 382.]

STATEMENT BY SENATOR HENRY BELLMON
TO SENATE FINANCE COMMITTEE HEARING
ON "PRO-COMPETITIVE" HEALTH CARE FINANCING PROPOSALS
MARCH 19, 1980

THE HEALTH CARE SYSTEM IN THE UNITED STATES IS UNDER CONSTANT CRITICISM BECAUSE IT IS TOO EXPENSIVE AND RENDERS INADEQUATE OR INAPPROPRIATE CARE TO MANY PEOPLE. GOVERNMENT SPENDING FOR THE MEDICARE AND MEDICAID PROGRAMS IS GROWING RAPIDLY.

IN 1978, TOTAL HEALTH CARE OUTLAYS BY ALL PAYORS WERE 192.4 BILLION. THIS WAS THE EQUIVALENT OF $863 FOR EVERY PERSON IN THIS COUNTRY. DURING FISCAL YEAR 1980, HEALTH CARE OUTLAYS WILL BE ABOUT $230 BILLION OR $1,000 PER PERSON. HEALTH CARE COSTS HAVE BEEN RISING AT AN ANNUAL RATE OF 12-15 % AND ARE PROJECTED TO CONTINUE DOING SO.

GOVERNMENT SPENDING FOR MEDICARE AND MEDICAID HAS DOUBLED EVERY FIVE YEARS SINCE THE PROGRAMS BEGAN IN 1966 AND WILL REACH $65 BILLION IN FISCAL YEAR 1981. CLEARLY THESE PROGRAMS HAVE HELPED MANY LOW-INCOME, ELDERLY, AND DISABLED PEOPLE TO OBTAIN NEEDED HEALTH CARE THEY WOULD OTHERWISE HAVE BEEN UNABLE TO AFFORD. BUT IT IS ALSO CLEAR THAT PUMPING OUT HUGE AMOUNTS OF FEDERAL DOLLARS, ON ESSENTIALLY AN OPEN-ENDED BASIS, HAS HELPED CAUSE RAPID INFLATION IN HEALTH CARE PRICES. PRIOR TO THE INITIATION OF MEDICARE AND MEDICAID IN THE MID- 1960'S, INFLATION IN THE MEDICAL CARE SECTOR WAS CONSISTENTLY LESS THAN IN THE REST OF THE ECONOMY. DURING THE PAST FIVE YEARS, INFLATION IN MEDICAL SERVICES HAS EXCEEDED THE GENERAL PRICE RISE BY AN AVERAGE OF NEARLY TWO PERCENTAGE POINTS PER YEAR.

DESPITE YEARS OF HAND-WRINGING ABOUT INFLATION IN HEALTH CARE COSTS, THERE HAS AS YET BEEN NO EFFECTIVE LARGE-SCALE ACTION TO CONTROL HEALTH CARE EXPENDITURES. CURRENT FEDERAL POLICIES AND REGULATIONS ENCOURAGE THE USE OF HIGH-COST INSTITUTIONAL CARE RATHER THAN PREVENTION, LOW-COST IN-HOME CARE AND OUTPATIENT CARE. REGULATIONS ADOPTED FOR THE PURPOSE OF CONTROLLING HEALTH CARE COSTS HAVE RESULTED IN EXTRAORDINARY REQUIREMENTS FOR COMPLETING FORMS AND MAINTAINING RECORDS. REGULATIONS WHICH WERE INTENDED TO INSURE THAT THE POOR, ELDERLY, AND RETARDED RECEIVE QUALITY CARE IN A SAFE ENVIRONMENT HAVE SOMETIMES HAD COUNTER-PRODUCTIVE EFFECTS ON THOSE PROVIDING QUALTIY CARE AT LOW COST. ON THE OTHER HAND, THE FAILURE TO ENFORCE REGULATIONS EVENHANDEDLY HAS RESULTED IN LESS THAN ADEQUATE CARE FOR MANY OF OUR MOST DEFENSELESS CITIZENS. I ASSUME MEMBERS OF THIS COMMITTEE HAVE HEARD FROM STATE OFFICIALS, AS I HAVE, THAT THE MORE THEY CHALLENGE FEDERAL POLICIES AND ACTIONS, THE MORE THEY SEEM TO BE THE TARGET OF FEDERAL OVERSIGHT AND SPECIAL ASSESSMENTS.

IN SHORT, OUR TRACK RECORD WITH THE REGULATORY APPROACH RAISES SERIOUS DOUBTS THAT WE CAN EVER HOPE TO RELY ON INCREASED REGULATIONS OR ON IMPROVED FEDERAL MANAGEMENT OF MEDICARE AND MEDICAID AS OUR PRIMARY APPROACHES FOR CONTROLLING COSTS AND ENCOURAGING APPROPRIATE CARE IN THE FIELD OF HEALTH. INSTEAD, WE NEED A CLEAR BREAK WITH THE PAST AND NEW FEDERAL POLICIES IN BOTH THE TAX AND HEALTH PROGRAM FIELDS THAT WILL HELP ASSURE ADEQUATE CARE FOR ALL OUR CITIZENS AT REASONABLE COST.

IT IS UNFORTUNATE THAT CONGRESS HAS NOT REPORTED OR PASSED ANY LEGISLATON WHICH WOULD BEGIN TO REFORM THE SYSTEM, REDUCE COSTS, OR LIMIT THE REGULATORY BURDEN ON PROVIDERS AND CONSUMERS OF HEALTH CARE SERVICES.

CONSIDERING THE PROBLEMS BOTH IN OUR ECONOMY AND IN THE FEDERAL BUDGET, WE NEED A BILL WHICH WILL BEGIN TO CHANGE THE MANNER IN WHICH THE HEALTH SYSTEM WORKS, SLOW THE COST INCREASES, AND DECREASE THE REGULATORY BURDEN OF GOVERNMENT INTERVENTION IN THE HEALTH CARE SYSTEM. THE SCHWEIKER BILL (S. 1590), THE DURENBERGER BILL (S. 1968), THE ULLMAN BILL (H.R. 5740), AND THE MARTIN BILL (H.R. 6405) ARE LEGISLATIVE INITIATIVES WHICH OFFER SUBSTANTIAL PROGRESS TOWARD THESE OBJECTIVES. ALL OF THESE BILLS ARE CHARACTERIZED AS "PRO-COMPETITIVE"; THAT IS, THEY STIMULATE COMPETITION IN THE HEALTH CARE SYSTEM.

THE FOUR PROPOSALS ARE CHARACTERIZED BY SEVERAL COMMON ELEMENTS, EVEN THOUGH THE DETAILS VARY AND EACH PROPOSAL DOES NOT CONTAIN EVERY ELEMENT. THESE COMMON ELEMENTS ARE:

1. EMPLOYERS WITH A MINUMUM NUMBER OF EMPLOYEES WOULD BE REQUIRED TO OFFER A CHOICE OF HEALTH INSURANCE PLANS, ONE OF WHICH WOULD BE A LOW COST OPTION.

2. EMPLOYEES WHO CHOSE THE LOW COST OPTION WOULD RECEIVE, IN DIRECT PAYMENTS OR IN SOME OTHER FRINGE BENEFIT, A PERCENTAGE OF THE DIFFERENCE BETWEEN THE COST OF THAT OPTION AND OF THE HIGH COST OPTION;

3. ONLY PAYMENTS MADE TO HEALTH INSURANCE PLANS WHICH CONFORM WITH THE STANDARDS SET BY THE LEGISLATION WOULD BE TAX-DEDUCTIBLE BUSINESS EXPENSES FOR THE EMPLOYER.

THERE ARE OTHER ELEMENTS IN THE BILLS WHICH SEEK TO INTRODUCE GREATER COMPETITIVE FORCES INTO THE MEDICARE AND MEDICAID PROGRAMS AND TO EXPAND THE UTILIZATION OF HEALTH MAINTENANCE ORGANIZATIONS. MORE ENLIGHTENED FEDERAL POLICIES IN THESE AREAS ARE ALSO URGENTLY NEEDED. IF THE FEDERAL GOVERNMENT IS TO ENCOURAGE, THROUGH CHANGES IN TAX POLICIES, GREATER COMPETITION AMONG INSURERS AND HEALTH CARE PROVIDERS, AND MORE RELIANCE ON LOW-COST FORMS OF CARE, IT CERTAINLY MUST DO THE SAME THING IN THE MEDICARE AND MEDICAID PROGRAMS WHICH ARE DIRECTLY FUNDED WITH FEDERAL DOLLARS

I AM A CO-SPONSOR OF THE SCHWEIKER BILL, BUT I URGE THE FINANCE COMMITTEE TO PUT TOGETHER A BILL WHICH ADOPTS THE BEST FEATURES OF ALL FOUR PROPOSALS AND BRING IT TO THE SENATE FLOOR. THE ADOPTION THIS YEAR OF SUCH A BILL WOULD AT LAST PUT US ON THE ROAD TO A SENSIBLE NATIONAL POLICY ON HEALTH CARE FINANCING. I RECOGNIZE THAT 1981 WILL BE A TIGHT BUDGETARY YEAR, BUT I BELIEVE THE PROBLEMS IN OUR HEALTH CARE SYSTEM ARE SO SEVERE THAT WE MUST PROCEED AS RAPIBLY AS WE CAN TO INSTITUTE FUNDAMENTAL REFORMS OF THE TYPES PROPOSED IN THESE BILLS. I AM VERY ENCOURAGED THAT ALL OF THESE BILLS WOULD APPARENTLY SAVE SUBSTANTIAL SUMS OVER THE LONG RUN, IF WE WERE TO DROP THE CATASTROPHIC BENEFIT FEATURES.

IN MY VIEW IT WOULD BE A SERIOUS ERROR TO ENACT, IN ADVANCE OF FUNDAMENTAL REFORMS IN THE HEALTH CARE FINANCING SYSTEM, A SO-CALLED CATASTROPHIC BENEFITS PROGRAM. THE INTRODUCTION OF SUCH A PROGRAM WOULD UNDOUBTABLY FUEL A NEW SURGE OF INFLATION IN HEALTH CARE COSTS. IT WOULD CERTAINLY SHIFT INCREASED NUMBERS OF PATIENTS INTO HIGH-COST HOSPITAL BEDS AND OUT OF NURSING HOMES AND HOME CARE.

BEFORE WE ADOPT A CATASTROPHIC BENEFITS PLAN, WE SIMPLY MUST INTRODUCE STRONGER COMPETITIVE FORCES AND GREATER INCENTIVES FOR LOW-COST ALTERNATIVES AND OTHER PROTECTIONS AGAINST UNNECESSARY USE OF HIGH TECHNOLOGY SERVICES. IN OTHER WORDS, I WOULD PERSONALLY OPPOSE A CATASTROPHIC BENEFITS PLAN THIS YEAR UNLESS IT IS PACKAGED WITH CHANGES OF THE TYPE PROPOSED IN THE SCHWEIKER, ULLMAN, DURENBERGER, AND MARTIN BILLS, AND UNLESS ALL THE CHANGES WERE PHASED IN GRADUALLY OVER A PERIOD OF SEVERAL YEARS SO AS TO MINIMIZE INFLATIONARY EFFECTS.

I DISCUSSED BRIEFLY EARLIER IN MY STATEMENT SOME CONCERNS ABOUT CURRENT FEDERAL REGULATORY POLICIES AND PRACTICES. I WOULD NOW LIKE

TO CALL THE COMMITTEE'S ATTENTION TO ONE EXAMPLE IN WHICH FEDERAL REGULATION SEEMS TO BE WORKING WELL. I REFER TO THE OKLAHOMA UTILIZATION REVIEW SYSTEM (OURS), WHICH I BELIEVE COULD SERVE AS A NATIONAL MODEL FOR ONE KIND OF REFORM NEEDED BEFORE WE LAUNCH A CATASTROPHIC BENEFITS PROGRAM. OURS HAS SUBSTITUTED A SYSTEM OF RETROSPECTIVE REVIEW OF CLAIMS FOR THE PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO) SYSTEM OF CONCURRENT REVIEW OF PATIENT CARE. INDIVIDUAL HOSPITAL DATA ARE COMPARED TO ESTABLISHED STANDARDS OF PERFORMANCE AND MONITORING ATTENTION IS FOCUSED ON THOSE HOSPITALS WHICH FAIL TO MEET THE STANDARDS. RECENTLY THE GENERAL ACCOUNTING OFFICE (GAO) COMPLETED A REVIEW OF OURS. WHILE GAO IDENTIFIED SOME PROBLEMS WITH OURS' DATA, GAO'S OWN DATA SHOWED THAT DURING THE EVALUATION PERIOD,

-- THE COST OF INPATIENT DAYS OF CARE FOR MEDICARE AND MEDICAID ELIGIBLE WERE REDUCED BY THE EQUIVALENT OF MORE THAN $11 MILLION;

-- FOR EVERY $1 SPENT ON OURS, $4.45 WAS SAVED. THIS COMPARES FAVORABLY TO THE NATIONAL PROFESSIOANL STANDARDS REVIEW ORGANIZATION (PSRO) COST-BENEFIT RATIO OF $1.10 SAVINGS FOR EVERY $1 SPENT.

I AM SUBMITTING THE REMAINDER OF MY STATEMENT FOR THE RECORD. IT DESCRIBES SOME BASIC ASPECTS OF THE HEALTH CARE SYSTEM AND THE EFFECTS OF COMPETITION IN TWO GEOGRAPHICAL AREAS. THIS EXPERIENCE SUGGESTS BETTER WAYS TO STRUCTURE THE HEALTH CARE SYSTEM AND THE FEDERAL INTERVENTION IN THAT SYSTEM. THERE ARE OF COURSE NO GUARANTEES THAT SUCH AN APPROACH WILL WORK EFFECTIVELY ON A NATIONAL SCALE. WE DO KNOW, HOWEVER, THAT OUR TRADITIONAL METHODS OF FINANCING AND REGULATING IN THE HEALTH CARE AREA HAVE NOT BEEN VERY SUCCESSFUL. THE DURENBERGER, SCHWEIKER, ULLMAN AND MARTIN BILLS REPRESENT A GOOD BEGINNING. I LOOK FORWARD TO THE OPPORTUNITY TO HELP THE FINANCE COMMITTEE SECURE SENATE ENACTMENT OF AN APPROPRIATE HEALTH CARE FINANCING BILL.

ATTACHMENT TO STATEMENT BY SENATOR HENRY BELLMON

LET ME TURN NOW TO SOME BACKGROUND INFORMATION THAT I BELIEVE WILL HELP THE COMMITTEE KEEP THE PROPER PERSPECTIVE ON THE HEALTH CARE FINANCING QUESTIONS. TWO ASPECTS OF THE HEALTH CARE SYSTEM POINT UP THE CRITICAL NEED FOR COMPETITION. THE FIRST IS THE ABSENCE OF ANY CLEAR RELATIONSHIP BETWEEN THE NEED FOR HEALTH SERVICES, THEIR UTILIZATION, AND HEALTH EXPENDITURES. THE SECOND IS THE DEGREE TO WHICH THE REIMBURSEMENT SYSTEMS, WHICH ARE USED BY PRIVATE INSURERS AND THE MEDICARE AND MEDICAID PROGRAMS, ARE INFLATIONARY AND BIASED TOWARD USE OF THE INSTITUTIONAL SERVICES.

NATURE OF THE HEALTH CARE MARKETPLACE

WENNBERG IN A PAPER PUBLISHED BY DHEW IN 1977 DOCUMENTED THE VARIABILITY IN THE UTILIZATION OF HEALTH CARE SERVICES AMONG THE FIVE LARGEST HOSPITAL SERVICE AREAS IN THE STATE OF MAINE.

TABLE 1 SHOWS THE HOSPITAL UTILIZATION FOR THESE AREAS. PATIENT DAYS OF CARE VARY FROM 831 DAYS PER 1,000 PERSONS PER YEAR IN AREA V TO 1,625 DAYS IN AREA IV. AREA IV HAS THE HIGHEST RATE OF HOSPITALIZATION, MOST PATIENT DAYS, HIGHEST PER CAPITA EXPENDITURES, THE MOST AVAILABLE BEDS AND A HIGH RATE OF ELECTIVE SURGICAL PROCEDURES, ESPECIALLY TONSILLECTOMY AND HEMORRHOIDECTOMY.

TABLE 2 COMPARES THE PER CAPITA RATES OF HOSPITALIZATION EXPENDITURES FOR NINE COMMON SURGICAL PROCEDURES AMONG THE 13 LARGEST MAINE HOSPITAL SERVICE AREAS.

THERE ARE NO INDICATIONS THAT THE POPULATIONS RECEIVING THE

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HIGHEST LEVELS OF CARE, AS REFLECTED IN TABLES 1 AND 2, HAD ANY GREATER NEED FOR THE HIGH LEVEL OF MEDICAL CARE THEY RECEIVED. VARIANCES IN UTILIZATION RATES ARE DEPENDENT ON FACTORS OTHER THAN THE MORBIDITY OF THE POPULATION. RESIDENTS OF THOSE AREAS SERVED BY PROPORTIONATELY MORE SURGEONS RECEIVE MORE SURGERY AND HAVE HIGHER ADMISSION RATES TO HOSPITALS.[1]

IN ANOTHER REPORT, WENNBERG SUMMARIZES THE CONCLUSIONS, BASED ON WORK IN VERMONT, IN THE FOLLOWING TERMS:

> INSURANCE IS VIEWED AS A RISK-POOLING DEVICE, AS A HEDGE AGAINST THE RANDOMNESS OF COSTLY ILLNESS. IT IS ASSUMED THAT ONCE CONTACT IS MADE WITH THE SYSTEM, THE CARE PROVIDED IS GENERALLY OF VALUE AND MORE OR LESS SIMILAR FOR THE SAME ILLNESS.
>
> THE DISTRIBUTION OF INSURANCE BENEFITS FROM BOTH PUBLIC AND PRIVATE MARKETS AMONG VERMONT HOSPITAL SERVICE AREAS ILLUSTRATES WHAT IS WRONG WITH THIS ASSUMPTION. ACROSS NEIGHBORING VERMONT AREAS, EQUAL INITIATING CONTACT FOR EPISODES OF ILLNESS WITH THE SYSTEM OCCURS AMONG THE ELDERLY, AMONG THE POOR AND AMONG EVERYONE ELSE. YET CONTACT AMONG THESE APPARENTLY SIMILAR COHORTS OF PEOPLE RESULTS IN VARIABLE APPLICATIONS OF HEALTH CARE TECHNOLOGY AND IS FOLLOWED BY VARYING PER CAPITA EXPENDITURES AND REIMBURSEMENTS.
>
> THE CASE OF TONSILLECTOMY ILLUSTRATES THIS PROBLEM. CHILDREN OF THE DIFFERENT VERMONT AREAS CONTACT THEIR PHYSICIANS AT SIMILAR RATES FOR UPPER RESPIRATORY INFECTIONS, BUT THE PERCENT OF CHILDREN WITHIN AN AREA WHO RECEIVE TONSILLECTOMY VARIES FROM 8% TO 63%. IT IS NOT CLEAR THAT CHILDREN ARE HEALTHIER FOR THE OPERATIVE EXPERIENCE IN THE HIGH AREAS, BUT WHO PAYS FOR WHOSE TONSILLECTOMY IS DIRECTLY SEEN. FOR MOST EXAMPLES OF PUBLIC AND PRIVATE INSURANCE AVAILABLE IN VERMONT MARKETS, EACH SUBSCRIBER PAYS A SIMILAR PRICE FOR SIMILAR INSURANCE, WITHOUT REGARD TO PLACE OF RESIDENCE. A FRACTION OF THE PREMIUM IS INSURANCE AGAINST THE RANDOM ILLNESS THAT LEADS TO TONSILLECTOMY. BUT, IT TURNS OUT, THE PROBABILITY OF TONSILLECTOMY IS RANDOM ONLY IN THE SENSE THAT PLACE OF RESIDENCE IS RANDOM; ESTIMATED ANNUAL PER CAPITA EXPENDITURE FOR TONSILLECTOMY IN VERMONT (1969-1970) VARIED FROM $.63 TO $5.69. RATHER THAN DIFFERENCES IN ILLNESS RATES, ESSENTIALLY EXTERNAL OR EXOGENOUS FACTORS, THE VAGARIES OF LOCATION AND PROFESSIONAL PREFERENCES FOR THERAPY DETERMINE THAT PEOPLE LIVING IN THE LOW-USE AREA SUBSIDIZE THE TONSILLECTOMIES CONSUMED BY

[1] WENNBERG, J.E., A. GITTELSOHN, N. SHAPIRO HEALTH CARE DELIVERY IN MAINE III EVALUATING THE LEVEL OF HOSPITAL PERFORMANCE. J. MAINE MED. ASSOC. 66(11). 298-306 NOVEMBER 1975.

THOSE IN THE HIGH COST AREA.[1]

IN THE MAY 10, 1978 WALL STREET JOURNAL, THE FOLLOWING EXAMPLES OF CORPORATE EFFORTS TO CONTROL THIS VARIABILITY WERE PRESENTED:

> ROCKWELL INTERNATIONAL HAS COMPUTERIZED ITS QUARTERLY "TREND REPORT" TO SPOT UNUSUAL DOCTOR OR HOSPITAL BILLS. NOT LONG AGO, THE REPORT SHOWED THAT ONE PHYSICIAN HAD DONE 30 OF THE 100 OPERATIONS PERFORMED ON ONE PLANT'S EMPLOYES THAT QUARTER. EVERY ONE OF THE 30 WAS A BRONCHOSCOPY, AN EXPLORATORY LUNG OPERATION.
>
> "THERE SHOULDN'T HAVE BEEN THAT MANY PEOPLE WITH LUNG PROBLEMS," SAYS EDWIN MCMANUS, A ROCKWELL STAFF VICE PRESIDENT. A ROCKWELL INSURANCE CONSULTANT VISITED THE DOCTOR, WHO OWNED THE LOCAL PROFIT-MAKING HOSPITAL. THE CONSULTANT SUGGESTED THAT THE PHYSICIAN PERFORM BRONCHOSCOPIES ONLY WHEN THEY WERE "ABSOLUTELY NECESSARY." THE RESULT? "ALL THIS BRONCHOSCOPY ACTIVITY WAS BROUGHT TO A STOP," MR. MCMANUS REPORTS.
>
> MOTOROLA INC. HELPED SET UP AND FINANCE A HOSPITAL-ADMISSIONS PROGRAM IN PHOENIX, ARIZ., THAT IS SAVING IT MORE THAN $800,000 ANNUALLY IN AVOIDED OR REDUCED HOSPITALIZATION FOR ITS 43,000 PHOENIX-AREA EMPLOYES AND THEIR FAMILIES.

A MOST BLATANT EXAMPLE OF THE BIAS TOWARD USE OF INSTITUTIONAL SERVICES CAUSED BY HEALTH INSURANCE WAS OUTLINED IN TIME, MAY 28, 1979:

> SOME INSURANCE PRACTICES OPERATE DIRECTLY TO DRIVE UP COSTS. MANY INSURANCE COMPANIES WILL PAY FOR LAB TESTS ONLY IF THEY ARE DONE IN A HOSPITAL ON A SUPPOSEDLY SICK PATIENT. THE RESULT IS TO ENCOURAGE HOSPITALIZATION OF UNTOLD THOUSANDS OF PEOPLE WHO COULD BE DIAGNOSED AND/OR TREATED AT FAR LESS COST IN A DOCTOR'S OFFICE. SAYS ONE HOUSTON PHYSICIAN: "SAY A MAN IN HIS LATE 30S TO EARLY 40S COMPLAINS OF CHEST PAINS. I TELL HIM HE NEEDS A THOROUGH PHYSICAL. IN THE OFFICE MY FEE WOULD BE $45, THE TESTS $250, FOR A TOTAL OF $295. BUT I HAVE TO PUT THE PATIENT IN THE HOSPITAL, SO HIS INSURANCE WILL PAY FOR IT. EVERYTHING IS SO SLOW IN THE HOSPITAL, SO FIGURE HE WILL BE THERE THREE DAYS. THE COST INCREASES FROM $295 TO $900, BUT HIS INSURANCE COMPANY WILL GLADLY PAY FOR IT."

CUSTOMARY, PREVAILING AND REASONABLE CHARGE (CPR), ALSO REFERRED TO AS USUAL, CUSTOMARY AND REASONABLE CHARGE, REIMBURSEMENT IS THE BASIC METHOD FOR REIMBURSING FOR HEALTH SERVICES. IN 1975 IT WAS USED

[1] J.E. WENNBERG, USING LOCALIZED, POPULATION-BASED DATA IN EVALUATING PLANNING PROBLEMS IN PAPERS ON THE NATIONAL HEALTH GUIDELINES: THE PRIORITIES OF SECTION 1502, DHEW, 1977.

BY MEDICARE, TWENTY-FOUR STATE MEDICAID PROGRAMS, BLUE SHIELD--FOR ABOUT HALF ITS BUSINESS, AND BY THE LARGER COMMERICIAL INSURORS.

BURNEY, SCHIEBER, BLAXALL AND GABEL IN THE SUMMER, 1979, HEALTH CARE FINANCING REVIEW DESCRIBED THE INFLATIONARY EFFECT OF CPR:

> ...CPR IMPLICITLY ENCOURAGES PHYSICIANS TO RAISE THEIR FEES BECAUSE THE HIGHER THE RATE OF INCREASE IN FEES THIS YEAR, THE HIGHER THE CPR SCREENS NEXT YEAR.

TABLE 3 SHOWS THE CPR BIAS TOWARD HIGHER REIMBURSEMENT OF SPECIALISTS FROM MEDICARE IN THOSE AREAS WITH MORE PHYSICIANS PER 100,000 POPULATION AND WITH HIGH PER CAPITA INCOME. ACCORDING TO BURNEY ET AL.,

> . . .TO THE EXTENT THAT MEDICARE FEES REFLECT PRIVATE MARKET PATTERNS, EXISTING PHYSICIANS FEE PATTERNS MAY PROVIDE FINANCIAL INCENTIVES FOR PHYSICIANS TO LOCATE IN HIGH-INCOME, PHYSICIAN-DENSE METROPOLITAN AREAS.

WHEN THERE IS AN OPPORTUNITY TO SUBSTITUTE OFFICE VISITS FOR OUTPATIENT TREATMENT IN A HOSPITAL OR MEDICAL TREATMENT FOR SURGERY, BURNEY ET AL. BELIEVE MEDICARE AND MEDICAID REIMBURSEMENT ENCOURAGE THE HIGHER COST, INSTITUTIONAL CARE. THEY CONCLUDE,

> ...SINCE MEDICARE AND SOME MEDICAID PHYSICIAN REIMBURSEMENT METHODS ARE BASED ON EXISTING PRIVATE MARKET FEE STRUCTURES, THEY MAY ONLY REFLECT FEE PATTERNS INHERENT IN THE OVERALL HEALTH SYSTEMS.

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Effects of Competition

Where competition has been introduced into the medical marketplace, health care costs have either decreased or risen less rapidly due to a significantly lower reliance on inpatient hospital care. Minneapolis and Hawaii are the two areas with the most experience with competition.

In the Twin Cities area of Minneapolis-St. Paul, Health Maintenance Organization (HMO) alternatives to the traditional health insurance options have been available since 1971. In 1978 with 12.7% of the Metropolitan population enrolled in HMO's, the following hospitalization data are available:

Hospitalization Days Per 1,000

	Metropolitan HMO Average	Blue Cross/ Blue Shield	U.S. Average
1976	494	906	---
1977	517	884	1,183
1978	456	787	---

According to Christianson and McClure in Competition in the Delivery of Medical Care (1978):

> The actions of HMOs and fee-for-service provider in Minneapolis-St. Paul are consistent with the predictions of a competitive model in many respects. HMOs have attempted to increase enrollment by explanding accessibility, controlling costs, and engaging in price competition. The different HMO organizational forms which have developed give consumers a meaningful choice among products with different characteristics. Physicians have responded by offering their patients alternative prepaid arrangements and submitting to increased efforts to control their costs. The restrictiveness of these controls may be unprecedented in a physician sponsored (excluding group practice) HMO and attest to the strength of the competitive challenge of competing HMOs. Hospitals have willingly sought HMO business and in the process have been forced to become more conscious of their own costs. Blue Cross/ Blue Shield has attempted to protect its market position by providing its customers with an HMO alternative, but

PRIVATE INSURORS HAVE NOT DEVELOPED MECHANISMS AS YET WHICH MIGHT SIGNIFICANTLY CONTROL THEIR PREMIUM INCREASES.

ENTHOVEN IN EFFECTS OF THE PAYMENT MECHANISM ON THE HEALTH CARE DELIVERY SYSTEM (EDITED BY ROY, 1978) DESCRIBES THE SITUATION IN HAWAII IN THE FOLLOWING TERMS:

> THERE IS SUCH A COMPETITION IN A FEW PLACES TODAY, DESPITE THE MANY BARRIERS TO THE DEVELOPMENT OF COST-EFFECTIVE ORGANIZED SYSTEMS. PERHAPS THE BEST EXAMPLE IS HAWAII WHERE THE HAWAII MEDICAL SERVICE ASSOCIATION (HMSA) INSURES ABOUT 64 PERCENT OF THE NON-MILITARY POPULATION OF THE STATE, WHILE THE KAISER-PERMANENTE MEDICAL CARE PROGRAM SERVES ABOUT 16 PERCENT OF THE POPULATION OF OAHU. THE EFFECT IS TO DIVIDE THE STATE INTO TWO COMPETING PROVIDER GROUPS. MOST OF THE PATIENTS OF A NON-KAISER DOCTOR OR HOSPITAL ARE LIKELY TO BE COVERED BY HMSA, WHICH GIVES HMSA SUBSTANTIAL POWER TO INFLUENCE CHARGES, FEES AND UTILIZATION. COMPETITION BETWEEN THE TWO GROUPS IS VERY KEEN. THE RESULT IS EFFECTIVE COST CONTROL, AND VERY LOW HOSPITALIZATION RATES IN BOTH GROUPS.

WRITING IN THE JUNE 1, 1978 NEW ENGLAND JOURNAL OF MEDICINE ENTHOVEN FOCUSES ON THE PRICE AND UTILIZATION BASES FOR THE COMPETITIVE ADVANTAGE ENJOYED BY PRE-PAID GROUP PRACTICE PLANS:

> ANOTHER LARGE STUDY, BY GAUS, COMPARED DAYS IN HOSPITAL AND SURGICAL ADMISSIONS FOR MEDICAID BENEFICIARIES ENROLLED IN EIGHT PREPAID-GROUP PRACTICE PLANS WITH THOSE OF BENEFICIARIES IN MATCHED CONTROL GROUPS WHO GOT THEIR CARE FROM FEE-FOR-SERVICE PROVIDERS. THE GROUP-PRACTICE BENEFICIARIES AVERAGED 340 DAYS IN THE HOSPITAL AND 24 SURGICAL ADMISSIONS PER 1000 PERSONS PER YEAR, AS COMPARED TO 888 DAYS IN THE HOSPITAL AND 50 SURGICAL ADMISSIONS PER 1000 PERSONS PER YEAR IN THE CONTROL GROUPS. THIS STUDY INVESTIGATED PRIOR HEALTH STATUS AS PERCEIVED BY THE BENEFICIARIES AND NUMBER OF CHRONIC CONDITIONS, AND IT FOUND NO STATISTICALLY SIGNIFICANT DIFFERENCE BETWEEN THE MEMBERS OF PREPAID-GROUP-PRACTICE PLANS AND THE CONTROL GROUPS.

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CONSIDERING THE EXPERIENCE IN THE TWIN CITIES AREA AND HAWAII, I BELIEVE CONGRESS SHOULD MOVE NOW TO INTRODUCE MORE OPPORTUNITY FOR A MARKET TO DEVELOP IN THE HEALTH CARE SYSTEM. THERE ARE NO GUARANTEES SUCH AN APPROACH WILL WORK. WE DO KNOW, HOWEVER, THAT OUR TRADITIONAL METHODS OF LEGISLATING AND REGULATING IN THE HEALTH CARE AREA HAVE NOT BEEN SUCCESSUL.

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Table 1

Indicators of performance in 5 largest Maine Hospital Service Areas by population data and institutional indicators

	Population data			Institutional indicators			
	Per 1,000 population						
	Incidence of hospitalization[1]	Patient days of care	Available beds[2]	Per capita Expenditures[2]	Percent Occupancy[2]	Average length of stay in days[1]	Annual bed turnover rate
Area I	145	1,104	4.1	$102	73	7.6	33
Area II	153	1,244	5.0	92	73	8.1	31
Area III	157	1,054	4.2	75	65	6.7	34
Area IV	235	1,625	5.7	109	72	7.0	39
Area V	127	831	3.8	72	72	6.6	32

1. 1973 data (incidence rate is age-adjusted)

2. 1971 data

Source: Wennberg, J.E., A. Gittelsohn, N. Shaprio Health care delivery in Maine III Evaluating the level of hospital performance. J. Maine Med. Assoc. 66(11). 298-306 November 1975.

A-9
Table 2

Per capita hospitalization expenditures for nine common procedures in areas with highest and lowest incidence rates, 13 largest Maine Hospital Service Areas and State average, 1973.

Procedure	High Use area[1]	Low Use area[1]	State Average
Hysterectomy[2]	$6.78	$2.88	$4.30
Cholecystectomy	4.98	2.51	3.45
Prostatectomy	3.54	1.47	2.34
Tonsillectomy	4.55	0.85	2.33
Hernia[3]	2.51	1.64	1.99
Dilation and Curettage[2]	2.68	1.08	1.82
Appendectomy	1.99	0.97	1.47
Hemorrhoidectomy	1.43	0.23	0.54
Varicose Veins	0.93	0.30	0.48
All Nine Procedures	29.39	11.93	18.73

[1]Areas ranked independently on each procedure

[2]For females only

[3]For males only

Source: Wennberg, J.E., A. Gittelsohn: Health care delivery in Maine 1: Patterns of use of common surgical procedures. J Maine Med Assoc 66:5, pp. 123-130 and 149.

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Table 3

MEAN AND RANGE FOR MEDICARE SPECIALIST FEE INDICES BY COUNTY PHYSICIAN POPULATION RATIO AND COUNTY PER CAPITA INCOME, 1975

	Number of Counties	Medicare Mean	Medicare Range
All Counties	3074	100	70-192
Physicians Per 100,000 Population (1973)			
/ 24	314	85	71-126
25-74	1,747	85	70-126
75-124	704	82	70-132
125-174	182	102	71-154
175-224	70	113	75-154
225-299	25	110	77-154
300+	32	113	80-192
Per Capita Income (1970)			
/ $2,499	628	83	70-103
$2,500-$2,999	877	83	70-113
$3,000-$3,499	874	87	70-117
$3,500-$3,999	479	99	70-154
$4,000-$4,999	153	100	75-154
$4,500+	63	121	75-192

Source: Medicare Carrier Survey, Intermediary Letter 74-19, June, 1974.

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Senator TALMADGE. The next witness is John W. Colloton, director and assistant to the president for health services of the University of Iowa Hospitals and Clinics, on behalf of the Association of American Medical Colleges, accompanied by Dr. John A. D. Cooper, M.D., president, Association of American Medical Colleges.

Mr. Colloton, you may insert your full statement in the record and summarize it, as you see fit, sir.

STATEMENT OF JOHN W. COLLOTON, DIRECTOR AND ASSISTANT TO THE PRESIDENT FOR HEALTH SERVICES, UNIVERSITY OF IOWA HOSPITALS AND CLINICS, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY RICHARD KNAPP, DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS, AAMC

Mr. COLLOTON. Thank you, Mr. Chairman.

I am John Colloton, executive director of the University of Iowa Hospitals and Clinics, and Chairman of the Council of Teaching Hospitals of the Association of American Medical Colleges.

With me is Richard Knapp, director of the association's department of teaching hospitals.

The association represents all of the Nation's medical schools, 70 academic societies, and over 400 of the Nation's major teaching hospitals. Thus, S. 1968 is of vital interest to our members and we appreciate the opportunity to testify on their behalf.

We commend Senators Durenberger, Heinz, and Boren for their sponsorship of S. 1968 as well as the other subcommittee members for their willingness to discuss alternative methods to achieve a goal we all share; that is, containing escalating health-care costs.

The association has no special expertise in assessing alternative tax reform proposals. We also are not in a position to evaluate the economic consequences competition will have on the total dollars presently spent on health care in this Nation. The association does believe, however, that we have an obligation to raise several questions about competition which have to date received inadequate attention in public forums. Hopefully, consideration of these issues will help to avoid unintended consequences of intended worthy objectives.

Our comments address unresolved issues related to the multiple contribution of the Nation's major teaching hospitals to the health care of our citizens.

Underlying the competitive models being proposed is the assumption that hospitals provide a relatively standardized product which is identifiable in terms of costs and quality. This assumption raises several issues for teaching hospitals which have multiple products benefiting not only the individual patient but also society as a whole.

Because these activities result in higher costs, presently financed through patient care revenues, competitive pricing resulting from the proposed legislation could jeopardize the future ability of teaching hospitals to meet these multiple responsibilities.

There are four specific contributions of teaching hospitals which we would like to call to your attention; namely, medical education, research, new technology testing and tertiary care, quality referral care, and large-scale charity care.

As you know, teaching hospitals are the setting for the vast majority of the clinical training of physicians at both the undergraduate and the graduate medical education levels. In this context, it should be recognized that medical school enrollment has more than doubled in the past two decades and there has been a corresponding twofold increase in the number of hospitals affiliated with medical schools.

With virtually all medical school graduates now participating in at least 3 years of residency training, graduate medical education has also experienced dramatic increases. Over 80 percent of all residency positions are sponsored by the 418 members of the Council of Teaching Hospitals.

New medical schools as well as established schools have in recent years sought broadened affiliations with community hospitals to accommodate increased and varied educational needs.

There are substantial costs associated with a hospital's participation in medical education. Resident stipends and benefits alone now total over $1 billion annually. These educational costs are presently recognized as necessary and legitimately reimbursable by third parties, including the Federal Government.

Competitive pricing could discourage insurers from purchasing care from providers whose educational and research costs make premiums noncompetitive. Competitive pricing could also encourage teaching hospitals to restrict their medical education activities.

A second general commitment by teaching hospitals is research, technology development, and tertiary care. Teaching hospitals have served as a setting where clinical research is translated into medical practice and thereafter disseminated to community physicians and other providers.

Often teaching hospitals accept medical and technological innovation as a mission, in spite of the cost implications involved. Competition among insurers and among providers may well jeopardize the continuing ability of teaching hospitals to meet this role in advancing medical research and new technology, and thereby improve the health services available to the Nation as a whole.

Related to a commitment to research and technology is the provision of regional tertiary care services to seriously ill patients. This commitment may be illustrated by the fact that members of the Council of Teaching Hospitals constitute only 5 percent of all non-Federal short-term hospitals, but over half of all the burn-care units of our Nation, supply 44 percent of all organ-bank services, provide 40 percent of the open-heart surgical services, and are the locations for over one-third of the Nation's newborn intensive care units.

These services are of unquestionable social value, but it is unclear how patients needing these services will have access to them under a competitive scheme. There are no assurances that insurers and HMO's, which contract with community hospitals, would be willing to establish adequate referral arrangements with high-cost tertiary care centers to avail their beneficiaries of these specialty services.

The reluctance to establish referral arrangements with tertiary care centers has significant implications for the quality of patient

care. Traditionally, physicians have been trained to provide the very best care available to their patients.

Given present health insurance coverage, the physician has been able to concentrate on securing the optimal prescribed treatment for each patient, with less emphasis on the cost of the treatment. It is possible that competition may move us too far in the opposite direction. Accordingly, we must seek assurances that competition will not create economic disincentives to provide an adequate level and quality of services for patients afflicted with complex disease.

Another quality of care issue relates to consumer knowledge.

Studies have repeatedly found that the quality of care can vary dramatically, depending on the hospital. Despite the results of these studies, it remains difficult to translate the findings into quantitative criteria that can be widely understood by the average consumer.

Thus, when a choice is made among health benefit plans, the premium costs of the various plans, which are explicitly stated, may receive disproportionate consideration because quality is a relatively unknown factor. It is conceivable that a number of plans may develop that are competitively priced but are without provisions facilitating access to patient care of an acceptable level of quality.

Many teaching hospitals, particularly in urban areas, provide large amounts of service to the poor and near poor of their communities. This care includes not only inpatient service but also ambulatory care on a large scale. In order to remain financially viable while providing charity care at no charge or below cost, teaching hospitals have historically priced their services so that the patients paying full charges pay not only for themselves but also help to underwrite the costs of charity care.

In a price competitive marketplace, large-scale buyers and third parties most likely will be unwilling to subsidize care for such charity patients; thus, teaching hospitals may have to restrict the availability of charity services and/or obtain governmental or other subsidies for patients unable to pay for their care.

Commitment to the activities I have mentioned—medical education, research, quality tertiary care, and charity care—create financial demands on teaching hospitals that are not present in nonteaching settings. Even if special funds could be set aside for these activities, which would be extremely difficult to do, most teaching hospitals will likely still have higher average costs due to the patient case mix they treat.

Teaching hospitals admit more seriously ill patients which require not only more complex ancillary services but also more intensive nursing and bedside care. As a consequence, the prices of teaching hospitals reflect a higher average cost per patient day than those prevailing in community hospitals which treat a less intensely ill patient population.

In a price competitive market, insurers may be reluctant to purchase care for their subscribers at teaching hospitals, recognizing that the average pure patient care costs in the tertiary setting will exceed that prevailing in community hospitals due to case mix differentials.

It is the AAMC's hope that these issues will be carefully studied before any legislative initiatives are broadly endorsed.

We thank you.

Senator TALMADGE. Thank you, Mr. Colloton, for a fine statement.

Do large deductible and copayments deter preventive care and early diagnosis?

Mr COLLOTON. On an ambulatory basis, I would say not. On an inpatient basis, I think there is a possibility that they do, although I don't believe that has been proven.

Senator TALMADGE. I have two similar questions of Dr. Knapp: If large copayments and coinsurance are required, what implications would that have on the hospital's bad debts situation?

Mr. KNAPP. I guess the answer would have to be that it is perhaps conceivable that those individuals in the low-income bracket might choose a policy with a higher coinsurance and deductible because they might want the cash.

When it came time to make those payments for coinsurance and deductibles, it is conceivable that the hospitals might be in a position where they could not recover those dollars, and you would have the bad debt problem we already have in many cases at the present.

I don't know that that is a fact, but that is one conceivable scenario that could take place.

Senator TALMADGE. What percentage of the patients in your hospitals would you estimate do not belong there?

Mr. KNAPP. Let me see, now. I am trying to understand what you might consider do not belong there. There are some people who might say that an institution that is staffed, organized, and set up to handle tertiary care should not be a place where a gall bladder is taken out or another routine procedure such as that. That is one way of looking at that situation.

I would have to say that in order to properly educate medical students, we do need the broad range of diseases present in those institutions.

Now, another way to interpret your question, I guess, would be——

Senator TALMADGE. I will try to simplify it for you: What percentage of the patients in hospitals do not need hospitalization?

Mr. KNAPP. I don't think I could give you an answer to that question. I would ask my colleague who sits in that chair every day.

Mr. COLLOTON. I would say in our particular hospital the answer to that is substantially zero; and the reason I would say that is because we serve as a tertiary level referral center and the screening of patients takes place within the 99 counties of Iowa.

Second, we run a very large ambulatory care operation that keeps the patient out of the hospital bed when it is at all possible.

Senator TALMADGE. How large a deductible do you believe would be necessary to keep the typical worker from insisting on receiving hospital care he does not need?

Mr. COLLOTON. I would be unqualified to state a precise figure on that. I would say I am in favor of those deductibles, as is the

association, in order to get the patient involved in the marketplace consideration.

What the precise number should be, I think we should leave to others more qualified, who have done studies in that area.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. Thank you.

I want to thank you both for the comprehensive nature of the statement.

You have raised a lot of good questions; but, some of them have been answered in practice. Our own University of Minnesota Medical School, despite living in the midst of a lot of competition, has had more problems with the health planning process in the communities than with competition.

But I guess I am sympathetic to the unique nature of the teaching hospitals, and several other witnesses have spoken of their own concerns.

Several of the doctors have mentioned their concern; but I am wondering if as an association you have a position on the role of the patient in financing certain functions that are not directly related to his or her care.

On page 7 of your statement you say, "This assumption"—relative to competive models—"raises several issues for the teaching hospitals, which have multiple products benefiting not only the individual patient but also society as a whole. Because these activities are expensive, result in higher costs for teaching hospitals and are presently financed to a large extent through patient care revenues, competitive pricing resulting from the proposed legislation could jeopardize the ability of teaching hospitals to meet their multiple responsibilities."

I take that as a statement of the fact that teaching hospitals are largely financed by patient revenues, and I would like to know what your position is on the role of the patient in financing other services.

Mr. COLLOTON. Our position is that because way back in history this country decided the health care dollar should carry the burden of medical education and clinical research, that that should be continued, particularly in this present era when some 95 percent of the population is insured and therefore it becomes a general tax burden upon all patients.

We are pleased that the Federal Government has brought that concept into the medicare legislation and has perpetuated it right up until today.

I think any other avenue of attempting to shift the very, very substantial costs involved out of the patient care dollar would be highly impractical.

Senator DURENBERGER. So, the answer is that you are aware of no alternative to the present system.

My problem, of course, is just what you said. Insurance in fact is a tax burden on all people in this country that finance teaching hospitals. I don't care whether it goes way back in history or not, if it is not good public policy today, why do we have to continue it? And we would consider continuing it only if we were totally without alternatives.

I, as a patient, I, as an interested party, claim no role in deciding how many medical teaching hospitals ought to be created in my State, in the region in which I live or in the country. I play no role in a variety of other decisions that are being made relative to the quality and quantity of medical specialties that are coming out of teaching institutions. Those who represent me in Government look only at the common concept of taxes that were levied by Government; they don't look at what you have very well stated as the tax levied on me in the form of a third party payment or my own payment for my health.

Mr. COLLOTON. Maybe the reason that we feel it is impractical to do it any other way is because we have had a considerable amount of effort expended in attempting to identify those costs which are not just educational in nature. I am talking about clinical research. We are talking about new technology testing. We are talking about a very substantial case-mix differential of which would have to be precisely identified in some way and then channeled to some other source of support in order to make the competitive scenario work in a teaching setting.

When one views that as an undertaking, it is a very, very complex, horrendous job and probably the case-mix dimension alone is probably going to take 3 to 4 years to get on top of.

Senator DURENBERGER. I would hasten to say that the same Government that encouraged the development of this approach and has added to it with medicare reimbursement is the Government that really bears the responsibility for helping you out of the situation, if the burden is not on the teaching hospitals in this country to get themselves out of a problem that might be created by this kind of legislation.

I just hope now that we have clarified why you have to take the position that you have. I hope that you can work with us in trying to handle this particular problem.

I thank you very much for your testimony.

[The prepared statement of Mr. Colloton follows. Oral testimony continues on p. 404.]

association of american medical colleges

SUMMARY OF TESTIMONY ON S.1968, THE HEALTH INCENTIVES REFORM ACT
BY THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
U.S. SENATE
MARCH 18, 1980

The Association of American Medical Colleges endorses efforts by the Subcommittee to explore methods to increase cost consciousness and efficiency in the health care industry. The Association hopes that discussion of the specific legislative language being proposed will be accompanied by careful consideration of the long-term consequences competition may have for the organization and delivery of health care services.

The teaching hospitals make major commitments in four areas that may be substantially affected by competitive pricing. These include:

1) Medical Education -- Teaching hospitals make major commitments to training undergraduate and graduate medical students.

2) Research, Technology, and Tertiary Care -- Teaching hospitals make major commitments to medical research, technology development, and complex, tertiary care services.

3) Quality of Care -- Teaching hospitals have demonstrated a high level of quality patient care.

4) Charity Care -- Teaching hospitals make a major commitment to providing inpatient and outpatient care to individuals who are unable to pay for the services rendered.

Each of these activities leads to higher costs for the teaching hospital and a relatively less attractive position under price competition. In addition, the complex case mix of teaching hospitals coupled with present pricing policies in hospitals may make it difficult for teaching hospitals to continue their commitment to these four activities. The Association urges these issues to be thoroughly discussed and studied prior to endorsement of legislation proposals.

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association of american medical colleges

TESTIMONY SUBMITTED ON S.1968, THE HEALTH INCENTIVES REFORM ACT
BY THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
U.S. SENATE
MARCH 18, 1980

The Association of American Medical Colleges (AAMC) is pleased to have this opportunity to testify on the Health Incentives Reform Act, S.1968. Many of the comments in this testimony will also pertain to the Comprehensive Health Care Reform Act, S.1590. In addition to representing all of the nation's medical schools and 70 academic societies, the Association's Council of Teaching Hospitals includes over 400 major teaching hospitals. These hospitals account for 18 percent of the admissions and 31 percent of the outpatient visits provided by all non-federal, short-term hospitals; provide a comprehensive range of patient services, including the most complex tertiary services; and are the primary location for undergraduate and graduate clinical medical education. Thus, S.1968 and S.1590, which advocate restructuring health financing, are of direct interest and vital concern to the Association's members.

S.1969 and S.1590 both call for changes in tax laws as a means to encourage restructuring of health care delivery and financing patterns. The AAMC and its staff do not have special expertise in assessing alternative tax reform proposals. The Association also is not in a position to evaluate the potential economic consequences of the legislation. However, as representatives of institutions which serve a critical role in delivering health care, training the nation's physicians, and conducting medical research, the Association has an obligation to raise several important

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questions about these proposals which have not surfaced in public debate. Careful consideration of the issues raised in the following testimony may help to avoid unintended consequences of intended worthy objectives.

Competition in Health Care: What are the Sources of Interest?

While the increase in hospital costs over the past two decades has been well documented, the reasons for the increases and the best approach to contain future escalation of costs have been continually debated. At the federal level, the Administration and a minority of the members of Congress have advocated mandatory controls which set a ceiling on allowable percentage increases in per admission costs. The House of Representatives and the hospital industry have supported voluntary controls on hospital costs. Hospitals have participated in the Voluntary Effort (VE), and relative to the rate of inflation in the general economy, the VE has been extremely successful. However, those opposed to mandatory controls and skeptical that the achievements of the Voluntary Effort can be sustained indefinitely have called for fundamental changes in the incentives of the present health system as the most promising long-term approach to containing costs.

The call for marketplace economics in health care, which has received bi-partisan support, appears to be part of a broader deregulatory mood in Congress and the country in general. Any proposal that offers an equally plausible solution without government intrusion and control is met favorably by all parties. Proponents of the competitive model argue that the health care system is too complex for centralized planning and that injecting cost consciousness in consumer, third party, and provider decisions will promote competition, efficiency, and rational resource allocation.

Most of the provisions of the competition proposals before Congress can be traced back to the efforts of university economists whose conceptually appealing models increasingly are being published in national journals and discussed in meetings and hearings such as the ones your committee are holding this week. Assessment of these conceptual models can hopefully provide an opportunity to move beyond consideration of the best methods to encourage informed economic decisions on the part of the consumer to serious review of the impact of these decisions on various sectors of the health delivery system.

The Legislative Proposals: What are the Objectives?

The two broad purposes of S.1968 and S.1590 are clear: to provide protection against catastrophic health expenses and to foster competition in health care by increasing consumer cost consciousness and choice among health plans. The AAMC would like to limit its comments to the second of these objectives.

The tax law proposals which have been introduced are directed toward influencing consumer demand and ultimately creating competition among insurers and among health care providers. Two distinct approaches appear to be under consideration. One approach attempts to increase consumers' cost awareness at the time they receive health services. Inherent in this approach is the use of deductibles and coinsurance to stimulate prudent consumer buying. Senator Schweiker's bill endorses this method by disallowing employer tax deductions for contributions to health plans unless at least one plan offered by the employer requires a 25 percent annual copayment for hospital services up to 20 percent of family income.

The second approach attempts to increase consumers' cost awareness at the time they obtain health insurance or enroll in a prepayment health plan. This approach requires that individuals be given a choice among competing plans, which offer varying levels of coverage. It is assumed that individuals will consider carefully their need for coverage, perhaps selecting "lower option" plans which require substantial deductibles and coinsurance, but are available at a lower premium cost. Both S.1590 and S.1968 advocate that employees be offered several health plan options. Senator Schweiker's bill would require employers having at least 200 full-time employees to make available at least three health plan options, each offered by a different carrier. Senator Durenberger's proposal would require health plan contributions to an employee to be included in the employee's gross income unless the employer offers three health plan options, each by a separate carrier. In addition, any contribution by the employer in excess of $125 per month for family coverage would be taxable as part of the employee's gross income.

Making several health plans available to all employees is intuitively appealing. The injection of competition among insurers at this level is easily understood. What is not clear is how competition would manifest itself over time among hospitals and physicians. Proponents of this approach argue that, in the long term, "the efficient providers of care would be rewarded with additional business." Presumably, competition on one level would be among health insurance companies, HMOs, and other health plans for participation in employers' health plan options. On a second level, these insurance groups, in an effort to offer the lowest premium possible, would be under considerable pressure to establish arrangements with hospitals and physicians who were the least ex-

pensive providers. Such arrangements might include negotiated rates between insurers and hospitals or groups of hospitals, or arrangements where physician groups share economic risks with insurers. Thus, the price of hospital services charged to the insurance carrier would be an important element of that competition. Competition among insurers would ultimately induce competition among hospitals for participation in health insurance plans. This development would be most prevalent among emerging alternative delivery systems (HMOs, IPAs, etc.) that restrict subscribers to specific institutions for hospital care. Hospitals not included in these systems would be at a substantial disadvantage.

It may be argued, as some have,[1] that the present, loosely-defined, scenario of competition falls short of answering the most difficult question: how many and what types of regulatory barriers need to be eliminated to foster competition in the health care field? This issue leads to a number of questions:

- Will competition foster group experience rating to the detriment of those individuals most in need of continuing health services?
- Does competition overemphasize the cost of health care without assurances that quality of care will be adequate?
- Does the complexity of health care services preclude, for a large number of citizens, informed choices among competing health plans?
- Will the regulations required to implement the competitive model be greater than the government regulations in the existing market?

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1. Bruce Spitz, "When a Solution is Not a Solution: Medicaid and Health Maintenance Organizations," Journal of Health Politics, Policy and Law, Vol. 3, No. 4, Winter, 1979, p. 506.

- Does competition eliminate the need for health planning agencies and certificate-of-need legislation? If not, what resource allocation decisions must be retained by governmental authorities and which should be left to competitive forces?

It is of interest that the last question about the role of health planning agencies in a competitive market was raised in the "Health Planning and Resources Development Amendments of 1979," P.L. 96-79, which was passed by Congress early last fall. The bill included the promotion of competition by stating the following objective:

> "The strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve to advance the purposes of quality assurance, cost effectiveness and access."

The Conference Report for P.L. 96-79 explained the basic legislative intent of this provision:

> "The conference substitute as a compromise includes findings which make it clear that for health services, such as inpatient health services and other institutional health services for which competition does not or will not appropriately allocate supply consistent with the plans of health planning agencies, the agencies should perform their functions to allocate the supply of those services, where appropriate to advance the purposes of quality assurance, cost effectiveness and access and the other purposes of title XV. For health services for which competition appropriately allocates supply consistent with the agency's plans, the HSA and State agency should in the performance of their functions give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness, access and the other purposes of title XV) to actions which will strengthen the effect of competition on the supply of those services."

The language of this Conference Report reflects some ambivalence about the effects of competition in the allocation of the supply of health services. It appears to say that if competition results in services consistent with the HSA predetermined plan, it should be ncouraged. One the other hand, there does appear to be a willingness to recognize that the outcome of competition is not well enough understood to assure that the supply of health care services will be consistent with the needs of a given population.

Consideration of the competitive approach, the AAMC believes, needs to focus more closely on the implications of some of these issues. While the legislative proposals, by themselves, appear to be relatively easy to implement, the adjustments required in the health system in terms of modification of existing regulations and creation of new regulations could be major.

Competition and the Teaching Hospitals

Strikingly absent from the literature and public discussions of this issue are the effects the competitive approach may have on specific types of health care providers. It is argued that growth of HMOs and alternative delivery modes will be encouraged, but there is no mention of the implications these systems may have for hospitals. Because hospitals vary dramatically in the types of patients treated, services provided, and programs supported, the effects of competition will vary depending on the type of hospital. The Association will address its comments to the group of hospitals with which it is most knowledgeable -- the nation's major teaching hospitals.

Underlying the competitive models being proposed is the assumption that hospitals provide a relatively standardized product which is easily identifiable in terms of costs and quality. This assumption raises several issues for the teaching hospitals, which have multiple products benefiting not only the individual patient, but society as a whole. Because these activities are expensive, result in higher costs for teaching hospitals, and are presently financed to a large extent through patient care revenues, competitive pricing resulting from the proposed legislation could jeopardize the ability of teaching hospitals to meet their multiple responsibilities.

These contributions are in four major areas: medical education; research, technology, and tertiary care; quality of care; and charity care.

Medical Education

Teaching hospitals are the sources for the vast majority of the clinical training of physicians at both the undergraduate and graduate medical education levels. More than 80 percent of all residency training positions in the country are sponsored by the 418 members of the Council of Teaching Hospitals of the Association of American Medical Colleges. The direct expenditures on resident stipends and benefits alone by these institutions amount to close to one billion dollars annually. This does not include the costs of faculty supervision and other indirect costs associated with the training of physicians. While these costs presently are explicitly recognized as necessary and legitimately reimbursable by third parties, a competitive model could discourage insurers from purchasing care from providers whose educational costs may make premiums uncompetitive.

The most direct impact of competition on medical education may be in the area of affiliation agreements between medical schools and hospitals. At the undergraduate medical education level, during the past two decades, 40 new medical schools have been developed and total enrollment has more than doubled. Most of the new medical schools have chosen to use presently existing community facilities to accomplish clinical educational objectives because of the difficulty in securing the necessary funding to build and subsequently operate a university-owned hospital facility. In addition, the established schools increasingly have looked toward community based hospital facilities to provide clinical settings whereby class size can be increased and a broader clinical exposure can be provided to physicians in training.

At the graduate medical education level, the need for additional clinical training sites for residents also has increased dramatically. The Liaison Committee on Medical Education, which accredits medical schools, adopted as policy in 1973 that "The undergraduate period of medical school leading to the M.D. degree is no longer sufficient to prepare a student for independent medical practice without supplementation by a graduate training period." Consistent with this policy is the fact that virtually all medical school graduates now expect to spend at least three years in a residency program prior to entering practice.

The pressures for new and different types of clinical training sites have resulted in an increase in the number of hospitals affiliated with medical schools from 517 in 1966 to 1,168 in 1976. Marketplace economics in health care could discourage future growth in affiliations as well as threaten existing agreements if hospitals perceive that the costs of affiliations may make consumer organizations such as HMOs less likely to enter into arrangements with their hospital. If competition forces community hospitals to disengage from participation in medical education, the tertiary care centers, which once were the settings for virtually all clinical medical education, could not accommodate the numerous and varied educational requirements of a vastly increased number of physicians in training.

For those hospitals that do remain affiliated with a medical school, the quality of the educational experience may change substantially. There will be considerable pressures for resident physicians in training to devote an increasingly large portion of their time to patient care services in order to maximize the competitive attractiveness of the hospital. This

unfortunate emphasis may be inevitable if the teaching hospital is expected to have low enough costs to attract large insurers who purchase care on behalf of their subscribers.

Research, Technology, and Tertiary Care

As biomedical research is constantly developing new techniques for medical practice, teaching hospitals have served as a setting where this research is translated into medical practice and disseminated to physicians and providers. Often teaching hospitals accept medical and technological innovation as a mission, in spite of the cost implications for their institution. While the direct costs of research are usually funded by grants or special appropriations, patient care services, which are medically necessary for the patient and simultaneously important to the research project, are paid for by patient care revenue. Competition among insurers and among providers may jeopardize the ability of teaching hospitals to continue their role in advancing medical research and technology.

Related to a commitment to research and technology is the provision of regional tertiary care services to seriously ill patients. This commitment may be illustrated by the fact that the members of the Council of Teaching Hospitals constitute only five percent of all non-federal short-term hospitals, but have over half of all the burn care units, supply 44 percent of all organ bank services, provide 40 percent of the open heart surgical services, and are the locations for over one third of the nation's neonatal units. These services are of unquestionable social value, but it is unclear that patients needing these services will have access to them under competition. There are no assurances that insurers and HMOs, which contract

with community hospitals that provide a narrow range of services, would be willing to establish referral arrangements with high cost tertiary care centers for services for their beneficiaries.

Quality of Care

The reluctance to establish referral arrangements with tertiary care centers has implications for the quality of patient care. Traditionally, physicians have been trained to provide the very best care available for their patients. Given present health insurance coverage, the physician has been able to concentrate on the benefits of the prescribed treatment, with less emphasis on the costs of the treatment. It is possible that competition may move us too far in the opposite direction. How can assurances be made that competition will not create economic disincentives to provide an inadequate level of services and quality for some patients? To be more specific: Will such a system create a conflict of interest for HMO-based physicians whose decisions regarding the scope and depth of care to be provided individual patients directly impact the HMO's financial well-being? Said another way, what protection will patients have that their needs for expensive specialty or longitudinal care will not be sacrificed to a competitive feature which puts at financial risk the HMO-physician making the decision regarding care to be rendered?

Another quality of care issue relates to consumer knowledge. For at least 30 years, studies have repeatedly found that the quality of care in teaching hospitals is higher than that in non-teaching hospitals. Despite the results of these studies, it remains difficult to translate the findings

into quantitative criteria that can be widely understood by the average consumer. Most individuals fortunately do not have to routinely use hospital services, but one unfortunate consequence of this is that they have limited direct and personal evidence upon which they can make a judgement about the quality of care. Thus, when a choice is made among health benefit plans, the premium costs of the various plans, which are explicitly stated, may receive disproportionate consideration in the decision because quality is a relatively unknown factor. It is conceivable that a number of plans may develop that are competitively priced, but these plans may not make provisions for access to patient care of a minimally acceptable level of quality.

Provision of Charity Care

Many teaching hospitals, particularly in urban areas, provide large amounts of service to the poor and near-poor of their communities. This care includes not only inpatient services but outpatient services. In fact, almost one third of all hospital based, ambulatory care in the country is provided by the 418 COTH member hospitals. In order to remain financially viable, while providing charity care at no charge or below cost, teaching hospitals have historically priced their services so that the patients paying full charges pay for themselves and help to underwrite the costs of charity care. In a price competitive marketplace, large scale buyers and third parties most likely will be unwilling to subsidize care for charity patients. Thus, teaching hospitals may have to restrict the availability of charity services and/or obtain governmental or other subsidies for patients unable to pay for their care.

Teaching Hospital Costs and Pri ing Policies

Commitment to the above four activities -- medical education, research, quality of care, and charity care -- create financial demands on teaching hospitals that are not present in non-teaching hospitals. In a price competitive market, the ability of the teaching hospital to continue these commitments may be threatened. One proposal to resolve this dilemma was suggested in an article in the New England Journal of Medicine:[2] "For them to be competitive, the teaching and research costs of university medical centers would need to be separately identifiable and subsidized on their own merits." Although this statement recognizes these unique costs, it does adequately articulate that: (1) teaching and research costs are not unique to the university medical centers, but also are present in hundreds of other teaching hospitals that participate, albeit to varying degrees, in medical education and research; (2) precisely identifying what these costs are has been and will continue to be a very difficult task because many arise as joint costs; and (3) establishing funding sources separate from patient care revenue would provide no assurances that each funding source, over time, would continue to recognize its full financial responsibilities.

Even if special funds could be set aside for the teaching, research, and charity care, teaching hospitals may have to change their pricing policies in a manner which could significantly increase the costs of care for their intensively ill and tertiary care patients. Traditionally, teaching hospitals

2. Alain C. Enthoven, "Shattuck Lecture -- Cutting Cost Without Cutting the Quality of Care," New England Journal of Medicine, Vol. 298, No. 22, June 1, 1978, p. 1236.

have not attempted to individualize patient charges to assure that each patient pays only the full and unique costs of his care. Rather than develop expensive and complicated cost finding systems which identify the unique costs of each patient, teaching hospitals have generally used pricing systems which are based on less expensive and more easily administered cost allocation systems. One result of this approach is that the costs of sophisticated services are partially supported with revenues received from more routine patients. As a result, all patients have helped finance the extensive service and program requirements accompanying the hospital's emphasis on tertiary care. In a price sensitive marketplace, such cross-subsidizing may be unacceptable to patients requiring primary and secondary care, and teaching hospitals may have to price each unit of service to recover its full direct and indirect costs. This significant change in pricing would dramatically increase the price of tertiary care services and lead insurers and consumers to question the desirability of including such services in routine prepayment contracts. Innovative, but costly new services which are not widely available would probably be most susceptible to exclusion from the benefit package. Limiting access to tertiary care services may be an unintended and undesirable social consequence of injecting marketplace economics in health care.

Summary

A great deal of thought has been given to how tax laws might be modified to encourage prudent, cost conscious decisions by consumers when they enroll in health insurance and when they purchase health care services. The two

proposals before the Senate reflect these conscientious efforts. There does not, however, appear to be an equal amount of thought given to the long-term consequences and secondary effects of competition on our health care system.

The AAMC is concerned that there are a number of issues for teaching hospitals that need more careful consideration. A competitive model in any industry requires sufficient consumer knowledge of the price and the product being purchased. Unfortunately, teaching hospitals have multiple products which include not only patient care services, but education and research as well. The latter two products are socially desirable activities that have costs associated with them that neither the individual consumer or insurer will want to purchase in a price competitive system.

The AAMC is not opposed to exploring methods to encourage cost consciousness and competition in the health care industry. Lowering the rate of increase in health care costs is an objective that we all share. The Association, however, is concerned that while consumer choice, deductibles, and copayments are being advocated as a means to stimulate competition and efficiency, no one has clearly articulated the limits of competition or the impact of competition on providers and the actual delivery of health services. Legislative proposals, such as S.1590 and S.1968, may achieve cost saving objectives, but there may be a real danger that the reorganization of the health care system which is intended may not end up being at all consistent with the health goals or priorities of the nation. The AAMC hopes these issues will be carefully studied before any legislative initiatives are broadly endorsed.

Senator TALMADGE. Our next witness is Willis Goldbeck, executive director, Washington Business Group on Health, accompanied by Andrew J. Weinberg, assistant director.

You may insert your full statement in the record, Mr. Goldbeck, and summarize it.

STATEMENT OF WILLIS B. GOLDBECK, EXECUTIVE DIRECTOR, WASHINGTON BUSINESS GROUP ON HEALTH, ACCOMPANIED BY ANDREW J. WEINBERG, ASSISTANT DIRECTOR

Mr. GOLDBECK. Thank you, Mr. Chairman.

Mr. Chairman, Senator Durenberger, we are delighted to be here today representing the Washington Business Group on Health, an organization with 186 member corporations.

The current and projected standing of the United States in world economic conditions suggests that not only are we not going to seriously consider a fully federalized national health system but also that even the rather minor things we might do need to be scrutinized considerably. A careful review of current needs suggests that four objectives need to be met:

One, correct the economic incentives now in the system which, if left unaltered, guarantee a continuing increase in medical care costs without a concomitant increase in health status; two, increase the Nation's commitment to health rather than continue the unsupportable overemphasis upon medical treatment; three, address the specific identifiable gaps in protection in the current system; and, four, remove the problem of financial catastrophe deriving from illness and/or accidents.

If one were to set priorities from the standpoint of political pressures, one would start from the bottom of the list. If one sets these goals from the standpoint of major changes to the medical care system, one would start at the top. Herein lies the dilemma we face when working with these issues.

While we are not prepared to announce support for any specific legislation and would want our preference or nongovernmental action be be clearly understood, we do want you to know that the only NHI design worthy of consideration is one which encompasses a private/public cooperative approach to these four objectives.

Few look ahead and do not realize that the major determinants of health policy in the 1980's will be exogenous to the health or medical industries. Aging, balance of trade, environment, inflation and unemployment, the value of the dollar, dwindling food supplies in the face of massive, impoverished population growth, defense spending and energy—these are the factors that will determine what we are able to do about domestic health issues.

The unfortunate truth is that not one of these factors when measured by even the most conservative standards, bodes well for our capacity to make vast new investments in medical care. Congress is left with the dilemma of trying to improve services, increase access—which means increased utilization—and decrease costs while facing an extended era of limited economic resources.

Given this array of conflicting demands and interests, Congress needs to face certain realities: no solution will be found that does not take years to implement, test, and modify; there is no need to destroy the whole system in order to correct incentives or close

gaps; the political priority that would suggest starting with catastrophic is contrary to the real economic and health priorities—therefore, if catastrophic is to be in an initial phase, it must be accompanied by plan features that address those other objectives of incentive reform, prevention, and gap closing; whatever the Government does in the 1980's must reflect the progress the private and public sectors have made in the late 1970's; and competition is often juxtaposed to regulation as though one or the other would be the system for the 1980's—this is just not possible. We are only talking about the kind of changes that build upon the system we have today and seek to improve it, but certainly not an either/or circumstance.

We provided a series of pages of technical information that may be useful to you and the staff as you consider specific impacts upon employees and employers.

In 1979 the average annual insurance premium in major industry was just over $800; however, the number now exceeding $1,000 and even $1,500 is increasing. The auto industry levels in excess of $2,500 are really exceptions and should be a signal to the committee that certain benefit plan designs are not affordable as national models.

This means that the $125 monthly levels as proposed in S. 1968 will not have an immediate impact on many employers.

Another concern also expressed somewhat earlier by others is that this could become an apparantly congressionally approved minimum level, when that was not your intent at all.

As a business group vitally concerned not only with health issues but also with broader issues of economic policy, we find this new direction in NHI proposal very, very affirmative. This does not mean to say we should accept them blindly, however, and I would like to at least touch on a variety of concerns that are articulated in more depth in the actual written statement:

No. 1 is, we are not at all certain the concept of multiple carriers will produce any kind of competition that will have a significant impact from a cost-reductive standpoint. We feel strongly that you will see as a result the carriers dropping HMO support which would certainly have a negative impact on the rate of HMO growth considering the source of sponsorship of large numbers of HMO's in the last couple of years.

Second, we do not feel there is any indication, simply because you carve out the plan and say you must go to a third carrier, that that will in any way bring about an increased quality or even competition among the health care plans.

The low-option plans appear, from the evidence we have been able to find to date, to be so poorly accepted that the low-option segment of the market is not likely to produce major levels of competition among the carriers.

We do not see a serious value to that particular element of the proposal. We think you should be concerned about the cost-variation issue, not just as it was expressed earlier but, for example, even within an individual company. There may be as many as 100 some programs. The cost variations can be dramatic, even within the same SMSA. The auto plan, for example, has identical benefits for identical groups of employees. In Kansas City your plan would

impose different tax levels on Ford, and General Motors employees, in the same town, with the same benefits, same economic levels.

We also have considerable concern—this was a point that Senator Talmadge alluded to—for the impact on prevention. If the allowable trigger is set so close to the current benefit levels that the next benefits that are provided by a firm are cost savings benefits and prevention benefits, those are the ones from a public policy standpoint that we want to encourage; but those are the ones that would be called taxable income to the employees, and they would be treated as additions, at the time we are trying to get these into the mainstream because of growing evidence of their efficacy from a cost-effectiveness standpoint.

So we think you should address that concern.

On the rebate issue, we think rebates should be shared. We think, first, there is little evidence that employees are anxious to have rebates.

Second, there is a much greater risk in the turning-off of the new-found interest on the part of employers in taking an active role in cost containment than there is gain to be made by the small degree of interest that would come about on the part of individual consumers by providing rebates.

There is little evidence of the degree to which rebates would be well received by individual employees. We can cite one example, of a survey of employees for 2 years in a row, which asked, "Would you prefer to have reduced cost plan with the benefits staying as they are now, or no rebates, no reductions, and increase the benefits?"

Eighty-one percent the first year and 84 percent the second year opted for no rebate and increasing the benefit package. In American Can's multiple-choice plan, which is indeed a multiple-choice plan with five different options, we find less than 3 percent selecting the low-option plan.

These are two of the few examples that exist outside of the Federal plan, which I won't mention because it was discussed previously.

We are concerned also about the development of HMO's in this plan, not because we don't support HMO's. We are strongly in support of HMO's, but the problem with getting more HMO's is physician opposition and poor quality HMO's, and the fact they take a long time to develop.

Even in your town of Minneapolis, were you to impose those idealistic concerns on the rest of the Nation and start tomorrow morning, the same development process would still take between 7 and 9 years before you had a major involvement of employees in HMO's.

So, we are talking about a long leadtime operation, not something where you can turn the switch, and get a new corps of HMO's around the country. We see more and more employers having problems with HMO's.

We see employees dropping out of HMO's due to lack of mental health benefits. We see employers expressing considerable concern about the requirement that HMO's be community rated after a certain level of development because that will be a major disincentive to future employer involvement.

There are other items listed in the testimony on the question of catastrophic insurance as a component of NHI. We certainly feel if there is to be legislation, catastrophic insurance should be a component. We do not believe the catastrophic should be a freestanding plan, and there are more reasons given in the testimony, should you wish to explore those.

I would like to make the statement on the record that we do have concern about the capital investment issue. There is no advantage to the future of our delivery system if we expend tomorrow's capital funds on today's operating costs in the guise of cost containment.

We must build and continue to maintain hospital infrastructure in this country as we do any other facet of our basic infrastructure.

We have suggested at the end of our statement a variety of experiments and demonstrations that might take place on the premise that we need not wait for complete national consensus or even congressional consensus before something affirmative is done to redress many of the gaps in the system today and many of the concerns that your bill and others speak to.

We have a list of items here you can refer to at a later date or ask questions about right now; but I want to make the point that there are any number of things that can be done, starting immediately with this committee's support, with the administration's support, and with the private sector's support, to help close gaps immediately.

I will stop and turn it over to you for questions.

Senator TALMADGE. Any questions, Senator Durenberger?

Senator DURENBERGER. Two, if I may, Mr. Chairman.

You indicated that with the multiple-choice provision in the bill there is a strong chance that insurers who might be going to create their own HMO's, would drop the HMO. Was that your statement?

Mr. GOLDBECK. Whether they drop the current ones or not, I am not sure, but it would reduce the incentive for them to start others. If companies can only go with the insurance carrier on an indemnity plan and can't use that insurance carrier's HMO's——

Senator Durenberger. That is what the bill says. The bill says you have to have at least three different carriers. It does not say you can't have Prudential Co. in with its indemnity plan and its HMO and Blue Cross do the same, plus Aetna. You just have to have three different carriers.

We don't preclude one carrier coming in with a couple of options.

Mr. GOLDBECK. That is very helpful, because the comments we received from both carriers and employers have been to that point, so there may have been ambiguity about your intent. Perhaps it is our interpretation problem, but it is useful to have you say that on the record.

Senator DURENBERGER. If you talk about prevention of suffering, if an insurer, an HMO, or whoever puts together a package of benefits in which you have both a wellness provision and illness provision, it would seem to me that kind of package might cost less than illness services standing all by themselves, might they not?

Mr. GOLDBECK. That is the long-term hope. It is certainly the logic. There is evidence today that the mental health component is much harder to separate than are such things as nutrition, physi-

cal fitness and other elements of the wellness spectrum. The mental health benefits, it seems, from the evidence, are growing strongly on the ability to reduce hospital, surgical, medical utilization, and because mental health has traditionally been discriminated against in the total health insurance reimbursement design.

Senator DURENBERGER. Thank you.

Senator TALMADGE. Thank you, gentlemen, for your contribution.

[The prepared statement of Mr. Goldbeck follows:]

PREPARED STATEMENT OF WILLIS B. GOLDBECK, EXECUTIVE DIRECTOR, WASHINGTON BUSINESS GROUP ON HEALTH—NATIONAL HEALTH INSURANCE: ISSUES AND CONCERNS FOR THE 1980'S

Mr. Chairman, Committee Members, it is a pleasure to have the opportunity to meet with you today to discuss the critical issues involved in the improvement of our Nation's health system.

My name is Willis Goldbeck, Executive Director of the Washington Business Group on Health; a membership organization for large employers with an interest in health policy. A membership list is attached. These employers currently provide the medical benefits for more than 50,000,000 employees, retirees, and dependents.

Our small organization, started just five years ago, has tried to become a resource to both industry and government. We strongly believe that providing for the health needs of all Americans is a responsibility to be shared by all sectors of our society. It is in this spirit that we appear before you today.

Before commenting upon some of the specific legislative approaches proposed, let me express our thoughts on several of the major policy issues about which we have concerns.

We need to be realistic about both the size of the problem we are all trying to correct and about the conditions affecting the possible acceptance and effectiveness of the solutions we propose.

PROBLEMS AND PRIORITIES

The current and projected state of world and U.S. economic conditions suggest that, not only are we virtually assured that no totally comprehensive, governmental, national health insurance system will be enacted, but that we must also very carefully measure what actions we can take to improve the existing system.

A careful review of current needs suggest that four objectives be met: One, correct the economic incentives now in the system which, if left unaltered, quarantee a continuing increase in medical care costs without a concomitant increase in health status.

Two, increase the Nation's commitment to health rather than continue the unsupportable overemphasis upon medical treatment.

Three, address the specific, identifiable gaps in protection in the current system.

Four, remove the problem of financial catastrophe deriving from illness and/or accidents.

If one were to set priorities from the standpoint of political pressures, one would start from the bottom of the list. If one sets these goals from the standpoint of major changes to the medical care system, one would start at the top. Herein lies the dilemma we face when working with these issues.

While we are not prepared to announce support for any specific legislation, and would want our preference for non-governmental action to be clearly understood, we do want you to know that the only NHI design worthy of consideration is one which encompasses a private-public cooperative approach to these four objectives.

Few look ahead and do not realize that the major determinants of health policy in the 1980's will be exogenous to the health or medical industries. Aging, balance of trade, environment, inflation and unemployment, the value of the dollar, dwindling food supplies in the face of massive, impoverished population growth, defense spending, and energy . . . these are the factors that will determine what we are able to do about domestic health issues.

The unfortunate truth is, not one of these factors, when measured by even the most conservative standards, bodes well for our capacity to make vast new investments in medical care. Congress is left with the dilemma of trying to improve services, increase access (which means increased utilization), and decrease costs while facing an extended era of limited economic resources.

Given this array of conflicting demands and interests, Congress needs to face certain realities:

No solution will be found that does not take years to implement, test, and modify;

There is no need to destroy the whole system in order to correct incentives or close gaps;

The political priority that would suggest starting with catastrophic is contrary to the real economic and health priorities. Therefore, if catastrophic is to be in an initial phase, it must be accompanied by plan features that address those other objectives of incentive reform, prevention, and gap closing;

Whatever the government does in the 1980s must reflect the progress the private and public sector has made in the late 1970's;

"Competition" is often juxtaposed to "regulation" as though one or the other would be the system for the 1980's. This is just not possible. * * * The two will have to work together in the unique health care economic market.

All of these points suggest that, as Congress seeks to design a financing and delivery system that is coordinated, it becomes increasingly imperative that the full range of governmental health programs become integrated into a single health strategy. Health programs are now sprinkled throughout the other departments and agencies should be brought into the new Department of Health and Human Services.

EXTENT OF UNCOVERED POPULATION

The exact dimension of the population unprotected against any of the costs of medical care by either private insurance or government programs is believed to be 12 to 18 million. Studies indicate that the most likely to lack coverage are the young (under 25) and the poor.

(1) Poor—those below the poverty line who are not eligible for Medicaid (approximately 3 million).

(2) Unemployed near-poor—families who are not employed and whose income is above the poverty line, but is insufficient to purchase private insurance (1 million).

(3) Working poor—employees and their dependents not eligible for employment-based coverage and who cannot afford to purchase personal health insurance (4 to 5 million).

(4) Unemployed—families who have temporarily lost group health insurance coverage while the breadwinner is between jobs (5 to 6 million).

(5) Uncovered dependents—employees' dependents who lost eligibility for group coverage as a result of the death of the employee, divorce, or attainment of maximum age for eligibility as dependent children. (1 million).

(6) Uninsurable—abnormally high-risk people who can afford private insurance but cannot purchase it because of poor health (1 million).

People with family incomes below $10,000 tend to lack coverage more than families with income of $10,000 or more. These low-income persons represent 55 percent of the uncovered population though they make up only 33 percent of the national citizenry. Only 6.5 percent of full-time employees are uninsured compared with 12 percent part-time wage earners and 15 percent of the self-employed.

EXTENSIVENESS OF COVERAGES

In recent years, private health insurance has made major progress to protect families from costly illness episides. In 1973, 67 percent of the insured population had policies with life-time payment limits below $50,000; while only 25 percent of the insured had lifetime benefits exceeding $100,000. In 1979, over 91 percent of the newly insured population holding major medical policies had benefits exceeding $100,000. In 1978, 140 million persons were covered with a type of major medical protection; up 70 percent since 1968.

Increasingly, limits have been placed on the maximum copayment amount an individual must pay out-of-pocket. In 1973 only 14 percent of those insured had policies with "stop-loss" provisions. For 1977, the HIAA surveyed 30 writers of group health insurance covering nearly 60 milllion persons. Over 45 percent had "stop-loss" provisions of $1,500 or less.

Medicare and Medicaid pose unique questions on coverages. Since Medicaid eligibility criteria and benefits are determined by each state it is difficult to determine both the extent and the adequacy of protection under this program. Arizona for example, does not participate in the Medicaid program. State Medicaid programs have been singled out by states for budget reduction. Thus, there has been a general tightening of eligibility standards or a curtailment of benefits. In 1977, 23 million persons received Medicaid benefits; the number of recipients declining for the first time since the inception of the program despite the increases in population, aging,

and medical care costs, all of which would normally be expected to expand the number of recipients.

In 1979, there were approximately 22 million Medicare recipients. Hospital Care (Medicare Part A) covers full reasonable costs for the first 60 days of confinement. During the 61st through the 90th day, the patient coinsures $45 each day. Except for the 60 day lifetime reserve at a patient daily copay of $90, the patient is liable for all hospital charges related to a particular confinement. It should be noted that Part A coverages do not provide patient protection following 150 inpatient days. Surgical and Medical Care (Medicare Part B) covers 80 percent of reasonable charges after a $60 patient deductible. Part B benefits do not have a patient "stop-loss" clause.

EMPLOYER INVOLVEMENT IN 1980

Employers coverages

Since many of the bills under consideration would alter the way employers provide health benefits, we thought it would be useful to present highlights of existing coverages that relate to the key issues you are considering.

These figures are a composite of work done in 1979 by the U.S. Chamber, Hay-Huggins Survey, and our own research. The trends these figures exemplify show the private sector moving to substantially reduce gaps in the current system:

HMOs were offered by only 11 percent of Hay-Huggins' sample in 1975. In 1979 the number was 44 percent—a growth which clearly parallels the growth of federally qualified HMOs and the maturing of the HMO program.

Employees frequently do contribute to their insurance premium, but only 12 percent are responsible for more than 50 percent of the cost.

Waiting periods are being voluntarily reduced. The trend is clear: now approximately 80 percent of large employers have no waiting period, or one which does not exceed one month. You should know, however, that the rapid turnover experienced by heavy manufacturing industries, such as auto, is causing them to revert to lengthier waiting periods. This has the cooperation of labor. They can see an unacceptable proportion of benefits being consumed by new workers who do not remain employed long enough to become contributing union members.

Benefit coverage for dependent students now extends to age 26 for better than 90 percent of those covered. If you legislated a plan with student coverage to age 21, it would reach only 3 percent of those who are now covered. On the other hand, an age 21 cut-off would capture over 80 percent of those non-student dependents for whom coverage is now provided.

Survivor benefits are provided by an increasingly large proportion of employers of which more than 80 percent provide the benefit to all employees rather than just for executives.

As you consider the appropriate number of hospital days to include in a minimum benefit package, you should know that the major employers are moving their coverage toward the full year level. According to Hay-Huggins: Less than 120 days, 22 percent; 120-364 days; 39 percent; 365 or more days, 39 percent.

Most employee benefits (greater than 70 percent) still require at least 3 days of hospitalization, whether medically needed of not, before approving nursing home reimbursement.

As the aging of the population increases, the current trend toward providing health benefits for retirees takes on increased significance. Currently, about three quarters of the large employers provide such benefits with about half of those fully paid by the employer.

Mental health coverage still contains the traditional and unwarranted bias toward hospitalization. Of those firms providing benefits, the Hay-Huggins survey found 85 percent providing in-hospital psychiatric care coverage while only 42 percent provide for the less expensive outpatient care.

Of the three benefits often cited as the wave of the future (vision, prescription drug, and dental) only dental has achieved a high level of accceptance by both employees and employers.

In 1979, the average annual insurance premium in major industry was just over $800. However, the number now exceeding $1,000 and even $1,500 is increasing. The auto industry levels in excess of $2,500 are really exceptions and should be a signal to the committee that certain benefit plan designs are not affordable as national models.

This means that the $125.00 monthly levels as proposed in S. 1968 will not have an immediate impact on many employers. * * * Another concern, that of perceiving the $125.00 level as a Congressionally "approved" minimum, needs to be carefully observed or this cost containment device could quickly become a cost inflator.

EMPLOYER CORPORATE AND COMMUNITY INVOLVEMENT

Many companies have a well documented history of aggressive cost containment efforts. Within the past 5 or 6 years, additional employers have initiated actions which are intended to improve employee well-being while containing costs.

Benefits redesign

By offering additional and different benefits, and shifting reimbursement levels under current claims payment policies, the imbalance in economic incentives that has traditionally relied on costly inpatient hospital services can be revised. Payments for less costly and often-times more appropriate treatment modalities are now offered. These sources include: Non-physician providers (physician extenders, nurse practitioners); out-patient services (home health, community mental health centers, hospice care, surgi-centers); immunizations; 2nd and 3rd opinions for elective surgeries; choice of coverages under pre-paid group plans including HMOs.

Improved dialogue with insurers

In greater numbers, companies are requiring their insurers to improve benefits' administration by such techniques as claims review using medical treatment profiles, coordination of benefits, preadmission testing before a person is hospitalized, and concurrent utilization review on in-patient hospital care.

Increase in worksite benefits

Many businesses feel a responsibility to provide certain services to the employee and these benefits are best offered directly to the employee at the job site. Voluntary, post-employment employee assistance programs are being developed by a growing number of companies. Counselling for alcoholism, substances abuse, psychiatric disorders, family, financial and legal problems are offered with follow-up referrals into community agencies. Reduced hospital/medical/surgical utilization and improved employee productivity have resulted.

Many companies reason that bad employee health habits increase corporate costs and the employers have the right to attempt to change employee life styles which affect these costs. Since 1975, a great many companies have begun offering programs for smoking cessation, hypertension control, fitness, stress management, nutrition education, and obesity control. Here too, there is evidence that due to reduced hospital and medical care utilization, health insurance premium cost increases are slowing.

Community action plans

Corporate cost containment plans do not stop with in-house efforts. Many management executives are trustees on hospital boards. Companies are finding this an appropriate and available avenue through which they can participate with providers in determing and developing community services.

Nearly half of all Health Systems Agencies (HSA) have business support. Additionally, several companies have now taken the position that those services or products which were not granted HSA approval will not receive any corporate philanthropy.

Employers have, in several communities, banded together to give positive direction to community planning for medical services. By working with providers, insurers, and planners, and other key agents, these "ccalitions" have been sucessful in shortening the length of a hospital stay, lowering utilization of selected services and stabilized costs for care.

The U.S. Chamber's Health Action program, the VE, the development of the Boston University Center for Industry and Health Care and our own work all point to new levels of employer commitment to the goal of working for a healthier society.

COMPETITION

As a philosophy, the business community is committed to assuring all Americans access to needed care in appropriate treatment settings, and protection from high costs for necessary services. Though one can easily see that national expenditures are rising, there appears little agreement by experts as to the degree to which future expenditure will result in improved health status. Thus, health policy participants must take due care in evaluating the impact of any new strategy in order to support only appropriate solutions to real problems without unnecessarily disrupting the world's best medical care delivery system.

As a business group vitally concerned not only with health issues but also with broader issues of economic policy we applaud the new directions in NHI proposals. The work of the Congresspersons, staff members and analysts who have developed

the so-called "competition" based proposals has made a major contribution. You have, finally, clearly stated that the massive proposals for a federalized system will not be accepted. Incentive reform, or new market forces, warrants our support, but not blind acceptance.

We must temper our enthusiasm for competition with the recognition that the private sector has already clearly demonstrated that health services cannot be left entirely to the vagaries of an open market, at least not in a Nation that espouses the value of assuring access to needed care for all. There is no indication that the private sector is prepared to, or should take over the responsibilities of public programs. Nor is there any reason to expect the poor to relinquish their hard-won entitlement programs (no matter how weak these may be) in return for promises of future market responses.

We would like to see competitive approaches be successful and when we question or even oppose various specific components, we do so only in the search for improvement, not delay for its own sake.

To be successful, the competition approach must bring with it certain changes not attainable only by mandating the shape of employee benefits: Physicians and all other providers must be allowed to advertise, including price information; schools must no longer be allowed to ignore health education, as the vast majority do now. Consumer choice will never be really meaningful without an educated public. Today, we consciously guarantee that each generation of new adults will be ignorant of health, of their own bodies, and of the medical system. We pay an awful price for this ignorance, a price compounded by the more than one million teenagers who annually become pregnant thanks in part to a society that says an excess of 700,000 babies and 300,000 abortions by teenage mothers is preferable to sex education in our schools; medical schools, if receiving any public financing or tax support, must teach health economics and educate providers to know how to value the price of the products they order as well as the services they provide; incentives to have providers serve in rural and currently underserved urban areas must be designed. We have more than enough physicians now with hundreds of thousands more on the way. Left unchecked, or left to await the long term impact of market forces, the system will simply continue to overload the "desirable" areas while leaving many other areas underserved.

The Durenberger bill S. 1968 addresses one major aspect of current health policy: tax subsidies for medical care. Assuming that present tax laws have created incentives for purchasing broad benefit plans, and that individuals tend to over use this benefit mix, the Durenberger approach places some financial burden back on to the individual. In this way, the bill seeks to promote cost consciousness by employees, greater competition by insurance plans, and system reform through greater efficiency in individual use of health resources. These are laudable objectives.

Under the bill, for employers over 100 people, health plans would have to meet certain requirements with respect to: (1) Specified health benefits under a plan; (2) The availability of 3 options to employees under employer based health plan; and, (3) The amount of the employer contribution made to the plan on behalf of employees.

Congress . . . closing the gaps

As proposed, S. 1968 affects only the portion of the workforce receiving rather broad health benefits offered through the employer. Because the bill addresses employer and employee tax subsidies on health fringe benefits, persons who are currently unprotected, whether they are employed or not employed, are generally unaffected by this proposal. Thus, the bill does not improve the availability of protection to millions who have none. Even the most ardent competition advocate must agree it will take years for the system to readjust and fill these gaps of its own volition. The long term perspective must be accompanied by specific plans to address short term needs and problems.

Addressing real needs

Senator Schweiker's bill applies to firms with over 200 employees; (50 for the catastrophic provision). Sen. Durenberger's to those with 100 or more. The small business voice has been heard and will be increasingly loud in opposition to any plan which mandates their participation. Without supporting or denying the validity of the small business position, I would note that their exemption poses a very real problem for the legislation's authors.

The U.S. Chamber has more than 80,000 corporate members better than 75 percent of which have 100 or fewer employees.

If all these firms are exempt, the primary gaps your legislation seeks to close will be exempt from the bill's impact. Rather than addressing the real problem of

making health insurance affordable to those employees and dependents now uncovered, the bills would focus on the employees of large firms. These are the companies that have the most extensive basic benefits; that do offer HMOs; that have major medical; and that are increasingly providing health promotion/disease prevention programs.

The large firms have the greatest potential for using their economic clout to foster incentive changes. They also are least in need of having the components of the benefits package mandated.

The small firms need to make the most progress to close gaps and also need the most help to achieve this goal.

Aging

Additionally, S. 1968 generally does not improve adequacy of coverages for the population, though the plan does require qualified benefit plans to include "stop-loss" clauses of $3,500. This proposal is silent on issues of protection for the elderly. Yet providing for necessary care at reasonable costs for the aging is going to become increasingly important for employers. From a limited survey of WBGH members the aging problem can be seen in the future workforce.

As a percent of the active workforce: Employees aged 65 plus, 0.05-0.30 percent; employees aged 60-64, 1.5-6.0 percent; employees aged 55-59, 4.0-11.0 percent.

Dependents

As written, S. 1968 uses the Internal Revenue Code § 151 (e) definition of "child", and by implication, uses the Internal Revenue Code Section 152 definition of "dependent." Within the meaning of the definition of a dependent "child", a desecendant of a covered employee's child would also be required to recevive medical benefits from the employer. We are unaware of any benefit plan which extends coverages to this population. Similarly, no employer benefit plan contribution would be "qualified" by this bill if the IRC § 152 definition of "dependent" is used. Several classifications of "dependents" under IRC are not protected by employee benefits. These categories include: (1) The father or mother of the taxpayer (worker), or an ancestor of either parent; (2) A son or daughter of a brother or sister of the taxpayer; (3) A brother or sister of the father or mother of the taxpayer; (4) A son-in-law, daughter-in-law, father-in-law, brother-in-law or sister-in-law; (5) An individual who, for the taxable year of the taxpayer (employee), has as his principal place of abode, the home of the taxpayer, and is a member of the taxpayer's household.

We are well aware that some dependents must always be able to receive medical protection from the worker. Though most dependent coverage currently terminates when the child reaches 22 years old (other than for students) those persons chiefly dependent on the employee due to mental or physical disability, continue to receive employer-based coverages regardless of age. However, making medical benefits available to additional collateral dependent group would cause massive disturbances in the management of health benefits, and great new costs for employers, unrelated to the normal costs associated with business and employee wellness. We recommend that the current interpretation of "dependent" be used by any legislated health policy.

Does a third carrier equal competition

There are additional issues raised by S. 1968 which warrant your attention. This proposal posits that, by requiring employers to provide these benefit plan options by three separate insurance carriers, competition among insurers will be stimulated. We are uncertain whether competition over low option plans will be very meaningful or will truly lower overall expenditures. Large employers are finally using their substantial premium payments to influence the delivery of services at the local level. Our concern stems from the likely loss of useful corporate participation at the community level, because their market payment penetration has been broken-up.

Cost variation

Indexing the contribution for employer to $50 for single workers, $100 for the employee and spouse, $125 for employee and family, would generally make very liberal benefits available to the employee household. However, there are broad regional differences in costs for similar benefit plans. For example, the UAW monthly family benefit plan costs approximately $120 in New Jersey, and Buffalo, New York. The same plan costs $175 in Los Angeles, and $205 in Michigan. For many companies regional differences for similar benefits vary 25 percent. Furthermore, there are noteworthy differences in costs within the same SMSA. The automotive contracts bear out this point. In Kansas City, Chrysler employee benefit plans cost $35 less than GM workers and $16 less than Ford employees. Thus,

within the same city, employees, with roughly equal income and benefits will be taxed differently.

Prevention disincentive?

Many rich benefit plans are already costing more than the allowable dollar limit for employees. Though it is not required by the proposal, many companies offer dental protection and vision care. The approximate individual monthly cost for the dental benefit is $10 and the average family monthly cost is $23.

Thus an even greater number of families would be required to pay taxes on existing benefits. The real concern here, is not so much that some of the present mix of benefits would be considered income to the employee. Our concern is that the bill may set the cost trigger so close to the present allowable dollar contribution, that future additions of the very benefits which are designed to slow cost increases, and redirect our emphasis toward wellness would likely be required to be counted as employee income. This would be a grave deterrent to the health promotion/disease prevention movement and to future health oriented benefits that depend upon long-term measures for their cost containment success. One might get around this problem by exempting the cost of such benefits from the income trigger formula. If, as Senator Schweiker's bill would do, "prevention" benefits are mandated, then such an exemption would even more necessary.

Employee rebates

It has been proposed that, as an incentive to get employees to either choose a low-option insurance plan or reduce their medical care utilization, the employees receive whatever savings result from this choice or utilization modification.

Employers have mixed feelings about this proposal because many negotiate benefits, not dollars, and thus feel that any financial savings that do not come from a reduction in offered benefits rightfully belong to the company. This is little more than a logical extension of the concept of experience rated insurance where reduced utilization results in lower premiums for the employer.

However, many employers also see the long-term advantage of encouraging employees to be wiser buyers and users of their benefits. As with any other advantage, there must also be a price.

Therefore, we would recommend that any legislation which addresses this subject simply require that the savings be shared by the employer and employees. This will meet the objectives of: (1) providing a cost consciousness incentive for employees: (2) maintaining the employer's incentive to push for cost containment through benefit redesign, claims management and participation in the local health planning system, etc.

The individual consumer cannot be expected to change the economic incentives of the delivery system—a system with which most are quite satisfied—as rapidly as major corporate purchasers.

It is difficult to assess the degree to which offering a low option plan would either be economically significant for systems-wide cost containment or would even be widely accepted by employees. The Federal Employees Plan experience suggests that consumers do learn to make wise personal choices but that these do not save the system any money. Now, Citicorp has released results of two years of employee surveys that would support our concern about acceptance. As part of a regular survey program, Citicorp asked:

If Citicorp's existing health benefits program were changed, I would prefer:

	Year 1 (percent)	Year 2 (percent)
Reducing the cost to one while keeping the program the same	18	15
or		
Keeping the cost the same while improving the benefits	81	84

While not a perfect test of the high-low option choice, this survey, which included both officers and wage level staff, gives a strong indication that people are nowhere near as attracted to reduced costs as they are to bigger benefits.

I would also note that there is no reason to assume that employees who take the rebate will alter their personal behavior or the demands they place on the medical system. As a nation, we are nowhere near as concerned about what we spend to create illness (i.e., smoking, drinking and seat-beltless driving) as we are about what we spend to repair the inevitable results of our voluntary behavior.

Multiple choice requirement

The basic concept seems sound. Many employers already offer several benefit plan options; more will do so when there are more HMOs to offer and fewer HMO management and marketing problems. Our Group has supported alternative delivery system development from the start, will continue to do so and our members are leading innovators in industry-HMO relations. Creating new market forces through the presence of new health plan organizations is a concept industry can support. It is not, however, viewed as the whole answer or a timely response to current political and economic pressures for greater access and reduced fear of catastrophic costs.

Adding the low-option offering is not something we would object to philosophically nor would the administrative cost be prohibitive.

However, there are several issues which at least call into question the ultimate value to be gained by this offering. The one major example which currently exists is the Federal Employee Health Benefit program. There, the employees have shown they can indeed make sound economic choices: i.e., go low option except when they want to schedule a baby or elective surgery! The resulting adverse selection does not save the health system needed resources even though it may be good for certain individual consumers. Reducing the annual open enrollment period, as a method of avoiding plan jumping seems completely contrary to the consumer choice concept.

The low option price should not be based on 50 percent of medical cost of Federally qualified HMO. This is certainly true if the bill were to become law in the near future. The vast majority of the population does not have such an HMO to which it could turn even if it wanted to do so. Also, there is no basis for assuring that the cost levels achieved by today's HMO bear any resemblance to what a national cost range should be for low option plans.

If there is to be a required low option plan, we would recommend that its price be set at a regional level and be determined by a process which considers hospital costs, provider availability, consumer demographics and health planning as well as HMO costs.

Mandatory versus voluntary

The private sector has never been united about whether or not NHI benefits should be mandatory for employers to offer, or employees to accept. On the latter issue I will only note that, if the program is well-designed and aims at real needs, there should be no need to force people to participate. For employers, the question is not so simple.

Our Group is comprised of the very largest companies. As such, all give extensive health benefits and have always taken the position that the requirements of any government-legislated program should be faced equally by all. Thus our stance was for a mandated program. However, we are well aware that many other employers, especially those that are much smaller, would find the mandate to be of great cost. The price will be paid by all of us in increased product prices, reduced marginal employment, increased bankruptcies, and other problems that, while not directly within the purview of the health program, are nonetheless detrimental to society as a whole. Today, we all pay the price of uncovered persons who must rely upon government programs or who cost us dearly because of the combination of low productivity and high service demands.

Therefore, we do not believe the effort to improve our health system should be hindered by the mandatory-voluntary debate. We will endorse the voluntary approach with the firm belief that most employers, large and small, will comply over time. If the program has the flexibility to meet local needs, compliance need not be a big issue.

HMO's

Without support and cooperation from employees, HMOs or other alternative health care delivery plans cannot succeed. Therefore, it is imperative that proponents of the market reform approach clearly hear the concerns among employees have about HMOs. These concerns and the current state of HMO development are real barriers to establishing a market force system: There is great concern about the financial stability of many HMOs including those Federally qualified; people are leaving HMOs because many of them seemingly cannot provide mental health benefits comparable to indemnity plans; HMO management and marketing are suspect; HMOs often cost more especially for the first few years, than the indemnity plans against which they are competing. This extra cost is an enrollment deterrent. If this is true for major employers whose indemnity plan itself is quite rich, just imagine how much extra cost there will be when employers with poor benefits have to offer the HMO option; even where the HMO may have proven savings, it may not

be a real option. For example, FMC, which is a strong HMO supporter, has seen a 40 percent savings for its employees enrolled in one of the Kaiser plans in California. However, that plan has been full for the past two years and expects to remain closed to new groups for at least another two years. FMC employees desirous of the HMO system can join another HMO company plan, but there the costs are 11.5 percent above the FMC indemnity plan . . . hardly an incentive to join; State laws, such as New York, which require employers to offer all HMOs detract from employee support for the entire concept.

We want HMOs to succeed. We want an infusion of healthy competition and we expect that there will be a price for this progress. However, we do not see the current HMO movement as a viable launching pad for the broad range of new health plans that will be necessary to achieve a delivery system based upon fierce market incentives. I would suggest that the HMOs now struggling for acceptance—indeed for their own existence—will be one of the barriers to the development of more competitive alternatives.

This is one more area which could benefit from a large, flexible demonstration program approach. Just as we have concerns about trying to quickly rearrange the whole medical system based on a concept in its infancy, so too we see no reason to do nothing. The status quo is unacceptable, change is desirable as well as inevitable, but we would like to suggest a process that manages change based upon growing experience rather than economic theory.

Catastrophic

To testify before this distinguished committee and not speak directly to the issue of catastrophic coverage would be inexcusable. We have always recognized that the fear of large medical expenses was a primary social issue and one responsible for great pressure on Congress. While the record of private sector provision of major medical coverage is remarkably good, there are still significant numbers of millions who are uncovered and considerably more who are worried despite having quite adequate—sometimes excessive—insurance.

The reasons that major employers have been able to so rapidly increase the levels of catastrophic coverage and do so very cheaply is the presence of an extensive basic benefits protection.

We have always felt that the provision of access to basic benefits was a higher priority, from a health standpoint, than was catastrophic coverage.

We have great concern that providing very low cost catastrophic protection without the underlying basic benefits structure will drain dollars unnecessarily from the prevention/early detection end of the spectrum . . . which is where the greatest health improvements must ultimately be made.

The private sector is increasingly responding to the catastrophic challenge. For example, my own company, which is truely a small business and is located here in high cost Washington, has insurance that provides basic and catastrophic benefits, with a maximum deductible of $100 and a very low stop/loss of less than $1,000.

For this, we pay an annual per person premium of $346 and family premium of approximately $1,200. While this is not easy to pay, it is not so high that we need government subsidy. The key point is that this type of small groups coverage was not even available only a few years ago.

Setting the public's mind at ease is a legitimate objective. The attainment of that objective, however, must be balanced against the greater needs of basic coverages and prevention services. We support catastrophic protection but do not believe it should be a stand-alone program.

Health promotion and disease prevention

The promotion/prevention end of the spectrum remains the least financially or politically supported. Many employers have had bad experiences with over-promoted, poorly designed and under-managed prevention programs. The federal government still spends far more on every other aspect of the health system than it does on all of prevention.

Until recently, prevention has been considered a separate issue from NHI. This is not longer so. Many observers now feel that should any NHI plan pass without specific provision for prevention services, the system would be even further biased toward the more traditional medical model.

The competition advocates must be especially careful about this since they presume that competition will result in providers utilizing more prevention techniques as cost control devices. HMOs were thought to do the same but today there is scant evidence that most HMOs provide any more prevention services than other delivery systems. The problem will be compounded if the "trigger" which causes premium

costs to become taxable income for the employees is set to go off when new, promotion programs are added to the benefit package.

We would prefer that Congress assist the promotion movement by assisting employers to do even more than that which is already under way. For example, currently the cost of in-house promotion programs is exempt from the Council on Wage & Price Stability's guidelines. However, reimbursement for similar or other services provided outside the company site are not exempt. These fees are counted as wages and taxed, thus decreasing the employee's incentive to want the program. The evidence of the cost effectiveness of health promotion and mental wellness programs grows daily. This nation needs leaders who will set public policy as a health rather than disease oriented cause.

Capital investment

It is very attractive these days to focus the cost containment attack on hospitals. In many respects, the past and current economic incentives in reimbursement and government policy make the hospitals a reasonable target. However, a few points must be kept in sight.

(A) There is no advantage to the future of our delivery system if we expend tomorrow's capital funds on today's operating costs; or if we guarantee obsolescence in the name of momentary cost containment. This is what is happening in New York.

(B) Destroying a hospital's rate of return on equity is not cost efficient for long-term community infrastructure management. At the very least, the hospital will have to include the cost of rapidly rising interest rates in its patient charges.

(C) The logical result of A & B, above, is to reduce or lose access to private capital markets and thus increase dependency on the federal budget . . . something which is not healthy for either the public or private sectors nor in keeping with the current budget cutting efforts of Congress and the Administration.

(D) Finally, debt-ridden hospitals will never close or be replaced fast enough to avoid a significant reduction in quality of care for those patients who have nowhere else to go during the period of cost containment induced demise.

Experiments/Demonstration

We would urge the Committee to recognize the potential value of establishing new health services delivery demonstration programs. Experiments, of sufficient scale to truly demonstrate replicable outcomes, can be conducted as has been proven even in such complex issues as housing allowances.

Numerous potential projects come to mind: *The 95 percent reimbursement system for HMOs.* Instead of continuing to fight this battle in the staff room of Senate Finance, why not designate several areas where the concept, using alternative percentages, could be tested? As I have stated before, we do not have a position on this issue and greatly repect the concerns expressed by the staff of this Committee. For this very reason, we believe the demonstration approach would yield the hard evidence that can never be obtained by debate or small studies of past problems; *Development of a munimum benefit standard.* Numerous examples already exist but no effort has been launched to test them. comparatively, at the local level. If we could agree to the minimum, we would all, private and public, have a target against which to measure future progress. The 1949 and 1969 housing goals provide an example of a process that, while imperfect, did give us the capacity to assess how well we we doing and what types of priorities Congress wanted to establish over the years.

Finance local adaptations of the Project Health program. This exciting program has proven it is possible to provide comprehensive benefits, including catastrophic protection, on a pre-paid basis, to the population known in most communities as "medically indigent". By every report, Project Health is a success and in Congressman Ullman's own words, can serve as a model for NHI. Project Health need not be restricted to one county in Oregon. It would be most appropriate for Congress to sponsor the replication of the Project Health concept in an additional 100 counties during the next three years. With careful evaluation we could learn how this system can be modified to close specific gaps in numerous local communities.

Anti-trust waivers for coordinated claims management. For years, the insurance industry has been calling for relaxation of the anti-trust rules which they feel now restrict their ability to do effective cost containment. Rather than doing nothing until Congress agrees on the merits of this request, why not grant various types of waivers so we can learn how these actions will work when combined with the emerging competition programs.

State pools. Instead of reviewing the pooling concept as suitable only for the uninsurables, who not assist the states to experiment with the concept to learn what other gaps for which it might be adaptable.

Conclusion

Each of us share the responsibility for ameliorating the problems in our health system. The future challenge is to stimulate improvements in medical services without losing those parts of our system which have achieved excellence. Though we have expressed concern regarding the extent of the effective impact of some pro-competitive incentives created by several legislative strategies, industry is committed to seek and support additional efforts which would achieve competition and cost containment. We commend the Committee for its continuing search for innovative approaches and pledge our assistance wherever it may be deemed useful.

AMAX
AMF
ARA Services
ASARCO
Abbott Labs
Aetna Life & Casualty
Air Products & Chemicals
Allied Chemical
Allis Chalmers
Aluminum Company of America
American Can
American Cyanamid
American Express
American Health Care
American Home Products
American Medical International
American Standard
American Telephone & Telegraph
Armco Inc.
Armstrong Cork
Ashland Oil
Atlantic Richfield
Babcock & Wilcox
Bank of America
Bechtel
Becton, Dickinson & Company
Bendix Corporation
Bethlehem Steel
Boeing
Boise Cascade
Borg-Warner
Bristol Myers
Buck Consulting Act., Geo. B.
Burlington Industries
Burlington Northern
Beatrice Foods
Campbell Soup
Carter Hawley Hale Stores
Caterpillar Tractor
Champion International
Chrysler
Citibank
Cities Service
Coca-Cola
CPC International
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E.I. duPont de Nemours
Eastman Kodak
Eaton
Eli Lilly
Employers Ins. of Wausau
Equitable Life
Ernst & Whinney
Esmark
Exxon
FMC
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General Foods
General Mills
General Motors
GTE Service Corporation
General Signal
General Tire & Rubber
GENESCO
Georgia-Pacific
Goodrich Company, B.F.
Goodyear Tire & Rubber
Gould Inc.
Grace, W.R.
Gulf Oil
Hanna Mining
Heinz, U.S.A.
Hellmuth & Assoc, C.T.
Honeywell
Hospital Corporation
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INA Corporation
Ingersoll-Rand
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Int'l Minerals & Chemical
International Harvester
International Paper
Jewel Companies
John Hancock
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Kaiser
Kennecott Copper
Kimberly-Clark
Koppers
LIFEMARK Corporation
Libbey-Owens-Ford
Macy, R. H.
Martin Marietta
McDonnell-Douglas
McGraw-Hill
Mead
Mercer William M. & Co.
Merck
Metropolitan Life
Milliken & Company
Mobil Oil
Montgomery Ward
Morgan Guaranty Trust
Nabisco
Northern Natural Gas
Occidental Life
Olin
Owens-Corning-Fiberglas
Owens-Illinois
PACCAR
PPG
Pacific Gas & Electric
Penney, JC
Pfizer
Philip Morris
Pitney Bowes
Pittston Company
Procter & Gamble
Provident Life
Prudential
Pullman
Quaker Oats
RCA
Ralston Purina
Republic Steel
Revlon
Reynolds Metals
Rockwell International
Rohm & Haas
SCM
Safeway Stores
St. Joe Minerals
St. Regis Paper
Schering-Plough
Scott Paper
Sears, Roebuck & Company
Shell Oil
Sherwin-Williams
SmithKline
Sperry Rand
Std. Oil Co. of California
Std. Oil (Indiana)
Stanley Works
Stauffer Chemical
Sun Company
Sundstrand Chemical
TRW
Tenneco
Texas Gas Transmission
Texas Instruments
Travelers
Union Camp
Union Carbide
Union Oil
Union Pacific
U.S. Home
U.S. Steel
Warner Lambert
Westinghouse Electric
Weyerhaeuser
Whirlpool
Wells Fargo
Xerox

Senator TALMADGE. And, without objection, the committee will stand in recess, subject to the call of the Chair.

[Whereupon, at 5:50 p.m., the hearing was adjourned, subject to the call of the Chair.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF DONALD E. CLARK, COUNTY EXECUTIVE OF MULTNOMAH COUNTY, OREG.

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE ON HEALTH, MY NAME IS DONALD E. CLARK AND I AM THE ELECTED COUNTY EXECUTIVE OF MULTNOMAH COUNTY, OREGON WHICH INCLUDES THE CITY OF PORTLAND AND SURROUNDING COMMUNITIES. I AM HERE TODAY REPRESENTING MULTNOMAH COUNTY, OREGON AND THE NATIONAL ASSOCIATION OF COUNTIES.*

I AM PLEASED TO HAVE THE OPPORTUNITY TO TESTIFY ON THE HEALTH INCENTIVE REFORM ACT (S. 1968), BECAUSE THE BILL ADDRESSES THE BASIC PRINCIPLE OF HEALTH CARE COMPETITION, WHICH IS A KEY ELEMENT OF MULTNOMAH COUNTY'S PROJECT HEALTH PROGRAM.

TEN YEARS AGO, AS A NEWLY ELECTED COUNTY COMMISSIONER, I REALIZED THAT DESPITE THE FACT THAT MILLIONS OF DOLLARS WERE BEING SPENT ANNUALLY FOR HEALTH CARE IN MULTNOMAH COUNTY, APPROXIMATELY 40,000 COUNTY RESIDENTS WERE WITHOUT ADEQUATE HEALTH CARE COVERAGE. THE POOR AND LOW-INCOME WERE NOT GETTING THE QUALITY AND DIGNITY OF CARE AVAILABLE IN THE PRIVATE SECTOR AND THE FINANCIAL DEMANDS OF OPERATING A COUNTY GENERAL HOSPITAL FAR OUTSTRIPPED THE RESOURCES AVAILABLE. TODAY, OUR PROJECT HEALTH PROGRAM IS POOLING LOCAL, STATE, AND FEDERAL RESOURCES AND PURCHASING HEALTH CARE SERVICES FOR THE MEDICALLY INDIGENT THROUGH THE PRIVATE SECTOR. THE HEALTH CARE SERVICES ARE OFFERED IN THE FORM OF FIVE COMPETING PREPAID HEALTH PLANS, INCLUDING TWO HMO'S AND PRIVATE PREPAID GROUP PRACTICES. CLIENTS SELECT THE PLAN THAT BEST MEETS THE NEEDS OF THEIR FAMILIES AND SUITS THEIR ABILITY TO PAY.

WE HAVE FOUND COST-SHARING TO BE AN IMPORTANT ELEMENT IN PROMOTING COMPETI-

*NACO IS THE ONLY NATIONAL ORGANIZATION REPRESENTING COUNTY GOVERNMENT IN AMERICA. ITS MEMBERSHIP INCLUDES URBAN, SUBURBAN, AND RURAL COUNTIES JOINED TOGETHER FOR THE COMMON PURPOSE OF STRENGTHENING COUNTY GOVERNMENT TO MEET THE NEEDS OF ALL AMERICANS. BY VIRTUE OF A COUNTY'S MEMBERSHIP, ALL ITS ELECTED AND APPOINTED OFFICIALS BECOME PARTICIPANTS IN AN ORGANIZATION DEDICATED TO THE FOLLOWING GOALS: IMPROVING COUNTY GOVERNMENT: SERVING AS THE NATIONAL SPOKESMAN FOR COUNTY GOVERNMENT: ACTING AS A LIAISON BETWEEN THE NATION'S COUNTIES AND OTHER LEVELS OF GOVERNMENT: AND, ACHIEVING PUBLIC UNDERSTANDING OF THE ROLE OF COUNTIES IN THE FEDERAL SYSTEM.

TION BETWEEN PLANS AND CONSUMER AWARENESS OF THE COST AND BENEFITS OF THEIR HEALTH CARE COVERAGE. IN A SERIES OF PROJECT HEALTH CLIENT INTERVIEWS IN 1977, MATHEMATICA POLICY RESEARCH, INC., FOUND THAT 20% OF THE ENROLLEES WOULD HAVE CHOSEN A DIFFERENT PLAN IF ALL PLANS HAD COST THE SAME. A FISCAL EVALUATION CONDUCTED BY ARTHUR ANDERSON & ARTHUR D. LITTLE, INC., FOUND THAT ENROLLEES WERE MIGRATING AWAY FROM THE MORE EXPENSIVE PLANS TO THE LESS EXPENSIVE, BUT EQUALLY COMPREHENSIVE PLANS OFFERED BY LOCAL HMO'S. THIS TREND HAS BEEN PROJECTED TO CONTINUE, SINCE HMO COSTS ARE EXPECTED TO INCREASE 6.7% TO 7.0% ANNUALLY, WHILE PLANS OFFERED BY HEALTH INSUREPS ARE INCREASING AT 9.5%.

LAST FALL, FOR THE FIRST TIME SINCE THE PROJECT BEGAN IN 1975, WE DROPPED A MINIMUM ENROLLMENT FEE REQUIREMENT FOR ONE OF THE PLANS. WE DID SO, TO FURTHER ENCOURAGE COMPETITION BY MAKING THE LOWEST COST PLAN (WHICH ALSO REQUIRES PATIENT CO-PAYMENT FOR CARE) THE "FREE OPTION" AVAILABLE TO ENROLLEES. AN ENROLLMENT FEE BASED ON THE ABILITY TO PAY AND THE COST OF THE PLAN SELECTED IS STILL REQUIRED BY THE OTHER PLANS. ALTHOUGH OUR EXPERIENCE HAS SHOWN THAT COST-SHARING IS SELDOM CITED AS REASON FOR DISSATISFACTION WITH THE PROGRAM, IT IS ONE AREA WE WILL BE ANALYZING FURTHER THIS COMING YEAR AS WE BEGIN TO ENROLL THF WELFARE POPULATION AS WELL AS THE MEDICALLY NEEDY INTO THE PROJECT.

INITIAL EVALUATIONS OF OUR COSTS AND UTILIZATION PATTERNS VERSUS THOSE UNDER THE STATE'S FEE-FOR-SERVICE MEDICAID PROGRAM HAVE BEEN EQUALLY ENCOURAGING. ARTHUR ANDERSON AND ARTHUR D. LITTLE FOUND THAT THE "TOTAL PER CAPITA MEDICAL EXPENDITURES FOR THE MEDICALLY NEEDY ARE LOWER USING THE PROJECT HEALTH MODEL THAN FOR THE AFSD (ADULT AND FAMILY SERVICES DIVISION STATE) MODEL. THE MAJOR REASON FOR THE APPARENT SUCCESS OF THE PROJECT HEALTH 'BROKERAGE' MODEL IN CONTAINING THE COSTS OF MEDICAL CARE APPEARS TO BE THE RATES NEGOTIATED WITH PREPAID PLANS, WHICH CLOSELY APPROXIMATE COMMUNITY RATES FOR INDIVIDUAL ENROLLEES IN SUCH PLANS." HOWEVER, BECAUSE OF THE HIGH PROPORTION OF PERSONS WITH ACUTE OR CHRONIC HEALTH PROBLEMS IN THE PROJECT HEALTH POPULATION (52% AGED, BLIND

OR DISABLED, VERSUS 12.5% IN THE WELFARE POPULATION), UNIT COSTS OF MEDICAL SERVICES FOR EPISODIC CARE IS HIGHER THAN THE STATE'S MEDICAID PROGRAM.

PRELIMINARY DATA ALSO INDICATES THAT PROJECT HEALTH IS CONTRIBUTING TO A DECLINE IN WELFARE ENROLLMENT. OVER THE PAST THREE YEARS, THE AVERAGE ANNUAL WELFARE ENROLLMENT DECLINED IN OREGON BY 6.2% OVERALL WITH THE DECLINE IN MULTNOMAH COUNTY THE MOST SIGNIFICANT, 7.3% AS COMPARED TO 5.7% FOR THE BALANCE OF THE STATE. WHILE SUCH A DECLINE CAN BE ATTRIBUTED TO A VARIETY OF FACTORS SUCH AS INCOME, INFLATION, EMPLOYMENT, AND OTHER SOCIO-ECONOMIC INDICATORS, THIS PRELIMINARY DATA INDICATES MEDICAL ASSISTANCE MAY WELL BE A FACTOR IN REDUCING DEPENDENCY ON WELFARE, AND MERITS FURTHER STUDY.

IN CLOSING, I APPLAUD THE EFFORTS OF THIS COMMITTEE IN CONSIDERING THE HEALTH INCENTIVE REFORM ACT AND OTHER MEASURES INTENDED TO PROMOTE COMPETITION AND REDUCE COSTS WITHOUT SACRIFICING QUALITY OF CARE OR JEOPARDIZING ACCESS TO SERVICES. PROJECT HEALTH HAS SERVED AS A WORKING LABORATORY IN MULTNOMAH COUNTY TO DEMONSTRATE THE FEASIBILITY OF UTILIZING COMPETITION TO KEEP HEALTH CARE COSTS DOWN WHILE ENSURING ACCESS TO QUALITY CARE. WHILE MUCH STUDY REMAINS TO BE DONE, WE FEEL WE ARE MAKING FAR BETTER USE OF OUR HEALTH CARE RESOURCES BY INCORPORATING THREE ESSENTIAL PRINCIPLES INTO OUR HEALTH CARE SYSTEM:

1. GREATER RELIANCE ON COMPETITIVE PRESSURES TO RESTRAIN INFLATIONARY COST PRESSURES;

2. CONSUMER PARTICIPATION IN THE COST OF HEALTH CARE COVERAGE BASED UPON THE COST OF THE PLAN SELECTED AND THE INCOME OF THE INSURED;

3. PROMOTION OF COST AWARENESS AND SERVICE COMPARISON BY HEALTH CARE CONSUMERS AND PROVIDERS.

WE BELIEVE OUR EXPERIENCE HAS IMPORTANT IMPLICATIONS FOR NATIONAL HEALTH INSURANCE.

THANK YOU FOR THE OPPORTUNITY TO TESTIFY ON THE HEALTH INCENTIVE REFORM ACT. WE WILL BE GLAD TO PROVIDE ANY ADDITIONAL INFORMATION YOU MAY FIND USEFUL IN YOUR CONSIDERATION OF NATIONAL HEALTH CARE INSURANCE.

SUBCOMMITTEE ON HEALTH

FINANCE COMMITTEE

U. S. SENATE

Statement Submitted by Converse Murdoch, Esquire

on Behalf of the Small Business Council of America, Inc.

S1968

(An act to encourage competition in the health care industry and to encourage the provision of catastrophic health insurance by employers)

April 1, 1980

This statement is submitted in connection with the Subcommittee's consideration of S1968 (sometimes hereafter referred to simply as the "bill") relating to amendments to the Internal Revenue Code (IRC) designed to encourage competition in the health care industry and to encourage the provision of catastrophic health insurance by employers.

This statement is submitted on behalf of the Small Business Council of America, Inc. (SBCA) of which I am President. The Small Business Council of America, Inc. is an organization created to monitor and comment on legislation and regulatory developments affecting small businesses -- particularly in the area of taxation and employee compensation plans.

I am also an attorney in private practice in Wilmington, Delaware. Most of the clients of our firm are owners and principals in small businesses -- mostly closed held.

Summary of Statement

The following is a summary of my statement.

Small Business Council of America, Inc. commends Senators Durenberger, Boren and Heinz (and others who may become sponsors of S1968) for seeking ways to encourage reduction in the cost of medical care.

However, SBCA does not favor mandated employer financing of the costs of catastrophic health insurance solely at the expense of employers and their employees.

SBCA believes that S1968 in its present form would add complexity in an area where there is a crying need of less, rather than more, complexity. In its present form, S1968 would be particularly unfair to employers in the small business area.

While SBCA sympathizes with the goals of the sponsors of S1968 -- we believe that in its present form the bill will not accomplish its stated objectives.

There are a number of technical problems with respect to the legislation. Attached to this statement is a supplement listing the technical problems with the legislation which have been noted at this time.

The Encouragement of Competition in the Health Care Industry

The thrust of S1968 is to impose an income tax at the employee level with respect to employer-sponsored health benefit plans (whether insured or self-insured) which do not comply with some very complex and strict rules.

The use of the federal income tax system in a futile effort to meet problems of run away health care costs is both unfair and unworkable.

The bill constitutes an almost classic case of "beating the wrong dog". Non-management employees, have little or no control over the type of health plan which their employer selects. An employer's selection of a health benefit plan is dictated by (1) what is available in the community, (2) budget restrictions at the employer level, (3) the particular health care needs of the employees, bearing in mind differing sexual and age make ups of employee groups, and (4) other factors -- practically none of which are under the control of the rank and file employees. Yet, the legislation would say to employees that (dependent on decisions over which they have no control) they may have to pay a substantial increase in their income and social security taxes.

Presumably, the bill could cause an increase in the taxable incomes of employees of government agencies, the health benefit plans of which are mandated by statutes and over which neither management nor rank and file employees have any control.

Many of us who spend much of our time working in the so-called "tax field" become almost totally immersed in tax thinking. Accordingly, we mistakenly assume that all decisions of any consequence are made strictly on the basis of tax results. We have to occasionally remind ourselves that what is our life work is not so pervasive in the minds of all our fellow citizens.

While tax considerations are obviously important -- they frequently do not override other business and personal considerations.

Legislation needed to encourage competition in the health care industry should be in a form which will directly effect those who can influence the health care industry competition situation - not those who are the victims of lack of competition. It will be impossible to convince a rank and file employee, that there is anything either fair or effective in increasing his taxes because his employer's health care plan failed to encourage competition in the health care industry. In the case of most employers -- and probably in the case of all small business employers -- not even the employers can do very much to encourage competition in the health care industry. The employees and the small business employers are stuck with what's available and have very little opportunity to create or encourage competition.

Insurance is not now (or has it ever been) noted as a field in which the usual customer can expect competition. The health care customer finds his ability to "shop around" very limited - even if he's inclined of doing so. "Discounts", "specials", "sales," "comparison shopping", "walk up and save", "cents off coupons", "we'll meet or beat any price" and "factory rebates" are terms completely alien to both the insurance and the health care industries. The concepts which such terms connote are simply not expected in those industries. Just as no one would

seriously consider putting a brain surgery job out for competitive bids, so too no small employer would get responses to an invitation for competitive bids for health insurance coverage.

The government has other and better weapons than the tax system to attack lack of competition - if that is one of the causes of high health care costs. One method (but not necessarily one SBCA would recommend) is to have the government directly enter the field itself and supply competition. Another is the traditional weapon against lack of competition; i.e., the anti-trust laws.

To attempt to encourage competition in the health care industry by increasing the taxes of workers is akin to attempting to break the OPEC grip on our economy by denying a salesman the right to deduct his gasoline charges unless he buys gasoline not made from OPEC produced oil. It simply won't work and will result in frustration and resentment from those who are punished for something over which they had no control.

The Bill Would Bear Particularly Hard on Small Business

The bill has super tough rules for plans having more than one hundred employees covered during a year. SBCA endorses the idea of attempting to give some relief for employers with less than one hundred employees. Nonetheless, the provisions of the bill applicable to small plans are complex and onerous and result in "beating the wrong dog" in the fight to encourage competition in the health care industry.

One of the most pressing problems of small businesses is the expense and hassle associated with trying to keep current with what seem to be ever-proliferating rules and regulations emanating from all levels of government. Small businesses can simply not afford the sophisticated computer hardware and software and the in-house or out-house expert accounting and legal help which must be secured to keep up with ever shifting rules in the tax and other areas. S1968 would merely be more of the same, in terms of added complexities for small business.

SBCA does not believe that big business should be asked to abide more complexities. We do say that small business can not absorb the costs of more complexities. We're rapidly approaching the phenomenon of a "death of a thousand cuts" in terms of the paperwork and regulatory cuts being inflicted on small businesses. S1968 would be one more cut - and a deep one.

Unless one has been engaged in the daily task of trying to run a small business and simultaneously keep up with what appears to be a never-ending stream of new statutes, regulations, rulings and forms -- one can't imagine the problems which beset the ordinary small business person. It's not difficult to imagine the added nightmares which will be caused in attempting to comply with legislation such as S1968.

Although this next comment is in the nature of a comment on a technical problem -- it points up the policy problems facing Congress in considering legislation such as S1968. The bill provides that in deciding whether an employer has more than one hundred employees covered under a plan during a year, the rules of IRC §1563 (having to do with controlled groups of corporations) and IRC §414(c) (having to do with commonly controlled trades or businesses, for purposes of pension plan rules) are to be applicable. Those referenced Code Sections are in themselves very complex and have spawned litigation which leaves many problems unanswered. Technicians in the tax field may consider highly polished refinements (such as the attribution rules just referred to) to be a must to achieve symmetry in the law. However, those who cannot afford the help to understand these refinements are simply going to throw up their hands in desperation or else unwittingly violate the law with the prospect that years later (during a tax audit) this violation will be called to their attentions.

The Burden of Catastrophic Health Insurance Coverage

If Congress determines that it is in the national interest that something needs to be done about catastrophic illness costs, it should forthrightly say so and proceed to treat it as a national problem affecting the whole country. If there is such a problem, the solution to it should be the burden of the entire community and not just of the employers and employees of the United States. The costs of meeting the problem should be paid out of general revenues.

Congress is already painfully aware of the fact that the burden of the social security system is reaching the breaking point as far as employers and employees are concerned. Many have urged that the welfare aspects of the social security system be financed from general revenues rather than treated as solely the responsibility of those who work for a living and those who employ them.

If there is a need for relief from the unbearable costs of catastrophic illnesses -- that need exists whether the ill person is a worker or is not a worker. There seems to be no justice or logic associated with saying that the cost of solving this problem must fall solely on those who work for a living.

SBCA believes that if this burden must be shared -- it should be shared by the entire community and that can best be accomplished by paying for the costs of catastrophic illness expenses out of general revenues.

Conclusion

SBCA respectfully urges the subcommittee to commit S1968 for further study on the basis of input from those most directly affected. In the process, there should be a move away from the assumption that these problems can be solved through the income tax system. Instead consideration should be given to the use of more direct methods, such as the use of anti-trust laws and general revenues as solutions to the two principal problems mentioned in the preamble of S1968.

Respectfully submitted,

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ATTACHMENT TO SBCA'S STATEMENT ON S 1968

TECHNICAL PROBLEMS

April 1, 1980

Set forth below are some technical problems with respect to S 1968.

1. The bill repeatedly refers to the creation of an exception to § 106 of the Internal Revenue Code of 1954 (hereafter simply the "Code"). It would seem that § 105 of the Code also covers this same area and the relationship of S 1968 and its amendments to § 105 should be made clear.

2. In proposed new Code § 86(b)(1)(page 3, line 4, of the bill) there is a reference to "dependents" of employees. That is not a defined term and should be.

3. In proposed new Code § 86(b)(2) there is a reference to a self-insured organization as being a "carrier". It's not clear whether that is meant to cover the situation of an independent organization (such as a trade association of which the employer is a member), which maintains a self-insured arrangement or whether it refers to the employer itself being a carrier if it has self-insurance. If the latter was intended, then the provisions of Code §86(b)(2)(B) become unworkable when applied to a self-insured program of an employer. That's

because the references in the last cited paragraph to "reasonable premium" rates determined by appropriate state agencies simply are not appropriate for a purely self insured program. There is no appropriate state agency in most jurisdictions, which regulates a self-insured medical benefit plan maintained by an employer.

4. In proposed Code § 86(c)(1) there are special rules introduced for employers having more than one hundred employees covered under any health benefit plan. It's not clear whether this means that if an employer has a high turnover rate and during a particular year has aggregate of more than one hundred employees, that employer is covered by this special rule, even though at no single point in time are there more than one hundred employees on the payroll.

   The same provision seems to indicate that even if the employer has more than one hundred employees, unless more than one hundred of them are covered under some form of health benefit plan -- the special rules do not apply.

5. Proposed Code § 86(c)(2) - in requiring an employer with a large plan to have coverage available from three carriers lays down rules for determining the separateness of the carriers. These rules require

a knowledge of the ownership of the various carriers (including ownership through very complex attribution rules). It is an impossibility for the ordinary employer to know the stockholdings or other ownership interest in insurance carriers. It is an unfairness to place on a customer the burden of attempting to get to the bottom of the maze of ownerships of insurance companies. It is worse to impose a penalty on the employees of the customer of the insurance company, if through control devices, not known to even the employer -- the carriers turn out not to be "separate".

6. In proposed Code § 86(e)(1) there is for the first time a reference to a "dental benefit plan". In context, the implication is that a dental benefit plan is different than a health benefit plan. If such is the case, that casts considerable doubt on the balance of the proposed new statute, as applied to a dental benefit plan.

7. Proposed new Code § 86 (f)(1) requires that group coverage under such plan continue to be available for a period of thirty days after death, separation from employment or divorce of the employee. As drafted this provision would apparently apply even though the employee immediately became covered under another employer's plan. Subsection (f)(2)

requires the offer of continued group coverage for 180 days beyond the thirty day period referred to in the immediately preceding paragraph. This indicates that only group coverage will qualify for this purpose. Many small business employers have so few employees that they cannot qualify under what is commonly referred to as a group policy. Under such circumstances, this employer of a small group will often reimburse employees for premiums on individual policies For purposes of the policy behind the proposed legislation, there seems to be no reason to force employers into group coverage, if group coverage is simply not available or is available with such limits as to make it not feasible.

STATEMENT

of the

NATIONAL RETIRED TEACHERS ASSOCIATION

and the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

S. 1968 - THE HEALTH INCENTIVE REFORM ACT OF 1979

before the

SENATE FINANCE COMMITTEE

Subcommittee on Health

March 18, 1980

62-511 O - 80 - 28

ABSTRACT

The Health Incentives Reform Act (S. 1968) promotes such laudable objectives as a greater degree of competition among health plans and greater employee cost consciousness. However, its impact would seemingly be limited to that portion of the workforce currently receiving a relatively broad range of benefits through their employer sponsored health plans. A single, national dollar "trigger" level for favorable tax treatment of health plan premiums fails to account for significant regional differences in the cost of medical care. Placing this "trigger" point close to current actual costs may reduce employer concern about health care costs.

Too often the rhetoric of raising consumer cost consciousness overshadows an equal if not greater need to raise the cost consciousness of employers and especially health care providers. The objectives of S. 1968 are unrealistically narrow to the extent that it ignores the primary reality of the medical care system, that it is the physician who controls the demand for medical services and therefore the cost spiral. Fiscal controls must be placed on the physician as well as the patient in order to make real progress toward controlling health costs. Consumers are best protected against high-priced, inferior providers in selecting among health care options when they are well informed as to the

comparative cost and performance records of health care practitioners. There is a danger, therefore, in overselling the potential short-term impact of such consumer choice, pro-competition proposals.

Our Associations find particularly objectionable the catastrophic protection provisions contained within S. 1968. The $3,500 stop-loss cap on out-of-pocket expenses is extremely high for an elderly individual on a fixed income and does not include under "covered services" the major sources of catastrophic health expenses for the elderly-long term (nursing) care,prescription drugs, eyeglasses, hearing aids, etc. Like other catastrophic national health insurance proposals, this provision would only intensify the already significant statutory bias of the Medicare system toward episodic, acute care and the institutional mode of treatment.

The success of efforts to promote competiton in the health care industry depend on a willingness to question long-standing beliefs about about the health care sector. Reform of the health care financing system is basic to any meaningful, long-range containment of health costs. A vital part of such system reform will have to be a combination of government legislative and regulatory action aimed at promoting cost restraint on the part of hospitals and physicians. Negotiated fee schedules and prospective reimbursement are two widely discussed actions our Associations support. Finally, efforts such as S. 1968 to restrain the demand for health care services and thus expenditures need to be complimented by similar public and private efforts to reverse those perverse economic incentives which have caused an uncontrolled expansion in the supply of medical facilities and manpower.

Health care cost containment is a matter of great concern to our nation's elderly. Recent surveys of our Associations' membership have clearly indicated that inflation is the number one concern of older Americans. In fact, nearly 80 percent of our volunteer leaders have voiced strong preference for legislation specifically designed to curb inflation over legislation designed to expand benefits to offset the effects of inflation. Within this context perhaps the greatest outpouring of support has been for immediate and effective legislative remedies to deal with rapidly escalating health care costs and to develop some semblance of competition in the health care marketplace. Given the federal government's role as a massive purchaser of health care services, our Associations feel that efforts toward a more responsible fiscal policy and balanced budget must incorporate strong and effective legislation aimed at this unique sector of our economy. We strongly believe that without immediate and effective legislative remedies to contain spiralling health care costs neither meaningful benefits expansion in our public health insurance programs nor national health insurance in any form can or should be undertaken.

Overview - Health Care Costs

As this Subcommittee well knows, the burden of health care cost inflation falls disproportionately upon the elderly, who while accounting for 11.2 percent of our population, represent 29 percent of our nation's total health care expenditures. Since older Americans in failing health utilize the health care system to a greater extent, the availability, affordability and accessibility of quality health care services is especially important to this segment of our population. While longer life has truly been one of our society's most conspicuous accomplishments, when combined with declining birth rates this accomplishment inevitably leads to a rapid growth in the number of older Americans and a greatly increased demand upon our health care delivery system. By the year 2025 the portion of our total population over the age of 65 will increase from 11.2 percent (1980) to 17.2 percent (or 50 million people).

Simply stated, we believe that there are two primary obstacles to promoting improvements in the health status of our nation. The first is the belief that all needed levels of care can be supplied through the present medical system. The second is rapidly escalating medical care costs and our country's limited resources. For the elderly, as well as many other of our citizens, those health services that are presently available are often overlapping, confusing,

fragmented and unevenly distributed.

In comparison, the costs of health care are sharply increasing, adding to the general rate of inflation and threatening the stability of government budgets. The nation's health spending is projected to increase from $206 billion in 1979 to approximately $393 billion in 1984 -- up from 9.1 to 10.2 percent of our Gross National Product (GNP) for these years. Federal health care expenditures (tied as they are to increases in the price of health care services), if unchecked, will also continue to escalate from $62.4 billion in FY 1981 to over $110 billion by FY 1984 -- or more than 15 cents out of every Federal tax dollar for that year (under current law projections and without hospital cost containment legislation). For individual health care needs, costs will also rise precipitously. Without strong and effective cost containment measures, the average annual health care costs of a family of four will jump from $2,373 in 1979 to $4,064 in 1984. During the same time period, the cost for a single aged person will rise from $2,259 to $3,868 per year.

The per capita health bill for persons 65 and over was approximately 3-1/2 times that for persons under the age of 65 in 1979. While Medicare was designed to pay 80 percent of the elderly's hospital and physician costs, in 1977 it covered only 73 percent of the former and only 55 percent of the latter. The results of this, plus escalating costs for other needed services such as nursing home care, drugs, dental care and eyeglasses (which are uncovered or inadequately covered) are that older Americans are spending more out-of-pocket for health

care today than they did before the inception of Medicare and that Medicare is presently covering only 38 percent of the elderly's total health care bill (when beneficiary deductibles and cost sharing are considered). A full 35 percent of the average health bill of an older American is now paid for out-of-pocket[1/]. Only 6 percent of per capita expenditures are covered by private health insurance. Clearly, increasing health care costs and diminishing benefits are constricting the elderly's access to needed health services.

Our Associations are very troubled by the bias of the Medicare system toward acute, espisodic and institutional (hospital) based health care . . . often at the expense of effective programs of health prevention, health maintenance and ambulatory services. In this regard we would note that a full 68 percent of all money spent on health care for the elderly in FY 1976 was spent on hospital and nursing home care and that by 1978 this percentage had risen to 76 percent. Quite clearly, catastrophic-only type health plans merely serve to reinforce the bias present in our Medicare/ Medicaid system while perpetuating and broadening its impact. We do not

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[1/] In 1977 older Americans were personally responsible for 98 percent of their total expenditures for eyeglasses, 94.5 percent of their dentists' fees, 86 percent of their drugs, 51 percent of their nursing home costs, plus other professional and health services

feel that it is advisable public policy to only provide protection against catastrophic (hospital) expenses and thereby "create" additional demand for these services, and coincidentally fill many of our presently empty hospital beds. To the contrary, the premise we work from is that Medicare is far from a model or exemplary public health care program and in fact it may be preferable to work towards improving the current program before replicating it in any fashion on a widespread basis.

The most serious benefit gap contained within legislative proposals purporting to provide protection against catastrophic health care expenses is the exclusion of skilled nursing home care -- the catastrophic health expense for the aged -- from the list of covered services subject to an expenditure ceiling. The non-coverage of long-term care services makes these so-called "catastrophic" plans somewhat of a mirage for a large number of elderly Americans. The lack of a well-designed long-term care system encompassing both health and social services in nursing facilities, the community as well as the home is without question the greatest deficiency in the present health care delivery structure. Plans providing catastrophic protection against inordinate expenditures for Medicare "covered services" only serve to perpetuate this deficiency at the very time that long-term care program costs are being driven up by high rates of inflation, emerging demographic trends and increased utilization of services.

Rising resource intensity in health care services is clearly a primary cause of health care cost inflation. Yet, our Associations question whether improvements in the health status of our citizens are commensurate with gains to be expected from this increased allocation of resources. We contend that a greater level of productivity from increasingly scarce resrouces can only come about as a result of a comprehensive series of structural and system reforms. Briefly, we see the causes of this rising resource intensity to be: (1) federal tax subsidies which provide open-ended financial support for the purchase of more extensive insurance; (2) third-party, cost-plus reimbursement of physicians and hospitals which provide incentives to overuse health services; and (3) the absence of an environment in which alternative health care delivery systems can effectively compete. These factors are hardly exclusive of one another. The health care cost inflation problem is a vicious circle of practices, such as those cited above, each driving the cost escalation problem and in turn being reinforced by these same sharply escalating costs and charges.

A number of legislative proposals similar to S. 1968 have advocated greater cost sharing by patients as a mechanism for controlling health costs. We believe that such an approach, while undoubtedly effective in reducing the demand for services, could be shortsighted. There is some question as to whether health services foregone would largely take the form of wasteful, excessive and unnecessary care or needed, preventive type care. We believe

that it is likely that such cost sharing would primarily reduce demand for (and access to) outpatient, Part B (Medicare) type services and that excessive reliance on copayments to reduce demand is obviously shortsighted to the extent that denying (or deferring) significant portions of the population regular access to health maintenance and preventive care leads to more than compensatory increases in other, more costly types of care (e.g. inpatient hospitalization).[2/]

On a broader policy level, our Associations do not view regulation "a priori" as a bad approach to the problem of rising health care costs. Quite to the contrary, with the health care industry being insulated from the normal forces of supply and demand by cost-plus, third-party reimbursement and government subsidies of supply and demand, regulation can and should be relied upon to alter the incentives driving providers and to curb their voracious appetite for an even greater share of our nation's increasingly limited resources. The goal of such regulation should be system or structural change and not merely price fixing. In this respect, our Associations are supportive of efforts such as the President's hospital cost containment legislation (S. 570) which would impose a cap on poorly performing hospitals while allowing them some flexibility in meeting cost containment goals. Performance standards, where possible, are preferrable to detailed and inflexible regulation.

2/ For evidence of the shortsighted effects of excessive reliance on copayments see: Jay Helms, Joseph P. Newhouse and Charles E. Phelps, "Copayments and the Demand for Medical Care: The California Medicaid Experience", Bell Journal of Economics, Vo. 9 No. 1 (Spring 1978).

Developing Competition in the Health Care Marketplace

As we have noted, the health care industry and marketplace is unique. The physician, acting as a purchasing agent for the consumer of medical services, effectively renders economic theory of consumer demand all but useless in assessing the problem of rapidly escalating health care costs and market failure.

Since Medicare began, health spending has increased at an average rate of 12.2 percent per year while the conomy as a whole has expanded at an annual rate of 9 percent. This rapid growth has been fueled by the expansion of the third-party, cost-plus reimbursement system and by government's subsidizing both the demand and supply sides of this growth. By 1978, third-party payments accounted for slightly over two-thirds of personal health care expenditures, 91 percent of hospital expenditures and 65 percent of expenditures for physician services. Government subsidy of the demand side has taken place largely through the tax laws which encourage first-dollar, broad-based insurance coverage. Government has subsidized the supply side (and hospital expansion) through the Hill-Burton program and by the tax exemption of hospital construction bonds.

Subsidies to increase the supply of medical facilities and services were expected to moderate costs for health care. However, the third-party payment system has made the patient indifferent to cost, except the part for which he is responsible. Consequently, there is little restraint on the rate of increase in provider charges or the rate of increase in the costs they incur. Third-party payers reimburse hospitals for virtually all costs incurred

and cover much of the fees charged by physicians and other professionals. In addition, we have already noted doctors tend to overutilize hospitals, the most expensive component of the medical care system. This overutilization is in turn promoted by the third-party payment system which tends to cover hospital services but not less costly, ambulatory services.

Government subsidies of the demand for and supply of medical services has profound cost implications. Federal tax law currently provides $16 billion per year in assistance to the nonaged and nonpoor toward the purchase of medical care. The tax structure permits (1) the exclusion of employer contributions for health insurance premiums or other medical payments for employees from taxable income and (2) the deduction of certain medical expenses from adjusted gross income on individual income tax returns. Yet these provisions entail tax expenditures (revenue losses) only to the federal government. There are further annual tax expenditure costs to States (with income taxes) of approximately $3 billion and reduced social security tax revenues of another $6 billion per year. In total, Federal and State revenues are reduced by about $25 billion in 1980 as a result of special tax treatment.

Numerous legislative proposals have been advanced in this Congress which aim to raise the consciousness of the health care consumer to increasing health care costs and give the consumer a greater degree of discretion in the purchase decision. There are a number of problems, however, with any legislative proposal (such as S. 1968) which would make the employee's choice

of a health plan critical and which assumes that Americans can be effective purchasers of health care. The first of these grows out of recent experience which dictates that Americans deeply fear medical bills and prefer paying predictable, fixed amounts -- even if they do not use the benefits. This is exemplified by the Medicare program, where in 1978 a total of 15 million elderly Americans spent nearly $4 billion for 19 million policies to supplement their cost-sharing obligations. Also, experience with the Federal Employees Health Benefit Program clearly points out that younger as well as older workers are quite willing to pay high premiums for high-option, first-dollar coverage to avoid paying significant medical costs out-of-pocket. In fact, HEW has noted that the majority of its "younger" employees still choose the more costly, high option plans which pay for more services and have lower deductibles. Contrary to what some economists who are proponents of pro-competition, consumer incentive plans would have us believe, purchasing health care is most unlike purchasing any other commodity since the consumer is seldom involved in deciding on either the form or the duration of the purchased service. It is still the physician who makes over 70 percent of all cost decisions while the third-party reimbursement system insulates both the patient and the physician from most of the normal supply, demand and cost decisions. Understandably, very few patients, especially older patients, feel qualified to challenge the physician's decision -- especially in cases of major, costly illness. In addition, reliance on market forces to distribute health services could further

exacerbate the already very serious problem of the maldistribution of physicians and other health care professionals.

Perhaps the biggest problem with the consumer choice, competition model is that for it to be a viable alternative to a more regulatory-intensive approach requires a significant shift in national attitudes toward health insurance. Right or wrong, the nearly universal perception is a need for insurance (protection) before one becomes poor and not after.

At first glance, providing all Americans with catastrophic coverage through prerequisites for favorable tax treatment for health insurance plans is most attractive. However, in the long run this will not alter the retrospective, cost-based reimbursement system which is the crux of the problem and which is in need of radical reform. It will instead only add momentum to the institutional, high-technology hospital setting as primary health care provider (with its attendant cost escalating implications). For the consumer choice model to be a viable alternative, moreover, consumers must have accurate, comparative information on the performance, quality and cost of different service providers. Data from Professional Standards Review Organizations (PSRO's) is most important in this regard.

Our Associations would be supportive of efforts to combine a cap on special tax treatment of employee health plans with strong cost containment measures and minimum federal standards requiring a multiple choice of health plans to encourage competition.

In this respect, we believe that proposals like the Health Incentives Reform Act should further require that, where available as an option, Health Maintenance Organizations (HMO's) be included as one of at least three health plan options. Only by encouraging the development of alternative delivery systems such as HMO's can we begin to implement necessary system and structural changes in our health care system. Indeed, while the 1973 Health Maintenance Organization Act officially marked the beginning of a favorable turn in federal policy toward the development of HMO's, many observers believe this legislation was drawn much too narrowly and may in fact represent the chief barrier to HMO development. Evidence of this is seen in the very high minimum standards of comprehensiveness of insured services, which in some cases exceed those typically contained in private health insurance policies. At best, current policy seems to offer HMO's as an occasional alternative to a dominant system.

The Health Incentives Reform Act (S. 1968)

Senator Durenberger's bill would amend the Internal Revenue Code to limit the amount of an employer's contribution to an employee's health benefits plan that could be considered tax-free to the employee. Employers with more than 100 employees covered under a health plan would face certain minimum requirements in order for any portion of the employer's contribution to such a plan

to remain nontaxable to the employee. Such requirements would include that there be offered to all employees at least three plan options meeting the following requirements: (1) continued coverage (and employer contribution) for at least 30 days following employee separation from employment and the option to continue group coverage for an additional 180 days; (2) family coverage for the employee; (3) minimum benefits at least equal to the same range of services covered under Medicare, though deductibles, copayments and requirements for patronage of specified providers could vary; and (4) a catastrophic benefit in each plan providing payment for 100 percent of the cost of services after a covered individual or family incurred $3,500 in expenses for covered services not otherwise reimbursable during any calendar year. The amount of the employer's contribution would have to be the same for all employees regardless of the option the employee choses. The limitation on the employer contribution for 1980 would be $125 for a family group, $100 for an employee and his spouse and $50 for a single employee - all indexed to the CPI (medical care component). If the employee selected an option of lower cost to his employer than the standard contribution, the employee would be entitled to a cash rebate or other form of compensation. Cash rebates would be taxable to the employee as income. And the Secretary of the Treasury would determine whether employer health plans or options met the criteria of the bill for favorable tax treatment.

S. 1968, therefore, is intended to foster competition by expanding the range of consumer choices in purchasing health insurance. Government is to assure competition (in terms of both cost and quality) by seeing to it that consumers have the freedom to make choices while at the same time assuring protection against "catastrophic" health costs and providing for continuity of coverage. To the extent that S. 1968 encourages employees to change from extensive, first-dollar coverage to conventional plans with more cost sharing S. 1968 does not compliment those comprehensive and universal national health insurance proposals offered to date. There is one area of overlap however in the requirement that premiums provide a certain level (i.e. $3,500/year) of catastrophic protection (in order to obtain favorable tax treatment).

Whereas the Health Incentives Reform Act supports and promotes such laudable objectives as greater cost consciousness on the part of employees and a greater degree of competition among insurance plans, it would in reality only affect that part of the workforce currently receiving rather broad benefits through their employer-sponsored health plan. Those that are currently unprotected, underprotected and unemployed would not be helped. Moreover, a single national dollar "trigger" amount fails to account for significant regional differences in the cost of medical care and such factors as anticipated utilization and geographic differences in the cost of service delivery. More importantly, placing the "trigger" point

so close to current actual costs may in fact reduce employer concern about health care costs -- even if this premium cap ($125 in 1980 for family coverage) is indexed. Too often the rhetoric of raising consumer or patient cost consciousness overshadows an equal if not greater need to raise the cost consciousness of employers and especially health care providers. Indeed, the goals of S. 1968 are most limited to the extent that this proposal ignores the primary reality of the medical care system, that it is the physician who controls the demand for medical care services and therefore fuels the inflationary cost spiral. Fiscal controls must therefore be placed on the physician as well as the patient if any real progress is to be made in controlling health care costs.

Finally, while our Associations can conceptually support minimum standards for employer plans, limits on out-of-pocket expenditures, continuity of coverage provisions and equity in employer contributions to employee health plans, we find the catastrophic protection provisions of S. 1968 most objectionable. The $3,500 limit on out-of-pocket expenses first of all only includes expenses for "covered" services (sect. 2(b)(1)) or the Medicare benefits package. Not only is this limit for an elderly individual extremely high for this segment of our population (many of whom are on fixed incomes with inordinate expenses for such necessities as energy, housing and food as well as health care), but this cap is for covered services only. Not included would be such health care expenses as skilled or custodial nursing care (the major source of catastrophic health expenses for

the elderly), physical examinations, eyeglasses, hearing aids and outpatient prescription drugs. Yet even this limit is subject to upward adjustment for employers offering plans meeting all other requirements except the $3,500 deductible (sect. 2(i)(5)). This provision clearly highlights the statutory bias of the Medicare system and the general health care delivery system toward episodic acute care and insitutionalization which we find most objectionable.

Conclusions and Recommendations

Many aspects of S. 1968 are at first glance attractive when isolated from the remainder of the bill. On balance, the Health Incentives Reform Act would likely encourage a greater degree of competition among health plans based on the quality and comprehensiveness of care and cost, but its impact would seemingly be limited to situations where relatively large employers offer only one type of health plan which currently provides a rather broad range of benefits. It would have at best only a marginal impact on the millions of employees working for small employers and would do little to protect those individuals who are currently unemployed and/or without any form of health insurance protection. Moreover, we would question whether this proposal will actually expand consumer choice and effectively instill a greater degree of cost consciousness - given the rather limited ability of most consumers to adequately judge the appropriateness and cost effectiveness of competing plans.

In essence, we would warn against the dangers of overselling the potential short term impact of such consumer choice, pro-competition proposals. While many aspects of the organization, financing and delivery of health services are amenable to the infusion of competition, this uniquely non-competitive sector of our economy is not likely to be transformed overnight into a free market, nor should it. Indeed the challenge is to learn how best to use competition along with necessary government regulation to achieve a much more efficient allocation of our health care resources, without abondoning commitments to equity, access, affordability and quality in the delivery of health services. The success of efforts to encourage competition depend on a willingness to question long-standing beliefs about the health care sector. In this regard, our Associations take exception to those who claim that the growth of alternative delivery systems (e.g. HMO's) and increased information on the price as well as availability of services would lead to an overall decline in the quality of care. Quite to the contrary, consumers are much better protected from high-priced, inferior providers in choosing among health care options when they are well informed as to the comparative cost and performance records of health care practitioners.

We are troubled by the basic premise upon which S. 1968 is constructed -- that some degree of cost containment can be achieved by limiting special tax treatment for employer offered health plans

to benefit plans with mutliple competitive options and provisions covering employees against catastrohpic health expenditures. We are concerned that any cost moderating effects from requiring a multiple choice of plans on the part of larger employers will be more than compensated for by the cost escalating effects of further institutionalizing the hospital-based, acute care bias of the Medicare benefits structure. In determining the range of "covered services" to be included under the $3,500 out-of-pocket threshold S. 1968 has provided further impetus toward high-cost, institutional care as the primary service delivery mode at the expense of outpatient health maintenance and preventive services (e.g. home health care). If such an approach is adopted at all, a percentage of income limit seems much more appropriate for the elderly than such a relatively high and absolute level of cost sharing.

Furthermore, as we have noted, this bill is very limited in its focus on health care cost containment. Reform of the health care financing system is basic to any meaningful long range containment of health care costs. We strongly belive that a vital part of such system reform will have to be legislative and regulatory actions on the part of government to promote restraint on the part of hospitals and physicians in the rate of increase in charges. Negotiated fee schedules and prospective reimbursement are two widely recognized approaches that are supported by our Associations as well as numerous other consumers and health care experts.

While enactment of legislation such as S. 1968 will likely moderate the demand for comprehensive, first-dollar coverage among certain groups in certain areas of the country, to effectively constrain the rate of increase in health care costs also requires a reversal of the perverse economic incentives which have caused an uncontrolled expansion in the supply of medical facilities. To constrain this expansion and more appropriately allocate resources we believe requires (1) a phase-out of tax breaks that promote the expansion of hospitals (and result in significant revenue losses) (2) subsidizing only the training of those health professionals who agree to work in underserved areas and (3) limiting the current blanket tax deduction for medical insurance premiums by requiring as a prerequisite for special tax treatment multiple insurance options including at least one pre-paid plan or Health Maintenance Organization (HMO) -- if available.

While the certificate-of-need program and the health planning process has been somewhat successful in shifting hospital investment away from new beds, this capital has gone into other types of hospital-related facilities and costly, high-technology equipment in many instances. Therefore, the composition but not the rate of increase in hospital costs has been affected. This trend we believe would only be intensified by a catastrophic health

insurance package. A national limit on annual hospital capital investment seems to us necessary in order to force local planning agencies to more closely evaluate the trade-offs among various proposals.

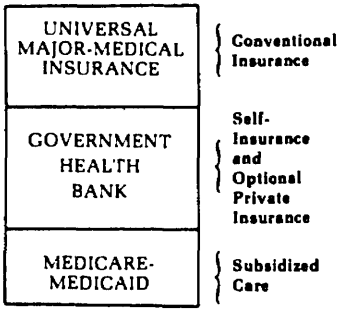
In summary, government should establish a limit on the resources it will commit to medical care and assume responsibility for allocating those resources. The current system allows, even encourages hospitals and physicians to set their own revenue targets and income. This should be replaced by a system in which providers and government negotiate acceptable levels of payment for services rendered. In this respect, payment and regulatory policy must apply equally to all purchasers of medical care, private as well as public.

STATEMENT OF COMMITTEE FOR A FEDERAL HEALTH BANK

AN AFFORDABLE PROPOSAL FOR MEETING HEALTH NEEDS NOW

This concept revolves around a three tier system of health financing developed with the chartering of a special purpose health bank, either state or federal. Such a government health bank will fill the gap between universal Major Medical Insurance and subsidized health care. This includes all routine health expenses and occurances below the deductible amount of Major-Medical. The greatest benefits are aimed at the group just above the poverty level who do not qualify for subsidized care.

At the heart of the plan is the utilization of our already existing withholding system. The collection of health dollars on a routine basis in anticipation of health expenses will have the same dramatic results as when the withholding system was first designed for the collection of tax dollars. Depositors pay their providers directly by executing drafts against their own accounts. They control their own costs, buy whatever insurance they choose, utilizing automatic loans when needed. In effect they manage an interest-free revolving health account.



Many more health dollars can be collected as a deposit than as a tax. A bank of this size (over 200 billion if federally chartered) will serve as a buffer for differences in sickness frequency, and as a buffer for differences in economic resources. In addition, the bank provides a means for financing major-medical insurance for those who lack such coverage.

Many questions come to mind. We will give our opinions as to how they should be handled. Regardless of how the framers of the Legislation ultimately decide on these issues, the concept of the bank will work to bring improved health care to our population.

Should deposits be compulsory?

If deposits were voluntary, many who most need the benefits of participation might decline the opportunity; therefore, we favor compulsory deposits. However, considerable latitude will be allowed in the selection of amounts to be withheld.

How is the amount of the deposit determined?

We believe a range should be offered. Depositors choose an amount within that range. The lower end of the range would be the amount needed to cover the cost of major-medical insurance. Those who already have such coverage, privately or through their employment, will have a lower minimal figure applicable. The high end of the range should be set at a figure determined to be the most anyone should reasonably be expected to pay for health care. We have seen figures of eight to ten percent of income advanced by our health economists as a maximum. No matter what amount is selected by the depositor that amount should be adjusted from time to time to reflect actual use of providers services. This will serve as both deterrent for abuse of the system and as incentive for minimal use of the system. In other words, the more checks one writes, the more one has withheld from his wages. This is a natural and effective way of keeping costs down and avoiding waste.

Should interest be paid on monies accumulated?
Should interest be charged on negative balances?

Sound operation principles dictate that either both or neither type of interest payment should be made. We feel that interest-free loan privileges offset the receipt of interest, and to simplify operations and costs of the bank, we believe no interest should be paid or charged at the offset. Once the bank has been operational for some time, a fiscally sound approach to interest can be made. We believe it will prove fiscally sound to pay interest on those accounts which show no withdrawals for a one year period. Another factor that bears on interest is how the bank is permitted to invest its idle funds. We recommend a conservative approach to all these issues.

Who would be eligible to participate?

All employees who do not qualify for subsidized care should maintain health bank accounts. If the bank is state operated, qualification for participation should dove-tail precisely with that states' Medicaid eligibility provisions. It is probable that some cases will qualify partially for both systems; receiving limited subsidized care and meeting non-eligible expenses through health bank accounts. Others will move from one system to the other, as their wage earning capacity changes. If the bank were Federally chartered, qualifications for participation would be designed to dove-tail with Medicare qualifications, so that everyone would qualify for one system or the other.

When does Major Medical coverage take over from Health Bank usage?

This, of course, is determined by the deductible amount of the Major Medical coverage. Current thinking places this figure at $3,500.

Because employees will be accumulating health dollars on a regular basis, and because of automatic loan privileges, depositors will be able to meet more of their own health needs. They will be able to purchase more private health coverage. We expect, therefore, that a higher deductible amount will be feasible. This in turn will lower the cost of premiums for Major Medical coverage.

What will be the impact of this system on consumers?

The impact on the great majority of the population who are self supporting and have adequate health care will be no more than the inconvience of changing banks. If they choose to expand their private health insurance, the health will provide a convenient means of financing additional coverage.

Those who are having difficulty meeting health needs will have the benefit of averaging their health expenses into the smallest possible increments. They will enjoy whatever loan benefits the bank can provide. Many will be covered by Major Medical Insurance for the first time.

Perhaps the greatest benefit to all will be the avoidance of tax increases, and maintaining some control over how their health dollars are being spent.

Is this system fiscally sound?

A study of this plan by a group of high level bankers states "any collection program, whether it be for health care or otherwise, which is programmed with a payout level below that of income levels would obviously be fiscally sound." The bank would be chartered in such a manner as to guarantee this type of program.

What are the advantages of this system?

1. Taxes need not be raised.
2. Non-inflationary. Employers not forced into costly programs whose expenses they must pass on to consumers.
3. The bank will be self-supporting once it is operational.
4. Start up costs will be less than for National Health Insurance. IBM has estimated an equipment cost of 23 million. Total start up cost projected at 79 million.
5. Coverage is more extensive.
6. Third party involvement is held to its minimal cost efficient level.
7. More difficult for cheaters to beat the system, because they end up paying up to 10% of their income.
8. Promotes preventive care.
9. Built-in incentives for minimal use.
10. Preserves all our institutions of free choice of providers, free choice of insurance carriers, and control of the expenditures of our own health dollars.

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