Jennifer –

Here are our notes from last week's health care hearings conducted by the Senate Labor Committee.

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Hearing Summary: March 14, 15, Senate Committee on Labor and Human Resources, Hearing on Health Care Reform in the Changing Marketplace

Opening Statements (March 14): **Chair Kassebaum (R-KS)** described changes in health care financing and delivery that have taken place since 1987. In 1987, 28 million individuals received health care from HMOs. Today, 45 million persons are covered by HMOs. Also, the cost of providing health are has fallen 1.4% for all employers -- 1.9% for large employers. However, the Chair stated that she receives dozens of letters from those who cannot afford health insurance or who have been excluded due to preexisting conditions.

Senator Wellstone (D-MN) stated that in 1994 another 1.1 million Americans in working families lost coverage, with a disproportionate share being children. He commented that today we would hear from innovative employers, but noted that employer-based coverage has been declining since 1988 and is projected to only cover 52% of Americans by the year 2000.

Panel 1: Leonard Schaeffer, CEO, Blue Cross of Calif.; William Custer, Custer Economic Group.

Leonard Schaeffer testified that he was the Carter Administration's Administrator of HCFA and had experience in managed care. His testimony traced the history of managed care in America, beginning in the 1920's. He explained that when Congress created Medicare and Medicaid they followed the fee for service model which caused the cost of health care to rise. According to Mr. Schaeffer, this was because there was no reward for appropriate delivery of health care under those systems.

He testified that we have seen a 451% increase in health benefits provided to workers but only a 7% increase in wages since 1965. As a result, more and more companies have been providing less in wages. Some companies are turning to managed care which features utilization review, case management and coordinated design of financing and delivery to help keep costs down. Today about 65% of Americans receive health care through managed care -- 75% of Californians. Mr. Schaeffer recommended that we slowly begin making changes to Medicare and Medicaid to utilize more managed care.

Dr. Custer presented data illustrating the rising cost of health care, including the fact that since 1970 expenditures on health care have increased at an average annual rate of 11.6 % -- 2.9% faster than GDP. If current trends continue, by the year 2000 only 52% of Americans will have employer-provided health care and more than 50 million will be without coverage. He also testified that the rate of growth in expenditures has slowed in recent

years. Much of that moderation can be explained, according to Dr. Custer, by past decreases in real personal income. The implication is that costs will rebound in future years in response to increasing personal income. CBO, HCFA, and private researchers all project health care cost increases in the coming years, according to Dr. Custer. He also testified that the health care delivery system has changed in response to an increase in costs, and while more American are covered by HMOs, the evolution of health care delivery still has a long way to go.

Questions and Answers: Panel 1

Senator Frist (R-Tenn) asked whether the shift to managed care represents a one-time savings. Mr. Schaeffer testified that it was not and explained that over time large savings will result as more and more consumers develop relationships with providers and seek preventative care. He also stated that health care delivery was essentially a local issue, but because local conditions vary, the federal government must set standards.

Senator Frist also asked whether academic health centers will suffer due to managed care. Mr. Schaeffer stated that traditional fee-for-service arrangements have funded academic research centers, but the system cannot afford it any more. He testified that we need to formulate a policy on whether we want to still lead in research and if so, how to pay for it. He recommended that research be funded separately from health care delivery.

Senator Wellstone (D-MN) stated that over 50 million Americans will be without health insurance by the year 2000. He asked what steps the government should take to address the lack of coverage. Dr. Custer stated that the choice was to either subsidize the system or to require an employer mandate. Senator Wellstone asked about the impact that cuts in public health care programs would have on the system. Dr. Custer testified that cuts in public programs would reduce access to health care. Senate Wellstone noted the irony that during last year's health care debates the Clinton plan was criticized for causing rationing, whereas, anticipated GOP cuts in public plans, would now cause rationing. Mr. Schaeffer explained that if the public plans moved to managed care, that would not mean less access to care.

Senator Jeffords (R-VT) asked whether all types of delivery systems can be regulated similarly. Mr. Schaeffer testified that since families buy health care based on need, the government should not regulate the product, but should instead regulate the market. For example, young families often want HMOs because of their high utilization and need market protection..
Senate Jeffords stated that he was concerned that the old, sick and the poor would become segmented into public plans. He asked what impact that would have on health care. Dr. Custer testified that the solution was to have large pools of consumers to spread

risk. Mr. Schaeffer stated that products have been designed in California that have lowered the costs for the old and elderly. He testified that the market can be encouraged to compete for these risks.

Senator Dodd (D-CT) noted that of the 41 million uninsured, 11 million are children. He stated that the GAO found that for uninsured children, 89% of their parents work, and that 61% work full-time. He stated that Medicaid has covered a large portion of children who would otherwise be uninsured, and that Medicaid cuts would increase the number of uninsured children.

Senator Dodd asked the panel about continuation of academic health centers. Dr. Custer stated that the system used hidden subsidies to support academics and that now was the time to make the funding explicit. Mr. Schaeffer stated that it was a policy decision. With respect to coverage of children, he commented that children were easy to cover because they tend to be healthy and that California covers children for about $400 per year.

Senator Abraham (R-Mich) asked how much money will be saved by moving to block grants with respect to Medicaid. Mr. Schaeffer testified that Medicaid is a cumbersome program because of the local administration and federal oversight. He commented that bureaucratic fears of being out of compliance with the program caused it to be inefficient, e.g., people are afraid to be innovative. He stated that streamlining might help.

Chair Kassebaum stated that the Committee would look at the issue of academic health centers. She asked if dividing Medicaid by giving AFDC to the states, but keeping SSI federal, would help. Mr. Schaeffer stated that the real problem was that authority and accountability were spread around which creates tension and friction. He urged that Medicaid be transformed into something like the MediCal plan which is user friendly and provides services to about 34,000 persons.

Panel 2: Managed Care and Barriers to Market Reform: Kathleen Angel, Digital Corp; Cristie Upshaw, Memphis Business Group on Health; Glenn Potter, Kansas University Medical Center; Dr. James Kimmey, St. Louis University

Kathleen Angel, Digital Corp, testified that she represents the Corporate Health Care Coalition, a group of 25 self-insured, multi-state companies that purchase health care. She testified on Digital's success in enrolling employees in managed care. Prior to 1991, 72 of employees were in fee-for-service plans and 85% were in HMOs. Today, 81% of employees are in HMOs and only 7% in fee-for-service, with 12% in a third plan. She credits ERISA with allowing the innovative solutions her members have created in order to ensure high-quality health care at a reasonable price. Changes to ERISA preemption, according to Ms. Angel, would stop this innovation.

Glenn Potter, Kansas University Medical Center, testified with respect to health reform measures undertaken in the private sector, including use of managed care (HMOs, PPOs) and the formation of provider networks. These changes, according to Mr. Potter, have slowed the growth of health care costs. He recommended that Congress consider: (1) modeling Medicare on the federal employees health plan (FEHBP); (2) providing incentives to Medicare beneficiaries to choose managed care options; (3) implementing insurance market reforms, and (4) enacting antitrust law reform to allow mergers of tax exempt hospitals.

Cristie Upshaw, Memphis Business Group on Health, testified that her group was formed by 11 employers in 1985 to address rising health care costs. Today, the group represents 54 companies with approximately 59,000 local employees and 147,500 covered lives. The group provides utilization and quality management services for health care services; psychiatric and substance abuse case management, and case management of worker's compensation. Member companies have experienced a decrease in length of hospital stays from 5.5 days in 1987 to 4.0 days in 1994 for all diagnoses and saved about $3,112,00. Ms. Upshaw urged the Committee to support models of health reform that will allow local, market driven solutions to continue.

Dr. Kimmey, VP, St. Louis University, testified on medical school training research. He explained that these institutions have historically depended on patient income to fund research. As providers evolve to managed care systems, hospitals have become leaner and must look to new sources of funding for their academic mission. He testified that we must develop a policy with respect to academic research hospitals.

Questions and Answers: Panel 2

Chair Kassebaum asked whether they agree ERISA preemption is beneficial. Ms. Angel testified that the ERISA umbrella is necessary because it allows plans to be flexible. She explained that Digital was restricted by the State of Massachusetts from establishing a PPO and had to apply to the state for a waiver. Ms. Travis explained that the Memphis group served workers in Arkansas, Tennessee and Missouri. She noted that a point of service option is only permitted for Tennessee residents because it is prohibited by the other states.

Senator Wellstone (D-MN) noted that the university of Minnesota's teaching hospital had cuts last year. Dr. Kimmey testified that the solution was to separate medical care from the research component.

Senator Ashcroft (R-MO) asked about promotion of healthy life styles. Mr. Potter stated that much has been done in that area by the life insurance industry, but that attempts to apply such rules to health insurance would "set groups off in opposition."

Opening Statements (Day 2): **Senator Jeffords (R-VT)** opened the hearing by stating that health care reform was a key to keeping the deficit under control. He also stated that the private and public health plans were linked -- changes to one affect the other. Senator Jeffords expressed concern that market segmentation was shifting the old, sick and poor to the public plans.

Senator Simon (D-IL) stated that by the year 2000, about one-fifth of all Americans will be without health insurance. He stressed the importance that health care costs play in balancing the budget. Senator Simon noted that the GOP has Senator Bennett, a freshman physician from Tennessee taking the lead on health care

Panel 1: Dr. Ellwood, Jackson Hole Group; Bill Gradison, Health Insurance Association of America; Dr. Diane Rowland, Kaiser Family Foundation

Dr. Ellwood, Jackson Hole Group, testified that despite the failure of the 103rd Congress, health care reform was moving ahead in the private sector. He stated that a draft discussion paper his group submitted to the Committee focused on those who have not shared in this improvement: small firms, the sick, and public plans. Four principles are outlined in the paper: (1) competition between health plans works. The paper cites the California public employee plan which experienced real premium reductions of 5.2 percent for 1995-1996; (2) Medicare, Medicaid, small businesses and individuals are not benefiting from competition; (3) the tax code should reward cost conscious purchasing of health plans, and (4) successful buyers of health care rely on the same four techniques: competition based on price and quality; purchasing as a large group; motivating consumers to be cost conscious, and providing comparative information on plans.

With respect to insurance reforms, he testified that proposals should include: guaranteed issue; renewability; limiting preexisting condition exclusions; continuity of coverage, and limited rating restrictions. Dr. Ellwood urged the Committee to consider allowing small groups to pool together under ERISA to purchase health care provided that they adhere to the same standards imposed on health insurers. He did not recommend that ERISA be amended to permit the states to tax plans.

Dr. Rowland, Kaiser Family Foundation, testified that 11 million children do not have health insurance, about 1 in 6. She stated that another 9 million would be without coverage but for the Medicaid expansion. She urged the Committee to protect the current Medicaid coverage of poor children, stating that cuts would increase the number of uninsured. Dr. Rowland stated that cuts in Medicaid cannot be offset by moving to managed care. She noted that it only costs about $1,000 to cover a child, but that

it costs about $8,000 to cover elderly beneficiaries.

Former Representative Bill Gradison, HIAA, testified that a HIAA survey found that 89% of Americans favor anti-fraud efforts; 85% favor allowing all workers to participate in a plan; 79% favor streamlining claims forms; 79% favor restricting preexisting condition exclusions; 73% favor limits on lawyers fees in malpractice suits. He testified that HIAA supports these reforms but commented that they could, however, increase the cost of health insurance.

With resect to small groups, Mr. Gradison testified that HIAA supported rating limitations for small groups. He testified that a balance could be achieved by directing carriers to establish rates within 25% of a community rate based on geography, family composition, age, gender and health behaviors. A 35% differential would apply to individual policies.

Questions and Answers: Panel 1

Senator Jeffords stated that with average incomes of $30,000, working Americans cannot afford individual policies costing $6,000/year. He asked what could be done to help the individual market. Mr. Gradison stated that unless there was a subsidy, insurers could not guarantee issue in the individual market. He cites COBRA experience as evidence that the individual market is a high cost group. Dr. Rowland responded that the answer was to reduce the cost of this coverage or to subsidize these individuals. Dr. Ellwood testified that tax credits might help this market.

Senator Jeffords stated that in the 1950's, during the Eisenhower Administration, the idea of creating a quasi-government corporation to spread poor health risks around was developed. Under that concept, according to Senator Jeffords, all plans would pay a premium to the corporation and would have poor risks covered, e.g. a system of re-insurance. Mr. Gradison noted that he helped work on that idea when he was with the Eisenhower Administration and recommended that the Committee pursue it. Mr. Gradison noted that the Clinton plan called for risk adjusting by April of 1995, but commented that it was hard to design. He stated that the State of New York has a similar, but different, mechanism in place. He commented that the public plans should also participate in the program so they stop shifting risks to the private sector. Dr. Ellwood stated that the proposed corporation cannot "be a dumping ground for bad risks" but stated that risk adjusting would help competition.

Senator Simon commented that the Clinton plan should have called for an income tax increase to pay for increased coverage, not a cigarette tax. He pointed to the inconsistencies that are being advanced in opposition to ERISA waivers for the states, arguing that if we are not going to have federal health care reform, it is unfair to stop the states from pursuing it. Noting declining

coverage rates, Senator Simon stated that he would only support leaving ERISA preemption intact if there was universal coverage.

Senator Frist (R-Tenn) stated that plans were competing on price, but commented that it was hard to measure quality. Dr. Ellwood testified that consumers do not have enough information to hold plans accountable and that purchasers of health care are calling for such measures. Senator First and Dr. Rowland proceeded to discuss reforms in Tennessee, a state that now insures 94% of its population with 25% of its population under managed care plans. Dr. Rowland stated that the real structural savings will not come from use of managed care because so much of the Medicare costs are in long-term care for the elderly. She stated that the results of the Tennessee reforms were mixed because the state still receives the same amount of federal payments.

In response to a question from Senator Wellstone, Dr. Ellwood stated that since the federal government purchased 38% of the health care in America, it should have a major say in reform. He commented that the government runs old-fashioned plans.

Senator Abraham (R-MI) and Mr. Gradison discussed portability features that have been part of many proposals. Mr. Gradison stated that while portability would help end job lock, it would not help in the situation where a covered worker moves to an employer that simply does not have a plan.

Senator Simon questioned the worth of guaranteed issue of coverage if the cost made it prohibitive. Mr. Gradison stated that HIAA supported limiting the premium differential for these policies to a 35% band.

Panel 2: History of ERISA and Its effect on State Efforts for Health Care Revisions; Frank Cummings, Lebouf, Lamb et al; Lee Greenfield, MN House of Representatives and the Reforming States Group

Lee Greenfield, MN House of Representatives, testified on behalf of the Reforming States Group (RSG), a group of 26 states that are leaders in health care reform. According to Mr. Greenfield, 47 states have enacted some form of small market reform. However, he testified that each state comes up against ERISA. He testified that the Minnesota 2% tax on gross health care receipts was challenged in court, but upheld by a federal judge that rejected the indirect economic impact argument only because the level of taxation was low. That decision is being appealed.

According to Mr. Greenfield, small market reforms have not worked, in part, because employers with good risks self-insure and then jump back into the small group market when their experience changes. Mr. Greenfield testified that the RSG supports allowing the states to move ahead, but at the same time allowing large interstate business to stay covered by ERISA and not be under different rules in each state. The federal

government should establish standards for miltistate plans. The federal government should also establish a mechanism by which states can meet the federal standards and then be free from further federal preemption. According to Mr. Greenfield, this approach would allow for a federal role in health reform, but would give states the flexibility to carry out health reform.

Frank Cummings testified that ERISA works well for health plans, that ERISA preemption should not be modified, but that some carefully targeted improvements may be worth considering. To support his argument, he cited that example of pre-ERISA litigation he was worked on involving the Packard pension plan. In this case, because the parties were from different jurisdictions there was no agreement on the law to be used. The judge advised the parties to settle the matter because the litigation would "go on forever." Mr. Cummings summarized ERISA's provisions applicable to health plans -- written plan document, named fiduciaries, annual reports, SPD, fiduciary provisions, etc. Mr. Cummings testified that Title I of ERISA has been a success, but that Title II was a failure because of the frequent tax law changes.

Mr. Cummings testified in support of HR 995. He stated that he supported the bill because it blocks state mandated benefits, anti-managed care laws, preserves the voluntary nature of the system, imposes no new taxes, and opens the door to MEWAs. He testified in support of the insurance market reform provisions in the bill and the formation of employer coalitions. ERISA waivers, according to Mr. Cummings, "are dangerous, unnecessary, and will not work."

Questions and Answers: Panel 2

Chair Kassebaum asked Mr. Greenfield to respond to Mr. Cummings' testimony. Mr. Greenfield stated that he was describing a framework whereby the federal government would set standards and the states would only have jurisdiction with resect to "in-state" plans and plans that did not conform to federal guidelines. Mr. Greenfield described the cost-shifting that occurs under current ERISA law when self-insured plans go bankrupt and leave workers without coverage for their bills.

Senator Jeffords asked Mr. Greenfield about the Minnesota 2% tax on gross receipts used to finance health reform. Mr. Greenfield explained that the funds were used to provide care to families that do not qualify for Medicaid, but whose income was less than 200% of poverty. He stated that although the law was upheld, they were also awaiting the Court's ruling in the Travelers case.

Senator Simon, noting that Mr. Cummings was an AA to Senator Javits, commented that Senator Javits would have wanted universal coverage. He asked Mr. Cummings who he was representing at the hearing. Mr. Cummings stated that he was representing only himself, not a client. [The rumor circulating at the hearing

was that he was representing a MEWA.] Senator Simon asked Mr. Cummings what he would do about the 41 million Americans without health insurance. Mr. Cummings stated that we need to facilitate the market. Senator Simon, noting the expected decline in employer coverage from 67% to 50% by the year 2000, stated that it was inconsistent to refuse federal reforms and then prevent the states from trying to enact reform. Senator Simon stated that he was not urging repeal of ERISA, but instead sought moderate change to help workers.

Senator Jeffords stated that ERISA set standards for pension plans, but not health plans. He introduced into the record a paper by Michael Gordon on the history of ERISA which states that the preemption language was added "at the 11th hour during the conference committee". He stated that the state's interest in health care was different than pensions. He also stated that while nothing should be done to impair multistate employers, something could be done to help with uncompensated care. Mr. Cummings stated that if there are going to be mandated benefits, it should be done at the federal level.

Senator Jeffords asked if the Committee should look at ERISA remedies under managed care arrangements. Mr. Cummings stated that the current remedies work and that punitive damages would be expensive. Mr. Greenfield stated that remedies under ERISA were poor and that it was too easy for self-insured plans to dump people. **Senator Wellstone** stated that he agreed with moving authority back to the states in this area.

Chair Kassebaum asked Mr. Cummings about benefit packages. Mr. Cummings testified that the market will dictate what the benefit package should be.

Panel 3: State-based Insurance Revisions and Barriers; Rick Curtis, Health Policy Solutions; Josephine Musser, NAIC, Insurance Commissioner of Wisconsin; Rick Smith, Association of Private Pension and Welfare Plans.

Richard Curtis, Health Policy Solutions, testified with respect to the need for rules in the small market. He explained that states regulate the market though insurance, but because of ERISA, self-insured plans are exempt from regulation. His testimony explained "cherry picking" , e.g., the way individual carriers selectively market and enroll individuals and groups. With resect to state reforms, he testified that partially insured entities were creative -- as soon as a state gets a handle on regulating them, a new problem will come up.

Josephine Musser, NAIC and Wisconsin Insurance Commissioner, testified that ERISA does not provide sufficient consumer protections to employees. She noted that her office was dedicated to consumer protection and handled 60,000 calls and 11,000 letters each year without litigation. She testified with resect to the harm brought about by fraudulent MEWAs, citing the

example of Mr. Zimmer who testified before the House Labor-Management Relations Committee in 1992 in support of MEWAs and subsequently pled guilty to fraud, according to a DOL March 9 press release. With respect to HR 995, Ms. Musser testified that the bill ties states hands in the area of small group reform and would be a step backwards. She testified that the bill's MEWA provisions would strip the states of their regulatory authority over MEWAs.

Ms. Musser also testified that consumers of ERISA plans and insured plans should be afforded the same protections. She stated that under HR 995 there would be disparity of treatment. According to Ms.Musser, the NAIC is also concerned that HR 995 would expand staff leasing arrangements under ERISA.

Richard Smith, APPWP, testified in opposition to state waivers from ERISA. According to Mr. Smith, many workers would lose health coverage if ERISA preemption were amended because employers would not pay the increased costs attributable to state regulation.

Questions and Answers: Panel 4

Chair Kassebaum asked **Ms. Musser** about solvency standards for self-insured plans. Ms. Musser stated that standards were needed because there is no guarantee fund covering these plans and when employers go bankrupt, workers lose benefits. Ms. Musser stated that self-insured plans should set funds aside to pay claims. Chair Kassebaum asked whether Wisconsin had community rating. Ms Musser stated that Wisconsin has rate banding which limits the amount of a premium that can be based on experience.

Mr. Smith stated that required capital reserves are a bad idea and that the current tax code would not permit it. Those funds should be invested into the company's productivity, according to Mr. Smith. Ms. Musser stated that the NAIC has worked with the states to develop solvency standards for self-insured plans.

TESTIMONY
OF THE
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
BEFORE THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
OF THE UNITED STATES SENATE

Josephine Musser
Recording Secretary, NAIC
Commissioner, Office of the Commissioner of Insurance
State of Wisconsin

March 15, 1995

Introduction

Good morning Madame Chairwoman and members of the Committee, my name is Josephine Musser. I am the Recording Secretary of the National Association of Insurance Commissioners (NAIC) and Commissioner of Insurance for the State of Wisconsin.

The NAIC is the nation's oldest association of state public officials, composed of the chief insurance regulators of the fifty states, the District of Columbia, and four U.S. territories. On behalf of the NAIC, I would like to thank you for providing me with the opportunity to address you this morning at this hearing on "Effective Health Care Reform in A Changing Marketplace." My testimony today will focus upon the experiences of consumers and the state insurance departments with the federal Employee Retirement and Income Security Act, also know as "ERISA."

I have recently learned that, in testifying before you, I am continuing a tradition within my state of testifying before this Committee on the topic of ERISA and consumer protections. In fact, just over twenty years ago, a predecessor of mine, Commissioner DuRose, then Commissioner of Insurance for the State of Wisconsin, testified before the U.S. Senate Committee on Labor and Public Welfare (as this Committee then was named) regarding some concerns he had with the then-proposed ERISA bill. He observed that it was a "grievous derogation of consumer protection" that the bill preempted state regulatory authority with respect to employee welfare plans without providing comparable substitute regulation at the federal level. See Hearings before the Subcommittee on Labor of the Committee on Labor and Public Welfare, United States Senate, 92d Congress, Second Session, on S. 3598, at 740. I am before you today to reiterate my predecessor's concerns. Now, over twenty years after the enactment of ERISA, and at a time when an ever-increasing number of Americans receive their health care coverage through ERISA-governed arrangements, many important consumer protections are still missing from the statute.

As you know, ERISA is a complex statute with broad applicability to the regulation of employee benefit plans in both the pension and health plan areas. Indeed, ERISA has established many needed protections for beneficiaries of employee benefit plans -- particularly pension plans. However, ERISA provides inadequate protections to employees who receive their health benefits through health plans governed by ERISA. Today, I will address what state regulators believe to be the shortcomings in ERISA's

regulation of employee health benefit plans. I also will raise issues which this committee is likely to confront as Congress examines certain health reform proposals.

The state insurance regulators believe that health care consumers who receive their health benefits through health plans governed by ERISA deserve heightened protection in several areas. First, all consumers of health care coverage should have the benefits of enhanced "portability" and a reduction in the use of exclusions and rate hikes based upon an individual's or group's health status. Thus, insurance reforms should be made applicable to all types of health plans, whether they are governed at the state or federal level. Federal proposals must be careful not to grant exemptions from certain reforms or regulations for multiple employer welfare arrangements (MEWAs). Such a proposal could foster fraud and undercut the success of insurance reforms.

Second, employees should be provided with a low cost, accessible, and meaningful way to address complaints they may have with either the administration or benefits provided through their health plan. Third, employees have a right to have the terms of their health plan disclosed to them in a clear and understandable fashion and to be assured that the plan will abide by these terms. Fourth, all ERISA health plans should be subject to requirements which assure that the plans solvent -- that is, that the plans are able to provide the benefits promised to beneficiaries. Finally, all health plans should be required to conform to quality control measures and report uniform data relating to the services provided to their beneficiaries. Such requirements will assure that consumers are provided with quality health care. In addition, in these days of spiraling health care costs, data collection concerning these plans will enable policymakers to understand where health care dollars are being spent so that they can work to control overall health care costs.

Background: ERISA and the Governance of Employer Health Plans

Admirably, the overarching and express purpose of ERISA is the protection of beneficiaries of employer-sponsored benefit plans. The preamble to the statute states that the statute seeks to protect:

> the **interests of participants in employee benefit plans and their beneficiaries**, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by

> establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and **by providing for appropriate remedies**, sanctions and ready access to the federal courts.

29 U.S.C. § 1001(b) (emphasis added). Importantly, employer health plans governed by ERISA are not excluded from this purpose. Thus, the statute seeks to protect the interests of beneficiaries of all employee benefit plans governed by ERISA -- including health plan beneficiaries.

However, many important consumer protections were omitted from the portion of ERISA governing health plans. In fact, the provisions in ERISA relating to health benefit plans only make up a small portion of the statute itself. Twenty years after the enactment of this statute, consumers continue to experience the detrimental effects of this imbalance.

ERISA currently contains sweeping language which preempts many state laws which would otherwise govern employer-sponsored health plans. ERISA preempts state laws "insofar as they may now or hereafter relate to any employee benefit plan...." 29 U.S.C. § 1144(a). The statute exempts state laws regulating insurance from this preemption. However, twenty years and many court decisions later, the one thing that is clear from this statute is that this preemption language is both far-reaching and confusing. Thus, in addition to the gaps in consumer protections under ERISA, there has been great uncertainty regarding its interpretation. The scope of ERISA's preemption and the lack of clarity in the statute has had a "chilling effect" on certain state-level health reform activity.

For the purpose of this testimony, I will call all health plans governed by ERISA "ERISA health plans." However, it is important to note that the nature of the federal requirements, and the extent to which the plan is subject to certain state laws, depends upon the specific structure of the plan. For example, different requirements apply to single employer-sponsored plans, as opposed to those formed pursuant to collective bargaining agreements. Furthermore, if an employer chooses to provide his or her employees with "insured coverage," the substance of that coverage and the solvency of the plan is regulated by the states. Whereas if an employer "self-funds" the coverage, the regulation of the plan, to the extent to which such regulation takes place, is entirely at the federal level. In either event, however, a broad array of elements of such plans are regulated by ERISA.

ERISA has had a huge impact upon the delivery of health care coverage in this country. A recent study by the General Accounting Office in 1993 estimated that only 24% of Americans received their health coverage through insured plans governed by the states. Health Insurance Regulation: Wide Variation in States' Authority, Oversight and Resources, GAO/HRD-94-26, December 27, 1993. That means that the remaining portion of the American public that has health care coverage receives this coverage through plans governed by ERISA—or through Medicare and Medicaid and other public programs. The growing portion of the population which is receiving its coverage through ERISA-governed arrangements makes it all the more important that Congress ensure that beneficiaries of ERISA health plans are accorded meaningful protections with regard to this coverage.

I will address several areas in which existing consumer protections within ERISA are insufficient. I also will comment upon the "ERISA Targeted Health Insurance Reform Act of 1995," H.R. 995, recently introduced by Representative Harris W. Fawell (R-Ill.). I am addressing this bill because it is one of the more significant health-related proposals introduced during this Congress, H.R. 995 relates to ERISA, and ERISA is within this Committee's jurisdiction. Furthermore, the bill raises issues which this committee is certain to confront in dealing with health reform.

Insurance Reform and ERISA Health Plans

As many of you may know, the states have paved the way in the area of small group insurance reform—and are continuing to do so. To date, forty-seven states have enacted some type of small employer group insurance reform. Many of these state laws are based upon the NAIC's Small Employer Health Insurance Availability Model Act, adopted by the NAIC in 1991. The NAIC Model Act and the reforms enacted in most states are designed to enhance market competition by creating a level playing field within the insured marketplace regulated by the states. These reforms limit the ability of insurers to raise rates due to the claims status or experience of a certain group. They also enhance portability by prohibiting insurers from imposing preexisting condition limitations on groups which previously had qualifying coverage.

In addition, just this past weekend, the NAIC, at is 1995 spring National Meeting, adopted amendments to its small group reform model act which, among other changes,

now extends the protections of small group reforms to one life self-employed groups and which includes an adjusted community rating methodology. The new rating methodology would only allow for premiums to vary based upon age, geographic location, and family composition. In addition, the NAIC has made it a priority over the coming year to develop a model law to address questions relating to the individual health insurance market. Thus, the states have paved the way in insurance reforms, and are continuing to move forward in this area. The NAIC's recent small group model provides the states with a means to continue to move forward in this area.

However, the states need your help in expanding the scope of these reforms. ERISA constrains the states' ability to promote portability among all types of employer-sponsored plans. The states are unable to apply their insurance reform statutes to ERISA health plans. The NAIC urges that Congress, if and when it enacts health insurance reform legislation, do so in a manner that ensures that the same reforms apply to insured and non-insured plans. Such a level playing field requires uniformity of not only the standards imposed, but of the stringency and level of oversight of these plans.

Insurance reforms are indeed important and can enhance the availability and affordability of health care coverage. However, these reforms do not take place in a vacuum. To the contrary, the potential success of insurance reforms is directly linked to the breadth and varied health status within the marketplace. If the market incentives are such that only healthy groups will find it beneficial to self-fund their coverage, the insured market place will become the refuge of individuals and employer groups with poor or "high risk" health status. Such an occurrence would make it virtually impossible to stabilize rates within the insured marketplace in a way which would make coverage truly affordable. It is therefore imperative that any federal insurance reforms create a truly level playing field -- in terms of the standards imposed, the level of oversight, and the coverage demands placed upon each segment of the marketplace.

The partnership created between the federal government and the states in the development and enforcement of standards for Medicare supplement insurance (Medigap) is an example of a way in which the federal government has promoted uniform standards across the country but has availed itself of the ongoing strength of the state insurance departments: consumer protection. In that instance, the states, through the NAIC, worked to develop the Medigap standards and implement and enforce these standards. The NAIC stands ready to offer the technical expertise of the states to members of Congress as you

consider insurance reforms. We encourage you to build upon the proven success of this type of federal/state cooperation.

Multiple Employer Welfare Arrangements (MEWAs)

As you may know, MEWAs provide a means whereby groups of employers join together to provide health care coverage for their employees. The states currently regulate MEWAs -- both those MEWAs which purchase insured coverage for their members as well as those which self-fund the coverage. Although the amendments to ERISA clarified certain aspects of the states' jurisdiction over MEWAs, as I will explain, the states need further federal action in order to help protect consumers from fraudulent and incompetent MEWA operators.

Furthermore, it is critical to realize that MEWAs provide health insurance -- nothing more and nothing less -- and such entities must be regulated using the same tools we use to regulate health insurers if we are to protect adequately the public. In addition, MEWAs must be subject to the same reforms as traditional insurers in order to prevent unfair competition in the marketplace.

MEWAs are very different from the other types of health benefit plans authorized under ERISA. Unlike traditional ERISA health plans, MEWAs market health benefits to small employers, they use insurance agents, they provide coverage through associations with looser affiliation and less permanence than traditional ERISA plans, and they compete directly for business with traditional insurers. The differences between MEWAs and ERISA plans require different methods of oversight of such plans.

While the states have the authority to regulate MEWAs, many MEWAs are camouflaging themselves as collectively bargained or staff leasing arrangements pursuant to ERISA and claiming to be exempt from state regulation. Because there is no federal certification process for ERISA-governed entities to which the states can refer, states often engage in lengthy jurisidictional battles with these entities even before states can assert their regulatory authority. Consequently, under the current structure, many years can and often do pass before states can oversee such fraudulent MEWAs. In the meantime, consumers' claims can go unpaid.

In order to give you a sense of the potentially devastating impact of inadequate regulation in this area, I would like to share with you a few statistics. The GAO estimated in a survey of state regulators that between January 1988 and June 1991 almost 400,000 participants were left with over $123 million in unpaid claims by MEWAs. In 1994, the state of North Carolina reported that there had been a total of $4,380,000 in unpaid claims from MEWAs not paying the claims of covered persons. This is just one state's experience. Unlike other types of insurance company insolvencies where a state guaranty fund would absorb the losses, there is not a guaranty or similar fund to pay the claims owed by fraudulent MEWAs.

Let me share with you a few examples of the harm brought about by fraudulent MEWAs. On January 26, 1995, Michael R. Stiles, the United States Attorney for the Eastern District of Pennsylvania, and Robert M. McKee, Special Agent in Charge, Office of Labor Racketeering, Department of Labor, announced the indictment by a federal grand jury of four men blamed for health insurance fraud that left victims in 26 states. In a 15-count indictment, the authorities charged Edward M. Zinner of Virginia Beach, Va., the founder of a rock band, a restauranteur, and the head of two MEWAs and related marketing and administration firms; Jeffrey C. Neal, formerly of Virginia Beach, a plan administrator and trustee; Mark "Waldo" Waldron of Portsmouth, Va., a plan trustee and keyboard player for the band; and William E. Moulton, Jr., also of Virginia Beach, a plan sponsor, with racketeering and bilking subscribers of more than $1 million. Allegedly, Mr. Zinner marketed and administered two fraudulent employee health insurance schemes that received $12.6 million in subscriber premiums from November 1990 to the present.

According to the indictment, Mr. Zinner, Mr. Neal, and Mr. Waldron falsely informed agents, brokers, employers, and state regulators that the MEWAs were qualified benefit plans under ERISA; falsely represented that the plans were insured and had adequate claims reserves when in fact they were uninsured and did not have adequate reserves; lied to actuaries about the plans' finances and ignored actuarial recommendations for fully funding the plans; used the plans' funds for personal debts, business debts unrelated to the plans' health claims, entertainment expenses, no-interest and no-term "loans," and increases in personal lines of credit; fraudulently diverted the services of MEWA administration employees for work in Mr. Zinner's band, "Southern Legends," and restaurant, the New England Lobster and Clam House in Virginia Beach; and evaded and

denied claims, among other things. The indictment alleges that Mr. Zinner and his associates marketed fraudulent insurance coverage to small businesses in Arizona, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, New Jersey, Nevada, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Virginia, West Virginia, and Wisconsin. *Business Insurance*, February 13, 1995, p. 1, reported that Mr. Neal has agreed to plead guilty to certain charges in the federal indictment and cooperate with the prosecutors. According to a news release from the Department of Labor dated March 9, 1995, Mr. Zinner has pled guilty to one count of racketeering and one count of forfeiture and has agreed to forfeit one million dollars. Mr. Waldron pled guilty to one count of wire fraud.

Allegedly, Mr. Zinner formed Atlantic Healthcare Benefits Trust (AHBT) in Virginia in 1991. He operated this company until October 1992 when he sold the plan and a related administration firm. Supposedly, the plan was "sponsored" by United Healthcare Association of America. The indictment shows that United Healthcare purported to be an association of small employers, but was actually controlled by Mr. Zinner through "straw" directors and officers, including Mr. Moulton. Mr. Zinner also controlled National Insurance Consultants, Inc. and National Investment Consultants, Inc., which functioned as third-party administrators and marketed AHBT through agents and brokers. Two weeks after selling National Investment Consultants and AHBT, Mr. Zinner established American Fidelity Trust (AFT), which was "sponsored" by the National Association of America's Workers and administered by National Insurance Consultants, Inc., a newly-formed Delaware corporation.

Most of AHBT's and AFT's policyholders were small businesses. For example, in Pennsylvania, those purchasing health coverage through AHBT included a screw manufacturing firm, a Ford dealership, a construction contractor, a restaurant, and others. The following is the story of one family who had thought they were thoroughly covered by AHBT.

In March 1989, a family in Brogue, Pennsylvania celebrated the birth of a baby daughter. Unfortunately, the baby was born with an extremely serious birth defect. At one point, doctors gave the baby a 1-in-5,000 chance of living. Even with such extraordinarily high odds, she lived, and the pediatric surgeons at Johns Hopkins Hospital in Baltimore referred to her as a "miracle baby." The baby was born with a large omphalocele—she

had no skin or muscle across her entire abdomen. She was in the neonatal intensive care unit for almost three weeks with only bandages covering her internal organs. The doctors opted to use donor skin as an improved covering. For the next three weeks, chances of an infection were great. Two doctors even took the couple aside and suggested they think about how to cope after the little girl's death. The doctors' biggest concern was that the infant's body would reject the foreign skin and would require some other sort of bandage. Because the infant had not yet developed an immune system, her body did not reject the donor skin. At the age of five weeks, she was old enough to have her own skin grafts taken, and the doctors were able to remove the donor skin and use her own tissues. The infant was two-months-old before she could go home. Since then, the family has returned to the hospital numerous times for various operations. As only skin covered the infant's internal organs, the doctors were concerned about her falling and rupturing a vital organ. So, the doctors implanted a mylex mesh that covered the infant's organs and lay underneath her skin.

The Pennsylvania parents noted that they had good insurance coverage through the husband's employer. Indeed, that company paid for the first seven operations. The problem the couple encountered was that insurance company took so long to pay their portion of the bills. The parents said collection agencies pursued some of these accounts because the insurer took up to 19 months to pay their bills. Then, the husband's employer changed to a new insurance company, Atlantic Healthcare Benefit Trust (AHBT). Before that switch, the husband's employer made sure to inform AHBT that the child had been born with birth defects, the number of operations she had, and the fact that she might need many more. The parents even sent a photograph of her protruding belly (the little girl had the appearance of being pregnant because she had no muscle under her skin). The new insurer said they would accept the family, even with all of the little girl's pre-existing conditions, and the AHBT representative stated that they positively understood her treatment had not ended and she would require even more care.

The eighth operation for the little girl, now almost three, was scheduled for February 3, 1992. This would have been the first operation under the new insurance policy. The parents followed the directions on the card from AHBT. The directions stated that the family was to notify the insurance company at least 72 hours before a scheduled operation. The parents called eight working days before the operation. A secretary from AHBT called back to say that the insurer did not cover birth defects and congenital diseases and would not pay for any of the young girl's expenses. The parents then

informed the secretary of a letter received from the vice president of the insurance company that stated: "... your coverage includes full takeover of all pre-existing conditions...." According to the parents, the secretary replied, "That letter means nothing."

The parents immediately called the hospital, which temporarily postponed the surgery for a short time. As of the time of that procedure, March 7, 1992, the parents wrote that the scheduled surgical procedure would cost at least $4,000 and the 10-day recovery period in the hospital would cost up to $15,000, with more required if the young girl needed to spend any time in intensive care. The husband's employer hired a lawyer who said the daughter should be covered, but AHBT continued to insist that they had no obligation to pay.

Regulators in a number of states filed cease and desist orders and temporary restraining orders against both AHBT and AHT. The Virginia Corporation Commissioner revoked Mr. Zinner's agent license in January 1993.

Interestingly enough, Mr. Zinner submitted a prepared statement on June 16, 1992 before the Subcommittee on Labor-Management Relations of the House Committee on Education and Labor. During that hearing, the Subcommittee on Labor-Management Relations considered three bills that would amend ERISA. Mr. Zinner endorsed "reasonable federal standards for MEWAs" and called for legislation to "preempt redundant and unreasonable state regulations." He continued, "Most of the proposals for reserve requirements reflect a confusion of our benefit plans with insurance. Well-run MEWAs want to be, and my operations are, actuarially sound, and conservatively so. As I stated earlier, sound actuarial practices, coupled with an ability to assess the participants, provides sufficient financial security."

Incredibly, in his statement, Mr. Zinner also offered his view that access to health insurance would not be improved by reliance on state insurance commissioners. "There is one point I want to leave with you in my statement," Mr. Zinner noted. "*This Committee should not adopt legislation which relies on the state insurance commissions*" (emphasis in original). He added:

> None of these negative experience with MEWAs, such as unpaid claims and fraudulent practices, are of primary concern to the Insurance

Commissioners in the states that seek to put MEWAs out of business. In fact, the States are engaging in unscrupulous practices which are blocking access to benefits and often causing unpaid claim situations to occur. That is, MEWAs can be perfectly sound but still will be run out of business by certain States.

* * *

I urge you to develop legislation to cure those problems. To continue offering low-cost healthcare benefit plans for small business, we need clear Federal pre-emption for ERISA plans from burdensome State requirements. We are willing to consider reasonable provisions for registration and certification by the Department of Labor, and they would be helpful if, and only if, coupled with clarified pre-emption of State regulations.

As time has borne out, not all individuals who decry state regulation do so out of the purest intentions -- nor would it appear that "uniformity" or the provision of health care benefits are their prime or sole concerns. Mr. Zinner's MEWAs had many victims. Their stories are too numerous to elaborate upon now.

The following additional story of a victim of a "sham union" plan should give you a sense of the potentially devastating effect such plans can have upon individuals when purported health insurers fraudulently escape proper oversight. A 42 year old man from Florida and his family were participants in a plan called the National Council of Allied Employees (NCAE) through which a local union (Local 444) offered "Physicians Benefit Plan" (PBP). PBP's brochure represented that NCAE was insured by Lloyd's of London. (See attachment 1) The man had enrolled for health coverage through this plan for his family-owned citrus company in Central Florida. The coverage documents led this man to believe he was well covered. Unfortunately, he was to face significant medical difficulties. The man saw his family doctor in May of 1992 for heart problems. He was admitted to a hospital shortly thereafter, then transferred to a hospital with superior cardiac facilities for a heart catheter and angioplasty; an aneurysm developed. He returned to the hospital in June to have the aneurysm repaired. In January of 1993, he returned to the hospital for another heart catheter and angioplasty. In April of 1993, he returned to the hospital for yet another angioplasty; he had a heart attack in the recovery room which required two additional angioplasties. He later required emergency surgery for a triple bypass and repair of a main artery. During surgery, he suffered an acute

hematoma in his stomach, groin, and legs. After this traumatic series of medical difficulties, the couple learned that their plan was fraudulent and that they had no coverage for the extensive medical treatment. The sham union plan left them with $150,000 in unpaid medical bills. Due to the overwhelming financial problems, the family was forced to relocate to North Carolina.

The state of Florida originally filed an administrative complaint against NCAE in March of 1992 as an unauthorized insurer naming the four local unions known to be operating under NCAE in Florida. As part of its overall efforts, Florida tried to track down the insurance agent who sold the plan to this particular family. Once the agent was finally tracked down in Oregon, the state of Florida hit a dead end in trying to collect money from him. The problem was that this plan was not connected with any authorized insurance company, even one acting as a third-party administrator. This is an example of the problems faced by insurance departments with sham plans which try to avoid regulation and then leave victims high and dry without any claims paid.

Several years ago, a working group of state regulators worked with representatives of the AFL-CIO to find common ground for addressing some of the problems associated with questionable collective bargaining arrangements. S. 2843, introduced in the 102d Congress by Senator Sam Nunn (D-Ga.), incorporated the work product of those discussions. The NAIC has supported such efforts to address the serious problems caused by questionable collective bargaining and staff leasing arrangements and pledges to work with this Committee and any interested members to enact appropriate legislative solutions.

Finally, as you consider health insurance reforms it is important not to single out MEWAs and exempt them from any reforms applicable to other health insurers -- such an exemption could greatly undermine the success of the reforms. If MEWAs are able to opt out of the rating pools applicable to other types of insured arrangements, adverse risk selection could ensue. For example, employers with young and healthy workers would opt to join MEWAs which either self-fund or purchase insured coverage which "pools" their risk separately. In either event, a fundamental tenet of insurance, the spreading or pooling of risk, would be undercut and market fragmentation could follow. The NAIC looks forward to working with members of this Committee in order to craft legislative solutions which foster a level playing field among entities providing health care insurance.

ERISA Health Plans Should be Subject to Solvency Requirements

Unlike pension plans, ERISA health plans are exempt from any meaningful financial standards or oversight. Self-funded ERISA health plans are specifically excepted from ERISA's minimum participation standards, minimum vesting standards, benefit accrual requirements, and minimum funding standards. Therefore, ERISA does not subject self-funded health benefit plans to the same initial financing standards as it does pension plans. ERISA also contains no requirements to regulate the continued solvency of self-funded ERISA health plans once such plans go into operation. Even worse, ERISA provides absolutely no financial safety net for the beneficiaries of self-funded ERISA health plans. This omission stands in sharp contrast to state guaranty funds, which undergird insured plans—including insured ERISA health plans, and the Pension Benefits Guarantee Corporation, the safety net for pension plans.

ERISA's limited requirements relating to the payment of claims have no teeth. While ERISA obligates claim fiduciaries to pay valid claims submitted—this does little to help plan participants if a plan becomes insolvent. In such a case, participants can do little other than join the bankrupt employer's other creditors to pursue the firm's remaining assets.

Congress should recognize that all entities which bear risk in connection with the provision of health care coverage, including ERISA health plans, should be subject to financial regulation and standards. Such standards include initial capital requirements, risk-based capital requirements (capital requirements adjusted for the level of risk assumed by the entity), and effective protection for participants in the event of health plan insolvency. Furthermore, all types of health plans should be subject to ongoing regulation of their financial condition.

Consumer Complaints and ERISA

Currently, ERISA does not assure that beneficiaries of ERISA health plans have access to either meaningful internal or external complaint procedures or remedies.

Internal Appeals and Review of Health Plan Decisions

ERISA does not guarantee that participants in both insured and self-funded ERISA health plans have an unbiased and independent internal review process. The statute does require that health plans provide a mechanism for participants to appeal a plan's denial of a participant's claim. However, if a person is dissatisfied with the result of this appeal, the next level of review may be conducted by the same fiduciary party whom denied the claim initially. Thus, plan participants do not have the opportunity to seek an independent review of a plan benefit decision.

Review of Consumer Complaints by a Public Agency

What can a beneficiary of an ERISA health plan do if he or she is dissatisfied with a decision made by his or her health plan? Unfortunately, ERISA plan participants do not have recourse to a public agency that has jurisdiction over these plans and the capacity to respond to the beneficiary's concerns in a timely and aggressive manner. The beneficiary may file a complaint with the U.S. Department of Labor (DOL). However, the Department of Labor's employee benefit complaint review program is very limited—as the Department itself has admitted.

The Department of Labor's Task Force on Assistance to the Public, in a 1992 report, stated that, for complaints that appear to have merit, its Division of Technical Assistance and Inquiries tries to seek a response from plan administrators. However, if the plan official does not agree to approve the benefits, the staff member will not pursue the matter further. Instead, DOL staff will either suggest that the claimant seek legal counsel or will refer the matter to the DOL's Office of Enforcement. Thus, as the Department of Labor's Task Force noted, the Department of Labor does not have an explicit statutory mandate to assist individuals who wish to pursue complaints related to ERISA health benefit plans. Further, the DOL's activity in this area is minimal.

By contrast, while participants in self-funded ERISA health plans only can appeal to an ill-equipped Department of Labor, beneficiaries of insured ERISA health plans have limited access to state insurance departments to obtain an independent and informal review of some of their complaints. Many state insurance departments try to help beneficiaries of ERISA self-funded and insured health plans, although they have no

jurisdiction over the self-funded plans and limited jurisdiction over the insured ERISA health plans. For example, during 1994, the Wisconsin Office of the Commissioner of Insurance (OCI) received 996 complaints relating to self-funded ERISA health plans out of a total of 4,666 complaints concerning health care coverage. Thus, complaints regarding self-funded ERISA health plans comprised over 20% of the complaints regarding health care coverage received by my office last year, even though our department has no enforcement authority over these plans. Despite its lack of jurisdiction over these entities, the Wisconsin OCI was able to help beneficiaries recover $281,347 from these plans. One could only speculate as to the additional numbers of beneficiaries of such plans who had complaints, but did not even attempt to call our state department -- perhaps because they realized that the OCI did not have jurisdiction over these plans. The Alaska Insurance Department recently reported receiving approximately twenty-five calls a week from consumers having problems with self-funded ERISA health plans.

Clearly, ERISA fails to provide participants with an effective external administrative appeal mechanism.

Limited Redress Available to ERISA Plan Beneficiaries through Litigation

As noted above, if participants in ERISA health plans believe they have been aggrieved by the decisions of their plan administrators, they may not have much success with the limited internal and administrative remedies available under ERISA. Consequently, despite the difficulty and expense presented by this option, a beneficiary may choose to pursue his or her claim through litigation. Importantly, it is unlikely that someone will choose to litigate smaller claims. Therefore, for many claims, ERISA provides consumers with no meaningful remedy. Furthermore, even when a beneficiary pursues a court suit, ERISA seriously restricts the avenues of redress available to ERISA beneficiaries.

ERISA does permit a participant to bring a court action for recovery of benefits which an ERISA health plan owes him or her. However, the plan can remove most state court actions to federal court -- a forum in which plaintiffs often must wait for many years before their claim comes to trial. In addition, once in federal court, ERISA preempts many state law claims. For example, it preempts a state common law cause of action for failure to process a benefits claim in good faith.

Furthermore, ERISA prevents states from implementing innovative dispute resolution mechanisms for participants in ERISA health plans. Hence the states' hands are completely tied; ERISA hampers state efforts to spare individuals and businesses the cost and time of litigation.

Thus, as outlined above, ERISA seriously impairs the ability of ERISA participants to enforce the benefits provided to them by ERISA health plans. All consumers can do is sue in federal court. This remedy is illusory for all but truly catastrophic claims because consumers likely will not find it cost effective or worthwhile to file a suit for smaller or medium-sized claims -- claims which nonetheless could be difficult for most Americans to bear in addition to their other financial responsibilities. Congress should correct this egregious deficiency within the statute. The current scope of ERISA's preemption of state law remedies only should remain if statutory changes are enacted which assure meaningful governmental oversight and authority over ERISA health plans' claim and coverage determinations. Further, participants must be provided with internal and external appeal mechanisms in addition to the right to appeal to federal court.

Fair Disclosure of Terms of Coverage

ERISA fails to ensure that ERISA plan beneficiaries receive complete and meaningful disclosure of plan benefits and plan changes. While the statute does require health plans to distribute a summary of the plan, annual reports, and a summary of material modifications to the plan to plan participants, it does not require any outside or administrative agency review of the documents. Furthermore, if a plan has been changed, ERISA does not require prompt notification of the changes. Instead, plan administrators have as long as 210 days -- about seven months -- to notify beneficiaries of plan changes.

This absence of meaningful notice under federal law contrasts with the rights available to beneficiaries under state law. If an employee is fortunate enough to have an employer who is offering an insured plan, the plan's policy forms are subject to review by the state insurance departments. Most states also require insured health plans, including insured ERISA health plans, to give participants prompt notice of changes to the plans. Beneficiaries of non-insured ERISA health plans are at the mercy of their plan. A recent U.S. Supreme Court decision highlights the fact that employers have a fair amount of latitude to cancel benefits with only general notice requirements. See Curtiss-Wright Corp. v. Schoonejongen et al., 63 U.S.L.W. 4201 (1995).

Fair Coverage

Critics of state insurance laws often object to the benefit requirements under certain state laws as overly onerous and restrictive. However, let us examine the shocking effect of ERISA's absence of coverage requirements. A family, the Browns, had a child born with severe congenital defects. Their self-funded single employer-sponsored ERISA plan refused to provide coverage for the child because it only covered newborns thirty-one days after birth, and, even then, only provided coverage if these newborns had no disabilities. For years, state insurance law has banned such shocking and disgraceful exclusions. However, when the Brown family challenged this exclusion in court, the U.S. Court of Appeals for the Fifth Circuit was forced to acknowledge that ERISA's preemption of state insurance laws left the Browns without coverage for their child. See Brown v. Granatelli, 897 F.2d 1351 (5th Cir. 1990).

While we would agree that employers should have certain flexibility with respect to the coverage they offer employees -- consumers deserve more protection than that currently provided by ERISA. congress should revise ERISA to ban egregious exclusionary practices.

In addition, the federal statute has permitted ERISA health plans to terminate or reduce the maximum amount of benefits provided for a certain type of illness. This has had particularly onerous consequences for individuals with disabilities or life-threatening illnesses, such as AIDS. See McCann v. H & H Music, 742 F. Supp. 392 (S.D. Tex. 1990) aff'd 946 F.2d 401 (5th Cir. 1991), cert. denied 113 S.Ct. 482 (1992). The Americans with Disabilities Act ("ADA") of 1990 has improved the situation somewhat. The U.S. Equal Employment Opportunity Commission (EEOC) has issued enforcement guidelines under the ADA which only allow an ERISA health plan to terminate benefits if the plan can demonstrate that the benefit termination is not a "subterfuge" or made with the subjective intent to discriminate against a particular disability. See "Interim Enforcement Guidance on the Application of the ADA to Disability-Based Distinctions in Employer Provided Health Insurance," EEOC, June 8, 1993. However, the federal courts have not definitively interpreted the relationship between ERISA health plan discretion and individual rights under the ADA. The application of the ADA to ERISA health plans should be clarified by federal statute. Further, since the ADA does not apply to very small employers, federal law should clearly prohibit all ERISA health plans from

discriminating against particular groups or disabilities in their provision of health care coverage.

Quality Health Care

With the increased prevalence of managed care in the health care market, the administration of ERISA health plans have become inextricably linked with the quality of the health care provided through the plan. For example, plan hospital preauthorization requirements or utilization review requirements can determine whether a beneficiary has access to coverage for certain medical care. Many states regulate heath plan utilization review procedures. However, in the case of ERISA health plans, federal courts have held that such procedures relate to the administration of a health care plan and therefore are preempted by ERISA. ERISA's preemption therefore removes an important existing check on the quality of ERISA health plans -- and provides no meaningful federal replacement for this void.

Federal courts have expressed concern regarding the scope of ERISA's preemption in this area. In addressing the question of whether ERISA shielded a self-funded ERISA health plan from claims relating to actions performed in connection with the administration of the plan, the U.S. Court of Appeals for the Third Circuit noted that "[ERISA] removes an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system ... there is no deterrence for substandard medical decision making ... bad medical judgments will end up being cost free ... ERISA health plans will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices." Corcoran v. United Health Inc., 965 F.2d 1321, 1338 (3d Cir. 1992). The NAIC shares the court's concern.

ERISA should be amended to provide plan participants with a way to seek redress if they suffer an injury due to the negligence or malfeasance in the administration of a plan.

Data Reporting

When used appropriately, health data on plan participants can lead to better management of health care costs, employee prevention and education efforts, improved quality of service, and more effective coverage. However, at the moment, there are no federal requirements which subject non-insured ERISA health plans to quality standards or any data reporting requirements. Further, states are restricted from requesting such information from these plans -- thus thwarting any efforts to monitor and improve the overall health status of communities. Furthermore, ERISA currently does not address the privacy concerns of participants in ERISA health plans.

ERISA should be revised to allow for the collection of health data concerning ERISA health plan participants and to protect the privacy and confidentiality of sensitive beneficiary information.

Comments Upon Future Congressional Action

Congress certainly will confront many challenges as it considers insurance reform and the relationship between such efforts and ERISA. A recently introduced bill on the House side, H.R. 995, suggests certain changes in the regulation of the small group insurance market and seems to attempt to apply some standards equally to insured and ERISA health plans. Unfortunately, it also ties states' hands in the area of small group reform and would force many states to move backwards, not forward, from existing market reforms. The bill also creates a federal exemption process which could strip the states of their regulatory responsibilities over MEWAs. The NAIC has only had a limited opportunity to review H.R. 995 and would like to reserve the right to provide a more detailed analysis on its provisions at a later date. However, I would like to highlight certain areas of the bill which raise issues this Committee is certain to grapple with if it attempts to enact federal legislation in the area of health insurance reform.

First, as I noted earlier, it is critical that consumers of insured plans and ERISA plans are afforded the same consumer protections. This can only occur if both the standards, enforcement, and consumer complaint handling systems are equally rigorous for all types of plans. The NAIC is concerned about any regulatory construct under which there is a

disparity, or a potential for a disparity, in the application of reforms to insured and ERISA health plans. Such a dissimilarity would harm consumers.

For example, H.R. 995 ostensibly creates a level playing field for ERISA-governed and insured health plans. However, as one example of the way this statute attempts to implement such standards, the bill provides that a set of standards developed by an unspecified private entity, would apply to all types of health plans, subject to federal approval. If no private entity develops standards which are approved by the Secretary of Health and Human Services, there could be no standards for ERISA health plans in this area. (The bill provides the NAIC with the opportunity to develop standards for insured plans). It is thus conceivable that there could be a disparity between the level of consumer protections available to consumers of insured plans and ERISA health plans in the important areas of provider network quality and services, and the rights of covered individuals with respect to denial of services through utilization review. Once again, persons covered under ERISA plans would lose out.

H.R. 995 strips the states of much of their existing regulatory authority in the areas of small group insurance and health insurance. Unless states are granted a waiver, states authority over insurance rating and several other important areas would be preempted. The bill only maintains minimal authority over such plans within the states' hands. Thus, the bill creates a confusing regulatory structure under which oversight of health insurance plans would be awkwardly split between the states and the federal government. Implementation of this split arrangement is certain to be confusing and may likely harm consumers.

One problematic consequence of the bill's suggested regulatory construct lies in the area of solvency regulation. Without a waiver, states would not have oversight responsibility over a small group health insurer's rating structure. However, it appears that states still would be expected to regulate plans for solvency. It is difficult to imagine how states could regulate solvency without full oversight authority over a health insurance company's revenue source: premiums. In the context of the federal health reform debate in the 103rd Congress, the NAIC opposed any split in the authority over premium rates and plan solvency. The NAIC continues to oppose any such split authority.

The bill also preempts many state laws in the areas of managed care, including utilization review statutes, without providing for a clear substitute to protect consumers in many areas relating to medical decision-making.

Federal legislation should clearly spell out the duties of any federal administrative body to which it delegates responsibility. Also, federal legislation should clearly provide for the resources for the agency to carry out its assigned duties. H.R. 995 gives the Department of Labor many more responsibilities without specifying the mechanisms or resources through which the Department is to carry out its duties. For example, nothing within H.R. 995 gives the Department of Labor any more of a specific statutory mandate to respond to and process consumer complaints than currently exists under ERISA. Thus, under H.R. 995, the existing gaps within the law would continue and grow worse, since the Department of Labor will have regulatory oversight responsibility for many more health plans under H.R. 995.

As illustrated in the unfortunate examples I relayed to you, the NAIC is concerned with federal law which allows for the creation of entities with only loose employer affiliation and over whom regulatory authority is unclear. Such a system is rife with the potential for the proliferation of sham, fly-by-night entities. Yet, H.R. 995 expands the types of entities which can qualify as staff leasing arrangements under ERISA. It also creates a bifurcated structure for the regulation of MEWAs by creating an exemption process by which a MEWA can be regulated by the Department of Labor rather than by the states.

The bill is unclear as to how much time could pass before the Department of Labor grants a MEWA an exemption and what, if any, effect a pending application would have on a state's ability to regulate these entities. In addition, the bill's provisions spell out only very loose criteria for the granting of an exemption. Finally, the bill contains no substantive standards for external financial examinations of a company or for market conduct review, nor does H.R. 995 clearly provide for how the Department of Labor would handle complaints by consumers about the exempt arrangements.

We look forward to working with you and any other Congressional committees that are considering the MEWA issue to try to develop standards which would best assure that the appropriate regulatory authorities can exercise meaningful oversight over these arrangements which promise, but do not always deliver, health care coverage to millions of Americans. The NAIC will be examining the provisions of this bill further. It does

appear that a structure such as that proposed by H.R. 995 would create even further opportunity for abuse. We would urge you, in considering any legislation before your Committee in the area of insurance reform, to avoid some of the pitfalls the NAIC has just enumerated.

Conclusion

Since its enactment, ERISA's provisions relating to employee health plans have had increasing import and meaning for the millions of Americans who receive their health care coverage under these arrangements. As I have spelled out, we urge you not to forget these Americans when you consider enacting federal health insurance reform. Any federal insurance reforms should be made applicable to ERISA health plans. Furthermore, all Americans deserve to be able to understand and enforce the terms of health care coverage offered by their employers. This requires affordable avenues of redress and meaningful access to independent parties to help them pursue their claims. Furthermore, there is a place for government in health care coverage. Effective regulatory oversight can ensure plan solvency and provide quality controls to avoid abusive denials of medical coverage when individuals most need it.

The NAIC looks forward to working with the 104th Congress as it attempts to enact meaningful market-based reforms of the health care coverage market.

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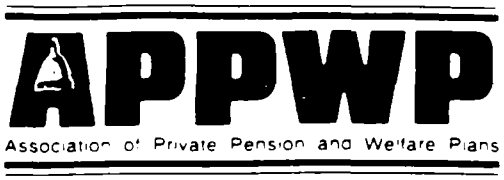


STATEMENT

OF THE

ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES U.S. SENATE

HEARING ON EFFECTIVE HEALTH CARE REFORM IN A CHANGING MARKETPLACE

MARCH 15, 1995

1212 New York Avenue N.W. • Suite 1250 • Washington, D.C. 20005 • (202) 289-6700 • FAX (202) 289-4582

I. INTRODUCTION

Madam Chairman, members of the Committee, I am Richard I. Smith, Director of Health Care Policy for the Association of Private Pension and Welfare Plans (APPWP). APPWP is the national association of firms and individuals concerned about federal legislation and regulation affecting employee health and pension benefits. APPWP's members include Fortune 500 companies, managed care plans, and consulting and actuarial firms. I appreciate the opportunity to testify today.

For twenty years, one of APPWP's principal missions has been to defend the integrity of the Employee Retirement Income Security Act (ERISA). We have adopted this mission because *ERISA is the preeminent health care reform statute.* ERISA has created a legal framework that has allowed private employers to (1) voluntarily sponsor health plans that cover tens of millions of American workers, and (2) lead the revolution in health care markets that is bringing health costs under control. ERISA, unlike many other federal statutes, benefits American workers and businesses by supporting rather than undermining effective markets.

Despite the success of employer-sponsored plans governed by ERISA, amending ERISA to provide for "state waivers" from ERISA preemption or to impose certain new and costly federal requirements on employers who voluntarily sponsor health benefit plans remains under discussion. These proposals sometimes are rooted in misunderstandings about how employers manage health benefits and the legal structure governing health plans voluntarily sponsored by private employers.

Enactment of such ERISA amendments would produce tragic results. Many American workers will lose their health insurance if Congress adopts state waivers or other ERISA amendments that increase the health costs of employers and employees who voluntarily pay for health coverage. *Rather than adding to the burden on employers at a time when we need to expand coverage rates, Congress should preempt the many anti-market state laws that raise costs for fully insured, and usually smaller, employers. These include, but are not limited to, state antimanaged care and mandated benefit laws.*

Ironically, the proposed cost-increasing ERISA amendments come at a time when employers, after years of intense effort, have achieved real success in controlling health costs. If Congress adopts ERISA amendments that reverse this success, it will be telling employers that they will not be permitted to control their health costs. Under these circumstances, many employers will "cash out" their employees rather than continue to offer health coverage.

The remainder of this statement discusses (1) the accomplishments of health plans governed by ERISA, (2) ERISA's place in the current political environment that emphasizes devolution of federal activities to state governments, (3) the reasons that APPWP opposes state waivers from ERISA preemption, (4) flaws in certain proposals for adding new federal standards to ERISA, and (5) the double standard that some advocates of amending ERISA seem to apply to private, employer-sponsored health plans and government-sponsored health plans that are not governed by ERISA.

II. ERISA PLANS' ACCOMPLISHMENTS

Employer-sponsored health benefit plans governed by ERISA set the standard for health insurance coverage provided to Americans. Firms that voluntarily offer health plans cover a very high percentage of their workers. In firms that offer health benefits, roughly 90 percent of full-time workers are eligible for coverage. The coverage is typically comprehensive. Notably, coverage in ERISA plans is far more comprehensive than the coverage offered by the federal government to Medicare enrollees. The high quality of employer-sponsored plans reflects the reasons employers choose to offer plans: to attract and retain a healthy, high quality, and satisfied workforce.

Employers who sponsor health plans governed by ERISA have led the ongoing revolution in the health care market that is improving health care quality and controlling health costs. Annual cost increases for employer-sponsored health plans are continuing to decline from their double digit rates in the 1980s, despite massive cost shifting from Medicare and Medicaid. FosterHiggins reports that employers' health costs *declined* by 1.1 percent between 1993 and 1994. (Large employers achieved better results than smaller employers. Large employers generally have better protection under ERISA from state laws that increase health plan costs and, to date, have made more use of managed care.) HMO premium increases have declined for five consecutive years. In 1995, HMO premiums are expected to decline in absolute terms. *Notably, employers have been far ahead of government programs in switching from inflationary fee for service medicine/indemnity-style insurance to managed care.*

Large employers have been well positioned to lead the health care revolution. They have joined their market clout as purchasers of a large volume of services and their technical expertise to demand more efficient delivery of health care and create real competition in the market. Recent innovations led by ERISA plans, often in collaboration with managed care plans, include:

- Creation of comprehensive health plan standards, which include but are not limited to data reporting, quality, and access. These standards are creating, for the first time, accountability for cost and quality in the health care market. Similarly, employers are requiring hospitals to report quality and cost data that facilitates prudent purchasing.

- Development of information that consumers need to choose among competing plans based on their performance.

- Creation of collective purchasing entities that enhance plan sponsors' ability to negotiate cost effective, high quality health care arrangements for their employees. Some collective purchasing entities have begun to insist on arrangements that benefit all purchasers, not just purchasers who are members of the entity.

- Development of new benefit designs, such as (1) flexible mental health benefits that eliminate arbitrary limits on covered services, expand use of services, and control costs, (2) income related cost sharing, which enhances individual responsibility, and (3) point-of-service plans that have held costs down and been highly popular with consumers.

According to Dr. John M. Ludden, medical director of the 550,000 member Harvard Community Health Plan, "Employers are a powerful voice for health care consumers. They have really become sophisticated customers. They know what to ask for and how to ask for it. They set goals for us--clinical goals, not just cost goals."

III. ERISA'S ROLE IN THE CURRENT POLITICAL ENVIRONMENT EMPHASIZING DEVOLUTION OF FEDERAL ACTIVITIES TO THE STATES

ERISA preemption bars some state health care initiatives. Some have claimed that this runs counter to the political tide emphasizing devolution of federal activities to the states, and point to the widespread discussion of giving states much greater flexibility to operate Medicaid and welfare programs as they see fit. This misses important distinctions between private, employer-sponsored health plans and Medicaid and welfare.

First, employer-sponsored health plans operate in the private sector. Unlike Medicaid and welfare, they are *not* government programs. Therefore, the view that states rather than the federal government are better positioned to manage Medicaid and welfare has no relevance to the management of private, employer-sponsored health plans.

Second, responsibility for how voluntary, employer-sponsored health plans operate should remain with the private sector. ERISA recognizes this and creates a legal framework that appropriately balances private sector responsibility and government regulation. In contrast, the purpose of states seeking ERISA waivers is to gain unprecedented control over private health plans voluntarily sponsored by employers.

Third, the best case for maintaining ERISA preemption is made by the National Governors Association (NGA). In its winter 1995 report, NGA calls for freeing states from federal rules that prevent states from operating Medicaid programs as they see fit. States are responsible for purchasing coverage on behalf of Medicaid beneficiaries. Employers are the purchasers for their employee groups. Both should have the flexibility needed to use effective purchasing strategies. Yet some states seeking Medicaid flexibility also are seeking ERISA changes in order to strip private employers of the flexibility needed to manage their employee health plans.

IV. WHY APPWP OPPOSES ERISA WAIVERS FOR STATE HEALTH CARE LEGISLATION

APPWP strongly opposes ERISA waivers, which would harm single state as well as multistate employers, and small as well as large firms. Contrary to assertions by some

states, NGA, and the National Association of Insurance Commissioners, ERISA is not a barrier to health reform. It permits health reform by the private sector, where it can be done well, while preventing enforcement of ill-advised state policies that would roll back private sector reform.

Allowing increased state interference with employer-sponsored health plans will make our nation's health system problems worse rather than better. *Unwarranted state government intrusion into the private sector can be every bit as damaging and characteristic of "big government" as federal government intrusion.* This is clear from the list of prohibited state policies NGA cites in its concerns about ERISA preemption. NGA's list includes, but is not limited to, establishing "minimum guaranteed benefit packages," health care price controls, statewide employer mandates, and various health care taxes. *Giving states "flexibility" to force employer-sponsored health benefit plans into state health care systems will destroy private sector flexibility.* State flexibility will impede private sector innovation and increase health costs, thereby putting expanded coverage rates permanently out of reach.

One of the reasons that employer sponsored health plans governed by ERISA have worked well is that ERISA has preempted state laws that increase costs. Cost control and therefore employers' ability to maintain comprehensive coverage would be compromised if states were given broader jurisdiction over employer sponsored health plans. States have a long record of enacting antimanaged care laws, mandated benefit laws, price controls that fail to contain costs but prohibit employers from negotiating their own cost control arrangements, and claims dispute remedies that create a litigation bonanza for plaintiffs' attorneys. Forcing ERISA plans to comply with these antimarket laws--whether the plans are sponsored by single state or multistate firms, or by small or large firms--would undo effective employer driven quality improvement and cost control.

Advocates of ERISA waivers also fail to consider that health care is delivered and paid for in interstate commerce, not within state borders. Many health care delivery systems cross state borders and patients frequently cross state borders to receive care (sometimes to receive care arranged for by an employer or managed care plan from an out-of-state center of excellence). Many individuals reside in one state and work and obtain their insurance in another; labor markets and labor contracts affecting health benefits encompass multiple states; and employers administer a single health plan for worksites in multiple states. Allowing the laws that govern health care delivery and financing to vary from state to state would create a very costly and difficult (if not impossible) to navigate patchwork of conflicting rules that will not work for patients, providers, or purchasers.

The Congressional Budget Office (CBO) addressed just one small subset of the questions about state-specific health systems in its analysis last year of Senator George Mitchell's health plan: whether it would be feasible for some states to have an employer mandate while other states do not. CBO concluded that "[T]he practical problems of implementing mandates in some states and not in others could be overwhelming...

Because of the disruptions, complications, and inequities that would result, CBO does not believe that it would be feasible to implement the mandated system in some states but not in others; the system would have to include either all states or none." While employer mandates may no longer be on the table, we believe that this conclusion is applicable to a broad range of state-specific initiatives.

States already have ample authority to address a broad range of health system issues without interfering with health plans sponsored by private employers:

- By converting Medicaid to managed care through waivers available under current law, states can control the impact of health costs on their budgets and pay for initiatives to cover uninsured individuals. Many states are successfully pursuing this strategy.

- States have complete freedom to manage their state employee health plans.

- States can reform small group markets and establish purchasing groups for small firms.

- States can pay for initiatives to reduce the number of uninsured persons through broad-based, visible taxes. Taxes that violate ERISA and thus require an ERISA amendment in order to be enforced are merely an effort by states to obtain low visibility, low accountability revenue.

Finally, all firms required to bear new costs under state law would be left with no choice but to cut benefits in order to recoup those costs. Multistate firms would be forced to make the deepest cuts, since they would face the administrative cost of complying with conflicting state laws in addition to the costs associated with state antimarket laws.

V. Proposals For New Federal Standards in ERISA Are Flawed

Some policymakers have advocated requiring ERISA plans to meet an array of costly, new requirements. On most issues, this position fails to recognize the standards already created by other federal statutes, the cost of compliance, and/or the lack of need for such standards.

A. Analogies Between ERISA's Pension Plan and Health Plan Standards Are Inaccurate

Advocates of adding a new array of detailed standards to ERISA's health care provisions sometimes point to the difference between ERISA's detailed pension rules and more general health care rules. *This analogy between ERISA's pension and health care standards is mistaken.* The lion's share of ERISA's pension rules govern vesting, prefunding, nondiscrimination, and fiduciary standards that are inapplicable to health benefits.

The ERISA rules governing pensions are inapplicable because virtually all health benefits, unlike pension benefits, are current year benefits rather than promises to pay benefits many years in the future. Moreover, Congress has adopted a policy against prefunding health benefits in a way that is similar to prefunding of pension benefits, since it has severely restricted tax-preferred prefunding of retiree health benefits in comparison to tax-preferred prefunding of pension benefits. Congress also has not enacted legislation under which the government assumes liability for retiree health benefits in the event of plan failure--a liability it has chosen to assume for pension benefits.

Pension-type nondiscrimination rules are inapplicable to health benefits because eligibility for employer-sponsored health plans and employer contributions to health benefits rarely vary by income. In fact, when employer contributions do vary by income it is usually for the purpose of increasing the premium payment required from highly compensated employees--the opposite of the concern that has led to pension nondiscrimination rules. Additionally, the practice among employers who sponsor health benefits is to make those benefits widely available to their employees. Even the smallest health plan sponsors--firms with fewer than 25 employees, offer health benefits to 84 percent of their full-time employees. Firms with at least 1,000 employees offer health benefits to 92 percent of their full-time employees.

Other differences between health and pension benefits abound, making the rules governing each inapplicable to the other. For instance, the fiduciary rules of ERISA are generally aimed at ensuring the protection of assets that are being held over a period of many years so that they are available to be paid at retirement. Again, this analogy is inapplicable in a context in which health benefits are paid on a current year basis.

Additionally, employers can impose vesting periods for pensions of up to seven years, and pension benefits can be made proportional to length of service. Employers can, at their option, recover all pension contributions they make to employees who leave employment prior to vesting. In contrast, because most health benefits are current year benefits, employers could not recover premium contributions made to health plan participants who leave employment prior to a predetermined period. It would be difficult to make current year health benefits proportional to length of service. These factors support the broad discretion employers have in determining participation standards for their health plans.

Policymakers who advocate imposing pension-type rules on health benefits should focus on one final point. The employer-sponsored pension system has been burdened by extensive regulation. The cost of excessive pension regulation has dampened retirement plan coverage, especially by leading to many terminations of defined benefit plans. Unquestionably, the regulatory burden is a major reason that retirement plan coverage rates are lower than health plan coverage rates. Forcing health plans to adhere to

pension-type rules will increase health plan costs, leading employers and employees to drop their health benefits.

B. Proposals For Adding New Standards to ERISA's Health Plan Rules

1. Increased Litigation and Damages for Claims Disputes. APPWP strongly opposes changing ERISA's procedures, standard of review, and remedies in claims dispute cases. Currently, ERISA gives plan participants the right to a de novo review of a denied claim by the plan's fiduciary and an opportunity to appeal the fiduciary's decision in federal court. The claim will be paid if the participant shows that the fiduciary's decision was arbitrary and capricious. Often, the court also will order payment of a successful plaintiff's attorney fees. Additionally, a fiduciary who violates ERISA's fiduciary standards can be barred from acting as a fiduciary. In practice, virtually all of the very small proportion of disputed claims are resolved before they reach federal court.

Some policymakers advocate changing ERISA's grievance procedures and adding economic and/or punitive damages to available remedies. The case for these changes rests on anecdotal "horror stories." The anecdotes often present compelling circumstances, but rarely provide any basis for evaluating the merits of a plaintiff's case and may not present the facts accurately.

Equally important, the anecdotes do not move on to seriously examine the incidence or severity of improper claims denials. In fact, only a minute portion of claims are ever disputed. Many of the disputes are groundless and nearly all disputes are quickly resolved. It is difficult to find any support for the notion that any appreciable number of Americans with private insurance is improperly denied payment for covered services. The anecdotes never evaluate the consequences--increased costs, decreased coverage, and decreased propensity to deny authorization for harmful services--of changing ERISA's grievance procedures, standard of review and remedies.

Changing ERISA's claims denial procedures and remedies will create a costly litigation lottery for employers and managed care plans as plaintiffs seek large jury verdicts. Employers and managed care plans will often be forced to settle unjustified claims to avoid litigation costs. (Litigation to the federal court level now costs roughly $250,000. This amount would increase dramatically if the litigation rules are changed and if cases could be heard in 50 different state courts as well as federal court.) Avoiding exposure to large jury verdicts in emotionally charged cases also will induce employers and managed care plans to pay unjustified claims, despite well-documented evidence that Americans receive much medically inappropriate care. As a result, employers will drop employer-sponsored health care plans to avoid increased health benefit costs and increased liability for denied claims.

Allowing state law rather than ERISA to govern these disputes would create extraordinary enforcement problems, due to the number of parties involved, the

interstate nature of many claims, and differences in state law. Many individuals might be less able to effectively appeal claims under state law than under current federal law.

2. State Taxation of Self-Insured ERISA Plans. States have a plethora of taxing options that do not violate ERISA. Nonetheless, much of the states' interests in obtaining ERISA amendments boils down to their desire to tax self-insured plans. *States' insistence on being allowed to enforce the few taxes that do violate ERISA merely reflects their desire to generate large revenues with little accountability or visibility.* APPWP opposes amending ERISA to require self-insured health plans to pay state taxes.

Congress clearly decided during the 1993-1994 health care debate that employers should not be obligated to pay for their employees' health coverage. It would make no sense for Congress to require employers who have voluntarily chosen to pay for their employees' health benefits to begin paying the added expense of new state taxes on their health plans. Employers who voluntarily pay for employees' health benefits would be singled out to pay the new state taxes, while employers who choose not to pay for health benefits and beneficiaries of government-sponsored insurance programs remain outside of the tax base. Moreover, because only employers who offer health benefits are subject to these low visibility state taxes, the opportunity to control their growth over time is limited. Employers who do not offer health benefits and beneficiaries of government programs would have no interest in opposing these taxes.

Requiring ERISA plans to begin paying state taxes that have been preempted until now also could expose employers and employees to taxes by multiple states. Individuals who work in one state and obtain care in another could trigger taxes by more than one state, since some states may tax medical services while other states tax "premium equivalents."

Finally, it is important to recognize that hospital surcharges, as in New York State, distort health care markets. This can increase total employer costs by more than the amount of the tax.

3. Risk Pooling Between Insured and Self-Insured Groups. Requiring self-insured firms to pay into a pool that subsidizes insured firms is an invitation to irresponsibility and inefficiency in the insured market. Such a pool also would be subject to major abuses by state officials, since they could provide a low visibility, low accountability source of revenue to defray state health care costs. Self-insured firms voluntarily bear the cost of their own employees' health benefits. They should not be compelled to pay for other firms' health benefits, compelled to pay for services which they have no opportunity to control, or singled out to pay for state programs.

The justification for risk pooling between insured and self-insured firms is sometimes based on the erroneous assumption that small firms, which are less likely to self-insure, pay more for health benefits than large firms, which are more likely to self-insure. A Lewin-VHI study commissioned by APPWP exposed the error of this assumption by

examining health insurance costs by employer size. Lewin-VHI found that the average cost of premiums for firms with fewer than 25 employees does not exceed the average cost of premiums for firms with more than 25 employees.

4. Participation Standards/Nondiscrimination Requirements. Advocates of adding participation standards/nondiscrimination requirements to ERISA's health plan rules rarely mention that self-insured health plans sponsored by private employers already are covered by participation standards and nondiscrimination rules in other statutes. These rules are found in Internal Revenue Code Section 105, the Americans With Disabilities Act, the Pregnancy Discrimination Act, the Older Workers Benefit Protection Act, Title VII of the Civil Rights Act, and Medicare secondary payer requirements. Other rules apply to structures that often are part of ERISA plans, such as cafeteria plans and voluntary employee beneficiary associations. In light of (a) these statutes and (b) employer practices which typically make the same level of benefits available to a very wide range of employees (evidenced by the 89 percent eligibility rate among full-time employees of firms that voluntarily offer health benefits), there is no reason to add participation standards/nondiscrimination rules to ERISA.

Under current practice, part-time employee eligibility for employer-sponsored plans is lower than full-time employee eligibility. A recent Hewitt Associates survey of mostly large firms that offer health benefits to their full-time employees reports that 24 percent of such firms do not offer health benefits to employees working between 30 and 39 hours per week. Thirty-nine percent of the firms do not offer health benefits to employees working between 20 and 29 hours per week. A FosterHiggins survey reports that 76 percent of small firms do not provide coverage to part-time employees.

Part-time eligibility standards reflect judgements made by employers who voluntarily sponsor health benefit plans. Legislation that would reverse these judgements by mandating eligibility for part-time workers would be counterproductive. The increased cost will lead employers who voluntarily sponsor health benefit plans to reduce premium contributions across the board, yielding more uninsured workers, and/or cut-back benefits.

In sum, any effort to enact additional participation standards/nondiscrimination rules will be highly controversial, sapping support for health reforms that are needed. A firestorm of criticism forced Congress to repeal the now infamous Section 89 nondiscrimination rules shortly after they were passed. Nondiscrimination rules discussed during the 103rd Congress also drew strong opposition from the business community.

5. Solvency Standards. Indiscriminantly imposing reserve or other solvency requirements on self-insured firms to assure payment of claims that are incurred but not reported or paid prior to bankruptcy makes little sense. Firms vary markedly in their exposure to bankruptcy and in their ability to assure payment of previously incurred claims in the event of bankruptcy. Additionally, there is much variation in the risk that incurred claims

will go unpaid in bankruptcy. For instance, health benefit plans that involve capitation payments or minimum premium plans with monthly payments present no risk or a very low level of risk. Under these circumstances, it would make little sense to establish reserve requirements that would tie up tens of billions of dollars of private capital that otherwise could be put to productive use and drain billions of dollars from the Treasury in the form of increased tax expenditures.

Other aspects of the solvency issue, including alternatives to traditional solvency requirements, deserve serious exploration. If the objective is to protect consumers from claims generated prior to plan insolvency, then the amount of business risk that providers should bear in the event of an insolvency should be examined.

6. Standard Benefit Package. It would be a costly mistake to eliminate all flexibility from benefit design and cost sharing schedules. No one can credibly claim to know the one best way to design benefits to maximize quality while minimizing costs. Only market-driven innovation can achieve this goal. Therefore, employers and health plans should be permitted to retain benefit design flexibility in order to promote cost control, and consumers should have a choice of benefit designs so that they can shop for the highest value plans.

Freezing a benefit package in place by legislation is likely to yield a package that lags far behind the state of the art in benefit management. For instance, flexible mental health benefits and point of service plans are new techniques that increase choices and control costs. They were unknown just a few years ago, and would have not developed had legislation frozen benefit design in place a few years ago. Similarly, income related cost sharing is a new strategy that gives highly paid employees the same incentive as lower paid employees to be cost conscious health care consumers. Today, about 10 percent of large firms use income related cost sharing. Yet none of the standardized benefit packages proposed in 1993-1994 would have permitted income related cost sharing.

Some advocates of amending ERISA to include a standardized benefit package base their argument on *McGann vs. H&H Music,* a case which involved providing different levels of coverage for AIDS as opposed to other serious medical conditions. The issues raised in *McGann* already have been addressed by the Americans with Disabilities Act.

7. Data Reporting. APPWP supports efforts to enhance the information available to group purchasers and individual consumers about the performance of health plans and providers. However, care must be taken in how this goal is achieved. Requiring employers to report cost, quality, and member satisfaction data on a state-by-state basis would impose enormous new administrative costs and burdens on multistate employers. We also are concerned that a single national data set dictated by federal officials would lag far behind the state of the art, thereby producing a mass of costly but irrelevant data. Medicare has collected mountains of data for many years, but has been incapable of making good use of it.

In contrast, private employers who voluntarily offer health benefits are leading the way in innovative collection and use of data. For instance:

♦ Four large Cincinnati employers used their purchasing power to persuade all 14 greater Cincinnati hospitals to use the same quality measurement system. The resulting data led many hospitals to quickly revamp their practices, yielding reductions in health care costs.

♦ In October 1994, a coalition of New England employers and health plans published a report card rating 15 health plans on more than 100 measures of performance. Similar employer-led efforts to improve data on provider performance and create health plan report cards are underway in national forums and numerous other communities.

This record provides good reason for approaching with extreme caution proposals that would take data standards out of the hands of private purchasers and place it in the hands of government officials. The rapid evolution of health care data and the variety of initiatives underway in different communities reinforce the need for extreme caution in creating a single, standardized data set.

8. Preexisting Condition Exclusions. APPWP is prepared to accept a *carefully designed* restriction on the use of preexisting condition exclusions in order to meet the need for portability of coverage. However, while we retain a voluntary health insurance system, employers and health plans must have the option to use a preexisting condition exclusion that is adequate to encourage healthy individuals to purchase insurance and avoid other gaming of the system. Additionally, preexisting condition exclusions should be available when individuals switch between different levels of health coverage.

We emphasize that our support for the principle of limiting preexisting condition exclusions will not deter us from opposing poorly designed limits that leave the health benefits system vulnerable to various forms of adverse selection and gaming.

C. The Double Standard Applied to Employer-Sponsored Health Benefits Governed by ERISA and Government-Sponsored Health Benefits Not Subject to ERISA

Health plans sponsored by federal, state, and municipal governments are not governed by ERISA. Nonetheless, because ERISA sets the right structure for providing quality health benefits at an affordable cost, many government-sponsored plans operate according to ERISA-like rules. These non-ERISA government plans cover about 35 million Americans.

Policymakers who criticize ERISA rules governing health plans voluntarily sponsored by private employers rarely, if ever, criticize government-sponsored plans or suggest that these government plans should adhere to the costly new standards they wish to impose on private employers. Two examples of this double standard follow:

♦ ERISA challenges have been brought against hospital uncompensated care markups set by state law in New York, New Jersey, and Connecticut. In 1990, Congress appropriately passed a law barring the Federal Employee Health Benefit Plan (FEHBP) from paying these taxes, and the Office of Personnel Management has appropriately directed FEHBP insurers not to pay the taxes.

We are not aware that advocates of ERISA waivers or other ERISA changes that would require private employers to pay these taxes also support repealing the federal law and appropriating funds so that FEHBP can begin paying state taxes on the health benefits provided to federal employees.

♦ Policymakers who wish to expand ERISA's claims dispute remedies rarely, if ever, mention that remedies available to individuals enrolled in Medicare, FEHBP, and many state employee health plans are essentially identical to ERISA remedies. Again, we are not aware that advocates of increasing private employers' claims denial liability also advocate increasing federal and state government liability for claims denials and appropriating federal and state funds to pay for judgements and increased health benefit costs.

VI. Conclusion

ERISA has facilitated a voluntary, employer-sponsored health benefit system that provides excellent coverage to tens of millions of Americans. ERISA also has facilitated the employer and managed care plan-led revolution that is improving health care quality and controlling health costs. Amending ERISA to allow state waivers or require employers to meet costly new standards will undermine this well functioning system. As a result, many workers will lose their health benefits or have their benefits cut.

We urge Congress to extend the full benefits of ERISA preemption to all employer-sponsored health plans by preempting states' antimarket laws.

STATEMENT OF

Cristie Upshaw Travis
Chief Executive Officer
Memphis Business Group on Health

BEFORE THE COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

March 14, 1995

Good morning Chairman Kassenbaum and Members of the Committee on Labor and Human Resources. The Memphis Business Group on Health (MBGH) is pleased to have the opportunity to present testimony regarding our organization, its history, purpose and efforts to support the delivery of high quality, cost-effective health care services.

A History of the Memphis Business Group on Health

In 1985, 11 Memphis-based employers formed the Memphis Business Group on Health (MBGH), a non-profit organization, in response to uncontrolled increases in the cost of health care coverage and to the absence of quantitative outcome measurement data. In 1986, results of a study commissioned by these employers indicated that there was a difference in the charges among area hospitals of up to 80% for the same services. As an initial step, the MBGH called a press conference and published the results of the study, notifying the entire community of the significant differences between hospitals. The member companies decided that networking to form cooperative programs was the most viable method to achieve cost containment, quality monitoring, and development of a competitive health care market in Memphis.

Today membership in the MBGH has grown to 54 companies, with approximately 59,000 local employees and 147,500 covered lives.

Madam Chairman and Members of the Committee:

I am Kathleen Angel, Worldwide Manager, Corporate Benefits for the Digital Equipment Corporation. I am here today also representing the Corporate Health Care Coalition, a group of 25 self-insured, multi-state companies that actively purchase health care benefits for employees and their families. Coalition companies operate health plans covering over 5.2 million workers, retirees, and family members (2.1 percent of the U.S. population) and provide more than $10 billion a year in health benefits.

The Coalition is distinguished by its exclusive focus on issues of significance to self-insured, multi-state employers. We approach the health care system as active purchasers of health benefits for employees, not as vendors of insurance or health care products. Members of the Coalition have been in the forefront of efforts to ensure high-quality and cost-effective health care for employees. We have extensive experience in designing, administering, and delivering employee health benefits and are a major force in ongoing efforts to restructure the health care delivery system.

Today I would like to talk with you about the role that large employers are playing in the market, how this is changing the way health care services are provided -- not just for our employees, but for the community as a whole -- and where we are headed in the future.

The Employer Role as an Active Health Care Purchaser

Twenty years ago, around the time ERISA was enacted, nearly all employers were passive purchasers of health insurance. A typical large employer had one indemnity health care plan that covered their workers -- unless they had separate collectively bargained benefits. They probably contracted with a Blue Cross Blue Shield plan or commercial carrier to provide coverage. The role the employer played was to select the carrier, design the benefit package, and oversee the activities of the carrier. The premiums were experience-rated, based on some average of previous years' claims.

The employer's role has changed dramatically since then. Most large employers have gone from passive purchasers of off-the-shelf insurance products to active and, in some cases, aggressive purchasers of health care delivery system services.

Employers took the first step in this transition by self-insuring their own populations and contracting with insurance carriers only to provide administrative services. Because their large groups had fairly predictable risks, self-insurance did not really increase financial exposure. It did lower administrative and other costs imposed by the carriers and enable them to manage their cash flow. Self-insurance also offered the opportunity and the flexibility for plan sponsors to manage their health plan costs.

Rapidly rising plan costs from unmanaged indemnity plans motivated employers to get more involved in health plan management. Rather than cut benefits to save costs (which would have compromised employee health, productivity, and morale), employers became more discriminating and skilled as active purchasers. This stepped-up involvement of self-insured employers in the market for coverage and services and has driven fundamental changes in health care delivery. Over the last decade, employers have transformed the health care marketplace.

In some cases, employers have become more active as purchasers of coverage by selecting from existing health plans and provider networks and requiring selected plans to meet employer-set guidelines. Employers dissatisfied with indemnity coverage have contributed to the growth of HMO enrollment and increased incentives for new managed care arrangements to enter the market. Employers unhappy with HMO premiums that seemed to shadow indemnity rates and with the lack of HMO accountability have helped develop quality measurement systems and encouraged HMOs to report regularly to their purchasers.

In other cases, employers have stepped directly into the health care market, setting up their own provider networks, contracting directly with specialized facilities, and encouraging competition among groups of providers. Employers searching for high-quality, cost-effective providers to perform complex medical procedures have encouraged nationwide price

competition among the best medical facilities over the provision of these expensive treatments. Employers concerned about the lack of information on hospital and physician performance have helped develop data resources to measure medical outcomes, and have used this information in assembling a quality-based network of preferred providers.

This ability of self-insured employers to engage as knowledgeable purchasers in the marketplace has opened a dialogue with providers. It also has brought change and greater competition among suppliers in a market that had become fairly entrenched and resistant to outside influence. The single federal architecture -- ERISA -- under which self-insured employers can operate flexibly has played a major role in large employers' transformation from passive to active purchasers and in the emergence of competition in the health care marketplace.

There are four key aspects to the employer role in today's health care market:

1) Screening and Selection of Health Plans: Armed with data, experience, and leverage in the market, employers are operating as agents for their employees. They are screening health plans, negotiating with providers, and holding plans accountable for quality and cost of care. Given their capacity to deliver large numbers of enrollees, large employers are influencing plans to improve cost-effectiveness and quality. They are stimulating competition among providers and affecting plan operations in ways that would not be possible for employees buying coverage as individuals. This is done in an environment in which companies do not contribute to the problems of cost-shifting.

2) Partnership with employees: Employers are expanding employees' choice of health plans -- providing a carefully selected array of indemnity, point-of-service, and HMO plans; improving the information employees have to make choices; and encouraging them to use their choice of plans to help drive competition in price and quality.

3) Risk sharing with providers: Employers no longer are purely self-insured but are increasingly sharing financial risk with health care delivery systems and provider groups in the hopes of encouraging providers to develop more cost-effective approaches to treatment. This change of incentives has the advantage of encouraging cost management through physician-patient treatment decisions rather than through benefit restrictions and claims denials.

4) Leadership in quality assurance: Employers are taking the lead in developing measures of health care quality for plan-to-plan comparisons, and in establishing standards for health care delivery systems. Employers are using their leverage to encourage delivery systems to adopt these standards and account to purchasers for their performance. Employers also are working with health care delivery systems to improve data collection and analysis and are conducting studies aimed at identifying medical treatments producing the best patient outcomes.

By playing this role, employers have driven fundamental changes in the way health care is delivered and paid for. The improvements health providers have made in response to large employer demands for quality and accountability accrue to the entire community, not just to the employers. When a plan, responding to employer concerns, alters operations to improve quality, quality improves for all plan enrollees. For example, an HMO that changes its procedures to eliminate unnecessary surgery changes them for all its patients. Improvements in plan services, say, to decrease waiting time in doctors' offices or to speed communication of lab results, apply to a plan's entire enrollee population. Nor do employers merely cause cost-shifting to others when they help improve a managed care plan. Rather, the plan's rivals are more likely to adopt similar changes to stay competitive.

Managed care organizations regard active employer purchasing positively. They appreciate a sophisticated, articulate purchaser that can identify and explain its expectations. In response, an HMO or other health plan can better prioritize goals to satisfy customer needs.

Active Purchasing at Digital

Digital Equipment Corporation is committed to the goal of ensuring that its health care programs meet the needs of its 30,000 U.S. employees and their families, a total of 88,000 people, while being cost-effective for both employees and Digital. This includes offering quality programs that provide flexibility and choice to its diverse workforce and to its retirees.

Digital has responded to escalating health care costs by becoming an active and creative purchaser of health care services. Based on its experiences, Digital believes that quality and cost efficiency in health care can best be achieved through organized, technologically advanced systems of care. These systems should integrate and be held accountable for the delivery and financing of comprehensive, necessary and appropriate care to their members and compete for membership based on comparable performance measures. Further, Digital believes these systems of care offer the greatest potential to control costs and deliver quality care. Digital has designed its current health care strategy around a model that encourages partnerships with well-organized, well-managed, efficient Health Maintenance Organizations (HMOs).

Background

In 1990, when Digital was considering implementing a managed care program, there was no "off-the-shelf" program that could fulfill the requirements of the Company and its U.S. employees, that is, giving its diverse workforce choice of quality, cost-effective health plans. To achieve these objectives, in 1991 Digital developed a strategy to implement point-of-service plans with the most efficient HMOs in those geographies which also had the highest concentration of employees. Implementing those point-of-service plans involved extensive negotiating arrangements with HMOs that were capable of meeting specific performance criteria developed by Digital.

Through the Digital point-of-service program, employees retain the flexibility to choose any doctor, hospital, or eligible health care provider. However, benefits and levels of coverage depend on how members choose to receive their medical care. If employees choose a provider outside the HMO, they are responsible for paying a larger portion of their medical expenses through deductibles and co-payments as in a fee-for-service plan.

In addition to 26 point-of-service plans, during annual open enrollment, employees can choose among 88 HMOs, two fee-for-service plans, and an Opt-out plan.

From a cost-sharing perspective, Digital's share of medical costs is based on the lowest cost HMO in each geographic area that meets Digital's HMO Performance Standards. Employees who choose less efficient, more costly health plans or fee-for-service plans must pay the incremental difference in the cost of these programs. As a result, Digital's cost is the same regardless of the plan the employees choose.

Measurable Results

Since the implementation of its managed care strategy in 1991, Digital has seen a dramatic shift in the enrollment of its U.S. employees. Prior to 1991, 72 percent of employees were enrolled in fee-for-service plans and 28 percent of employees were enrolled in HMOs. As of January 1, 1995, 81 percent of employees were enrolled in managed care plans, 7 percent in fee-for-service plans and 12 percent in the Opt-out plan. As a result of this strategy, Digital's savings from 1991 through 1995 exceeded $100 million, or $765 per employee in 1995. In 1990 the weighted average HMO premium increase for Digital was 12 percent. By 1994, Digital's weighted average HMO premium increase was 4 percent and for 1995, Digital will experience a 1 percent decrease in the weighted average HMO premium.

Digital's HMO Performance Standards

Digital's HMO Performance Standards are today the hallmark of the Company's quality approach to managed care. The standards of care, which can be described as "purchasing

specifications" for health care services, have been developed by Digital for the management of the participating HMOs. The standards provide the framework for developing new relationships, recommending new HMO partners, and influencing the ongoing management of the HMOs. The management process is based on the principles of Total Quality Management (TQM) focusing on major areas of specific concern to Digital. These include access of HMO members to services and member satisfaction; quality of clinical operations and treatment; mental health and substance abuse; data reporting; and financial stability and management.

Proven Leadership in Quality Health Care

In an effort to encourage continuous quality improvement in the delivery of health care to its employees, Digital is partnering with several of its HMOs, and in some cases other employers, in several leadership efforts:

- Since 1989, Digital provided the impetus for developing a standardized data collection instrument which has evolved into the Health Plan and Employer Data Information Set (HEDIS). The goal of this data collection tool is to capture comparable data on each HMO regarding utilization, quality and financial reporting. Additionally, Digital drove the development of and provides leadership to the HEDIS Coalition, which consists of employers and HMOs, to implement HEDIS V2.0 in the marketplace.

- Under a project sponsored by the National Committee for Quality Assurance (NCQA), a group of large employers, including Digital, and some of its larger HMOs have been participating in a program to compare HMOs' performances in 60 key categories. Digital also has representation on an NCQA Steering Committee to develop "report cards" comparing HMO performance in these areas.

- Digital has facilitated the collaboration among three major New England HMOs, including Harvard Community Health Plan, Fallon Clinic and Matthew Thornton Health Plan, in the design and implementation of the New England Psychiatric

Outcomes Project. This is a significant project that addressed the need for consistent treatment approaches and outcomes measures in order to allow for the return of a productive employee to the workplace.

- Partnering with other FORTUNE 500 companies and the nation's leading HMOs, Digital is participating in a landmark study on outcomes measures for the treatment of angina and asthma.

- Digital joined forces with GTE and Xerox to implement a standardized member satisfaction/health risk assessment survey of employees across a broad spectrum of health plans. The goal is to compare enrollee satisfaction levels across health plans and model types.

Looking Ahead

Digital is implementing its strategy to provide a more viable, long-term solution to the health care cost issues that continue to face the Company and its employees by:

- focusing on the managed care delivery system;
- holding plans accountable for the delivery and financing of quality, cost-effective care;
- developing long-term partnerships with HMOs; and
- setting up a proactive management process utilizing TQM principles that clearly articulate performance standards that balance quality and cost.

Digital also believes that its experience will serve as a working model for other health care system planners. Appendix A outlines Digital's health care strategy in greater detail.

Coalition Member Activities

Digital is only one of the many Corporate Health Care Coalition members involved as active purchasers in the health care market -- all approaching it a little differently. I would like to take a moment to talk about some of these efforts.

General Electric Corporation (GE)

GE manages over $900 million a year in health benefits for over 450,000 employees, retirees, and dependents associated with facilities across the country. Its strategy in recent years has been to focus on managing local markets. In its Health Care Preferred (HCP) plan, GE builds long-term partnerships with a selected health plan in each area and invites the participation of other employers and public purchasers to improve quality and lower costs. GE initiated this strategy in Cincinnati, Cleveland/Columbus, and Louisville in 1992, and has since expanded it to 32 local markets.

In each market, GE selects a single "best partner" health plan, based on the capabilities and performance of that plan. GE builds enrollment by bringing in other employers, and then actively manages each plan at the local level. By selecting one health plan partner, GE can work cooperatively with that partner to improve quality and costs over time. Active management means that GE has its own staff periodically on-site at the health plan to work collaboratively with plan managers. The GE health care team searches throughout the country for national benchmarks against which to measure the performance of its plans in each local market. GE then provides on-going consultation in developing strategies to bring plan performance up to these benchmarks. The net effect is to improve quality and lower costs not only for GE and its employees, but for all other enrollees in these health plans, and for other members of the community who benefit from the increased local competition among health plans.

The process of identifying best practices is a two-way street. In its relationship with Tufts Associated Health Plan, GE has helped Tufts identify practices in other markets that would improve Tufts performance, and has adopted practices from Tufts that it can take to other markets. For example, GE brought in a consultant from a New Jersey-based group with state-of-the-art case management tools and introduced Tufts to a midwest vendor specializing in X-ray capitation and management. At the same time, GE adopted a physician practice pattern software package from Tufts that it then introduced to other GE partners.

Through its cooperative relationship with Tufts, GE established performance targets for the plan. The targets for 1995 include a five percent reduction in GE premiums at the same time that Tufts continues to meet its goals for customer service and steadily improves the quality of its care. GE's benchmarks help Tufts to identify changes in practices that not only will enable it to meet GE's performance targets, but also will lower costs and improve quality for other Tuft plan enrollees as well.

GTE Corporation

GTE provides health plans for over 300,000 employees, retirees, and dependents in association with its operations in 40 states. GTE has structured a comprehensive approach to managing its health benefits that includes health plan selection, consumer education, value pricing health benefit options, employee satisfaction evaluation, and quality assurance.

HMOs that want to participate in the GTE program must comply with GTE's Health Plan Requirements: they must be an organized delivery system and offer the standard GTE benefit design; meet requirements for access to care; be able to provide data in the HEDIS format; be accredited by NCQA (by 1996); agree to participate in GTE's Quality Improvement Partnership (QIP); and have a demonstrated capacity to manage costs.

GTE offers employees a choice of indemnity, HMO, and HMO/point-of-service health plans. GTE contributes at a different rate for different types of health plans in a way that creates "value pricing" of the employee premium. Employee contributions are priced in relation to the ability of the health plan to deliver quality health care at an affordable price. The ability to enroll the sickest beneficiaries in the highest quality plans without an impact on employee premiums may raise costs for GTE in the short run, but it will save money in the long run from better management of care. Its purpose is to ensure that employees have an incentive to select health plans that will give them the best value. Employees are provided detailed information on the plan choices in the GTE Health Care Consumer Guide. The percentage of GTE employees voluntarily enrolling in HMOs has increased from 32 percent to 60 percent in the last four years, and is expected to rise to 75 percent within 2 years.

All HMOs that cover GTE employees participate in regional GTE Quality Improvement Partnerships (QIPs). The purpose of the QIP is to manage quality improvement activities with the plans. Regional QIP meetings focus on GTE requirements and objectives, quality management, plan performance indicators, and sharing of best practices. These groups identify problems in treatment rates, medical outcomes, or patient satisfaction, and develop shared strategies for resolving these problems.

In markets where GTE has not had a choice of managed health plans, it has contracted directly with providers. In San Angelo, Texas, GTE had 1700 employees and no managed care. Health care utilization rates were 50 to 100 percent above their norms in other communities. GTE negotiated directly with the two local hospitals to develop competition on price and access, and in the end developed the beginnings of an organized delivery system, selecting one of the hospitals to serve its employees.

In the Tampa Bay area of Florida, GTE created its own primary care center -- the Family Health Center -- to meet the needs of employees, retirees, and their families

in that area. The Center provides preventative and educational services and primary care, urgent care, laboratory services, pharmacy, and x-ray services for a $5 visit copayment on a voluntary basis. The Center was well received by retirees and employees -- saving them an estimated $431,000 in the first year -- at no additional cost to GTE. Over the long term, the greater emphasis on preventative and primary care should reduce GTE costs while improving the quality of services for its employees.

GTE's active purchasing of plans and health care is changing not only its own health plans, but the nature of the surrounding health care markets. The growing accountability of plans for quality and cost and the increased competitiveness among health care providers are measurable improvements that benefit the entire community in locations where GTE is active.

Hershey Foods Corporation

Hershey Foods has played a direct role in developing state-wide reporting systems that enable employers and health care networks to identify and select high-quality providers, and in using this information to set up networks for its employees.

Hershey was a partner in the development by the Pennsylvania Health Care Cost Containment Council of a state hospital effectiveness reporting system based on clinical information collected and analyzed using the MedisGroups effectiveness measures. In 1990, the state began reporting comparable data on treatment outcomes in specific disease categories for every hospital in Pennsylvania with more than 100 beds.

Hershey combined the state hospital effectiveness data with data on hospital costs and on other providers which it developed independently. Hershey then selected hospitals and physicians for its own network on the basis of their cost-effectiveness and physician practice data. Employees were offered the choice of continuing to use

their own providers with the full indemnity cost-sharing or using Hershey network providers with little or no cost-sharing.

This network strategy coupled with viable HMO alternatives has allowed Hershey to discontinue its indemnity plans in 1995 for all but a small portion of its employees. Moreover, employee satisfaction with the health care program is at an all-time high.

The availability of Pennsylvania's hospital effectiveness data and Hershey's use of cost-effectiveness data in selecting providers has helped to increase the sensitivity of providers to price and quality differences -- creating a more competitive market for medical care in their area. Hershey has also been able to improve the quality of health benefits for its employees, with greater accountability from providers to Hershey for the cost-effectiveness of the medical care provided.

The Importance of ERISA

The role that employers are playing as innovators and active purchasers is largely possible due to their self-insured status governed under a single set of federal standards enacted in the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides a set of national rules and procedures that give employers the flexibility to structure coverage and financial incentives to meet the needs of employees and actively manage plan costs. Because ERISA preempts any and all state laws that would apply to employee benefit plans, employers are able to operate their plans free from the need to condition each action on state level approval or to demonstrate compliance with state law in every state in which company employees reside. Given this flexibility, employers have been able to act quickly to develop innovative solutions to health care problems and negotiate new arrangements with providers to ensure that appropriate high-quality care is provided for employees at a reasonable cost.

The protection ERISA affords employers is substantial. It is protection from state taxation, and thus regulation, of their health plans. It is protection from state anti-managed care laws that would prevent them from selecting specific health care providers and excluding others.

It is protection from community-rating insurance regulations that would force them to turn over the financial returns from effective management of their plans to a state pool. It is protection from state rate-setting and cost containment laws that would eliminate risk-sharing arrangements with providers. It is protection from state claims reporting and data collection specifications that would force changes in their claims and outcomes reporting activities and interfere with efforts to hold health plans accountable.

Lack of uniformity and administrative complexity are not the most serious consequences of relaxing ERISA's preemption of state law. Far more serious are the societal implications of the effects of state regulation on the private health care markets that have thrived within ERISA's zone of federal oversight. The emergence of multiple, and sometimes contradictory state regulatory schemes, perhaps separated only by a line on a map, could well stifle the innovation of many national employers, jeopardizing the achievement of health care modernization over the last 20 years. We have included for the record a Corporate Health Care Coalition publication entitled "ERISA Preemption: The Key to Market Innovation in Health Care".

Conclusion

The Corporate Health Care Coalition believes that the long-term solution to health care cost issues involves the active participation of employers in the health care marketplace as advocates, brokers, and sophisticated purchasers for their employees.

Turning individuals loose to buy their own health plans from among the hundreds of available options would be pure folly in today's market. They are unlikely to get adequate information to make educated choices about plans, as employers can. Nor can individuals command the attention of large, sophisticated health care plans and providers. Only purchasers representing many individuals, such as employers, have enough market power for that. It would be quite easy for health insurers and HMOs to sway individuals' purchasing decisions by promising amenities, marketing name brands, differentiating products and using

a variety of other marketing techniques that only serve to obscure true distinctions in price and quality.

The employer is an important agent for the employee today -- negotiating financial risk sharing with providers, developing long-term relationships with health plans to build capabilities and improve quality, and holding plans accountable for the delivery of high-quality care. The fact that we are selecting health plans enables us to deliver large numbers of enrollees to the plans we select and encourages the plans to work constructively with us to make improvements. We would not be able to affect these plans if employees shopped individually for coverage among the multitude of plans available. Without our involvement in the market, we believe this concentrated effort to improve quality and lower the cost of care would flag, even as its success begins to show in declining health plan premiums and in high emplovee satisfaction with managed care plans.

As employers we have much more work to do before we have truly established a vibrant competitive health care market focused on improving quality and lowering cost. ERISA and ERISA preemption of state law are critical factors that have contributed to the role of employers as "laboratories of change". They must remain in place if we are to reach our goals and contribute to your own hopes for better and more affordable health care for every American.

Digital Equipment Corporation's
Managed Care Approach to Health Care Benefits

Digital Equipment Corporation has responded to escalating health care costs by becoming an active and creative purchaser of health care services. Based on its experiences, Digital believes that quality and cost efficiency in health care can best be achieved through organized, technologically advanced systems of care. These systems should integrate and be held accountable for the delivery and financing of comprehensive, necessary and appropriate care to their members and compete for membership based on comparable performance measures. Further, Digital believes these systems of care offer the greatest potential to control costs and deliver quality care. Digital has designed its current health care strategy around a model that encourages partnerships with well-organized, well-managed, efficient Health Maintenance Organizations (HMOs).

Background

In 1990, when Digital was considering implementing a managed care program, there was no "off-the-shelf" program that could fulfill the requirements of the Company and its U.S. employees, that is giving its diverse workforce choice of quality, cost-effective health plans. To achieve these objectives, in 1991 Digital developed a strategy to implement point-of-service plans with the most efficient HMOs in those geographies which also had the highest concentration of employees. Implementing those point-of-service plans involved extensive negotiating arrangements with HMOs that were capable of meeting specific performance criteria developed by Digital.

Through the Digital point-of-service program, employees retain the flexibility to choose any doctor, hospital, or eligible health care provider. However, benefits and levels of coverage depend on how members choose to receive their medical care -- either within the HMO system or outside the HMO. If employees choose a provider outside the HMO, they are responsible for paying a larger portion of their medical expenses through deductibles and co-payments like a fee-for-service plan.

Since introducing 4 point-of-service plans in 1991, Digital has expanded its point-of-service offerings to employees who reside in 28 different geographies across the country. Based on a January 1, 1995 population of 30,000, 91% of employees are eligible for a point-of-service plan. In addition to these 26 point-of-service plans, during annual open enrollment, employees can choose amoung 88 HMOs (based on residence), 2 fee-for-service plans and an Opt-out plan.

From a cost-sharing perspective, Digital's share of medical costs is based on the lowest cost HMO in each geographic area that meets Digital's HMO Performance Standards. Employees who choose less efficient, more costly health plans or fee-for-service plans must pay the incremental difference in the cost of these programs. As a result, Digital's cost is the same regardless of the plan the employees chooses.

Measurable Results

Since the implementation of its managed care strategy in 1991, Digital has seen a dramatic shift in the enrollment of its U.S. employees. Prior to 1991, 72% of employees were enrolled in fee-for-service plans and 28% of employees were enrolled in HMOs. As of January 1, 1995, 81% of employees were enrolled in managed care plans, 7% in fee-for-service plans and 12% in the Opt-out plan.

Digital has found that the managed care delivery system has already contributed significantly to controlling health care costs, while maintaining the quality of care provided to employees and their families. As a result of this strategy, Digital's savings from 1991 through 1995 exceeded $100 million. Per employee savings of $52 in 1991, $176 in 1992, $363 in 1991, $572 in 1994, and $765 in 1995 account for this total.

Yearly cost increases for HMOs have risen considerably less than fee-for-service plans. For instance, in 1990 the weighted average HMO premium increase for Digital was 12%. By 1994, the weighted average HMO premium increase was 4%. For 1995, Digital will experience a 1% decrease in the weighted average HMO premium.

Digital's HMO Performance Standards

Digital's HMO Performance Standards are today the hallmark of the Company's quality approach to managed care. The standards of care, which can be described as "purchasing specifications" for health care services, have been developed by Digital for the management of the participating HMOs.

Adherence to Digital's HMO Performance Standards is the key to the HMO management program. The standards provide the framework for developing new relationships, recommending new HMO partners, and influencing the ongoing management of the HMOs. Digital has contracted with John Hancock Mutual Life Insurance company to play the role of Network Manager to assist Digital in monitoring HMO performance against these standards.

The management process is based on the principles of Total Quality Management (TQM) focusing on major areas of specific concern to Digital.

- Access/Administration/Member Services and Satisfaction - choice of primary care physician in defined geographic areas; established ratios of providers to patients; availability of urgent care; telephone response time monitoring; implementation of member satisfaction surveys.

- Clinical Quality - integration of TQM principles into the HMO's clinical and operational systems; maintenance of medical records, preferably automated; commitment to outcomes research; maintenance of provider selection and credentials process; monitoring and evaluation of provider practices and treatments protocols.

- Behavioral Health - the ability to offer a continuum of care; the willingness to flex the limits of coverage for inpatient and ambulatory visits; the availability of alternative treatment settings; the presence of an active triaging and case management program; the ability to track outcomes.

- Information Management and Reporting - prescribed format on patient satisfaction survey, patient utilization, and audited financial statements. (Health Plan/Employer Data Information Set - HEDIS).

- Finance and Contracts - detailed financial reporting and a statement of liability protection.

As of October 1993, HIV/AIDS care standards were included in Digital's HMO Performance Standards. These standards were developed by Digital, John Hancock, and Digital's HMO partners to help ensure consistency of care for Digital employees and families who are living with or are affected by the HIV disease. This leading initiative in HIV/AIDS care attests to Digital's commitment to provide necessary and appropriate health care to all of its employees and their families.

Proven Leadership in Quality Health Care

In an effort to encourage continuous quality improvement in the delivery of health care to its employees, Digital is partnering with several of its HMOs, and in some cases other employers, in several leadership efforts:

- Since 1989, Digital provided the impetus for developing a standardized data collection instrument which has evolved into the Health Plan and Employer Data Information Set (HEDIS). The goal of this data collection tool is to capture comparable data on each HMO regarding utilization, quality and financial reporting. Additionally, Digital drove the development of and provides leadership to HEDIS Coalition, which consists of employers and HMOs, to implement HEDIS V2.0 in this marketplace.

- Under a project sponsored by the National Committee for Quality Assurance (NCQA), a group of large employers, including Digital and some of its larger HMOs have been participating in a program to compare HMOs' performances in 60 key categories. Digital also has representation on an NCQA Steering Committee to develop "report cards" comparing HMO performance in these areas.

- Tufts Associated Health Plan, Harvard Community Health Plan and Fallon Clinic is called the Clinical Indicators Project. Its goal is to establish benchmarks for cross-plan comparisons of Caesarean section, prenatal care, asthma admission, hypertension screening, mammography and mental health.

- Digital has facilitated the collaboration among three major New England HMOs, including Harvard Community Health Plan, Fallon Clinic and Matthew Thornton Health Plan, in the design and implementation of the New England Psychiatric Outcomes Project. The study has been designed to include all inpatient mental health admissions at several local facilities. This is a significant project in that it addressed the need for consistent treatment approaches and outcomes measures in order to allow for the return of a productive employee to the workplace. In June of 1993, a "Special Presidential Commendation" was awarded to Digital by the American Psychiatric Association (APA) in recognition of outstanding leadership in providing high-quality mental health services for its employees and their families, both at the work-site and through HMOs.

- In partnering with other FORTUNE 500 companies and the nation's leading HMOs, Digital is participating in a landmark study, the Managed Health Care Association (MHCA) Outcomes Management Study, for the treatment for Angina and Asthma. The conclusions of Phase I were that outcomes measures can be collected and pooled by HMOs, competing companies can cooperate for a common goal, instruments are reliable and valid, and standardization of data collection processes across organizations is needed.

- Digital has representation on the Board of Directors of the Washington Business Group on Health (WBGH).

- Digital joined forces with a consortium of large national employers to implement a standardized member satisfaction/health risk assessment (SF-36) survey (Employee Health Care Value Survey) of employees across a broad spectrum of health plans. The goal is to compare satisfaction levels across health plans and model types, as well as to identify areas of improvement through performance monitoring and assess the health risk of employees across these Plans.

Looking Ahead

Digital is implementing its strategy to provide a more viable, long-term solution to the health care cost issues that continue to face the Company and its employees by:

- focusing on the managed care delivery system;
- holding plans accountable for the delivery and financing of quality, cost effective care;
- developing long-term partnerships with HMOs; and
- setting up a proactive management process utilizing TQM principles that clearly articulate performance standards that balance quality and cost.

Digital also believes that its experience will serve as a working model for other health care system planners.

Digital is committed to the goal of ensuring that its health care programs meet the needs of its employees and their families, while being cost-effective for both employees and Digital. This includes offering quality programs that provide flexibility and choice to its diverse workforce.

Digital Equipment Corporation is the world's leader in open client/server solutions from personal computing to integrated worldwide information systems. Digital's scaleable Alpha platforms, storage, networking, software and services, together with industry focused solutions from business partners, help organizations compete and win in today's global marketplace.

January 1995

Initial Activities of the Memphis Business Group on Health

The original mission established by the MBGH was:

> *To exert a moderating influence on rising health care costs in the community, without sacrificing quality or access to medical care.*

In order to accomplish this mission, the MBGH adopted a two-pronged approach of reducing costs through group purchase agreements and management of health care resources. Only one hospital responded to the MBGH's initial competitive bidding process for health care services. It is important to note that, among the major health care systems in Memphis, the hospital that responded was the lower charge hospital. The MBGH group purchase preferred provider network has been operational since 1988. There have been four bidding cycles. Beginning with the second contract period, all area hospitals have submitted proposals in each cycle. The current PPO contract includes per diems for inpatient services and a 20% discount off billed charges for outpatient services.

The MBGH has recognized from the beginning that discounts alone are not the answer to controlling health care costs. As such, in 1987, the MBGH initiated utilization and case management services for member companies. Today, we provide:

- Utilization and Quality Management services for basic health care services;
- Carve out psychiatric and substance abuse case management, which utilizes a provider network that is separate and distinct from the full-service PPO network; and
- Case management for workers' compensation.

Member companies have experienced significant savings due to these utilization review and case management services. For example:

- The average length of stay for all diagnoses (excluding psychiatric and substance abuse) has decreased from 5.5 days in 1987 to 4.0 days in 1994.

- In 1994, member companies saved an estimated $3,112,000 in basic health care costs;

- The average length of stay for companies using MBGH psychiatric and substance abuse case management decreased from 26.9 days in 1987 to approximately 10.5 days in 1994.

In 1994, member companies, on average, saved $6 for every dollar they invested in utilization review and case management services at the MBGH.

The average annual increase in health care costs per employee was only 6% from 1987 to 1992 for member companies that submitted data to the MBGH. This compares favorably to the national annual average increase of 14.7% for that same time period. The MBGH is currently collecting data to estimate savings since 1992. These savings reflect the success of the MBGH in controlling health care costs.

A New, Broader Mission

With the development of a successful PPO arrangement and the establishment of cost-effective utilization review and case management services, the MBGH essentially accomplished its original mission. Activities of the MBGH began to expand and the new mission, adopted in 1994, more accurately reflected the purpose of the group:

> *The Memphis Business Group on Health is dedicated to making conscientious business decisions by striving to facilitate the purchase of effective and efficient healthcare for MBGH and the Memphis business community.*

Activities (in addition to those described previously) designed specifically to address the effective and efficient healthcare component of the mission include the following:

Quality Initiative. The last two PPO contracts have included a quality initiative between the PPO network and MBGH. Specific utilization and patient outcome data are reviewed periodically and patient satisfaction surveys are conducted. With the recent availability of

national and regional comparative data, benchmark data is now being used to compare the PPO's performance. Any trends that need further investigation are identified. For example, there is currently a special task force charged with establishing PPO network-wide policies, procedures and critical paths designed to reduce cesarean deliveries (C-Section). As a result of the quality initiative, we have been able to decrease MBGH's C-Section rate by greater than 10% over the past nine (9) months. In addition, a breast cancer task force and an education committee have been formed to address specific issues of concern identified through the MBGH quality initiative.

The efforts of MBGH to work with providers in continuously improving the quality of services have a community-wide impact. The policies, procedures, critical paths and treatment programs developed as result of this initiative will benefit all PPO patients, not just MBGH members.

Point-of-Service Program. In 1994, the MBGH determined that further cost savings could best be accomplished through the introduction of a "gate-keeper" component and more comprehensive management of health care resources. As a result, a group purchase point-of-service option is now available to member companies. By offering a group purchase POS, the MBGH is supporting the continued development and evolution of effective and efficient delivery models.

This new mission also reflects the expanded role for MBGH within the Memphis community. The following points provide examples of programs and services that have had a community-wide impact:

The Business Group Health Insurance Alliance. In 1994, the MBGH, in alliance with an insurance company and health care providers, developed a fully-insured health care benefit plan specifically designed for small employers with 2 to 100 employees. The benefit plan is priced favorably and is more affordable to small employers because it is based on the pricing negotiated by the MBGH for its self-funded PPO network. The following statistics reflect the experience of the plan during the first 11 months of operation:

- 123 groups with 2,618 employees;
- Average group size of 21 employees;
- 7% of the groups had no prior coverage;

Based on a sample of participating companies, these companies saved an estimated 24% by accessing health insurance through the Alliance compared to their previous health care coverage.

Policy renewal pricing will be based upon specific company experience and the combined experience of the Alliance. It is anticipated that if there are premium increases, they will be significantly lower than would have been experienced outside the Alliance.

Composition of the Memphis Business Group on Health. The profile of MBGH member companies indicates that small, medium and large employers in the Memphis area have accessed membership and its benefits. As presented in the following table, employers with 100 to 299 Memphis-area employees represent the largest category of member companies:

Company Size (Employees)	Number	Percent
Less than 100	4	7.4
100 - 299	23	42.6
300 - 499	8	14.8
500 - 999	6	11.1
1,000 and over	13	24.1
Total	54	100.0

All member companies, regardless of size, benefit through membership in MBGH. Large companies are able to increase their purchasing power in the community by associating with other large companies. Smaller companies have the opportunity to benefit from the purchasing power of these large companies and realize significant savings in their company's overall expenses.

Conclusion

All of these efforts to develop and support high quality, cost-effective health care services in Memphis have been undertaken by local employers seeking local solutions to the specific health care issues in Memphis. These initiatives have been undertaken based upon

our membership's identification of a problem and have not been mandated by third-parties. Because these have been private initiatives, the solutions have been both creative and targeted. This competitive, market-driven approach is working. We encourage you to support models of health reform that will allow this type of local, market-driven solution to continue.

Remarks Prepared for Testimony
before the
U.S. Senate Labor and Human Resources Committee
Washington, D.C.
March 14, 1995

Glenn Potter
Vice Chancellor for Hospital Administration
University of Kansas Medical Center

Madam Chairman and distinguished members of the Senate Labor and Human Resources Committee. Thank you for the opportunity to be with you today to share our experiences in the local health care marketplace.

I am Glenn Potter, Vice Chancellor for Hospital Administration, the University of Kansas Medical Center. The University of Kansas Medical Center was formed 90 years ago when three proprietary medical schools in Kansas City were reformed under the control of the University of Kansas. We are a major health care asset for Kansas City, our region and the State of Kansas, providing the majority of health care professionals from our schools of medicine, nursing and allied health who practice in Kansas City and the majority of 5,000 physicians who practice in Kansas. K.U.'s Medical Center itself is the seventh largest employer in greater Kansas City. Our biomedical research efforts are a significant economic development factor for the region and the state. Yearly, we treat patients from each of Kansas' 105 counties as well as patients from neighboring states of Missouri, Nebraska, Iowa and Oklahoma. We are proud of our role in providing quality tertiary care services and proud, too, that we are making bold steps to encourage new students in the primary care practices.

In Kansas City -- like many other cities across the country -- hospitals, health systems, physicians, other health care providers and practitioners, insurers, local agencies and business leaders are working together to make our community healthier. We are forming partnerships that bring greater focus towards keeping people healthy and creating a more coordinated health care delivery system to better serve people's health and care needs.

Health care has historically been focused on restoring people to health. Health care today and in the future is focused on keeping people healthy. That simple change in wording is a major change in focus, behavior and mindsets. It's a societal, cultural shift.

Today in Kansas City, partnerships or networks are being designed to create major cultural shifts not only in how we deliver and finance health care, but also in our individual and collective mindsets about the importance of our health, our community's health, and how we access and use health care services.

These emerging partnerships are taking on a variety of forms and legal structures. But they are all striving to design a greater focus on community needs and addressing underlying problems that contribute to poor health. They are being designed to better coordinate care, aligning incentives to ensure that the right care is available at the right time. Through cooperation and collaboration, these partnerships or networks are also beginning to reduce excessive duplication of services and technology; and by increasingly aligning the incentives of all the parties involved, they are also reducing costs. A Group Health Association of

America study shows nationwide that coordinated care plans, on average, reduced their overall premiums 1.2% for 1995. In Kansas City the industry seems to be solving many of its own problems as evidenced by:

- Rate increases have moderated considerably over the last 18 to 24 months.

- similarly, rate increases seem to have stabilized for all medical health insurance products. True managed care products, such as health maintenance organizations (HMOs), show increases of 1 to 2%, while increases for moderately managed products such as Preferred Provider Organizations (PPOs) have been somewhat higher in the range of 8 to 10 %.

- observed cost trends are being pushed downward by a combination of factors, including more people selecting more effective managed care plans and providers, who are gaining efficiencies, being able to offer and accept better (lower) pricing.

In the emerging partnerships in Kansas City, network partners are beginning to share the risk with each other for bottom-line, per-person cost and performance. This strengthens the common interests of all the partners. All partners now have an interest in delegating quality improvement and cost management responsibilities to the most appropriate effective partner, and in finding ways to help each other execute these responsibilities.

For now, it is the players' responsibilities and relationships that are changing more than the interventions. But the more the risk/rewards and objectives are shared, the more we'll be able to reduce wasteful or duplicate processes, procedures and capital. There's also a greater potential for developing and implementing innovative, cost-effective processes for maintaining people's health.

Traditionally, relationships between insurers and providers have been based on arms-length negotiations. In these new partnerships, the parties are creating shared or consistent objectives and financial incentives. So, rather than an arms-length negotiation, the relationship focuses on gaining a better understanding of each others' perspectives and concerns; and developing together, new approaches to achieve these common objectives.

As these relationships evolve, partners begin to no longer distinguish between their interests and their partners' interests. The partnership is only successful for any partner, if all interests -- including the community's -- are satisfied.

The emerging primary objective is keeping people healthy and happy.

As I mentioned, in the Kansas City area and Kansas, a number of such community focused networks are emerging. For instance, a couple of efforts with which our hospital is involved...

- Five hospitals/health systems including KU Medical Center, and two Blue

Cross Plans, one from Kansas City , the other from Kansas, have come together to form a corporation called Tri-Source. Tri-Source has implemented and operates a health maintenance organization that is marketed throughout eastern Kansas and western Missouri to a population of nearly three million people within a 75 mile radius of Kansas City. As important as the product we have produced is the collaboration among the partners that seeks innovative ways to work together for the benefit of the communities served.

- The Jayhawk Health Alliance is another collaborative venture that involves KU Medical Center and seven other suburban and rural hospitals all within a 75 mile radius of Kansas City. A few of the stated objectives of this Alliance are to:

    a. integrate financing and delivery of care;

    b. focus on primary and preventive care;

    c. provide access to a full continuum of health services in a variety of delivery settings;

    d. enhance quality through demonstrated outcomes management, and

    e. reduce cost through collaborative patient care management.

- At KU Medical Center, our Schools of Nursing, Allied Health and Medicine are seeking closer working relationships with various managed care entities to

better prepare tomorrow's practitioners for their role in "coordinated care." Our outreach efforts reach into virtually every corner of Kansas through teaching affiliations, compressed video-teleconferencing, continuing education programming and specialty clinics. Our goal of enhancement of primary care teaching services and research includes a strategy to change residency mix so that 50% of all residency positions are in primary care by the year 2000. To accomplish this, we are adjusting the curricula in all schools to emphasize primary care, evaluating and establishing sites for training affiliates throughout the State of Kansas, reallocating faculty positions to primary care disciplines and emphasizing selection of students with an interest in primary care.

- The states of Kansas and Missouri are both in the process of creating new Medicaid managed care programs. In Kansas, Wyandotte County -- University of Kansas Medical Center's home county -- is being selected as one of the demonstration sites. The state will be requesting bids from organizations with an HMO license. KU Medical Center is currently exploring our partnership opportunities for this demonstration program.

- The Greater Kansas City Chamber of Commerce's "Chamber Choice" program also offers the areas' smaller employers the advantages of today's competitive marketplace. Subsequent to a highly competitive bidding process, the Chamber selected a plan which offers subscribing businesses, with 25 or fewer

employees, the opportunity to allow their employees to select between:

-- a health maintenance organization (HMO) which offers 100% coverage for most services, extra benefits, and no annual deductible; and

-- a preferred provider organization (PPO) that offers freedom of choice of providers, and extra cost savings when provider networks are used.

Since Chamber Choice was launched last May, over 350 employers have signed up to cover over 1,500 people. These small businesses not only have a plan that gives their employees options, they have a guaranteed rate increase cap for their first renewal. While this cap is 8%, it is believed actual renewal rates will be lower consistent with lower premiums of smaller rate increases being realized in Kansas City and nationwide. This initiative has the potential to give greater rate stability for small employers because of the "pooled" experience concept.

All of these initiatives and ventures are "works in progress". We will need to continue improving them as we learn how to become more integrated, coordinated health care delivery systems. But we know coordinated care is the right thing to do. It is a fundamental change and fundamental change is needed to:

o rein in compounding increases in health care costs; and

- o improve people's health and the health of our communities.

However, there is a right way, and a wrong way to stimulate such changes. The wrong way is to create managed care programs that are really only managed costs. The right way is putting the care back in managed care. Care must become more coordinated, integrated and community-focused.

Managed or coordinated care's . . .

- o emphasis on prevention and responsibility for the full continuum of services can improve quality as one organization is held accountable, instead of a variety of providers; and

- o shifting of the care emphasis from treating sickness to promoting wellness can also reduce costs.

In Kansas City, multiple provider partnerships and insurer/provider partnerships are giving us the opportunity to leverage and capitalize on our respective strengths to better serve and affect our greater community's health.

There are barriers to making these changes, however. One of the greatest barriers or complications is that public programs (i.e., Medicare and Medicaid) are not following the

private sector trends towards managed care.

Instead, Medicare and Medicaid often create incentives that are in conflict with our private sector trends to coordinate care. This is particularly problematic, given these programs, on average, represent 50% of hospitals' revenues.

We need to move toward coordinated care. Beneficiaries need to be encouraged to select coordinated care options. Providers need to be encouraged to offer coordinated care options.

For Medicare beneficiaries, coordinated care means greater ability to meet their needs and to receive preventive care. More and more, coordinated care is covering all Medicare services, plus coverage for vision, dental, preventive services and even hearing aids -- benefits that most "Medigap" policies don't provide. Many coordinated care plans eliminate the 20% co-payment seniors must pay for doctor visits, and at the same time eliminate mountains of claim forms. These may be key reasons why a recent survey by the consulting firm of Frederick/Schneiders found that Medicare enrollees in coordinated care plans are as satisfied with their overall care as those with fee-for-service insurance.

Most importantly, coordinated care networks can bring Medicare beneficiaries closer to a better vision of health care for the future: a connected health system with everyone who provides care -- doctors, hospitals, nurses and others -- linked together and communicating with each other at every stage of treatment and service.

Moving the Medicare program toward coordinated care is an idea that makes sense, and one that many people believe will save money for our health care system. Take a look at the tremendous change that is going on right now in the private sector and the impact this change has already had on health and health care costs. According to the most recent Congressional Budget Office (CBO) projections, a shift from fee-for-service health care to coordinated care in the Medicare and Medicaid programs would generate overall savings of about 8%.

Coordinated care works. It works better than the old-fashioned, fragmented system we must pull away from. And it can bring better, more efficient care to older Americans who entrust their health to Medicare. There are a number of options Congress could consider that would help move Medicare into coordinated care. Here are some ideas to explore:

- **Model the Medicare program after the Federal Employees Health Benefit Program (FEHBP).** Similar to FEHBP, where the government makes a fixed contribution and federal employees choose from a wide variety of plans, Medicare could make a fixed contribution on behalf of its beneficiaries and allow them to choose to enroll in a coordinated care plan in the private sector. Under this proposal, beneficiaries choosing to receive services through a coordinated care plan would pay little or no additional costs. Beneficiaries choosing to receive services through traditional fee-for-service providers would pay the difference between the fixed contribution and higher costs of fee-for-service care. This option provides Medicare beneficiaries with a financial

incentive to choose a coordinated care option where available.

- **Provide financial INCENTIVES for Medicare beneficiaries TO choose a managed care option available in their area.** For example, require beneficiaries who select the fee-for-service benefit package to contribute a supplemental premium. Consumers would have an economic incentive to chose more cost-effective types of care and the government would take in additional revenue.

- **Explore new ways of paying managed care organizations that contract with Medicare through a series of demonstrations.** There are many problems with the way in which Medicare currently pays managed care organizations. A new approach would allow plans in the same market area to bid competitively for Medicare contracts. Bidding, which could not exceed current managed care payment rates, would have the effect of setting different market prices in local areas for Medicare managed care enrollees in a way that takes into account local costs and health care needs. Different ways of treating winners and losers in a given market could be explored through demonstrations to determine the appropriate incentives for plans that would not have a disruptive effect on beneficiaries.

- **Work to develop quality standards**, including conditions of participation, quality improvement activities, and performance measures that address issues

of importance to systems that coordinate care. Insure that new standards do not duplicate, but rather coordinate with efforts already underway in the private sector. The standard should be flexible enough to apply to a variety of delivery mechanisms, be patient-focused, and emphasize ongoing quality improvement.

- **Expand the types of plans from which Medicare beneficiaries can choose.** Today, Medicare beneficiaries can choose to receive care through an HMO or through traditional fee-for-service providers. But many non-HMO provider-sponsored networks for care are available, and can offer a full continuum of services to seniors for a fixed premium. Medicare should expand the types of risk-bearing plans with which it contracts to include these non-HMO networks of care. New types of contracts could be negotiated with these non-HMO networks in which the networks and the Medicare program would share risk. For example, for a fixed payment, networks would be responsible for providing services up to a certain pre-determined cost limit based on reasonable use of services by the network's enrollees. If a network's enrollees were unusually sick and required more than expected care, the Medicare program could be responsible for absorbing the "outlier" costs in excess of the predetermined limits. Payment to networks would be adjusted to reflect the risk borne by the government and economies of direct contracting.

- **Medicare should provide its beneficiaries with more information on managed care plans.** The program should send a list of local managed care plans directly to beneficiaries and give seniors an annual report that compares managed care and fee-for-service plans on the basis of premiums, supplemental benefits, cost sharing, and quality ratings. These efforts will make seniors smarter consumers of health care and highlight the benefits of managed care.

- **Allow for an open enrollment period each year during which Medicare beneficiaries can elect to receive services from a managed care plan.** Also, make seniors' choice of a managed care plan valid for one year -- longer than the 30-day period required today. Annual open enrollment will give seniors more opportunities to select managed care options. Making their managed care choice valid for one year enables plans to better manage beneficiary needs, practice preventive care, and achieve cost savings. This should encourage more managed care plans to enter the market and reduce Medicare costs overall.

Other barriers to coordinated care include the lack of insurance or the breaks in insurance coverage that many people experience. Insurance market reforms need to be seriously considered to provide greater portability of insurance coverage and greater security that a pre-existing illness or chronic condition will not leave people without access to any health care insurance.

Formation of community health networks can also be impeded by antitrust policies that prohibit providers, practitioners and their communities from assessing local health care needs and creating mechanisms to jointly address those needs. We are all concerned with inconsistent, conflicting and burdensome requirements of the various fraud and abuse laws.

Adoption of "any willing provider" proposals could also hamper efforts to maintain quality and cost effectiveness standards if networks are forced to contract with or hire any qualified provider who agrees to the networks' terms. Requiring all plans to accept all providers means the cost of health care goes up and the quality may go down.

How we structure the Medicaid program in terms of funding, benefits, eligibility and administration also is a serious concern. Kansas' demonstration project for Medicaid managed care offers some hope of better aligning the program in Kansas and the incentives among all the stakeholders. Meantime, welfare reforms could have direct or indirect impact on the future need for or viability of the Medicaid program. We wish to work with you as you explore alternatives for welfare's reform and their implications for people's future health care needs.

Yet, when all is said and done, as Wilbur Cohen once remarked, health care reform is, "10% legislation, 90% implementation." Health care is a local, people-intensive service -- it's people serving and caring for people. And our long term health and need for health care services is predicated on people caring about and for their own health. Finding real solutions

to the complex, interwoven problems in health care will require people working together on a local level. It requires major cultural shifts. There are no quick fixes or easy, painless answers.

Madam Chairman and Senators, we look forward to working with you to create constructive changes -- and to protect and improve the health and health care of our nation's communities and the people we all serve.

Statement of
James R. Kimmey, M.D., M.P.H.
Vice President for Health Sciences and Chief Executive Officer
Saint Louis University Health Sciences Center
before the

Commitee on Labor and Human Resources
United States Senate

March 14, 1995

MADAME CHAIRPERSON AND MEMBERS OF THE COMMITTEE--

I am Dr. James R. Kimmey, Vice President for Health Sciences of Saint Louis University and Chief Executive Officer of the Saint Louis University Health Sciences Center. I appreciate the committee's invitation to appear today to discuss the impact of the rapid changes in organization and financing of medical care on academic health centers in the United States. Although my testimony will draw heavily on the changes occurring in the St. Louis (MO) medical market area, similar changes are occurring in virtually every major metropolitan area in the nation. These changes, which I will collectively call "prudent purchasing," have both anticipated and unanticipated consequences for the purchaser, the patient, and the provider of care. They have similarly diverse effects on the institutions which our society has charged with the dual missions of educating health professionals and expanding our knowledge of health and disease as well as of the systems in which that knowledge is applied.

An academic health center is defined as a complex of institutions involved in education of health professionals which includes a university, a medical school, at least one other health professions school, and one or more teaching hospitals. At the present time, there are 125 centers in the United States which meet this definition. Academic health centers are mission-driven non-profit organizations which comprise the principal settings in this country for health professions education, medical and health services research, and management of complex medical cases. Their programs include undergraduate and graduate medical education, undergraduate and graduate training for other health professions, and a variety of related educational and research endeavors

Education and research are two of three mission elements which are common to these unique institutions. The third element is service and that element is most often expressed in provision of medical care to those who cannot afford its cost. In part because of their largely urban locations, academic health centers have by default become major providers of uncompensated care. Many major teaching hospital are also designated as disproportionate share hospitals under the federal Medicare program, documenting the fact that they provide care to the indigent at a much higher rate than community hospitals.

The Saint Louis University Health Sciences Center is one of the most complete such institutions in that it offers a full range of health professions' education programs. The Health Sciences Center comprises a School of Medicine, a School of Nursing, a School of Allied Health Professions, a School of Public Health, and a Center for Advanced Dental Education. In addition, the University owns and operates a 320 bed acute care hospital providing tertiary and quaternary level care, and maintains substantial teaching affiliations with several other community hospitals and long term care facilities. It is also located in the inner city, a mission-driven decision made two decades ago when other institutions were fleeing to the suburban ring.

Academic health centers are supported financially from many different sources, including tuition, endowment income and gifts, state appropriations, federal and private grants and contracts, and from revenues received for patient care. Table 1 shows the sources of revenue for allopathic medical schools, the most resource-intensive educational component of an academic health center, by source for three time periods.

Table 1
U.S. Allopathic Medical School Revenues,
by Source, Three Time Periods
(Dollars in Millions)

	1960-61		1980-81		1992-93	
Revenue Category.	Amount	% of total	Amount	% of total	Amount	% of total
Federal research	133	30.5	1,487	22.9	4,817	19.1
Other Federal (non-service)	43	9.9	529	8.2	630	2.5
State/Local (non-service)	74	17.0	1,503	23.2	2,958	11.7
Tuition & fees	28	6.4	348	5.4	1,048	4.2
Medical services	28	6.4	1,729	26.7	11,985	47.5
Other	130	29.8	885	13.7	3,812	15.1
Total	436	100.0	6,481	100.0	25,250	100.0

Source: Association of American Medical Colleges, 1994

These are totals for all schools, both public and private. Within those categories, there are substantial variations in the sources of funds. Public medical schools receive the bulk of the $2.9 billion in state/local non-service funds which represents 22% of their total revenue. Private medical schools receive only 1% of their revenue from state and local sources. The public schools are less dependent on income from medical services offered patients (40% of their total) than are private schools (48% of their total.).[1] In the case of Saint Louis University, the proportion of support from clinical activities to academic and research endeavors is substantially higher, representing almost two-thirds of the School of Medicine budget. This makes our institution and other private academic health centers particularly vulnerable to policies that reduce clinical income.

As complex institutions with varied funding streams, academic health centers are subject to many different pressures in their environments. The degree of strain has never been greater than it is today, and the changes in the financing and delivery of medical care currently under way in the private sector will on' intensify the pressures on such institutions. Similarly, changes in Medicare and Medicaid, in foundati and other private giving, in state tax support, and in federal research policy and funding directly affec such centers.

Current Pressures on Academic Health Centers

Examination of the data in Table 1 emphasizes the large number of funding streams which flow to medical schools. Each of these types of funding is threatened in the current environment. The sources of difficulty are several-- prudent purchasing activities on the part of business and government, pending changes in reimbursement policy, and health reform legislation at the state or federal level are most critical. Many of the sources are relatively minor as contributors to total revenues (e.g., endowment, parent university transfers, gifts) and are unlikely to be affected by financing policies. The largest sources of support--faculty practice plans and hospital transfers--summarized in the table under "medical service" are heavily affected by reform, however, and deserve further discussion. These can be considered as the revenues from the medical enterprise of the academic health center.

The Medical Enterprise

As the costs of medical education and of maintaining the large teaching and research establishments required to support such education has spiraled upward, tuition revenues have become less and less capable of providing the resources required. Increasingly, the education and research process has become dependent on the medical enterprise which is operated in conjunction with the educational and research enterprises. Two major components make up the medical enterprise--the clinical practice of faculty and the patient care activities of affiliated hospitals. In 1992-93, revenues from these sources comprised 47.5 percent of the total revenues of medical schools

Linking the costs of medical education to patient care has been essential but is not without controversy. This linkage has contributed to higher costs in most teaching hospitals than those in non-teaching hospitals. Among the factors cited for explaining these differences are the greater complexity of illness in pa

[1] These are 1991-92 figures, accounting for their variation from the percentage figures in Table 1.

tients seen in such institutions; the presence of multiple problems in such patients; a higher proportion of indigent patients seen in teaching centers; the added costs of the learning process in terms of length of stay and amount of testing done as an adjunct to teaching; and the greater capital intensity in the teaching institution which needs the latest technology to prepare practitioners conversant with such modalities.

Academic physicians tend to be less productive in terms of patient care. This is because of demands of teaching students and residents, both in the classroom and at the bedside. Another factor is the faculty's activity in carrying out basic and clinical research, a major component of their responsibility. Since such physicians are generally salaried by the educational institution, while payment for services to patients has been based on fees charged such patients or their insurers, a mechanism was required to collect such fees and effect their disbursement in accord with the individual physician's compensation agreement. Practice plans were developed as a mechanism for accomplishing this business transaction. There are many different types of such plans, but fundamentally they are organized arrangements wherein fees are assigned to the organization by the physician. The organization in turn provides financial and administrative services in support of the physician's activity. Usually, a portion of the revenues of the practice plan pass to the faculty member's department and the school. These funds are used to advance educational and research activities which would otherwise fall on the tuition dollar or the parent university. Clinical income from practice plans has allowed growth in the size and scope of these schools despite limitations on tuition and other academic sources of revenue.

Teaching hospitals, and particularly those owned by an academic health center or its parent, have also been "taxed" to support the academic enterprise. In part, the funds transferred from the hospitals are reimbursement for services provided the hospital by the faculty. Like the practice plan revenues, these hospital revenues have supported expansion of the medical (and often other) educational programs of the academic health center beyond that which would have been possible without the influx of dollars generated from inpatient care.

In addition to these sources of support for the general educational mission of the academic health center, there has been major support provided from clinical income to graduate medical education--the advanced training of physicians in specialties. Charges for services in academic health center teaching hospitals have incorporated the costs of maintaining residency programs, often extensive, both in types of residencies and numbers of resident physicians. A major source of support for graduate medical education has come through the federal Medicare program, which adjusts payments to hospitals both for the direct costs of such training (resident stipends, costs of supervision, direct and allocated overhead) and the indirect costs known to be associated with such training such as extra testing and procedures.

The Need for a Policy

The practice of supporting health professions education from hospital and physician practice revenues has elements both of expediency and policy. On the expediency side, as the complexity and cost of such education increased, volume-based revenues were a ready source of funds to substitute for inadequate tuition dollars. Cross-subsidization was a common practice in the field, and payors were willing to pay a premium price to academic health centers. On the policy side, the Medicare program institutionalized the concept with the introduction explicit payments for these educational activities. These funds were seen as essential to maintaining the resource represented by teaching hospitals, both as sites for educating professionals and conducting research and as providers of care to underserved and indigent populations. Linking education costs to patient care, either indirectly or directly, also avoided a fundamental policy issue for society and government--how appropriately to pay for health professions' education, which meets a broad need for society as a whole. With the growth of managed care and the expansion of prudent purchasing practices on the part of business and government, that basic issue must come to the agenda.

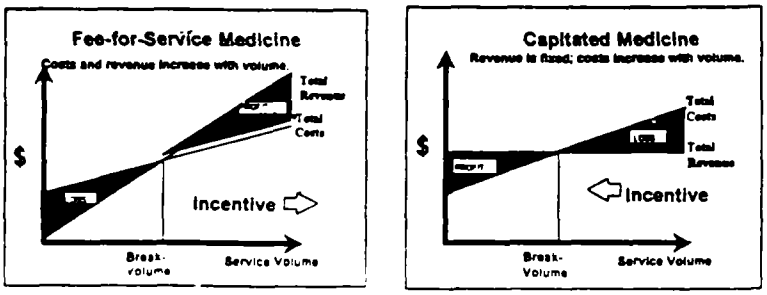
Managed Care and Academic Health Centers

Managed care is a general term which covers a wide range of arrangements under which individuals are enrolled in organized systems which accept responsibility for providing a defined range of services at a predetermined charge or premium. Managed care organizations have demonstrated an ability to offer high quality care at lesser costs than the traditional fee-for-services system. Such organizations are based on a strong network of primary care providers--providers who provide first-contact care sensitive to the individual's social and psychological situation as well as his/her medical problem and which incorporates a strong element of prevention. Generally, managed care organizations achieve economies by appropriate use of referrals and decreased use of expensive diagnostic techniques and inpatient services. When the

managed care organization pays on the basis of a capitation per enrollee, the pressure to cut all extraneous cost out of the system becomes most acute.

The effects of capitation payment are particularly harsh for academic health centers. The effect of a from fee-for-service to capitation payment is to "turn things upside down" for providers of services. Figure 1 compares the fee-for-service market forces and those in a capitated situation.

Figure 1
Relationships Among Factors in Payment Systems



The change in incentive from increasing volume to decreasing volume in order to make a profit is a problem for all health care providers. It is particularly acute for teaching institutions. Clinical teaching involves more testing, procedures, and hospital time than does non-teaching care. Yet these are the very things that the capitation model drives out. The academic health center finds itself torn between conflicting goals--to provide value attractive to the market on one hand and to meet its academic requirements on the other. When managed care is a small part of the total mix, this is not a problem; as managed care is promoted as a preferred approach, it becomes a huge problem.

Although managed care organizations have existed in the United States for decades, they have only recently become widely utilized as a source of care for a significant portion of the population. Since the organized system is at risk financially for the amount of care provided, it seeks out advantageous prices from providers through negotiation. Although quality is a desired factor, the critical item for the "at risk" organization is price

As more and more care has shifted from the traditional fee for service model to the managed care model, high cost providers like academic health centers are less competitive, and their market share is eroded. Even in the case of the "high-tech" care which is commonly available only in such centers, the prudent purchasers have been able to negotiate discounts, playing such high cost providers off against one another in a quest for the low price. Although managed care organizations do not yet dominate the market in most places, they have achieved dominance in several locales, and in those locales academic health centers have experienced severe financial problems as their clinical income has decreased.

The Saint Louis University Experience

The St. Louis market demonstrates many of these features. The market is making the transition from a fee-for-service market to a managed care market very rapidly. As the number of individuals served through managed care arrangements increases, the utilization practices of managed care organizations impact the market, increasing the surplus of hospital beds and specialist providers already present in the community. This in turn challenges providers to change behavior in ways earlier regulatory approaches never did. Hospitals and physicians discount charges to maintain a market share. Consolidation of hospitals, closure of excess beds, sale of physician practices to hospitals and formation of Physician-Hospital Organizations designed to package services for managed care becomes a frenzied activity. Downsizing, administrative consolidation, and other cost cutting measures occur. In short, the market is alive and well and living in St. Louis. The changes in the delivery system are exactly those that proponents of private market-based reform predict.

These changes in the financing environment locally are driving strategic development activities at the Health Sciences Center. An organization which as recently as two years ago led a comfortable, independent, traditional academic existence in the St. Louis community has begun an often wrenching process of transition into a lean, mean competing machine. At the end of 1993, the clinical enterprise of the Health

Sciences Center consisted of thirteen semi-autonomous clinical departments and a hospital presenting thirteen volume driven enterprises to the market. Competition was not an major issue. All the hospitals in the community were independent, and non-university physicians were entrepreneurs in partnership or small group practices. Market penetration by managed care companies was small and stable.

We recognized that this situation was not going to last, and that the Health Sciences Center like the rest of the system in the community was going to have to adapt to a new reality, one in which purchasers were going to be unwilling to pay a premium price to support academic endeavors. For the organization, it meant rethinking our role, our organizational structure, and our relationships in the community. I want to stress that we are not fighting the managed care revolution. Indeed, we are undertaking substantial changes to position the Health Sciences Center as an asset to a more cost-conscious environment. If an institution's orientation is toward community-responsive services and a prevention oriented approach, and ours is, it cannot but support the basic tenets of a managed care approach. However, the institution must find new ways to support its primary educational mission in the new context. That is the challenge all academic health centers face currently.

The strategy developed for the Health Sciences Center was designed to permit it to respond effectively to a managed care environment. Three phases were envisioned to take the organization from its traditional configuration to one consistent with current realities.

In the first phase, the clinical practices of the faculty were consolidated into a single organizational unit, the University Medical Group (UMG). Under faculty leadership, the departmental business activities were consolidated into one organization. This step promoted administrative efficiency and allowed the faculty as a whole to develop and market products and product lines to the purchasers in the community.

In the second phase, we are consolidating the UMG and the hospital into a single economic entity with a corporate identity separate from the University. This new company combines all the clinical activity of the University into a single provider structure which aligns physician and hospital incentives, permits rapid and coherent responses to changes in the market, and achieves additional administrative cost savings. This step, approved by the University Trustees ten days ago, was a major adjustment for the University and for the faculty of medicine. From the University perspective, it is allowing another entity to manage a significant portion of the University assets. The faculty required assurance that the new entity would not be so focused on its financial performance and marketing that it would lose sight of the basic educational mission it serves.

The third phase, which is proceeding concurrently, involves merger of the new single provider with another health care provider in the community which has a strong primary care physician base and broader geographic coverage than the University alone. This third step is essential to providing the academic health center with the base of covered lives required to support its teaching mission and with access to a network of primary care providers who can participate in the teaching programs for both medical students and residents.

These structural changes, difficult as they are to achieve, are only a first step. Extensive cultural change will be required as well if the new structures are to be effective in establishing a competitive position for the Health Sciences Center. And even though we believe we are making the right moves to position us for a competitive market, there are no guarantees that the market will recognize or be willing to pay for the added value we perceive in the services provided by an academic center.

Academic Health Centers and Special Populations

While these market driven changes are drawing our attention and we strive to make all available adjustments, another problem looms on the immediate horizon, changes in the Medicare program. As indicated earlier, Medicare reimbursement under the DRG system is adjusted upward for teaching hospitals to reflect the costs associated with teaching status. There are two such adjustments: the indirect medical education adjustment (IME) which compensates teaching hospital for the increased costs associated with patient care in their institutions and the direct medical education payment (DME) which supports a portion of the cost of resident salaries, supervision of residents, and other costs specifically identified with the training activity.

Both of these allowances for teaching institutions have come under scrutiny as the federal government seeks ways to cut expenditures in the interest of deficit reduction. If these allowances were to be reduced substantially or eliminated without an opportunity for the recipients to adjust to the loss, the results--

combined with the existing problems occasioned by reductions in other sources of support to the academic health centers--would be disastrous. In the case of the Health Sciences Center, a reduction of the IME from the current 7.7% rate to a 3% rate, as some have suggested, would drop $10 million [illegible] revenue in the first year, eroding our ability to sustain significant parts of our teaching program.

Another area which should be carefully monitored as cost constraining policies are entertained is the effect of such policies on charity care. Academic health centers in most situations are major providers of care to those without insurance or other means of paying for care. This is particularly true of high tech procedures, an area of care so expensive as to be beyond the reach of many who can handle costs of routine care. As the ability of academic health centers to cross-subsidize such care decreases, access to such services will be impaired. The contribution of academic health centers to care for those unable to pay is substantial. In St. Louis, the two primary teaching hospitals for the two academic health centers in the community provided $29.6 million in charity care in 1992. This represented 37 percent of the total charity care provided by the 37 hospitals in the metro area. The ability of academic health centers to sustain charity care at these levels and at the same time to continue the teaching and research activities society expects will become an impossible task as sources of revenue drop. It makes little difference whether the drop is the result of prudent purchasing, or cuts in Medicare reimbursements, or any of the other factors which affect revenue. The result will be deterioration in the ability of academic health centers to perform adequately the social responsibilities they bear.

Perspective on the Future

These problems will intensify markedly in the coming years. The clinical funding stream which supports a significant portion of both undergraduate and graduate medical education, as well as non-physician education activities in many centers, will slow to a trickle compared to the recent past and the present. Failure to recognize these unanticipated consequences of efforts to constrain health care costs both to business and government payors, and to deal explicitly with the problems which result, surely lead to a deterioration in the quality and quantity of medical education, push its costs to the individual beyond the reach of all but a few families, and erode the nation's role as the world leader in medical research. Changes must be made to accomodate this new reality, but they should be planned changes which take advantage of the opportunities it offers. Forced reactions in response to the market will not meet either the institution's needs or serve society's interest. They will force solutions--such as decreasing care for indigent patients or less research investment or less comprehensive educational efforts--which are inconsistent with academic health centers' missions.

These problems are soluble, but must be recognized before they can be dealt with effectively. This is a challenge to both private and governmental payors in this managed care era.

This completes my statement. I would be happy to respond to any questions the committee might wish to pose.

Chris Dodd
U.S. SENATOR FROM CONNECTICUT

FOR IMMEDIATE RELEASE
March 14, 1995

CONTACT: Marvin Fast
(202) 224-0345

DODD HIGHLIGHTS KIDS AND HEALTH CARE

WASHINGTON - In an effort to focus attention on the health care needs of children, Senator Chris Dodd, D-Conn., today released data from the General Accounting Office (GAO) showing that kids continue to suffer when it comes to receiving adequate coverage.

"Children are the heart and soul of a nation," said Dodd. "They shouldn't be shoved to the back of the line when it comes to getting decent health care."

The GAO study, requested by Dodd last year, found that children who face the biggest risk are those whose parents make up the working poor. Even parents who work full year, full time are unable to afford health care for their kids. Those on welfare are covered.

Below are highlights provided by GAO:

* The number of children receiving insurance through their parents' employer has decreased 9 percent in 4 years.

* Eighty-nine percent of uninsured children have at least one working parent with sixty-one percent employed full time for the full year.

* Medicaid has picked up a large portion of kids who would be uninsured. The percentage of Medicaid enrolled kids with working parents has increased dramatically. Cuts to this program will increase the number of uninsured children.

-30-

Testimony:
The Changing Health Care Marketplace
Senate Labor and Human Resources Committee
March 14, 1995

Packet Includes:

- Statement from Senator Kassebaum
- Testimony from all witnesses

Nancy Landon Kassebaum

United States Senator
Kansas

For Immediate Release

KASSEBAUM SAYS SENATE SHOULD BEGIN REEXAMINING HEALTH CARE REFORM IN LIGHT OF CHANGING MARKET

WASHINGTON, D.C.--March 14, 1995--Senator Nancy Landon Kassebaum, R-Kan., issued the following statement today during hearings before the Labor and Human Resources Committee on the changing health care marketplace:

"While congressional action on health reform bogged down last year, the private health care market continues to change at a rapid pace. Since 1987, the number of Americans enrolled in Health Maintenance Organizations (HMOs) has grown from 28 million to more than 45 million. In the past year alone, enrollment in traditional fee-for-service plans declined from 48 percent to 37 percent while overall managed care enrollment climbed from 58 percent to 65 percent in firms with more than 200 employees.

"Health care costs and insurance coverage patterns are also changing. According to a recent survey, employers' 1994 health care costs were down 1.1 percent, falling for the first time in a decade. Large employers reported decreases averaging 1.9 percent. However, overall health expenditures are projected to reach 18 percent of gross domestic product (GDP) by the beginning of the next century, the number of Americans who are uninsured continues to climb, and many families and small employers are finding it more difficult to obtain health coverage.

"The politics of health care reform have also changed dramatically since last year's debate and, in part, as a result of last year's debate. Each week, I receive dozens of letters from Kansans who cannot afford health coverage or who cannot buy insurance because they have a preexisting medical condition. Increasingly, however, most of those letters also encourage us to fix what is broken in the health care system without relying on big government solutions.

"That leads to the two main questions I hope these hearings will begin to address: what we should do now, and how we should do it. As most physicians will tell you, you cannot prescribe the proper treatment unless you first make the correct diagnosis."

The committee will begin a second day of hearings at 9:30 a.m., in Dirksen 430 on Wednesday to explore possible directions for market-based reform.

# # #

Contact: Mike Horak - Press Secretary
Joel Bacon - Deputy Press Secretary
(202) 224-4774

STATEMENT OF

LEONARD D. SCHAEFFER
CHAIRMAN AND CEO
BLUE CROSS OF CALIFORNIA

BEFORE THE

COMMITTEE ON LABOR
AND HUMAN RESOURCES

U.S. SENATE

MARCH 14, 1995

Written Testimony of Leonard D. Schaeffer

Presented to the
Committee on Labor and Human Resources

March 14, 1995

Good morning, Madame Chairman and members of the Committee. My name is Leonard Schaeffer and I am chairman of Blue Cross of California (a non-profit public benefit corporation) and WellPoint Health Networks, Inc. (a publicly-traded company). Our companies serve more than 5.8 million Californians through a variety of managed care plans, as a participant in the Medicare supplemental market, and as a Medicare intermediary.

I appreciate the opportunity to testify today because of my long-standing involvement in the private and public health care sectors. I have formerly held positions as Administrator of the Health Care Financing Administration (HCFA); Director of the Budget for the State of Illinois; Deputy Director for Management, Illinois Department of Mental Health and Developmental Disabilities; and President of Group Health, Inc., a large staff model HMO in Minnesota.

The most important lesson I have learned from this experience is that health care is a locally delivered and locally consumed service. If you are in the business of financing or delivering health care to diverse and rapidly changing populations, your organization--whether public or private-- must be flexible enough to respond continuously to local consumer demands and changing provider practice patterns. Managed care plans today are demonstrating this flexibility which requires providing different markets with different choices of health plans.

My goals today are to describe the evolution of health care financing and to show how managed care plans are creating the infrastructure for future health care delivery based on the coordination of care in local markets. In my discussion, I also hope to convey how the demands of purchasers for products with measurable value are transforming the private marketplace.

THE RISE OF VOLUNTARY HEALTH INSURANCE

First, let's look briefly at some of the historical background because revisiting the past can help us sharpen our rethinking about the future.

Prior to 1929 and the Great Depression, only a few dangerous industries—mining, lumber, and railroad construction— provided health care to workers through a physician employed by the company. After 1929, hospitals began an insurance movement which adopted the symbol Blue Cross. Baylor University Hospital in Dallas is considered the first Blue Cross plan which charged 1,500 teachers 50 cents per month for a guarantee of 21 days of hospital care a year. In 1939, the California state medical association organized similar non-profit insurance plans to pay doctor bills. As the concept spread, such plans became known as Blue Shield.

Many employers were already providing commercial pension policies and disability benefits when wages were frozen during World War II. Adding health insurance as partial compensation for frozen wages attracted commercial insurers, expanding the health insurance market in a major way. Employers offered health insurance as a fringe benefit to compete for workers, and insurers benefited from the ease of group marketing. The non-profit Blue plans and the commercial insurers both reimbursed providers or consumers directly for services, a payment approach known as fee-for-service. This approach paid for services after they were rendered thus creating an incentive for providers to deliver more and more services. Fee-for-service systems reward service volume and penalize the efficient provision of appropriate services. (A few prepaid group practice plans such as my old plan, Group Health of Minnesota, had coexisted with the Blues and commercials, but organized medicine had opposed them for decades.)

Because the growth in health coverage was employment-based, however, retirees, the unemployed, and low-income workers often did not have insurance. By 1960, the lack of health coverage for the elderly and the poor became a political issue that led to the creation of Medicare and Medicaid. These programs filled a critical gap. However, these federal programs also contributed greatly to the soaring costs of American health care because they were based on the then-prevalent fee-for-service model which encourages utilization of more services than needed.

In 1971, recognizing the need to slow the rate of growth in health expenditures, Congress enacted the Health Maintenance Organization Act of 1973 which provided subsidies to increase the number of HMOs.

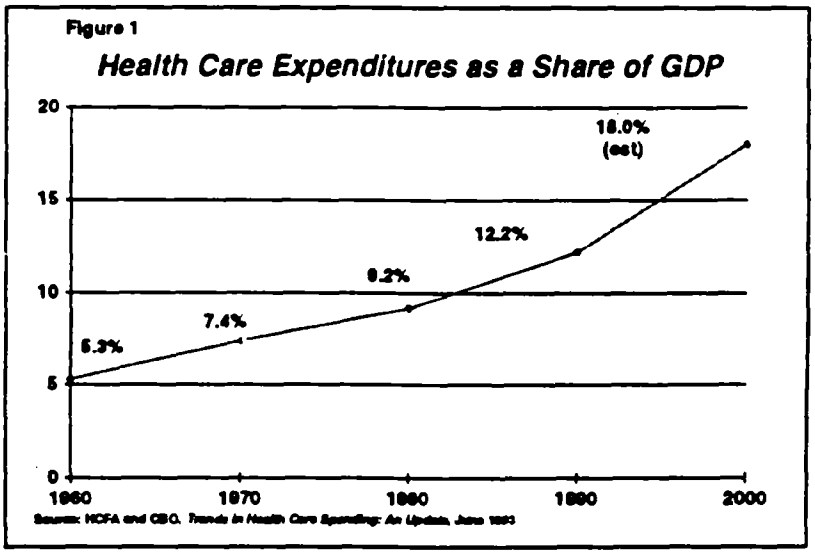
In addition to the incentives of fee-for-service, other factors have also contributed to the explosion of health care costs after World War II including the

building of new hospitals, advancements in medical technology, the rise in per capita incomes, the increase in health insurance, and the growth and aging of the population.

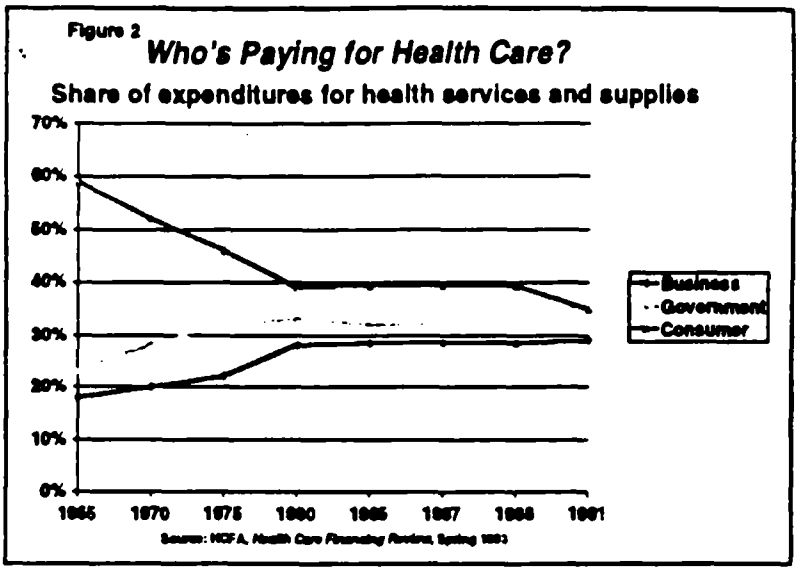
THE TRANSITION FROM FEE-FOR-SERVICE TO MANAGED CARE

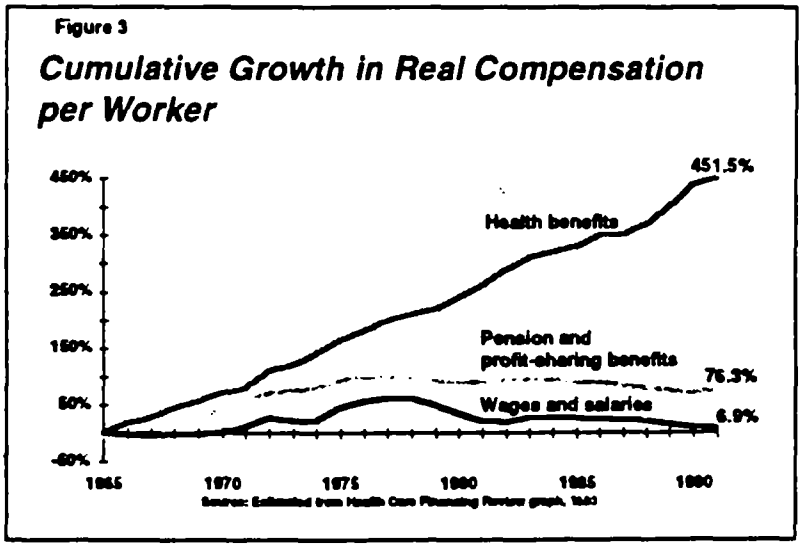
The Economic Context: Business Demand for Cost Containment

Describing the evolution of the health care financing market requires review of the economic trends that underlay private sector health care reform. Health care spending has been rising rapidly (see figure 1). In 1960, health care expenditures were $27 billion or about 6% of GDP. In 1993, expeditures reached $884.2 billion; 14% of GDP. By the year 2000, at current growth rates, spending will exceed $1.7 trillion or 18% of GDP.



Since 1960, the consumer share of medical costs has declined significantly, while the proportion paid by business and government has steadily risen (see figure 2). Business could offset some of its rising health care costs by shifting some costs of total compensation from wages to benefits (see figure 3). However, as costs continued to climb, and as domestic and international markets became increasingly competitive, business increased the pressure on the insurance market to offer more cost-effective managed care options.





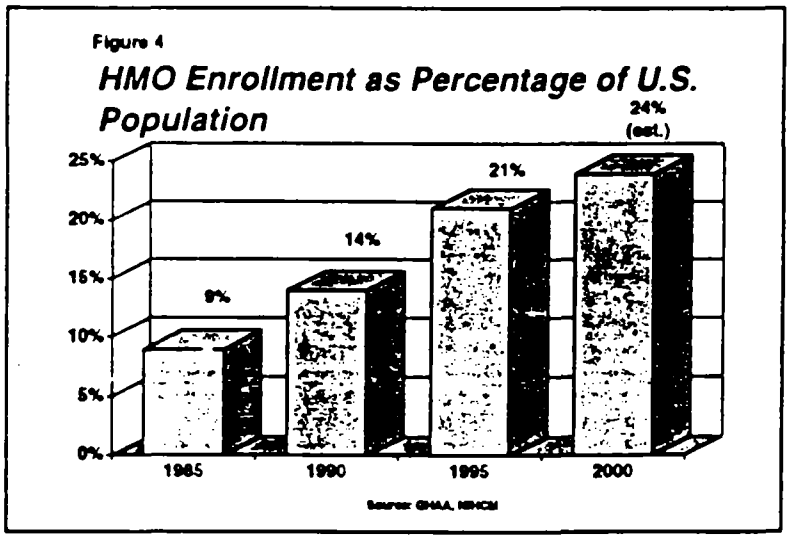
Health Plans Respond to Business

Health plans responded to this increasing demand for a combination of cost control, quality, and coordinated care, with the development— and continuing adaption—of managed care plans. Starting with traditional staff and group practice model health maintenance organizations, the market rapidly evolved to create independent practice associations, networks, and more recently, PPOs and POS products which allow access to out-of-network specialists in exchange for higher cost-sharing. Today, traditional fee-for-service plans without utilization review and case management are rare. Instead, most plans exhibit a range of managed care techniques for providing high quality care at lower cost.

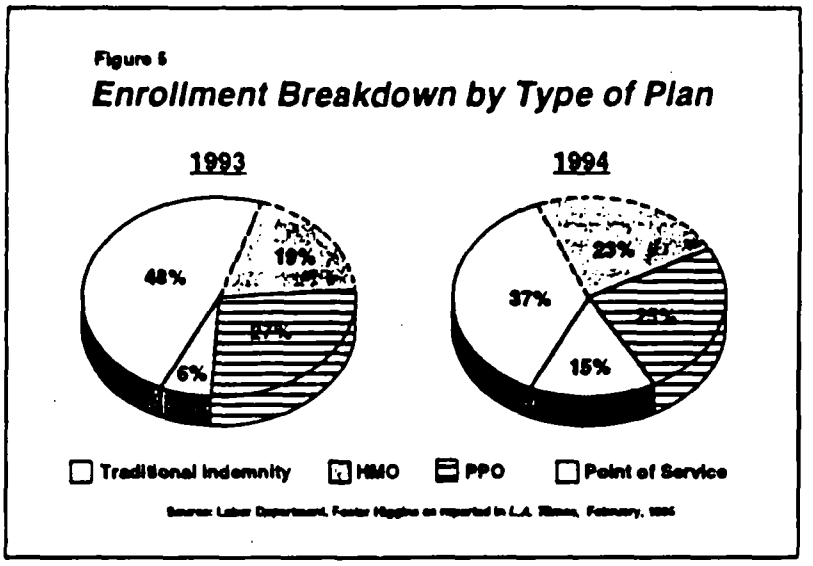
These techniques include selective contracting with providers based on cost, access, and quality; subscriber incentives to use plan providers; utilization review to assure necessary and appropriate care; case management to select the best and least expensive treatment plan; and coordinated design, financing, and delivery of health care.

Enrollment and Growth Trends in Managed Care

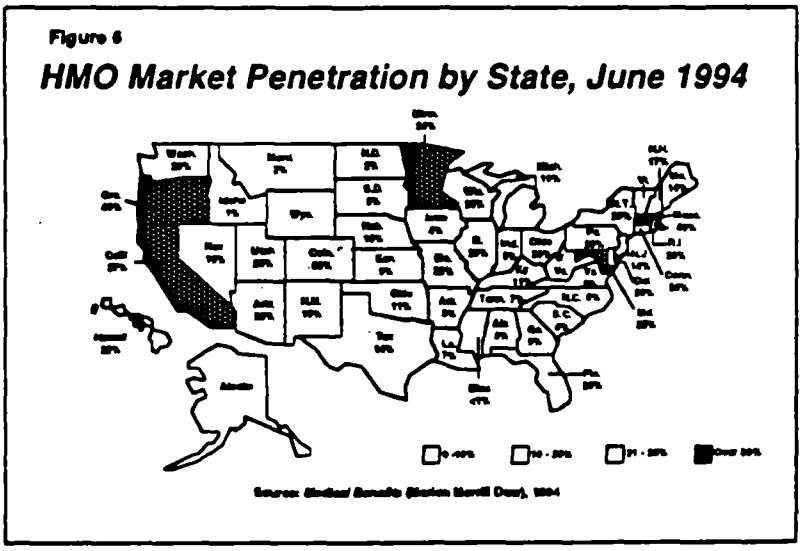
HMO and PPO enrollment is impressive. By mid-year 1994, more than 52 million people were enrolled in HMOs, about 20.3 percent of the population (see figure 4). This upward trend in enrollment is expected to continue, reaching more than 64 million in the year 2000. In California, HMO enrollment was 37 percent of the population in 1994, up nearly 3 percent from 1993. Nationwide PPO enrollment exceeded 60 million in 1993 (latest available figure). In California, more than 7 million people (23 percent of the poulation) belong to PPO plans.



A recent Foster Higgins survey for 1994 showed that only 37 percent of U.S. workers are covered by indemnity-style fee-for-service plans compared with 48 percent in 1993 (see figure 5). Only 3 years ago, this was the standard plan for a majority of workers. Today, 23 percent of workers are enrolled in HMOs, 25 percent in PPOs, and 15 percent in POS.



As figure 6 indicates, managed care has advanced fastest in the West relative to other regions. Washington, Oregon, California, Nevada, and Arizona all have HMO penetrations exceeding 15 percent. There are, however, a number of regions where managed care has also taken hold. Three examples include Minnesota, Maryland, and Massachusetts.



There are some key factors that account for the acceleration of managed care in some markets, such as California. Markets experiencing rapid migration to managed care are characterized by private sector competition, regulations favorable to network development, and a medical community characterized by larger group practices.

Managed Care Impacts on Costs

According to Foster Higgins, employers' health care costs for 1994 declined 1.1 percent for the first time in a decade primarily because of workers switching to managed care plans (see figure 7). Large employers reported decreases averaging 1.9 percent, while small employers had an average increase of 6.5 percent. Small employers are more likely to offer one plan and that plan is likely to be fee-for-service. Foster Higgins saw no evidence that the good news was due to massive cost-shifting to employees or decreases in coverage. Prior to the release of this survey, GHAA had already shown that the annual change in HMO premiums which has been declining through the 1990s, was a negative 1.2 percent for 1995 (see figure 8).

Figure 7

Percentage Change in Total Health Care Costs per Employee

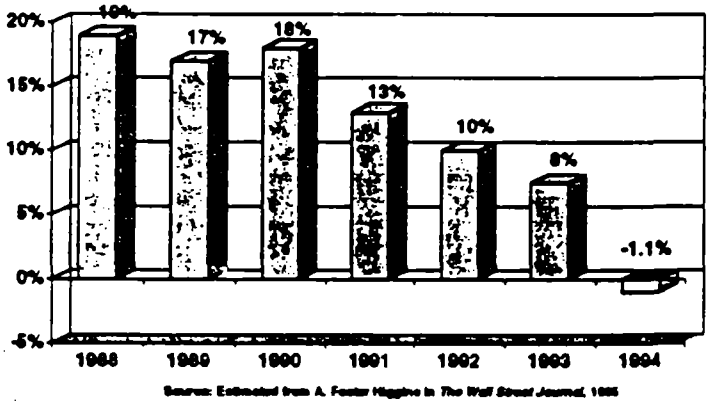
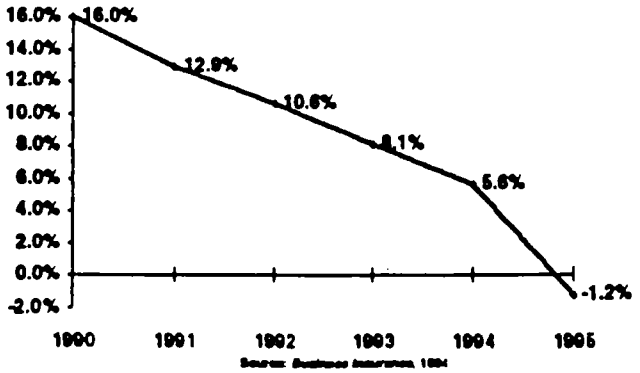


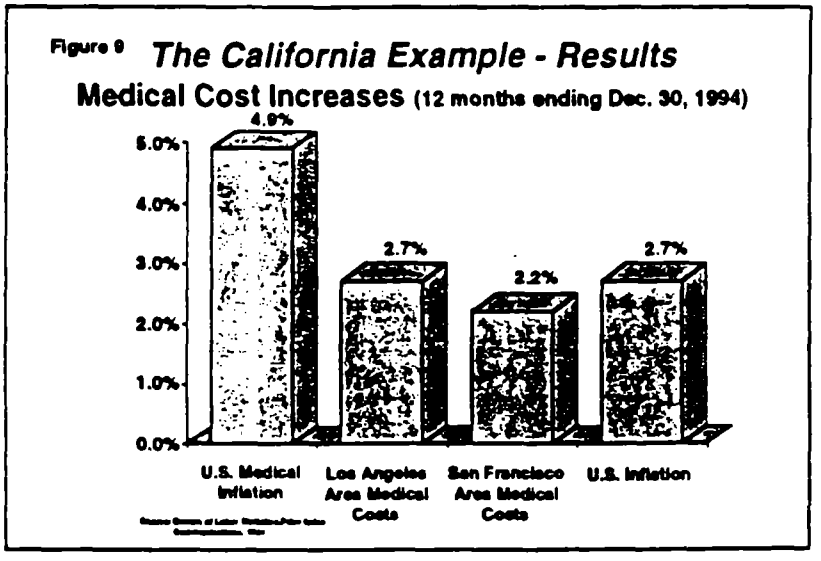
Figure 8

Annual Change in HMO Premiums



Critics of managed care continue to turn a blind eye to the evidence that managed care does control costs. In the debate over managed care competition versus regulation, advocates of more regulated approaches contend that competition cannot generate long-term savings but only one-time savings concentrated in the hospital sector. The evidence in California refutes this belief.

Recently, the Bureau of Labor Statistics released data showing that San Francisco and Los Angeles are significantly below the U.S. medical inflation rate for 1994. And while Los Angeles medical costs are increasing at the same level as the general inflation rate — 2.7 percent — San Francisco, at 2.2 percent, is actually below (see figure 9).



A RAND study compared the cumulative growth in per capita health expenditures in California with four states (New York, New Jersey, Maryland, and Massachusett) with hospital rate regulation programs from 1980 to 1991. The study determined that California experienced the lowest rate of growth compared to the four rate-regulated states and to the U.S as a whole (see figure 10). The study not only looked at total spending, but analyzed the hospital, physician, and retail drug sectors separately. In each sector, California still emerged with the lowest growth rates (see figure 11).

Figure 10

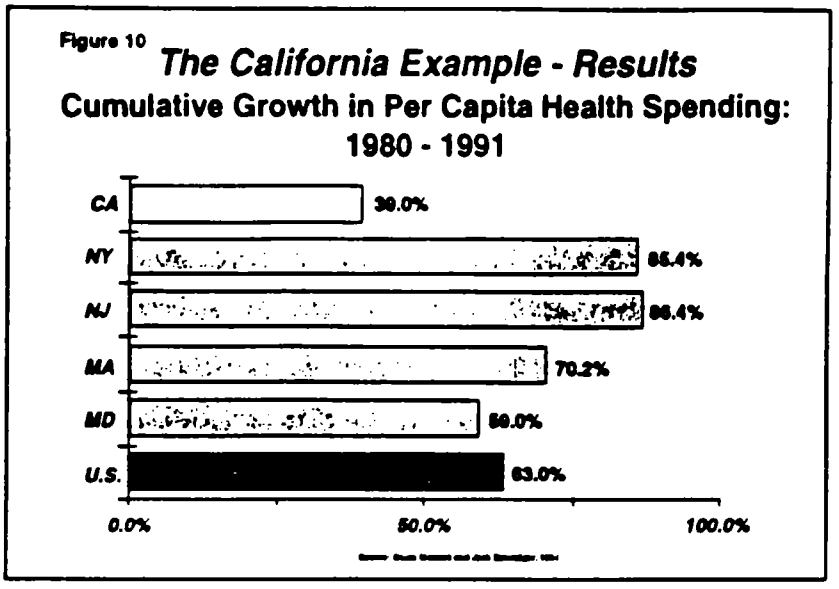
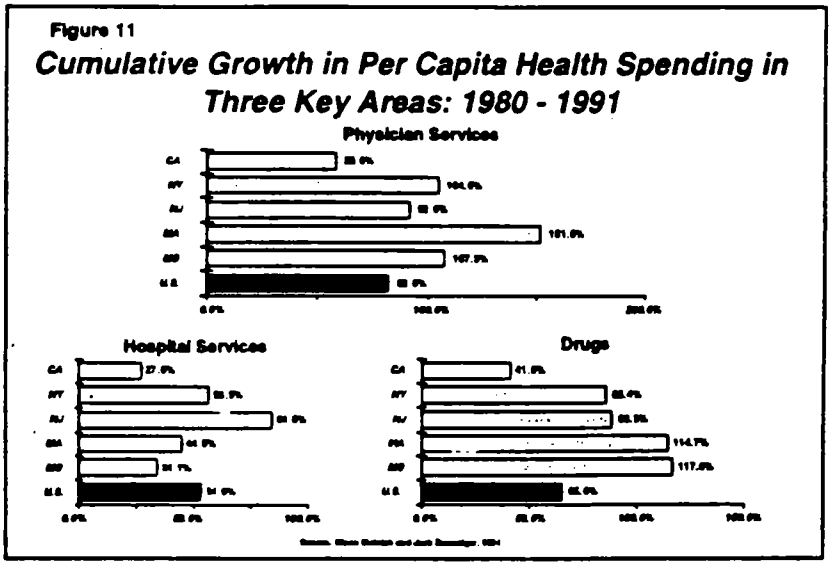


Figure 11



Managed Care Impacts on Quality

Systematic studies of managed care plans, particularly HMOs, have determined that the quality of care is equal to or superior to care delivered in a fee-for-service environment. Reviews of the literature (GHAA, CAHMO) have found that HMOs produced more positive or no difference in outcomes from fee-for-service despite shorter hospital stays and less surgery. HMOs also scored higher on the prevention of disease, another measure of quality of care. Some examples of typical study findings comparing HMOs to fee-for-service include:

- Elderly HMO members with cancer are more likely to be diagnosed at an earlier stage (American Journal of Public Health 1994);

- A study of 100,000 California adults found that HMO appendicitis patients were 20 percent less likely to suffer a ruptured appendix (New England Journal of Medicine, Dec. 9, 1993); and
- Women in HMOs are more likely to obtain mammograms (CDC/NCHS Advance Data No. 254, Aug 3, 1994).

In addition to high quality care, study after study has demonstrated that consumer satisfaction levels of managed care members across the spectrum of health status are highly satisfied.

Market Consolidation

Much has been written about the consolidation occurring in the provider and health plan markets. There is also growing aggregation among purchasers to increase employer bargaining power. Nearly half of all states have enacted purchasing alliance legislation that establishes a publicly or privately administered mechanism for pooling risk. In California there are purchasing alliances that represent not only small groups, but in the case of the Pacific Area Business Group on Health, large groups as well.

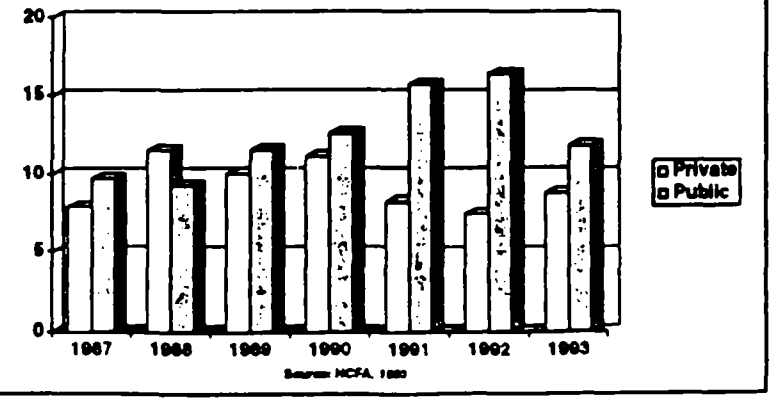
MANAGED CARE'S POTENTIAL IN THE PUBLIC MARKET

The number of people enrolled in government health programs (Medicare and Medicaid) has grown dramatically and explains some of the increase in health care expenditures. Spending on public health has generally outpaced private sector payments since 1987 (see figure 12). During the 1990s, the annual percent increase in public sector health expenditures has been significantly higher compared with the private sector. As I'll touch upon later, government has lagged far behind employers in using managed care to lower its costs.

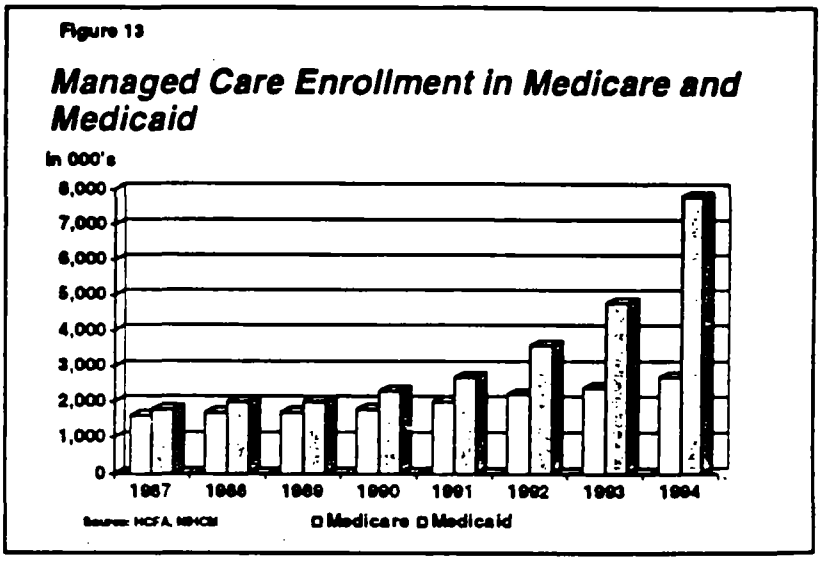
Figure 12

Public Sector Health Payments are Increasing

Average annual percent increase



The Medicare program and many state Medicaid programs have turned to managed care more recently in order to lower costs and increase access. Medicare HMO Risk enrollment stands at 2.7 million, up 13 percent from 1993 (see figure 13). Medicaid managed care enrollment is 7.6 million beneficiaries, up an astonishing 62 percent from 1993. States have implemented different Medicaid managed care models to reflect the diversity of their counties.



While managed care enrollment in both Medicare and Medicaid is growing, the real potential to control the high rates of inflation that plague these programs hasn't been tapped. Most Medicare beneficiaries remain in the old-fashioned fee-for-service plan.

Managed Care and the Medicare Program

Improving the Medicare program for seniors and increasing savings for the government necessitates a practical approach based on incremental steps. This will be more effective than trying to change the entire program.

The first step in Medicare reform must be to make Medicare Select permanent. Medicare Select is an extremely popular Medicare supplement program. Medicare Select uses PPO networks to save seniors between 10 and 37 percent from the premiums charged for traditional fee-for-service Medigap policies for the same benefits. Real innovation based on consumer choice could be unleashed in the supplemental market if managed care plans were allowed to design Medicare Select alternatives that contain incentives to increase in-network utilization. When beneficiaries elect to stay in network, the government saves because it benefits from the low-cost, high quality providers that account for the lower—more appropriate— utilization.

The broader issue is Medicare's role as purchaser of care. If Medicare is to provide coverage and choice comparable to the rest of the population, substantial changes must be phased in. These changes should be based on the standards that include giving seniors a choice of qualified health plans; setting a Medicare payment level based on some percentile of premiums charged in the private market; and phasing in the capacity for beneficiaries to pay for more enhanced benefit plans. Those seniors choosing a higher priced plan than the standard government level would pay the difference in premium.

Managed Care and the Medicaid Program

A recent Lewin-VHI study (1995) concluded that managed care works to increase access and reduce costs for state Medicaid programs. Although the states are moving quickly to enroll their Medicaid populations in managed care (nearly one fourth are in managed care), 90 percent of Medicaid dollars are still paid on a fee-for-service basis. The reason is that long-term care and services for the blind and disabled account for 70 percent of Medicaid expenditures, but are generally not included in Medicaid managed care programs.

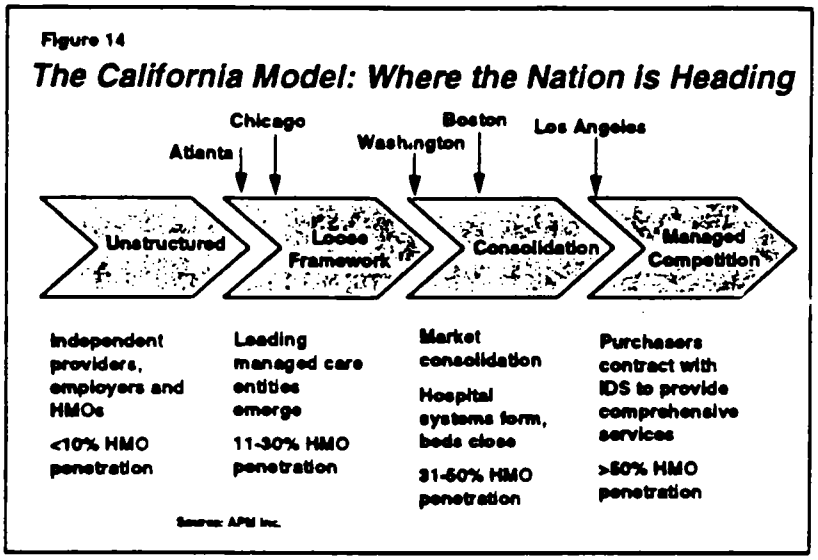
Blue Cross of California participates in the California Medi-Cal managed care program. I believe the program will be very successful, but there are some lessons learned in establishing the program that are worth sharing with legislators and colleagues in other states. Prior to implementation, three key state activities would help communities make the transition to managed care. These include informing providers early about the change so that they can begin to assess how it will work, ensuring that the state-produced literature is user-friendly, and working closely with community leaders, local politicians, and the media to promote understanding of the program before it is implemented.

THE MARKET OF THE FUTURE

I believe the market is evolving as a natural response to consumer demand for high quality care delivered at a lower cost. There is no fixed end point to this evolution as long as competition remains the driving force. In the near-term, I think we are heading toward a competitive marketplace in which managed care systems that accept clinical and fiscal accountability for an enrolled population will dominate.

The California Model: Where the Nation is Heading

Figure 14 graphically presents this movement towards managed competition. Compared to other major cities, Los Angeles— though still changing— represents one of the most advanced or mature markets where HMO penetration is high, excess capacity is being reduced, and delivery systems that integrate financing and delivery are forming. Across the country, there are still numerous markets characterized by independent providers, low HMO penetration (less than 30 percent), and considerable excess bed capacity that will attract managed care plans which will serve as the catalyst for rationalizing local health care systems.



The Role of State Reforms

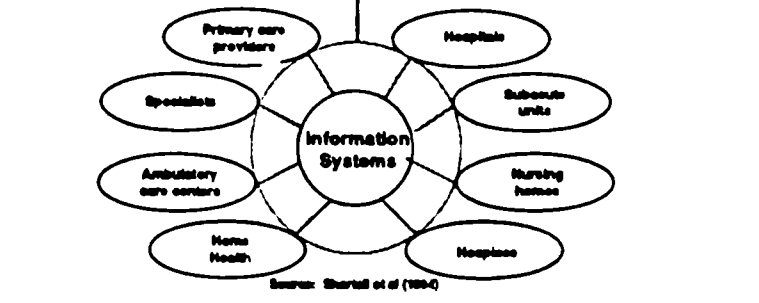
The success of future managed care markets depends in part on an appropriate regulatory framework that fosters innovation, establishes rules for fair competition, and protects consumers. Many states are striving to achieve this balance through incremental reform. In 1994, seventeen states enacted or modified laws to reform the small group and/or individual markets. California began this process in 1992 with the passage of A.B. 1672. This small group legislation eliminated redlining, blacklisting, and cherry picking; guaranteed issue and renewability; established rate limitations, limited pre-existing conditions; and established a small group purchasing alliance. The focus in 1995 for many states will continue to be incremental reform to improve coverage for individuals and small groups.

Models of the Future

Given the differences in markets, the managed care models of the future are unlikely to all converge on one model, but will continue to grow and change. Already we see the emergence of four prototypes that are being tested in the marketplace today. These models are led by hospitals, physicians groups, PHOs (hospital/physician organizations), and insurance companies. As figure 15 indicates, at the heart of these models are information management systems for decision-making that address the demand for increased accountability.

Figure 15

Marketplace Testing of Different Models



IMPLICATIONS OF MARKET-DRIVEN REFORM

Predicting the success of the new world of managed care is a job for futurists. However, it is never too early ask whether the transforming managed care market alone can alleviate current health care financing issues.

Competition and Access for the Uninsured

As market-driven reform continues, one concern is that providers will deliver fewer services to the uninsured who are disproportionately lower income, children, and members of minorities. The uninsured fall between the cracks because nearly 85 percent are workers or their dependents and do not qualify for Medicaid. Most of the working poor are also employed in small firms which are less likely to provide health coverage.

A related concern is that health plans will find ways to segment the market in search of the healthiest members. Both of these concerns really speak to the role of policymakers in ensuring that health plans compete on a level playing field.

In California, for instance, our small group legislation mentioned previously banned unfair practices of the past, instituted rating reforms, and established a small employer purchasing alliance to intensify competition. As health coverage becomes more affordable and the costs more predictable from year to year, more employers will provide coverage as a way to compete for the best workers. However, given the constant of economic cycles, there is no guarantee that all small employers will eventually be able to afford coverage no matter how low the cost.

Another challenging issue is in the individual insurance market where the potential for adverse selection under a voluntary system is the greatest. Adverse selection occurs when people wait until they are sick to purchase health insurance. Since it is unfair to ask already insured individuals and small groups to subsidize the excess costs of high risk cases in the individual market, some thought must be given to identifying a broad-based subsidy to cover these costs.

Given our experience as a participating plan providing care to a majority of California's high risk pool enrollees and also covering above average risks in our Guaranteed Coverage Program, I am convinced such cases can be managed cost-effectively in the private sector. Doing so, however, requires not only a broad-based subsidy but also rating flexibility within limits and, I might add, incentives for more plans to follow our example.

Competition and Health Professions Education

Financing for key societal benefits, such as health profession education, must also be considered. Academic Health Centers (AHCs) are concerned about two fundamental changes they may need to make for the future. First, over time as more systems become capitated, more primary care physicians, and fewer specialist and beds, will be needed (see figure 16). Consequently, educational institutions will have to change dramatically and produce more primary care physicians to meet the demand. AHCs may also have to consider the feasibility of downsizing if the specialists don't exist to fill the beds.

Figure 18

Comparison of Fee for Service and Capitated System Requirements

	FFS	Capitated
Covered lives	**100,000**	**100,000**
Primary care physicians	**30 - 50**	**50**
Specialty physicians	**175**	**50**
Hospital beds	**275**	**150**

Source: Health Care Advisory Board

The new world of managed care also means that AHC's, already faced with the potential loss of Medicare funding, also will have limited ability to cost-shift to the private sector. Furthermore, they will have to compete with other community providers rendering specialty care. While AHCs must control their costs, there is no question that as a society we will need to address the additional costs of AHCs attributable to research, technology development, and education.

CONCLUSION

Madame Chairman, there is no doubt that the marketplace is changing in response to consumers' demand for low-cost health care delivery. There is probably no single best model. Rather, health care systems will continue evolving under the influence of the communities they serve. Blue Cross will be pleased to work with the Committee as you further explore health reform issues. I would be happy to answer any questions that you may have today.

The Changing Health Care Delivery System

Statement by

William S. Custer, Ph.D.

Committee on Labor and Human Resources

U.S. Senate

March 14, 1995

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Statement of William S. Custer
Committe on Labor and Human Resources
March, 14, 1995

Highlights

- Since 1970, expenditures on health care have increased at an average annual rate of 11.6 percent in the United States, 2.9 percentage points faster than Gross Domestic Product (GDP). Health expenditures are estimated to be $938 billion in 1994, or 13.9 percent of GDP. Projections indicate that by the year 2005 health expenditures will reach 18 percent of GDP.
- The latest data available indicates that 18 percent of Americans (almost 41 million) under the age of 65 are without health insurance at any given time.
- If these trends continue by the year 2000 the percentage of Americans with employment based coverage will fall to 52 percent and more than 1 out every 5 nonelderly Americans will be without health insurance: over 50 million people.
- Much of the moderation in the growth of national health expenditures can be explained by past decreases in real personal income. The impact of the recession in the early part of this decade is being felt presently in the reduction of health care inflation.
- There is mounting evidence that managed care, in all its forms, has lower costs than traditional indemnity plans and lower rates of cost increases. The evolution of the health care delivery system toward a market of competing organized systems of care has the potential for bringing health care cost inflation closer to the rate of general price inflation.
- Although the changes the health care delivery system has undergone over the last decade have laid a foundation for the creation of an efficient health care services market there is a long way to go before achieving that goal however, and many obstacles remain. Without government action it seems likely that health insurance coverage will continue to erode and that costs will continue to increase through the end of the decade.

The health care delivery system has evolved dramatically in the last decade, largely in response to health care cost inflation. Since 1970, expenditures on health care have increased at an average annual rate of 11.6 percent in the United States, 2.9 percentage points faster than Gross Domestic Product (GDP). Health expenditures are estimated to be $938 billion in 1994, or 13.9 percent of GDP. Projections indicate that by the year 2005 health expenditures will reach 18 percent of GDP.

Increasing health care costs have led private and public purchasers of health care services to change their relationships with both providers and patients within the health care services market. This in turn has affected the practice of medicine. Care has moved out of the hospital to a variety of sites, referral patterns of physicians have been affected, the relationship between hospitals and their medical staffs has been altered, and the way providers market themselves has changed.

Rising health care costs have resulted in an increasingly segmented health insurance market, leading fewer employers, especially small employers, to offer health insurance as an employee benefit and also resulting in an increase in the number of Americans without health insurance coverage. Changes in health care financing have limited providers' ability to provide uncompensated care, limiting the uninsured's access to care.

This statement examines the changes the health care delivery system has undergone in the past decade and their implications for the evolution of the health care delivery system.

Health Insurance Coverage

From the beginning of World War II until the early 1980s both the number of people receiving employment-based health insurance coverage and the scope of that coverage expanded. This expansion, together with the

introduction of the Medicare and Medicaid programs in 1965, greatly increased the number of Americans with health insurance. It also produced an inflationary push in the health care services market that has created an evolutionary pull in both the health services market and the employment-based financing system.

Health care cost inflation gradually changed the dynamics of the employment-based health care financing system. As health care costs rose and became a larger component of total compensation the focus of employment-based plans moved from expanding coverage to containing costs. Moreover, the increase in health costs began to reduce the number of employers, especially smaller employers, who offered coverage and reduce the number of workers who participate in their employer's health benefits.

The number of Americans without health insurance increased slowly through the 1980s, grew sharply during the economic downturn at the beginning of the decade, and has apparently returned to the slow but persistent upward trend. The latest data available indicates that 18 percent of Americans (almost 41 million) under the age of 65 are without health insurance at any given time. (Table 1)

Table 1
Sources of Health Insurance Coverage for the Non-Elderly
1988-1993

Year	Employment Coverage		Public Coverage		Uninsured		
	Millions	Percent	Millions	Percent	Millions	Percent	Total
1988	141.5	66.8%	26.3	12%	33.7	15.9%	211.8
1989	140.8	65.9%	26.1	12%	34.4	16.1%	213.7
1990	138.6	64.2%	29.1	14%	35.8	16.6%	215.9
1991	139.8	64.1%	31.6	15%	36.2	16.6%	218.1
1992*	138.8	62.0%	34.2	15%	39.8	17.8%	223.8
1993*	137.5	60.8%	36.4	16%	40.9	18.1%	226.2

Source: March supplement to Current Population Surveys, 1989-1994 as reported in Employee Benefit Research Institute, EBRI Issue Brief 158 (February, 1995) p. 7
* Uses 1990 Census as basis for estimating total population numbers from survey results.

The shift in the number of nonelderly individuals with employment-based health insurance has been more dramatic in recent years. Partly as a result of the recession beginning in 1990, 2 million fewer Americans had employment-based health insurance in 1990 than 1989. At the same time the number and percentage of Americans with public insurance increased by almost 3 million due to increased eligibility and to falling incomes. In the last 3 years employment-based coverage has continued to erode and public coverage has continued to expand.

Table 2
Wage and Salary Workers Coverage and Participation in Employer Health Plans

	1988			1993		
	Total	Employer Sponsors	Employee Participates	Total	Employer Sponsors	Employee Participates
			(millions)			
Workers	98.5	78.1	64.1	103.2	80.9	64.6
Less than 10	13.3	5.2	4.0	13.6	4.5	3.5
10 to 49	14.4	10.0	7.7	14.8	9.8	7.2
50 to 99	5.4	4.5	3.7	6.1	5.0	3.9
100 to 249	7.3	6.5	5.2	7.6	6.5	5.2
250 or more	49.8	46.1	39.3	53.4	49.8	40.9
			(Percentage of Wage and Salary Workers)			
Workers	100%	79%	65%	100%	78%	63%
Less than 10	100%	39%	30%	100%	33%	26%
10 to 49	100%	69%	53%	100%	66%	49%
50 to 99	100%	83%	69%	100%	82%	64%
100 to 249	100%	89%	71%	100%	86%	68%
250 or more	100%	93%	79%	100%	93%	77%

Source: EBRI tabulations of the May, 1988 and April, 1993 supplements to Current Population Survey, EBRI Issue Brief Number 152 (August, 1994)

Between 1988 and 1993 the number of wage and salary workers increased by 4.7 million, but the number of workers participating in their employer's health plan increased by only 500,000. (table 2) For small employers the change in coverage and participation is even more pronounced. The percentage of workers at employers with less than 10 employees whose employer offered a health plan decreased by 6 percentage points. It also fell for workers at firms with between 10 and 49 employees, and between 50 an 99 employees, but for workers at those sized employers the participation rate fell

even more. This implies that more workers at these size firms were either ineligible or choose not to participate in their employers plans.

The reasons for the increase in the number of Americans without health insurance is primarily the increase of health care costs relative to family income. Just as national health care expenditures have increased as a proportion of Gross Domestic Product so has personal health care costs increased as a proportion of families' budgets. As these costs increase families decrease their purchase of health care services and especially health insurance. Insurance is a hedge against the likelihood that an individual or a family will need health care services. The two groups most likely to reduce their purchase of health insurance are therefore those whose family incomes are low and those whose risks of needing health care services are low. In the labor market those workers will seek out jobs where compensation is weighted toward cash and not health benefits.

Low wage workers are much less likely to work for an employer who offers a health plan, and less likely to participate in that plan when it is offered (table 3). For those making less than $10,000 annually over half work for employers who do not offer a health plan. For these workers only 30 percent participate in that plan when it is offered, although most are ineligible because they are part-time or contract workers.

Just over three quarters of workers making between $10,000 and $20,000, or just above the Federal Poverty line for most families, work for an employer who sponsors a health plan. In turn, three quarters of those workers whose employer sponsors a plan participate in that plan. The majority of those who do not participate (60%) are eligible but choose not to participate, most because they are covered through another plan, but many because the plan is too costly or they do not want or need the coverage. Of those workers without health insurance from any source 61 percent had annual earnings less than

$20,000 and just under 60 percent worked for employers with less than 100 workers.

Table 3
Workers Whose Employer Offers Health Plan and Workers Who Participate

Number of Workers
(Millions of Workers)

Annual Earnings	All Workers (a)	Employer Offers Coverage (b)	Employees Who Participate (c)
Total Workers*	112.5	82.4	65.6
Less than $10,000	15.7	7.6	2.3
$10,001 to 19,999	29.3	22.3	16.88
$20,000 to $30,000	22.1	19.7	17.33
$30,000 to 49,999	19.8	18.6	16.99
Above $50,000	8.5	8.2	7.7

Percent of Workers

Annual Earnings	Total All Workers	Employer Offers Coverage (b/a)	Percent of Offered Employees Participating (c/b)	Percent of Workers Participating (c/a)
Total Workers*	100%	73%	80%	58%
Less than $10,000	100%	48%	30%	15%
$10,001 to 19,999	100%	76%	75%	57%
$20,000 to $30,000	100%	89%	88%	78%
$30,000 to 49,999	100%	94%	91%	85%
Above $50,000	100%	97%	94%	91%

Source: Custer Economic Research tabulations of the April, 1993 Supplement to the Current Population Survey

* Includes workers whose annual earnings were unknown.

Health insurance coverage is dependent upon two factors: the ratio of health care costs to income and the individuals self-assessment as to the risks of needing health care services. As health care costs increase faster than income those individuals whose incomes are low or who are better risks will continue to drop out of the health care market. As those better risks are removed from the health insurance market premiums, which are based on average risk, increase driving still more from the health insurance market.

The erosion of the employment based health insurance coverage and the increase in the number of Americans with no health insurance has been pronounced over the last decade. If these trends continue by the year 2000 the percentage of Americans with employment based coverage will fall to 52 percent and more than 1 out every 5 nonelderly Americans will be without health insurance, or over 50 million people.

The consequences of being uninsured increase with health care cost inflation. The uninsured face a much different process of care than those with insurance. They much less likely to have a usual source of care, more likely to receive care in an emergency room or a hospital outpatient department, and less likely to be admitted to a hospital. Moreover, the uninsured are more likely to experience avoidable admissions, or admissions that could have been treated on an outpatient basis had they been diagnosed early enough, and are likely to be more severely ill upon admission. Once admitted to the hospital studies have found that the uninsured are likely to have short lengths of stay than privately insured individuals with similar conditions. Finally, the uninsured are more likely to have adverse results, and higher mortality rates even after adjusting for the severity of illness.

The question is: will those health insurance coverage trends continue? The answer depends on health care cost inflation. If health care costs, and therefore health insurance premiums, increase faster than personal income these trends are likely to continue. In fact, given that coverage through the public sector is unlikely to increase in the future, as it has in the recent past, the rate of growth in the number of uninsured Americans may in fact increase if health care cost inflation returns to the level of the 1980s. If however, health care cost inflation moderates and the economy remains strong the erosion of the employment based health insurance system is likely to moderate, and the growth of the number of Americans without health insurance would slow.

Health Care Cost Inflation

National health expenditures have consistently risen faster than national income at least since 1965. In that year national health expenditures accounted for less than 6 percent of Gross Domestic Product (GDP). By 1993 national health expenditures accounted for just under 14 percent of GDP.

Yet the rate of growth in national health care expenditures has slowed in recent years. Both the Congressional Budget Office and the Health Care Financing Administration project that national health expenditures will grow at roughly the same rate as GDP in 1995. Surveys of employers and insurance plans have found that premiums are rising at rates less than general price inflation, and in some cases, actually falling.

This moderation of health care cost inflation occurs after a decade of rapid evolution in the health care delivery system. The health care delivery system has undergone a rapid evolution during the past decade, both in terms of technological innovation, and in the organization and financing of the delivery of health care services. Increases in health care cost inflation, fueled by technological innovation, have changed the way health care services are purchased, the delivery of health care, and access to health care.

These changes have had profound effects on the health care delivery system, and the effects of these changes are likely to become even more important in the future, but it is unclear that the moderation in health care cost inflation results from the changes in the health care delivery system.

In fact much of the moderation in the growth of national health expenditures can be explained by past decreases in real personal income[1]. The impact of the recession in the early part of this decade is being felt presently in the reduction of health care inflation. That implies that health care cost

[1] Cookson, John P., and Peter Rielly, "Modeling and Forecasting Health Care Consumption" Milliman and Robertson, August, 1994

inflation will rebound in future years in response to increasing personal income. The Congressional Budget Office, the Health Care Financing Administration, and private researchers are all projecting health care cost inflation to increase in the coming years.

The projection that health care costs inflation is likely to rebound in the near future does not negate the importance of the changes occurring in the health care delivery system, nor indicate that those changes have been ineffectual in reducing health care costs. Rather its is an indication of the enormity of the challenge of reducing health care cost inflation while maintaining or increasing the quality of care in an almost trillion dollar sector of the economy that is composed of hundreds of interconnected local markets, each with its own characteristics and idiosyncrasies.

The Changing Health Care Delivery System

Public programs and private health plans have been evolving rapidly in the last 15 years in response to health care cost inflation. The federal government's efforts at controlling costs in the Medicare program has differed greatly from efforts by private payers. The Medicare program instituted the prospective payment system (PPS) for reimbursing hospitals in 1983 and began reimbursing physicians using a relative value fee schedule in 1992. PPS changed hospital incentives was the bundling of the services provided a patient during a single admission. Under PPS hospitals have an incentive to reduce the length of stay and provide the minimum services necessary to care for the patient. In fact, a number of studies have found that PPS reduced both the average length of stay per admission and the number of admissions.

The reaction of employers to increases in health care costs has varied depending on the labor market they face, the amount of competition in their product market, and their level of market power in their specific health care services markets. In general employers have adopted four types of cost

management strategies: cost sharing, utilization review, packaging provider services, and selectively contracting with providers. These strategies have been combined in the various managed care plans employed by many employers.

These attempts to manage health care costs have been a major factor in the restructuring of the health care services market. Between 1987 and 1994, total enrollment in Health Maintenance Organizations (HMOs) increased from 28.6 million to 45.1 million, representing 17 percent of the United States population. It is estimated that as many as 85 million more Americans are covered by some sort of Preferred Provider Organization (PPOs), although the evidence on the ability of PPOs to manage care is at best mixed. Providers are coalescing into larger groups and hospital's relationships with their medical staffs are increasingly built on explicit financial relationships that were rare 15 years ago. In many markets the health care delivery system is becoming more concentrated. One rational for this concentration is that it makes the exchange of information vital to managing care more efficient and therefore less costly.

Public and private attempts to manage health care cost inflation have focused on two issues: reducing the amount of waste in the health care delivery system and applying cost-benefit criteria to the introduction of new technology. Measuring the amount of waste in the system, or the benefits of any health care procedure, requires an ability to measure the effect of health care on a patient, or a population.

Managed care bundles services together to alter incentives for providers. It also relies on monitoring physician treatment patterns in a variety of ways (utilization review, physician profiling, and case management), and changing the financial incentives faced by providers. The first approach requires an explicit definition of the quality of health care services. Without that definition there are no criteria for evaluating care as its being provided.

Changing provider incentives also relies on quality of care measures. It would be difficult to justify a financial incentive to provide too little care if there were no checks on the quality of care being provided under such incentives.

The need to evaluate providers for selective contracting and to evaluate care as it is being provided has led to the development of a health information industry.This industry supplies providers, insurers, employers, and consumers with information on the quality, appropriateness, and cost effectiveness of the care they are producing or consuming. Methods are being developed and implemented for measuring health service outcomes; measuring patient satisfaction; and evaluating competing physicians, hospitals, and health plans.

Unfortunately, measuring the effects of the changing delivery system on costs and quality of health care services has been a difficult task, resulting in a considerable amount of disagreement as to whether or not costs have been affected. A 1992 Congressional Budget Office (CBO) report stated that "It cannot be assumed that further growth of managed care would reduce either the level or the rate of increase of system wide health care spending" (U.S. Congressional Budget Office, 1992). In October 1993, the General Accounting Office released a report on the effectiveness of managed care (U.S. General Accounting Office, 1993). The study concluded that there is very little empirical evidence, and the evidence that does exist does not adequately control for key factors affecting health care costs such as a person's age and health status. Recently, CBO released an update to its 1992 report. The 1994 CBO report recognizes two new major findings. First, managed care can provide cost-effective health care at a level of quality that is comparable with the care typically provided by a fee-for-service plan. Second, independent practice associations can be as effective as group- or staff-model HMOs under certain conditions (U.S. Congressional Budget Office, 1994). In addition,

Miller and Luft[2] find more evidence of cost savings from managed care but suggest that generalizations of their findings need to be made with caution.

Other recent studies have also found that managed care can save costs. A KPMG Peat Marwick study found that HMO and PPO premiums increased at an average annual rate of 2–5 percentage points below fee-for-service plan premiums between 1988 and 1993 (KPMG Peat Marwick, 1993). Data from A. Foster Higgins found a 14 percent increase in the premium cost of a traditional indemnity plan between 1991 and 1992, compared with a 9 percent increase for all managed care plans (A. Foster Higgins, 1993). This survey found that the cost of a traditional indemnity plan is 23 percent higher than the cost of an HMO. The traditional indemnity plan premium costs an average of $4,080 while the average cost of an HMO is $3,313.

There is mounting evidence that managed care, in all its forms, has lower costs than traditional indemnity plans and lower rates of cost increases. The evolution of the health care delivery system toward a market of competing organized systems of care has the potential for bringing health care cost inflation closer to the rate of general price inflation.

The Future of the Health Care Delivery System

Despite the important changes in the health care delivery system that have taken place over the last decade it is only at the initial stages in its evolution. It is perhaps unreasonable to expect the market to have evolved to a point where health care cost inflation has been brought under control so quickly.

The health care delivery system is composed of interconnected local markets. Each of these markets has unique characteristics that determine the

[2] Miller, Robert H., and Harold S. Luft, "Managed Care Plan Performance Since 1980: A Literature Analysis," *Journal of the American Medical Association*, vol. 271, May 18, 1994, pp. 1512-1519.

providers' and purchasers' relative market power. The evolution of the health care delivery system has not been uniform across these markets.

The increase in market penetration by managed care plans has not been evenly distributed. HMOs have not been established in rural areas, in large part because these areas lack the population size necessary to maintain an independent health plan. The market penetration of HMOs also differs considerably by region. Over a third the residents of Californian of Massachusetts were enrolled in an HMO in 1994, but only 16 percent of Floridians and 9 percent of Texans. (See Appendix 1) There are other important differences in local markets that affect the evolution of the health care delivery system, such as the number and specialty distribution of physicians, the number and ownership of hospitals, state laws regulating health care and health insurance, sources of health insurance coverage within the local community, and demographic characteristics.

There are many reasons for differences in local health care markets and their adoption of managed care. One is that each of these markets has started with important differences. For example, hospitals on the west coast reported lower admission rates and shorter length of stays than eastern hospitals well before the expansion of managed care in the 1980's. The initial impact of managed care is to lower admission rates and length of stays, so perhaps managed care had less of an impact on physician practice patterns out west and faced less resistance from providers and patients as a result.

These local differences also effect the way managed care entities organize and market themselves. Research has shown that managed care entities themselves undergo an evolution. They often begin with a strategy of attempting to achieve market share. During this stage they may be less interested in controlling costs and more interested in attracting physicians and enrollees. New insurance organizations often benefit from positive selection in that people most likely to switch plans are those who have not

forged a relationship with a provider, most likely because they have not needed health care services. As these entities mature, that benefits of selection may wear off, and these managed care entities become more active in controlling costs, and they begin to be more aggressive utilizing the cost management tools available.

The tools available however, are at best rudimentary. The health care delivery system has made great strides in developing quality assessment methods and information systems necessary to make the health care services market function efficiently. However, there are no set standards for measuring quality, the methods for evaluating care vary widely, information necessary to evaluate care is only haphazardly collected, and the infrastructure for collecting that information efficiently is not yet in place.

Reimbursement methodologies are being developed that provide incentives to providers and patients to achieve cost effective care. There is a great deal of experimentation in reimbursement methodologies however, and not all experiments should be expected to work. Moreover, without adequate information almost any reimbursement methodology can be gamed by providers, patients, or health plans.

There is evidence that cost savings are being realized without jeopardizing the overall quality of health care services. What is not clear is how close we have come as a nation in constructing a health care delivery system in which the market promotes cost effective high quality care.

Conclusion

The market for health care services is changing rapidly. It has not, however changed rapidly enough to declare victory over health care cost inflation. As health care costs increase faster than income it is likely that the erosion of employment based health insurance will continue. Moreover, those individuals mostly likely to lose coverage will be the low income and

the healthy. As the healthier individuals drop out of the health insurance market premiums will rise exacerbating the problem.

The changes the health care delivery system has undergone over the last decade have laid a foundation for the creation of an efficient health care services market. There is a long way to go before achieving that goal however, and many obstacles remain. Last year's debate on health care reform illuminated most of the difficulties with enacting comprehensive reform. Yet the problems that triggered the health care reform debate have not been addressed and are unlikely to be resolved easily. Without government action it seems likely that health insurance coverage will continue to erode and that costs will continue to increase through the end of the decade.

Appendix 1
Selected Health Care Statistics by State

State	HMO Penetration	Percent Uninsured	MDs per 100,000	Hospital Beds Per 100,000	Per Capita Expenditures Hospital Care	Per Capita Expenditures Physician Care
Alabama	6.2%	21%	155	440	$1,105	$561
Alaska	0.0%	16%	136	300	$1,155	$548
Arizona	22.5%	24%	189	280	$964	$619
Arkansas	5.4%	24%	149	430	$994	$523
California	33.7%	23%	215	250	$1,025	$761
Colorado	22.2%	15%	204	280	$1,070	$628
Connecticut	21.2%	12%	283	290	$1,242	$679
Delaware	16.6%	16%	180	290	$1,177	$718
Florida	15.7%	24%	192	370	$1,146	$744
Georgia	6.7%	22%	173	380	$1,148	$589
Hawaii	21.1%	14%	222	230	$1,135	$634
Idaho	1.1%	17%	122	250	$733	$382
Illinois	16.2%	15%	201	360	$1,195	$496
Indiana	7.4%	14%	155	370	$1,074	$515
Iowa	4.6%	11%	139	430	$1,049	$463
Kansas	5.2%	15%	165	430	$1,020	$563
Kentucky	10.6%	15%	170	440	$1,052	$489
Louisiana	7.5%	27%	189	450	$1,241	$564
Maine	5.1%	13%	168	340	$1,018	$443
Maryland	24.5%	17%	295	280	$1,072	$676
Massachusetts	34.5%	14%	307	360	$1,517	$708
Michigan	18.3%	13%	180	320	$1,138	$549
Minnesota	25.4%	13%	217	330	$1,039	$806
Mississippi	0.1%	21%	124	460	$936	$356
Missouri	15.0%	14%	188	430	$1,291	$546
Montana	1.6%	18%	156	370	$944	$388
Nebraska	6.9%	14%	167	420	$1,123	$489
Nevada	11.9%	22%	141	280	$930	$736
New Hampshire	14.2%	14%	188	280	$1,022	$581
New Jersey	11.4%	16%	236	370	$1,138	$589
New Mexico	12.7%	26%	174	310	$1,014	$452
New York	23.4%	17%	298	400	$1,404	$588
North Carolina	6.7%	17%	183	340	$1,009	$475
North Dakota	0.7%	17%	175	540	$1,255	$697
Ohio	15.2%	13%	188	370	$1,154	$557
Oklahoma	7.1%	27%	141	390	$950	$463
Oregon	29.6%	17%	192	260	$877	$595
Pennsylvania	18.3%	13%	223	400	$1,390	$559
Rhode Island	26.6%	12%	250	330	$1,210	$541
South Carolina	3.6%	20%	160	330	$1,015	$409
South Dakota	2.9%	16%	141	550	$1,136	$487
Tennessee	11.0%	16%	195	470	$1,260	$579
Texas	9.1%	25%	168	350	$1,042	$562
Utah	23.4%	12%	175	240	$853	$464
Vermont	11.2%	15%	226	290	$886	$429
Virginia	7.2%	16%	197	320	$1,019	$551
Washington	21.0%	15%	200	250	$913	$665
West Virginia	4.1%	23%	167	460	$1,111	$500
Wisconsin	22.4%	10%	181	320	$1,005	$621
Wyoming	0.0%	18%	128	370	$857	$337

Source: The Interstudy Competitive Edge, Vol4, No 1, 1994
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