SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

"Effective Health Care Reform in a Changing Marketplace"

Witness List

March 14, 1995

Day One: The Changing Health Care Marketplace

Panel 1.

Mr. Leonard Schaeffer
President and CEO of Blue Cross of California
Woodland Hills, California

Mr. William Custer
Custer Economic Research
Washington, D.C.

Panel 2.

Ms. Kathleen Angel
Worldwide Manager for Benefits, Digital Corp.
Maynard, Massachusetts

Ms. Cristie Upshaw Travis
CEO, Memphis Business Group on Health
Memphis, Tennessee

Mr. Glenn Potter
Vice Chancellor for Hospital Administration
Kansas University Medical Center
Kansas City, Kansas

Dr. James R. Kimmey
Vice President for Health Services
Saint Louis University
Saint Louis, Missouri

from the office of

Senator Edward M. Kennedy

of Massachusetts

For Release: March 15, 1995
Contact: Theresa Bourgeois
(202) 224-4781

STATEMENT OF SENATOR EDWARD M. KENNEDY AT A HEARING ON EFFECTIVE HEALTH CARE REFORM IN A CHANGING MARKETPLACE

I thank Senator Kassebaum for holding these hearings and for the cooperative spirit in which she has approached them. There are few issues on which bipartisanship is more important than health reform, and there are few issues of more concern to the American people than improving health security for working families. Every member of this Committee has heard from families in their states who have either lost their coverage or are concerned that they will lose it.

The crisis in health care has not gone away. Last year, despite the economic recovery, the number of Americans without health insurance increased by another million. The nation's health spending rose by $100 billion. Per capita health expenditures grew faster in 1994 than in 1993. Worst of all, no American family can be confident that the insurance protecting them today will be there for them tomorrow, if serious illness strikes.

The hearing yesterday focussed on many of these problems that are continuing to worsen.

--By the year 2000, we will reach an unprecedented 50 million uninsured. Only 52 percent of under-65 Americans will be covered by employment-based insurance, down from 67 percent as recently as 1988. If current coverage had not expanded by 10 million since then, the number of Americans without insurance would be even higher.

--The health care cost problem has not been solved. While managed care and a more competitive marketplace may be generating savings for some businesses and individuals, the underlying rate of cost increases has scarcely changed.

--The more competitive marketplace, combined with the growth in the uninsured, is putting great pressure on academic health centers and other institutions serving the needy. Without government action, the uninsured could find themselves without

-more-

access even to charity care. Essential institutions could be destroyed, and the nations' health training and medical research could be seriously damaged, with drastic consequences for the future of quality care. Medicare and Medicaid cutbacks could be disastrous for these vital institutions.

The hearing today will discuss directions for reform. The ultimate goal must be health security for every family and effective cost control, and I hope we can make a significant bipartisan downpayment this year.

Any meaningful program must have two components. First, it must reform the insurance market so that we can end the practices that put health care out of reach for millions of families. Pre-existing condition exclusions should be abolished. No Americans should be told they cannot buy the insurance they need because they are in the wrong line of work, or they live in the wrong part of town, or they are too old or too sick. No Americans should find their coverage canceled or their premiums raised out of sight when they develop serious illness and need coverage the most.

But, insurance reform alone is not enough. It will not substantially expand coverage or make it affordable for large numbers of citizens. President Clinton has suggested steps that would make a major difference and are consistent with Republican and Democratic proposals. We should provide help to make coverage for children affordable for every family. Coverage for children is not expensive, and there is no better investment in the future and no better way to help working families. A number of states already have such programs, and we can benefit from their experience.

We must also provide help when the breadwinners in families lose their job. We help families deal with the loss of income by providing unemployment insurance. It is time to extend that same protection to health insurance. Finally, we should make a start on better home care for senior citizens and their families.

It would be a mistake to slash Medicare or to attempt to force senior citizens into managed care programs which deny them free choice of a doctor. The elderly have worked for their Medicare benefits; they have earned them; they need them; and it would be wrong to try to reduce them or take them away.

Managed care is proving increasingly attractive to many senior citizens, and we should expand options where possible. But there is no excuse for cutting benefits to those who prefer to stay with the program they have been promised.

We have many issues to discuss today, and I look forward to the testimony of our expert witnesses.

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Fax TO DAN Maguire 219-7346

AIMD-95-84, March 3.

• Information Integrity: Using Technology to Determine Eligibility to Work and Receive Benefits, by Frank W. Reilly and Hazel E. Edwards, directors of Information Resources Management Issues, before the Subcommittee on Government Management, Information and Technology, House Committee on Government Reform and Oversight

T-AIMD-95-99, Mar. 7.

• Financial Management: Indian Trust Fund Accounts Cannot Be Fully Audited, by Lisa Jacobson, Director of Civil Audits, before the Subcommittee on Interior and Related Agencies, House Committee on Appropriations

T-AIMD-95-94, March 8.

General Government

• Bankruptcy Professional Fees: Guidelines for Reviewing Fee Applications.

GGD-95-36FS, March 6.

• Federal Downsizing: The President's Fiscal Year 1996 Budget and Its Compliance With the Federal Restructuring Act of 1994, by Nancy Kingsbury, director of Federal Human Resource Management Issues, before the subcommittee on Treasury, House Committee on Appropriations

T-GGD-95-105, Mar. 7.

• Regulatory Flexibility Act: Status of Agencies' Compliance, by Johnny C. Finch, Assistant Comptroller General for General Government Programs, before the Senate Committee on Small Business

T-GGD-95-112, March 8.

• Community Reinvestment Act: Preliminary Results of GAO's Study on CRA Problems and Proposed Reform, by James Bothwell, Director of Financial Institutions and Market Issues, before the Subcommittee on Financial Institutions and Consumer Credit, House Committee on Banking and Financial Services

T-GGD-95-113, March 8.

• Resolution Trust Corporation: Implementation of the Management Reforms in the RTC Completion Act

GGD-95-67, Mar. 9.

• Border Control: Revised Strategy Is Showing Some Positive Results, by Laurie E. Ekstrand, Associate Director for Administration of Justice Issues, before the Subcommittee on Immigration and Claims, House Committee on the Judiciary

T-GGD-95-92, Mar. 10.

• Federal Retirement Issues, by Nancy Kingsbury, Director of Federal Human Resource Management Issues, before the Subcommittee on Civil Service, House Committee on Government Reform and Oversight

T-GGD-95-111, Mar. 10.

Human, Education & Health Services

• Multiple Employment Training Programs: Information Crosswalk on 163 Employment Training Programs.

HEHS-95-85FS, Feb. 14.

• Veterans' Benefits: Basing Survivors' C pensation on Veterans' Disability Is a Viable Option.

HEHS-95-30, M ch 6.

SenateFutureMeetings

habeas corpus process, by which death row inmates challenge the constitutionality of their sentences.

Time TBA SD-226 Dirksen Bldg. **date TBA**

Agenda:

S 3 - A bill to control crime, and for other purposes.

Labor & Human Resources

HEALTH CARE IN CHANGING MARKETPLACE

Senate Labor and Human Resources Committee (Chairman Kassebaum, R-Kan.) will hold a hearing on health care issues, focusing on how to address the changing marketplace.

10am SD-430 Dirksen Bldg. **March 14**

9:30am SD-430 Dirksen Bldg. **March 15**

Agenda & witnesses scheduled:

March 14 *See "Committee Meetings Scheduled Today" section for witnesses*

March 15

Potential for Constructing Targeted Market-Based Health Care Revisions and the Role of Federal and State Government:

PANEL 1: Models for Targeted Revisions:

Dr. Paul Ellwood - The Jackson Hole Group, Teton Village, Wyo., Bill Gradison - president, Health Insurance Association of America; Dr. Diane Rowland - senior vice president, Kaiser Family Foundation

PANEL 2: History of ERISA and Its Effect on State Efforts For Health Care Revisions, Availability and Delivery of Health Care Services:

Frank Cummings - Lebouf, Lamb, Greene, McCrae; Lee Greenfield - chairman, Steering Committee, Reforming States Group, Minnesota House of Representatives

PANEL 3: State-Based Insurance Revisions and Barriers, Role of the Federal Government In Insurance Revisions:

Rick Curtis - president, Institute for Health Policy Solutions; Josephine Musser - insurance commissioner, Wisconsin and recording secretary, national Association of Insurance Commissioners; Rick Smith - director, Health Care Policy, Association of Private Pension and Welfare Plans

SURGEON GENERAL NOMINATION

Senate Labor and Human Resources Committee (Chairman Kassebaum, R-Kan.) will hold a confirmation hearing on the nomination of Henry Foster to be Surgeon General of the United States.

Time TBA SD-430 Dirksen Bldg. **date TBA**

Nomination: Henry Foster to be Surgeon General of the U.S.

Note: This hearing may take place as early as April.

Rules & Administration

FUNDING FOR ARCHITECT OF CAPITOL

Senate Rules and Administration Committee (Chairman Stevens, R-Alaska) will hold a hearing on the Architect of the Capitol's req for funding authority for new projects.

(Chairman Stevens, R-Alaska) will hold a sight hearing on the Smithsonian Institut plans for its future.

9:30am SR-301 Russell Bldg. **March 30, 6**

"MOTOR-VOTER" OVERSIGHT

Senate Rules and Administration Commit (Chairman Stevens, R-Alaska) will hold a sight hearing on the so-called "motor-vote which in part requires states to allow citi register to vote when applying for or rene drivers' license.

Time TBA SR-301 Russell Bldg. **date T**

Note: This hearing was originally scheduled 31.

Select Intelligence

PENDING INTELLIGENCE MATTE

Senate Select Intelligence Committee (C man Specter, R-Pa.) will hold a closed h on pending intelligence matters.

2pm SH-219 Hart Bldg. **March 15 (CL**

CIA NOMINATION

Senate Select Intelligence Committee (C man Specter, R-Pa.) will h hearings c nomination of Gen Carns to be of the Centra gence Agency. CANCELED

Time TBA SH-219 Hart Bldg. **date TB**

Note: The Carns nomination was withdraw March 10.

HOUSE FutureLis

Agriculture

CONSOLIDATED FARM AGENCY

Resource Conservation, F rch and Subcommittee (Chairman Allard, R-Co House Agriculture Committee will hol ing on the information gathering techn the Consolidated Farm Service A c

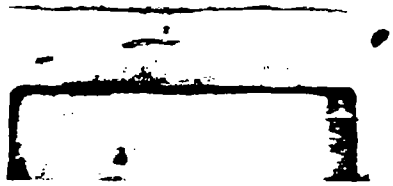
9:30am 1302 Longworth Bldg. **Marc**

PERISHABLE COMMODITIES

Risk Management and Specialty Crops committee (Chairman Ewing, R-Ill.) o Agriculture Committee will hold a hea the Perishable Agricultural Commodit (PACA) and possible revisions to it.

9am 1300 Longworth Bldg. **March**

IDLING FEDERAL ACREAGE



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UCI NON-PROLIFERATION REATY

·nate Governmental Affairs Committee (Chairan Roth, R-Del.) will hold a hearing to discuss e p· ·ility of giving a permanent extension the Nuclear Non-Proliferation Treaty.

10am SD-342 Dirksen Bldg. **March 14**

Witnesses scheduled: Thomas Graham - U.S. Arms Control Representative; Kenneth Edelman - vice president, Institute for Contemporary Studies; Andrew Goodpaster - co-chairman, Atlantic Council of the United States; James Schlesinger - former Energy and Defense secretary

Note: This hearing was originally scheduled for March 9.

udiciary

IMMIGRATION ISSUES

·nate Judiciary Committee (Acting Chairman mpson, R-Wyo.) will hold a hearing on propos s to reduce illegal immigration and to control nancial costs to taxpayers.

9am & 2pm SD-226 Dirksen Bldg. **March 14**

Witnesses scheduled:

9am:

PANEL 1:

Sens. Kyl, R-Ariz.; Feinstein, D-Calif.; Hutchison, R-Texas; Bryan, D-Nev.

PANEL 2:

Janet Reno - attorney general, Justice Department

PANEL 3:

Lawton Chiles - governor, Florida

PANEL 4:

Doris Meissner - commissioner, Immigration and Naturalization Service; Shirley Chater - commissioner, Social Security Administration; Dr. Susan Martin - executive director, U.S. Commission on Immigration Reform

2pm:

PANEL 5:

Michael Fix - Urban Institute; Lawrence Fuchs - professor, Brandeis University; Charles Keely - pro- r, Georgetown University; Mark Miller - pro- :, University of Delaware

PANEL 6:

Dr. Elizabeth Ferris - vice chair, Immigration and Refugee Program, InterAction; Elisa Massimino - legal director, Washington Office, Lawyers Com for Human Rights; Gregory T. Nojeim - leg counsel, American Civil Liberties Union; Simcox - Negative Population Growth Inc.; Dan Stein - executive director, Federation for American Immigration Reform; Cecelia Munoz - vice president, National Council of La Raza

UBCOMMITT MARKUP:

Labor & Human Resources

HEALTH CARE IN CHANGING MARKETPLACE

Senate Labor and Human Resources Committee (Chairman Kassebaum, R-Kan.) will hold a hearing on health care issues, focusing on how to address the changing marketplace.

10am SD-430 Dirksen Bldg. **March 14**

Agenda & witnesses scheduled:

Current Health Care Market:

PANEL 1: Changes in Health Care Delivery System and Trends In Health Care Costs and Coverage:

Leonard Schaeffer - president and CEO, Blue Cross of California, Woodland Hills, Calif.; William S. Custer - Custer Economic Research

PANEL 2: Managed Care and Barriers to Market Reform:

Kathleen Angel - worldwide manager for benefits, Digital Corp., Maynard, Mass.; Cristie Upshaw Travis - CEO, Memphis Business Group on Health, Memphis, Tenn.; Glenn E. Potter - vice chancellor, Hospital Administration, Kansas University Medical Center, Kansas City, Kan.; Dr. James R. Kimmey - vice president, Health Sciences and CEO, St. Louis University Health Sciences Center, St. Louis, Mo.

HOUSE CommitteeMeetings

SCHEDULED TODAY

Appropriations

FY96 AGRICULTURE APPROPRIATIONS

Agriculture, Rural Development, FDA and Related Agencies Subcommittee (Chairman Skeen, R-N.M.) of House Appropriations Committee will hold hearings on FY96 appropriations for programs under its jurisdiction.

1pm 2362-A Rayburn Bldg. **March 14**

Agenda & witnesses scheduled:

1pm

Eugene Moos - under secretary, Farm and Foreign Agricultural Services; Grant Buntrock - acting administrator, Consolidated Farm Service Agency

FY96 COMMERCE, JUSTICE, STATE APPROPRIATIONS

Commerce, Justice, State, and the Judiciary Subcommittee (Chairman Rogers, R-Ky.) of House Appropriations Committee will hold hearings on FY96 appropriations for programs under its jurisdiction.

10am & 2pm H-144 Capitol Bldg. **March 14**

Agenda and witnesses schedule:

10am:

International Information; Cultural and Exchange Activities:

Joseph Duffey - director, U.S. Information Agency; Carl Gershman - president, National Endowment for Democracy; William Fuller - president, Asia Foundation; Kenneth Pyle - chairman, Japan-U.S. Friendship Commission; Ambler Moss Jr. - director, North-South Center; Andrew Mason - East-West Center

2pm:

International Broadcasting Activities

Joseph Bruns - acting associate director, U.S. Information Agency; Kevin Klose - president, Radio Free Europe/Radio Liberty inc.; Richard McBride - executive director, Board for International Broadcasting; Geoffrey Cowan - Voice of A ica

Agenda & witnesses scheduled:

10am

Department of Energy - Solar and Renewables

Christine A. Ervin - assistant secretary, Energy Efficiency & Renewable Energy 2pm

Department of Energy - Nuclear Fission, Uranium Supply & Enrichment Activities

Ray A. Hunter - acting deputy director, Office of Nuclear Energy

FY96 INTERIOR APPROPRIATIONS

Interior Subcommittee (Chairman Regula, R-Ohio) of House Appropriations Committee will hold hearings on FY96 appropriations for programs under its jurisdiction.

10am & 1:30pm B-308 Rayburn Bldg. **March 14**

Agenda & witnesses scheduled:

Hazel O'Leary - secretary of Energy

FY96 LABOR-HHS APPROPRIATIONS

Labor, Health and Human Services, and Education Subcommittee (Chairman Porter, R-Ill.) of House Appropriations Committee will hold a hearing on FY96 appropriations for programs under its jurisdiction.

10am & 2pm 2358 Rayburn Bldg. **March 14**

Agenda & witnesses scheduled:

10am:

Harold Varmus - National Institutes of Health

2pm:

Tony Fauci - director, National Institute of Allergy and Infectious Diseases

Ken Olden - director, National Institute of Environmental Health Sciences

FY96 DEFENSE APPROPRIATIONS

National Security Subcommittee (Chairman Young, R-Fla.) of Ho Appropriations Committee will hold hearings on FY96 appropria-

Effective Health Care Reform in a Changing Marketplace

Testimony:
Directions for Reform
Senate Labor and Human Resources Committee
March 15, 1995

Packet Includes:

- Witness List
- Testimony from all witnesses whose testimony was submitted to the committee prior to 3 p.m., March 14, 1995

"Effective Health Care Reform in a Changing Marketplace"

Witness List

March 15, 1995

Day Two: Directions For Reform

Panel 1.

Dr. Paul Ellwood
The Jackson Hole Group
Teton Village, Wyoming

Dr. Diane Rowland
Senior Vice President, Kaiser Family Foundation
Washington, D.C.

Mr. Willis Gradison
President, Health Insurance Association of America
Washington, D.C.

Panel 2.

Mr. Frank Cummings
Lebouf, Lamb, Greene and MaCrae
Washington, D.C.

The Honorable Lee Greenfield
Minnesota House of Representatives
Chairman, The Steering Committee
of the Reforming States Group
Minneapolis, Minnesota

Panel 3.

Mr. Rick Curtis
President, The Institute for Health Policy Solutions
Washington, D.C.

The Honorable Josephine Musser
Insurance Commissioner, The State of Wisconsin
Madison, Wisconsin

Mr. Rick Smith
Director of Health Care Policy
Association of Private Pension and Welfare Plans
Washington, D.C.

TESTIMONY OF

PAUL M. ELLWOOD, M.D.

PRESIDENT OF THE JACKSON HOLE GROUP

BEFORE

THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

HEARING ON EFFECTIVE HEALTH CARE REFORM

IN A CHANGING MARKETPLACE

MARCH 15, 1995

Madam Chairman and members of the Committee, I am Paul Ellwood, M.D., President of the Jackson Hole Group. I appreciate the opportunity to testify before you today on our recommendations for targeted, effective reform of the health care system.

The Jackson Hole Group is an informal and fluid group of leaders drawn from the health sector, employers, and policy makers, who have been meeting in my living room over the past two decades. Our focus has always been on how to make market forces work in the health system, with an emphasis on competition and accountability under governmentally-established ground rules. We address specific topics related to health reform, develop potential solutions, persuade each other to apply them, and then keep tabs on whether or not they are working. This informal process of consensus building fostered the development of the managed care industry and of the document "The 21st Century American Health System" (1991), better known as the managed competition public policy proposals.

During the past six months, we have been revisiting the original proposals in light of the instructive health care reform debate last year, as well as the rapidly changing private health care market. We have included for our testimony a draft of the revised policies, which we are calling "Responsible Choices for Achieving Reform of the American Health System." The document focuses on those areas that are currently the greatest barriers to a better-functioning marketplace:

- Medicare and Medicaid recipients not being required to make value-based choices;
- Tax policy that fuels increased spending on health care, regardless of the value of services provided;
- Continued discrimination against small employers and individuals in the health insurance market;
- Lack of health system information in the areas of benefits, consumer satisfaction, access, and health outcomes, to help individuals in choosing a health plan, and to aid policymakers in monitoring health sector developments and in deciding on the right direction for further reforms.

The proposals outlined in "Responsible Choices" represent the collective thinking of a large number of purchasers and providers. These recommendations have been reviewed and analyzed by 100 or more individual experts with practical experience in these areas. We have included the full draft for the Committee's review, as the recommendations together provide a unified approach to incremental reform. Given the jurisdiction of this Committee, however, my remarks will focus specifically on remedies for the small group and individual markets, and improvements in the areas of health system information and health plan accountability.

RESPONSIBLE CHOICES FOR ACHIEVING REFORM OF THE AMERICAN HEALTH SYSTEM

A Draft Discussion Paper
from the

Jackson Hole Group

Paul Ellwood, MD and Alain Enthoven, PhD

March 1995

"Responsible Choices" is a living document that will change as the market changes and in response to suggestions and criticisms. Comments should be directed to the respective chapter author(s) or to the overall editor, Ellen Wilson, at:

Jackson Hole Group
P.O. Box 350
Teton Village, Wyoming 83025
Phone: 307-733-8781
Fax: 307-739-9312

TABLE OF CONTENTS

INTRODUCTION

Paul M. Ellwood, MD

"Responsible Choices" identifies the actions that the private sector and government should take to improve the American health system and accelerate and expand the health care revolution that is already underway. It spreads the benefits of and responsibility for better quality, lower cost health care with a minimum of prescriptive interference by government at no overall increase in cost. "Responsible Choices" is not based on untested economic and social theory. The recommendations are taken directly from actual clinical and operational experience gained in providing health care and health insurance to over 100 million Americans. These suggestions refocus the Jackson Hole Group's approaches outlined in "The 21st Century American Health System" (1991), which called for accelerating value-based competition in the health care marketplace and assured health care for all Americans.

We devised "Responsible Choices" as a set of practical, bold proposals to continue pushing the public policy process and keep the health care revolution on track. It identifies where progress can be increased while warning where it can be thwarted. It does not promise health insurance for everyone since that is an impossible goal without raising taxes, creating unfunded mandates, or prolonging the deficit. The Jackson Hole Group has not backed off of its commitment to adequate health protection for everyone but proposes that once the size of the problem is decreased and understood, we will be better able to identify and deal with those still left out of the system.

The United States has been rapidly transforming health care by implementing a market-driven system that works—a unique approach that has resulted in significantly reducing rate increases for private purchasers and consumers of medical services. This evolution, turned revolution, which has been underway for at least twenty-five years, is being driven by corporate purchasers and cost-conscious consumers. It has created an extraordinary array of health plans aggressively competing with one another on price and quality. HMO enrollment has grown by 30 percent since "The 21st Century American

Health System" was written. However, some consumers—such as most Medicare beneficiaries, individuals with preexisting illnesses, and the employees of small firms—are not fully benefiting from the health care revolution that is propelling us toward the twenty-first century. And, despite being the largest single purchaser of health care, the federal government has been particularly slow in bringing public programs into line with those in the private sector.

It has taken at least twenty-five years for the new American health system to become established. As it continues to evolve rapidly, care must be taken not to disrupt its progress. In the United States, the market works in health care because multiple purchasers, not just the government, are in a position to introduce bold new methods of buying health care and because providers and insurers have substantial freedom to respond with new approaches to organizing and paying for care. "Responsible Choices" makes proposals to foster this market driven progress and innovation.

Keeping the market working in health care requires the consideration of factors that are unique to the health sector. When a day in the hospital can cost thousands of dollars, people need health insurance. But when this is fee-for-service insurance, there are few incentives for sick individuals and their trusted physicians to try to save money. Those who are poorly insured or with a high deductible have an incentive to avoid costly health care but are too vulnerable to shop effectively for medical care based on price once they become truly sick. Historically, medical care has been a product best understood by doctors who were selling it and thus were in a position where they made both the key clinical and economic decisions for their patients and their practices. "Responsible Choices" intends to change this by enhancing the responsibility of consumers with better information and more power to make choices about their own lives. As in any industry, genuinely lowering costs means vast increases in productivity. In this case, change threatens the livelihood of more than 100,000 specialist physicians, one-half of the country's hospital beds, and hundreds of health insurers. The likely result is resistance to competition from these sectors.

"Responsible Choices" assumes that the combination of revolutionary change, health insurance, consumer vulnerability, inadequate information, extraordinary oversupply, and shared responsibility are factors unique to the health sector that cannot be ignored. It calls for intervention in selected facets of the marketplace to make it function better, while warning policy-makers that preventing or distorting further expansion of price and quality competition will disrupt the progress that the market is making.

The U.S. health system has been transformed thus far by adherence to the following principles:

- **Health plans and health insurance, including Medicare, should compete on the basis of price and quality.** Health plans that both finance and deliver comprehensive health care competing on price and quality are pacing the new health market. Combining health insurance with health care is perhaps the most important change in the structure of the health system. It shifts the emphasis from increasing earnings by subjecting the patient to more services to reducing demand for costly extended treatment by keeping people well. To effectively lower costs and improve quality, health plans must carefully select those providing care and match their numbers and skills to the needs of their consumers. This practice has been criticized for restricting doctor opportunities and patient choices, but shepherding resources remains as critical to health care quality and cost as to the management of any enterprise. Health insurers that offer more provider choices but greater consumer cost sharing should be given the same equal opportunities to compete.

- **Consumers can be cost-conscious when selecting health insurance.** Consumers can be motivated to be cost-conscious at the time they select health insurance and will choose lower cost plans when they are convinced that health care will be readily available and of good quality. Cost-consciousness at the time of illness is less predictable and can cause expensive and dangerous delays in seeking care. This is making limiting premium contributions more powerful than high deductibles in motivating consumer choice.

- **Group purchasing of health care is essential to spreading risk and reducing costs.** Health care must be purchased by groups large enough to exert real leverage over competing health plans. Size allows these groups to exploit their knowledge of health plan performance and, above all, to spread the cost of insurance over both healthy and unhealthy individuals. "Responsible Choices" requires shared responsibility by those who are still well for those who are sick. As in any market, the presence of many powerful buyers and multiple competing sellers has been shown to be beneficial to consumers and encourages continued innovation and vigorous price competition. Diminishing the clout of group purchasers or inadvertently dividing consumers into good and bad risks will destroy the burgeoning health market.

- **Information about the quality of care must be available to consumers.** For the health market to function properly, consumers, purchasers, and providers need understandable and comparable information on the cost and quality of care from various health plans. The quality of care information currently available to consumers is still incomplete and is perhaps the weakest link in the health care revolution. Because reliable and objective information is not available, the organizations providing the best quality of care are not necessarily attracting the most consumers. This information gap jeopardizes the entire health revolution. The lack of comparative information on quality also makes the system vulnerable to unsubstantiated criticisms about costs being down because quality is deteriorating.

Without expanding entitlements or mandates, "Responsible Choices" expands the revolution in health care by asking government to play by the same rules as the private sector, by increasing the power of consumers, and by minimizing risk selection against individuals and small employers. The various pieces of "Responsible Choices" can be implemented as stand alone proposals. However, they will most effectively generate progress and improvement in the health system if implemented in the designated incremental manner.

"Responsible Choices" has five objectives:

1. Align Medicare and Medicaid costs with revenues while expanding choices by offering public beneficiaries the same cost-conscious choices now available to private consumers through employers or purchasing groups. Use competition and consumer choices to limit the per capita growth of Medicare and Medicaid expenditures to revenue growth.

2. Make the tax benefits of health insurance coverage equitable, while increasing consumer awareness of cost and quality through a value-based tax credit for health insurance, health plans, and Medical Savings Accounts.

3. Give individuals and the employees of small firms, regardless of their health status, the same opportunity to purchase reasonably priced health insurance as large group purchasers. Insurance reforms mean all forms of health insurance—the self-insured, sellers of health insurance, health plans, and Medical Savings Accounts—should be subject to the same marketplace rules.

4. Ensure that consumers know what the various health plans offer in terms of benefits, satisfaction, access, and health outcomes.

5. Set timely realistic targets and measure results as reform proceeds. Manipulating a trillion-dollar enterprise may require a change in course if cost containment, health outcomes, consumer satisfaction, and access to health care do not improve as predicted.

21st CENTURY MEDICARE

Graham Rich, MD, MBA

As the largest purchaser of health care in the U.S., the federal government is responsible for the continual growth in Medicare cost by maintaining a dysfunctional payment methodology and by failing to encourage intensive price competition and cost-consciousness. Like any other purchaser, it needs to adopt some aggressive management policies so that all taxpayers, including seniors, can benefit from better quality and efficiency through competition among Health Plans and value based choices by seniors.

Even with the present underdeveloped system for encouraging enrollment in managed care, the number of seniors choosing this option increased by 25 percent in one year to 2.3 million at the end of 1994. To enable new seniors to stay in managed care and to offer more choice for current beneficiaries, we need a better Medicare payment methodology based on competitive bidding, better access to comparative information, and the option of enrolling in any participating Health Plan. Each senior should be able to use a sum of money (a voucher or specific contribution which will be referred to in this paper as a Medigrant) from the federal government to purchase health insurance from traditional Medicare or competing Health Plans and thus make cost-conscious decisions. Only then can seniors make responsible choices. This idea was originally proposed for Medicare in 1970 but got caught up in gridlock. Instead, the private sector successfully adopted the approach.

Why Update the Medicare Program?

Medicare expenditures were $160 billion, or 2.4 percent of gross domestic product (GDP), in 1994 and are projected to grow to $460 billion, or four percent of GDP, by 2005 which is obviously an unacceptable prospect. When the private sector faced the same prospect, and hence a threat to its own competitiveness, it completely changed the way it bought health care and achieved a projected decline in private sector HMO

premiums of, on average, 1.2 percent in 1995.[1] In addition, the one million member California Public Employees Retirement System, by adopting consumer incentives and price competition among Health Plans, achieved reductions in HMO premiums of 0.4 percent in 1993/4, 0.7 percent in 1994/5 and 5.2 percent for 1995/6.

If Medicare growth can be slowed to six percent per year, the cumulative savings between 1996 and 2004 will be $401 billion, and annual savings in 2005 will be $129 billion.[2] Medicare's traditional indemnity insurance structure and its conflicting role as purchaser and insurer have a negative impact on Medicare and the rest of the health care market. The traditional structure cannot be sustained because:

- Cuts in reimbursement cause cost shifting and drive up the cost of care for others.
- Hospitals suffer unpredictable changes in reimbursement rates.
- Physicians try to maintain income by increasing volume.
- Medigap policies that drive up use by covering first dollars become more attractive when consumer deductibles are increased in an effort to reduce program utilization. Seniors already spend, on average, $502 (18 percent of their out-of-pocket health spending) on additional Medigap insurance.[3]
- The system rewards doctor's office visits and hospital stays instead of improvements in the health of seniors.
- Medicare cost problems will only get worse under the current system as managed care Health Plans, using resources efficiently, force nonparticipating physicians (perhaps as many as 165,000)[4] to depend on Medicare to earn a living.

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[1] Group Health Association of America (GHAA), 1994 HMO Performance Report

[2] Based on growth projections contained in "The Economic and Budget Outlook: Fiscal Years 1996-2000." Congressional Budget Office, January 1995.

[3] Public Policy Institute, American Association of Retired Persons, "Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans," 1994.

[4] Weiner, Jonathan P., DrPH, "Forecasting the Effects of Health Reform on US Physician Workforce Requirement," JAMA, July 20, 1994, Vol 272, No. 3.

Parallels with the Private Sector

When unsustainable expenditures on health benefits threatened competitiveness, employers made the transition from traditional health insurance to offering a fixed payment for health care and a choice of competing managed care plans. As a result, they have seen a consistent increase in managed care enrollment with a corresponding reduction in costs. The government could experience the same savings by learning from enlightened employers and adopting the same strategy.

How Do We Get There?

There are a number of political and programmatic difficulties inherent in making the transition from a legally prescribed cost reimbursed Medicare indemnity plan with minimal consumer cost-consciousness to a program where consumers make value based choices. But, the practical problems in gearing up the private health system to compete on price and quality to serve seniors are not as great. For example, 74 percent of seniors live in an area where they have access to a Medicare risk contracting plan and, in 1995, 38 percent of HMOs are planning to develop new Medicare contracts. Early implementation would bring the greatest savings but would require the most support from seniors and a substantial managerial effort by the Health Care Financing Administration (HCFA) to effect the changes.

This proposal relies on competition among Health Plans coupled with a fixed Medigrant contribution for each senior. It expands the scope of benefits and offers beneficiaries access to well managed health care. It requires competing Health Plans to offer a more appropriate set of benefits than the traditional Medicare program, such as the federal standard HMO package with a prescription drug benefit. As a result, seniors who join Health Plans would not need to buy Medigap insurance. A Medigrant set at the average premium charged by the least costly half of the participating plans will give seniors access to a range of Health Plans.[5] The option to stay with traditional Medicare would still be available.

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[5] Competitive bidding to set the government contribution has been recommended by Bryan Dowd et al., in "Issues Regarding Health Plan Payments Under Medicare and Recommendations for Reform": The Milbank Quarterly, vol. 70, no.3, 1992, 423.

Promoting Consumer Cost-Consciousness

Each senior should be able to choose between traditional Medicare or a range of Health Plans using a Medigrant. Seniors who choose a more expensive plan would be responsible for making up the cost difference be it traditional Medicare or a Health Plan. Those who choose a less expensive option would receive a refund. To ensure full choice, all participating competitive Health Plans should participate in a coordinated annual open enrollment.

The amount of the Medigrant for each Medicare enrollee who joins a Health Plan could be initially limited to the amount the government currently spends on traditional Medicare adjusted downward annually by at least a percentage point each year. It should ultimately be based on the average premium of the least costly half of the competing Health Plans in each market area. This could be calculated using the previous year's enrollment to weight premiums.

Moving to Competitively Driven Prices

The current formula for paying Health Plans in Medicare is based on traditional Medicare costs. Thus the more expensive traditional Medicare actually drives up government payments to Health Plans. Instead, the reverse should be true with traditional Medicare being required to compete with Health Plan prices. As long as this perverse linkage between traditional Medicare and Health Plans is built into Medicare law savings from competition will elude us. At some point, the program expenditure should become pegged to competitive Health Plan prices. There are two options for making this transition. The Fast Track option would require the government to set the same growth rate, say six percent per annum, for traditional Medicare and Health Plan Medigrants during a transitional period. The slower, or divided track would temporarily separate the payment rates and growth rates of traditional Medicare from those of Health Plans. Under this divided track option the growth rate for traditional Medicare using CBO projections would be ten percent, on average, while the Medigrant for Health Plans could be eight percent in the first year, seven percent in the second year, and six percent in the third year, at which point enrollment should be sufficient to allow competition to

set prices. Under both options, there ultimately would be a common method for calculating the amount of money to be spent on traditional Medicare and Health Plan payments which would be driven by competitive Health Plan premiums.

Transitional Techniques

Traditional Medicare can no longer be considered as a well designed or adequate insurance policy. It tries to control demand by cost sharing and deductibles. There is a need for a more comprehensive and appropriate set of benefits which should convince Medicare beneficiaries that they are not losing out in the transition to 21st century Medicare. The Health Plans competing for beneficiaries should be required to offer an improved benefit package which should preferably eliminate the need for Medigap policies.

Beneficiaries with preexisting illnesses are reluctant to leave the traditional Medicare fee-for-service program which drives up the costs for this option during the transition. Under this proposal, a richer set of benefits, lower out-of-pocket costs, and increased quality accountability should encourage the higher risk beneficiaries to make the switch to a Health Plan. However, beneficiaries with a higher risk will be attracted to Health Plans that have a reputation for providing superior care. Therefore, some method for identifying this uneven spread of risks and compensating for them by shifting Medigrant dollars from plans with better risks will be necessary.

The availability of Health Plans across the country is uneven and costs are variable between regions. Medicare is the last frontier for competitive Health Plans that are eager to provide a service to this large sector of the population and are confident they can provide better benefits for less. In 1995, the Medicare capitation rate is $467 in San Francisco and $559 in Los Angeles while the premium for a non-Medicare, non-Medicaid Kaiser plan is the same for northern and southern California. With the current formula, HMO rates in some counties factor in excessive use of services and so are too high for Medicare to realize the potential savings from managed care. In other counties with lower service use, Medicare rates are too low to encourage HMO participation in the

risk contracting program. In encouraging competition between Health Plans in areas of the country where health care costs are lower or where the number of providers are limited, some have suggested that there should be no initial limit on the government contribution for Health Plans. "Responsible Choices" assumes that as Medicare is such a large buyer and the oversupply of providers so great, competition will develop even in those areas where traditional Medicare payments are low. If competition fails to develop in those areas, the federal government might consider using savings from higher cost areas to increase payments.

Fast Track Option

Under this approach, the growth in expenditure for traditional Medicare and Health Plans could be explicitly budgeted for each year. These sums of money could be given to seniors in the form of a Medigrant which they could use to purchase care from traditional Medicare or a Health Plan. The method of calculating the federal government contribution, or Medigrant, and its maximum growth could be specified in legislation to be, say, six percent per year and adjusted for the increasing age of beneficiaries. The growth rate for traditional Medicare would be the same and program costs would need to be controlled using techniques such as high deductibles combined with Medical Savings Accounts (MSAs). By adopting this approach, the government would be defining, in advance, what it is prepared to spend per beneficiary on Medicare, as other purchasers are increasingly doing. This would not be the same as introducing price controls as set out in President Clinton's Health Security Act but would merely set the limit of the government contribution. In fact, it would be analogous to the current Medicare practice of setting provider fees or deductibles where individuals and providers must make up any difference.

Divided Track Option

With this approach, the federal government would temporarily allocate different rates of growth for traditional Medicare and competing Health Plans. Traditional Medicare could be budgeted to continue increasing at the current predicted rates, (ten percent per year), while the maximum Medigrant growth rates would be set at nine percent the first year

and at one percentage point less each ensuing year until the market penetration is great enough to determine payments.

Competitive Health Plan Prices to Drive Traditional Medicare Payments

Under both options, when more than, say, 30 percent of seniors in a particular market are enrolled in competing Health Plans and are satisfied with the benefits they are receiving, then the government's Medigrant payment for traditional Medicare and Health Plans should be based on the average of the least expensive half of competing Health Plan prices. It may be necessary to grant new managerial powers to HCFA to allow traditional Medicare to adopt Preferred Provider arrangements and other managed care cost containment developments that have been employed by transitional managed care plans. This may include the setting of premiums for traditional Medicare or other cost saving or revenue producing measures.

Ensuring Plan Competition on the Basis of Price and Quality

To enable Medicare beneficiaries to use their Medigrant wisely, the HCFA, or its designee, should provide information, including quality and price comparisons of traditional Medicare and Health Plans by market area. Health Plans should price and offer a standard benefits package. Seniors should be given comparative information on out-of-pocket costs for care of common conditions, consumer satisfaction data, etc. It would be particularly valuable if government pursued the same health accountability methods being used by the private sector (see Health Accountability System section, page 34). Responsible marketing should be encouraged to ensure that seniors understand the options.

Stage 1: Fiscal Year 1996

The Secretary of Health and Human Services should establish market areas to calculate the value of the Medigrant, as counties are too small for stable prices. If Congress elects to use the fast track option, the Medigrant value for traditional Medicare and Health Plans would be set at the level of payment for traditional Medicare the first year with an annual percentage increase of, say, six percent thereafter. If the divided track option is

chosen, the growth rate for the Health Plan Medigrant would be one percentage point less than traditional Medicare, as described above. Under both options, legislation should allow Health Plans that cost less than the Medigrant to give consumers rebates. A Health Plan that costs more than the Medigrant value should charge seniors the difference. HCFA should simplify its approval and other regulatory requirements, such as the 50 percent commercial rule, so that it is less costly for new Health Plans to enter the Medicare market.

Stage 2: Fiscal Year 1997

HCFA, or its designee, should establish and coordinate an annual open enrollment period to ensure that each individual can choose among all participating plans. Medigrant payments should be risk adjusted to allow for the extra risks involved in enrolling individuals with chronic diseases. All participating Health Plans should be required to offer at least the new standard benefits package.

Stage 3: Fiscal Year 1998 and beyond

Under either option, many markets will exceed the 30 percent market penetration when Medigrant payments to traditional Medicare and Health Plans are determined by the average of the least expensive half of Health Plan prices.

Stage 4: Fiscal Year 2004

If competitively derived Health Plan prices are growing more rapidly than the economy or if Medicare prices adjusted for health status are growing faster than private sector prices, the whole program should be reassessed. It may be necessary to use a different formula for calculating the government's contribution, such as paying 100 percent of the lowest cost high quality plan or using a formula which is closer to the premium of the lowest cost plan. If employers do not encourage retirees to make a cost-conscious choice of Medicare Health Plan by giving them a defined contribution, legislative reform of retiree benefits may be required. The federal government should consider relinquishing its responsibility for providing indemnity insurance by asking private

indemnity plans to take over this function, as long as there is no restriction on access to providers.

Benefits of Medicare Reform

The phased introduction of premium competition, starting with areas of high managed care enrollments and where Medicare costs have tended to be high, ensures competition and early savings. Over time, there should be a reduction in regional Medicare price and utilization variations. Prices in today's populous high cost areas should come down first, while utilization and prices may go up in those areas (mainly rural) where seniors seem to be underserved. Allowing seniors to make the same responsible choices as the rest of the population will provide greater incentive for plans to improve their cost-effectiveness while maintaining or improving quality. Seniors and the health system as a whole will benefit from an expansion of choice and an end to the cycle of cost shifting.

ENCOURAGING STATE SOLUTIONS FOR ACUTE MEDICAID

Graham Rich, MD, MBA

The dramatic increase in, and unpredictability of, costs in Medicaid programs is a persistent challenge to state governments. The nation spent $82 billion, or 1.2 percent of GDP, on Medicaid in 1994; expenditure is projected to increase to $234 billion, or two percent of GDP, in 2005. States should use the same methods as successful private purchasers of health care by offering a choice of managed care plans to encourage choice and effective price competition for the acute care portion of Medicaid. Although states are already ahead of Medicare in adopting price competition, they have been impeded by the federal waiver process and the lack of health plan availability.

The Jackson Hole Group is not certain that the concepts behind "Responsible Choices"—that medical care volume can be decreased and efficiency increased—necessarily apply to long term care. In addition, the Medicare health plan package is likely to be comprehensive enough and offer cost sharing provisions that are

low enough to allow states to cease supplementing Medicare for acute Medicaid or to have their contribution be minimal. We do encourage state experimentation with SSI, particularly if some satisfactory means of risk adjusting the premiums of this population could be devised. For these reasons, the following recommendations are only for the acute care portion of Medicare.

Accelerating the Use of Competitive Managed Care for Acute Medicaid

States that received section 1115 waivers from HCFA have introduced innovations tailored to local needs and preferences. These changes brought variations in eligibility based on income, categorical requirements, new services, and a choice of managed care plans. In an effort to protect the Medicaid population from what it views as ill-conceived or hasty reform, HCFA developed detailed criteria for approval and set goals for implementation. Because criteria and goals can vary from case to case, the approval process is lengthy and cumbersome, causing state dollars to support inefficient and ineffective financing mechanisms while the application is pending. To stop such waste, the 104th Congress should grant states the authority to make the transition to managed care for Medicaid without obtaining waivers.

The Federal Contribution

The federal government should give states per capita grants for the acute Medicaid program (i.e., the government would provide a fixed amount per eligible beneficiary). To facilitate state management of the program, the federal government should specify in advance the rate of growth in the federal share of the capitation rate. If the current GDP growth rate and inflation remain the same, this could be set at 6.5 percent per year in 1996, six percent in 1997, and five percent in 1998. These ground rules would need to be reconsidered if managed care premiums began to decline to the same extent that they are currently declining in the private sector or if there were a drastic change in the number of people eligible for Medicaid. States should face a maintenance of effort requirement in determining their contribution based on fiscal capacity. Additionally, disproportionate share payments to a state should be phased down to a level of around four percent over a period of five to seven years from the current level of 12.5 percent.

Medicaid eligibility requirements should be federally determined, but scope of benefits should be set by the state. States could adopt the benchmark benefits package, as suggested in the Benchmark Benefits section, page 30.

Minimizing Federal Reporting

Allowing states to define their own solutions puts at risk the comparison of quality, cost, and coverage information essential to enhance consumer choice and aid policy-making at the state and national levels. The problem can be overcome if states follow the example of other purchasers by requiring standardized accountability for quality by the health plans they use (see A Health Accountability System, page 34, and Health System Information, page ?) and adopt the benchmark benefits package for state Medicaid programs (see Benchmark Benefits, page 30).

INCREASING COST-CONSCIOUSNESS: REFORMING THE TAX TREATMENT OF HEALTH INSURANCE

Alain Enthoven, PhD and Sara Singer, MBA

The internal revenue code excludes employer paid health care and insurance from the taxable incomes of employees without limit. It also, through Section 125, allows employees to tax shelter their premium contributions, as well as contributions to medical spending accounts. The states generally conform. This exclusion will cost the federal budget $90 billion in 1995. The exclusion provides a powerful incentive for employers and employees to agree that part of pay will be in the form of health insurance benefits. This has contributed to the rapid growth and persistence of employment-based coverage.

The exclusion, however, has negative consequences—the most important of which is to make the additional cost of more costly coverage lower to employees, inducing them to choose more costly coverage than they would if they were using their own money. To motivate responsible, price sensitive choice of health plan and to limit the loss of revenue to the federal government, this provision should be changed.

A Tax Cap

The natural solution is to cap the exclusion: set limits for individual, couple, and family coverage low enough that the premiums of most health plans exceed them, and legislate that employer contributions above the limit must be included in taxable income. At the same time, repeal Section 125 which allows employees to tax shelter funds spent on health care, so that the total tax sheltered premium—not just the employer's part—is limited by the cap. This would correct the current government-created lack of cost-consciousness by motivating consumers to be responsive to the full differences in premiums when they make choices. To be maximally effective, employers must limit their contributions to a fixed dollar amount and should offer a choice of plans. Employers would have to estimate the value of coverage in the case of self-insured plans, making such employer contributions explicit.

Numerous issues arise in connection with the "tax cap" on health benefits. Should the caps be adjusted for geographic variations in the cost of living, like Medicare prospective hospital payments, or for medical costs? If they are not adjusted, people will argue inequity. On the other hand, the tax code is not indexed for the regional cost of living, and there is legitimate concern that to do so in this case would precipitate endless technical arguments and open a new field for pork barrel politics. It may be better to keep it simple. The categories in which the exclusions are allowed (e.g., individuals, couples, head of household, etc.) would need to match the categories in which insurance rates are quoted, both for equity and efficiency. There is no need to give individuals a tax break sufficient for a family. To do so would undermine their incentives for economical choice. So long as premiums may vary by age, the categories would need to include "age bands" so that older, higher cost people would not be disadvantaged by a tax cap set for the average. Some comparable limited tax-subsidized treatment of health care benefits would need to be extended to the self-employed, non-employed, and employed whose employers do not offer health insurance.

Substantive arguments against the tax cap include that it would perpetuate "job lock." Job lock is a two-edged sword in that it helps perpetuate a desirable pooling of "good

risks," with low expected medical costs with "bad risks," with high expected costs. A tax cap would also give more incentive to become insured to higher tax bracket people who need it less; less incentive to lower bracket people who need it more.

A Tax Credit

These shortcomings have led people to propose replacing the exclusion with a refundable tax credit, available only to those who buy coverage meeting certain criteria.[6] Again, Section 125 would be repealed. Taxpayers would be allowed to reduce their tax bill by a fixed amount (or by an amount determined by a formula) if they met certain conditions. Individuals would get cash refunds if the credit exceeded the rest of their tax bill.

The tax credit approach offers some distinct advantages over the tax cap:

- The tax credit would end job lock by providing portability of the tax subsidy. The credit would be available to the self-employed, non-employed, and those employed by an employer that does not provide health insurance. This seems particularly appropriate since such a credit could help to reduce the burden of adverse selection in the individual market by giving healthy people a strong incentive to maintain coverage.
- Both low and high income people would receive the same credit. The tax credit could also be designed so that the poor could receive more.
- The existence of a tax credit for the non-poor would ease the work disincentive associated with the reduction of benefits as subsidies for low-income people are phased out.
- It could be characterized as giving people something in exchange for the abolished exclusion, as opposed to a tax cap which has been perceived as taking something away.

[6] Alain Enthoven, PhD. "A New Proposal to Reform the Tax Treatment of Health Insurance." Health Affairs. Spring 1984.

Tax Credit Structure

There are many variations on the tax credit theme that can result in a substantial improvement in the efficiency and equity of our health care system. Under one version, Congress would pick a dollar amount that reflects the price of an efficient comprehensive health plan meeting federal standards in most parts of the country, say $4000 per family. Next, it would pick a percentage for the credit that would make the whole program a budget-neutral trade for the exclusion, say 25 percent. A family buying coverage of up to $4000 could take a tax credit equal to 25 percent of the premium (i.e., up to $1000).

This would give everyone an incentive to buy coverage up to the $4000 amount. Above that amount, people would be required to use their own money, so they would be cost-conscious. In another version, Congress would set a fixed dollar credit amount for individuals, couples, etc. that would be a budget neutral replacement for the exclusion, say $750 per family per year.[7] The whole credit would be available to anyone buying coverage meeting federal standards.

Both proposals would require that, to qualify for the credit, the coverage purchased would meet federal standards of adequacy. Both would require people to pay more for more expensive coverage. Under appropriate conditions (see below), both could be recommended by the Jackson Hole Group as a means of increasing consumer cost-consciousness, reducing tax losses, and lowering the rate of medical inflation.

A switch to the tax credit approach risks creating other problems. The employment-linked tax exclusion is an important part of the "glue" that holds insurance purchasing groups together. Converting to a tax credit direct to individuals would weaken the glue and could threaten the employment-based group purchasing system because good risks might demand their employer contributions in cash and seek better rates elsewhere. Pooling of health risks within groups might be destroyed, although some employers might resist this, preferring to keep their risk pool together and their

[7] This credit would be slightly less than in the first example because people buying coverage for less than $4000 would forego some of the tax credit.

average costs per employee down by refusing to turn employer contributions into cash. Individuals not covered through employment groups (including those who successfully took their cash out of the group) would face a market beset by the pathologies that we observe today in the market for individual and small group coverage. To make this market work well, institutions need to be created for small employers and individuals that perform the functions now performed by large employers and purchasing groups (see "Insurance Reforms and Group Purchasing" Section, page 23 for recommendations for reforming the small group and individual market.).

A Tax Credit Linked to Group Purchasing

The tax credit should be structured so as not to dismantle the group purchasing based system. Standards governing the use of a credit would be necessary. For example, if your employer offers coverage, the credit should be available only if you buy insurance through your employer. Employers might be mandated to offer, but not necessarily pay for, several coverage options and could do this by contracting with a voluntary, certified purchasing group. If you are self-employed, non-employed, or employed by an employer that does not offer health care coverage, you should be able to use the credit independently in the individual market, or through a voluntary certified purchasing group that would agree to take all comers within the market in which the purchasing group chose to participate (e.g., groups size 5-50 or 1-100) and to abide by the rules established for the rest of the insurance market.

Stage 1: A Tax Credit for the Self-Employed and Individuals in 1995

Since there is mounting urgency to reinstate the 25 percent tax deduction for the self-employed, this opportunity should be used to shift from tax exemption to a tax credit for this group. Tax policy changes should start with a tax credit program for the self-employed, non-employed, and employed whose employers do not pay for coverage to go into effect in 1995. This is attractive for the following reasons:

- A tax credit would give this group a greater tax subsidy than they received under the limited tax deduction. A tax credit would give these people tax-subsidized health benefits while making them price-sensitive. It would eliminate the tax code

inequities that the self-employed currently face, without expanding the cost-increasing incentives created by the present tax treatment of health benefits for employed persons.

- Anyone who does not currently receive employment-based health care benefits would benefit from the tax credit without threatening employment-based health care purchasing.

Stage 2: A Tax Credit for Employer-Based and Group Purchased Coverage

After successfully implementing a tax credit for individuals, employer-based tax deductions of health benefits should be replaced by a tax credit with provisions to avoid unraveling employment-based health care purchasing.

CATASTROPHIC COVERAGE AND MEDICAL SAVINGS ACCOUNTS

Alain Enthoven, PhD and Sara Singer, MBA

The Jackson Hole Group tended to object to the approach advocated by proponents of the tax-favored MSA theory because it favors one form of health insurance, catastrophic coverage, and because it would encourage good risks to leave the risk pool. But, recently Mark Pauly and John Goodman (one of the architects of the MSA idea) proposed a new version that is much more neutral and less likely to split the risk pool. Therefore, the Jackson Hole Group regards this as an approach worth trying. Under the Pauly-Goodman approach, Congress would set a fixed dollar tax credit amount (presumably one for individuals, couples, etc.). The whole credit would be available to anyone buying coverage meeting standards that would include a deductible no higher than, say, $3000 and a requirement that anybody choosing a plan with a deductible (possibly above another threshold such as $200) would have to fund the deductible up-front with after-tax dollars in an MSA. The purpose of the account would be to ensure that people would have the money to pay their bills up to the deductible. Individuals could select first dollar coverage, $3000 deductible coverage with an after-tax MSA, or anything in between. After-tax MSAs may still cause some risk selection

problems because the $3000 deductible would continue to be attractive to the healthy and wealthy. Risk selection should be monitored and an appropriate remedy employed if a problem occurs.

Tax-Favored MSAs with Catastrophic Coverage Could Damage the Market

Recently, we have seen great enthusiasm for the combination of insurance coverage with high annual deductibles (e.g., $3000, called "catastrophic coverage") and tax-favored MSAs to encourage people to set aside the money needed to pay for care below the deductible. The idea is that if consumers were using their own money to pay their own bills, they would be much more cost-conscious in their use of care. If they could have tax-favored MSAs, they would be much more likely to accept high deductibles.

Unfortunately, catastrophic coverage would do little to moderate cost growth in the long run. Health care spending is concentrated on a few people with expenses that exceed $3000. For them and their families the additional cost of more care is zero. Catastrophic coverage would also increase costs due to lack of preventive services and early detection and treatment. For example, a recent study of acute appendicitis patients in California found that patients covered under indemnity insurance were 20 percent more likely than those in prepaid (first-dollar) plans to develop ruptured appendices.[8] The important opportunity for savings is not in deterring primary care, but in motivating doctors to provide high cost care only when it is appropriate and to do that efficiently. Catastrophic coverage has no impact on provider incentives.

Some of the enthusiasm for catastrophic coverage comes from the segment of the insurance industry that would like to give indemnity insurance a better chance to survive in competition with managed care. But, managed care organizations would easily be able to develop products to compete with catastrophic insurance, taking advantage of their superior ability to control the costs of high cost cases.

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[8] Braverman, Paula et al., "Insurance-Related Differences in the Risk of Ruptured Appendix," New England Journal of Medicine, August 18, 1994.

The $3000 deductible policy would be especially attractive to the healthy and wealthy. Those who could afford to do so could save so long as they did not need to use their deductible. This would reduce the costs of the healthy who take catastrophic coverage—an ironic result when one considers that it is the expenditures of the sick that need to be reduced. The bad risks would increasingly bear the burden of the additional costs associated with their care. In a spiral of increasing costs and higher risks, first dollar coverage would be driven from the market—a desired outcome in the view of the proponents of tax-preferred MSAs. In the end, this raises a question of social policy: Do we want people with costly chronic conditions (e.g., a woman in a five-year struggle with breast cancer) to have to pay $3000 per year out-of-pocket more than those who have the good fortune to be healthy?

Tax-favored MSAs raise a number of additional problems. A dollar increase in deductible does not translate into a dollar decrease in premium. The additional money to fund a MSA would increase tax losses to the federal government. Some proposals effectively allow people to pass funds through tax-favored MSAs without limit, as long as the money is spent on IRS-eligible medical expenses. Like today's limited Section 125 accounts, this effectively cuts the cost of goods and services by 30 percent to 50 percent (depending on tax bracket), thus undermining cost-consciousness, and costing the Treasury a great deal. Consumer out-of-pocket health expenditures in 1993 were $158 billion, much—though not all—of which would be eligible for tax shelter.

INSURANCE REFORMS AND GROUP PURCHASING

Jay Carruthers and Ellen Wilson

The rising costs of health care over the last decade have affected the large and small group markets in two very different but instructive ways. Cost pressures on large groups have inspired major innovation, including greater use of managed care, incentives for cost-conscious purchasing, and better information for making choices. The same cost pressures when applied to the small group and individual market have had a deleterious

effect. Small groups are unable to spread risks, to achieve economies of scale, to benefit from competition, and usually to offer multiple plans. As a result, the small group and individual market is characterized by:

- High premiums or unavailability of coverage to high-risk individuals.
- Steep premium increases (especially for individuals or small groups with individuals who get sick): small and mid-sized businesses faced an average increase of 14 percent over the last twelve months. Over the last three years, it totaled about 57 percent.[9]
- High administrative costs: a carrier's administrative expense, by one estimate, reaches 40 percent of claims in groups of one to four, compared with less than five percent for groups of more than 10,000.[10]
- Segmentation of the market by risk (i.e., health status).
- An inability to influence the development of the market to better meet the needs of small groups and individuals.
- A growing number of uninsured or partially insured workers.

Small employers and individuals need a purchasing infrastructure capable of putting the same pressure to bear on the market as large employers. The recommendations that follow encourage the formation of buying groups that would improve access to, and affordability of, coverage in the small group and individual insurance market. A stable insurance market, however, depends on the contributions of a broader population of healthy individuals to pay for the costs incurred by sick members of the risk pool, and so long as insurance remains voluntary, you need some mechanisms or incentives to ensure that risk is spread sufficiently. We propose the following:

- Group purchasers should be prohibited from selecting membership on the basis of health status or past claims experience.
- Receipt of the proposed tax credit (See page 18) should be linked to purchasing through a group for employees of firms of two or more.

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[9] Arthur Andersen, " Survey of Small and Mid-Sized Businesses: Trends for 1994."

[10] Congressional Research Service, "Private Health Insurance: Options for Reform," September 20,1990.

There are two ways to spread risk—modified community rating or group purchasing. The Jackson Hole Group favors the latter for several reasons. Group purchasing offers a proven, powerful tool for structuring a competitive, well functioning market, including creating a market with choices among competing health plans, side-by-side comparisons, comparative information about cost and quality, standard coverage contracts, equal rating rules, etc. Such institutions would spread risk more broadly and decrease the ability of health plans to discriminate on the basis of health status. They would also significantly reduce administrative and marketing costs associated with contracting with individuals and small groups. If group purchasing is not extended to small groups and individuals, this market will continue to be beset by weak incentives for competition among plans and high costs, and the market will continue to favor large groups while being disadvantageous for small groups.

While both community rating and group purchasing require some form of incentive to keep good risks in the pool so that premiums remain affordable, group purchasing offers a far more feasible way of spreading risk with minimal government intervention. We lack the cost shifting mechanisms, technical expertise, and standardization of benefits to implement an effective risk adjusted community rate in a perspective reimbursement environment.

Although we favor group purchasing to spread risks, forcing purchasing groups, made up of primarily small employers, to take individuals would put them at a significant disadvantage. Therefore, we encourage purchasing groups to take individuals but at the same time suggest that carriers serving the individual market be required to community rate and not be permitted to select on the basis of risk. However, this may lead to a situation where the premiums of individuals are excessive. If that becomes the case, other policy options will have to be considered to extend access to coverage for this population.

National Standards

A prerequisite to effective group purchasing is a set of uniform market rules or national standards. Despite current efforts to give states more power in developing local policy solutions in areas like welfare, there are several reasons why health system standards need to be national. First, health care markets do not adhere to state boundaries, making it impossible for states to structure rules that apply consistently across markets. Second, the preponderance of large multi-state employers reinforces the need for a federal framework. Moreover, with the rapid change in the delivery of medical services and the proliferation of varying levels of risk-bearing arrangements, state regulations designed to monitor traditional insurance carriers are outdated. Enforcing uniform federal standards, however, would be a logical extension of the state's traditional role as insurance regulator. Finally, and perhaps most importantly, national standards are needed—in the current system where there is tremendous variation in the regulation of health benefits from state to state and between the state regulated insurance market and federal regulation of self-funded plans—to uniformly shift the basis of competition from risk avoidance to the delivery of cost-effective high quality care.

Insurance Reforms

National standards should begin with enacting those insurance reforms at the federal level that have already been implemented in most states—e.g., guaranteed issue of all products, guaranteed renewal, portability, limitations of preexisting condition exclusions, and limited rating restrictions (not community rating). In doing so, the most blatant forms of risk selection would be eliminated while providing greater uniformity to the system and the necessary preconditions for the formation of purchasing groups. These reforms are designed to prevent health plans from discriminating on the basis of health status and claims experience—a widely accepted principle—and should apply to all health plans regardless of risk-bearing arrangements, whether it is a traditional insurance carrier, a health plan, or an ERISA self-funded plan. Guaranteed issue, for example, would not mean that a self-insured plan would have to take anyone who wanted to join. They would, however, not be able to deny coverage to a sick employee or family member based on their health status. Portability and continuity of coverage provisions

are particularly important because they not only reward those already in the system by improving access to coverage, but also foster a more competitive market by allowing people to change plans more easily—an essential component to any functioning marketplace. As a result, health plans are less able to predict the health status of their enrollee population and must therefore rely on spreading risk.

Table 1
Proposed Insurance Reforms

Guaranteed Issue of All Products - Health plans would be required to accept all individuals and their dependents, and all groups that apply for coverage. Health plans could not deny coverage based on health status. This would apply to all products sold in the marketplace by health plans.

Guaranteed Renewal - Health plans would be prohibited from terminating or otherwise failing to renew coverage for groups or individuals except under certain conditions - e.g. nonpayment, fraud, etc.

Limit on Preexisting Condition Exclusions - Health plans could not exclude coverage of treatment for a preexisting condition for more than six months from date of plan enrollment. A condition is preexisting if it was treated or diagnosed in the 6 months prior to the date of enrollment.

Continuity of Coverage - Health plans would be prohibited from applying preexisting conditions restrictions to applicants with continuous coverage (defined as coverage with lapses no greater than three months)

Limited Rating Restrictions - Health plans would be subject to limited rating restrictions to ensure that coverage is not denied through price.

*General language for the above taken from 6-28-94 Chairman's Mark of the Health Security Act, Senate Finance Committee.

Clearly, insurance reforms are limited in what they can achieve. Applied uniformly, however, insurance reforms serve as a critical step in shifting competition among health plans from risk avoidance to risk management. In addition to insurance reforms, all health plans, including ERISA plans, should adhere to uniform quality reporting standards adopted by the health industry (see Health Accountability Foundation section page 36).

Table 2
ERISA Reforms

- ERISA plans should have to allow employee family members the option of purchasing coverage through the plan. However, employers should in no way be required to pay for such coverage.
- ERISA plans should have to abide by marketplace rules relating to portability.
- ERISA health plans should be subject to the uniform quality reporting standards developed by the health care industry to allow employees to assess the coverage they receive.
- ERISA plans should be subject to solvency standards that ensure an appropriate level of capital reserves.
- States should be prohibited from taxing ERISA plans to finance efforts to expand coverage. Doing so would penalize those employers already providing coverage for their employees.

Certifying Voluntary Purchasing Groups and Enforcing Standards

To ensure compliance of national standards or market rules, the states should have the responsibility of enforcing those standards through the accreditation of Certified Purchasing Groups (CPGs). To receive accreditation and hence enable members to claim a tax credit, a purchasing group would need to adopt certain standards, such as:

- Accepting all who are eligible and wish to purchase coverage through the group. (Eligibility criteria would be left to the purchasing group as long as they precluded any discrimination on the basis of health status and past claims experience.)
- Offering a choice of health plans.
- Conducting an annual open enrollment period.
- Experience rate the group as a whole, with adjustments for age, family status, etc.
- Risk adjustment within the purchasing group (developing/adopting an actuarially sound methodology would be left to the purchasing group and participating health plans).
- Surveying members about their experience with their health plans and provide quality related information.

- Assure insurance reform compliance in contracting with health plans.
- Purchasing groups should not be allowed to demographically risk select in defining their service areas (i.e., split up Metropolitan Statistical Areas).

Many purchasing groups already perform several of these functions and could easily receive state accreditation as a voluntary CPG. If multi-employer arrangements are afforded ERISA protection, as some have proposed, the federal government should enforce compliance of uniform standards.

By establishing uniform market rules and fostering the development of voluntary, certified purchasing groups, access to, and affordability of coverage would be significantly improved as small groups pool their purchasing power and are able to exert more influence on the market.

PRIVATE SECTOR INITIATIVES

"Responsible Choices" assigns two important initiatives to the private sector. The first initiative is the introduction and maintenance of a benchmark benefits package which will serve as a reference benefits standard for comparative purposes. The second initiative is the establishment of a new health accountability system which will focus on the provision of understandable quality information to consumers, based upon plan performance and health outcomes. Each function is described in some detail in the two sections which follow. The two proposed private sector groups, the Benchmark Benefits Group and the Health Accountability Foundation could function under a single umbrella organization, funded primarily by user fees. Specific proposals for implementation are addressed on page 37.

THE FIRST INITIATIVE—BENCHMARK BENEFITS

Nancy Ashbach, MD, MBA

The Need for Fair Disclosure and Comparability

Health plans, consumers, pharmaceutical manufacturers, physicians, legislators, the courts, and others have struggled in the past with benefit plan offerings. In particular:

- Consumers have been unclear about the criteria for inclusion of specific benefits in their health plans. This has led to suspicion that managed care plans are motivated to skimp on needed care.
- Consumers have had difficulty comparing health plan offerings with differing benefits.
- Physicians and others have been unclear as to the benefit and technology review processes in health plans, leading them to view the process as secretive and unscientific.
- Health plans have been hampered in their ability to deny coverage for specific interventions clearly and concisely and to support such decisions with cogent reasons.
- Pharmaceutical and technology manufacturers have suspected that such decisions are based upon cost alone and that their products are not receiving a fair and open hearing by health plan policy-makers.
- The courts and legislators have received conflicting advice from interest groups.

It is for these reasons that a benchmark benefits package is needed. This product should be a voluntary, real, and valid offering of all health plans, but need not and should not be the only offering. Plans can and should be able to offer packages both richer and leaner to respond to the needs of purchasers. Many plans have had lengthy experience with the federal HMO benefits package, and we recommend that until the process for revising and improving upon it is in place, it serve as the initial benchmark package. A specific benefits package with a high level of detail will be developed as quickly as possible to deal with the ambiguity and lack of specificity inherent in the use of the federal HMO benefits package.

The process of defining and maintaining the benchmark benefits package should be open, fair, understandable, and for information purposes only. The criteria for additions and deletions should be available and the process should be clear so that coverage decisions by the health plan would be protected from unreasonable challenge. Physicians, drug manufacturers, consumers, purchasers, health plans, and others who might wish to influence the process of coverage inclusion and exclusion would therefore be able to do so. In addition, the public would be assured of appropriate care being provided and of coverage for expensive therapies not being denied solely because of cost. There should be no opportunity for collusion between health plans for the inclusion or exclusion of benefits. For the purposes of avoiding antitrust law suits, health plans may need to be excluded from the process.

In addition to disclosing criteria for coverage, a standard product must be available for price and quality comparison. In the absence of a voluntary benchmark, plans will vary benefits to satisfy the demands of various customers and comparability to the consumer will remain elusive. By using a benchmark benefits package as a standard product against which the differing needs and requirements of purchasers can be measured, comparability of benefits and price offerings can be determined.

Maintenance of the Benchmark Benefits Package

The benchmark benefits package should be that collection of benefits that is most likely to produce health in the population. While the federal HMO benefits package is an excellent starting point, producing health in the population will require ongoing evaluation, revision, and updating of benefits. Also, a high level of specificity and detail will be required in the definition of the benchmark benefits package. Technology assessment and cost-effectiveness analysis will be needed to achieve this objective in a rational way.

Technology assessment and evaluation are necessary because:

- Technology in medicine is in a constant state of flux, with new technology entering the market at a staggering rate. The cost of such technology creates a strong

economic requirement for a valid process to determine coverage under a typical benefits package.

- Much existing technology has not been evaluated for effectiveness. To date, we have had no mechanism for doing so, and many interventions in medicine are covered under existing benefits packages as a result of historical precedent.
- Cost-effectiveness has not been a major element of technology evaluation in the past but will surely become so in the future as group benefits are valued against individual demands.

An open, clear, fair, and scientific process to include or exclude specific technologies in the benchmark benefits package will benefit all parties. Since technology assessment is currently done in several different organizations, expertise would be available from the private market. This would mean purchasing technology assessment expertise from organizations such as ECRI (Emergency Care Research Institute) or the Blue Cross/Blue Shield Technology Evaluation Committee or networking current expertise. A principle of the new organization would be to utilize expertise currently available in the private market in the most effective way.

Additionally, individual coverage decisions on the part of health plans often require an independent evaluation and recommendation, which plans could implement on a voluntary basis. Such individual evaluations would be carried out by experts in the appropriate field of medicine and would be free of vested interests to deny coverage based on cost considerations. Independent expert reviews would support removal of coverage decisions from the legal system, where judges and jurors often rule in favor of coverage if there is uncertainty or urgency.

An Independent Approach

A new, independent organization, the Benchmark Benefits Group (BBG), should be formed to address these needs in the health system. The BBG's proposed functions are outlined in Table 1. It would be private and not-for-profit, although government collaboration would be possible in key areas, such as clinical trials, Medicare, and

Medicaid. Representatives could come from purchasers, consumers, managed care organizations, self-funded employers, academic medical centers, physicians, and the government. Funding for the organization would come primarily from user fees—that is, per capita assessments of the participants and users of the organization's efforts. Special projects funding could come from foundation grants.

Table 3
Functions of the Benchmark Benefits Group

- Definition, updating, and maintenance of the benchmark benefits package using the criterion of production or maintenance of health.
- Recommendation of inclusion or exclusion of new technology into the benchmark benefits package based upon technology evaluation done by recognized groups.
- Recommendations regarding continuation, limitation, or exclusion of existing technology.
- Cost-effectiveness information and recommendations based upon information from competent entities.
- Individual disputed coverage decisions in defined situations. For example, an autologous bone marrow transplantation case for breast, ovarian, or cervical cancer denied as experimental by a health plan would be referred to a group of experts entirely outside the plan for scientific review.

A critical element to the success of the BBG will be its independence and autonomy. Many elements of the health care system are characterized by suspicion and doubt as to the methodology regarding coverage decisions in the policy-making and in the individual case. The autonomy of this organization will reassure doctors that an appropriate process exists with adequate clinical input. It will reassure patients that their interests are being dealt with fairly, and it will reassure new technology providers—e.g., drug and device manufacturers—that a fair process exists, facilitating level playing field competition for all. Thus, the processes and criteria of the BBG should be open, published, and available for revision as the health care industry develops and matures.

Target Goals:

- 90 percent of health plans offering the benchmark benefits package by 1998.
- Reconsideration of decisions made in individual cases by the Benchmark Benefits Group upheld by courts in 60 percent of cases by 1998.

THE SECOND INITIATIVE—A HEALTH ACCOUNTABILITY SYSTEM

Sarah Purdy, MD

A New Quality Accountability System for a New Health Care System

The expectation that consumers would be able to choose among competing health plans, on the basis of comparable quality and cost information, has not been realized. This failure is partly due to information about the quality of health care not being as easily available, understood, or compared, as information about costs. Consumers have been inhibited from assuming responsibility for their own health care choices by inadequate information that does not facilitate side-by-side comparison of health plans or encourage participation in decisions about health care and treatment. To evaluate the impact of health care on the population, it is necessary to measure the result, or outcome, of the interaction between individuals and health plans—to hold health plans accountable. At present, there is a health care quality measurement industry that uses different definitions of quality and differing methodologies to measure quality. While these initiatives are admirable and more extensive than any previously undertaken, there is pressure from the purchasing community to move forward at a more rapid pace. Therefore, we propose a new health accountability system which would not rely solely on the traditional systems of quality assurance that fail to disclose health outcomes or assure consumers of receiving excellent care by choosing a specific plan. The principles and assumptions upon which the new health accountability system is based are:

- Comparable, reliable, valid quality accountability data must be available to consumers.
- A move toward outcome based accountability data is feasible.

- Purchasers, consumers, and providers may have different information needs. Quality improvement activities should result from internal use of quality data.
- A clear distinction should be made between defining measurement and disclosure requirements and verifying that requirements are observed. Organizations that define data disclosure requirements, and those that audit data, should be independent of each other, with neither being subject to undue influence by the provider or insurance communities.
- Providers, health plans, and researchers create the capability for choices to be made on cost and quality, but group purchasers and individual consumers should have input on the requirements of the system.
- The same data on quality should be demanded by, and be available to, both private and public sector purchasers.
- Uniform data disclosure requirements could lead to the formation of regional and national data bases, which would inform providers, purchasers, and policy-makers.

These principles raise several potentially controversial issues. First, the intention of the system is to compare health plans, not individual providers. Second, there is debate on how to compare the results of care provided by different health plans when the health and demographic characteristics of the populations they serve are not comparable. The issues of severity adjustment, or case mix, and demographic variation require continuing refinement. Third, the system would require health plans to collect additional information about quality and use some form of standardized record keeping. By cooperating with this, plans would potentially be putting themselves in a position of being unfavorably compared with competitors. Finally, the degree to which consumers want and understand information about quality of health care is still uncertain. However, those whose lives are impacted by health care—patients and those who represent their interests—must have the dominant input into the quality accountability system.

The health accountability system would also require group purchasers, whether public or private, to provide valid, comparable information to consumers. To achieve this, and

avoid further increase in the number of data sets requested by purchasers, collaboration is needed within the health industry.

What Would a Health Accountability System Look Like?

Table 2 outlines the proposed system, which suggests collaborative efforts to address two areas: the research, design, and evaluation of health accountability measures, and the selection and endorsement of uniform data disclosure requirements.

Table 4
Elements of a Health Accountability System

1. **Accountability Measures Clearinghouse**
   Clearinghouse function, to collate and disseminate information about measures, methodology, and previous experience. Identify areas that need further research.

2. **Health Accountability Foundation**
   Select and endorse uniform data disclosure requirements. Purchaser and consumer dominated board, permanent executive staff, input from other players.

3. **Auditing of Health Plan Data Disclosure**
   Verification that data has been collected, analyzed, and interpreted in a reliable and valid manner.

4. **Selection of Health Plans by Group Purchasers and Consumers**
   On the basis of uniform, comparable data disclosed by plans.

5. **Quality Improvement**
   Assist health plans to be proactive in the improvement of quality and to respond to the results of the measurement process.

Health Accountability Foundation

A Health Accountability Foundation (HAF) should be established as an independent collaborative body between the private and public sectors. Its responsibilities would include setting quality accountability goals and selecting and endorsing uniform measures of health plan accountability. These measures and the agreed methodology by which they are collected would then form the core of all health plan reporting activity. Care must be taken to ensure that standardization does not quash innovation, and that

evolution of the core measures is assured as information capabilities improve. It is important to consider the clinical implications for plans and providers, and to build incentives and feedback mechanisms for quality improvement activities to result from the internal use of quality data. Standard setting should not be isolated from the implementation of quality improvement activities. The experience of the health plans and the accrediting bodies will be vital to ensuring a link between the foundation and clinical practice.

It is envisaged that the HAF would have a permanent staff of scientists, who would systematically consult with outside experts. They would present recommendations to the foundation's board, whose majority would be represented by purchasers and consumers from the private and public sectors. A mechanism needs to be devised, by which health plans, providers, researchers, the pharmaceutical and technology industry, and the health care quality organizations would have input. The closest existing model for the HAF is the Financial Accounting Standards Board (FASB). The recommendations endorsed by the HAF should be scientifically justified and subject to scrutiny at public hearings. It is important to link health plans into the system, in order to ensure that the data requirements specified by the board inform quality improvement and the furthering of medical knowledge, and are fair and feasible. Data that is valuable to providers is more likely to be included in medical records and incorporated in computerized medical information systems.

Funding of the HAF should preserve its independent status. Funding should be assured, but not dominated by health plans. A possible mechanism would be an annual subscription, and an assessment on the health plan premiums of those plans that choose to participate.

Implementation of Private Sector Initiatives

The two private sector initiatives proposed in "Responsible Choices" are benchmark benefits and the health accountability system. These two functions could work synergistically under a private umbrella organization sponsored by a broad range of

participants and involved parties, and funded by user fees. The organization would be a not-for-profit entity. We propose to convene a representative set of purchasers and consumers in June 1995 to determine if there is agreement on the idea of the Health Accountability Foundation and the Benchmark Benefits Group and to get their thoughts on how funding for these initiatives would be accomplished. Initial estimates of cost suggest that funding in the range of $0.10 per member per month would be sufficient to accomplish the task with a broad membership. It is intended that participants at the June meeting will define and adopt a set of initial health plan benefit and accountability requirements.

Once sufficient support is generated for the new organization, a board of directors should be chosen and an executive director selected. The new organization should move quickly to begin work on its primary goals. The proposed benchmark benefits should be available by July, 1996. The goals of the Health Accountability Foundation will be more difficult to accomplish due to the lack of uniformity of quality data in the health system today but even if a single meaningful measure is chosen, the expansion of goals can proceed from that starting point.

The other elements of the proposed health accountability system are as follows:

Accountability Measures Clearinghouse

Many groups and individuals have developed considerable expertise in devising and implementing health plan performance measures. Currently, no organization documents all of these efforts and evaluates them, or assists others with questions of methodology or implementation. A collaborative approach would achieve economies of scale, resulting in more funding for such projects, greater availability of information, and a reduction in the duplication of effort. It is proposed that a scientific assembly be formed that serves two main functions:

- To act as a clearinghouse for the collation and exchange of information about quality accountability measures and methodology.

- To call attention to the need for research, development, and continual evaluation and improvement of performance measures.

The clearinghouse is not meant to engage in research. It should be a private/public partnership, perhaps set up to collaborate with an existing organization, such as the Agency for Health Care Policy and Research (AHCPR) or a consortium of government and private research institutions. Funding would come from foundation grants and government agencies.

Completing the Health Accountability System

The other criteria for the proposed system can be satisfied by well-established mechanisms already in place. Because organizations like the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations have considerable experience in accrediting plans and providers, they could play a major role in auditing the process and facilitating quality improvement activities. The organizations that focus on internal quality improvement, such as the Institute for Healthcare Improvement, would be an obvious medium for the quality improvement role. Continuing education of physicians and other health plan staff members is important to each stage of the process. There will be considerable overlap between the components, and continuous feedback to the clearinghouse and HAF functions will be necessary.

Target Goals:

- Comparable information about the quality of care provided by health plans should be available to 100 percent of consumers purchasing through groups by 1998.
- Preliminary health plan data on condition specific outcomes by 1998.

HEALTH SYSTEM INFORMATION

Robyn Lunsford, MSE, Nancy Ashbach, MD, MBA and Sarah Purdy, MD

Why Is Coordinated Health Data Needed?

Making responsible choices will require that better information be available on who is insured, what it costs, and whether better health is the result. As the system changes, data must be collected faster and from different sources: per capita expenditures by health plans, for example, are becoming more valuable than the numbers of physician visits and hospital days. Attempts at federal health care reform last year showed that the data available was not sufficiently timely or accurate. In fact, inadequate data on consumers' responses to price competition tilted some proposals toward price controls. Congressional Budget Office estimates of the cost of various bills were hampered by their inability to evaluate the effects of undocumented improvements that were under way and differences in inflation rates from community to community. While in some areas premiums are reported as declining, these figures do not show if there is a corresponding increase in copayments. In order for policy-makers to address the problems of attaining broader coverage while containing the cost of health care, they must have data about the numbers and characteristics of the insured and uninsured and the cost of different delivery systems. Though multiple sources of health care data are available, one of the major obstacles is how to access, analyze, and compare this disparate information.

Why Are the Current Data Inadequate?

- Multiple data sets are not comparable or accessible from one source: For example, information about coverage and utilization of services is collected in the annual National Health Interview Survey (NHIS), but it does not provide information about household income or costs.
- Data regarding costs and coverage is not timely: e.g., the information from the NHIS takes twelve months to process. The National Medical Expenditures Survey is completed only once every ten years.
- The validity and accuracy of some sources of health data has been questioned; e.g., the medical care component of the consumer price index (CPI) does not measure

costs borne by third-party payers, hence it reflects price to the consumer, not true overall cost. In fact, the CPI is a poor measure of medical cost to the consumer.

- Data are not available in useful formats: e.g., it would be very helpful to have data sorted by state to deal with issues such as Medicaid reform.

The problems associated with the existing data sets and with setting up an alternative system are acknowledged by federal agencies[11] and at the state level. We have set out some basic principles for the development of a coordinated system in the following sections.

What Should Be Collected?

Data will be required in four basic areas in the health system:

1. Cost—What is the per capita cost of health care, to third-party payers and to the individual?
2. Coverage—Who is and is not covered by the health insurance system?
3. Vital Health Statistics—Morbidity, mortality, reportable diseases.
4. Quality—What are the measures of quality of services provided?

Quality of services (health status, outcomes, and consumer satisfaction was covered in: A Health Accountability System; page 34). This section focuses on the data needs of cost, coverage, and vital statistics.

The process of collection should be guided by some basic principles:

- Confidentiality of records and privacy rights of individuals must be preserved. Use a unique, encrypted identifier.
- Data must be exchanged electronically, either directly or indirectly.
- Data must represent the minimum required to serve the basic needs of the health system.
- The information needs of the health system will change as the payment system changes.

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[11] Physician Payment Review Commission, Annual Report, 1994.

- Data collection must be timely.
- The aim of the uniform data system should be to reduce administrative costs in the health care system.
- Determination of which data elements are collected should be driven by a clear mission—to improve the health of the population.
- Data should be collected at the state level, and then aggregated nationally.

Cost: Information is needed on per capita costs for all individuals in the health care system. The purpose of information at this level is to determine the per member costs of health care—those borne by a health plan and those borne by the individual. It will be necessary during a period of transition to reconcile the methodology of data collection between capitated systems and fee-for-service systems. It will be the responsibility of a federal entity (see page 43) to define appropriate standards to integrate information from the two payment systems.

Coverage: Information will be required from health plans and self-insured groups with respect to numbers of enrollees (including dependents) and member demographics. Timely information on enrollment and disenrollment will be needed. Information will be required both on the insured population and on the uninsured population. The basic questions to be answered in this context are: "Who is covered?" "Is their coverage adequate?" and "Who is not covered and why?" Surveys, using demographically representative subsamples, should be conducted at least annually with the resulting data forwarded to the responsible federal agency. These surveys should incorporate questions regarding coverage status—including an accurate assessment of why an individual or family does not have coverage; the cost of coverage—including premium amount and health plan provider, deductible and copayment amounts, and out-of-pocket expenses for the most recent one-week period; type of coverage—i.e., fee-for-service, managed care, Medicare, and Medicaid; and the family's source of coverage (employer, purchasing group, individual, other group plan, etc.). Data on the characteristics of both groups, such as employment or lack thereof, income, and demographics, should be collected. Information should also include an employer's size and industry classification. Data on

the various health plans offered to an individual would also be helpful. Care should be taken to ensure that data on the Medicaid eligible population is incorporated in any survey.

There are two possible methods for conducting surveys:

- The ideal means to collect this information would utilize a national sample size of 50,000 to 80,000 households and result in national average data. Difficulties associated with this method are the expense and inability to analyze data with respect to localized market areas. In order to eliminate the possibility of duplication, unique identifiers should be used for each survey respondent and all family members included in the survey with appropriate safeguards for confidentiality of the data.

- Alternatively, surveys of discrete market areas, at differing stages of market reform, should be conducted. Collecting longitudinal data in these areas would allow analysis of the changing market. The effect of reforms in other areas could then be more accurately estimated. Particular attention should be focused on states undergoing policy changes.

Vital Statistics: The new health data system should continue to collect information on morbidity, mortality, reportable diseases, births, and other issues, possibly including immunizations. Such information should be collected in a standardized way and integrated with information collected by providers and health plans for purposes of comparability and to reduce administrative costs in the health care system.

How Can the Goal Be Accomplished?

We believe that the ability to collect uniform, timely, accurate health system cost and coverage data is a goal that justifies a federal presence. Private industry collaboration alone will be neither comprehensive nor sufficiently rapid. However, it is in the interest of the health care industry to encourage federal financing of this endeavor. This function could be performed by an existing agency, such as HCFA's Office of National Health

Statistics or the AHCPR, or by inter-agency collaboration. It should be separate from all purchasers, including Medicare. The agency should be advised by a broad group of experts from the private and public sectors, to include those with expertise in information systems, health care financing, health economics, and other scientific and technical fields. We propose that the delegated agency take responsibility for reporting on cost, coverage, and vital statistics. Information on quality reporting will fall within the purview of the Health Accountability Foundation. Federal legislation will be required to ensure reporting of the chosen data elements by all parts of the health care delivery system as well as by states.

Target Goals:

- Health data system should be functioning by the end of 1996.
- Data on costs of health services should be available quarterly.
- Data on coverage should be available annually, and within the first three months of the following year.

CONCLUSION

"Responsible Choices" recognizes that the health care market is moving rapidly toward reform and offers proposals to foster this restructuring. Private purchasers are driving the market and causing health plans to compete on price and quality. However, not all purchasers are exerting this force on the market. As the largest purchaser of health care in the U.S., the federal government has tremendous potential to drive improvement in the market which it has not yet exercised. Small groups and individuals have limited access to group purchasing arrangements that pool risk, provide choice, and achieve administrative savings that would enable them to be active, value purchasers of health care.

This demonstrates that market mechanisms alone are not solving all of the problems. "Responsible Choices" depends on the willingness of government and the private sector

to work together to improve the American health system. Federal involvement is necessary to bring public programs into line with the private sector, increase consumer cost-consciousness, establish a fair market, promote group purchasing that offers the small group and individual market access to reasonably priced health coverage, and provide information. "Responsible Choices" recommends a tax credit as the means for bringing structure to the market. Without the tax credit device, bringing order to the health care market will be much more complicated and require considerable regulation.

For its part, the private sector must be willing to be more accountable. Benchmark benefits and quality reporting are the first steps that the private sector should take to voluntarily hold itself accountable. Implementing these policies would bring comparability to the market and provide information enabling consumers to make informed decisions and drive competition. If the private sector cannot follow through, it may be necessary to link these proposals to the tax credit by requiring health plans to price and offer the benchmark benefits package and report on quality in order to receive tax credit eligibility for their plan.

"Responsible Choices" does not address the issue of achieving universal coverage but recognizes that other primary problems must be solved first, such as building a better marketplace so consumers and purchasers can make informed decisions. Other important issues, such as malpractice and antitrust, are not taken up directly since they are being actively addressed by others and dealt with in the market. These proposals are the necessary incremental steps forward in containing costs and fostering effective public and private purchasing. With these reforms in place, there will be more data and the capability to effectively and efficiently deal with those left out of the system. The elements of this proposal can be put in place rapidly and will accelerate the reforms already taking place in the market.

HEALTH CARE BENEFIT AVAILABILITY FOR EMPLOYEES: THE ERISA FRAMEWORK

TESTIMONY OF FRANK CUMMINGS

prepared for delivery at a hearing before the U.S. Senate Committee on Labor and Human Resources, 9:30 a.m., Wednesday, March 15, 1995, in Room 430 Dirksen Senate Office Building.

* * * *

Frank Cummings, now a Washington, DC, member of the law firm of LeBoeuf, Lamb, Greene & MacRae, L.L.P., was from 1965 to 1967 Minority Counsel to the Senate Labor Committee, appointed by Senator Jacob K. Javits, and was Javits' Administrative Assistant/Chief of Staff from 1968 to 1972. Before working for Javits, Cummings was a lawyer at a New York law firm and was that firm's labor lawyer assigned to the Studebaker shutdown in South Bend, Indiana. Cummings designed the original Javits pension reform bill, first introduced in 1967 (S.1103, 2/28/67), which was the basis for ERISA in 1974.

Health reform hearings sometimes prove the adage that *everyone has at least one "good" idea that will not work*. A corollary would be the 2400-year-old advice of Hippocrates to the medical profession: "*First, do no harm.*"[1]

This Committee's agenda item - "Health Care Reform" -- targets a health care system which, *for those who are covered by it*, is the envy of the world. Make it better, yes. Expand coverage, yes. But first -- do no harm.

There *are* good things Congress can do about health care, without doing harm,

- *if* Congress proceeds carefully,
- *if* Congress listens to what the market tells you,
- *if* Congress does not try to swallow too much in a single gulp, and then choke on it, as in 1994,
- *and if* Congress learns from the past.

ERISA -- invented by this Committee more than twenty years ago -- is your legislative past. It is a good guide. By consensus among those who live under it, ERISA Title I works well. In fact, *it already works well for health benefit plans*, though some carefully targeted improvements may be worth considering now.

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[1]Epidemics, Bk. I, ch. 11.

THE PRIOR, CHAOTIC, MULTI-STATE LAWS
THAT ERISA SUPPLANTED -- AND THAT
"ERISA WAIVERS" COULD RESUSCITATE

ERISA was not born in a day. It was almost 15 years after "the Studebaker problem" before Congress acted. It took 7 years after Senator Javits' first bill[2] before the idea became law.[3] But in the meantime, the States were passing laws right and left, without helping matters. In the late 1960's and early 1970's, a number of states enacted state laws governing the content of plans (mainly pension plans)[4] -- just as they are doing now as to health plans.

The inherent limits of state jurisdiction made the system unworkable, and often did more harm than good. Technical problems in enforcing benefit rights were often insurmountable under state laws. Those hurdles included: inability to achieve service of process on necessary parties outside the boundaries of a single state; choice-of-law uncertainty; insufficiency of the law of equity since the real decisions were made by persons who were not defined as "fiduciaries" (other than the trustee). Interstate businesses could not comply with these laws separately, and yet benefit plans were most effective and efficient if they were company-wide in scope.

A wondrously chaotic pretrial conference in Detroit in the 1960's displays all the troubles that local employee benefit laws may generate. As one of the lawyers representing the old Studebaker and Packard companies (which had merged), I appeared in a judge's chambers in litigation challenging the shutdown of a pension plan when Packard automobile production terminated.

- The judge asked: Who are the necessary parties to this litigation? We responded that we needed the trustee (in New York), the insurance company (in Canada), the investment manager (in New York), the union(s) (in Detroit and South Bend), the employees as a class (everywhere), the employer (South Bend), and a number of other key players who had not appeared and over whom the local court doubted that it could get jurisdiction under state law.

- The judge asked: Whose law applies? The bank had a trust agreement which said that New York law controlled. The union claimed it was all under the Taft-Hartley Act. The insurer (Canadian) said it had a contract which said it was

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[2]S.1103, 90th Cong., 1st Sess. (2/28/67)

[3]Public Law 93-406, 93d Cong. (9/2/74).

[4]See Legislative History of the Employee Retirement Income Security Act of 1974 (Committee Print, Senate Labor & Public Welfare Committee), v. 3, at 4745-46 (Sen. Williams), 4770-71 (Sen. Javits).

governed by Ontario law. The plan said it was governed by state law (Indiana law, I think).

- The judge said: This litigation will go on forever!

Additional questions in our minds -- which were implicit in the judge's questions and which would follow inevitably from them -- included:

- Exactly what is the "claim" or "cause of action"?
    - A claim against whom?
        - The employer?
        - The plan?
        - The trustee, or investment manager?
        - The union? (the International? the Local? which Local?)
        - The insurer?
        - A service provider? (actuary, accountant, lawyer?)
    - Are there separate claims, and are they under the laws of different states, depending on where each separate claim "arose"?
- Who has "standing" to assert this claim(s)?
    - The participant?
    - The union? (the International? the Local? which Local?)
    - A class of participants? (more than one class?)
- What sort of relief may be granted?
    - Equitable/injunctive relief? (against whom, and for what?)
    - Damages? (against whom? In favor of whom? the plan? the participant?)
    - What measure of damages?
        - Compensatory damages?

- Consequential damages?
- Punitive damages?
- Attorney's fees?

- Who decides -- judge or jury?
- What are the preconditions of suit?
  - Exhaustion of the plan's administrative claims procedure?
  - Exhaustion of administrative claims appeals?
- What is the scope of judicial review of claims denial?
  - "Arbitrary and capricious"?
  - "Abuse of discretion"?
  - "De novo"?
- Whose burden(s) of proof? To prove what?

Most of those questions either had no answers or uncertain answers under state law. What was certain was that the *state laws were all different*. The parties (plaintiffs and defendants) were dispersed in a number of states. **The only certainty was uncertainty. It was a prescription for a legal shambles.** ERISA, in 1974, provided a single federal answer to every one of those questions.[5]

How does a new local health law avoid all that, all over again? ***Surely nobody with memory of the pre-ERISA situation would want to return to it.***

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[5]E.g., ERISA §§ 409 (fiduciary remedies), 502 (jurisdiction, standing, causes of actions, venue, necessary parties, service of process, etc.), 503 (claims and administrative claims appeals), 514 (preemption).

CURRENT ERISA TITLE I PROTECTIONS FOR EMPLOYEE BENEFIT PLAN PARTICIPANTS

The enactment of ERISA in 1974 established a battery of administrative and procedural standards governing *all* employee benefit plans -- both pension plans and *health* plans, as well as other types of plans operating in the employment context. In addition, ERISA set substantive standards for pension plans.

No employer was told, "you must have a plan." But if an employer chose to have a plan, then Congress set *some* standards of what must be in that plan. Even then, no plan sponsor was told how high the benefit level must be, how beneficial the plan must be, or even what kind of plan it must be. But as to pensions, rates of accrual and vesting and minimum funding standards were set, as were a few other requirements. Those were minimum standards, however. The hallmark of the 1974 law, even as to pensions, was protection of the employer's *freedom of plan design*.

It worked, and pensions (as well as other employee benefit plans) simply bloomed on the American employment scene, voluntarily, vastly expanding the coverage and protection of American employees. The reserves of private pensions, particularly defined benefit pension plans, kept expanding -- until *later tax amendments to ERISA Title II* began to pile requirement on requirement, and then the growth of private defined benefit pensions began to collapse under the *sheer regulatory weight of it all*.

ERISA TITLE I ALREADY PROVIDES BROAD PROTECTIONS FOR *HEALTH* PLAN PARTICIPANTS

ERISA has created a considerable array of protections for the participants in all employee benefit plans, including *all employee health benefit plans*. Here are some (but by no means all) of the ERISA standards which *already* govern *every* employee health benefit plan:

- Plans must be in writing: Every plan must be established by a written instrument. ERISA § 402(a)(1).

- Plans must be run by named fiduciaries: Every plan must be controlled and managed by named fiduciaries, who must jointly or severally have authority to manage and control the operation and administration of the plan. ERISA § 402(a)(1).

- Annual Reports must be filed: Plans are required to file annual reports with exhaustive detail concerning plan finances. ERISA §§ 103, 104(a).

- Mandatory disclosure of plan documents and plan information: All the key documents and necessary information must be disclosed to plan participants, on request, subject to severe federal penalties for failure to disclose. ERISA § 104(b)(1) and (2).

- Amendment Procedure: Each plan must state its procedure for making plan amendments. ERISA § 402(b)(3).

- Basis of payments: Each plan must specify the basis of payments into and out of the plan. ERISA § 402)b)(4).

- Claims procedures and claims appeals, with full and fair fiduciary review: Every health benefit plan must provide that when a benefit claim is denied, the plan must provide a written statement of the specific reasons for denial, written in language calculated to be understood by the participant. And every health benefit plan must afford a reasonable opportunity to any participant whose benefit claim has been denied for a "full and fair review by the appropriate named fiduciary" of the decision denying the claim. ERISA § 503.

- Summary plan description in plain language: Every health benefit plan must provide to each participant and beneficiary a "summary plan description," written in language calculated to be understood by the average participant, describing all the details of the plan under which a participant may receive a benefit, or under which a benefit may be denied, the administrative structure of the plan, the source of financing, the requirements for eligibility and participation, the identity of any entity through which benefits are provided, the names and addresses of the plan and the key people who run the plan, the claims procedures, and many other details. ERISA § 102.

- Federal fiduciary standards, imposed on all the key players, including many who would not be deemed "fiduciaries" under state law: Every health plan must be administered by a named fiduciary, and the people with important discretion are deemed "fiduciaries" under ERISA. Each fiduciary is subject to federal standards of prudence and prohibitions on conflict of interest. ERISA §§ 404-409.

- Procedure for allocating responsibility: A procedure for allocating administrative responsibility among fiduciaries must be provided in the plan. ERISA § 402(b)(2).

- Co-fiduciary liability and responsibility: A co-fiduciary is liable for another fiduciary's breaches of duty if the co-fiduciary participates knowingly in the breach, or enables the breach, or has knowledge of the breach and does not take reasonable efforts to remedy the breach. ERISA § 405. Co-trustee liability is even greater. ERISA § 405(b).

- Federal jurisdiction for enforcement of the plan and the requirements of the law: Every plan and every plan fiduciary is subject to federal court jurisdiction to enforce the

plan and the terms of the law. The types of actions which are allowed are carefully circumscribed to allow the federal courts to do what is necessary and not to do what is counterproductive. Restitution and other equitable remedies are allowed for fiduciary breach, but punitive damages are not. Attorneys fees are allowed. National service of process is allowed. Plan participants and fiduciaries, and the government, may sue, but strangers may not. What is needed is allowed; what is superfluous is excluded. ERISA § 502.

- Federal preemption displaces 50 state laws with a single national set of standards. ERISA § 514.

- COBRA continuation coverage: Participants losing coverage must be allowed to purchase continuation coverage at reasonable cost. ERISA § 601.

- Medical Child Support Requirements: "Qualified medical child support orders" must be honored. ERISA § 609.

And over the last 20 years, a considerable array of court rulings, regulations, advisory opinions, and administrative interpretations have filled in the interstices between these and other provisions of ERISA, creating an effective protective cover for all health benefit plans.

The system is effective. **Title I of ERISA, at least, *works*.**

ERISA Title II (Tax Qualification Requirements): Annual Amendments, Growing Confusion, and the Gradual Undermining of the Defined Benefit Pension System

The greatest weaknesses in ERISA have arisen not from Title I but from the tax provisions of Title II.

It was in Title II that Congress injected the infamous "Section 89" requirements for employee health plans, only to repeal it after an uproar of protest from "the real world" forced a retraction.

It is in Title II where Congressional "tinkering" *year after year* (sometimes twice a year) has generated so much chaos particularly in the areas of defined benefit pension plans. If you read the amendments to the Internal Revenue Code's qualified plan rules appearing in IRC §§ 401-424, you will begin to understand why only this year, in 1995, is the IRS finally beginning to catch up on reviewing and qualifying plan amendments which Congress required under the Tax Reform Act of *1986*, but which the Service has not yet reviewed because the regulations under those tax law amendments were so far behind!

Keep in mind three of the most central features of ERISA Title II (tax provisions):

- Licensing: When it comes to qualified plans, the Internal Revenue Code is a "*licensing* statute" -- in the sense that a sponsor submits the plan to the IRS and, if it passes, you get back a "determination letter" which is a kind of "license" to run a pension plan.[6] (Technically, a sponsor is permitted to run a plan without such a "license," but that is ordinarily viewed as an act of madness.)

- "Regulations Projects": ERISA Title II operates through a giant and growing maze of tax *regulations*[7] governing the contents of qualified plans. Almost every sentence of ERISA Title II plants the seeds of one or more IRS regulations projects.

- Additional Bureaucracy: Because most individually-designed pension plans must be reviewed for "determination letters" (again and again, as they are amended), it takes a large federal *bureaucracy* to implement the statute.[8]

What caused the Title II "mess"? ERISA was not perfect, and it included some mistakes -- most of them growing out of the parliamentary tangle that led to the ERISA "sandwich" of labor and tax provisions. Indeed, a fair inventory of mistakes -- from which the current Congress may well discern some useful lessons for health legislation -- would include the following:

- The largest 1974 ERISA mistake -- conflicting agency objectives: Congress thought the IRS, a tax-collection agency, could be made to assist and foster a benefit system based on tax deductions and exemptions that reduced the tax revenue of the United States. Congress thought the fox would be the best protector of the chicken coop. Wrong.

- The largest post-1974 ERISA mistakes -- excessive complexity, "budget balancing" in the guise of benefit "fairness," and member abdication in favor of "technician takeover": Post-ERISA repetitive amendments and expansion of the tax rules governing employee benefits have made the Code so complex that few

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[6]E.g., Rev. Proc. 94-37.

[7]As well as Revenue Procedures, Revenue Rulings, Private Letter Rulings, IRS Notices, GCM's, Manuals, and the like.

[8]This comment is *not intended to demean* in any way the members of this division of the IRS. **They are extraordinarily dedicated and skillful people.** But the possibility of needing to develop yet another such bureaucracy for health plans ought not to be accepted if there is any reasonably effective less bureaucratic alternative.

> if any members of Congress understand what's in the tax portion of ERISA. Loss of understanding has combined with abdication of control in favor of technician takeover. The only policy considerations that really seem to matter, when it comes to employee benefits, seem to be budget consideration -- "revenue loss" rather than benefit enhancement. Hardly anyone pays attention to the real interests of the benefit delivery system -- benefit sufficiency, efficient administration, an efficient market, workability, simplicity.

Compare that with ERISA Title I, which Congress had the good sense to design carefully in the first place and then -- for the most part -- to leave it alone. If there is a moral to that story, it is:

- Do it carefully
- Do it right the first time
- Try to leave it in place long enough for the sponsors, the participants, and the enforcement agencies to get the details worked out.

The latter point is not inconsistent with some gradual change, with Congress revisiting certain rules from time to time. Even here, the ERISA history is instructive. The original rules for pensions under ERISA required 10 year "cliff" vesting or 15 year "graded" vesting (ERISA § 203(a)(2), as enacted in P.L. 93-406 (1974)), and 30 year funding for new plans (with 40 year funding for old plan liabilities) (ERISA § 302, as enacted in P.L. 93-406 (1974)). In effect, ERISA as originally enacted required pension plan vesting and funding only in accordance with *the standards that many of the better plans had already adopted voluntarily*. In other words, Congress knew it would work -- it was already working for the better plans. Then, later, Congress revisited the vesting and funding rules, several times, tightening up the vesting standards (now 5 years) and funding standards (now down to about 12 years for underfunded plans catching up under "deficit reduction contributions" under ERISA § 302(d)), as the practices prevailing in the industry gradually improved.

Pensions, of course, are quite a different funding problem compared to health benefits. Pension money must be set aside, invested, and protected over a long period of time so that it can be paid out in retirement. Health premiums are paid annually and cover benefits which are for the most part paid in or shortly after the plan year in which the contributions are made. Thus, if "solvency" of health benefit plans is to be addressed, it need not involve anything like the long-term investment and security protections that have been at the core of ERISA's pensions standards.

Nonetheless, the funding problems of health benefits are worth examination -- *provided that the cure is not worse than the disease*.

"MARKET REFORM" UNDER ERISA

"Market reform" sounds innocuous, particularly when a bill proposes *"only"* to enact market reform.

But the market is the thing that tells you what works and what doesn't work. *Legislation which directs the market to market the unmarketable is not "only" market reform, it is market destruction. Beware.* Market reform is possible, but effective and workable market reform requires not just that the market listen to you -- you must also listen to the market.

How do you "target" health reform without fouling up the market?

When it comes to employee health benefits, "market reform" turns out to be a code phrase for a set of requirements protecting employees who may undergo a gap in coverage when they lose or change employment and then develop an illness which makes them currently uninsurable. The components of "market reform" in this sense would be provisions for (i) guaranteed issue, (ii) coverage of preexisting conditions, and (iii) so-called "portability," which is really just a combination of the first two provisions, perhaps also incorporating COBRA continuation coverage.

The core of the market problem you are dealing with is that insuring a very sick insurance applicant is like buying insurance on a "burning building." Nobody sells insurance on burning buildings, because the cost, as an actuarial matter, is equal to the cost of reconstructing the building. And nobody sells insurance on one very sick applicant, if that applicant is viewed as a single unit. But many (perhaps most) large employers will cover a *new hire without pre-ex exclusion (as part of a group)*, because the overall premium to cover a large number of active employees is adequate to cover the risk.

What, then, would be a reasonable legislative requirement? That will not be easy to design, but your guidelines ought to be based upon the best of current practice, and not developed in the abstract by someone without a good sense of what the market requires. You can't just say to the employer -- particularly the small employer -- that you must cover everyone, well or sick, who applies for coverage *whenever* they apply. If you do it that way -- if you say "you must insure all burning buildings" -- then there may be no incentive for well employees to contribute for current insurance:

- It would be too costly for the employer
- It would be too costly for contributing employees
- And it would invite participants to "game the system" -- inducing healthy employees to wait for the moment when they are sick, and to buy-in *then*, when they need it.

In other words, *that just won't work.*

But if you have *limited* guaranteed issue, *limited* market reform, then you might consider saying to an employer: If you have a plan that covers all your employees, or a class of employees, then the plan must cover all new participants when they enter the covered class, without regard to "pre-ex," or at least with *limits* on the exclusion of pre-ex. At that point you still have the problem of mutualizing the risk -- over a broad enough base to allow a smaller employer to absorb the risk of a "large single cost" incurred because of pre-ex coverage. But at least you may be able to solve the anti-selection problem.

Can you accomplish that? Probably, if you do not assume that it's easy and that you already know how. Instead, if you spend the time and take the trouble to study the market, to talk with insurers and employers and find out how they do it, you may discover that they are already doing it, now, and so it can be done, and done right. It can also be done *wrong*, if you're not careful.

The targeted health reform bill recently introduced in the House by Congressman Harris Fawell (H.R.995) is a giant step in the right direction. On the positive side, this bill, among other things,

- Operates mainly as an ERISA Title I amendment.[9]

- Provides for market reform, in the sense that it deals with portability, limits non-coverage of preexisting condition, assures annual open enrollment, limits certain exclusions, but nonetheless seeks to protect against "gaming the system" -- and these rules apply evenhandedly to insured plans and self-insured (uninsured) plans;[10]

- Enables voluntary formation of employer health coalitions and requires that small employers have access to the market;[11]

- Facilitates optional use of State insurance regulatory agencies to enforce federal standards;[12]

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[9]E.g., Bill § 1001(a), amending ERISA Title I, Subtitle B.

[10]Amending ERISA §§ 800-804.

[11]E.g., § 842.

[12]ERISA §§ 835-36.

- Limits insurance premium rating variations to increase affordability.[13]

In other words, it sets up health plan rules, *within ERISA Title I*, comparable to the pension plan rules that have been there for 20 years.

The House Bill (H.R.995) also protects health plans from the threat of regulatory balkanization, in that the bill

- Blocks State law benefit mandates;[14]

- Blocks State anti-managed-care laws,[15] and replaces them with a single federal standard, and generally preempts State laws relating to insured plans just as they have already been preempted for self-insured plans;

- Leaves it to the employer to decide whether to have a plan;

- Leaves it to the sponsor to design the benefit plan;

- Leaves it to the market to price the benefit;

- Imposes no new taxes or assessments;

- Opens the door to more active development of multiple employer health plans and "MEWA's", subject to federal uniform protection from certain abuses;[16]

- Seeks to avoid extensive "regulations projects" and the creation of extensive new bureaucracies;

- And restores full federal preemption to the field.[17]

Will it work? If enacted, would it achieve its objective of better and broader coverage on a voluntary basis, without damage to the market or to the health delivery system? The

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[13]Amending ERISA §§ 734-37.

[14]Amending ERISA §§ 823, 841.

[15]§ 843.

[16]Bill § 1203; Amending ERISA §§ 701-11 (including reserve requirements) (§ 707).

[17]Bill § 1202; ERISA § 823.

communities of providers, administrators, employers, employees, insurers and others who make up the market must come forward and respond to such questions, in as much detail as they can muster. The bill, after all, has been in the public domain for less than a month. But obviously the bill was intended and designed to be responsive to those needs, and to build upon the ERISA Title I model which has been so successful over the past 20 years.

CAN AN ERISA-FOCUSED MARKET REFORM BILL EXPAND HEALTH CARE COVERAGE? -- WHAT ABOUT THE RECENT ADVERSE STUDY OF "STATE MARKET REFORM" EXPERIENCE?

Clearly, market reform, if done properly and on a national basis, can expand coverage.

It can expand coverage by allowing employers to use MEWA's, "stop loss" insurance, and other market-developed devices to provide coverage at a more reasonable cost.

It can expand coverage by allowing small employers who have no plans because they have no bargaining strength, to exert more bargaining strength.

It can expand coverage by allowing employees between jobs or changing jobs to be protected from coverage loss.

Other market reforms (e.g., limited protection for preexisting conditions, guaranteed issue reissue, and the like) are all expansions of coverage.

In short, market reform can provide and expand and/or improve coverage to those employers (and to their employees and family members) *who want to* provide and expand and/or improve coverage, under improved market conditions.

Voluntary employer-provided expansion of coverage obviously will not be universal. But it can be very substantial -- a lot more substantial than a recent study of state market reforms would suggest. This month's release of *state* data by the George Washington University Intergovernmental Health Policy Project[18] ought not to deter or discourage legislative efforts at the *federal* level. This would be an apples-and-oranges comparison: a study of 12 states each with some aspect of market reform written into local law, compared to a national standard. Any failure or weakness in local efforts in the same direction ought be viewed in two central contexts:

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[18]See BNA Health Care Policy Report, v. 3, No. 10, p. 381 (3/6/95); Washington Post, March 5, 1995, page A-10.

- First, while a state law may regulate insurance, no state law can regulate an employee benefit plan, because of ERISA preemption.

- And second, no state law can get very far in providing a hospitable market environment for an employee benefit plan which is subject to all the cross-currents of competitive interstate business, described further above in this testimony.

Of course those State efforts did not work. That is precisely the point of the ERISA initiative.

IDEAS THAT WILL NOT WORK:
STATE ERISA WAIVERS, STATE "FLEXIBILITY" AND
MULTIPLE EXPERIMENTAL "STATE LABORATORIES"

It has been suggested that, if only the states are given "ERISA waivers," they will each develop small "health reform laboratories," and the nation will somehow get the benefit of their trial and error.

That notion is dangerous, unnecessary, and it will not work.

It is *dangerous* because the odds on success at the state level are zero -- employee plan problems cannot be solved at the state level, for obvious reasons. No state can deal with the problems of interstate business, of multistate plans, of employees commuting from one state to another, of all the procedural problems which ERISA § 502 was engineered to solve.

It is *unnecessary* because, if you want laboratories, you can get them -- indeed, you already have them -- within the flexibility under ERISA that allows each employer to design new and innovative programs. You can then see "what works," in practice, and what doesn't work. And then Congress may wish to require -- as it did when it enacted ERISA's pension standards in 1974-- that all plans conform to the "better practice" (vesting, funding, etc.) which had already become a widespread practice and therefore was clearly feasible, in fact and not just in some state legislative "laboratory."

But most fundamentally, the "ERISA waiver" notion is simply *unworkable*. The proposals to grant "ERISA waivers" for state health laws do not make ERISA inapplicable -- they simply allow state law, *in addition to ERISA*, to apply, without benefit of preemption.

But what does it mean to say -- as one bill with broad bipartisan support would say -- that, although ERISA applies in a state, it does not prohibit a *state-mandated benefit package*,

a *common administrative procedure* imposed by the state, and an electronic *claims processing procedure* imposed by the state?[19]

- How does a participant enforce that, one may fairly ask, if the plan is not administered in the state which passes this law, and/or the participant commutes from a state with this law into a place of employment in a state without this law?

- Which court reconciles the provisions of this law with the provisions of the plan itself, and of ERISA § 404(a)(1)(D) that make the plan binding unless it is inconsistent with "the provisions of this Title" (ERISA Title I)?

- Is the state claims fiduciary an ERISA fiduciary?

- Do the ERISA co-fiduciary rules apply, so that one fiduciary has the duty to stop another fiduciary from violating ERISA?

- Who writes the summary plan description -- the plan administrator or the state insurance commissioner?[20]

This sort of proposal can only be written by someone who doesn't understand the problem. The more closely you examine it, the more unworkable it appears to be. Nonetheless, it has broad

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[19]The provisions are found in S.3180, 102d Cong., 2d Sess. § 2108 (1992), which would amend ERISA § 514 to provide ERISA "shall not be construed to prohibit" state requirements so providing. S.3180 had the sponsorship of Senators Leahy, Pryor, Mitchell, Rockefeller, Reigle, Chafee, Danforth, Kerrey, Wellstone, Adams, Akaka, Bingaman, Graham, Inouye and Jeffords. Senator Leahy and several colleagues have announced their intention to resurrect the proposal in 1995. 21 BNA Pension & Benefits Rptr. No. 38, at 1839 (9/26/94).

[20]Other questions arising from provisions of the same bill could include: (1) If the plan provides money (via "tax") to the state plan -- are the assets still "plan assets" (after all, the state is paying "benefits" to an "employee" with money from the employer)? How does the plan administrator keep track of it, and report it? Who is the "trustee"? (Must there be a "trustee" as required by ERISA § 403?) And if the plan is a multiemployer or multiple employer welfare plan, operating on a multistate basis, which law controls it? How is it enforced? Are attorney's fees under ERISA § 502 available in enforcement actions against the state plan?

political support.[21] A Congress without memory of the procedural ills ERISA overcame can drive employee benefits into a relapse.

RECONCILING ERISA PREEMPTION WITH RESTORING REGULATORY POWER TO STATE AND LOCAL GOVERNMENT

Wouldn't it be better -- more citizen-sensitive, more efficient, less bureaucratic -- to do *it* by the exercise of state power? Definitely, if "it" is the same "it." The trouble with the question is that it assumes an impossibility -- that there is a way for state laws to accomplish what ERISA title I has accomplished: a law which works for interstate benefit plans, serving interstate business, with beneficiaries, employers, employees, retirees, service providers (doctors, hospitals, HMO's, pharmacies, service providers (lawyers, accountants, actuaries), fiduciaries, insurers and spread out in different states. And there is simply no way that a state law can govern an efficient interstate employee benefit system efficiently.

The "it" we are talking about is a single, comprehensive, carefully targeted employee benefit law designed to bring all these competing interests, dispersed parties, and policy objectives into a productive relationship without damaging the marketplace. You cannot leave "it" to the states, because the states, try as they may, are inherently incapable of accomplishing it.

Given that this type of legislation must, inherently, be done nationally, the challenge to Congress is even more fundamental: to get this done with the absolute minimum of bureaucracy, the fewest possible "regulations projects," and the minimal intervention in the marketplace.

Congress' best model is ERISA title I, which has managed to do its work over the past 20 years:

- by setting forth the rules in relatively simple comprehensible fashion,

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[21]Just as mindless would be the enactment of "source tax" enabling legislation which, though not framed in terms of ERISA waivers, would seek to enable states to tax pensions paid to non-residents, if the state claims that the pension was earned in the taxing state. H.R.546, approved by the House Judiciary Committee 9/29/94 (see also comparable provision in S.540, which passed the Senate but was deleted in the House). But how does one determine the state in which a defined benefit pension (a "final average" pension, for example) is "earned"? Just as important is the administrative question: how does a multistate employer handle the disputed withholding taxes? Local laws applied to employee benefits are harmful, counterproductive, and they simply do not work.

- by assuming that most people obey the law voluntarily and therefore do not need a "license" or prior approval in order to go about their business,

- therefore, by avoiding the creation of new "licensing" bureaucracies, and

- by providing that, if the law is broken, liability will then be imposed, and the offender will, if necessary, be sued. That is essentially how ERISA Title I works, and that is how market reform ought to work.

That kind of health reform is based on a model which works, and reform, if done right also ought to work.

STOP THE CURRENT, ONGOING
EROSION OF ERISA PREEMPTION:

Small Plan Health Benefits: State Efforts
to Balkanize Regulation of "Stop Loss"

A small health plan frequently cannot afford full insurance coverage, particularly in light of the Supreme Court's ruling that if a plan is *fully insured*, the states may regulate and mandate the plan's benefits by mandating the content of the insurance policy. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). The effect of the *Met Life* ruling has already been very damaging to private plans, by forcing small plans into the arms of conflicting state regulations, while allowing the larger plans to self-insure and gain the benefits of ERISA's full federal preemption.

The availability of "stop loss" coverage has enabled many small employers to self-insure, by protecting them from excessive risks in unexpected situations. The states, in turn, have attacked these stop-loss policies by establishing state laws and regulations which "define" a plan with stop loss as being an "insured plan" (and therefore subject to state regulation under *Met Life*) if the employer's plan does not retain a certain level of uninsured risk (the "retention"). The state would in effect prohibit the purchase of such stop loss, because stop loss would be deemed to be a health insurance policy, and therefore subject to state mandate as to its content!

That effort by certain states (legislators and regulators) is nothing but an attack upon preemption. It is an effort to gut the protections of ERISA preemption and return employee health and welfare benefits to their pre-ERISA balkanized and chaotic condition.

Reverse the *Met Life* Ruling

Can Congress protect health benefits federally, and stop that erosion of preemption? Should it? Yes. Obviously.

In fact, why not legislatively reverse *Met Life* altogether? **Why not assure that both insured plans and uninsured plans operate under the same rules as to *content*** (though of course the business of insurance, insurer solvency, etc., would remain in state hands)? After all, the Supreme Court has already found a way to preempt state efforts to impose state standards on claims disputes -- even under fully insured plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Why not go the whole way, and restore to plan content and plan administration the very federal uniformity which was the cornerstone of ERISA's success from the very beginning?

CONCLUSION

Using the ERISA model will not produce a perfect world. There will still be those whose employers do not have the profits to justify this kind of coverage even after market reform. And there will still be those left on Medicaid who have no employer and who cannot afford individual coverage. ERISA, after all, is a law governing employee benefits in the employment context only, and it is a law governing plans that employers decide, voluntarily, to install.

So whatever Congress does, there will still be those who demand "more." In fact, there will still be more to do. But if 1994 taught anything, it was this: Demands for "more and more" sometimes produce less and less.

There is an *obtainable consensus now* for targeted health and market reform now. That presents a current opportunity. Why not do it now? And then stand back, assess the results, and determine what more, if anything, should and can be done.

Testimony of

Kathleen Angel
Worldwide Manager, Corporate Benefits
Digital Equipment Corporation

on behalf of the

Corporate Health Care Coalition

on

Effective Health Care Reform in a Changing Marketplace

before the

Labor and Human Resources Committee
United States Senate

March 14, 1995

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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 employee 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

Senate Labor & Human Resources Committee

"Effective Health Care Reform in a Changing Marketplace"

Testimony of

Richard E. Curtis, President

Institute for Health Policy Solutions

March 15, 1995

9:30 a.m.

Room 430, Dirksen Senate Office Building

First Street and Constitution Avenue, NE

Mr. Chairman and members of the committee, I am Richard E. Curtis, President of the Institute for Health Policy Solutions, a not-for-profit, non-partisan education and research organization that does not advocate specific legislation. The Institute was established to objectively analyze and develop approaches to solve health system problems, and brings special expertise and interest to policy approaches that complement or harness private sector roles.

A broad range of states has enacted health insurance reforms to regulate industry practices for the small-employer market and in some cases for the individual market as well. These reforms generally require insurers to accept all applicants regardless of risk, to guarantee to continue coverage, to limit employer-to-employee or group-to-group premium variations (often requiring modified community rating), and to strictly limit the practice of imposing coverage waiting periods or denying coverage for preexisting conditions. Nevertheless, Congress should consider federal health insurance market reforms for a variety of reasons that include limitations in states' ability to extend such protections.

Overview

There are three key reasons health insurance market reforms have been popular at the state level on a broad bipartisan basis. First, they address the access barriers and inequities that have been so often reported in the press. Second, they are meaningful and popular reforms that do not require new government spending. Third, such regulation was needed to harness competitive market forces that in other sectors of our economy create incentives for efficiency and quality. In the small-group and individual health insurance sector, these positive incentives were often overwhelmed by incentives to compete on the basis of risk

selection, that is, attracting healthy persons and avoiding people who appear to be at higher risk of needing medical care.

The need for such rules has been most acute in the health plan market for small groups and individuals. (States generally have authority to regulate this portion of the market through regulation of insurance; traditionally, very few small firms are fully self-insured and thus exempt from state regulation under the ERISA preemption. But a growing number of entities are apparently developing hybrid partially insured plans to attract lower risk populations.) Because of the few people in each small group, there is no natural spreading of risks within each group, as there is for large employers. The risk profiles of small groups thus differ greatly. When individual carriers can selectively market to and enroll individuals and small groups, they can "pick off" low-risk populations and avoid higher-risk populations. Insurers have strong incentives to spend resources on such risk selection as a way to avoid the few people who need very expensive care: 2 percent of the population accounts for 40 percent of health care costs, and the top 10 percent accounts for approximately 70 pecent of costs.

In this highly fragmented market, then, health plans have strong incentives to compete by focusing on attracting low-cost enrollees and avoiding high-cost enrollees rather than by being effective managers of health care costs and their own administrative costs. Even if a well managed HMO can achieve a real 10 percent to 15 percent saving on health care costs, it cannot compete against an otherwise inefficient carrier that successfully avoids coverage of high cost people. This helps explain both the relatively low market penetration of HMOs and high administrative overhead costs in traditional small-employer and individual insurance markets. Such risk segmentation also results in relatively lower premiums for groups and individuals that are currently healthy, but it produces higher premiums for other groups and individuals.

As a result of risk segmentation, premiums have varied widely, and many higher-risk small groups and individuals have had to either pay prohibitively high premiums for often less-than-adequate coverage or go without coverage entirely. In either case, access to medical care is compromised, and people suffer substantial financial hardship and inadequate care as a result.

In considering alternative approaches to insurance market reform, it is critical to remember that people's health status can and does vary significantly over time. Employers, employees, and dependent family members who are healthy and generate low costs this year may become severely ill or have a serious accident a year or two later. And people who need expensive medical care in one year may have low costs in subsequent years. Actuaries refer to the tendency for different peoples' medical costs to be more similar over longer periods of time as "regression towards the mean." This phenomenon is documented in data analysis by Medstat Systems, Inc., which found that of a group of individuals who each incurred charges of more than $10,000 in 1987, over half incurred charges of under $500 in 1989.[1]

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[1]See "Tracking the Dollars," Richard E. Curtis, Figure 5, *Health Care Management Quarterly,* Fourth Quarter, 1991.

To minimize their own costs, some employers are likely to look for insurers or other entities that have been successful in employing risk-selection techniques. But the apparent savings to such currently low-risk groups in reality puts them and their employees at risk of either cancellation or unaffordable premium increases when they need coverage most—for example, when they become severely ill, experience a traumatic injury, or are otherwise likely to incur catastrophic costs.

Insurance market reform rules are generally designed to solve such problems by assuring access and continuity of coverage. But they need to create a level playing field for all competing health plans. If market rules require only some kinds of plans to guarantee access to affordable coverage for all small employers or individuals while other plans are allowed to select only lower-cost populations, another problem will result. If employers can belong to such select groups when they are healthy and are then guaranteed access to (or continuity of coverage by) other plans that are required to broadly pool risks when they are sick, they are in effect guaranteed the ability to save money by shifting costs to other employers. When their health care needs are low, they can choose not to pool their costs with a broad community of other employers; but when their health care needs are high, they join the pool and share those costs with that community. In effect, they do not pay their fair share over time.

And the plans available to the broader community that are subject to guaranteed access and rating rules are therefore at risk of experiencing "adverse selection death spiral." As they enroll these cost-shifting populations only when they are sick, their prices will have to reflect their higher cost experience. As a result, more and more of their low-cost enrollees will seek price relief from health plans that selectively enroll similarly lower-cost populations. This domino effect will ultimately drive the regulated plan's costs to untenable levels and force it out of business.

It is for these reasons that many states with guaranteed issue, continuity, and tight rating rules do their best to extend the same rules to all health plans that serve small employers. In general, it would therefore be unwise for federal legislation to preempt these efforts by creating new categories of health plans that can offer lower rates by selecting healthier employer groups. If such categories were created, it would be critically important to at least carefully develop appropriate rules, or allow states to develop such rules. In particular, transition rules need to build walls between insurance pools to protect plans serving the boarder community from such cost-shifting behavior. It is also important to distinguish between proposals to preempt state laws that restrict health care cost management techniques (e.g., state-mandated coverage of provider groups or services or state "anti-managed care" legislation) and proposals to preempt state laws that prevent competition based on risk selection. Some interest groups advocate legislation that would actually do both but provide a rationale only for those elements that would allow them to manage health care costs.

I believe it is desirable to allow small employers to come together to exercise joint purchasing clout and economies of scale, especially when their employees can also benefit from a choice of competing plans. In fact, several states have

enacted legislation which both establishes tight market rules and authorizes or permits health plan purchasing cooperatives to do precisely that. And we work with employer coalitions as well as states to develop such workable approaches. However, if federal legislation were to allow any of a plethora of organizations to offer a health plan at a special price to only those small employers it brings together, it would create huge incentives for them to compete based on risk selection.

We now turn to a discussion of the market practices addressed by state insurance market reforms.

Preexisting Conditions and Continuity of Coverage

Health plans often impose a waiting period before they will cover certain preexisting medical conditions (typically defined as conditions for which a person has sought, or a prudent person would have sought, medical treatment in the last six months or year). In some instances, health plans permanently exclude coverage for specific conditions. Some plans (often HMOs) impose a waiting period for coverage of any services.

Such exclusions for preexisting conditions are justified as a way of preventing people from waiting to purchase coverage until they need medical care, since such behavior would unfairly drive up premiums for everyone. Insurance works as a mechanism for pooling risk and making coverage affordable only so long as people pay premiums when they do not use services as well as when they do.

On the other hand, if health plans impose excessively long limitation periods or exclude certain pre-existing conditions entirely, some people will face high risk of having to make large out-of-pocket payments. Moreover, for people who are already in the insurance system and are simply changing carriers, such limitation periods are disruptive and not necessary to preserve the insurance principle.

States have attempted to respond to these problems by limiting health plans' rights to impose waiting periods before covering preexisting conditions. Reform legislation may limit the period for which coverage can be excluded to a reasonable amount of time, for example, six months or a year (41 states have such a provision that applies in the small-group market[2]). To deal with the problems posed for people who are simply changing health plans (because of a job change, a move to a new area, and so forth) states have stipulated that individuals changing coverage sources should not be required to face new preexisting condition limits or waiting periods. Specifically, states often require that periods of coverage under a previous plan of comparable scope be counted toward meeting waiting periods for succeeding coverage (40 states have such a small-group requirement[3]).

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[2]Gretchen Babcock, Susan S. Laudicina, and Brice C. Oakley, *State Legislative Health Care and Insurance Issues: 1994 Survey of Plans,* State Services Division, BlueCross and BlueShield Association, December 1994.

[3]Babcock *et al.*

Guaranteed Issue and Guaranteed Renewal

As discussed earlier, health plans have strong financial incentives to keep medical claims expenses down by insuring only lower-risk people. As a consequence, health plans have often refused to issue coverage initially to groups that they perceive as being likely to incur substantial medical expenses. Similarly, they may decide to refuse to renew coverage for groups that appear to have become more risky—for example, because someone has become sick and is likely to need further care or because the group composition has changed over time and includes more high-risk people.

It is common for state insurance reform laws to require that insurers in the small-employer (and sometimes individual) market make coverage available on a guaranteed-issue basis by accepting any applicant regardless of risk. Similarly, insurers may be required to renew coverage for any group (except in the case of non-payment of premium or fraud). Some reform legislation requires these guarantees only with respect to one or two specific standard benefit plans (21 states for the small-group market[4]). Insurers are free to sell other plans on a nonguaranteed issue basis. This approach presents an opportunity for carriers to select lower-risk groups for these other products and thus poses the threat that the guaranteed-issue plans will suffer adverse selection as a result of being the only plans open to high-risk groups. Recognizing this problem, a number of states require that *all* of a carrier's small-employer products be sold on a guaranteed-issue basis (13 states for the small-group market[5]).

Full Disclosure of All Products

A requirement that health plans offer coverage on a guaranteed-issue basis may have limited effect if health plans and their distribution agents do not, when selling to a customer, affirmatively disclose all products available. If higher-risk groups do not know that various plans are available to them, they may be persuaded to buy a plan that is less desirable and/or more expensive (which allows the health plans to "reserve" certain plans for low-risk groups). If only lower-risk groups are made aware of certain plans, only they will buy them.

To solve this problem, some states have required that health plans and/or their distribution agents affirmatively disclose all products that are available on a guaranteed-issue basis. In some instances, this may be only one or two standard benefit plans; in others, it may include all plans sold in the small-group market.

Standardized Plans

As we summarize later, a number of states have required that carriers offer one or more standard benefit packages. In part, this has been seen as necessary to insure that other reforms have the desired effect of improving access.

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[4]Babcock *et al.*

[5]Babcock *et al.*

Guaranteed-issue requirements, for example, would not mean much if the only products a carrier makes available on this basis are those that offer inadequate, inappropriate, or excessively expensive coverage or coverage that would appeal only to lower-risk groups (for example, plans with high deductibles). In addition, the administration of state reinsurance pools could be prohibitively complicated if insurers sought fair reinsurance prices for a very great variety of plans.

Standardized benefits have often been supported for a number of other reasons. Many analysts believe that consumers can meaningfully compare plans and make cost-effective choices only if the plans offer essentially the same sets of benefits. Comparing plans that vary not only in characteristics and price but also benefits is viewed as too complicated for people to do well. Moreover, it is argued that if benefits are not standardized, health plans may be able to use benefit differentiation as an indirect way of attracting low-risk enrollees and thereby thwarting the risk-spreading purpose of insurance reform. States that have accepted this view have defined standard sets of benefit plans (often five or six plans) and have required that health plans offer *only* these standard plans (at least four states have adopted this policy).

Specific Rating Factors

Carriers have used a number of factors for differentiating premium rates among small-employer groups. The more common of these factors are defined and explained in the following material. Later we will indicate the extent to which states permit carriers to use these factors.

Health status/claims experience

Health status (or medical claims experience as a proxy) has often been used by health plans to differentiate premiums among small groups. But the use of health status has been heavily criticized because the number of people insured within small groups is generally acknowledged to be too small to allow for adequate spreading of risk, so that rates vary widely from group to group. Thus individuals and groups pay very different amounts for similar coverage, even though the basis for the difference—that is, health status—is largely beyond the control of either the individual or the employer. Furthermore, the use of health status or experience can result in very large rate increases for a group if one or two employees get sick. Both results are often seen as being unfair.

A number of states have concluded that health plans should not be permitted to use claims experience or health status of individuals in small-employer groups to establish premium rates. Duration of the contract with a particular group (which acts as a proxy for claims experience)[6] is also often not permitted as a rating factor.

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[6]As the effects of preexisting condition limits and waiting periods wear off (and medical underwriting wears off, to the extent it is used), claims experience will rise over time. Some companies vary rates based on duration to reflect this claims phenomenon and in doing so offer more attractive rates to new groups and less attractive rates to others.

Gender

The use of gender is commonly used in setting rates in the small-employer and individual markets. Actuarial data indicate that health care costs for young females are substantially higher than costs for young males, principally because of pregnancy-related expenses.[7] Females also tend to use medical services with greater frequency than males through the middle-age years.

A number of states have concluded that the case for retaining gender-based rate variations is weak. Individuals obviously have no control over their gender, and while employers may have control over the gender of those they hire, few would justify job discrimination based on gender as a mechanism for limiting health insurance costs. Further, pregnancy-related costs, a major source of the gender-based costs differences, are obviously derived from the actions of males as well as females.

For these reasons, a number of states have determined that the use of gender as a factor in setting premium rates is inequitable and have restricted or prohibited its use.

Age

Health plans have generally used age as an important determinant of premiums for small employers. Age is strongly correlated with use of medical services. For example, individuals who are 60 years old incur roughly three to four times the medical expenses of 20-year-olds. Not surprisingly, older workers tend to place a higher value on health insurance and are more likely to be insured even through their coverage is more expensive. Young adults, on the other hand, are most likely to be uninsured despite the relatively low premium prices available to them and their employers.

Since people cannot control their age, the use of age might at first seem to be unfair. But younger individuals also tend to earn less. As a result, age rating tends to be "progressive" in nature: lower-income (younger) people pay less than higher-income (older) people. Of course, this is little consolation to those older workers who have low incomes. But eliminating age rating entirely appears to result in reducing insurance coverage among younger, less affluent workers because the premiums for groups employing disproportionate numbers of young workers would rise. (Although the data is not definitive, this appears to be what happened in New York.[8]) To put it another way, the use of age rating appears to result in more people voluntarily purchasing insurance coverage.

All but four states that have passed insurance reform will permit the use of age as a rating factor even when reforms are fully phased in. Only New York has fully implemented flat community rating. But most have limited the extent of

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Among other things, durational rating has been criticized for encouraging groups to move from one carrier to another.

[7]According to one estimate, 20-year-old females are roughly twice as expensive as males of the same age.

[8]Kala E. Ladenheim and Anne R. Markus, *Community Rating: States' Experience,* Intergovernmental Health Policy Project, The "eorge Washngton University, July 1994

premium variation based on age—for example, allowing rates to vary by a ratio no higher than 3 to 1.

Geography

Health costs tend to vary substantially from area to area, even within a single state. Health plans have almost universally used these geographic cost differences in determining premiums for small employers.

To the extent that cost differences reflect differences in the efficiency of the medical systems in different areas, the use of geography as a basis for determining rates could be useful to create incentives for people in high-cost areas to work to make their medical systems more efficient. (Even the term "community rating" with all of its implications of rate spreading suggests that community-to-community costs differences are an appropriate basis for differentiating rates.) Overly broad geographic areas may also create disincentives for health plans to move into new areas.[9] Finally, use of geographic rate variations may be more fair in some states, because areas with lower health care costs (such as rural areas) also tend to be populated by individuals with lower incomes.

On the other hand, geography, like other rating factors, can be used in ways that may be inequitable or have undesirable social consequences. For example, some insurers have used geographic adjustments to redline certain areas, such as those with a high incidence of AIDS.

States that have passed insurance reforms have generally allowed geography to be used as a factor in establishing small-employer rates but have sometimes imposed constraints on how small the rating areas can be. For example, insurers might be required to establish rating areas no more narrowly than at the three-digit zip code level and might not be permitted to subdivide a metropolitan area. A number of states have also established uniform geographic rating areas for use by health plans.

Subscriber family type

Virtually all health plans vary rates according to family size and composition, the justification obviously being that the cost of coverage increases with family size. Health plans have not, however, used uniform methods for distinguishing among families of different size. Some health plans have only a single and a family rate (a common approach for larger employers). Other plans use additional categories—for example, single; single and spouse; single and child[ren]; and single, spouse, and child[ren]. The market trend has been toward the use of more family unit categories. In general, this approach may be financially progressive, since single-parent, lower-income families would tend to

[9]A plan operating in a lower-cost area may be reluctant to move into a higher-cost area, because it would have to increase rates for its existing business to break even in the more costly (but uniformly priced) new area. The opposite case could also be true. Health plans in higher-cost areas may be reluctant to move into lower-cost areas because doing so could require having noncompetitive rates in the lower-cost area (or underpricing the higher-cost area).

pay lower rates (because they would not subsidize two-adult, higher-income families).

The use of family size as a rating factor is largely noncontroversial, and virtually all states have allowed its continued use. Some states have, however, established uniform family categories that all health plans must use. The logic for this policy is that uniformity makes it easier for people to compare plans on the basis of price and value.

Industry and occupation

It is common for health plans to vary rates based on industry or occupation. In some cases these practices are intended to reflect differences in underlying health care costs; in others they are intended to reflect differences in administrative or credit risk.

Although there are clearly real cost differences by industry and occupation, the question is whether there is a justification for using such differences in setting premiums. Should firms and workers in certain industries and types of employment be penalized because of the nature of their employment? At first glance it might seem that rate variation by industry and occupation would encourage small employers to maintain safer work environments. But work-related injuries and illnesses are generally covered by the workers' compensation system. Moreover, industry or occupation adjustments do not provide strong incentives for individual employers to improve worker safety because individual employer behavior does not appreciably change the industry or occupation premium. A disadvantage of industry- and occupation-based rating is that it creates opportunities for insurers and health plans to select low-risk groups and avoid high-risk groups. In the extreme case, this practice can be used to redline higher-risk industries. As with other risk segmenting practices, efforts are spent on identifying low-risk groups rather than improving efficiency as a way of keeping premiums down and making the health plan competitive.

State reforms have generally curtailed and occasionally eliminated use of industry and occupation as a factor in setting rates.

Association plans

On a related issue, many associations of employers in particular industries, trades, and professions currently offer health coverage to their members and not to others. Because of associations' membership limitations, they tend to compromise the risk-spreading objectives of insurance reform. The intent of guaranteed-issue requirements is to ensure that health plans accept all applicants regardless of risk. Failing to apply this rule can give association plans an unfair competitive advantage if the association can be defined to exclude higher-risk employers.

A few states require association plans to conform to the same reform rules as other insurers, essentially making them like other insurers in the market. That is, carriers servicing the association business are required to make the same products available on a guaranteed-issue basis to any small employer in the

community at the same rate. States passing insurance reform have generally not required association plans to open their doors to all applicants, though they have sometimes applied other reform rules to the association plans. But where association groups can be selective in their membership, insurers understandably argue that to maintain a level playing field, rating rules should allow them to compete by adjusting rates to reflect the relative risk of a given occupation or industry.

Summary of State Insurance Reform Provisions

During the past five years 45 states have passed insurance reform laws designed to make insurance for small businesses more accessible, more reliably available, and in some cases more affordable when needed most. In most cases insurance reform laws contain a number of provisions that work together; and thus, it is crucial to recognize the importance of the interrelationships of different reform provisions. The following table indicates state insurance reform provisions and distinguishes among states that have passed a combination of provisions resulting in loose restrictions, moderate restrictions, or tight restrictions.

The size of groups covered by small-group reforms differ from state to state, as summarized in the table. The table also indicates which states have passed individual market reforms. Fewer states (8) have passed individual market reform than group reform. This is in part due to apprehension that the individual market might be overwhelmed with high-risk individuals not now covered, thereby driving up the premium rates to unaffordable levels. However, most states that have passed individual market reforms tend to be the same states that passed the tightest small-group market reforms (Kentucky, Maine, New Hampshire, New Jersey, New York, Vermont, and Washington.)

Continuity, rating restrictions, and guaranteed-issue requirements exemplify the way a combination of provisions can significantly impact the small-group market. In this case, the reform objective of providing better access and affordability may be compromised if certain reform elements are not included. For example, rating requirements may make rates more affordable for some, but if carriers are allowed to deny coverage to small businesses perceived as high risk, the rating laws will not ensure access to health insurance for those small businesses that need it most.

It is for this reason that the second row of the table indicates states that have the combined reform provisions of continuity, rate bands restricting the use of certain rating factors, and guaranteed issue for at least some plans. (The sixth row of the chart indicates which states have this same combination of provisions in the individual market.) For the small-group market the second row also distinguished states with tight bands ($\pm$ 20 percent, that is, a band which allows rates to vary only from 80 percent to 120 percent of the midpoint rate or a 1:1.5 ratio from the lowest to the highest rate).

Currently, 34 states require carriers to guarantee at least basic or standard-plan coverage to small businesses in addition to requiring continuity of coverage and at least some rating restrictions. Seventeen of these states have also passed rate

bands that limit variation to at most ± 20 percent of the average pooled rate. In the individual market, eight states have passed laws requiring carriers to guarantee issue at least a basic or a standard plan in addition to passing continuity requirements and at least some rating restrictions.

However, requiring guaranteed-issue of only some products may result in a disproportionate number of higher-risk groups or individuals enrolling in the guaranteed-issue plans. And if this does occur, the costs for the guaranteed-issue plans would rise, and the goal of affordable accessible health insurance may be lost. To prevent this type of segmentation of the market, 13 states have required guaranteed issue of all benefit plans offered in addition to continuity requirements and tight rating bands.[10] In the individual market, seven states have passed continuity requirements, rating restrictions, and a guaranteed issue requirement of all products. The third and seventh rows indicate the states that have guaranteed-issue requirements for all products.

It is also important to recognize that even with guaranteed-issue requirements, carriers may not be required to disclose all of their products and may subtly attempt to steer higher- or lower-risk groups into certain plans. Recognizing this, California, New Jersey, and Vermont not only require carriers to guarantee issue all plans but also require carriers to disclose all of the products they offer in the small-group market. Vermont and New Jersey also mandate disclosure of all products in the individual market.

In addition to passing continuity and guaranteed issue requirements, some states have passed rate restrictions prohibiting the use of certain rating factors. This is shown in the fourth and last rows of the table. Currently, five states (Colorado, Kentucky, Maryland, and New Hampshire) limit rating factors to age, family composition, and geography, while the other three (New Jersey, New York, and Washington) do not allow variations based upon age.[11] In the individual market, seven states have passed rating restrictions in addition to continuity and guaranteed-issue requirements.

Most states phased-in (or are in the process of phasing-in) the prohibition of the use of specified rating factors, with the exception of New York. When age is allowed as a rating factor, most states specify age bands and limit the variation from one age band to another. For example, New Hampshire and Kentucky limit the premium for the oldest age bracket to three times the premium for the youngest age bracket.

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[10]Texas also recently passed legislation containing guarantee issue for all products, but allows rates to vary 2:1 based upon experience, health status, and the amount of time the policy has been held.

[11]While Vermont is considered to have community rating, the rating factors age, gender, geography, industry, experience, duration of coverage can deviate from the community rate by + 20 percent. Maine and Massachusetts are also considered to have community rating and variations may vary based upon gender and industry. Oregon does allows the use of health status.

State Small-Group and Individual Insurance Reform Provisions

	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA[1]	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT
Small Group Market size		2-25	3-40	1-25	3-50	1-50	1-50	1-50	1-50			2-49	3-25	3-25	2-50	3-50	All groups	3-35	1-24	2-50	1-25		2-49	2-35	3-25	3-25
Continuity, rate bands, and guaranteed issue for all or some products (XX indicates rate bands of ±20% or tighter).		X	X	a	XX	XX	XX	X	XX			X	X	X	XX	X	XX [2]	X	XX	XX	XX		XX	X	X	X
Guaranteed issue of all products					X[c]				X[3]								X	X	X	X	X[c]		X			
Rate adjustments at most for age, family composition, geography.						X											X			X						
Individual Market																										
Continuity, rate bands, and guaranteed issue for all or some products												X			b		X		X				b			
Guaranteed issue of all products																	X		X							
Rate adjustments at most for age, family composition, geography.																	X		X							

The provisions in this chart reflect the law once fully implemented.

[a]Has rating bands, but does not have continuity or guaranteed issue requirements.
[b]Has rating bands and continuity, but does not have guaranteed issue of any product.
[c]*Carriers are required to fully disclose all products offered.*
[d]Age adjustments not allowed.

[1]Georgia does not have portability or guarantee issue requirements, but rates can not vary from pool rate by +25% if based upon experience.
2 *Rating requirements apply only to groups with 100 or fewer employees, individuals, and coverage purchased through the alliance.*
3 Fo groups of 1 or 2 , the guarantee issue requirement only applies to certain products.

Source: This chart uses information from the following reports: "State Legislative Health Care and Insurance Issues," BlueCross BlueShield Association, 1994; "Small Group Enactments," The Health Insurance Association of America, November 1994; and "Small Group Market Reforms: A Snapshot of States' Experience," The Intergovernmental Health Policy Project at the George Washington University; as well as phone conversations with several state insurance department officials and the National Association of Insurance Commissioners.

	NE	NV	NH	NJ	NM [4]	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
Si group et size	3-25		1-100	2-49	2-50	1-50	2-49	1-25	2-50	2-50	3-25		1-50	2-50	1-25	3-25	3-50	1-50	1-49	2-49	All groups	2-49	2-25	2-25
Continuity, rate bands, and guaranteed issue for all or some products (XX indicates rate bands of ±20% or tighter).	X		XX	XX	b	XX	XX	X[2]	b	X	XX		X[3]	X	b	X	X	b	XX	X	XX	a	X	X
Guaranteed issue of all products			X	X[c]		X											X		X[c]		X			
Rate adjustments at most for age, family composition, geography.			X	X[d]		X[d]															X[d]			
Individual Market																								
Continuity, rate bands, and guaranteed issue for all or some products			X	X		X								b					X		X			
Guaranteee issue of all products			X	X[c]		X													X[c]		X			
Rate adjustments at most for age, family composition, geography			X	X		X													X		X			

[a]Has rating bands, but does not have continuity or guaranteed issued requirements.

[b]H rating bands and continuity, but does not have guaranteed issue of any product.

[c]Carriers are required to fully disclose all products offered.

[d]Age adjustments not allowed.

[4] New Mexico has continuity requirements, tight rate bands and limited rating factors to age after 1998, but does not have a guarantee issue requirement for any products.

[2]The guaranteed issue requirement applies to groups of 3-15.

[3]The guaranteed issue requirement only applies to groups of 3-50.

It is true that insurance market reforms alone will not cover the uninsured population. But the experience at the state level indicates that signficant health insurance market reforms can be enacted that extend meaningful protections without driving younger and healthier groups out of the insured population. While definitive data is lacking, the experience in New York seems to indicate that eliminating premium adjustments for age will ultimately reduce the insured population by causing price increases for younger groups, which will cause them to drop insurance coverage.

On the other hand, the experience in some states such as California suggests that adequately tight market rules, together with other measures, can make lower health plan prices available for small employers. And of the 24 states that enacted the original (1991) NAIC model health insurance market reform bill, one-third have been so satisfied that meaningful reforms are workable that they have gone back and tightened their rating rules. [12]

Although many states have made great progress in implementing insurance market reforms, there are compelling reasons why Congress should consider federal health insurance reforms. Most obviously, only the federal government can establish rules to assure that people moving from one state to another can continue to be insured. In 1993 alone, 4 million workers moved from 1 state to another and 1.5 million of them also changed employers.[13] In addition, states cannot assure continuity of coverage for workers who move from a small-firm job to a position with a large, self-insured employer. Further, federal policymakers may want to establish baseline protections for residents of all states. For example, the Congress may wish to ensure that a small-firm employee[14] can continue to get affordable coverage even if she is laid off and has to seek coverage as a non-working individual. And only federal legislation could extend health insurance access or continuity assurances to all Americans.

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[12] Ladenheim.

[13] Based on tabulations of the March 1994 current population survey by Mathematica Policy Research, Inc. for this testimony.

[14] Federal COBRA continuation protections pertain only to firms with over 20 employees