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EFFECT OF NEW FEDERAL POLICIES ON MEDICAL INSURANCE

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1. The federal cost shift. How will budgeting limitations on federal financing of Medicare and Medicaid, plus other restrictions, affect health care cost inflation for employers and insurers?

2. The pro-competition, consumer choice bills. What are their likely effects?

MR. WILLIS W. BURGESS: During the past few years, a relatively new concept for containing health care costs has emerged. This concept was based on the premise that efforts to contain costs have failed because the health care system is not competitive.

The economists who articulated the marketplace principles underlying this concept feel that what is needed is to make health care providers more competitive. They advocate the creation of a nationwide network of Health Maintenance Organizations, Individual Practice Associations and other forms of limited providers to compete with the fee-for-service system.

The consumer choice bills introduced to date seek to further increase competition among insurers and insurance plans rather than directly among providers. Regarding the insurance industry, the bills would result in greater regulation. They could not be implemented without the creation of a massive new federal bureaucracy.

In order to achieve a truly competitive environment, any consumer choice bill should correct the major inequities and obstacles to competition resulting from cost shifting.

What is cost shifting? The federal and state governments do not provide full reimbursement to the hospitals for the expenses of Medicare and Medicaid patients. Many Blue Cross plans have similar arrangements with hospitals. Hospitals, therefore, shift these unreimbursed expenses to their remaining patients.

To discuss the nature, effect, and future of cost shifting, we will now turn to Bill Keffer and Dick Sieben.

MR. WILLIAM W. KEFFER: My own definition of "Cost Shifting" is the result of underpayment by the government of its fair share of expenses incurred by hospitals and physicians in the treatment of patients covered by Medicare and Medicaid; and the subsequent increases in charges which providers must make to private sector patients to compensate for this underpayment.

The Medicare legislation has given rise to a substantial degree of underpayment compared to true cost allocations for a number of years. Recently, however, pressures for cost containment in the health care field and reduction in the Federal budget generally have caused accelerating increases in the levels of these underpayments.

For example, the Health Insurance Association of America (HIAA) calculated the total government payment shortfall in 1975 for short term hospital costs at $1.1 billion; by 1979 this had increased to $3.0 billion. The shortfall total is estimated at $4.8 billion for 1981, increasing to $5.8 billion in 1982. Taken in the context of projected Medicare hospital in-patient expenditures of $33 billion over the next year as estimated by the American Hospital Association (AHA), and total hospital care personal health expenditures now above the 1979 level of $85 billion, the magnitude of these underpayments and the significant effect on costs under private insured health plans can be appreciated.

The character and reasons for this cost-shifting, and the appropriate dollar values, have been highly publicized over the past few months, and are probably familiar to most of you. I would like to consider the implications of this cost-shifting from the perspective of a group insurance actuary for a private health insurance company, with some efforts at quantifying the impact and translating it to the cost measurement process under such plans; and to discuss some of the remedies for this problem and the means of controlling it, and the serious ramifications for us if we are not successful.

ESTIMATING THE MAGNITUDE OF GOVERNMENT UNDERPAYMENTS

First, it might be useful to review the process by which a joint study group of the HIAA determined the magnitude of government underpayments and the resulting cost-shift.

I am referring here to a report of this Study Group, published last fall. The Group was chaired by Allen Maltz of the Travelers. I was not a member of this Study Group and obviously cannot speak authoritatively about their work. However, it is evident that a very careful and thorough review of available data was made.

The Study Group's work involved substantial review with government agencies, including the Health Care Financing Administration (HCFA), and testing of various methodologies for deriving the cost-shift results. Computations used both utilization and fiscal data to apportion aggregate dollars into payor categories. Two approaches, which yielded similar results, were finally endorsed by the Study Group. The final published figures were derived from Mr. Maltz's process using a combination of HCFA charge data and adjusted patient days by payor category as weights to arrive at a calculation of the Medicare/Medicaid differential. The differential is used to calculate the total Medicare/Medicaid cost shift. There is a one to two year lag in the availability of the aggregate data used. Calculations for 1979 and earlier were prepared and then projected on a conservative basis to develop 1980 and 1981 estimates. It is my understanding that this work has now been updated for 1982.

The principal sources of information used were AHA data on gross and net patient revenue and utilization figures (patient days), and HCFA information on Medicare and Medicaid hospital days, charges and reimbursements. For the private sector, the separation of national totals between Blue Cross covered patients and commercially insured patients was not available directly and was estimated from the proportions of persons under 65 covered for hospital and surgical expense in the various payor categories, as developed by the HIAA.

A further review of an AHA survey in 1979 produced an overall estimate of the average national Blue Cross discount against full charge levels of 10.38%.

With this data base, the process for determining the government shortfall and cost-shift can be summarized conceptually as follows:

-Gross patient revenue for all short stay hospitals is defined and determined as the total charges hospitals would have made on a full billed basis for all categories of payors.

-Net patient revenue is these total charges less the charges not recognized by various categories of payors, such as Medicare, Medicaid and Blue Cross, and less bad debts and charity care.

-It was assumed that this net patient revenue in the aggregate would provide hospitals with sufficient income for their financial needs. We are working towards a total of the actual net patient revenue available to the hospital.

-The percentage distribution of the gross patient revenues, or hospital charge levels, is determined for each payor category: Medicare, Medicaid, Blue Cross, private insurers and bad debts.

-We can then establish the equation that the aggregate net patient revenue accepted by the hospitals is equal to the aggregate gross patient revenue multiplied by the weighted percentage of this gross revenue paid by each payor category. The weights for the private sector would be 100% and for the bad debt category would be 0. For the Blues the weight is determined at 100 minus the 10.38% average discount.

-The aggregate differential for Medicare and Medicaid can then be derived from this formula as a balancing item.

For 1979, this differential was determined to be 21.1% from the billed level of charges.

From the AHA data, an estimate of bad debts and similar allowances of 4.5% of the aggregate gross patient revenues was derived.

The Medicare and Medicaid savings, or the "cost-shift", is the difference between the appropriate fair share of net revenues, less the actual share of the gross revenues paid, after the differential or discount.

For the 1979 data, Medicare and Medicaid were calculated as 48.5% of the gross revenue, or theoretical full billed charges. Spreading the 4.5% in bad debts and charity care over all the payors, Medicare and Medicaid should have paid a fair share of 50.8% of the aggregate net revenues. In fact, they paid at a 21.1% discount from the gross, which is actually 46.1% of the aggregate net revenues.

Stated more simply, Medicare and Medicaid can be said to have paid, in 1979, 4.7% less of the country's total short term hospital "costs", or net revenue, than they should have. On a total of $63.4 billion, this is the $2.99 billion reported by the HIAA.

This shortfall of $2.99 billion is about 10% of the actual Medicare and Medicaid net payments of $29.2 billion.

That is the process for developing the overall dollar shortfall.

QUANTIFYING THE IMPACT OF HOSPITAL COST-SHIFTING

As I see it, one problem we have as actuaries is making appropriate allowance for the effects of this hospital cost shifting in our projections of changes in hospital cost levels from inflation and other factors.

The aggregate figures on national Medicare and Medicaid underpayments are not in a form permitting direct translation to cost inflation factors for private sector insurance plans because:

(1) we are dealing with the effects of independent judgements and decisions made by six to seven thousand separate hospitals;
(2) these hospitals have wide differences in the proportions of Medicare patients and in operating costs;
(3) there are differences in the financial ability and willingness of hospitals to tolerate shortfalls in government payment and hence in the actions they can be expected to take in response to these shortfalls;
(4) there are differences in the reimbursement basis for non-government patients, such as the cost reimbursement contracts negotiated by some Blue Cross plans and the effects of state regulation (i.e.: Maryland and New Jersey).

I mentioned the calculation of average national Blue Cross discounts at 10.38% in 1979. A current AHA summary shows for 1981 that over 60% of Blue Cross plan enrollments (based on the number of people covered) were paying on a cost reimbursement basis, and presumably were shielded from the cost shifting of underpayments by Medicare and Medicaid. These contracts exist in 18 states and for 27 Blue Cross plans.

The historical data we have on private sector plan costs already includes the effects of past cost-shifting by hospitals, responsive to earlier restrictions on government reimbursement. In projecting from any such data, we would be concerned with the changes in levels of government underpayment, rather that the aggregate of such underpayments.

The best we may be able to do with this somewhat inadequate information base is to determine a rough indication of the possible range of cost-shifting impact, using the national statistics, and modify for the particular situation, using whatever additional specific information is available.

Even without the introduction of this additional margin of error, our abilities in projecting inflationary costs in the health care field have been severely tested in recent years. Being asked to deal with further imprecise data in this environment is not a pleasant assignment. But it is really one of our primary functions as actuaries.

A simple approach to this problem is as follows:

(1) Take a rough estimate of the current shortfall in government payments as a proportion of total hospital costs for government sector patients (about 10% based on 1979 data).

(2) We can then consider the overall increase in hospital cost levels from 1979 to 1980, on the order of 15%, and relate that to the HIAA's projection of the dollar shortfall for 1980 of $3.9 billion, or a 30% increase over the 1979 value. There is also a 2% increase in the total volume of hospital services, which we could recognize as contributing to the dollar aggregates.

(3) Then, we might conclude that the 1980 shortfall in government reimbursement of costs would relate to an actual cost increase for government sector patients of something in excess of 17% over the 1979 dollar level.

(4) Our shortfall dollars for 1980 then relate to the actual government sector 1980 cost dollars by the ratio of 130% over 117% times our original 1979 estimate of 10%.

(5) This yields an estimate of an 11.1% shortfall for 1980 in the government sector payments. Without consideration of this increase, our normal cost projections would presumably cover the continuing of hospital charges aimed at recovering the 1979 10% shortfall level. We therefore need to take into account the possibility of further action by hospitals to make up the additional 1.1%.

(6) If this 1.1% relates to 40% of the total hospital cost base and it is to be recovered from the other 60%, we would project an additional 0.7% to 0.8% cost increase on private sector patients, over and above any other increases.

(7) Further, if 50% of the private sector patient cost is being recovered under a Blue Cross plan where the negotiated reimbursement contract shields Blue Cross from this cost impact, the hospital might conclude an increase of 1.5% was required from the other private paying patients, including private insurance company health plans. We could incorporate this as an addition to trend factor projections otherwise determined.

I think the above analysis is a good illustration of the level of actuarial work which may be found when an actuary has been recycled into marketing responsibilities. A more refined approach, including the construction of a model hospital financial pattern and a more careful look at historical trends, might yield more valid and reliable results.

The HIAA study group did feel that there were serious data base difficulties with any breakdown of the national data into state by state calculations.

In any event, it is important that these continuing and substantial increases in government payment shortfalls be recognized and quantified in our work to the degree possible. This year, the objective in Washington is to achieve additional savings on the order of $1 billion. We are also looking at the problems created for some hospitals by severe tightening of qualifications for Medicaid eligibility, which add to revenue needs from other sources.

RESPONSES TO THE COST-SHIFT PROBLEM

My comments on quantifying this cost shift impact are directed at just one area of the actions we should be considering with regard to cost-shifting. These should not be limited to steps which are merely defensive, directed at properly reflecting the results in our analyses. We should be doing something about the underlying problem itself. We should consider what

can be done to eliminate or control the cost-shifting process, or at least assure a broad based sharing of the burden.

Actions in this area can be classified as those available to individual companies, and those which can be pursued on an industry basis, or in collaboration with the business coalitions now developing an increasing concern about rising health care costs.

SEPARATE ACTION

Consider separate action at the company level. Some of the Blues' arrangements appear to shield them from cross allocation of costs of the nature involved in the cost-shift problem. This naturally suggests the possibility of similar arrangements being negotiated by private insurance companies. Some efforts have been made in the area of discounts for prompt payment and perhaps these could be extended by separate negotiation with hospitals. There are some difficulties with this concept.

In the first place, such arrangements are ultimately contrary to the interests and objectives of the hospitals. If successful, and carried to the extreme, there would be no place for hospitals to recover costs not reimbursed by the government. Already, some inner-city hospitals with Medicare and Medicaid government patient loads are struggling with this problem.

Additionally, this process would be contrary to the fundamental principle of equity in billing among all classes of patients. This is a principle that I regard as ultimately essential to the survival of private insurers in the health care protection field, because no one of us, acting independently as we must, can exercise the "clout" necessary to protect our customers, if discriminatory pricing not based on actual value differences to the hospitals is freely occurring among them.

A further area for possible relief is Health Maintenance Organization (HMO) involvement. If the HMO includes hospital services, those services could theoretically be negotiated on a basis exclusive of cost-shift charges, particularly if the insurer is involved as a sponsor, financing source or marketer for the HMO. Questions of equity are involved here, as they appear to be arising in places such as the Twin Cities.

More generally, a company can consider what services it could provide to hospitals with sufficient value to justify offsets to the cost-shift increases. Efficient claim handling, statistical services and prompt and reliable payment schedules could be among these.

Plan design is certainly an area for our attention. We should probably focus on changes that reduce total health care costs rather than changes benefiting only ourselves as insurers, resulting in a cost shift to the patient. Pre-admission authorization requirements are an example of a useful area to explore.

JOINT INDUSTRY EFFORTS

At the industry level, industry associations have recognized the importance of the cost-shift problem. A full scale program to attract public attention and understanding and to develop remedies is now underway. Just this month a new national advertising program has been initiated with these objectives.

The primary focus of our current industry efforts is on obtaining Federal "waivers" in additional states with respect to the Medicare reimbursement process. This is possible under present law in cases where the state establishes a budget and rate review process with a reasonable prospect of delivering the same or lower costs to Medicare as does its normal reimbursement structure. Our interest as private insurers is that such rate setting mechanisms apply equitably to all patients. Such systems are operative in New Jersey and Maryland, where there is evidence of significant savings to the government, as well as other payors. The extension of these waivers has priority because it can theoretically be accomplished without new federal legislation.

It would also be helpful for federal legislation to be modified so that the inequities inherent in the present process would no longer occur. The American Hospital Association has prepared a prospective rate program which it hopes to have enacted, but initially, the program would apply only to Medicare in-hospital patients. Our problems could possibly continue. The HIAA is developing some ideas on transforming this process to apply to all patients. I have a comment here from a recent internal report of the Health Association that brings out the significance of this:

> "Prospective payment of hospitals for Medicare patients as opposed to the current restrospective cost payment makes much sense, but does not necessarily answer the cost shifting problem. HCFA has a task force at work now evaluating eight different options for a prospective payment system for hospitals under Medicare. Every one of these options would apply to Medicare only and would allow hospitals to shift cost to their private patients if the government's payments under the new system were insufficient."

Accomplishing change on the federal level is difficult. One of the requirements is good data concerning the results of cost-shifting and, more broadly, data showing accomplishment by the private health insurers in cost-containment, quality of coverage, and fairness and promptness in settlement. We are engaged here in an undertaking at the public and political level and must establish our credibility and the value of our services to the public. Clearly, actuaries can play an important part in this process, both in plan design and administration at the individual company level and in the assembly of convincing statistics to show what we are accomplishing and what is happening to us.

Actuaries can also play a key part in improving the ways our benefits and services interface with hospitals, thus lowering the cost incurred by hospitals under insured plans. This is action in a direction that benefits all parties; hospitals, insured patients, employers, and the insurers themselves.

OTHER PROBLEMS

I have not dealt with cost-shift problems other than hospital expenses and charges. Similar effects can occur with other health care providers, of course. We have not progressed as well in identifying these impacts and constructing remedies for them, but they should be recognized. Medicare's reimbursement of physicians follows specific formulas that measure and recognize the cost components of delivering the physician's service; support personnel costs, office operation, equipment and services,

as well as his own compensation. Unfortunately, these formulae have restricted his net compensation below the general patterns of inflation in the economy. Presumably physicians look elsewhere for making up the differences, just as hospitals must.

They do have the option, however, of declining assignment of benefits and attempting collection directly from the patient, which is not possible for the hospitals. This can reduce the pressure to shift costs relative to the hospitals.

Perhaps our most constructive effort in this area can be working in conjunction with other interested parties on development of monitoring systems and health delivery processes that do not interfere with the physician's delivery of quality medical care, but do provide measurement and independent assessment of performance and of the reasonableness of charges.

COMPETITION VERSUS REGULATION

Probably all of us here are strong supporters of competition and freedom in the marketplace as more desirable than close government regulation, whether for our business or anyone else's. Until more workable methods for assuring true competition in the health care field can be provided, I would urge support for carefully structured requirements in the areas of disclosure, quality and necessity assurance, and equity in cost reimbursement methods.

MR. RICHARD B. SIEBEN: My purpose today is to alert you to the possibility that the cost shifting and pro-competition topics we are discussing are only the tip of an iceberg. Bill Keffer has accurately and reasonably assessed the unfairness and arbitrariness of the cost shifting situation. I don't believe reason is likely to prevail, and the current initiatives are merely the first salvoes in an attack on total and federal health care costs that will continue for several years. The financing and delivery of health care will undergo broad restructuring, and our tasks as health care actuaries will require far deeper attention to the economics of that system than has been necessary in the past.

Several years ago a Canadian Finance Minister addressed the Society on the impact of certain U.S. economic policy shifts on Canada. He quoted Prime Minister Troudeau as saying that when a mouse gets into bed with an elephant, he will have no rest; for, should the elephant roll over in his sleep, it could well be fatal.

Ladies and gentlemen, we are the mouse; and a very consciously awake federal elephant is thrashing about in the financing of health care bed as part of a very serious weight reduction effort.

All sectors of the federal government are absolutely committed to reducing the "business as usual " fiscal year 1983 momentum costs of federal outlays for health care. There is no question as to whether there will be cutbacks, merely where they will fall and how much they will total. The long-term policy objective is clearly to reduce or eliminate the excess rate of growth in the cost of the health care sector as compared to all other competing sectors. The more specific federal objective is to stabilize or reduce the federal share of total health care expenditures. If these

objectives can be met through true cost reductions in the system, through elimination of waste and inefficiency, fine. To the extent that programs securing such outcomes don't clearly evolve, the federal initiatives will be crude, clumsy, arbitrary, and inequitable, shifting the burden to the private sector in order to stimulate resolution by whatever the free market works out. The tools are structural change and cost shifting; terribly blunt hammers to catch a mouse's attention.

Let's look at some numbers to put the problem in perspective from the elephant's point of view. Total health care expenditures increased from $41.7 billion in 1965 to $247.2 billion in 1980. HCFA projects 1990 expenditures as $821 billion. The total government (federal, state and local) share of the personal health dollar in 1965 was 22%. The 1981 share is estimated at 41%. The private insurance share has grown from 25% to 27% in 16 years. The primary beneficiary of increased government participation has been direct consumer payments, reduced from 52% in 1965 to 31% in 1981. Lest you think the consumer has had a totally free ride, total consumer expenditures increased 9.1% per year over those 16 years. The 1981 government share was $100.8 billion. 1982 fiscal year costs include a federal Medicare cost of $49.6 billion and a combined federal and state cost of $17.8 billion for Medicaid.

The 1983 fiscal year Medicare costs are projected at $57.9 billion, before taking account of the $2.5 billion cuts in the administration's original proposal. Were that proposal adopted, the 1983 fiscal year costs would still be 11.7% over fiscal year 1982 Medicare expenditures. This has not escaped congressional notice, and the recent pronouncements of Senators Dole and Domenici indicate that a $2.5 billion rollback is insufficient in their belief.

The administration's Medicaid proposal is to reduce total Medicaid costs from $17.8 billion in fiscal 1982 to $17.0 billion in fiscal 1983, with the federal government absorbing the cost of the total program from the states in exchange for transferring the responsibility for certain social welfare programs to the states.

Although the changes in Medicaid are extreme, the largest visible impact will be in Medicare, and particularly in the reimbursement of hospitals.

Medicare can be characterized as being a victim of its own success. Constituting over 50% of federal expenditures for health care, it is an obvious and visible target for budget attack. The focus of Medicare on hospital care makes hospital reimbursement the most promising area for attack. Hospital care consumed 33% of national health expenditures in 1965, compared to 31% in 1950. That share in 1980 was 40% and is projected at 43% in 1990 by HCFA.

Medicare is the fastest growing part of the nation's Social Security system and is the biggest of the entitlement programs. Since President Reagan has apparently decided that Social Security cash benefits are politically untouchable, Medicare becomes a prime target. The long-range concern about the rate of growth of Medicare was expressed in Secretary Schweiker's Ways and Means Committee testimony in support of the Administration's budget proposals. Fuel has been added to the fire by the April 1 report of the Social Security Trustees, who noted that hospital payments are already outstripping hospital insurance trust fund revenue, and the worst case forecast shows the hospital trust fund going broke as early as 1986.

These statistics and projections obviously set the stage for rollback attacks on Medicare, but why is the response in Washington so enthusiastic?

Bill Keffer outlined the history of cost shifting, describing the HIAA's research quantifying the hidden tax that has been assessed over the years. Despite all the eloquence we can muster about the unfairness of the practice and our efforts to disclose the hidden costs passed to the private sector, those are the exact features that appeal to the elephant.

Until a year ago, cost shifting was a bureaucratic administrative phenomenon. The sovereign has always exhibited skill at developing two sets of rules, and the section 223 administrative interpretations are typical: use averages if your costs are higher; and demand a lower charge if they are not.

Legislative attack on Medicare was unheard of until last year when Medicare lost its untouchable status with the 1981 Budget Reconciliation Act. The initiative came from Congress, and the Administration eagerly endorsed the $1.2 billion cut for fiscal 1982. Increased cost sharing by beneficiaries, with a $56 increase in the basic Part A deductible, provided much of the savings.

The Administration climbed on the cut Medicare bandwagon with a passion in February, and the principal tool in its $2.5 billion cut proposal was to pay 98% of hospital costs, as defined under Medicare. The approach was crude, widely attacked, and is probably dead.

In the collapse of negotiations between the White House and Congress, Senator Dole has proposed a program of $3.3 billion in Medicare cuts. Quoting from the May 3rd edition of "Washington Report on Medicine and Health", the Dole package is summarized as follows:

> "The current limits on reimbursement for routine costs would remain at 108 percent. On top of that, Dole would limit the per patient payments for ancillary costs to 115 to 120 percent of median costs. He would also place an overall 110 percent cap on all Medicare reimbursement. The amount of the Part B premium would be increased annually to keep it a constant percentage of the total costs of the Medicare Part B program. It currently nets about 22 percent of that total. Private employers would be required to keep elderly workers on private insurance and Medicare would become a secondary payor. Reimbursement for radiologists and pathologists would be reduced from 100 percent of cost to 80 percent. Dole also plans to count administrative savings achieved through regulations as part of his Medicare package. Revenue would be increased by placing federal employees under the 1.3 percent Medicare portion of the Social Security tax."

The Budget Committee raised the targets substantially, and President Reagan has endorsed a Republican budget plan authored by Senate Budget Committee Chairman Pete Domenici that would reduce Medicare by $5.1 billion in fiscal 1983, $8.1 billion in 1984 and $10.3 billion in 1985. Again, quoting from the May 10th edition of "Washington Report on Medicine and Health":

> "The plan....goes far beyond President Reagan's budget cut requests for Medicare...through a combination of tight controls over reim-

> bursements to hospitals and higher out-of-pocket expenses for beneficiaries. The plan takes as its base Senate Finance Committee Chairman Robert Dole's package of $3.3 billion in Medicare spending reductions. Another $1.8 billion in savings would be made through a new coinsurance for beneficiaries for the second through sixtieth days in the hospital. Currently these days are covered entirely by Medicare."

In addition to direct attack on hospital reimbursement, there is increasing fervor for direct cost shifting to Medicare beneficiaries. Part of this cost shifting fervor, I believe, is based on real belief that there will be disincentive to use, in the case of beneficiaries, and an incentive to cut waste and inefficiency by providers.

A second source of the fervor is a recognition that it will be hard to find the victims in the very short run.

Consider the impact on beneficiaries. Medicare, as we know, principally benefits the very sick. In 1980, 72% of Medicare payments went for hospital care. Many of the elderly are either quite healthy, or do not require the acute care with which Medicare is so involved. HCFA estimates that 77% of the elderly use Medicare services at a rate that required program payments of less than $500 per year. 8.8% of the elderly consume 70% of the expenditures, with average payments of over $3,000 per year.

Quoting from "The National Journal" of May 1, 1982:

> "An internal working paper circulating within HCFA....shows that Medicare pays the medical bills of many persons who die. Medicare cost $509 in 1976 for every person who received benefits and survived, but it cost $3,351 during the last 12 months of life for every recipient who died that year. Those were only 6.4 percent of the Medicare population in 1976, but they accounted for 31 percent of the program's benefit payments."

In plain terms, from a politician's perspective, the dying don't vote. Medicare cuts don't impact as clearly as a hand in the pocketbook to the powerful constituency of the elderly.

Second, there is real conviction that retrospective reimbursement has insured survival of the fattest -- that Medicare's concentration on acute care has led to the overbuilding of a bloated plant for acute care. If HCFA had the technically skilled staff to support the public commitments of Carolyne Davis and could deliver an admnistration bill on prospective reimbursement, this would be the primary policy thrust. They don't, and it is unlikely that such a system will be in place for fiscal 1983. However, the fear of the meat ax approach has prompted the American Hospital Association to publicly endorse a prospective payment system for Medicare. With that kind of stalking horse, it is close to certain that such a system will be put in place after the 1982 elections.

The AHA stance is highly controversial within the industry. One of the fears is that the shakiest institutions can't survive under it. Indeed, two different experts in hospital finances have predicted that as many as 1,000 hospitals will go bankrupt by 1990.

However, if you believe that there has been excess, that there are too many beds, that there are inefficiencies and waste, and that the solution is to have the market deal with these excesses and determine the survivors, then you believe that cost shifting is merely a removal of the props that have caused and prolonged the problem. The bankruptcies won't happen until after the election, and it will be difficult to pin the blame for the less efficient local hospitals' failure to survive on the U.S. government.

The tax is hidden, and its assessment is postponed. That's exactly what makes it so attractive. The elephant was well trained by the old elephant prodder, Everett Dirksen. As he said: "a billion here, a billion there -- sooner or later it adds up to real money."

So that's what the elephant is all about.

Back to the mice. We might consider the advice of another politician, Harry Truman, who said that if you can't stand the heat, you'd better get out of the kitchen.

The words by Stockman and Schweiker to describe the rate of increase in hospital care have been blandly non-judgemental -- words like "excessive", "intolerable", "unacceptable". For the latest blow to rational debate, turn to the CPI March .3% decline, the first drop since 1965. Hospital charges increased .9%, or an annualized number of 14% on cumulative totals.

The HIAA has joined the AHA in supporting prospective rating. Since there is little chance for such legislation in this session, we may be helping to design our own noose. Given even the remote possibility of such legislation, any hospital that doesn't increase its charges to position its base year starting point is suicidal. So we're suffering the pain of the price positioning, extending our underwriting agony and reinforcing the commitment of those who would use the meat ax.

In the worst case, Congress will put a cap on the Medicare fiscal 1983 increase, endorse prospective rating, go home, and hand the whole problem to the understaffed minions of HCFA to work out the details. In addition to cost shifting through limiting reimbursement to providers, the final bill is likely to increase beneficiary participation and make Medicare secondary to employer provided benefits for the 65-69 year old population.

Who will take the heat, through drastic increases in the prices charged for policies supplementing Medicare and through incraases in group health premiums, to reabsorb the cost of the working elderly? The private insurers.

Bill, I agree with everything you said and applaud the HIAA's effort. It's unfair. It's not right. Unfortunately, I don't think right is going to have very much to do with it.

MR. BURGESS: The pro-competition approach to health care financing and delivery has been ballyhooed as a panacea for most of the ills that have beset the medical section of our economy for the past few years. While there have been three major pro-competition bills introduced in Congress this session, the administration version has not been unveiled. The last session of Congress actually had six major pro-competition bills, so that the architects of the Reagan plan have plenty of building material to work with.

There are many persons involved with health care, from doctors and hospital administrators to actuaries and employee benefit specialists, who all feel like the girl waiting for her blind date to arrive. She has ambivalent feelings, hoping he'll hurry up and arrive, mixed with thoughts that she'd be better off if he never came.

The pro-competition approach has been foremost in the last and in the current Congressional sessions. We can get an idea as to what sort of blind date to expect by looking at the pro-competition bills that have been placed in the Congressional hopper in the past couple of sessions. Rather than look at the individual bills, let's examine some general features of all of the bills and find out what the proponents of pro-competition have to say. Let's also review the arguments of those who oppose competition fostered through federal mandate.

One of the features of many of the pro-competitive proposals is a limitation on the amount of an employer contribution to a health benefit plan which may be excluded from the employee's gross income. The proposals establish the limit on the contribution which may be excluded in a variety of ways - fixing a dollar amount in the legislation, establishing a formula to be administered by the Secretary of Health and Human Services based upon health care costs in a geographic area, or permitting the employer to establish a contribution amount for his employees subject to a maximum limitation.

Under many of the pro-competitive proposals, an employee who chooses a health plan for which the premium is less than the employer contribution amount would receive a rebate of cash or other benefits. Under some proposals, an additional incentive to purchase a low-cost plan is provided by making the rebates, or a portion thereof, non-taxable.

Sometimes mentioned in connection with the pro-competitive approach are proposals to reduce or eliminate the present medical expense deduction; convert the medical expense deduction to a credit; eliminate the health insurance premium deduction; or disallow the employer business expense deduction.

Another feature frequently found in pro-competitive proposals is a requirement that an employer offer a multiple choice of health benefit plans to his employees with an equal contribution by the employer to each plan. Those pro-competitive proposals would deny the exclusion of employer contributions from employee's gross income, or deny the employer's business expense deduction, or both, where an employer did not offer a choice of qualified health benefit plans. Each such proposal establishes certain conditions which a plan must meet in order for the employer's contributions to qualify for the exclusion or deduction.

Pro-competition theorists believe that a large part of health care cost escalation is attributable to the current structure of health care financing. In their view, this structure insulates the consumer from the expense of health care and rewards providers for inefficient use of resources.

They see the main culprits as:

- -Laws which exempt all employer-paid health benefits from personal income taxes of the employee;

-Employer-union negotiation of health benefits which restricts the number of options available to an employee;
-Consumption or purchase decisions made by physicians for their patients under a system where the physicians have no financial risk. This, they believe, provides perverse incentives (that is, the physician can make more money by providing or prescribing unnecessary patient services);
-Retrospective cost reimbursement of providers;
-Government regulation which either limits the entry of new competitors into the health care market or adds unnecessary reporting and other burdens, thereby increasing health care costs.

The overriding objectives of pro-competition are cost containment and greater productivity in the provision of health care.

Proponents believe that the introduction of consumer choice will at least result in lower utilization of health care services among employees who choose traditional insurance coverages, since they are likely to select coverage with higher cost-sharing.

Proponents are also convinced that the competitive model will stimulate consumer interest in HMOs or other organized systems which may provide more cost-effective care. A few believe the health benefit marketplace will be so transformed that insurers and providers, in order to maintain their share of the market or patients, will be motivated quickly to organize HMOs or some other model capable of providing more care for the employee's benefit dollar.

Advocates also believe that the economic discipline exerted in this highly competitive market will substantially change provider incentives and render obsolete and unnecessary most of the government regulations imposed upon health care today.

In other words, pro-competition proponents see:
-Greater consumer acceptance of lower-cost, lower-benefit insurance plans, causing individuals to feel the bite of health costs through payment of significant coinsurance and deductibles at the time of care, thereby reducing consumer demand for services;
-Greater demand for (and insurer or provider willingness to provide) alternative delivery systems, such as HMOs and other forms of provider organizations, which are able to deliver health benefits at lower costs and save the consumer premium dollars (or win him rebates);
-Increased competition among insurers of fee-for-service health care which forces them to "lean harder on providers" to be more cost-effective, ultimately forcing the least efficient providers to change or go out of business.

The sponsors' presumption is that employees would seek to avoid paying taxes on imputed income resulting from employer contributions in excess of the maximum contribution level. They anticipate that employees would therefore choose a plan costing less than the maximum contribution level. But such employee action appears doubtful. Because no individual is in a 100 percent tax bracket, it would seem more reasonable that employees would rather receive the benefit and pay tax on it than forego the benefit.

A single national tax cap for employer contributions also fails to recognize that medical costs, and therefore plan costs, vary widely both by geographic area and by age composition of employee groups, among other factors. A single national tax cap, set at a realistic level to accomplish its purpose, would necessarily discriminate against employees in high medical cost areas and those in groups with higher than average age. A single national tax cap may discourage the employment of older workers. It would allow tax-free purchase of much more generous benefit plans by young groups and those in low medical cost areas.

These consequences could be avoided by varying the tax cap according to geographic area and age. This would, however, greatly complicate administration, and would reduce the number of individuals electing low-cost plans. It would also introduce potentially undesirable variables into the federal tax code.

Arguments concerning the rebate are also impressive. When it comes to health benefits coverage, Americans tend to be highly risk-averse. Most people seem to prefer broad, comprehensive coverage, even with respect to individual health insurance and Medicare supplements, neither of which is significantly tax-subsidized. We should consider carefully who is most likely to choose a lower cost benefit plan and why.

The rebate of the difference in cost between high and low-cost plans provides the motivation to choose the latter. Individual employees will select the plan which appears more advantageous to themselves and their families.

An employee will weigh the value of the additional coverage of the higher option against the amount of the rebate for the lower option. Based on family health status, employees who expect large medical expenditures in the near future will tend to select the most comprehensive benefit plan available. Employees who do not anticipate large expenses will tend to choose a lower cost plan so long as the difference in cost is an attractive inducement.

The premium for a group plan is a composite of the rates applicable to each employee and dependent enrolled. Age rates are lowest for young persons and highest for older persons. If the amount of the rebate is based upon the composite group rate, the rebate will stimulate young, healthy employees to choose the low-cost plan, but will not motivate older or unhealthy employees to forego the high-cost plan.

The principal effect of the tax cap with rebate, therefore, may be that the lower cost plan will be selected most often by younger employees, except those who are unhealthy. The higher cost plan will be selected by unhealthy employees of all ages and by older employees regardless of their health.

To compensate for the tendency of younger employees to choose low-cost plans, it is essential that an age factor be computed into the refunds. However, this would introduce administrative difficulties and also reduce the number of employees who elect low-cost plans.

Medical benefit costs vary by geographical area. To maintain equity, these cost variations should also be reflected in the determination of the refund.

In addition to recognizing age and geographical area in calculating the rebate, it is also essential to introduce controls against adverse selection occurring if employees are free to switch their enrollment between options whenever their health status changes. One alternative is to schedule re-enrollment periods at relatively infrequent intervals, with changes to a lower cost plan becoming effective the following month and changes to a higher cost plan becoming effective one year later. Another possibility is to schedule re-enrollment periods at relatively infrequent intervals with a charge to employees for switching.

Unless such adjustments and controls are introduced, the high-cost plans will attract the older, less healthy lives. As a result, high-cost plan premiums will increase to reflect their experience while low-cost plan premiums will decrease. As the difference between plan costs widens, even fewer younger, healthier employees will choose the high-cost plan, both because it is too expensive and because the rebate, the reward for choosing the low-cost plan, grows larger.

Consequently, the cost of the high-cost plan will, over time, increase disproportionately and be more likely to exceed the tax cap. Younger, healthier employees would receive a windfall rebate. In non-contributory plans, their rebates would be paid for by the employer, and in plans jointly funded by employer and employee contributions, by a combination of higher contributions by both the employer and older, less healthy employees.

A number of pro-competitive proposals also include a Medicare voucher system. This system includes some or all of the following features:

1. A system (either mandatory or optional) under which Medicare eligible individuals would receive a voucher with which to purchase a qualified health plan from private insurers.
2. The value of the voucher would be established as a fixed amount and would be indexed annually.
3. Qualified plans would be required to provide a minimum benefit package covering the same services provided by the regular Medicare program, but would be permitted to vary deductible and coinsurance amounts, subject to a catastrophic limit.

Among the concerns which have been raised on the Medicare voucher concept are:

1. Under Medicare, providers are reimbursed at less than full charges. Insurance companies do not have the advantage of such reimbursement arrangements with providers. It would be impossible for private carriers to offset the substantial reimbursement advantage of the government program. Insurers could not deliver the same benefits for the premium provided. Unless some change is made in the reimbursement arrangement, insurance companies could not offer medical expense policies which would be competitive with either Medicare Part A or Part B.

2. Medicare beneficiaries would be offered the opportunity of using a voucher roughly equivalent to the average per capita cost of Medicare to obtain a private insurance policy. The Medicare beneficiaries who do not use the voucher would remain under the government program.

If the differential reimbursement problems were resolved, the younger beneficiaries in relatively better health might choose to be covered under the voucher system, while the older beneficiaries in relatively poor health would remain under the government program because their vouchers could not purchase equivalent private coverage. This anti-selection would result in greater per capita costs to the government program. There is likely to be additional anti-selection since beneficiaries using vouchers may come largely from geographical areas where the average per capita cost of Medicare is below the national average.

3. Several proposals have presented the concept of voucher rates by age, sex, institutional status, disability, health status, and geographical area to offset this concern. These proposals would require considerable additional regulation to a sure equitable application of these measures. The cost of monitoring the carriers, HMOs, and other entities involved could be substantial.

4. Providing vouchers for Medicare beneficiaries to stimulate competition, while at the same time retaining the government program for those who do not choose the voucher, would result in an increase in administrative costs. The administrative mechanism for the government program would be retained at the same time that private administration would be instituted, with a further increase in regulatory oversight. The government program would compete with private programs under rules made by the government. In such a situation private plans would be driven from the market as social and political pressures force the government to keep its program costs artificially low.

5. Medicare, along with Medicaid and other public programs, has provided a solid framework of medical coverage for senior citizens. Why not stay with a workable program instead of confusing the elderly with alternatives that won't benefit them and cost them more?

As Dick pointed out, Medicare is going to have to bite the bullet, but where and when it will is unknown. Of course, one of the strongest lobbies we have these days is the senior citizens' lobby. They are a very powerful group and are not about to lie down and roll over for any substantial reductions in the Medicare program. Medicare is a popular program, accepted by senior citizens, and they don't want the program ruined.

The voucher proposals have not generated great enthusiasm. In fact, at the congressional hearing last fall the Congressional Budget Office analysis of these proposals sounded very negative. They reported that vouchers for Medicare beneficiaries who would enroll in qualified private health plans would increase somewhat the number of Medicare enrollees served by HMOs, but would not induce many other beneficiaries to switch to private plans. The low amounts of the vouchers, compared with the Medicare benefits per enrollee, would discourage their use, as would the disadvantages that private insurers would face in competing with Medicare.

There appears to be support for pro-competition bills from five different sources:

1. Supporters of HMOs, who perceive the advantages of stimulating competition among providers. Some HMO proponents support pro-competition bills on the basis that competition among carriers or among insurance options will promote the organization of more HMOs. There is, however, no link between the multiple choice of health plan options and the economic pre-conditions to the formation of an HMO.

2. Opponents of national health insurance, who believe that pro-competition bills will avert the pressure for NHI. This is not likely to happen because pro-competition bills do not address the problem of "filling the gaps" for those still without health insurance, public or private, or with inadequate coverage. In fact, the effect of the pro-competition bills may be to increase the extent of inadequate coverage.

3. Those who believe that increased competition among providers will forestall the need for cost containment legislation or regulation of providers. Adequate competition among providers would indeed reduce the need for supply-side regulation. However, the provisions of the pro-competition bills are not likely to generate such competition.

4. Those who believe that placing increased responsibility on the individual for the cost of his health care will reduce his utilization of medical services.

5. Those who see pro-competition bills as revenue raising measures which will help bring the federal budget into balance. The tax cap feature would produce substantial federal revenues due to the additional tax on employees who elect high-cost plans.

Opposition to the pro-competition bills is likely to come from:

1. Employers. The aggregate of their premium and rebate costs may increase even if the rebate amounts are adjusted by age and area. Wages and costs of other plans may also increase. In addition, some bills greatly diminish the role of the employer. Some create new federal bureaucracies and impose increased administrative burdens on employers.

2. Organized labor. The expansion of health insurance coverage is the result of many years of collective bargaining. Eli Ginzberg of Columbia University writes, "The imposition by Congress of a ceiling on non-taxable health-care benefits would represent an arbitrary tax on the income of certain workers that would be hard to justify on grounds of equity or efficiency."

3. Financially distressed inner-city hospitals and teaching hospitals. These institutions, because of their special social obligations, might find it impossible to compete as to price with more favorably located facilities.

4. Insurers. Private health insurers would be subject to new and expanded federal regulation. Insurers would view the foundations of group health insurance as being disrupted and weakened.

5. Consumers. Individuals might resist the idea that "less health insurance and more out-of-pocket expenses are desirable."

6. Employees in high-medical-cost areas. Most of the larger metropolitan areas fall into these categories. People who work there would be hardest hit by a uniform tax cap on employer contributions.

The pro-competition bills have evolved from an initial concept of enhancing consumer choice among competing plans. Many of the most serious adverse effects of the proposals relate to the high-cost, low-cost plan choice, with associated tax cap and rebate provisions.

Many noted medical economists express doubt that the consumer choice proposals will produce the promised changes in the medical delivery system. They raise the following questions:

1. Will the proposals produce more responsible and cost-effective consumer behavior?

2. Will the consumer be able to shop intelligently for a cost-effective doctor and hospital?

3. Will the proposals sufficiently motivate doctors to adjust their practice patterns? The system will not change until doctors work to change it. The chance of this happening will be remote if doctors have little to gain.

4. Will the quality of medical care or equality of access to medical care be adversely affected?

5. What will be the effect on medical education, health manpower, provider licensing and capital formation for medical construction?

6. Are the proposed goals so ambitious that they should first be tested and studied as demonstration projects in local areas?

Strong reservations to the pro-competition approach have been voiced by the Washington Business Group on Health, the American Medical Association, The Blue Cross/Blue Shield Association, the American Hospital Association, the Health Insurance Association of America, the AFL-CIO, and the Council of Teaching Hospitals (COTH). COTH rejects as dangerously inadequate suggestions that the difficulties inherent in underwriting research and education in a price-competitive system are "resolvable in principle". Anticipating below-cost payments by government for care rendered to government program beneficiaries, private insurers object vehemently to the substantial transfer of public sector obligations to the private sector.

The competitive philosophy is "fend for yourself in a complicated marketplace where good health is rewarded and comprehensive health insurance discouraged."

Few are comfortable with the prospects of consumer choice proposals. But the escalation in health care costs hasn't gone away, and neither have the consumer choice proposals.

MR. GREGORY S. BENESH: I have a question on cost shifting. What are the prospects for other states using a system similar to the diagnostic related groupings system that New Jersey has used in the past few years? I would like to know the panel's opinion on that type of system.

MR. KEFFER: I can give you my view on the merits of the system. I think that it really gets to the issue. The effectiveness of it is, of course, one question. The conceptual idea of a hospital being reimbursed on a flat rate basis for a given diagnosis regardless of the expenses incurred is in the direction of providing motivation for the hospital. I hear that the program is working quite effectively. It has recently been improved to consider some of the difficulties with the cut off points. I am personally supportive of the idea. As for extension to other states, it seems that there would be considerable political effort involved. It is more likely that the federal government will move in that direction. Some of the proposals that are being considered with respect to prospective rating for hospitals at the federal level do involve diagnosis related payment.

MR. SIEBEN: I'd like to refer you to the May 10th issue of "Medical Economics", which has a long article on New Jersey. The article reports that the physicians in the aggregate do not think that there has been any negative impact on care. They think that part of this has to do with the base that has been set. A few of the hospitals that were most vulnerable, principally inner city, have become financial survivors as a by-product of DRG. There are some anecdotes about the diagnosis groupings, such as the fractured finger with a pin treated the same as a hip with a pin. What would have normally been a $400 expense ended up as a $3,000 reimbursement. It has really raised havoc with the various classes of payors. The HMOs in New Jersey took a terrific beating, went to the courts and couldn't get relief. The benefit that they'd had in maintaining their prices in the past was no longer available to them. The Blue Cross and Blue Shield New Jersey plans started picking up the bad debt shares and other costs that they hadn't covered under their hospital contracts, resulting in severe economic disjoint. There was a survey showing that under this particular legislation in New Jersey, the Prudential did rather well.

One of the claimed results is the impact on awareness of cost at the physician level. A doctor may be totally oblivious to the fact that he's way out of step with other doctors treating the same disease. There are a number of specific examples given where it has started to impact and change practice. They have found that the total increase in cost for DRG hospitals is about one-half point below others. The threat of prospective rating and diagnostic grouping has caused sensitizing of physicians in terms of the cost of the particular ways they are managing care. The hospital industry is starting to find there is benefit and value in cost containment as a by-product of the threat. I refer you to the Medical Economics article for a good survey on the topic. As to whether DRG will spread further, I think it will.

MR. KEFFER: It's a little hard to feel sympathetic for a Blue Cross operation that's been cut back from a 28% average discount to a still unsupportable discount of only 6%.

MR. SIEBEN: With the prospective rating in Maryland, the process has not necessarily eliminated differentials between different classes of payors. Differentials are established based on the fact that one payor may save the hospital money through prompt payment or avoidance of bad debts. I agree that they are narrower in the aggregate than the ones that have occurred in the past, but differentials do exist between various classes of payors under the Maryland legislation.

MR. DAVID V. AXENE: I enjoyed your illustration of the mice and elephant. I think it's interesting to see that the elephant in the state of Washington is trying to make friends with the mice. For the Medicaid program HCFA has recommended that all the Medicaid departments try to contract and transfer risks to carriers and HMOs. It's amazing how the elephant is trying to court the mice so he can transfer the risk of losing money. Mr. Keffer mentioned that cost shifting data is available in the aggregate, but in the state of Washington, it's really important to know things on a localized basis for pricing. The State of Washington had about an 8% trend jump a year ago because of the lack of reimbursement project with the government on hospitals. Right now they are looking into the DRG type of approach and are going to be experimenting with that. Recently, there was a letter sent to all carriers doing business in the state of Washington announcing hearings being held on discounting costs for both Medicare and Medicaid in hospitals, and transferring costs to the other carriers. I think that it must take a whole army to keep up with all of the changes by region, and that it is really important to look at them on a localized basis.

MR. KEFFER: I had that reaction after going through the Committee's statistical analysis of national data. It was sort of like Moses striking a rock and water coming forth - it's a miracle. I think the group developed from imprecise and hard to work with numbers as good a picture as could be obtained. When you get down to trying to look at what is happening in the state of Washington on a comparable basis, it's almost impossible.

MR. SIEBEN: We have seen the use of primary care networks to subcontract government services. The state of Colorado mandated that in Grand Junction, Colorado, all the Medicaid recipients would get their care from a specific HMO and had no choice. Now, from their perspective, it isn't dumping them on the HMO. They are contracting with that HMO to manage the care of these people in place of the unmanaged care and the freedom of access they perceived as the problem in the past.

MR. MICHAEL R. MCLEAN: Mr. Sieben, you mentioned that there was a Congressional proposal to make Medicare secondary to group insurance for active employees age 65 through 69. Do you have any estimates of the dollar increase in claims cost the insurance companies will have to pick up and an estimate of what the claims cost increase would be on an average group case with a typical age distribution?

MR. SIEBEN: No. The debate and concern has been more as to whether it will have an impact on the cost of hiring people in that age group and the social impact of adding that burden to the employer.

MR. ARTHUR L. BALDWIN: I have a rather unfair question to ask you. Given all the unfavorable characteristics of the government proposals, what elements would you incorporate into a program to accomplish those ends?

MR. KEFFER: I will respond to that somewhat in the context of what our associations are now struggling with. They say that state rather than federal hospital cost containment plans are preferred. Any qualified plan should treat all payors equally. A federal law is needed to establish standards for qualified state programs and provide Medicare recognition and participation in those programs. An interim federal program is needed to contain rising costs until state programs can take over. A federal law

is needed to overcome the political resistance of state hospital associations. That's a conceptual framework of what some of our association people think we should be doing.

MR. SIEBEN: I go along with most of what Bill said. I think the situation of having created an oversupply, such as a larger hospital plant and a 30% increase in the number of physicians per capita, will require a long range shake out in the system, whether the federal funding is direct through programs like Medicare or indirect through tax subsidy. The number that they are attacking is the value of the non-taxibility of employers' health contributions to individuals of $22 billion. That's an attractive number to shave by that 10%.

Those proposals that assume that federal funding of the health care delivery system is averting many little Chryslers going under, conclude that strain has to be inserted into the system. The problem is that any way you consider it, you have more regulation in order to have less regulation, with the risk of massive disjoints on a local basis. I think pain has to be put into the system. If I had the answer, I'd be running for Congress.

MR. BURGESS: There's been concern raised as to taking immediate action, as some of these federal proposals do, without any evidence that the action will accomplish the purposes they intend. There ought to be demonstration projects in many areas before anything as drastic as some of these proposals are implemented. For example, studies have been proposed of existing multiple choice plans to determine if wide variations between high and low option plan experience is due to adverse selection or cost effective behavior. There is evidence in some plans, such as the federal employees plan in the state of Colorado, that the employees do not respond to lower cost plans and select against the company. The figures that the Blues association obtained indicate that the difference in cost far exceeds the real actuarial differences in cost between the plans.

MR. SIEBEN: I've seen parallel plans where the difference in benefits is 5% and the difference in experience is 50%. Who happened to choose the program rather than what they did once they had it made a significant difference.

MR. BENESH: You referred to the voucher system for Medicare. What are the prospects of that happening? Are they talking about it in Congress? Should we be gearing to take over the Medicare system?

MR. SIEBEN: I think it's among the more popular things discussed in Congress but I don't see it as more likely to be adopted than some of the other proposals. I think the prognosis is that it's unlikely to happen this session. There is a real dilemma philosophically in a voucher system from the federal perspective. The one that really has value is a mandatory system, but the philosophical opposition to mandatory is strong, so they talk about a voluntary voucher system. Likewise, the voluntary approach is favored for some of the competition choices at the employer levels, yet the big savings are only available through a mandatory program.

MR. BURGESS: We've been hearing since around December that the administration was going to come forth with full competition proposals in certain areas. Feelers have gone out, but the reading that we're getting at the

moment from our Washington representatives in the HIAA is that, as Dick said, the chances are nothing will be forthcoming.

MR. SIEBEN: Some kind of change in regard to taxation is fairly likely, because Congress can do it, and they'll do it in the Ways and Means, Finance and Budget Committees. The other elements of pro-competition in which the federal government is not the direct immediate beneficiary in its current budgetary problem require better work from HCFA than is likely to come. A consensus for full competition is not likely to develop. You referred to Eli Ginzberg in your comments, Will. He had an article in "Hospitals" Magazine on competition in health care. He takes the stance that all of the proponents of pro-competition and of the restoration of free marketplace competition to health care are trying to restore a world that never was. He makes the point that there never was competition between the Park Avenue doctor and the doctor serving the indigent. If you turn it around, some of the competition that we may be talking about going back to is really competition for survival rather than the type of competition that we think about in terms of normal free market forces. It's a good article and I refer you to it for the opposite side of the rhetoric coming out on pro-competition.

MR. MCLEAN: What is the insurance industry's position on most of the pro-competition bills? Is there any bill in particular that we would favor?

MR. BURGESS: The insurance industry's position is that we do not favor any of the pro-competition proposals that have been advanced. There are various committees in the HIAA that are continually discussing these bills, so there's no official, positive policy or program being advocated. Our position has been that we really need careful studies to be made of the situation and that demonstration projects are in order, rather than going full scale with any pro-competition proposal. Nothing that's come out of the Congress or the Administration has had any support from any of the insurance industry, Blue Cross, Blue Shield, the American Hospital Association, employers, or labor unions. This is not a popular approach because there appear to be so many holes in it. It isn't going to turn the providers around and make them more competitive. As Dick pointed out, Eli Ginzberg said we are talking about competition that may never have been or may never be.

MR. SIEBEN: One quote from Ginzberg on that: "The two pre-conditions for a competitive market, free entrance into the industry and the inability of producers to affect prices, never existed."

MS. BETSY K. UZZELL: I want to go back to an earlier point in the presentation. It was stated that one way to account for cost shifting would be to add something on the order of a one and one-half percent to the trend factor that is required. I think most insurance companies probably look at past results and project using either AHA trends in hospital costs or CPI medical care inflation. My question is, how long will we be adding that one to two points? Secondly, at what point do people think we will be able to see the results of cost shifting in the CPI so that we will no longer have to be adding an additional cost shifting factor to our trends?

MR. KEFFER: I should explain further the limited type of actuarial analysis that I was referring to. When we look at results we are seeing the results of everything that happens. If a hospital adjusts its rates because of the effects of cost shifting or any other factor in its operation, those adjusted rates get into the mix of data that is analyzed. I was attempting to illustrate an increase in the rate of change occurring from the acceleration of the cost shifting factor and suggesting that we, perhaps, get ahead of ourselves. Also, looking at 1979 versus 1980 and drawing rough conclusions from that wouldn't satisfy me and I don't think it would satisfy any of you. It's not a fixed relationship. If I came up with an addition of 1½% to the inflation factor that I observed from changes during the year 1979, that certainly wouldn't tell me much of anything about 1981 or 1982. I was making the point that the information base for analysis is a very difficult one to work with. The cost shift effect was demonstrated to be 10 to 20% of the total cost involved. It's the rates of change we are dealing with and are trying to forecast. You know we have a poor record over the last couple of years of correctly assessing that and working with it. Just look at some of our companies' financial results in the health business.

MR. SIEBEN: On the basis of that terrible record, my operating assumption has been don't count on it stopping until after it does. Don't make any bets the trends are going down until you have actually experienced that they have. We've been experiencing some of this cost shifting through current price positioning by the hospitals. I've seen one instance where Medicaid cutbacks in one state probably transferred an estimated 3.4% to the private system. There has been a tremendous lag in the working through to hospital prices of the decreases in the CPI that we've experienced over the course of the last 2 years. We've been looking at sustained trends of 20% for 2½ years. I would estimate at the end of this year, when we are looking backwards, 1982 will look like 1981, which will look like 1980. I hope that it doesn't, but when you are down to your last nickel in the game, you don't dare make bets that things are going to get better, and that the lagged relief is going to pass through.