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AN OVERVIEW OF COST CONTAINMENT EFFORTS—U.S. AND CANADA

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1. Possible changes - improved plan design
   a. Deductibles and copays
   b. Second surgical opinion
   c. Surgicenters/hospices/home health
   d. Limiting free choice of providers/forming health care alliances of cost-effective providers
   e. Predetermination of benefits

2. Ways to stimulate change - market forces vs. regulation
   a. Pro-competition bills
   b. Prospective vs. retrospective reimbursement (New Jersey experience)
   c. Health planning
   d. Health Maintenance Organizations
   e. Employer coalitions

3. Untapped cost control-health education for employees (health lifestyles; disease prevention)

4. Information sources
   a. Health Insurance Association of America newsletter
   b. American Council of Life Insurance clearing house

5. Discussion questions
   a. In items 1 and 2 above, how is cost control achieved?
   b. Pro-competition - What do consumers want? (Differentiate between consumers and purchasers). What do health care providers want? Is there a conflict?
   c. Are cost containment and quality of care mutually exclusive?
   d. What can the actuary do to improve the overall health delivery system?
      1) Volunteer for Health Systems Agencies or hospital boards
      2) Develop innovative, sound plan design features to create desired health system changes

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MR. H. MICHAEL SCHIFFER: Instead of the usual banter about utilization review, second opinion surgery, coinsurance and deductibles, I will try a different approach to cost containment, discussing the history of why we are where we are. It will be clear as we go along that federal health policy and regulation has had a dramatic impact on health benefit plans and the whole cost containment debate.

Widespread third-party financing evolved during this century as consumer purchasing power could no longer keep pace with the cost of increasingly sophisticated medical services. The turning point came during the Depression. Necessities even more basic than medical care meant lower utilization of hospitals and increased bad debt. In desperation, the American Hospital Association sought state legislation to create a special class of non-profit corporation and of hospital insurance. From this Blue Cross was born. Their service plans guaranteed payment to the hospitals; the subscriber need not even see the bill. The commercial insurers, meanwhile, concentrated principally on life insurance and disability income benefits with a few modest ventures into the health insurance field prior to World War II. During the war, employee benefits in general and health insurance benefits in particular, flourished. This was followed in 1950 by the advent of major medical insurance which progressed strongly over the next 25 years. Today, over 165 million Americans are insured for health insurance through the private sector.

The myth that medical care is free began with the advent of widespread availability of health insurance, and this myth has become ingrained for most of our society. Third-party financing has assured access to the system, from the simplest types of care to the most sophisticated. As a society, we have had the best of all worlds, an explosion of medical technologies and the freedom to investigate all possibilities during diagnosis and treatment without having to make difficult "tradeoff" choices. In short, the explosion of the medical care product has been unimpeded by price considerations.

In any other market, price would have been a major factor controlling the growth and development of the product. In medical care, however, not only are price controls absent, but also the nature of the product is unique. The buyer's choices are not rational; they are based on emotional considerations. Receiving or not receiving a certain treatment may determine one's continued existence. Further, choices for buying one's medical care product are usually made when one is in discomfort. The perceived urgency of treatment combined with the highly technical nature of the services gives consumers little control over choice.

During the post-World War II era, health care has been perceived as a right. Organized labor led the fight for health benefits to be incorporated into employee benefit plans. Increased access has fueled the trends we have been talking about. It was inevitable that as the size and extent of benefit plans grew, the government would get involved. But up until that time, regulation of health care providers was pretty much restricted to life and safety codes, and regulation of the health insurance industry was minimal.

But employee benefit plans could reach only the employed population. As the gap in availability of health services between the employed and the unemployed, mainly the elderly and the poor, widened the government assumed the role as third party financer of medical care. In 1965 the passage of the Medicare and Medicaid Acts marked a massive intervention into the health care system. From a relatively modest beginning these two programs have grown to over $80 billion and with each successive increase in spending, further regulation has resulted.

The government's intrusion into the health arena marked the beginning of a new era in our health delivery and financing system and is perhaps the single most influential event impacting on employee benefit plans. First of all, the Medicare minimum benefit package became a template for standards in employer plans. Secondly, the mass of regulation that spelled out the way providers would be reimbursed, the information that had to be provided and the controls on payments that were established, profoundly influenced our system of investigating and paying claims. Finally, the addition of Medicare and Medicaid to other third party financing mechanisms meant that nearly 90% of the population was covered. Utilization and prices soared. A whole new round of regulatory programs aimed at controlling capital spending, utilization and even operating budgets, was proposed and, for the most part, implemented. Meanwhile it was clear that the increased access had not solved the many problems plaguing our health delivery system. Proponents of National Health insurance, still concerned about equity and access questions, were pushing for even broader government control of the health financing and delivery systems. Opponents were concerned about the cost implications of this ultimate free ride in health care.

During all this lively debate, costs continued to skyrocket, but not to the benefit of society's medical problems which remained entrenched. A number of regulatory attempts were implemented to address these ills: Professional Standards Review Organizations(PSROs), Health Planning, Hospital Cost Containment, State Prospective Budget Review.

Now, let us talk specifically about some of the major interventions of government regulation into the health care, delivery and insurance systems.

Health Planning. The premise of the 1974 federal health planning law is that states and locales know best what their population's chief health problems are, and that they should be responsible for planning and developing services to meet those identified health needs. The planning law established a network of 200 regional consumer-majority Health Systems Agencies (HSAs) and 50 state health planning agencies to determine the need for health providers' proposed new services and the appropriateness of existing services.

Considerable controversy has surrounded the quasi-governmental health planning agencies from the beginning. Providers resisted increased regulation of their professions and resented the decision-making authority the law gave to consumers of health care. Local interest groups did not always agree on which services were most needed in their regions, and which they would have to do without. In addition, the law's preamble contained three inherently conflicting goals, improve access to health services, assure

high quality care, and contain costs. The Department of Health, Education and Welfare (now the Department of Health and Human Services (DHHS)) focused almost exclusively on the cost containment aspect. Meanwhile most of the letters Congress received about the program warned that too much emphasis on cost had compromised quality of and access to services. Meeting the full mandate, in the short term, became impossible. Under President Reagan's initial budget recommendations to Congress, the health planning program is targeted for elimination by 1983.

PSROs. Established under the 1972 amendments of the Social Security Act, the Professional Standards Review Organizations (PSROs) are physician peer review panels which evaluate the hospital services provided to Medicare and Medicaid beneficiaries. PSROs determine if hospitalization, length of stay, course of treatment, and cost of care were appropriate to a beneficiary's illness or injury. They also monitor for potential fraud and abuse. Medicare and Medicaid will not pay for any services not approved by the PSROs.

Like the health planning program, PSROs have come under fire. Even though these panels were made up of their peers, many providers felt they intruded on their professional judgment. The cost of administering the program was also criticized. A recent report from the General Accounting Office concluded that it cost more to run the program than the savings it produced. The Reagan Administration has also suggested phasing out the PSROs by 1983.

State Hospital Cost Containment Programs. Mandatory hospital cost control programs exist in six states, including my home state of Connecticut. About twenty other states now operate voluntary cost containment programs. Design of the mandatory programs varies from state to state, but all share the following characteristics. They cover all hospitals and compliance is mandatory, and they all review prospectively hospitals' revenues (price of services and utilization).

A Johns Hopkins University report, published last fall in the New England Journal of Medicine, concluded that hospital costs in these six states rose at a rate 3.1% less than in non-regulated states from 1976-1978, at an estimated savings of $3.1 billion. The Health Insurance Association of America (HIAA) conducted its own evaluation of state cost containment programs and came up with strikingly similar results.

These programs, too, are the subject of much controversy as evidenced by the defeat of the Carter Administration's hospital cost containment bill. The political heat, however, is the price of the programs' effectiveness.

In spite of their controversy, our industry has consistently supported health planning, PSROs, and mandatory state hospital cost containment programs. We believe that these programs have effectively restrained the rate of increase in health costs, without producing any demonstrably adverse effects on the quality or availability of services. The current dilemma we face is that we support the overall Reagan economic program but it is difficult to argue publicly for retention of these programs and not compromise that support.

Cost-Shifting. Potentially, the most oppressive federal regulatory activity is the Medicare and Medicaid regulations. It was never the intention of the original drafters of Medicare and Medicaid to have government pay less than an equitable share of the health care bill. Over time, as inflation in general, and in the health care system specifically, got out of hand the Federal government increasingly turned to the regulatory process to hold down government spending. First it was an elimination of the 2% "plus factor" which allowed for the fact that educational, research and bad debt costs were excluded from the normal reimbursement formula. Then it was a definition of reasonable cost based on comparison with the mean level of payment by other hospitals. More expensive, higher class hospitals, which were above the mean did not get full reimbursement. Next, it was an attack on such items as payment of malpractice premiums, on the theory that government patients did not bring malpractice suits against practitioners and providers. This situation has progressed to the point that an estimated $3- 4 billion annually is shifted from public patients to private patients. Not only is this clearly a form of hidden taxation, but it is having a devastating effect on the hospital financing system in those areas where hospitals rely heavily on Medicare or Medicaid patients for their reimbursement. It has spawned a rash of bankruptcies in the hospital community and generated the introduction of "distressed hospital bills". Obviously, cost shifting has leveraged inflation in private sector hospital charges with a scramble among the private payors to pick up as little as possible of the cost shift. In some states, like New York, for example, the problem has reached epidemic proportions and without some immediate attention to the equity issue, commercial health insurance plans will no longer be viable.

Health Maintainance Organizations (HMOs). The HMO movement provides another example of "federal fallout" on employer benefit plans. During the early seventies HMOs were perceived as a cure-all; merging the financing and delivery system in a prepayment plan would achieve access objectives while containing costs. The Federal government saw itself as the prime mover of the HMO surge. They would provide demonstration monies, incentives and mandates to provide easy entry into the marketplace and from there the private sector would take over. Also dual-choice regulations were enacted to give HMOs better market **access**. Needless to say, the Federal government felt justified in protecting its investment by promulgating regulations. In addition, some regulations were designed to ensure that access goals would be achieved. Private investors have been subject to the same regulations as publicly funded HMOs. The result is that the HMO movement has been placed in a rigid cast which cannot adapt to the marketplace. Furthermore, if the cost objectives are achieved (and there is no definitive proof that they are), then they are achieved at the expense of a profit margin. This fact along with over-regulation by the Federal government has discouraged private investment in HMOs. The movement seems to be withering away rather than blossoming.

Employer benefit plans have been affected by the HMO movement perhaps more than by any other federal health legislation in the past decade. The dual choice mandate has increased administrative burdens, and in the few areas where HMOs have a significant market share small employers may see their indemnity plans' experience rates increase as the HMO siphons off employees and therefore decreases their group size. Even more critical is the risk

employers bear by offering an HMO that is not on firm financial ground. The Federal government has made no provisions for the casualties of insolvent plans. Employers are faced with reincorporating HMO subscribers into their indemnity plans.

So, there have been regulatory and programmatic attempts to restrain escalating costs. Yet, these attempts have been fragmented and are for the most part stabs in the dark. No one fully understands the root cause of the cost escalation problem. It is undoubtedly multi-faceted; there is no one single action that will solve the problem.

The latest attempt at solving the cost problem is the pro-competitive or consumer choice approach. This "alternative to National Health Insurance" aims to address access as well as cost issues. Interestingly enough, many of its advocates were also advocates of the HMO movement. The essence of the pro-competition argument is that in order to contain costs we can no longer have our cake and eat it too. We must take away something that we have come to expect, full payment for medical expenses. The employer must no longer subsidize full payment plans; the subscriber must be given incentives to pay at the point of service rather than in anticipation of service. Competition in both the financing and delivery systems must be stimulated because "monopolies" induce price escalation. The consumer must be put in a position where s/he can drive the system by pressures indicative of a free-market economy.

It certainly sounds good. In fact it sounds too good, which is dangerous because frustrated politicians, health policy analysts, planners and advocates are easily tempted to grab onto what sounds like a quick-fix.

If we examine the pro-competition theory more closely we see that the tenets of the free-market economy are not so easily transferable to health care. First of all, for the competitive market to function smoothly, the buyer must have full control over choices. As I discussed earlier, this is rarely true in medical care due to the urgency of the situation, to the fact that consumers fully expect physicians to make treatment decisions, and to the technical nature of the product. Second, only in non-emergency situations would the consumer have time to shop and compare. Since choice of medical care is based on emotional considerations more than rational ones, consumers are not inclined to shop and compare. Third, there is little product diversity in the medical market. The provider market is dominated by one group, physicians, all of whom have similar backgrounds, training, and approaches to medical care. Hospital procedures, protocols, and set-ups are similar. Aside from size and physical plant, one hospital is similar to any other. Finally, in order for competition to be effective, there must be a limited demand for the product and services. This is not the case in medical care, as the difficult lessons of Medicare and Medicaid have taught us.

In fact, the conditions I have outlined exist in very few medical sub-markets. But where they do exist, competitive forces should be allowed to operate to contain costs. For example, demographic and social pressures on hospitals have forced them to tailor maternity services to consumer demands. The uniqueness of maternity care is that maternity beds can-

not be filled by medical/surgical patients and birth is a predictable event with enough lead time to allow consumers to shop and compare. Pharmaceuticals is another market where competitive pressures are effective. Also some non-emergency care may fit a competitive model (e.g. second opinion surgery, or concepts relating to self-care).

The haunting question is, what is responsible for health cost inflation and do the pro-competitive bills address that issue? Since we do not know the answer to the first question, it is difficult to answer the second question.

Thus we must be very skeptical of a quick-fix. The pro-competitive bills attempt to make major changes in our financing and delivery systems without any evidence that their tenets are valid. What are the implications for employer benefit plans? One goal of the bills is to decrease the amount of "free" insurance employees receive. Employers face severe penalties if they contribute more than a specified maximum to employee health benefit plans. Either their contributions will become taxable income to their employees or they will lose premium deductibility, or both. The second goal is to provide "freedom of choice" of insurance plans to employees by offering one or more plans by one or more insurers. The employer will thus exercise less control and consumers will lose the benefit of the employer's more effective bargaining power. Furthermore, the employee group will be subdivided into several smaller groups; rates will thus be based on a small group size. The irony of this situation is that the cost savings supposedly achieved by competing benefit plans will be neutralized by the cost of an insurance policy that is based on smaller groups. Indeed, the pro-competitive bills undermine the concept of group insurance. The tradeoff is freedom of choice for the insured vs. a more cost-effective insurance mechanism (i.e. group insurance) with restriction of choice.

Another goal is to force a plan design that provides less comprehensive insurance. Most of the proposals require a "low option" plan to be part of the choices offered to employees. Although undefined, presumably this means higher deductibles and more coinsurance.

Certainly one point we would not want to overlook is that all of the pro-competitive programs introduce in one form or another a whole new level of federal regulation of benefit plans. Benefit standards must be established, maximum contribution levels calculated, instructional material developed in relation to the multiple choice options and the circumstances under which they will be offered. A multitude of oversight and enforcement mechanisms would also need to be created. The most prominent of the pro-competitive bills, the Stockman-Gephardt Bill, sets up a whole new court system to moderate disputes. If you think we have regulation now, be prepared for massive new regulatory programs if the pro-competitive bills see the light of day.

We have seen that the Federal government has become involved in the health care problems on all levels, to increase access through Medicare, Medicaid, and HMOs, and to curtail costs through PSROs, health planning, and the HMO movement. Of course there have been unsuccessful attempts to address access and cost questions, National Health Insurance and federal cost containment bills. The crucial question for the 80's is what is the appropri-

ate role for the Federal government to play. Already HMO, PSRO and health planning programs are threatened with extinction. Competing interests and priorities, diverse geographical needs all spell an intricate problem that eludes definition, let alone solution. But precisely because the problem is so complex, the attempted solution must be multi-faceted. Public-private partnerships, local health care coalitions can perhaps work in concert to tailor their solutions to individual situations. In many cases this is perhaps more appropriate than an overly simplistic federal approach that while attempting to speak to all, actually speaks to no one. Yet, it is often appropriate and necessary to have federally sponsored programs to achieve unified goals.

The irony of the situation as it strikes me is this; when Lyndon Johnson was "playing hardball" to get his Federal Medicare program passed in 1964, I wonder if he really perceived how profoundly this program would influence the future of private health care delivery and financing. I wonder if he ever thought that ultimately the issue would be cost, not access. I wonder if he ever imagined that his staunchest free market advocates of the day, insurers and doctors, would one day argue against pro-competitive bills.

In closing, let me say there is a legitimate role for government to play in both the financing and regulation of health care. There are 1 million uninsurables who should have access through pooling arrangements. There are 4 or 5 million temporarily unemployed whose coverage could have been continued. There are 15 million people covered under Medicaid today and 7 million more who ought to be covered who cannot afford adequate health care. They can and should look to government to assist them. Also, if government is to spend 30 or 50 or 80 or 100 billion dollars of taxpayer money, they have a legitimate right and even responsibility to see that money is well used. It is unrealistic to think that we are going to see a quick end to regulation in the health care field which makes it all the more imperative that we influence the direction of the regulatory process in the proper direction.

DR. ROBERT R. HENDERSON: The business coalition concept has started in the last few years. There was a great deal of concern on the part of all the provider groups and of the private sector, in general, to put a cap on medical care costs which had been skyrocketing. Over a period of about seven years in the 70's the escalation of health care cost was greater than the escalation in either the federal deficit or the federal budget. As costs rose, industry saw their potential impact on profit. They turned to their carriers to solve the problem. However, the carriers were not in a position to solve the problem, nor was the government. Consequently, when industry decided to get involved, coalitions of providers, regulators, insurers and buyers were formed.

Table 1 contains a list of some of these coalitions. They are in various stages of development, with a half dozen or so operational. There are two basic types - 1) coalitions of the insurance industry, government, buyers and providers and 2) more recently, industry only. This development of industry only groups is based on the question "do you want the fox sitting in on your meetings when you are trying to keep him out of the chicken coop?"

TABLE 1

BUSINESS GROUPS ON HEALTH/COALITIONS

- CINCINNATI COST CONTAINMENT NETWORK
- CITIZENS LEAGUE COMMITTEE ON HOSPITAL/TWIN CITIES
- CLEVELAND (TENNESSEE) ASSOCIATED INDUSTRIES HEALTH CARE COMMITTEE
- DAYTON COST CONTAINMENT ACTIVITIES
- EMPLOYERS HEALTH CARE COALITION OF GREATER LOS ANGELES
- EMPLOYERS HEALTH CARE COST COMMITTEE OF SAN DIEGO
- FAIRFIELD/WESTCHESTER BUSINESS GROUP ON HEALTH
- GREATER CLEVELAND (OHIO) COALITION ON HEALTH CARE COST EFFECTIVENESS
- JOINT HEALTH COST CONTAINMENT PROGRAM - PHILADELPHIA
- MARYLAND HEALTH CARE COALITION
- MICHIGAN COALITION ON BED REDUCTION
- MIDWEST BUSINESS GROUP ON HEALTH
- NEW YORK CITY BUSINESS GROUP ON HEALTH
- ROCHESTER (NEW YORK) COALITION OF HMOs

In Table 2, the left hand column shows a sample of coalitions and across the top is listed activities of the coalitions.

I would like to talk about the Fairfield/ Westchester Business Group on Health as an example of such a group.

Table 3 is a list of the twenty-four members of the Fairfield/Westchester group. Fairfield and Westchester are two adjacent counties in New York State and Connecticut. This group has several unique features. First, it is an industry only group. Secondly, it only contains large companies, Readers Digest being the smallest company involved. Finally, all the companies are national. The group is a non-profit corporation with each member contributing dues and receiving a seat on the board and an alternate.

The group plans to use the two county area as a laboratory to see what can be developed and applied at a national level. The general goal is to achieve quality health care at a reasonable cost. There are three types of attitudinal approaches. First, all patients will receive appropriate care in the appropriate setting at the appropriate price. Next, the duplication of high cost technological equipment and sophisticated services should be minimized. Lastly, the individual user will better understand the cost problem and become a better, more effective buyer.

The group was formed in July 1979. The first six months were devoted to educating ourselves about the local and national health care problem and to establishing lines of communication with the providers in the area. In addition, we had outside speakers and materials. We selected representatives of a few of our companies' insurance carriers to give us an overview of the feelings and programs of the insurance industry on cost containment. Every month, there were mailings of information. At the end of the six months we organized working committees (e.g. an executive health education committee, a provider health care regulation legislation committee).

One of our first problems was how to get twenty-four different corporations to go along with anything. One of the reasons for limiting the group to large corporations was to keep the number small and therefore have a board that could be handled. We were first confronted with writing a position paper on HMOs. The group contained both haters and lovers of HMOs. To bring them together and still not have a wishy-washy paper, we included a paragraph stating that the paper was a consensus and not necessarily the view of any one company. This is how we have worked ever since. In addition we put the hater of HMOs on the board of an HMO and since then, he has changed his views.

We are working on a series of health education brochures and materials. These materials would not be limited to the Fairfield/Westchester area but will be used throughout the corporations.

With the hospitals we have two relationships. In one county, we have monthly meetings with the hospitals on selected topics. Each group presents a topic which may not be of equal interest or value to the others. For example, in the area of utilization review, we are interested in seeing

TABLE 2

OBJECTIVES/ACTIVITIES

BUSINESS GROUPS ON HEALTH	EDUCATION	INT. HOSP. PLANNING	INCR. AMBULATORY CARE	PLAN DESIGN	PROMOTE HMO'S	UTILIZATION REVIEW	HSA COORDINATION	DATA BASE
CINCINNATI COST CONTAINMENT NETWORK	X	X		X	X	X	X	
CITIZEN LEAGUE COMMITTEE ON HOSPITALS/TWIN CITIES	X	X			X			
CLEVELAND (TENN) ASSOC. INDUSTRIES HEALTH CARE COMM.	X			X	X			X
DAYTON COST CONTAINMENT ACTIVITIES		X				X		
EMPLOYERS HEALTH CARE COST COMMITTEE OF SAN DIEGO	X	X						
FAIRFIELD/WESTCHESTER BUSINESS GROUP ON HEALTH	X	X	X	X	X	X	X	X
GREATER CLEVELAND (OHIO) COALITION ON HEALTH CARE	X	X					X	
JOINT HEALTH COST CONTAINMENT PROGRAM-PHILADELPHIA	X			X				X
MARYLAND HEALTH CARE COALITION	X					X		X
MICHIGAN COALITION ON BED REDUCTION		X						
MIDWEST BUS GROUP ON HEALTH	X					X		X
ROCHESTER (NY) COALITION OF HMO					X			

TABLE 3 MEMBERS OF THE FAIRFIELD/WESTCHESTER BUSINESS GROUP ON HEALTH

AMAX
AMERICAN CAN
AMF
CHAMPION INTERNATIONAL
CIBA-GEIGY
COMBUSTION ENGINEERING
CONTINENTAL GROUP
GENERAL ELECTRIC
GENERAL FOODS
GENERAL TELEPHONE & ELECTRONICS
IBM
ITT RAYONIER
MOBIL
NEW YORK TELEPHONE
OLIN
OLIVETTI
PEPSICO
PITNEY-BOWES
READER'S DIGEST
RICHARDSON-MERRELL
SINGER
UNION CARBIDE
XEROX

TABLE 4

FORMING A LOCAL BUSINESS GROUP

. STEERING COMMITTEE
. SPECIFICATION OF ATTAINABLE OBJECTIVES
. INTERESTED AND COMMITTED EMPLOYERS
. WORKING COMMITTEES
. TIME - EFFORT - COMMITTMENT
. MEETINGS - CONTINUITY
. COOPERATION WITH/FROM LOCAL
  - HOSPITALS
  - PROVIDERS
  - HMO's
  - HSA's
  - PSRO's
. COOPERATION FROM MEMBER COMPANY CARRIERS
. DIRECTOR/CONSULTANT
. FUNDING
. BY-LAWS

what can be done if PSROs go down the tubes or if they do not, how all the hospitals in that county can have utilization review done to all admissions. As discussions have progressed we are reaching a common wave length with the institutions. In the other county we had such a committee but at the same time the hospitals in that county were forming a joint planning group. I am now on the steering committee of that joint hospital planning group, and they have asked us to send two permanent members for that planning group.

Table 4 shows what is needed to start a business group, whether it is a coalition or industry only. The requirements are fairly clear-cut. However, you have to have a leader, one industry who is willing to invite the other area industries to meetings to talk through their interests, and possible joint efforts.

How will these groups impact on the carrier community? The first impact is in data. The classic large industry regardless of carrier, whether it is Blue Cross, Blue Shield or some other third party carrier, feels that they have not received sufficient data to understand the problem. The question has to be asked, "what are you going to do with the data when you get it?" But if you look at the major efforts of most of these business consortiums, data are a high priority.

There are certain advantages in the industrial community getting involved in this whole scene. For the first time they are becoming educated in the broad picture, from what is going on locally up to the federal level. It is amazing that some of the people on the board, who vary from a Vice President of a legal department to a medical director of a corporate headquarters, have become sophisticated about issues they knew very little about a year and a half ago. This self-education is very valuable. It forces discussion by all the participants in this health care area in a way that has not been achieved before.

Whether these groups will all fold in a year or two because they accomplished nothing, no one knows. However, it is a new and interesting phenomenon because for the first time the largest private buyers are involved.

MR. RICHARD J. MELLMAN: First, a few words about two of the points that Mr. Schiffer made in his opening remarks. The cost shift simply emanates from the natural desire of elected officials to provide benefits to people without raising taxes and once it gets started, it grows and grows.

I recently heard a speaker from the State of Florida talk about how they were saving money on Medicaid. When they cut the reasonable and customary reimbursement to physicians down to 80%, 70% and 60%, they found that it was resulting in inferior care because they were freezing out the good doctors and promoting Medicaid mills. However, they just reduced the reasonable and customary reimbursement from 25% to 15% and it is having a good effect on quality because they froze out the mills and were left with the good doctors who felt it is their social responsibility to take care of the poor at these prices. That is where we are heading. We have a tremendous job to educate the Congress in a way which will not come across as self-serving on the part of the Blues and insurance companies.

Concerning the pro-competition bills, if you look at most any reform movement, like civil rights for example, there are two kinds of people. There are the Rap Browns who get on the soap box and make the statements that make the press, and there are the people who quietly work behind the scenes, put through the legislative programs and get the package assembled. Pro-competition is a classic example of this. One of the people on the soap box is Walter McClure at Inter-Study in Minnesota who refers to the present set of programs which are supposed to contain costs (e.g. PSROs, health planning, hospital prospective budget review) as the "omnibus tinkering" approach. Another is Professor Alain Enthoven of Stanford who says the problem is that we are trying to regulate and channel a river to flow up stream. What they both say is we have to get to the root causes of the problem and make the incentives positive rather then perverse and then if we can restore a free market place with these positive incentives, everything will improve. This idea has been latched onto by the economic academic community and it makes a lot of economic sense. It is widely embraced by the providers of medical service because they see it as a deregulatory mechanism.

Unfortunately, economists are not actuaries and when they go through this concept which makes sense from an economists' point of view, they do not give consideration to the fact that medical costs vary by area, that premium rates vary by age, and that adverse selection is a danger. Therefore, many of these noble ideas get warped in the real world of insurance underwriting. For example, in the federal employees plan the actuarial difference between the benefits of the high and low option which the employees have a choice of is 9% but the experience difference in the two plans is 70%. Now the economists think that the 70% as compared to the 9% shows that if you have a higher deductible and more copay, people will be more cost conscious in their use of medical services. We think that because of open enrollment, people who do not anticipate very large medical expenses in the coming year tend to sign up for the lower plan and vice versa. HIAA has done a study on this. It is entitled "A Critical Evaluation of the Pro-Competition Bills." If you are interested in learning more about this we will send one to you.

Let me just close with the word that this concept is becoming widespread. It will not be satisfactory for our business to oppose it. Rather, we have to influence the debate so as to amend it and make it workable in terms of the real insurance world.

DR. HENDERSON: Mr. Schiffer noted that one of the reasons that he did not think the pro-competition bills would succeed is that there is no diversity in the medical care industry. How do you feel this differs from the insurance industry and do you think the insurance industry is competitive?

MR. SCHIFFER: The insurance industry is highly competitive. We compete in the services we provide. Employers are now becoming interested in the services we can provide in the cost containment area. We also compete with Blue Cross, HMOs and self-insured programs. The competition is growing in intensity. In health insurance our basic service is in the payment of claims. Large carriers have more sophisticated systems to do this but all companies provide basically similar service.

MR. MELLMAN: We have been talking to the authors of the pro-competition bills. There were six of these bills in the last Congress and several of the sponsors have key spots in the current administration. For example, some of the sponsors are DHHS Secretary Schweiker, Senator Durenberger, Chairman of the Health Subcommittee of the Senate Finance Committee, and Office of Management and Budget Director, David Stockman. We said that what you seek to do is provide competition among providers but it comes out in the bill as competition among insurers, and the insurance industry is already highly competitive. Requiring the employer who provides group insurance to offer the employee a choice of three different carriers is not going to accomplish competition. What you really want is three different HMOs. Their answer is that insurance companies are competitive when it comes to services and retention but not competitive with respect to benefits since you all offer free choice of providers. What we want is for you to go into Fairfield and Westchester counties and line up a group of doctors and hospitals that will provide cost effective treatment. If that is the Aetna's plan and people who enroll in it can go to those hospitals and doctors that offer more care for the dollar, then most of the employees will enroll in that plan. Thus, the bill sponsors think in terms of a different kind of competition among insurance carriers. Whether the public is ready to forego free choice of physicians and hospitals is the question.

MR. LOUIS GARFIN: The business group concept which you describe is intriguing but it seems to require initiative and organization from the business community itself. Is there a way for insurance companies to take an interest or try to be an organizer or promoter of this activity?

DR. HENDERSON: It does not make any difference who initiates these groups. For example there is one group just getting off the ground in the southeast of Florida which was initiated out of the governor's office. It is a coalition, including the state of Florida, carriers, etc. Prudential could do this in the northeast New Jersey area. There is no reason you cannot get interested people together and discuss the issues.

One comment about competition. I have observed in Washington that there seems to be a lack of understanding of what competition is as it affects the health care industry. Antitrust suits are being brought by the government to stop hospitals from joint planning. They do not understand that when hospitals in the past have talked about competition, they were talking about competition for status and for the best of this and newest of that, just the antithesis of what we mean when we talk about market competition. That is the problem with much of the government approach; they do not understand where the game is yet, but they are learning.