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CURRENT FEDERAL ISSUES THAT IMPACT HEALTH INSURANCE

Moderator: RICHARD J. MELLMAN. Panelists: HELEN DARLING, MARION EIN**, ANDREW WEBBER****

A round table discussion with three prominent observers of the federal health policy scene.

- The Federal Government's role in health care financing.
- Discussion of major current issues --
  - Prospective reimbursement of hospitals
  - Tax treatment of individuals medical expenses
  - Primacy of group health insurance for workers over 65
  - Budgetary pressure on Medicare/Medicaid
  - Whatever became of NHI?
- The role of the actuary in relation to these issues. Are the political and actuarial approaches compatible?

MR. RICHARD J. MELLMAN: In my work I have become friendly with the three members of our panel this morning. Let me introduce the panel.

On my left is Helen Darling who is Director of Human Resources for the Government Research Corporation. GRC is an organization in Washington which performs client services by advising them how policy making works in Washington and also publishes an excellent weekly analysis of the Federal scene called the National Journal with which many of you may be familiar.

Immediately to my right is Marion Ein who is Associate Director of the National Health Policy Forum. The National Health Policy Forum is a non-profit group which is housed at George Washington University. The Forum operates on grants and provides educational type discussions, meetings and seminars for senior level people in the Federal establishment. Examples include health legislative assistants to Senators and Congressmen and management people in the Executive Branch especially HHS. For several years

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they have been putting on about 50 programs a year for this shifting audience of people who need the show done over again every 2 years because of the high turnover.

On my far right is Andy Webber who is Assistant Director of the Washington Business Group on Health. The Washington Business Group on Health is essentially a health off-shoot of the Business Roundtable. Its membership consists of approximately 200 of the top members of the Fortune 500. It is oriented towards health issues at the Federal scene and its members are generally the benefits managers of these large corporations. Thus, Andy views these problems from the point of vantage of the large employer community.

Our recorder is Gabe Cillie. So Helen, Marion and Andy we're very happy to have you with us this morning and without taking any more time, let's begin the session.

These 4 parts will be:

1. An overall view of the federal health scene
2. A discussion of several of the major specific issues currently before us
3. The role of the actuary in relation to these issues
4. A discussion of political science philosophy generally, which is as we all know frequently at variance with the actuarial approach to problem solving

So, if we could start off with the overall view, I would like to ask Helen to lead off. Helen if you could discuss "what is it that drives the Federal Health Policy Machine?"

MS. HELEN DARLING: Well, I began my life as a demographer and I previously earned my living as a Health statistician. So with my love of numbers I have often been accused of thinking that facts were more important than anything else. This is particularly dangerous, as you might imagine, in Washington.

I'd like to give you a few figures that I think capture perfectly what is in fact driving health policy. These are Congressional budget office estimates for Federal outlays and deficits for Fiscal Year 1983. Out of the total Federal budget of 788 billion dollars this year 216 billion goes for defense, 270 billion for income security which is mainly Social Security pensions and other benefits (79 billion for health, Medicare and Medicaid alone) 115 billion for interest (that's a little bit alarming, they don't even get to deduct it on their taxes, do they?) There is a deficit of 155 billion. Those figures emerged from what this past year was a series of absolutely marathon sessions that literally went on for months during which time the Congress, the President, and the Administration looked for ways to cut the budget. That's the outcome of budget cutting. As you know, these are budget estimates which tend to be optimistic.

In any case, those figures essentially drive everything else and will continue to drive everything else. So, when you see a news item in the paper, you can look for two things: Does the item have the potential for raising revenues or does it have the potential for reducing costs?

I won't go into subsequent years. They have figures on two more years. We are talking about roughly a 150 billion dollar annual deficit for three years in a row if there are no changes in Federal policies. Either taxes must be raised or budgets cut. Also you know that entitlement programs have been declared off limits by the President and since this year is an election year nobody is going to touch the entitlement programs. Everyone wants to be reelected, and being reelected is considered more important than anything else.

The one other issue that drives the Federal Budget, and certainly one you'll be hearing a lot about in the next two years is the Social Security trust fund condition. As I am sure you know, the pension side of the trust fund was scheduled to go broke this year. Literally broke. Not even technically bankrupt. I mean there would not be money to write the checks. That's broke. But of course, the Congress in its wisdom noted that the Medicare trust fund was in relatively good shape as was the Disability trust fund. There are three trust funds, as you may know. They are allowed to engage in inter-fund borrowing. What we used to call, when I was growing up, robbing Peter to pay Paul. But in fact this is happening at a very lofty level. This means that the Social Security trust fund will not go broke this year but all of the funds will go broke next year. So much for solving the deficit problem.

There is no reason to assume that the President's Commission on Social Security which is to make a report in November, will have answers that are politically acceptable. For one thing the commission itself is a microcosm of the Congress in many respects, and the President has already ruled several options off limits which certainly limits what they can say or do. So look for changes in that area next year. But again in the short term, every attempt will be made to find ways to cut expenditures or to raise revenues. Further, this will be driving everything in this town, probably for many years to come.

MR. MELLMAN: Thank you Helen. Marion there has been a lot of talk in the last year about the pro-competition approach as a device for bringing some of these programs under better cost control. Could you bring us up to date quickly on where that stands and some of the developments there?

MS. MARION EIN: I'll answer that by briefly reviewing findings that came out of a 17-session series on competition my organization did for senior and mid-level health policy officials here in Washington, staffers working on the hill and in the Executive agencies. We invited people from all parts of the health care infra-structure, the parties with vested interests in this competition debate, to make presentations. We had a panel from the commercial insurers, we had representatives from the Blues, physicians, hospital administrators, as well as several of the architects of the competition debate, such as Allan Enthoven, Walter McClure, Clark Havighurst. All these people addressed the issues, and answered questions relating to the pros and cons of competition, would it work and how should it be implemented. The series started in September and ended in February.

On many of the issues there was no overall agreement. However, everyone did feel there was a need for reform, that the status quo was no longer tenable, costs were going out of sight, we couldn't continue to spend at the level we are spending, and that some change was therefore in order. People agreed

that government was the main pressure behind the current impetus for change. You can see why, they have such a large stake in the health care system. In 1981, government paid for 54% of all hospital care, 27% of all physician's services and 56% of all nursing home care, so it has a vested stake in making sure that costs are contained and services delivered more appropriately. The states are in a similar position. Because of that, Corporate America sees the burden shifting to itself. If the Government doesn't want to pay, Corporate America may be left holding the bag and so business has become much more interested and actively involved in the health care debate. We see many coalitions, voluntary efforts at health care reform and health care cost containment sprouting up around the country. Everyone wants change but on the other hand, the vested interests, the hospitals, the physicians, and the insurers, to some degree, are happier with the status quo. You're happier with what you have even if it isn't perfect.

We found that as much as we had heard the discussions about competition, when it came to actually being for it, very few people were willing to stand up. Also the President, when push came to shove, had other more urgent priorities (Social Security reform, economic recovery, defense build-up), so he never put the needed support behind the competition debate to make it move.

People were struck by the complexities of implementing a competitive program. While the rhetoric of competition is attractive because it promises less government and deregulation, when you look more closely at the fine print of these proposals you realize that they may mean more rather than less regulation.

There was also a question of how to proceed. Nobody felt we should change the system in one fell swoop. Everyone felt we should take an incremental approach. Generally there was support for some modification in the current tax treatment of employment based insurance to make the purchaser more cost-conscious about medical care. When it came to mandating voucher programs, and multiple choice or rebates, people had serious questions about how appropriate, equitable, and effective these programs would be.

Is competition a viable strategy? Our people felt that price competition might work selectively. It would benefit the healthier people (who need less insurance) and would adversely affect the sicker people (who need a lot of insurance). Consequently, it would compromise the whole basis for insurance, the spreading and sharing of risk. People looked at FEHBP and saw the destructive repercussions of adverse selection. They therefore had some serious questions about the viability of price competition and how it would affect the market for health insurance. As Helen said, the budget is driving policy and nothing will be passed unless it's cost reducing. Competition at least initially is perceived not to be cost reducing. That I believe is another large reason why competition did not move further.

I think people feel though that even with nothing being enacted, the landscape is changing. More people are accepting the idea of less comprehensive insurance coverage, larger deductibles, and greater cost sharing. Besides HMOs, other alternative delivery systems are sprouting up. We don't know how effective they will be but they are appearing across the land, preferred provider plans, other alternatives to conventional insurance plans. So the changes are happening even without anything actually being enacted in Washington.

MR. ANDREW WEBBER: I'd like to respond by expanding on what Helen and Marion have said. I agree completely that the budget is the driving force in Washington right now. That's unfortunate. It also conflicts with the philosophical tenet of this administration, which is to foster competition. The simple fact is that reimbursement cut-backs to Medicare and Medicaid have been driving the health care budget. This Administration has to find ways to cut back the Federal deficit and in the health budget they're doing that primarily through reimbursement cut-backs. The problem with reimbursement cut-backs is, as this audience well knows, that we are not talking about savings in the aggregate health care budget, we are simply talking about shifts, costs shifts, on to the private sector. That, in my mind, is the main health policy theme of this administration, cost shifting to the private sector. When the Government arbitrarily cuts reimbursement below cost, providers very conveniently increase charges to the private payers. That's us.

We are in a period when the overall economy is in recession. The aggregate health care costs of WBGH's employer members are rising at the highest rate since World War II. The other problem with cost shifting is that it's antithetical to the very idea of price competition. How can we increase price competition in the health care market place? How can you have cost shifting with different payers paying arbitrarily different amounts of money, reimbursing at different levels and also have real price competition? How can we have a private sector payer paying twice the amount for a given service as the Government purchaser? As far as private business is concerned, there is no question that if we had a choice between going towards a public utility model or greater price competition in the market, our choice would be price competition. But our employer members are not naive about the realities of the health care market place.

The health care market place is structurally unsound. The consensus of our membership is that as we move towards competition we're going to have explicit regulation, that is, explicit cost controls, and tougher utilization review programs. We're going to have some capacity controls as well. That's why we've been resisting the Administration's moves to phase out health planning program, which is a capacity resource allocation control program, and the PSRO program, which is a utilization review program.

We have criticized this Administration. Let me tell you it's hard for a business association to criticize a conservative Republican Administration. We have taken a lot of heat from day one for criticizing the Reagan health policies on these issues.

In the short term, there may be a mix of regulations. Indeed the whole focus of the Federal debate right now is on prospective payment, a Medicare-only prospective payment system. That my friends is a regulatory cost control program, because government is setting rates. Again, this reflects the Administration trying to control its budget, rather than designing a structurally sound, price competitive market place. Clearly the great concern that we have for a Medicare-only prospective payments system is that it will further aggravate the magnitude of the cost shift to the private sector. We are looking first to see whether prospective payment is a right way to go. In the interim we will need some cost controls on the system. That is why we are looking so closely now at statewide all party prospective payment programs with Medicare, Medicaid, the Blues and private insurers all

on one uniform hospital prospective payment system. This really eliminates the problem of cost shifting.

What are the key elements of competition? I think a major one is putting physicians at risk. We have had a cost based reimbursement system where the suppliers of the good, hospital physicians, have not been at risk for the services they deliver. I believe risk is one of the essential components of greater competition; that is, putting the providers and suppliers at risk. You can do that in two ways, first through health maintenance organizations and other alternative health care delivery systems where a group of providers are at risk for the cost of services over and above a budget, and second, through a prospective payment system with the hospital at risk. You say to the hospital "this is the amount of money you're going to get for this admission or type of case", or you put on a total revenue cap. Suddenly the hospital administrator has to find ways to deliver those services in the most cost effective manner because it is to his economic advantage to do so. He can retain any excess of the negotiated rate over the actual cost of delivering those services.

The other key element of competition is consumer knowledge. The economic text books tell us that for there to be true competition in any market place, the consumer has to know what he is buying. That's a real problem in the health care market place, not only for the individual consumer, approaching physicians and approaching the medical care system, but it's even a great problem for the group purchaser. I am talking about my members, the large group employers who provide health insurance benefits for their employees. The simple fact is that employers historically have had their heads in the sand. They have not been good knowledgeable consumers of the product they buy. All our focus of attention right now is away from Washington. It's really at the grass roots level. How can we make our purchasers use their clout, their economic leverage, to increase competition at the local community level?

As Marion mentioned, we are seeing a tremendous increase in coalitions, employers coming together to educate themselves to how the market place works, and then aggregating their economic clout. They are starting to negotiate with providers, to negotiate for specific cost containment programs, and down the road even starting to negotiate on prices. Buyers and sellers in the health care market place will negotiate services and prices. There is no quick fix. It's going to be a mix of regulation and competition in the future. We have to be realistic about how quickly we can get from one point to the other. Given the obstacles to real competition in this market place, a structurally sound market place, will take many, many years to mature.

MR. MELLMAN: Before we conclude the discussion of the general environment, I would invite questions from the audience to the panel.

MR. JAY RIPPS: I would like to ask Mr. Webber if he could give us some examples of specific employer actions with respect to negotiation with health care providers. You mentioned these things were taking place, sort of springing up across the country. Are there any specifics you could mention which are examples of that kind of activity?

MR. WEBBER: The concept of preferred provider organizations has already been mentioned. Briefly it is simply trying to identify in a given community who the cost-effective providers are. Then negotiating and guaranteeing them some amount of volume, which increasingly physicians, for example, are going to be concerned about in this environment. The idea is that guaranteeing them some volume of patients will aid in negotiating discounts, lower prices, or explicit utilization review programs, for example. Then through design of your health insurance benefits trying to direct your employees towards those cost effective providers. You can do that for instance by saying you will reimburse insurance benefits at the 100% level if your employees and their dependents seek out these preferred providers, and you will only reimburse at the 80% level if the individual employee maintains his freedom of choice and seeks out another provider. Again, this is currently more a concept than a reality.

We are heading toward an over supply of physicians. There is a growing consensus now that doctors will therefore be concerned increasingly in the future with volume. Historically, when physicians lose volume, they have often simply made up for it by upping per unit service charges. I think in this environment as aggregate consumer group purchasers become more discriminating and really start to look at prices and do price utilization and quality profiles that upping per unit service charges will be harder to do. So I think the great competition for volume, guaranteed volume in the market place increasingly will drive physicians to start negotiating with group purchasers on prices, utilization controls, and cost containment endeavors.

The problem now is that our members can't identify who the cost effective providers are. That raises one of the key issues in the debate, and that is data. For us to have a competitive market place, group purchasers need data, profiles, on utilization, on price and on quality of institutions and ideally on individual physicians. How can you identify the cost effective providers if you don't have that sort of data? We could discuss data for several hours. However, in a few words, let me tell you that, in terms of our membership education programs data is the key issue they raise. We need a better picture of what we are buying and I think a lot of the focus of the attention is on how group purchasers can get better data on the services that they are purchasing.

MR. KIRAN DESAI: I have a question for Mr. Webber. You mentioned data and you also mentioned shifting risk to hospitals and providers. You didn't mention shifting risk to consumers. You don't need all the data on good providers, you could just shift the risk to consumers and let them decide. Give them a set allowance and they will find good physicians who are good providers themselves. Has any thought been given to shifting the risk to consumers?

MR. WEBBER: No, and I couldn't agree with you more. I think that is an element of it. We have to increase consumer cost consciousness and we have to put physicians at risk. These concepts are not incompatible, you have to do both at the same time. Increasingly, employers are talking about increasing the cost sharing burden on employees. There is no question about that. You see that with companies now in their salaried-employee plans. They can't negotiate it in their union plans yet, but increasingly they are talking about increasing cost sharing provisions in their salary plans. Then

down the road I think you will see it come up in union negotiations. So I think that's important as well. Although you have to be careful, again because of the lack of consumer knowledge of the health care market place. That's where I have some concerns about how viable, how much of an influence increased cost sharing and increased cost consciousness will have. The simple fact is I don't believe consumers shop around like the text books say they would if they had greater out-of-pocket expenses. It is a very debatable point. Certainly there would be greater incentives if there were increased cost sharing, but we have enough of a problem getting our group purchasers to identify cost effective providers. For an individual beneficiary out there in the market place to identify who the cost effective provider is I think is a bit too much to ask. Although again I agree with you, I think that's an element of cost containment as well and needs to be pursued.

MS. EIN: The Medicare voucher concept that's being discussed is another example of trying to make the Medicare population more cost-conscious shoppers.

MR. CHUCK SARKISIAN: Mr. Webber you were talking about putting the providers at risk. I can understand putting the hospitals at risk through prospective reimbursement and putting the HMO's at risk, but most people do not choose HMOs. You seem to ignore the independent physicians, the consumer decides he wants to go to his own family physician. How would you propose to put those physicians at financial risk?

MR. WEBBER: Well, I think at the individual market place level physicians will be at risk increasingly if consumers become more knowledgeable of the market place. It will be the knowledge of the consumers that puts physicians at risk. As consumers become able to discriminate increasingly in the future between the quality of services and the actual performance of physicians, then physicians will be at risk in the future. Again I think that is long term since it is hard to get to that point in this particular market place where I think consumer ignorance is the norm rather than the exception and I just think that we are years from really that happening.

MR. MELLMAN: At this point we have laid out the parameters of the broad environment in which all this is taking place, and we're set to move into specific issues.

There are obviously a myriad of specific issues that we could talk about. In preparing for this session, we laid out a list of them. We intend to discuss the five we ranked the highest. I would like to tell you what those five are before moving on. First is the question of prospective reimbursement to hospitals which is dominating the debate in the newspapers today. Second, is the income tax treatment of individuals with regard to health insurance,not the employer contributing but the 50% deduction up to $150 and the 3% deductions. Third, is the the recent changes that will make the employer's group coverage primary for people who continue to work past 65, rather than Medicare being primary. Fourth, is the issue of block grants and rationing which are involved in the changing expectations that surround the whole subject of health care for the poor, the Medicaid program. Fifth, is the question of whatever became of National Health Insurance?

MR. MELLMAN: Would someone now volunteer to discuss prospective reimbursement which is number one on our specific issue list?

MS. HELEN DARLING: Andy already talked quite a bit about prospective payment. Technically that's a misnomer. We really mean prospective determination of prices or revenues.

Several weeks ago the Secretary of the Department of Health and Human Services, in response to a Congressional mandate that he develop a new prospective payment system, outlined what will be his submission first to the Office of Management and Budget and then to the U.S. Congress in January. I mention this because while it sounds dull and bureaucratic, it is important, since it is the Office of Management and Budget that is responsible for finding this year's six billion dollar's worth of cuts. So even if the head of the Department of Health and Human Services says hospitals are to be reimbursed in a certain way, if that doesn't help come up with enough cuts, you can be assured they will mess around with that proposal before it goes to the Congress. Also we will talk about this later in relation to the role of actuaries. But it's important I think to understand some of these steps because, if in fact you want to intervene at any point, formally, informally, in any way, by knowing the steps you know the points at which you can in fact intervene and what the opportunities are.

At the moment there are plenty of opportunities. The prospective payment system which the Secretary is proposing will be based on cases, not patient days, and will be based on a complicated system called Diagnosis Related Groups which was developed at Yale University for completely different purposes than rate setting, I might add. That system is trying to capture the notion of diagnosis related groups and the way resources are used. For example, a certain specific amount may be paid for an appendectomy, no matter what. If you can get that patient in and out of that hospital in a few days, and it is uncomplicated and all of that, you're going to make money. If you are stuck with that patient for many days and all sorts of things go wrong you still get the specified amount, and you are going to lose money.

So the whole purpose of the new system is again to put the hospital at risk for getting the patient in and out. That probably is the most important difference. In addition, there will be probably some incentive payments for hospitals that come in way under target. They will get to keep a little more. Penalties will apply to hospitals who go way over. They will have exceptions probably for certain cases. They do now for Psychiatric care and general public hospitals that serve a lot of indigent patients. So this is the system that in theory could affect the hospitals of America.

The last major change in reimbursement principle I am sure you all know was in 1965. This new one could be one we live with for 15 to 20 years also. Unless things just fall in a heap which we sometimes suspect they might. So the next 12 months are very important.

MS. MARION EIN: I wanted to add that when a new proposal like this comes along we may get requests to do a program on it. Regarding prospective payments, certain concerns have been raised that we intend to address in coming programs. For example, some people are concerned that prospective payments, since they're directed at hospitals, will not really get at the physicians. More and more the central question is how do you change

physician practice behavior? What you see happening is that physicians are moving many of the more lucrative hospital services outside of the hospital, getting paid for them outside of the hospital. So how will prospective payment solve the overall health care costs problem as physicians "unbundle" services outside the hospital where the prospective payment structure won't apply.

Another concern is the DRG Creep problem that was raised in the New England Journal of Medicine. Will there now be an incentive, if you get paid by the case and you give a case a certain number for reimbursement purposes that instead of calling it a simple fracture you call it a complicated fracture and get higher reimbursement? The issue of DRG Creep, in New Jersey where the system is in its third year is apparently not a severe problem. But there is the issue of there being incentives to make cases more complicated in order to get higher reimbursement. Another concern is that there will be incentives for hospitals to prefer some patients over others. For example, hospitals may want the patient who has a clear cut case, not one that will linger where they may lose money instead of coming out ahead. So there is this problem of how will hospitals market under DRG type of reimbursement. Will they refuse to treat certain patients and market only for a certain part of the market?

MR. WEBBER: The critical issue for us is whether the business community can support a Medicare only prospective payment system. Given again the aggravation of cost shifting that that implies on the private sector. We are concerned about locking into a Medicare-only system. Also we are concerned that down the road that many states forestall coming in and asking for waivers to go to all-party systems. Especially when initially at least, a statewide all-party prospective payment system often incurs added costs for the government payors. So we're concerned about a Medicare-only system. If prospective payment is good, why isn't it good for everyone? It's going to be a topic embroiled in a lot of political controversy. The Federation of American Hospitals and American Hospital Association are for prospective payment for Medicare-only. But if you ask whether they're for prospective payment for all parties, they give you a different answer.

In terms of DRG specifically I think DRG's are a good system. I think they inherently start to control ancillaries and lengths of stay. I think the critical thing that you have to look at in the DRG system is the incentive toward increased admissions. The economic incentives for hospitals in DRG are to get a lot of people in and out of the hospital quickly. So I would like to see any kind of DRG system married to a utilization review program that has as its essence a pre-admission certification program, at least for surgical procedures. So in any kind of DRG system let's make sure we look at admissions very closely because that's the part of the system that you don't control by the DRG.

Marion mentioned the DRG Creep problem, and again data looms as a critical issue there. Purchasers need hospital discharge abstracts. We need the final diagnostic clinical information if we are really going to understand and know what actually happens in the hospital. That is another issue embroiled in a lot of controversy.

MR. MELLMAN: It is very difficult for a moderator who comes from New Jersey to sit and remain quiet on the New Jersey DRG program. It is an important

and controversial subject. I urge you to learn about it and to read the material being put out by both the advocates and the critics.

Now let's move on to the next topic. How about the one involving the income tax treatment for the individual of health insurance? Would one of the panelists describe the change and what you think the importance of it is to this group?

MS. DARLING: As many of you know, that same tax act, with its wonderful euphemism, "tax equity and fiscal responsibility" for a $150 billion dollar deficit, did change the individual medical deductions which for many people will make an enormous difference. As you perhaps know, they have changed the percentage beyond which you must have out-of-pocket medical expenditures to claim them on the income tax form from 3% to 5%. It may be important to know that the 5% itself was a compromise. That one leading Senator proposed 10%, there was considerable debate about 7%, and they ended up with 5%. I don't know whether that gives you any hint what might happen next year. I do know that the debate mainly was that if you get too high, you don't make any money anyway. This is true because almost nobody has that many expenditures and if they do they are essentially broke. So they might even be eligible for some kind of public assistance or charity care. So you don't get very much tax revenue out of a very high rate. We sort of cynically reasoned: why make it high, lose the votes and get everybody mad at you when you will only pick up another few million in tax revenue. Of course the other change is the elimination of the $150 deduction for health insurance which is a separate line item on the form. I think that's a good example of something where the debate really was "how can we make a little more money?" Somebody said "what will we gain if we make these changes?" They said, "you'll mainly hit the people who are in the middle income bracket and will get X amount more dollars." Nobody really cared that much. I mean there wasn't a great outburst of frustration. They did beat back the 10% and 7% on the argument that was over-penalizing people. Most everybody, however, thought the 5% was reasonable. There wasn't a whole lot of argument.

MR. MELLMAN: Let's move us to another item that perhaps will arouse more discussion. Namely, the question of group insurance primacy rather than Medicare insurance primacy for people who continue to work past 65. Andy, would you start off on this one?

MR. WEBBER: This summer Congress passed in the Reconciliation Bill a law saying that elderly people from 65 to 69 who are in the work force will have the choice between Medicare as primary payer or the company private health insurance plan. I think it was interesting to note that while it's a voluntary program, the clear reason why the Senate Finance Committee led the effort to do this was simply to shift costs on to the private sector. That is the essence of this change. We are talking not about indirect cost shifting where hospitals just up charges, that hidden tax if you will, we are talking about explicit direct cost shifts on to the private sector. That is the essence of the Bill. They are right now mired in trying to write the regulations for this program, and given that it's a voluntary program, it makes it all the more complex. I just talked to folks at HCFA and EEOC and they have got the race discrimination folks involved in this one, and they are just in a panic about what to do with this new change in the law. My members are screaming down my back because they're in negotiations right now. They know the law has passed, but they don't understand how it's going to

work. How are they going to coordinate Medicare and the private plan? Will there be any coordination at all? It's also a scenario where I think we will get the regulation the day before it goes into effect.

MS. DARLING: I would like to just add one thing because it illustrates what Andy was saying. Something that seems to have been happening in the past two years that I think will get worse in the next two. It is pretty insidious. Which is, that any time there is a choice between something that is politically difficult that everybody would agree to informally, even if it would make more money or would be more reasonable, nothing will be agreed to. What will happen instead are all these tiny little changes that chip away, and it will be the private sector that will pay. What's bad about this unconscious process is that by taking away from this group or that group in very small ways through a deductible or co-insurance, you essentially dissipate the opposition. Now for instance everybody is talking about this prospective rate setting program, but nobody mentions that in fact the way it is being set up will effect the largest cost shift that the private sector has ever experienced. In a way it's brilliant, if you want to shift massively and quickly huge amounts of cost to the private sector. So it's that sort of thing that's happening, but it's happening in a lot of different ways. So it makes it much harder to see it and much harder to fight it in a unified way.

MS. EIN: Let me just add two brief thoughts to give you the scope of this cost shifting. First, people over 65 consume four times as much health care as people under 65, so that you can see the added burden on the private employer. Second, and this is more of a question than a statement because I don't really know the answer, what will happen, for example, to smaller groups who self-insure when they have even one person in the firm who needs dialysis and what will that do to the group rating and the cost of premiums? I think there may be some real implications of the changes in these policies.

MR. MELLMAN: I would like to add a couple of points. Helen, I think makes an excellent point when she talks about chipping away. This is what Walter McClure refers to as the "omnibus all purpose tinkering approach" rather than a "reform approach." That's a good phrase.

Secondly, on this question of regulations, I believe it was Andy who said we may wait for clarifying regulations until the day before the change becomes effective. I submit that we may wait a good deal longer than that because my impression is that we're still waiting for the regulations on the Renal Dialysis change which became effective in October 1981. So it may be a long wait until we get clear instructions as to whom this change applies to and how. My impression though is that we're talking about group insurance only not individual policy coverage. Also we're talking about workers age 65 to 69 and dependents age 65 to 69.*

(* correction of what was actually said)

MS. ANNA MARIA RAPPAPORT: Would anyone care to venture a guess as to what kind of choices employers might offer employees 65 to 69?

MS. DARLING: Employers are required to offer exactly what they offer younger employees.

MR. WEBBER: So the choice is just between accepting Medicare as primary or the private health insurance plan that they provide everyone else.

MR. MELLMAN: I think they are talking about employee contribution rates. For example, if the employer plan is non-contributory and Medicare requires a contribution for Part B, the person may elect to go with the employer plan. On the other hand, if the employer plan has an employee contribution of $50 a month, the employee may elect not to enroll and go with Medicare for $11 contribution.

MR. WEBBER: If you want my cynical view, I think the rules on this will be so biased towards the private plan, that in essence it's not a voluntary choice program at all. I hear for instance, that if you select Medicare as primary payer, the private coverage will not be permitted to fill-in for instance on the Part B deductible. Even though the supplemental plans and the carve-out policies that companies now have often do that. Again the intent of this Bill was to shift costs directly on to the private sector. They are going to come up with ways to make sure that happens.

UNIDENTIFIED MAN FROM THE AUDIENCE: Isn't there another complication? That this does not apply to small employers?

MR. WEBBER: That is correct. It does not apply to employers with 20 employees or less.

UNIDENTIFIED MAN FROM THE AUDIENCE: I believe there's also some confusion in the way the law is written whether it applies to employers of 20 or less or to the age discrimination part of the law, where they have to provide equal benefits. We've called people at HCFA and at HIAA and there doesn't seem to be a real clear reading on this question yet.

MS. RAPPAPORT: If it's your suspicion that there isn't likely to be any real choice, then are you recommending to your members that they go ahead and do anything or are they all sitting tight until 12/31 and are they going to do something on 12/31?

MR. WEBBER: I don't know what they're doing. They're just screaming down my back. I think they're going to hold tight until the final regulations come out. Although I'm telling them informally that I think the regulations when written will have this bias and they had better be prepared for it. But there's no way I can tell them right now what's going to happen because the key decisions still have not been made within the agencies. The other key question is, for instance, if you're already in a union contract agreement, whether you have to go back into that contract to make the changes or whether you can wait for the next contract to be up and then make the changes. You know those sorts of issues are still not worked out. All I am getting is guesses but there have been no final decisions made within the agencies yet on it. So I think to answer your question, employers are going to wait to see what happens before they respond.

MS. DARLING: I would be surprised if some people don't feel that it makes a lot of sense to influence the rule making process itself. In many instances, that happens routinely. In instances where there is very strong feeling, it is not without precedent that regulations have totally eviscerated a law by the way they are written. Then two years later they may have to go back

before the Congress who rants and raves at them, but basically they manage to either slow something down or change it enough so that it is in fact not a lot of trouble. This is very important, since there was a piece not long ago in the Washington Post describing the notice of proposed rule making. If you know something is being developed whether they published it or not, and they keep saying to you "well we haven't proposed the rules" don't accept this. Tell them if you're going to do it the last minute like you did it last time, we want to get our comments in now. This is an Administration which is in fact very much influenced by the business community, particularly local groups, and particularly in an election year. So if anybody has strong feelings about it, whether as an individual or as a group, it makes a lot of sense to act now.

MR. WEBBER: That's a good point. We at the business group are setting up meetings of our benefit managers with both EEOC and HCFA. We intend to talk to them about the issues that are implied by the changes.

MS. RAPPAPORT: I have two more questions I'd like to ask. Our opinion as consultants is that employers will not have to pay Medicare Part B premiums anymore. Can anybody confirm that? Do the carriers know at all what they are going to do yet, or are they also waiting?

MR. WEBBER: I can't confirm that. That's a rumor I hear. I don't know what insurers are going to do.

MR. MELLMAN: Part B premiums are purely voluntary at the present time. Are they not?

MS. RAPPAPORT: But suppose there's a bargaining agreement that provides that the employer will pick up the Part B premium?

MR. WEBBER: Yes, the rumor is that if the employee selected Medicare, employers will be prohibited from filling in the Part B premium costs.

MR. RICHARD SIEBEN: If the law clearly says the individual has the right to elect his private coverage to be primary. That's one thing. However, I've heard carriers express the opinion that like the situation with renal dialysis, if the interpretation is essentially that the same benefit program has to be offered that exists for workers under age 65, then we have a problem. If that plan is so written to prohibit being primary in the instance where there is a Governmental program, carriers felt they were off the hook and employers also did because the plan had a prohibition against renal dialysis. The contract is written is such a way as make Medicare primary in this instance. Is there any hope this this loophole can be closed?

MR. MELLMAN: I don't believe we can answer that question. We seem to have uncovered an important area here that needs a lot of work. It's something we can get at through the Society, or the HIAA or Blues, or the Business Group on Health or Chamber of Commerce. There are many groups that will have the chance to study, to explore this and to lobby on it.

MS. DARLING: May I just make one addition to that comment. I heard not too long ago someone sort of chuckling and saying "if there are any loop holes left, old or new, created by the last Act, the first thing we are going to do

at the beginning of 1983 is close them." First of all, I don't think that is going to happen. The Federal law itself will force those changes and it won't be the first time the federal government has done something that's made everybody run around and change all the contracts and everything else. However, even if that were true, if some good lawyers, and of course Washington has a lot of ex-Congressmen and Senators who are good lawyers, decide to take that one to court, I think Congress will just clean it up. Congress will tack it on as an amendment to some bill that goes through very early in the year and just straighten it out. I mean they're not going to let such loopholes exist.

MR. CHRISTOPHER GEORGE: Will this new bill cause hospitals to receive better reimbursement for employees ages 65 to 69 because a private plan is primary? Will the private plan have to reimburse the full charges as opposed to what Medicare would otherwise pay?

MR. MELLMAN: My impression is that the private plan will be subject to whatever reimbursement the private plan is normally subject to. That is, it will not pay at Medicare rates. So depending on whether the primary plan is Blue Cross or insurance company or self-insured, that will determine whether it's cost- reimbursed or charges.

MS. DARLING: It's an interesting question. My sense is that there is some bad debt and charity care generated in the Medicare program. I would suspect this since Medicare doesn't do much about catastrophic illness and doesn't cover a lot of things. I would suspect that by having this very small percentage of working elderly who become ill, the hospitals would lose less on bad debts and charity care, however you want to classify it.

MR. MELLMAN: I couldn't disagree more. There can be a tremendous difference amounting to several hundred dollars per day per patient between what Medicare pays and what the Prudential Insurance Company, for example, pays in a given hospital. If we are talking about someone age 65 to 69 who is working and that person has commercial insurance and goes to one hospital I'm aware of where the difference is extreme, the hospital can now start charging $700 a day instead of $400 a day for that patient. That's a major difference.

MS. DARLING: I was only talking about what happens to the hospital, if a patient walks out with an unpaid balance. If a normal Medicare patient goes out and owes the hospital $2,000 and that patient has no other insurance, that would be a bad debt or a charity care case for the hospital. Now with this new program in place there will be some small percentage of these cases where the employer plan will now be picking up the bill. I think we're saying the same thing.

MR. MELLMAN: OK.

MR. STAN OLDS: Mr. Webber you mentioned that your employers may just wait for the regulations. The insurance industry may feel, however, that they may be on the hook for those people because when that choice is made, it's going to be effective as of January 1. They may not wait. People may not wait and your employers may start getting bills for those people. That may cause even more problems.

MR. WEBBER: That is a good point. We are trying to get with the agency now so that our benefit directors can sit down with the agency people and have some influence on the final regulations. We're trying to influence the process as much as we can.

MR. WILLIAM HSIAO: I think I missed two key points here so I am seeking clarification from any panel members. First, on this group insurance primacy which has drawn major interest. If my calculations are correct, roughly only about ½% to 1% of American workers are people over age 65 who today are in a full-time status. Their medical care costs at age 65 to age 69 are roughly two times the average cost for the working population. So roughly then, even if all the costs are shifted to the private insurance world, the insurance costs may go up as much as 2%. Therefore I am not sure why that is such a horrendous problem that generates so much interest.

My second question concerns the assumption that under the prospective rate reimbursement from the Federal Government, the cost of hospital care is going to be shifted to the private insurance. I don't know much about the health care industry, but I do know a little about the steel and car industry. When the American automobile industry, which purchased roughly about a third to half of the rubber and glass, began to set very stringent purchase policies on what price they would pay for rubber and glass, what happened was that both the rubber and glass industries started to cut down in order to increase their efficiency. They really cut the price so they could meet the demands of the auto industry. It was not totally a cost shifting. It seems that here we are assuming that a hospital is a rigid animal and if the Government buyer, which pays roughly half of the hospital cost, is going to put a prospective rate reimbursement limit on, the hospital is still going to do business as usual and just shift that cost to private industry. I am puzzled as to why and what evidence do we have that that is going to be their behavior reaction.

MR. MELLMAN: On your first question Bill, I think I can agree with you. I was involved in HIAA's pricing of this change, and we agree that the pricing was pretty small potatoes in relation to national health expenditures of $287 billion. The figure was something like $600 or $700 million. However, it is an example of the camel's nose in the tent and that's what concerns people. I think the other thing that concerns the small employer with a disproportionate number of elderly people is that the burden may fall on him. It's not going to fall very heavily on a group of airline stewardesses, for example, but it may fall on some other group. Helen would like to answer your second question.

MS. DARLING: You actually did a terrific job of making Andy's point about the connection between prospective payment and competition in pricing. It would be true, what you said. Although I am a little bit nervous about anything that talks about the steel industry and the auto industry, I hope the hospital industry doesn't go the same way. For hospitals though, if the price set by Medicare was the price that everybody paid, or even allowing some minor discounts for group purchasing or something like that, that would be one thing. But what is different about hospitals, unlike the steel industry and the auto industry, is that the hospitals get reimbursed their costs or their charges by anybody who is not going to be under that system. They have total flexibility on how they set their charges. I am on a hospital board and I can tell you that when Medicare announced that we were

$7 over our Section 223 limit, we changed our charges to cover those costs. I am not saying that we weren't more cost conscious. We worried a lot. In fact, effecting change in institutions as large and complicated as hospitals are, where the doctors make most of the decisions, is in fact not easy. It is a lot easier to change by making minor modification in your charge structure. That's why most people who object to cost shifting argue for a payment system that affects all payers. Set a price, and let everybody live with it within some reasonable amount.

MR. MORT HESS: I have two questions. First, I wonder if anyone has heard what happens to the spouses of employees over age 65 who have also earned Medicare independently of coverage through their spouse. Secondly, if I want to write to anyone, who are all these people writing regulations now that we might ask questions of or make comments to? Is there a list of officers or individuals available for us to write to?

MR. MELLMAN: My impression is that if a spouse has earned Medicare credits for herself or himself and is 65 to 69, and is also eligible as a dependent of an active worker age 65 to 69, that depending upon the way that active worker exercised his or her choice in enrolling, the employer's group insurance plan may well become primary. The whole point is to relieve Medicare of the financial liability of paying benefits to that person while there is an employer plan that can pay the claims instead. As to whom does one write, a good place to start would be Secretary Schweiker, with carbons to your Senators from New York State, for example.

MR. WEBBER: What I have been hearing is that if the spouse is Medicare eligible and the employee selects a private plan, the private plan would cover the spouse even if the spouse were Medicare-eligible. I think that will be how it comes out.

MR. MELLMAN: I think the first part is clearly true, because all of these people are Medicare-eligible, aren't they?

MR. WEBBER: The question was whether the spouse would be covered, if the spouse was Medicare-eligible, whether they would automatically take Medicare because they are not working or whether they would come under the private plan. It's one of the questions being debated.

MR. MELLMAN: I think the answer to the question of whether the private plan could be primary for the spouse is "yes."

MR. WEBBER: I agree.

MS. EIN: If I could just go back to a previous question: the issue of why we continue to let this cost shifting happen? Why aren't we more effective in controlling it? One of the criticisms that is thrown at insurers is that they haven't effectively or do not want to effectively negotiate with hospitals to lower costs. Much as they would like to charge lower premiums, they don't want to alienate physicians and hospitals in order to be competitive. Therefore they are partly to blame for not exerting more clout in order to deal with this problem more effectively.

MR. WEBBER: I would like to supplement that also. I think you are absolutely right. I think that cost shifting is a blessing in disguise

because it has finally gotten not the insurer's attention, but the attention of the real purchasers of care, their clients, the employers. There is no question that historically employers have had their heads in the sand and have written blank checks. They have completely abdicated their responsibility in this market. I think increasingly you will see direct negotiations between purchaser and provider. This has implications for insurers. I think insurance is increasingly not going to be part of the market place. Already the major purchasers are self-funding or self-insuring and many of them have gone to self-administration as well. They have thrown the insurers out completely. I think in the future you will start to see more of a direct buyer-seller relationship, with third party payment, the insurer, being out of the system all together. Again the critical issue is volume. Since providers will be more concerned with volume in a more competitive market place, I think they will not be averse to directly negotiating.

MR. MELLMAN: If all the big employers negotiate preferred deals for themselves, then the cost shifts will fall on the small employers and the individuals. Correct?

MR. WEBBER: That is correct.

UNIDENTIFIED MAN FROM AUDIENCE: My question is to Mr. Webber on this very point. It seems to me that an objective of the Blue Shield plans for the last number of decades had been to do just that: to make contracts with providers and get cost concessions, yet somehow this system seems to be breaking down. It seems to me that the Blue Shield market share is eroding. What do you see in the current environment to make your theory work any better than the Blue Shield plans have been trying to do for the last half century?

MR. WEBBER: I think that, number one, we are paying the bill. So I think the incentive for us is much greater than for Blue Cross plan. Blue Cross is an intermediary and let's face it, historically was created by the provider community. We are the direct purchasers and I think the incentives are there for us to get involved and to negotiate price. We're concerned with cost shifting and that's why we are shifting our approaches within the private sector. If we can cut our own deals, the cost implications for the smaller businesses are real. One of the reasons we are looking so closely at statewide all party prospective payment systems where you set a rate for everyone, small employer, big employer, the Blues, commercial carriers, everyone under one system is because we're footing the bill. We have more of an incentive to do it. I think it is the group purchasers that are forcing insurers right now to collect better data. I mentioned that earlier. The historical job for insurers has been to facilitate payment, to pay bills. Increasingly the insurer who is going to win in the market place and this is going to be true for the Blues as well as the HIAA, is the one who can evolve a system not only of paying bills but one that can track, monitor utilization, price, and quality, and be more discriminating about passing the payments along. Those are the insurers in the future that I think that are going to win out and still maintain their contracts with individual purchasers.

MS. EIN: Andy, let me also add a comment concerning making that data available. I think one of the issues creating impetus for self-insurance is

that the insurers do not make that data available, and companies would like that data because that's the only way they can act to contain their costs.

MR. MELLMAN: This question is also controversial. I refer you to the last issue of Modern Health Care which indicates that Maryland hospitals are upset at the comparisons that are being made there as a result of the use of such data.

MR. DON PETERSON: Knowing the way the bureaucracy operates, do you realistically think on January 1 the Medicare payors can actually implement whatever the regulation writers come up with? I just cannot envision that when a claim hits someone's desk January 1, the Medicare payors will try to avoid payment by asking "are you employed, does your employer have more or less than 20 employees, have you opted out, etc." Do you think there may be some sort of compromise to phase it in so that it can actually happen efficiently?

MR. WEBBER: We have already asked the question. I think there is going to be an extended grace period for companies to comply with the law. I don't think there is any other way around that one.

MR. MELLMAN: Now let's take the rest of our agenda, combine it all, and throw it all open. We have two remaining specific issues: number one, the question of block grants, rationing, two class medicine with the second lower class for perhaps the elderly and the poor and, number two, whatever became of NHI? Then the two remaining broad issues, first, "what is the role of the actuary with respect to relating to the Federal Government? Finally comes the question of political science philosophy. So panel, the floor is yours.

MS. EIN: I think when you talk about rationing and a two tier system, that these are more and more going to become a reality. You already see states eliminating freedom of choice in order to save dollars. There is the question about the limits of the medical care system to treat everything and anything and at all costs, even when the case is hopeless. I think that is a very important policy issue that is going to have to be addressed. It is interesting that in all this discussion about competition and regulation we haven't mentioned the long term care dilemma which I think is a very crucial issue. That is where the big dollars are going. Since 1971 costs for hospital expenditures have increased 400%, for physicians services, 350% and for nursing home services, 450%. Long term care is an issue that somehow no one is able to get a handle on.

MR. WEBBER: I would like to tackle the issue of NHI. I don't think it's a dead issue, since I see in the future the Government controls coming more at the State level instead of at the National level. You can also write a scenario and say if the Democrats, for example, either Ted Kennedy or Walter Mondale, get elected in two more years more could be heard on NHI given the price escalation. There is much attention on this issue since health care is booming again at rates that we haven't seen since World War II. So you can write a scenario that when the Democrats come in, they'll say, "Well, you didn't like Carter Caps and we tried competition and competition didn't work. Then you talked about all those private sector coalitions around the country, but we haven't seen any evidence that private sector coalitions are saving community dollars and there won't be any evidence in the near term that

private sector coalition will save money in local communities. So we need greater cost controls."

And indeed that's what we are looking at now. We're looking at prospective payment systems. Health planning has not been phased out so I think states will maintain capacity controls. We're looking at all-payer statewide prospective payment systems and also at greater utilization review programs. The Durenburger Bill was passed this summer. It creates a new utilization review program with a lot of focus on the private sector. You have elements of reimbursement controls, utilization controls, and capacity controls that are still with us, and are being talked about more, even with a conservative Administration that espouses greater competition. Therefore, I don't think National Health Insurance is dead. While it's certainly dead for this Administration, I think we will have many NHIs, if you will, at the state level, increasingly in the future.

MS. DARLING: Those of you who have been around for a while are probably beginning to feel very cynical about the fads. There was a time 15 years ago when multi-phased screening was going to solve everybody's problem. Then came disease prevention, health promotion, the Voluntary Effort, and new coalitions. Stick to your cynicism, since those things do come and go. In fact, we often find repeatedly new fads do come and go. It may take one year or it may take ten years. But the fact of the matter is that there is a lot of solidity in the nation and change should occur more slowly at the top of the ocean rather than the bottom of the ocean.

Washington is particularly bad about this in case you haven't noticed. Washington tends to take up ideas that oversimplify. It takes a nation of 230 million people with literally 50 Governors, 50 State Capitals, with vast differences for example between a Texas, a New York or a Massachusetts, and it tries to make policy, which if we are lucky makes sense for half the nation. Most of the time it only makes sense for a small part of the nation.

I think that one of the real strengths of this country is it is a democracy. It is possible for the most ordinary citizen to influence policy. You can do it by writing directly, and sometimes totally by accident, because you're the only person who wrote a letter on a particular arcane rule or regulation, your opinion will influence the policy making process. I was at HEW for three years during the health planning guidelines development and I can assure you almost everything that came in was read carefully and did influence where it wasn't a hot political issue, but was a technical regulation detail. Also, often the people writing the regulations don't know very much about the subject. Many times, believe it or not, they may never tell you this, but the writers are eternally grateful for someone pointing out something that they never thought of. This tends to be vastly underestimated in its importance.

I think it is particularly important for people to understand the technical details. There are not many actuaries in Washington D.C. who are working in the Government on these matters. So, in fact, you actuaries know an lot that Washington doesn't know. This is particularly true on a technical level where there is a lot of good that can take place. On the policy level you can intervene in the process in many different ways. Not the least of which is always starting at the top and because now we have that cynical world of PACs and all sorts of ways to help get people elected that you believe will

represent the points of view of the policies that you want to do. All of that really does work.

MR. MELLMAN: What a beautiful wrap-up summary, Helen. I doubt that anyone would have the temerity to ask a question after that. On that note please join me in giving a hand to the panel. Thank you very much.