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FUTURE OF GOVERNMENT PROGRAMS

Moderator: GORDON R. TRAPNELL
Panelists: MARK FREELAND*
Panelists: STANLEY B. JONES**
RANDY TEACH***
Recorder: GORDON R. TRAPNELL

- Future of prospective payment in Medicare
- Sequels to the Omnibus Budget Reconciliation Act
- Deficit Reduction Act
- COBRA: What is Congress considering now?
- Fallout from the administration's Catastrophic Illness Study
- Evolution of the voucher proposal: employer demonstration

MR. GORDON R. TRAPNELL: The first speaker is Dr. Mark Freeland, who is the Chief Economist of the Office of the Actuary of the Health Care Financing Administration (HCFA). His current areas of responsibility include projecting national health expenditures in future years, revising the Medicare economic indices that are used to set Medicare's prevailing physician fees, and determining cost components for nursing homes and hospitals. He is also involved in developing and refining the framework and methodology used to revise the DRGs (the Diagnostic Related Group amounts paid to hospitals under Medicare).

* Dr. Freeland, not a member of the Society, is Chief Economist of the Office of the Actuary of the Health Care Financing Administration in Baltimore, Maryland.

** Mr. Jones, not a member of the Society, is President of Consolidated Consulting Group in Washington, D.C.

*** Mr. Teach, not a member of the Society, is the Deputy Assistant Secretary for Health Policy at the Department of Health and Human Services in Washington, D.C.

I have asked Dr. Freeland to describe the framework that they follow in revising the DRG amounts from year to year. Of all the changes in how health care is financed in the United States that have taken place in the last decade, none has had more dollar impact than the change by Medicare from reimbursing hospitals for their cost of providing care to basing payment on DRGs. Within a few years, the system of payment was totally revolutionized. Right from the beginning in 1965, cost reimbursement was regarded as kind of a temporary system to be used until a better system could be devised that paid according to what hospitals needed. It took 17 years and tremendous cost pressures to bring about this change. But no change since the beginning of Medicare is more revolutionary as far as the dollar impact. Hospitals get something over 35% of their revenues from Medicare, and for many it is over half. As the DRG system spreads to state Medicaid programs, the proportion of hospital revenues affected is close to 50%. Many private payors also are using DRG systems or DRG-like systems, both in paying hospitals and also increasingly in making case mix adjustments when they study and analyze claims to determine how efficient and effective hospitals are.

Each year the Secretary of Health and Human Services has to promulgate a new set of DRG amounts. They are basically adjusted for three different types of factors. First, there is a recalibration: how much is paid for one DRG relative to others. As the practice of medicine changes, relative DRG amounts should also change to reflect the resources used. Recalibration should have a negligible impact on the total amount being paid to hospitals.

Second, the overall level of the DRGs should be rebased; i.e., reset the DRG amounts to where they should have been when it started. This allows for DRG "creep" as hospitals take advantage of the opportunities to assign the highest paid DRG to every case where there is a choice.

Third, adjustments are needed from year to year to allow for the change in the cost for hospitals to provide these services. It is this area that I have asked Dr. Freeland to emphasize. I think the type of analysis they have developed constitutes a new tool that is available to analyze health care costs.

DR. MARK FREELAND: The legislation that enacted the Medicare Prospective Payment System (PPS) for Hospital Inpatient Services transformed the payment

system from a cost-based system to a fixed price per case, one in which the prices are adjusted for the diagnosis related group or DRGs. There are about 470 different prices that Medicare pays for hospital inpatient services.

The framework that I'll be discussing deals with the average rate of increase for these 470 DRGs. It does not deal with changes in the relative prices of these 470 DRGs. That is a different process which is called recalibration.

The conceptual framework does not provide precise point estimates for this update factor, but rather, provides a framework to integrate quantitative and qualitative information with judgment. I might note that the Office of the Actuary is continually trying to improve the framework that is used to update the PPS rates and so we solicit any suggestions you have on improving it.

Congress specified that the average price increase per case should take into account five factors. These five factors are the hospital input price index, hospital productivity, technological and scientific advances, long-term cost effectiveness, and the quality of health care. The Office of the Actuary of the Federal Health Care Financing Administration was given responsibility for developing a framework to quantify, and, in a sense, to justify, the rate of increase in the payment per case.

The staff of the Office of the Actuary translated the intent of Congress into a very simple Accounting Identity (Figure 1) [1].

FIGURE 1

Accounting identity

A	*B*	*C*	*D*
$\frac{\text{Cost}}{\text{Number of discharges}} \equiv$	$\left(\frac{\text{Cost}}{\text{Real input}}\right)$	$\left(\frac{\text{Real input}}{\text{Real output}}\right)$	$\left(\frac{\text{Real output}}{\text{Number of discharges}}\right)$
It can also be described as:			
Average cost per discharge $\equiv$	Average cost per unit of input	Average relationship between inputs and outputs; that is, the inverse of productivity	Average real output per discharge

[1] "A framework for analyzing prospective payment system ratio-increase factors," by Ross H. Arnett III, Carolyn Cocotas, Mark Freeland, and George Kowalczyk, reprinted in *Health Care Financing Review*, Summer 1985, Vol. 6, No. 4, pp. 136.

The average cost per unit of input, that is Term B, is the Office of the Actuary's hospital input price index, also known as the Hospital Market Basket. It is a weighted average of the prices of input used to produce a constant quantity and quality of care. It is the analogue of the consumer price index for household purchases. The input price index is used to adjust for inflation in the price of goods and services used to produce hospital care. It includes things like hospital wages, fringe benefits, and prices of food, energy, supplies, etc. So this is the first variable that Congress specified that we must take into account in the year-to-year percent increase in the average cost per hospital admission.

The second thing Congress specified that we take into account is Term C, which is productivity or efficiency. Engineers and Congress have defined productivity as real output over real input. You will notice that in the accounting identity, it is turned into input over output and that is because productivity in this updating system is an offset factor. That is, when productivity is increased, you can produce the same output with less input; therefore, unit costs decline and so there is a rationale that when productivity goes up, the price of hospital care ought to come down.

The Office of the Actuary interpreted the intent of Congress to divide outputs into two categories: cost effective outputs and cost ineffective outputs. Consequently, Term D of the Accounting Identity was partitioned into two categories: D-1 Cost Effective Outputs and D2-Cost Ineffective Outputs. The Cost Effective Outputs are associated with new technologies and scientific advances. That is, the intent of Congress seemed to be, to the extent that there are new scientific discoveries and technologies available, these should be encouraged and should go on. So, we have technological progress in the health care industry. This should add to the cost to provide health enhancements where the value you are getting is in excess of the cost.

The cost ineffective outputs include two components. One type of cost ineffective output is when services or outputs are provided in a hospital inpatient setting when they would be more cost effective if they were provided in a lower cost setting, such as ambulatory care. Some type of services that were formerly provided inpatient could be provided in a less costly setting such as ambulatory surgery, maybe in a skilled nursing facility or through a home health agency. That is one component of ways you can reduce costs. An additional one is some

types of services do not have value for the money expended, that is, there are benefits in terms of enhanced health status that are not commensurate with their costs. An example of that would be laboratory tests which have little or no impact on the health status of the patient. As a matter of fact, one of the things that we observed after the prospective payment system came in was the reduction in ancillary service tests that apparently had little to do with changes in health status. So, in more simplified terms what we're talking about in the update factor for the average cost per case is an addition for the input price index, that is, for the prices the hospitals pay for a fixed quantity and quality care, price of food, energy, wages, etc. We have a subtraction factor for productivity because if you can produce more outputs with the same inputs or you can produce the same outputs with less inputs, the price should go down in a competitive type market. One way to view the update factor is that the hospital market is an imperfect market. Prospective payment is trying to stimulate the type of outcome that you would get if you had a more or less competitive market situation; i.e., pressure to reduce costs and increase productivity. So we have an add on for new sciences and technological items, and we have offsets for productivity and reductions in ineffective practice patterns.

These four factors of the Accounting Identity, that is, input prices, productivity, new science and technology, and ineffective outputs, include four of the five factors that Congress specified that we take into account. The fifth factor, quality of care, was deemed inappropriate for an accounting relationship. We considered several ways to look at the quality of care. One way is to look at outcomes; i.e., things like death rates, and morbidity rates. Another way is to look at the structure of quality, i.e., the process and the quality of inputs. That dimension of quality, in fact, is caught up in the factors that were mentioned before. That is, if you have adequate input prices that allows you to provide the quality of care. Similarly, offering the new science and technology improves quality from a structural point of view, but not from the outcome point of view. So, we think our formulation takes quality into account, both from a structure and from an outcome point of view.

Some other outcome variables that we considered in determining the update factor include access to care, payment adequacy and the Medicare Part A trust fund liability.

I would now like to turn to Figure 2[2]. It is called "Use of the Framework for the Fiscal Year 1986 DRG Percent Increase."

On the left hand side, we have the factors for the market basket, productivity, technology, etc. Then we have the percent changes which the Office of the Actuary recommended for the fiscal 1986 update. Following is a brief rationale concerning how we came up with the percent increase for that particular component.

For the hospital market basket, a 4.85% increase was forecast. The Office of the Actuary uses the forecasts of a private consulting firm for components of the hospital input price index, Data Resources, Inc.

The other factors are called policy target adjustment factors. There are two reasons for the designation "policy." One is that we think that it is very difficult, and, in some cases, perhaps impossible, to quantify these components individually in such a way that different people will uniformly agree on the precise number. I think Congress appropriately suggested that these concepts be taken into account because they are very important in determining what the update factor should be.

The second reason they are called policy target adjustment factors is that they are, at least in part, likely to reflect the targets rather than trends in historical experience. For example, let's take productivity. After 20 years of cost-based reimbursement with little, if any, incentive to increase productivity, it is likely that the historical experience would have shown negative productivity in the hospital industry. The more inputs you used, the more Medicare and private insurers would pay. So looking at historical trends on productivity would not necessarily provide the type of productivity behavior that we should expect under the prospective payment systems. So, after extended consideration, both by the Health Care Finance Administration and the Prospective Payment Assessment Commission, we decided that it was most appropriate to use a target rather than to look at historical indexes of productivity. It should also be noted that there are no available indexes of aggregate hospital productivity. There are at

[2]Ibid., p. 139.

FIGURE 2

Use of the framework for the fiscal year 1986 DRG rate percent change

Annual DRG increase factors	Percent change	Brief rationale
Hospital market basket	+4.85	This is the percent increase forecast for fiscal year 1986. It reflects a complete passthrough for hospital input price inflation. Because hospital industry wage rates are used in calculating the market basket, shifts in occupational mix and skill mix are automatically included in the market basket.
Policy target adjustment factors	- 1.5	
Productivity (efficiency) offset	- 1.0	Valid productivity indexes are not currently available for the aggregate hospital industry (Prospective Payment Assessment Commission, 1985b). Various Bureau of Labor Statistics economywide productivity indexes indicate productivity increases of approximately 3 percent annually for the last 2 historical years (1983 and 1984). However, long-term average rates of increase vary substantially depending on the time period covered, the industries included, and the type of productivity measure used—multifactor productivity or labor productivity (Prospective Payment Assessment Commission, 1985b). A 1.0 percent productivity offset is conservative. It allows for most of productivity gains to accrue to the hospital industry.
Cost-effective technologies add-on	+1.5	This is a target rate of increase that allows significant growth over time in cost-increasing, health-enhancing new technologies and scientific advances, as they affect operating expenses (Prospective Payment Assessment Commission, 1985a and b). This target rate of increase recognizes that long-run, historical intensity increases are not compatible with the viability of the Medicare Hospital Insurance Trust Fund. By increasing productivity and eliminating ineffective practice patterns at rates higher than shown here, hospitals free additional revenues. These revenues can be used to purchase additional technologies at a rate in excess of the 1.5-percent target rate of increase and/or to increase profit margins. Capital costs associated with new technologies continue to be reimbursed on a retrospective cost basis.
Ineffective practice patterns offset	- 2.0	Ineffective practice patterns include services that are more appropriately provided in lower cost settings or services that do not give value for money expended. The average length of stay for Medicare patients decreased 11.0 percent for hospitals in States with prospective payment in fiscal year 1984. Physicians reduced outputs associated with this decline in length of stay. Presumably, physicians deemed that such outputs would not give value for the money expended and/or could be provided more effectively in a lower cost setting. If marginal cost is assumed to be 40 percent of average cost, then costs would be reduced 4.4 percent. A 2.0-percent offset has been chosen. This allows for more than one-half of the fiscal year 1984 estimated savings to accrue to the hospital industry and does not take any additional amounts for potential gains in fiscal years 1985 and 1986.
Composite increase	+3.35	

least three groups that are working on hospital productivity indexes: The Prospective Payment Assessment Commission, The Health Care Finance Administration, and the Bureau of Labor Statistics. It is very difficult to measure. But as I said, even if we had such indices, it doesn't necessarily mean that that is what we would use in setting the update factor. We would want to set normative targets of what we think should be occurring, and also take into account all of the evidence of what's actually going on to see if our target is in the range of the reasonable.

The second policy target adjustment factor is cost effective technology add ons. I mentioned that the Congress wants to encourage technological progress in the hospital industry, for those types of outputs where health status has changed proportionately to costs. What we used at the beginning in 1986, the first year this was put into effect, was an add on factor of 1.5%. In some ways this may appear high, but in the historical period analyzed by the Office of the Actuary it was about 3%. Times have changed somewhat, but when you put it into historical perspective, 1.5% was viewed as being fairly restrictive. Again, this is a target. There is no one, to our knowledge, that has actually been able to disentangle what Congress wants to precisely get at with the cost of new technologies and scientific advances. As far as we can tell, technologies are interwoven with other labor and non-labor inputs, and it is almost impossible to identify the cost of new technologies and scientific advances separately. So again we are using a target that allows technological progressiveness but at a slower rate. The Office of the Actuary studies on trust fund viability clearly showed that the 3-4% increase in this factor in the first 15 years of Medicare clearly lead to financial problems in the Hospital Insurance Trust Fund. This is a key element in lowering the rate of increase in the Medicare outlays.

The third factor, the ineffective practice pattern offset, basically gets at ways to reduce costs for practice patterns that we consider to be inefficient. These are primarily services that should be provided outside of the hospital. For example, one of the indicators of ineffective practice patterns that we look at is length of stay. The first year of the prospective payment system, length of stay went down an incredible 11%. Now presuming this was done under the guidance of physicians, they feel they could reduce length of stay without hurting the quality of care and, from the statistics that we have available to us, we have every indication to believe that is true.

So, then the question becomes, how do you translate something that we can observe, that is length of stay, into cost? What we did is to look at the marginal cost of an additional day in the hospital and related that to the overall cost. The analysis was based on an assumed marginal cost for an additional day of 40%. (We also looked at 60% and 80%. We don't think there is any precise answer, so we look at a range.) Using this assumption, we estimated an offset of 2%, which took out only a fraction of the cost reductions that we believe are potentially available from the reduction in length of stay. Then, when we added these factors up, we came to a composite increase of 3.35%.

MR. TRAPNELL: Our next speaker is Randy Teach, who is the Deputy Assistant Secretary for Health Policy, the key advisor to the Secretary of the Department of Health and Human Services on health policy matters, including the Medicare and Medicaid programs, the Food and Drug Administration, the Centers for Disease Control, the National Institutes of Health, and many other aspects of health policy that are influenced by the Secretary of Health and Human Services. Mr. Teach's staff functions as the Secretary of HHS's private researcher on analytic care expenses, AIDS, tort reform, medical malpractice, vaccine compensation, the growing cost of medical care and finding ways to make health care more competitive.

Prior to joining the Department, Mr. Teach served as a health policy advisor in the White House, and, before coming to Washington, he served under Governor Reagan in California for a number of years in various positions. Mr. Teach is one of those delightfully unpredictable speakers who always has something interesting and informative to say. But I find it very difficult to predict, and one of the arts of being an actuary is not to predict when you don't have to, especially if you might be wrong: So I will wait as eagerly as the rest of you to hear what he has to tell us.

MR. RANDY I. TEACH: I will address the future of capitation, particularly how I see the government utilizing HMOs and competitive medical plans (CMPs). It's a subject that I think this administration certainly does need to explain simply because we've been pushing it for a very long time, beginning in California and now carrying that concept forward to Washington. I think it is important that we clarify first what we are doing and why we're doing it.

First, I don't think we're enamored of capitation per se. It really isn't the point at all. It's a means to an end, and the end is managed care. If HMOs and CMPs cannot manage care better than the fee-for-service system, we will have gained nothing at all.

The alternative is what business has been doing with respect to third party administrators: What many Medicaid programs have done and what we did in California with fiscal intermediaries is to put utilization controls in place and manage it directly. But there is an underlying reason why we would prefer not to do that. This is because we would prefer to try to maintain competitive markets rather than to rely on regulation. If you remember a couple of years ago, there was some consideration for carrier capitation, in which Medicare would turn over the management of the program to a fiscal intermediary. In theory, that's probably an interesting thing to do. We probably would have cut costs faster than we are now.

On the other hand, you've got a down side to the extent that you eliminate competition, and I think this was driven home in a study that was done by the Urban Institute with respect to the value of competition. And, the Institute did the study with a very interesting product, which is the end stage renal disease program, which is clearly a price regulated system.

So why should we care about competition? Well, the findings of this study are very interesting. The competitive structure of the market affected the services that were delivered. The more competitive the market, the higher the quality of service and the more services that were provided for the fixed price. The less competitive the market, the poorer the quality and the less services that were provided per unit price. So, not only is capitation important, the other element in it is equally important. That is why we develop competitive markets. In the long term, the beneficiary gains with respect to improved quality and improved services.

I want to lay out three separate issues that deal with my sense of where this market is going.

First, I want to describe what Medicare is projected to do. As you know, 10% of the population is now enrolled in over 500 HMOs, 150 of which are participating

in the Medicare program. It has been projected that 50% of the population will be enrolled in HMOs by 1995. I find that a gross overestimate, and I want to describe some of the reasons why.

We are in the final days of drafting a piece of legislation that will modify our current risk contracting program. To try to make the federal government a better business partner with HMOs and CMPs, the first thing we will propose is a three-year rate structure instead of a one-year structure. We will also allow HMOs and CMPs to modify their rates for supplemental coverage at mid-year if Congress takes action as they did a couple of years ago to reduce the Medicare rates.

The second thing we will do is to eliminate the ACR, or Adjusted Community Rates, in areas where there are three or more plans and for small HMOs and CMPs. We will also eliminate the provision that profits must be plowed back in terms of additional benefits to beneficiaries. But, we will also allow beneficiaries to share in profits up to $500 per year to the extent that the plan chooses to use that as a marketing mechanism. So, conceivably beneficiaries who use a low volume of services could be paid back by a plan for doing so.

And, finally, we would restructure the administration of the HMO/CMP program to look more like the FEHBP program, or the Federal Employees Health Benefits Program. We will have annual open enrollments, and we would control marketing material. We have to get serious growth in this program to be sure that we are protecting beneficiary access to care and beneficiary free choice of plans.

Aside from those changes, we will also attempt to move in to the employer market, particularly employers that are self-insured and have annuitants, and into Taft-Hartley trusts. The reason, of course, for our interest in this is that employers and labor unions are getting interested. They are getting interested because the cost of their annuitant health care is growing significantly faster than the growth of health care for their active employees. This creates a few problems with respect to labor negotiations. In addition, unlike their active employees, many of whom may be in some form of managed care, the annuitants are not. This legislation would extend the ability of the Health Care Finance Administration (HCFA) to contract directly with employers without the restrictions of the Adjusted Average Per Capita Cost (AAPCC). In other words, we

will simply negotiate the best deal that we can get with employers to go at risk for their annuitant population.

Now, why would employers want to do this? Well, one reason is that many employers are currently at risk for more services than the Medicare program is. For some employers, Medicare is covering about 45% of the cost, and the employers cover the other 55% of the cost. So, there is some economic reason.

Another initiative is to examine the AAPCC itself. I think that the present AAPCC was clearly the best that we had when the at-risk program began, and continues to be the best we know how to do. But, I think everybody now recognizes that it provides an imperfect measure of what HMOs would have cost Medicare. Major improvements have already been made. The HCFA actuaries with Guy King moved last summer to bring more of Prospective Payment System (PPS) (i.e.; DRG) based payments under the AAPCC rates, rather than using the historic pattern which reflects the cost reimbursement of hospitals. This has the interesting effect of evening out some of the disparities throughout the country in AAPCC rates. Consequently, as we move from cost based reimbursement to PPS, the AAPCC rates will become more equitable or, at least, reflect the real cost of an area better than the historic cost reimbursement did. I think modifying that payment mechanism is very important for the future integrity of the program.

Now, let's turn to Medicaid. The Office of Management and Budget, in their pass back to us, included some language that would encourage the Department of HHS to try to move towards capitation of the Medicaid program. The Health Care Financing Administration has been working aggressively on a proposal that would essentially go to a per beneficiary price. We would pay the states a certain amount per month for each type of beneficiary rather than our current system of simply sharing in whatever the state programs spend.

Now, whether all the details can be worked out satisfactorily and whether there will be legislation this year, I'm not sure. But, I have to emphasize that even if Medicaid pays the state on a per beneficiary basis, I'm not optimistic that the states are going to be able to pay providers on a capitation basis. And, the reason that I say that is, the demographics aren't very promising. The first thing that you have is that 20% of the Medicaid beneficiaries are over 65 or they

are disabled, and they are consuming 75% of the costs of the program. These are not good candidates for capitated types of programs.

The under-65 population is even more interesting. Half of the under-65 population is in the Medicaid program for less than a year, which means that you have an enormous turnover rate. Many of these are people in the program because of a family break-up. The other half of the program is for long-term beneficiaries who are on it for longer than three years. A substantial part of this population has social problems that extend far beyond the health problems -- drug addiction, alcoholism and a number of other problems -- that any capitated system is going to be very reluctant to take on.

So, I'm not terribly encouraged, and I speak from some experience, having tried this in California and having had it blow up in my face back in the early 1970s.

California tried another interesting approach recently, trying to contract for services for Medicaid. Although it's an intriguing idea, I think the evidence is fairly compelling now that it created some real access problems for some beneficiaries.

They subsequently had to rethink the approach. The reason that it provides access problems stems from the nature of the delivery system for the poor in this country which is really very different as a result of geography, not because we have a two-tier health care system. Trying to get Medicaid beneficiaries to change their behavior is a very difficult thing to do. We tried to do it very aggressively in Los Angeles County in 1972 when they reconfigured their health system. And, it is very difficult because you have a whole system of free care, such as public health clinics, public hospitals, and prenatal clinics, that are easily accessible within the geographic locations where low income people live. Trying to move them out of that into some suburban hospital is a fairly difficult thing to do. So I think that from the onset you can probably write off 15% to 20% of the low income population as being reasonable candidates for HMO enrollment. So now we're down to 80% to 85% of the population and trying to hit 50% out of that becomes much more difficult. That's the 1995 projection.

Now, I want to talk about a couple of other things that are impinging on the market as well. Consider the self-insured employer. If you look at the

California market, it has more HMO enrollment than any other place. You've got 25% or 6 million people in California enrolled in federally qualified HMOs, CMPs, and IPAs. Where do the rest have their health insurance? Most are covered through employer plans, of which 55% are in self-insured plans. Now there is absolutely no reason why these self-insured employers who are not now using HMOs and CMPs, but are managing care and controlling their costs are going to have their employees suddenly go out and join an HMO or CMP.

So, if one simply adds those two numbers together, 15%, let's go low end for Medicaid, and let's take 25% of employees who are in self-insured plans that aren't going to enroll in HMOs, that's 40% of the population right there. That means to hit the HMO mark, you've got to enroll nearly everybody else.

Now, is that possible? Probably unlikely because you've got some other factors.

One major factor is the PPOs, largely sponsored by Blue Cross/Blue Shield. These are primarily discount pricing arrangements that do not manage care. They have a significant, although dwindling, market share. That certainly is going to be an important factor.

Another major factor is the physician supply. Where you had growth you had concentration of physicians. Therefore, you can buy physicians at a fairly reasonable price. Well, that isn't true in all parts of the country. The number of physicians per 1,000 population is very uneven. Therefore, there are areas in which fee-for-service practice can be sustained because you simply don't have enough physicians in those areas to reasonably buy.

The third major factor is going to be peer review organizations (PROs). I have to admit that six years ago I did not believe that PROs were going to come back into existence or were going to have the power that they have. In fact, I used to tell a little joke about them: Do you know what a PRO, a PLO and and PPO have in common? All three are terrorist organizations.

But they are here, and I think they are part of the health care system for at least as far as I can see, and they are going to have an enormous effect on fee-for-service prices. The PROs are having several major impacts.

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1. We now have national screens for quality: things like unscheduled re-surgery, and any readmission after 30 days.

2. An approved discharge planning system is required. That means the PROs have to approve the discharge planning system of every hospital.

3. PRO review is extended out to all non-hospital providers: nursing homes, home health, HMOs, CMPs.

4. PROs may recommend denial of payments for substandard care, whatever that may be.

5. Carriers are required to implement prior authorization screens for the 10 leading admissions.

Now, the final issue is the types of competitive health plans, CMPs, including HMOs, that are causing the great growth rate. They are not the staff-model HMOs; they are the Individual Practice Association (IPA) models. In fact 70% of the new federally qualified HMOs are IPAs. The reason is that you can enhance your enrollment much more easily by capitating a physician who takes his patients with him into a plan, rather than hiring staff physicians and trying to recruit patients into your plan.

However, Congress, in the Omnibus Budget Reconciliation Act (OBRA), passed legislation that will have a very serious effect on the future growth rate of IPA models. The first thing they did, effective in April 1987, is to make it illegal for a hospital to make physician incentive payments in which the physician is in effect paid for reducing inpatient hospital services. No ifs, ands or buts. If the physician gets a payment from a hospital for reducing inpatient services, it's illegal.

The same provision will go into effect in April 1989 with respect to current HMOs and CMPs. The statute also provides that the Department of Health and Human Services can come back to Congress and can define those incentive payment arrangements which do not result in substandard care. The burden of proof is on us. In other words, the preemption goes into effect if we do nothing. We have to go back and seek statutory language to change it, and we have to prove

to Congress that there are IPA kinds of arrangements out there that will not result in substandard care.

One interesting arrangement that we're looking at and that we're investigating the legality of is an HMO arrangement with a hospital which then has an arrangement with a physician. Is that covered by the April 1989 statute, or is that covered by the April 1987 statute? We're not sure. But given the fact that all the growth rate is happening in IPAs, it certainly has to have some effect on future growth rates of HMOs and CMPs.

But, the more interesting issue is what is happening in these IPA arrangements in which physicians are capitated. It would seem to me on the face of it that it is a great opportunity to skim healthy patients into the system and to keep your sicker patients in a fee-for-service market. That may be true, and I don't know that it is except for hearsay from a number of physicians who think they have a great deal going here. It's the whole notion that if that's the way the system is going to work, that's the easy way to make money. But, in the long term, there is a finite number of patients which you're going to be able to do that with, and ultimately you've got to face the hard issue of managing care. This is what Bill Schwartz was talking about in terms of patients who have some serious problems and services that have to be managed. I think some of you reinsurers in the market with respect to these catastrophic cases are realizing that the only way you've have any future in this business is that you've got to begin to manage care.

Now, I don't believe that, given the current market, HMOs and CMPs are any better at managing care than some of your good group practices are. In fact, some of your big group practices are probably better at it. So, I think that while HMOs and CMPs can have some rapid growth early on by enrolling healthy beneficiaries, ultimately their growth rate is going to depend upon the extent that they can manage care of more complex conditions and I don't believe they are equipped now to do that.

So, I guess the bottom line is I am very confident that traditional insurance does not have much of a future. I agree with my friend Paul Elwood in that regard. Managed care in one form or another, whether it be through government programs directly, Medicaid, Medicare, or whether it be through self-insured

employers, is clearly what the future holds. I think how much of that managed care market HMOs and CMPs will have, however, is still an open question. But, I don't believe that they are going to approach a 50% share by 1995.

MR. TRAPNELL: First, the biggest issue on the Hill now is the Administration's proposal for a catastrophic cap on Medicare cost-sharing. In fact, this is probably the fastest track proposal that I've ever seen in the health care field because something is definitely going to happen, and my guess is that there will be legislation along the lines of the Administration's proposal developed by Secretary Bowen by September 1987 with an effective date like January 1, 1988, July 1, 1988, or, at the latest, January 1, 1989.

The biggest items in dispute are how high the catastrophic deductible would be and how it's going to be financed. There are some other peripheral issues that are being discussed; for example, whether to include some other services, especially prescription drugs and whether, if they are covered, they will be subject to an independent deductible, such as $200-$250.

Interestingly enough, although there is a lot of pressure, especially from the senior citizens groups, to include long-term care in a catastrophic proposal, all the smart money is betting that Congress won't touch it because of the cost. Even Congressmen realize that there is no way to balance the budget or to keep their favorite programs intact if they were to try to finance long-term care for the general population.

The main proposals are, of course, the Bowen proposal of the Administration, which really has two independent parts. The first is really a reform of Part A of Medicare that is completely independent of the catastrophic program. Instead of one inpatient deductible of $520 currently per spell of illness and the copayments beginning with the 61st day and increased for the lifetime reserve, there would be simply an inpatient deductible of $520 per admission, and a maximum of two such deductibles in any calendar year. The copayments would in effect be eliminated.

The catastrophic program would cover the eligible services, which would be the two inpatient hospital deductibles per year, plus the Part B deductible, and the 20% coinsurance in Part B. These would be limited to $2,000 in any calendar

year. For this, the beneficiaries would be charged a premium which would have been $4.92 if the program had existed in 1987, and would be around $5.85 if the program went into effect in 1988.

The principal alternative proposal is being developed by Chairman Stark of the Ways and Means Health Subcommittee which has primary jurisdiction over Medicare issues. There would be separate deductibles for separate services. For example, Part A would have a maximum $500 catastrophic cap which, in effect, means that the inpatient deductible amount is reduced from $520 to $500 with a maximum of one per beneficiary per year. There would be a separate $1,000 cap on Part B cost sharing. In addition, prescription drugs would be covered with a deductible like $200 or $250.

A premium would be charged that would be closer to $15 a month for beneficiaries and would probably not be voluntary. By combining the catastrophic with Part B, everyone would be covered. But, an interesting aspect is that they are using estimates that in private markets this coverage is probably worth something in the range of $25. Therefore, when you consider that 55% to 60% of Medicare beneficiaries have Medicare supplement policies,and that another 10% or 12% are Medicaid beneficiaries, they will be able to finance this proposal with the money that Medicare beneficiaries are now paying for Medicare supplement policies. They plan in effect to expropriate the administrative allowances in Medicare supplement policies and use them for benefits for the people who are not now covered by Medicare supplement policies.

That is the key feature of this proposal from the Congressional point of view. It's a free lunch. They can do something dramatic for beneficiaries at no cost to the federal treasury, and prove that they are back in power in Washington. Further, just about all of the important players are now in favor of it: the Administration, the Republicans, the Democrats -- they all support it. It should slide right straight through.

The fact is that it is self-financed. Here is a new proposal that benefits beneficiaries and doesn't add to the deficit. Seldom has there been such a concurrence of political forces. It looks like it will produce legislation in a hurry. Congress can act in a hurry as it proved when the issue of making pro football games available on TV when the stadiums were sold out came up about 10 years ago.

Another proposal, which does not seem to be receiving a great deal of attention, was introduced by Senator Kennedy. And it would, in effect, remove all the copayments in Part A and Part B for somewhat higher premiums. Additional financing would be needed from other sources. The requirement for substantial added general revenue expenditures precludes it from being one of the mainstream proposals at this time.

On the under-65 front, there is great interest, at least among Congressional staff, in a proposal that would mandate insurance coverage by employers, especially small employers. It is basically motivated by a desire to insure the uninsured.

The idea of mandating employer health insurance has been given a lot of steam by survey data showing that close to 40 million uninsured persons in the United States live in households where there is at least one employed person. Unfortunately, in the surveys like the Current Population Survey of the Census Bureau, they use what we call a "census family," as opposed to families as defined by health insurance policies. A census family is basically everybody who is living in a household -- aunts, uncles, brothers, sisters and cousins, etc., and frequently unrelated people. When the Census reports a family, that's what they mean. Consequently, when you do a tabulation to see how many uninsured persons are living in families that have a full time employee, you get a much higher number that you would really be able to reach by health insurance plans issued to those employees. It takes a lot of difficult analytic work to go through one of these survey files and proxy what we call "health insurance families," that is, the ones that health insurance policies actually cover: spouses and children up to age 22-25 that are full-time students. And there are a host of difficult problems to solve to do that, particularly when you have children of children living in the same household, and when some of the family members reported are really not living there.

Our figure for the number of uninsured persons living in families with a full- or part-time employed person is 25 million people.

Another motivation for federal intrusion into employer sponsored plans is reports of very high administrative costs, and difficulties of obtaining insurance for small employers. Congress tends to act as a collection point for everything

that's really gone wrong anyplace. People write their Congressman to report all the horror stories. Reading Congressional mail provides a distorted perspective of a number of things, including how private health insurance works.

Also, the typical staff member on the Hill is very young, very bright, and knows everything that can be read in academic journals about health insurance. But there is almost no familiarity with how insurance really works.

There is an informal group that has met periodically which has been referred to as the "Atkins Group," after a staff member on the Hill. The group includes staff from all of the major committees that affect health insurance, including the Ways and Means, Senate Finance, the Senate Health and Environment Subcommittee on Health, and the Health Subcommittee of the House Interstate Commerce Committee. The group also includes members of the Administration staff, and wide representation from industry.

The outline of a proposal (see Atkins Group Proposal) has emerged from these meetings that mandates small employers to offer coverage. There would be a deductible somewhere in the range of $300 to $500, 20% coinsurance and a cost-sharing cap. Benefits would include basic services such as hospital, physicians, surgery, x-ray, lab, prescription drugs, and preventive care. (Usually, that's the first thing the Hill staff wants to include in a proposal, apparently on the presumption that neglect of preventive services greatly raises the cost of acute care.) And, of course, mental health benefits are included.

Another feature is to set up something that looks like the Federal Employees Health Benefits Program, where a number of insurers can offer a product to small employers in a structured competition with annual open enrollments. I don't think it's really been thought through that much, but it would have the effect of totally changing how the small employer health insurance markets work, and replace everything that's there with something totally different.

The tea leaves are interesting. There is intense interest among those on the staff who are interested in health. But the interest does not seem to really reach to the real power bastions of influence in Washington. In other words, there doesn't seems to be a strong, wide constituency for radical proposals of this nature. The advocates have tried to sell mandatory coverage to some of the

ATKINS GROUP PROPOSAL:
Staff Draft of Minimum Benefit Proposal

Standard applying to all employers:

Objective:
To set a standard:
- o low enough to avoid disrupting most existing health plans;
- o high enough to provide adequate minimal protection for workers and their families; and,
- o low enough to avoid forcing large numbers of marginal employers out of business.

Mandate:
Employer must provide 100% of the premium cost of minimum family health coverage for each worker.

Coordination of benefits: employer plan is primary a) for own workers, b) for non-working spouse and dependents, and c) for the non-working dependents of half of their two-worker families. Employer plan is secondary for working spouses and non-working dependents of the other half of the two-worker families.

Minimum Benefit:
Employer must provide <u>at least</u> family coverage under "comprehensive" benefits with:

- o deductibles no greater than:
  $500 individual (per calendar year)
  $1,500 family

- o coinsurance no less than:
  75%

- o maximum out-of-pocket limits no greater than:
  $3,000 individual (per calendar year)
  $6,000 family

- o maximum lifetime benefit no less than:
  $500,000 per individual

"Comprehensive" benefits would include basic inpatient hospital, outpatient services that are medically necessary and provided by or under the supervision of a physician. No specific inclusions or exclusions of benefits would be required.

Employers with Existing Benefits:
Employers now requiring employee contributions for either single or family coverage could meet the minimum standard in one of three ways:

- o providing all employees with a basic employer-paid benefit meeting the minimum standard, and offering a supplemental plan to reduce cost-sharing and/or add benefits at a premium cost to the employee;

- o covering non-participating employees under an alternative minimum benefit provided by the employer or providing a cash contribution to the Group Insurance Plan to purchase minimum coverage for non-participating employees; or

- o establishing that the benefits provided are actuarially equivalent to minimum required family benefits.

Features of the Group Insurance Plan:

Administration:
Regional federal administration would enroll and bill employers, provide information to employers and employees on alternative plans, and provide information on enrollees to carriers.

Carriers:
To be certified to market to employers in the Group Insurance Plan, carriers would have to be licensed by the State, offer a minimum benefit, offer HMO and PPO options, and charge a single "composite" premium (combining individual and family coverage) for all employer groups in the Group Insurance Plan. Carriers could additionally offer higher-priced coverage.

Enrollees:
Employers with fewer than 50 lives, employers not previously providing health benefits, unemployed individuals, and certain employees not participating in employer plans (part-time workers and workers not participating in contributory plans).

Cost-saving Features:
In addition to the availability of a low-cost minimum family benefit with a "composite" premium, the Group Insurance Plan would achieve cost savings through three features of the plan:

- o the pooling of a single large group, with no medical underwriting for employer groups, administrative costs absorbed by the federal government, reduced marketing costs, and exemption from state mandated benefit laws;

- o coordination of benefits to families covered under duplicate plans; and

- o availability of managed care options with incentives to enroll, and other cost-containment features (e.g., second surgical opinion, pre-enrollment screening, agreements between carriers and providers to reduce costs).

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large employers on the grounds that it would create a more level playing field by forcing small employers to pay for health coverage, and stop them from shifting health care costs to larger employers where there are two employed persons in the family. At best there has been a mixed response. Apparently the AFL-CIO does not like the proposal because it is worried about the increased employment costs of small employers, which might interfere with its attempts to raise the minimum wage. The United Auto Workers is apparently more sympathetic to this

type of proposal, but wants to keep the deductible amount down. The consensus of opinion is that it's not really an issue for this year or even next year, but possibly an election issue in 1988. It could become a live issue if there is a major change in the type of administration in 1989.

There's another proposal taking shape on the Hill, developed by Senator Kennedy and Mr. Waxman. A summary of the Kennedy proposal follows.

1. All employers are required to provide a minimum health insurance package to employees and dependents of employees.

2. Employees are required to accept the package.

3. Employers and employees not subject to minimum wage laws are exempt.

4. Employers are not required to cover workers and dependents insured by another plan meeting minimum standards.

5. Required plan benefits include:
   - -- hospital care
   - -- physician care
   - -- diagnostic tests
   - -- prenatal care, well-baby, and preventive care for children according to a schedule established in regulation by the Secretary
   - -- catastrophic stop-loss provision for covered services set at $3,000/year and indexed to the CPI

6. Share of premium paid by the beneficiary may not exceed 20%

7. Deductible may not exceed $250/individual and $500/family

8. Copayments may not exceed 20%

9. No copayments or deductibles may be applied to prenatal, well-baby, and child preventive care

10. Covered services, copayments, and deductibles may be changed if the resulting benefit package is actuarially equivalent; however, no substitutes may be made for stop-loss or prenatal, well-baby, and child preventive care.

11. Applies to all full-time workers (defined as 17 1/2 hours per week or more).

12. Medical exclusions, or pre-existing conditions exclusions for coverage may not be applied.

13. Special provisions for small employers (less than 25 employees):

    a. Small employers will buy coverage from small business "structured-choice" offering in geographic area.

    b. Structured choices shall be developed by the Secretary of HHS in consultation with businesses, labor unions, and insurance companies in geographical areas defined by the Secretary.

    c. Structured choice offerings shall include a limited number of plans.

    d. Structured choices shall include a range of plans:

        1) At least one plan shall be a minimum benefit package.

        2) At least one plan shall include a broad range of benefits typical of the most comprehensive plan offered in the state.

        3) Some of the plans offered shall be managed care options.

        4) All plans shall include cost containment features mandated by the Secretary, including but not limited to second surgical opinion, pre-admission certification, and utilization review.

        5) Any federally-qualified HMO shall be eligible to participate as a structured choice plan if it agrees to accept any business that is eligible to participate in the structured choice offering.

e) Community rating is required for each plan.

f) Right to offer options will be granted to the plan that is financially sound and meets service requirements established by the Secretary and that will provide specified benefits at the lowest cost.

g) Structured choice plans would not be subject to state regulation of content of benefit offering, but would still be subject to state continuation of coverage rules and regulation of financial soundness.

The handicapping for the Kennedy proposal is much the same as for the Atkins group. What I see as much more likely to occur during the next couple of years is little bits and pieces of proposals enacted as part of other legislation. The model is Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). If you have influence, the right connections, and some substantial constituency behind a proposal, you may be able to have something slipped into legislation that doesn't really get reviewed. These types of proposals, like COBRA, and many changes in Medicare and Medicaid, seem to come from nowhere. Suddenly there is legislation affecting every health plan in the country. I think you'll see more of that. You might say that Congress, after exhausting its own sources of financing and not being able to raise taxes any further, is hunting around for someone else's money to spend and has hit upon insurers and employers as being wonderful pockets of money.

There are several little bits and pieces which I think have a chance to be enacted in this way.

In the COBRA extension, where a person has to pay the full premium of 102%, the staff is aware that participation tends to be very low. So one of the things that might be considered is requiring a minimum employer contribution, for x months at y% of the 102%.

o Another proposal that has some currency and is floating around is to require small employers to at least have a plan and bear the administrative costs so that the employees would at least be able to buy what they think is a reasonable value.

- Another kind of proposal that could slip in would be to require coverage of dependents. There are 1 or 2% of plans that show up on surveys as saying that they don't offer coverage of dependents.

- Another idea is to require an employer to pay the same percentage of the dependent coverage as of the employee coverage. Of course, that could work both ways because many employees may just drop the portion that they have in employee costs down to what they pay for dependents.

- Other areas that are being examined include straightening out the tax subsidies. There are a lot of staffers on the Hill who are keenly aware that the current tax system greatly favors employees of corporations over other individuals, especially persons who are not employed at all, and they want to spread the present tax subsidy over more people.

- There is also a lot of interest in pecking at exclusions. There are a lot of horror stories circulating on the Hill about the effects of exclusions that are denying coverage that people deserve, because of a pre-existing condition or some other fine print, which of course is always assumed to be attributable to the perfidy of insurance companies.

The one thing that looks like it ought to be on the short list of things that could come up and pass is to require the formation of state pools modeled on the one in Minnesota and a number of other states. But I don't think that any bill has actually been reintroduced. I'm not sure why there isn't more interest; it seems like the type of proposal that would appeal to the Congress. After all, it can place the cost of financing the pools on the insurance business in the state, perhaps including the self-insured plans. Interest seems to be relatively low because of the low estimates of the proportions of uninsured people that would sign up for these pools.

FROM THE FLOOR: Dr. Freeland, I was wondering if you would be willing to share your estimates of the DRG increases in 1987 and 1988 and what effect do you think they would have on cost shifting?

DR. FREELAND: I don't have the number for 1987 with me right now. They're still working out the number for 1988. The Prospective Payment Assessment

Commission has come up with a recommended increase of 2.3%, and Bowen said recently that the rate could be as high as 2% increase per case, but the key thing here is that the Administration says it wants to wait until closer to the new fiscal year when more additional information is in and, at that time, the rate could come down or it could go up.

And, the cost shifting question -- that's an interesting one. The work done in the Office of the Actuary has shown that, since the prospective payment system began, the Medicare payment rates have actually been significantly higher than for other payors, that is, private health insurance. Since Medicare has come in we've really documented in a very sound way that Medicare is paying significantly more than its share. Further, the percent increase in cost per case for Medicare and non-Medicare was roughly in balance over the previous 15 years. Profit rates under Medicare are in the order of 15-16% for fiscal 1984-85. This is documented in Medicare cost reports as analyzed by the Congressional Budget office, the Prospective Payment Assessment Commission and HCFA. So in fact there is a reverse cost shift going on now which appears as if payments from Medicare are being used to subsidize other payors. No doubt it is quite a controversial thing, but this is what our analysis seems to indicate.

MR. TEACH: It is significant, Dr. Freeland, that the Prospective Payment Assessment Commission in its report came to the same conclusion that Medicare was paying above charges whereas other payors were paying below charges.

MR. GARY MCCOLLINS: Dr. Freeland, I understand that there are organizations that offer consulting services and computer software to hospitals so that they can maximize their DRG income. I was wondering if you could comment on just how that is done, and also what is DHHS doing to prevent any manipulation or abuse of that kind and is it taken into account in the DRG pricing?

DR. FREELAND: It was certainly predictable that this would happen, that is, that the hospitals would try to maximize prospective payment income, just as they did under a cost based reimbursement system. They did it with Medicare, they did it with Blue Cross, etc. Prior to PPS they were depending on the case mix of patients, and they would set charge structures to maximize reimbursement. As a matter of fact, this was true even before prospective payment hospitals were able to change the charge/cost relationships so that charges were

higher where Medicare had high proportions of the patients. Work done by the Chief Actuary seemed to give some evidence that this was going on, that there were different charge cost ratios for those categories of patients for whom Medicare paid a high proportion. If you look at the *Health Care Financial Management Journal* since PPS began, and actually a good bit before it, advertisements of the Big Eight accounting firms started to proliferate. It looks like they have been quite effective at doing that in the aggregate. One place this manifests itself is in better coding of diagnoses, which may be called "DRG Creep." The Office of the Actuary, HCFA, has done a lot of the key work on DRG Creep. One thing I didn't discuss is the update factor. I dealt in a sense with the percent increase for a single DRG, the average price. Now when you bring all these facets together, you bring in this one phenomenon that you were talking about of gaming the system. Perhaps they are coding more comorbidities which give a higher cost DRG. Work by the Office of the Actuary attempts to separate what is a real case mix increase from a pure coding increase. An aggregate adjustment is made by the HCFA Office of the Actuary to strip out the part that is due to coding changes from the part that is real.

The Prospective Payment Assessment Commission is working with the people who designed those programs to see what kinds of things are going on there. Over time, we're learning how hospitals are behaving under the prospective payment system. This includes how capital costs and parts of medical education are passed through now.

MR. TRAPNELL: I might just add that the adjustment for the DRG Creep is part of "rebasing" the system. In other words, it was recognized right from the beginning that a statistical data base was being used to estimate what would occur under a reimbursement system and that the way the data was coded would change with the financial incentives provided by the DRG system. Rebasing is designed to address this problem.

MR. RONALD E. BACHMAN: Part of Secretary Bowen's plan for long-term care was to encourage private industry and insurance companies to offer the coverage, and he proposed a medical IRA with use of those funds to accumulate assets and also to purchase reinsurance protection. Where does that part of the proposal stand at this point?

MR. TRAPNELL: You're talking about the medical IRA for long-term care. Of course, the Administration's Long-Term Care Task Force proposed that. Tax incentives are badly needed for financing long-term care services in the future. I'm sorry the proposal did not include provisions that would be directed to straightening out the position that insurance companies are in with respect to their policy reserves on long-term care policies. Present regulation was designed for term health insurance policies and not for a policy that is in effect more like an annuity product than it is like a hospital surgical insurance product. I have not detected much interest on the Hill in medical IRAs, perhaps because it opens up a question of huge numbers of requests for changes in the tax bill that they just passed; for exemptions for practically everything that used to be in the tax code. It is difficult for the Congress to explain why one change is meritorious enough to pass, regardless of how much you may think it is, and all those other cases are not. So my guess is that Congress really does not want to get involved in any tax change this year.

MR. TEACH: The White House is making a decision regarding the Secretary's report, which actually addressed three separate components. One was the over-65, which is legislation that's moving forward. The other was the under-65 and a series of activities that were supposed to be undertaken with respect to them, and the third was long-term care. The White House decision was to refer the issue to the Treasury for further study. The Secretary is still committed to the idea. The Treasury, which views its responsibility as preserving the revenue base, of course, has the predictable concern that there is a cost to this. So, it's still on the agenda, and the Secretary is very committed.