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WHAT WILL THE FEDS DO TO HEALTH CARE?

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MR. WILLIAM C. WELLER: I am senior actuary with Health Insurance Association of America. We are going to discuss the reverse of the Society's motto in that we will be talking about our impressions even though the facts are not out yet. The panel members have been involved to a fair extent in reviewing health care reform because of the positions that they are in: looking at what's been reported, what can be inferred and what can be discerned based upon requests that have come from the task force to various bodies. Because things are probably changing even now as we speak, there will be no prepared remarks. Instead, we are going to have a free wheeling discussion. We picked out four topics to focus on: (1) managed competition, (2) universal coverage versus universal access, (3) taxes, funding and budgets, (4) benefits: what's going to be included, excluded, how is that going to be decided?

We have three panelists; the first is Harry Sutton. Harry graduated from Williams College and went on to the University of Michigan where he got an M.A. degree. He spent 25 years with Prudential. After Prudential, he was with the consulting firms of George Stennis and Towers Perrin for 16 years, and is now with R. W. Morey. Harry specializes in health care analysis, actuarial rating practices for government, prepaid health plans and insurance companies. He is currently in charge of the actuarial functions at R. W. Morey, Inc. For the past 20 years, he has been involved in developing the regulatory framework for the operation of HMOs which are going to be very critical in the future. He also has been very involved, from the Academy point of view, in all of the health-related matters, and he has been involved in developing the Academy's responses when the task forces ask for specific information.

The second panelist is Charles Huntington. Charlie is director of the Washington office of the American Academy of Family Physicians. He has a master's in Public Health from George Washington University and is working on his dissertation for a doctorate in public health from the University of Michigan. Prior to joining the Academy, he practiced as a physician's assistant in a rural, underserved area in upstate New York.

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The third panelist is Erling Hansen, general counsel of the Group Health Association of America, the Washington, D.C.-based trade association for organized prepaid health care systems. Mr. Hansen graduated from Hamilton College in New York, and obtained his law degree from Syracuse University in 1973. He then worked for several years with the Health Law Center of Aspen Systems Corporation, a specialty publishing firm in Rockville, Maryland, where he served as editor of the HMO Law Manual, spent a year with the U.S. Civil Service Commission, and in 1977 joined Group Health Association of America (GHAA) as associate legislative counsel. He assumed the position of General Counsel in 1979.

Each of the panelists will outline the subjects that I have mentioned. There will be some discussion among the panelists, and then we hope that the audience will raise questions or make comments. I am going to ask Erling to start by giving us a little bit of input on managed competition.

MR. ERLING HANSEN: This is a rare opportunity for me to get a few words in ahead of Harry Sutton. I have had a previous dealing with the Society; I helped prepare a study note on HMOs and managed care a few years ago and for anyone who has had the opportunity to use that study note, I hereby make a public apology, and I will try to do a much better job on this topic of managed competition.

Managed competition is a totally academic concept, untried in the real world. It involves a restructuring of the marketplace so that health plans can compete on the basis of service, price and quality rather than on risk selection. It establishes incentives for purchasers to buy the most cost-effective coverage. This concept is closely identified with Professor Alin Enthoven of Stanford and the Jackson Hole Group. Professor Enthoven used the term in the title of a 1986 article published in the *Health Care Financing Review*. He says he got the idea from a structured competition proposal made in the early 1970s during the Nixon administration. That was Nixon's CHIP proposal -- the comprehensive health insurance plan proposal.

The author of that proposal was Scott Fleming, a lawyer who was on loan to the government from the Kaiser Foundation Health Plan. Scott was working with the government to help develop and then implement the HMO Act which was signed by President Nixon in 1973, and which was part of the overall CHIP proposal at that time. We have the HMO Act, but it has taken 20 years to get the rest of the structure.

I think along the road to managed competition, Enthoven tried the term "regulated competition" which is arguably more accurate at describing this concept, but he rejected the term according to columnist, Bill Safire, because it had a "nasty government sound" to it. Perhaps he was correct because managed competition, as envisioned by the Clinton administration, will require Congress to enact a broad range of new federal legislation affecting states, insurance companies, health plans, employers, employees, providers, the uninsured and, somewhere along the way, you actuaries as well.

This managed competition program starts with a National Health Board. There are absolutely no specifics about the National Health Board, but I assume that it will be entrusted to decide everything that the administration and the Congress cannot agree

on, which ought to be a lot. So under managed competition, health care services would largely be offered through health plans referred to by Enthoven as accountable health plans (AHPs), a new acronym, the full definition of which remains mostly unspecified. However, all will offer a national standard benefits package, the details of which are very undecided. There have been some suggestions that it will look like the federal HMO Act basic benefits package. All these health plans will use community rating. They will not be allowed to use preexisting condition exclusions or waiting periods. So they may look a lot like today's HMOs, but they may also be PPOs as the administration is suggesting that they want to preserve traditional freedom of choice health insurance as well.

Health plans would offer their services to employers in two ways. One way would be indirectly through regional purchasing pools described by Enthoven as health insurance purchasing co-ops or corporations (HIPCs), which are now called health alliances by the administration. These alliances would be set up by the states to decide how many co-ops there should be and how they should be run. Second, large employers (there is no definition of large – is it over 500, 1,000, or 10,000 employees?) will be able to deal directly with health plans and possibly retain current self-insured arrangements.

Under managed competition, why would employers play? The answer is that reform legislation will undoubtedly require employers to offer coverage to employees and to pay a significant portion of the cost. It is said that there will be some cost sharing by employees. Professor Enthoven envisioned tax caps as a mechanism for encouraging consumers to choose the most cost-effective health plans, but the administration apparently rejected tax caps for all but the richest benefit plans if there is flexibility to offer other than the national standard benefit package. The administration favors global budgeting as their incentive mechanism to be implemented on a state-by-state basis, and as a way of achieving savings under health care reform. Now Professor Enthoven says that global budgets are absolute anathema to managed competition, but others, economist Uve Reinhardt among them, suggest that managed competition and global budgets go together like a hand and glove. The price and cost controls have been also put forward as necessary interim measures to curb inflation until the savings of managed competition kick in, perhaps five to ten years down the road.

There are additional major issues with managed competition. What do we do with people who don't receive coverage through employment, Medicaid, Medicare, etc.? How do we deal with rural, intercity and other medically underserved areas where competition does not exist, much less structured or managed competition? How do we pay for all the new entrants getting coverage, the 37 million uninsured – that large number long touted? A national sales or value-added tax may be how we pay for the new coverage. Finally, Greg Herrle has said that managed competition will not reduce health care costs. So the question that I ask myself and you and the other panelists is, why are we doing this, where is the real reform in managed competition?

MR. HARRY L. SUTTON, JR.: The fear is that if we merely provide blanket coverage to everybody who is uninsured, cost will absolutely go out of control. Therefore, it is presumed that HMOs or managed care plans will have some control of their average price because they negotiate with providers. The health plans are presumed to be even better with the providers and controlling costs, plus they also will provide internal

utilization control and quality outcomes. These organizations as competitors really will not exist very well except in big metropolitan areas where they exist now. You could budget by saying this is going to be the capitation for every health plan in those areas. The HIPC may set some kind of limit on the budget for a metropolitan area, even though the large employers may escape rate controls. Now large employers may have to pay taxes if their cost of health benefit plans is higher than the basis cost of the health plan in the HIPC. They don't have to use the HIPC, but they might want to if their health care cost is a lot higher than the artificial cost in the HIPC. Also, managed care, in the long run, will be of better quality. In the beginning, setting up health plans and getting them functional (all with the same benefit plan), and measuring outcomes from data studies to compare medical management capabilities will be expensive. It is hoped to ultimately reduce the cost of medical care.

I think the various elements in Washington have said it will take quite a few years to get all these set up and in place. HIPCs cannot be set up in every metropolitan area or in other areas of every other state overnight. Therefore, there is going to be a lot of fudge time until we learn how to both negotiate with providers and manage care properly. So it is just going to take a long time to do it. Part of the panic over major financing needs that we will talk about later is that the government has recognized that there will be no savings in the beginning. We are revolutionizing the whole system of marketing, particularly to smaller employers, individuals, and unemployed people -- probably moving Medicaid in as well. The planners are probably afraid to touch Medicare at all, but they will have to come into Medicare.

Prepaid health plans offer more for the buck; they are fatter plans, but essentially they can control the medical delivery side, although they can't necessarily completely control the demand of the patient. To the extent you can control costs through the delivery side, they should be capable of doing so.

MR. CHARLES G. HUNTINGTON: First of all, there is some suggestion that managed competition may in fact control cost. The California Public Employees Retirement System health plan embodies many of, if not all, the elements of managed competition and has had some positive experience in controlling costs over the last two years. However, clearly that is not enough experience on which to base a lot of confidence about managed competition. That is why most proponents of health system reform are looking to other means of controlling costs. The one most talked about is the use of global budgets. Global budgets are not completely contrary to the theory of managed competition, and even Al Enthoven has acknowledged that. What is anathema to managed competition is price setting. One can respond to a blown budget in many other ways besides fixing prices, and many of those would be consistent with the managed competition model.

MR. WELLER: It seems to me that two assumptions were made by those that developed managed competition and they said that there was going to be some savings. First, the accountable health plans were going to compete with the same benefits on the basis of price and quality. The price was essentially going to be taxable in excess of the lowest cost plan in the area so that employers would be looking for that plan and employees would be more interested in the price of the various affordable health care plans. That does not appear to be part of the Clinton administration package at this point in time, and I think that fact is going to have a

decided effect on the usefulness of the accountable health plans to really control costs. If the employees do not see a great deal of difference in their paychecks or their April 15 tax forms, their involvement will be nonexistent. So I think that is one thing that managed competition assumed but will not be able to actually produce if the plan goes forward as it appears to be moving.

Second, the HIPC was supposed to essentially do two things. One is obtain discounts because they would have a larger number of people. Obviously, the question is, do providers give discounts based upon reducing their profit, or do they give discounts based upon trying to cost shift from other areas. I think part of the concern with managed competition as being untried is that if you eliminate all of the areas where providers can have a payor of last resort to meet a profitability goal, just what discounts do you receive.

The other area is administrative expense. There are clearly higher administrative expenses in offering insurance to small groups than to large groups and to individuals versus groups. The assumption was that if the HIPC did all of this administrative work on a large basis, they would be able to do it cheaper than the insurance companies who are in the small group market. I think that is probably a fallacy because the largest difference between the expenses in the large group market and the small group market come from areas which will still be needed. One is the level of assistance that an agent or broker or somebody provides to the employer in deciding what plan they are going to choose. I do not see a lot of HIPCs providing that kind of assistance. The second thing is the degree to which the employer is doing the administrative work on a monthly basis in terms of maintaining enrollment, etc. Again, that is going to be done by HIPCs, and I don't know that they are going to be any more efficient than the average insurance company or HMO that is trying to maintain enrollment. So for several key areas in which savings is expected, I am not sure it is going to be obtained.

MR. HANSEN: I think that a lot of political realities are intruding into this process, and President Clinton was noted during his term as Governor of Arkansas for accommodating many interested parties, special interest groups if you will, in forging solutions. We already have seen that President Clinton still puts on his Governor Clinton cap in suggesting that the states should have a lot of flexibility beyond just regulating HIPCs. Perhaps joining HIPCs with a single payor system is the answer. For those who think that the Canadian approach is off the table -- not so fast. Also, as Bill Weller points out, the interest groups are very powerful and concerned with those administrative expenses. Bill was mentioning the agents and brokers. I noticed a couple of weeks ago in Maryland that there was a proposal as part of their health care reform to have HIPCs and for the legislation to specifically prohibit agents and brokers from being involved in that. One of the HMO participants in that process said, "I came out looking like Swiss cheese after the agents and brokers got involved." So there are many questions and many interested parties, and it is doubtful that managed competition will ultimately look like anything that Al Enthoven had in mind.

MR. WELLER: I agree that the name provides a lot of cover for federal or state regulation. If this was presented as a federally run program, adding a lot of regulation, people would be a lot less interested in having their health insurance be a

modified Medicaid program. The use of the words "managed competition" allows them to appear to be continuing in a framework even when it is being changed dramatically.

MR. JAMES N. ROBERTS: I think the methods of how managed competition would attempt to control cost are numerous. I think you have hit on the broker and agent commission which is clearly one area for potential savings, and it depends on how strong that interest group is in maintaining their current role in distribution of the product. If that were to be overcome and product was essentially distributed through a simplified catalog, a la the Federal Employees Health Plan or some other system, then that would be one source of savings. The other concept seems to be that the marketplace views health insurance as confusing and complex, and the less sophisticated the buyer, the more the product is sold through relationships and other means. So if that process can be replaced with a very simplified product and turned into a commodity so that the price becomes more dominant, that will force providers of the product to compete on a more clearly price-driven basis than they already have. There is some potential cost savings there. I think those are the intents. Whether they are resolved to accomplish these and whether the original road map can be followed through to the political process seems to be the big question. If the original concepts are followed through to their conclusion without tremendous amounts of compromise, there is some potential savings or incremental savings. That is my opinion.

FROM THE FLOOR: In the discussion of managed competition, I have not heard much in terms of the expected competition that is going on as sort of a quiet revolution. Maybe it isn't so quiet with Physician Hospital Organizations (PHOs) and network development. The discounts that are occurring to eliminate a lot of the waste and unnecessary expense from both the hospital and the physician community is the area of competition that I see managed competition addressing. I wonder if people on the panel could talk about the explosion of PHOs and what is happening in terms of local development of managed competition among these networks and how it will ultimately feed into the national programs.

MR. SUTTON: HIPCs essentially have a monopoly in a local market. They do not necessarily contract with all the providers, and some of the hospitals and doctors are going to be left out of the system. Therefore, I see a state of panic, particularly with hospitals that are not quite mainstream, or trying to protect their market. If they don't participate in an HMO or PPO or something, I think it will be a course for their disaster. One alternative is creating a PHO.

Back in the 1970s when all the little HMOs were formed, there were probably several hundred that could never even get past a feasibility study phase. Now you look at hospitals whose only object is to preserve a segment of their local population. They are going to build a risk plan around their medical staff. They often have no management and may have no capital.

In Minnesota, we have Integrated Service Networks (ISNs), which we are now rebuilding based on our HMO statute as a form of HMO, including low-capital requirements.

Clearly, some of the providers are afraid of being frozen out of this market for a major segment of the population. I think most of these will go down in flames because they won't be able to manage. If they come in with a competitive price, they may go bankrupt, so you will need a whole new layer of regulation. In 1986, before the current prosperity phase of the HMO business, approximately 75% of the HMOs lost money nationwide. There have been a number of insolvencies, mergers and rescues. I see us having a big influx of these new kinds of organizations, which are merely a hospital and a bunch of doctors trying to preserve a segment of the market to try to get into an HIPC with a contract. They are not likely to be very good or long lasting competition.

MR. HUNTINGTON: I don't have a lot to add to what Harry said. The realization that managed competition is based on a managed care model, and that managed care controls cost primarily by constraining supply is slowly making its way through the provider community. Right now what we are witnessing is the combination of either denial or panic depending upon whether that realization has occurred. Clearly a managed competition model will prove to be extremely disruptive surely for providers and perhaps also for patients.

MR. HOBSON D. CARROLL: I heard several of the panelists discuss things like the networks or HIPCs will be able to negotiate discounts from providers and get these savings. I have been a proponent for some time now of what is referred to as the all-payor system. I think providers should be able to set whatever rate they want to charge, but all comers have to pay that rate. I firmly believe that if you do not have that in the system, you are certainly not going to have the rest of the free enterprise system be able to work. I also think you are not going to get savings because you will not be able to pin down the service, the quality, or the utilization control aspects if you cannot pin down the savings. The reason I think it should be there is because, if society has deemed that we are going to have universal coverage or provision of medical care as a right at some basic level, then that means that the usual way of doing business has got to go out the window. Cost shifting is and has been one of the biggest bugaboos, and you only get rid of it by going to this all-payors system. Networks and HMOs, and to a large extent the prepaid plans, get credit for saving all this money, and all they did was shift cost because the provider just jacked it up on the other side. That is not a legitimate means of bringing savings to society as a whole.

MR. WELLER: An all-payor system for hospitals exists in Maryland. It is the only all-payor system left in the country for hospital purposes. I can tell you that there is still cost shifting going on. The shifting is going from inside the all-payor rate to separate bills for every other service; in essence you pay more but the hospital rate is the same for everybody.

It is nice to avoid cost shifting. There are certain levels at which it should not be allowed. But, I cannot imagine that the federal government with all the things that they want to do in this, is going to agree to pick up the portion of Medicare cost that is not being paid by the Medicare system at this time.

MR. SUTTON: I don't necessarily agree that people shouldn't charge different prices depending on the volume of patients they bring in or other factors. However, I do

think the system will constrain that. You cannot have a monopoly and negotiate 20% discounts below cost from everybody because everyone will go bankrupt. With HIPCs, the providers cannot discount below cost and there probably is going to be an evening out of the payment because they will know they cannot discount because there is too big a share of the market for them to cut the price and cost shift. They will toughen up in controlling internal costs. In our area, they have toughened up their negotiating already because 60% of the population is in two or three HMOs.

MR. HANSEN: Just a thought connecting the last comment with the previous topic of the PHOs: If HIPCs have to compete on the basis of quality and they must create a greater identity between the health plan and the providers, then in all likelihood health plans will over time look more and more like group and staff model HMOs. Over time that would address the cost-shifting problem.

MR. SUTTON: I might just add something on Enthoven's theory. He believes eventually the market should split into three or four pieces with no overlap of providers. In other words, the market would pay all of the income of a certain subset of providers, and the large employers would divide their patients up into these organizations in a similar way. So you would not have cost shifting because a subset of the population is 100% enrolled in one of these and they have to manage their health costs including the compensation to their subset of providers.

MR. WELLER: He has the Medicare population in his theory as well.

MR. ROBERT E. CIRKIEL: I have a question about or at least an approach to managed competition that I wanted to break into three pieces and get your comments on. First, managed competition was supposed to succeed in bringing down cost by addressing four areas: administrative cost, malpractice, defensive medicine, patient malpractice and unnecessary surgery. So the first question is, do you believe that there is a bona fide opportunity with managed competition to control those costs? Second, as I understand the current system with group health delivery, if an employer is insured, the insurance company is taking the risk, but if an employer is self-insured, the employer is taking the risk. With national health reform, it seems to me that the providers will be the ones taking the financial risk, and that managed competition will essentially bring down cost by bringing down the provider's compensation. If large employers or any groups are allowed to opt out and go on their own, isn't there a natural antiselection going on and if so, doesn't the whole thing break down?

MR. SUTTON: You've asked a lot of questions. The answer to the last one is yes, and most of the rules propose that to get into an HIPC voluntarily you have to have a risk evaluation, and if you are a substandard group, you would pay a higher rate in the HIPC than their community rate in order to prevent the borderline antiselection. Now whether that is a solution, I don't know. I do think prepaid health plans change the utilization patterns. Administrative costs might go down. Erling might speak to malpractice, but based on my experience in malpractice, there is no knowledge that malpractice rates are lower for prepaid group practice plans although many of the big groups self-insure a big chunk of it. The American propensity to sue for any perceived unfortunate outcome is not limited to fee-for-service. Now there have been some intimations that a big corporation like Kaiser may have lower malpractice costs, particularly since they have no bills. One of the reasons why people sue is that some

accident happens and they see a $50,000 bill, so they are sure something was wrong. If you are in Kaiser, you don't get a bill so you don't know if anything was wrong or not. Some people thought because prepaid group practice is closer to the long standing patients it would lower malpractice rates, but I don't think that's true. You really have to change the whole malpractice system separately from that. If the providers are tied up and being limited in their fees, and other income sources, whether it is capitation or whatever, if they cut corners, malpractice might even be worse.

MR. HANSEN: I don't think the malpractice issue or defensive medicine is in any way a source of savings in this system. These items as expenses in the managed care industry are running somewhere fairly constantly over the years between 1-2% of expense, so I suppose that if you are looking at a trillion dollars, 1-2% is a big number, but as a percentage it is very small. With regard to the question of squeezing out unnecessary surgery, probably diagnostic-related groups (DRGs) ten years ago did as much to reform the propensity for unnecessary surgery as competition, and I wonder how much fluff there really is left in that area.

Probably the biggest problem is the compensation to providers themselves. They expect high salaries because of the loans they take to get through medical school and the perception that there is something special about tinkering with the human body as opposed to a V-8 engine. I do not think we will be able to do much with health care expense until there's some change in that perception and expectation.

MR. HUNTINGTON: As much as we complain about malpractice, I would not wish to oversell the savings that could be gained from tort reform. Clearly there are differences in utilization rates between the fee-for-service sector and the managed care sector even though the malpractice climate is the same for both. So I suspect it is the financial incentives that the providers face that has a lot more to do with utilization differences than defensive medicine, although it is likely that some form of tort reform or alternative dispute resolution recommendations will be included with the President's plan. The surgery rates have come down for a variety of reasons. However, there has been an astronomical increase in diagnostic and treatment procedures which has explained a lot of the increase in health care cost. Managed care's ability to make utilization more appropriate to eliminate unnecessary care is certainly the basis for creating incentives for managed care within the managed competition model. The glory days of $1 million salaries for subspecialists are perhaps gone. However, the actual net income of physicians and other providers does not make up a huge hunk of the health care bill. The 75-80% of the expenditures controlled by physicians is the problem. Once again, the change in the financial incentives moving towards capitation is much more likely to result in significant cost savings than constraining the income of providers even though we certainly all expect that will happen.

MR. WELLER: The second area is the subject of universal coverage versus universal access. I hope you understand the difference between those two. I have asked Charlie to start off and describe this area of health reform.

MR. HUNTINGTON: I am sure you would all agree that achieving universal access in this country means getting health care costs under control, and it has become fairly

widely accepted that no matter what your vision of health system reform might be, controlling costs means enhancing the system of primary care that is available in this country. Certainly every developed country that has brought health care costs under control has a much better developed system of primary care. Primary care is that part of the health care system that serves as the entry point for care, and more importantly that appropriately manages the care be it primary or of a more intensive nature.

Being uninsured in this country does not mean that you cannot get health care services. Truly the utilization is less, but still there is a lot of health care services provided to those who lack health care insurance. The services they obtain though are different from those available to and used by those who have insurance. What is primarily lacking is access to primary care-financial access. The uninsured tend not to go to a physician and very often leave health care problems unattended until the point where care is absolutely required. Then they tend to go to emergency rooms rather than primary care physicians' offices. Their conditions at that time require treatment that is much more costly and intensive than they might have needed if they sought care earlier. Providing everyone in this country with an insurance card will clearly overwhelm this country's current and totally inadequate primary care capacity. The American health care system is characterized by a severe specialty and geo-graphic maldistribution. In this country, probably 70-75% of the physicians are in subspecialties.

In addition, the cultural diversity of this country is not reflected in the health care system, and very often access in terms of cultural appropriateness is blocked. Finally, there are special populations in this country such as migrant farm workers who are liable to continue to experience severe access problems even though they might have an insurance card. Getting providers into areas that are currently underserved which are typically rural and nonintercity areas is not simply a matter of moving bodies from one place to another. We simply have the wrong capacity and having been moved, it will not provide the right kind of access.

Three parts of what we understand to be the President's developing health system reform proposal address these problems. The first is a revision to establish some sort of work force planning process that would presumably assess the needs for health care providers and establish some goals for getting from our current situation to one that more closely approximates need, and then direct training resources accordingly. In this country, we do not have any sort of formal process for establishing what kind of health care provider work force we need. Basically, the medical training enterprise has been left to determine what the output will be, and that has clearly shown its proclivity to sort of recreate itself.

The second recommendation that we expect is some sort of program to develop capacity in underserved areas, particularly in rural areas. Right now, it is unlikely that a health plan that has insured individuals in many rural areas would be able to find sufficient providers with whom to contract and be able to meet whatever standards for access are developed. Developing that kind of infrastructure is probably beyond what is envisioned to be included in the capitation rate that a plan might get.

Additionally, it is thought that managed competition would have trouble working in areas characterized by a lack of capacity. If you will picture communities on a continuum between high- and low-population density, in high-density areas in cities and their suburbs, one can envision competition occurring between providers as well as between plans. As one gets into communities that have perhaps a barely adequate supply of providers, there is obviously not going to be any competition between providers unless new ones are brought in. However, if those providers can contract with more than one plan, there still could be competition on the basis of the referral arrangements and perhaps on the basis of price between different plans seeking to sign up individuals in those areas. Then as you move into really low-population density areas, frontier areas where plans would have trouble meeting access standards, it is easy to envision that plans would be reluctant to cover anyone there, and certainly they would not be able to achieve any economies of scale.

One proposal that is being floated to address that problem is to identify areas of extreme shortage and perhaps give a plan an exclusive franchise for that area and provide, through a separate funding stream, some monies to develop infrastructure. Once the provider capacity is developed in these areas, it probably would no longer be necessary to have an exclusive franchise and different plans could again contract for the same providers and compete on the basis of other things than the local providers.

Finally, there are likely to be some specific programs or a process for identifying and serving particular populations that remain underserved. The most common example is the migrant population because they tend to move across fairly predictable migratory pathways to provide services to the agricultural community. It may be possible to create a special program that addresses their needs. Perhaps they would have their own HIPC or some other program, but it is a specially recognized population to be dealt with somewhat outside of the normal system. All of this must be fleshed out. It is assumed that plans will be reluctant to go into areas where the population density is low and where provider supply is inadequate, but I am not sure that is entirely a safe assumption. Do any of you or the other panelists have any experience with plans moving into rural or underserved areas?

MR. HANSEN: We have had some experience at least among some of the member companies of GHAA. Minnesota has something called a hub-and-spoke approach to providing care to rural areas. A health plan can offer some very tangible and welcome incentives to rural providers such as occasional replacement coverage when they want to go on vacation or just need some time off. There could be some rotation. Obviously, the health plan also offers a backup network of secondary and tertiary health care resources. This seems to be working reasonably well in Minnesota.

MR. SUTTON: If we have universal health insurance out in the more rural areas there will still be major difficulties attracting physicians. It is a common feeling that where the doctor's spouse wants to go is where the doctor goes. If the spouse does not want to move out into the boondocks, the doctor will not go. One of the major problems is that the bulk of the patients in rural areas are either on Medicaid or Medicare. The reimbursement levels are so low doctors don't think they can make a living there. Again we have the question of whether a single payor – paying the same fees for all patients (Medicare, Medicaid and so on) – might solve that problem,

but it's probably more likely that you are going to have to put a physician on salary. If he knows he can get paid and he does not have to worry about collecting money or worry about a lot of people having no insurance in his rural area, the financial aspect would look a lot better.

Blue Cross in Minnesota has a statewide PPO, but the rural hospitals will not give it a discount on anything because it is the only provider there – why would they? This PPO is on the verge of bankruptcy anyway. With universal health care (which will cause the total utilization to go up), and a guarantee of payment in some form (perhaps putting your outpost physician on a salary), it will be a lot easier to attract a physician to rural areas within a network. At least he won't think he is going to starve to death. Of course, that is not the only reason they might be reluctant to move to rural areas.

MR. HUNTINGTON: Most of the physicians who are in rural areas are in primary care. More are in family practice which is in great contrast to the physicians in the general population and certainly to the physicians in urban areas. As a whole, rural physicians tend to make less money than urban physicians, and yet practice costs are just as high. Family physicians in rural areas actually make more money than family physicians in urban areas. In part, that is because they see a lot more patients, and they also work a lot more hours. We still have some trouble getting physicians to work in rural areas, so clearly the consideration is not just financial. A lot of the hesitation has to do with professional isolation. Medical education is a cultural process, and that culture is not supported in rural areas. Physicians tend to want to talk to each other, have access to referrals, to consultants, and to be able to feel like they are practicing high-quality, contemporary medicine no matter what the setting. That is very difficult in a rural community. The formation of networks, which is occurring rather rapidly, has been occurring for some time and this formation may help to address those needs and improve recruitment and retention in rural areas. I am not sure the networks will develop as quickly or as extensively as they need to without some sort of capital fund to assist that infrastructure.

MR. WELLER: With regard to universal coverage and universal access, HIAA moved from an access point of view, which guaranteed access to issue, to a new vision statement with a universal coverage position stating that there should be an employer mandate and that every individual should have coverage. When this part of the vision statement was presented to some focus groups, the comments that we got back were that cradle-to-grave health care is a basic right of every U.S. citizen, and the public generally supports an employer mandate. I think the suggestion that it will cost jobs, particularly by the small employers, has not been sold to the public. The public thinks the government should support and subsidize the health care cost of those at low incomes. They also suggest that the health care industry in which many of us practice is a significant part of the problem. They do not like some of the things that we do, they want portability, they want to eliminate any preexisting condition exclusions, and they want no risk of cancellation of coverage once they have had it. Of course, they probably would like to see no rate increases in the future either. I think that President Clinton was correct when he said we are candidates to be pictured as a significant villain in this whole situation. That does not mean that we are, but the charge sticks.

One of the major problems that we ran into in small-group reform was that, as the rules were presented and developed in various states, the timing of various aspects frequently did not fit together very well: the reinsurance pool, the development of a standard benefit package and other key aspects. We had to go back to the state and say, look, you need to change the time frames for a lot of this. I see the same thing potentially developing as we try to move to universal coverage. They are talking about the smart card. Everybody is going to have a card yet they also are saying that we are probably going to have to transition the uninsured into coverage. I think that there could be a major problem in terms of the timing of those two items.

MR. WESLEY S. CARVER: If part of the reform package is employer-mandated coverage, and if in fact some contribution is even required of employers for that coverage, what would the panel see as the role, if any, for individual health insurance?

MR. SUTTON: Under the managed competition system, they propose mandated coverage for all employers with the employer paying somewhere between 50-100% of the premium. Most small business associations are fighting both of these. This essentially only covers full-time employees, 30 hours a week or more. If you have part-time employees, you do not have to provide insurance, but you have to pay a tax (the play-or-pay approach), such as 8% of employee's gross income which is relatively low. The other funding mechanism seeks out state or federal funds through some other tax source which we are going to talk about next.

Individuals are supposed to be mandated into coverage as well. They will apply to the HIPC as an individual or family and, based on filing a statement of their income, will receive a subsidy from the state and financed by some kind of a tax source. If your income is only $15,000 and you have a family of four, the state might pay two-thirds of the premium and you would pay one-third of the premium; it is similar to the Minnesota bill. So there is much subsidy needed and the cost of the subsidy is going to depend on the richness of the benefits and the prices.

It would be possible, but they are not talking about it yet, to avoid an employer mandate and to eliminate the small employer completely; this is one of my views, not necessarily Hillary Clinton's. You could have a mandate that every individual purchase coverage through the HIPC and leave the employer out of it, but you are probably going to have to raise revenue by taxing all employers. Of course, 30-50% of the very small employers already have some kind of coverage. So you would be taxing them, but it would be the same amount they are already paying for coverage; it might be 5-6% of their payroll. I don't think that has been settled yet.

Small-employer associations are really fighting the mandate. They claim two to three life employers could not possibly afford it. I don't know who will win. They are leaning heavily towards mandating for employers, and they are talking 50-100% of the premium, with subsidies for small employers with low-income employees.

MR. HANSEN: Generally the subsidy would apply to only the first couple of years of an employers' existence.

MR. SUTTON: A number of states have tried subsidy programs and by in large, they have not worked.

MR. HANSEN: But it has not been a mandate either.

MR. SUTTON: No, the programs had no mandate.

MR. WELLER: The third subject is taxes, funding and budgets. How are we going to pay for all of this?

MR. SUTTON: This is the most interesting subject. There is a trial balloon in Washington everyday to address where money can be raised. They have proposed at various times some 20 different methods of raising money to pay for the uninsured. I will discuss the taxes and then discuss the budgets and how many total dollars we are talking about.

Enthoven's proposal requires taxing the employee on the excess value of the employer's contributions. I have talked to him personally because I feel you should tax the total employer contribution. If you have a mandated benefit, it will level the playing field, and it also would be very progressive as a form of taxation because the high-income people would pay a lot more in taxes than the low-income people. If you were to tax employees the total value of employer contributions, it would produce some $50-70 billion of tax revenue, and it would be very progressive.

However, even though they floated balloons about taxing some contributions, the union influence in Washington was adamantly opposed. Now they say they might require a tax on the $5 a year for a hearing aid for the United Auto Workers (UAW). Essentially they have pulled that approach off the table, but it will be back again.

Another revenue enhancement, which is similar to the Minnesota system involves taxing providers. In other words, taxing hospitals' and physicians' gross revenues (assuming conflict with ERISA does not overturn it), will be used to finance universal health coverage in Minnesota. One political problem with this is the tax is being passed on to the employers that are already paying for coverage, and indirectly, particularly with the large employers, it is a way of getting around the ERISA preemption for self-insured plans; you are taxing them. Currently self-insured plans escape most state taxes. So taxing the providers and adding it to the bills that the large self-insured employers pay is one way of taxing them for part of the cost. Indirectly, this would also be taxing the health plans and the HIPCs so there is a circular flow.

There is a really interesting tax proposal based on the notion that if we had universal coverage, cost shifting would be eliminated. So there is the concept of taxing the savings that the employer will get because with universal coverage, he no longer is paying for the 26% cost shifting due to Medicare and Medicaid underpayment. Therefore, the employer is presumed to have a huge savings because cost shifting is eliminated and the government will "recapture" it, it is called an excess profits tax.

Another source of taxes is the play or pay approach. If you have part-time employees that are working 15-20 hours a week the employer does not have to provide coverage but he must pay a tax. That tax would produce some revenue. Likewise,

individuals who are going to come into the HIPC and get universal coverage, assuming you can find them and force them into it, would have to pay some kind of a premium or equivalent of a tax to support the system.

The most popular tax is a sin tax because nobody argues much against it except the cigarette companies, the liquor companies, and the lobbiers for blue collar workers. A $2 tax per pack of cigarettes is proposed. This has the big cigarette companies in a down spin. Proposals could greatly increase taxes on beer and alcohol. The results were very disappointing the last time they raised cigarette taxes at the federal level. The IRS projected it would get $14 billion of revenue if the sales stayed up, but they only got $11 billion of revenue which means when they raised the tax, the utilization of cigarettes dropped so they didn't reach the projected revenue. Also, if you tax these items enough, people won't buy them or they'll smuggle them into the country or buy them in Canada and hide them in the trunk of their car when they come across the border. The proposal that was floated most recently is the value-added tax (VAT), and it could produce hundreds of billions of dollars at the drop of a hat. We have a $5.5 trillion economy, and they would tax commodities at various levels of production.

They have the negative effect of adding the tax amount to the inflation rate. It also affects the supplies of hospitals and doctors, furniture, etc. If half of GNP at 5.5 trillion was taxable, a 1% tax would produce $27.5 billion without the expense of trying to collect it. It also would take a number of years to set up the system of taxing each layer of manufacturing. Half of the manufacturing is done in Taiwan or Korea or somewhere else. I don't know how they are going to tax that. It is viewed as regressive and a lot of people are negative.

The administration has proposed short-term savings by reducing Medicare and Medicaid costs. (If we froze Medicare reimbursement rates for hospitals, physicians and other providers, it would save about $10 billion a year, which is a drop in the bucket.) The extra total budget for universal coverage and reform is estimated at $30-90 billion, mostly to cover the uninsured who need their premiums subsidized.

If we have a national benefit plan, it is almost certainly going to include prescription drugs in some form. Then you would have a Medicare program that does not have prescription drugs and a national health program which does, and that will be intolerable politically. You will see the American Association of Retired Persons (AARP), et al, camped on the doorstep of Congress getting prescription drugs covered by Medicare. I estimate that alone would cost $25-50 billion a year depending on the level of co-payment, the deductible or phase-in. I have checked with the Health Care Finance Administration (HCFA), and they are estimating $25 billion would be added to the $30-90 billion.

One other effect in the market results from many small businesses having sizable deductibles and coinsurance. If employers have to change to a rich benefit plan -- the benefit plan described by Ira Magaziner is somewhere near the 85th percentile, which means it's slightly higher than UAW or similar to the HMO Act -- employer costs and utilization will rise sharply. A large segment of the population will have their benefit plans increased to a basic level that has been set by Congress. Rates for existing benefits may go up 25-30% for those who have individual coverage. Those with a

$1,000 deductible might have to switch to a $100 deductible, and the premium might double even if the new coverage is offered through an HIPC. It is not clear whether you could keep your old policy in force, and I am not sure whether the carrier would want to let it stay in force.

So a possible scenario to me would be an increase of $125 billion, and then I double it for conservatism. Even then I am usually too low.

Another thing that is going to effect the budget, and it would effect the states dramatically, is if you put Medicaid into the HIPC. Most states are trying to get HMOs to cover their Medicaid members because they think the costs can be controlled. The costs now are based on paying many providers 50% of prevailing fees. They want to believe they can convert it to prepaid care for the same average cost they are paying now. Well, maybe HMOs can do something about controlling utilization, but they are not necessarily miracle workers. If you put Medicaid into private programs, all the big discounts will be lost. The HMOs or affordable health plans will pay the providers the discounted fees per the contract network and those costs may go up. The state or federal government would be paying the premium to the HIPC because the Medicaid recipients are either unemployed, disabled or whatever and they are very costly. Although Aid to Families with Dependent Children (AFDC) has a young population, the cost is very high. The government predicts that $25-50 billion might be added to the cost of this program to switch all Medicaid into it.

We are not talking about peanuts for a budget in my opinion. Taxing cigarettes and liquor won't do it. A VAT or payroll tax is the only solution to come up with real big chunks of money. I would prefer taxing the employer contributions and then throwing those taxes back into the system, state by state. Let states come up with their own health plans. It is very difficult to get anyone to agree to pay a tax on health insurance premiums. I would be willing to pay, but a lot of individuals aren't. For me, the point of it is to lower the expectations for unlimited access and demand for health services. By knowing how much you or your employer are paying for health care, you might buy something a little cheaper. I don't know if that would work immediately, but I think it would over time. Can you think of anything else that would increase the cost to the system or am I too conservative?

MR. WELLER: I tend to agree. I was very surprised that there appears to be much more acceptance in Washington of a valued-added tax than the approach of taxes on employer contributions for a health benefit plan above a certain level. One of the problems that they are going to have is if there is no relationship in terms of the employee's cost and the cost of the benefit package. Only the providers will be lobbying in Washington. They will make sure they have full coverage of their benefits whether it is for podiatrists, breast implants, etc. They are going to be making sure that they are covered. There is not going to be any organized or public objection. I also wonder if it had been President Bush who suggested a value-added tax if there would have been tremendous cries from the Democratic Congress about the unfairness of it because it clearly is a regressive tax. Lower-income people spend more of their money than upper-income people do on the kinds of things that the value-added tax applies to.

The one way to control this is by Washington offering a very large package of benefits and then setting a very low global budget. After setting the very low global budget, the federal government tells each state what their budget is and then the state has to convey how much we are going to pay per service or how we are going to spread the cost. The poor governors, as opposed to Washington, Clinton, or Congress, have to deal with the anger and the problems. This year there has been an incredible explosion of bills in the state legislatures which I attribute to a desire to get ahead of Congress and to be able to opt out of the ultimate federal system. I don't think the states need to worry about that, I think that the federal government will be very happy to pass all of the responsibility for global budgets down to the states. If a state has a global budget, would there be enormous pressures on the HMOs or the affordable health care groups in that state to keep all of the care within the state thereby killing the center-of-excellence-type of programs that essentially go to the most cost-efficient place? Because centers of excellence essentially move some of the state budget out of the state, I would think that the hospitals and providers in the state might have a real objection. Therefore instead of seeking the best quality of care, we end up making sure it is the best quality within the state.

MR. HANSEN: That is a good question. I think that is probably a concern, and I don't know how to square it with the more recent suggestions from the health care reform task force which wants to allow traditional freedom-of-choice plans through the HIPCs. If the consumer is going to have the traditional freedom of choice, then it is going to make it very difficult to keep the dollars in the state. It just points out once again the number of issues that have yet to be resolved. I think the connotations for quality are very significant.

MR. HUNTINGTON: I suspect the issue of border crossing is going to be dealt with largely by constraining patient choice. A resident of a state functioning under a global budget will find that their choice of providers even within, but certainly outside, the state is going to be limited to those that agree to whatever price, be it capitation or fee-for-service, the plans within that state impose. Again, this is not something I think is well recognized by the public, but the polls seem to indicate some willingness to sacrifice choice to get costs under control.

MR. SUTTON: *Our business runs a transplant network around the United States.* We view our business as national even though our HMOs are local. We have seen signs of what Bill was alluding to. For example, in Ohio, if you want a heart transplant and you are covered by Medicaid, you have to get it in Ohio because the state is controlling expenditure of Medicaid monies and it will then go to a state or university hospital. That has caused a problem: the hospital refuses to discount and you can go to Chicago and get it done at half the price, but then the state won't pay for it. There are a couple of incidents like that where the states have been trying to be protective of their own university and high-tech medical procedure centers. I hope they won't do that; New York state has these lump-sum payments for bone marrow transplants under their new small group reform. It is a perfect reason to send bone marrow transplant recipients to Mayo where they can get it for less than the lump-sum payment in New York State, and it includes airfare too. So I really think we need to push for a global medical economy.

Here's an interesting point about the University of Minnesota Medical Center which is financed by the state. It is in much disarray now on the medical side because of huge salaries being reported. The head of surgery, one of the dominant U.S. transplant surgeons, was being fired from his administrative post. He is still a surgeon, but he is not running the survey department. There may well be a feeling that the state will want to contain it all inside, but half of Minnesota's Mayo Clinic patients come from more than 500 miles away. If we are going to be islandized or insulated in trying to capture all of our health delivery in one state, then your big medical centers are going to die. There is no way Mayo Clinic could do well if it just treated patients from Minnesota.

MR. HUNTINGTON: I have one additional comment about the taxation of employer provided health benefits. Certainly the value of that sort of tax, be it for all benefits or excess benefits, is not lost on the Clinton administration. The administration is backing away from that. It represents more of a political compromise than a philosophical change of heart. Given that the cost-containing incentives of managed competition will take about five to ten years to be effective, chances are the administration will be willing to sacrifice that in the initial years in order to get the proposal passed. Undoubtedly you will see this being considered again in a year or two.

MR. SUTTON: Just one final comment from me on the budget. I think the administration recognizes that cost could run away depending on how they set this thing up. The government is seriously considering a price freeze on physician fees, Medicare fees, hospital DRG's, hospital pricing and premium rates. They are not talking about just a short freeze like you had back in 1971 but a permanent freeze where no carrier can raise their rates by more than a specified index, or an equivalent to average wage increases – something that nobody has ever been able to live with yet. Employers have tried to keep the benefits constant as a percentage of payroll. They are talking seriously about this option because if costs are out of control and coverage is guaranteed to everybody, the federal budget is going to skyrocket. It is an emergency provision, but it may just completely disrupt the whole marketplace, especially carriers whether they are an HMO or whatever. The faulty assumption is that the carriers know how to influence the providers to get the prices down if necessary, but they cannot raise their rates. Now that might be true of an HMO that has salaried physicians. It's a little bit more simple there. But what about a small insurance company who doesn't even know who its providers are?

MR. WELLER: An article in the *New York Times* April 13 issue discussed a fairly generous package in which somewhere between 10-20% of individuals might end up getting less coverage than what they have now. It listed what would be included; you can see how complete a package they are talking about: mental health care, occupational therapy, physical therapy, hearing, vision, dental services for children, long-term care for elderly, (isn't that a wonderful one), and treatment for drug abuse. These are things that are going to be in the standard benefit package that employers would have to provide and employees would have to pay 20% of. I question whether employees are going to agree to pay 20% of those costs.

MR. J. MARTIN DICKLER: I'd like to discuss managed competition. I do not have a lot of faith that it is going to control cost, but that is another subject. My question is more practical. As an insurance company, we have to learn to live with whatever

emerges for the four or five years that managed competition is in effect. I am concerned about the term "capitation." Are you talking about capitating physicians only or capitating hospitals and possibly other vendors? In other words, what is the insurance risk that would remain with an insurance company under the HIPCs?

MR. SUTTON: The insuring organization would be capitated or paid a premium. That would not vary based upon who enrolled. It would be up to the insurance company to decide how much it could lay off on the providers. If you were smart, you would capitate your hospitals or set up a pool that they all live within; then capitate your physicians whether you have an individual practice association (IPA) or medical groups. In California and Minnesota, most physicians practice in groups, and they are used to taking a capitation often including referrals. So the assumption is that the accountable health plan will lay off the risk and control the providers. Now there is nothing illegal about the carrier taking the risk if it is a carrier taking the premium and paying fee for service underneath, as long as they think they can live within the premium. But the premium is going to have to be competitive. The assumption is that whether you have a staff model or group practice or IPA, you are going to lay off the risk to a large extent because it is generally hard to guess who is going to enroll.

MR. WELLER: There also is talk about risk adjustors to deal with differences in enrollments, but that is another topic.