THE POTENTIAL ROLE FOR EMPLOYERS, ASSOCIATIONS, AND MEDICAL SAVINGS ACCOUNTS IN THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MAY 25, 1995

Serial 104–49

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
25–328 CC WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-053614-6

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM McCRERY, Louisiana
MEL HANCOCK, Missouri
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
DICK ZIMMER, New Jersey
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska

SAM M. GIBBONS, Florida
CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ANDY JACOBS, JR., Indiana
HAROLD E. FORD, Tennessee
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
L.F. PAYNE, Virginia
RICHARD E. NEAL, Massachusetts

PHILLIP D. MOSELEY, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

BILL THOMAS, California, *Chairman*

NANCY L. JOHNSON, Connecticut
JIM McCRERY, Louisiana
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
PHILIP M. CRANE, Illinois
AMO HOUGHTON, New York
SAM JOHNSON, Texas

FORTNEY PETE STARK, California
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia

CONTENTS

THE POTENTIAL ROLE FOR EMPLOYERS, ASSOCIATIONS, AND MEDICAL SAVINGS ACCOUNTS IN THE MEDICARE PROGRAM

THURSDAY, MAY 25, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 9, 1995
No. HL-11

CONTACT: (202) 225-3943

Thomas Announces Hearings on Increasing and Improving Options for Medicare Beneficiaries

– Private-Sector Lessons to be Sought –

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a series of hearings to explore increasing and improving options for Medicare beneficiaries, with a focus on private-sector successes.

The hearing dates and subjects are as follows:

Tuesday, May 16, 1995:	**Experience in Controlling Costs and Improving Quality in Employer-Based Plans**
Wednesday, May 24, 1995:	**Medicare HMO Enrollment Growth and Payment Policies**
Thursday, May 25, 1995:	**The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program**

The hearings on May 16 and May 24, will be held in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The hearing on May 25 will be held in room B-318 of the Rayburn House Office Building, beginning at 10:00 a.m.

Oral testimony at these hearings will be heard from invited witnesses only. Witnesses will include health policy experts, representatives from the health care industry, and employer groups. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee or for inclusion in the printed record of the hearing.

BACKGROUND:

According to the 1995 report of the Board of Trustees, the outlays of the Medicare Hospital Insurance (HI) trust fund will exceed income beginning in 1996 and the HI trust fund is projected to run out of reserves in 2002, using the intermediate set of assumptions.

To keep the HI trust fund in actuarial balance for 25 years would require, in the absence of spending restraints, an immediate 44 percent increase in the payroll tax rate. As a result, taxes on a person earning $20,000 would be increased by $260 annually and a person earning $30,000 per year would see their taxes hiked by $390 a year. Those who make $75,000 a year would pay an additional $975 in taxes every year.

In the report, the Board of Trustees called for "prompt, effective, and decisive action" to put the HI trust fund into balance.

(MORE)

The Board of Trustees also expressed "great concern" about spending growth from the Supplementary Medical Insurance trust fund. As noted by the Board of Trustees in the 1995 report:

> "In spite of evidence of somewhat slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past. Growth rates have been so rapid that outlays of the program have increased 53 percent in the aggregate and 40 percent per enrollee in the last 5 years."

Medicare insurance coverage remains largely as it was originally enacted in 1965: traditional fee-for-service indemnity insurance with beneficiary cost-sharing requirements to control utilization.

However, private health insurance has evolved substantially since that time. More and more privately insured Americans are enrolled in managed-care plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations. According to the Group Health Association of America (GHAA), some 56 million Americans were enrolled in HMOs in 1994, up from 36 million in 1990, and 65 percent of people with employer-based health insurance plans were enrolled in some form of managed-care arrangement, according to the KPMG Peat Marwick Health Benefits in 1994 (October 1994).

Moreover, managed-care organizations have recently been successful in slowing the rate of growth of premiums. In 1995, on average, HMOs are expected to reduce their per person premiums by 1.2 percent, according to GHAA.

Some private employers have also begun to offer their employees Medical Savings Accounts. Such accounts allow employees and their dependents to control their health care dollars, providing strong incentives for cost conscious spending.

Medicare beneficiaries can enroll in HMOs under the risk contracting program and other managed-care arrangements, but, due to certain features of the program, managed-care remains a relatively small part of Medicare, with only 8 percent of the beneficiaries enrolled in managed-care plans as of December 1994. Medicare beneficiaries are also not currently able to enroll in any kind of Medical Savings Account.

FOCUS OF THE HEARINGS:

The hearings will focus on successful private-sector approaches at controlling costs and improving quality and an exploration of how such approaches can be made more available to increase choices for Medicare beneficiaries.

The hearing on Tuesday, May 16, 1995, on "Experience in Controlling Costs and Improving Quality in Employer-Based Plans" will review the approaches employers have taken to improve the cost-effectiveness and quality of their coverage for their employees, the issues and problems encountered as these approaches were implemented, the effectiveness of these approaches, and lessons the Federal Government can learn from these private-sector experiences.

The hearing on Wednesday, May 24, 1995, on "Medicare HMO Enrollment Growth and Payment Policies" will investigate the reasons for increasing beneficiary enrollment in Medicare risk contracting HMOs, and current and alternative HMO payment methods.

The hearing on Thursday, May 25, 1995, on "The Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program" will explore issues involved in enabling employers and associations to offer Medicare coverage to former employees and members, respectively, and the potential role Medical Savings Accounts could play in the Medicare program.

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Thursday, June 8, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under 'HOUSE COMMITTEE INFORMATION'.

*****

** *NOTICE -- CHANGE IN LOCATION* **

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 17, 1995
No. HL-11-Revised

CONTACT: (202) 225-3943

Thomas Announces Change in Location for Health Subcommittee Hearing on the Potential Role for Employers, Associations, and Medical Savings Accounts in the Medicare Program

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on the potential role for employers, associations, and medical savings accounts in the Medicare program, which was originally scheduled for Thursday, May 25, 1995, at 10:00 a.m., in Room B-318 of the Rayburn House Office Building, **will be held instead in the main Committee hearing room, 1100 Longworth House Office Building.**

All other details for the hearing remain the same. (See Health Subcommittee Advisory No. HL-11, dated May 9, 1995.)

*****

Chairman THOMAS. The Subcommittee will come to order.

I want to welcome all our friends to our hearing on the potential for employers, unions, and medical savings accounts to add to the Medicare Program. As I said yesterday at the Subcommittee hearing, this Subcommittee is going to undertake a major effort to make Medicare a better program, both to improve its insolvency and to provide better choices for beneficiaries.

Today we will examine how we might provide options through former employers and through medical savings accounts. In addition to that, labor unions, I believe, are a very fruitful area of new endeavors.

Last week we heard from a series of employers about their successful efforts to control their health care costs and improve the quality in the coverage they provided for their workers and families. For instance, the Pacific Business Group on Health reported a successful effort in negotiating a nearly 10-percent reduction in HMO, health maintenance organization, premiums for their members in 1995.

I would like this Committee to explore how we can tap into that kind of creative energy by employers on behalf of Medicare beneficiaries and the Medicare Program. I believe we must find a way to allow employers to play a more defined role in Medicare coverage so that beneficiaries can stay with the plan they had as workers, and if they like it and it is cost effective for the program.

Clearly, this kind of change raises many questions: What would be the payment rate for Medicare in that situation? How would we define an employer's retirees? What would we do about retirees who want to stay in the Medicare fee-for-service program?

I am pleased that the list of witnesses in our first two panels, who will address the concept of an employer role in Medicare, have a background that will allow us to ask the kinds of questions that I just outlined and more. I am also pleased that our last panel will address an equally exciting concept, and that is the medical savings account for Medicare beneficiaries.

Clearly, one very promising approach to cost control and quality health care is medical savings accounts. With medical savings accounts, MSAs, as they are called, a person has the protection of a very high deductible for significant health expenses. They also have the freedom to make wise choices with their money in a medical savings account because it is their money and their choice.

This option is apparently working very well already for one company, the RCI Corp. of Michigan. We will hear from that company's director of benefits about how they have successfully instituted a MSA Program for their workers, and I believe Members of the Subcommittee have already been enrolled in that particular health program by virtue of the cards that we have received.

We need to explore how we might make a MSA option available to Medicare beneficiaries as well. There are some serious questions that must be answered before we proceed: What is likely to be the premium for the high deductible coverage for an average senior beneficiary; how much would that leave in an account for medical expenses each year; in addition to a number of other questions. Who would sponsor MSA accounts and high deductible insurance and who would regulate it? Should all Medicare beneficiaries be

given this option or just those beneficiaries entering into the plan? Should this be a one-time option for beneficiaries? Should they be allowed to disenroll at some point from the MSA and reenter traditional Medicare?

I look forward to hearing from our distinguished witnesses about the MSA concept for Medicare and how we might answer some of these questions as well as the role of employers and unions. Today, this Subcommittee, is to look at new and novel ways to create a better Medicare for all seniors.

And I would yield to the gentleman from California, the Ranking Member.

Mr. STARK. Thank you, Mr. Chairman, and I am sure we are going to hear some very novel ideas today. I understand the purpose of the Chair's hearing is to assess the potential of various ideas to improve the Medicare Program.

While it may or may not be the Chair's intention, I am afraid we could head down a troublesome path for Medicare and its beneficiaries. If I were going to create the short title, I would call it the Medicare Beneficiary Partition Act. It reminds me a little bit of what is going on in Eastern Europe. Unless we are careful, we will end up carving up the Medicare beneficiary pool with retirees in plans sponsored by the former employees, young, well seniors in HMOs, the healthiest in medical savings accounts, and the sickest staying in the traditional fee-for-service coverage.

Yesterday, the chairman of the Prospective Payment Assessment Commission said that Medicare was beginning to run the risk of becoming a very different program, depending upon where a beneficiary happens to live. I think we are asking for trouble if we attempt to divvy up the Medicare population beyond our ability or willingness to adjust the per capita payments to correspond to the health care needs of the various beneficiary groups.

If we go down the road of subdividing the Medicare population before we know how—and we do not—to adjust the Medicare capitated payment appropriately, we can just mess up the one good system that works in this country. I would urge my colleagues, while they have the votes and the will to do whatever they choose to Medicare, it is fragile and could easily literally be destroyed by capricious experiments when we do not have either the data or any experience in trying some of these areas.

I have no problem with capitated payments or providing beneficiaries with additional health options, but I do have a concern that we are already losing an average of 6 percent for every Medicare beneficiary that enrolls in an HMO and the percentage of retirees with employer-provided health insurance has been declining from over 60 percent today to 40 percent. Why in heaven's name would employers want to take on the whole liability of the over 65 population? Only, I suspect, because they can make some money and help pay for the under 65 population.

As has happened with HMOs, the bucks to be made are not necessarily from efficient operation, but from cherrypicking the healthiest beneficiaries or denying services to the very sickest.

A more extreme example is medical savings accounts, but I think that any empirical evaluation and any reasonable disinterested study will show that it benefits, to a small percentage, I think it

is 6 or 8 percent, the young healthy people, and adds tremendously to the costs of those who are sicker and need to spend more in the medical delivery system.

It is not fair. It flies in the face of any kind of social insurance or commercial insurance. It robs money from the insurance pool, which the Chair is already complaining is going broke, and is an idea that is right up there with sun spots.

I want to ask, or I want people to keep in mind that in the Chairman's budget the Medicare growth will have to be limited to meet the budget projections to under 4 percent, perhaps 3.7 or 3.8 percent. I would like these companies who suggest that they might like to continue operating their retirees' programs to tell us today if they could survive if the increased payments that they could make was limited to under 4 percent—3.8 or 3.9—if we do not have to adjust for adverse selection. I don't think they can do it.

I think if they combine the idea of continuing to maintain Medicare beneficiaries in their retirement plans, with the budget reductions that are being discussed, and very likely to happen, that the idea will lose its attractiveness.

I hope they will have a chance to review that today for us as we hear the ideas being presented.

Thank you, Mr. Chairman.

[The prepared statement follows:]

The Honorable Pete Stark

May 25, 1995

Hearing on the Potential Role of Employers, Associations, and Medical Savings Accounts in the Medicare Program

Thank you, Mr. Chairman.

I understand that the purpose of today's hearing is to assess the potential role of various parties, and certain insurance products, in the Medicare program -- a benign enough topic for a hearing.

While it may or may not be the intention of the Chairmen, I am afraid that we are heading down a troublesome path for the Medicare program. We seem to be looking for ways to break-up the Medicare population into numerous sub-groups. If I were creating a short-title for legislation, I would call it "The Medicare Beneficiary Partition Act." Unless we are careful in how we proceed, we may very well end-up carving up the beneficiary pool with retirees in plans sponsored by former employers; young, well seniors in HMOs; the healthiest of Medicare recipients selecting medical savings accounts; and the sickest remainder in whatever is left of traditional Medicare coverage.

Yesterday, in the Subcommittee's hearing on Medicare HMO enrollment, the Chairman of the Prospective Payment Assessment Commission said that Medicare was beginning to run the risk of becoming a very different program depending upon where a beneficiary happens to live.

We are asking for trouble if we attempt to divvy-up the Medicare population beyond our ability or willingness to adjust the per capita payments to correspond to the health care needs of the various beneficiary groupings. If we go further down the road of sub-dividing the Medicare population before we figure out how to adjust the Medicare capitated payment appropriately, we will make the adverse selection problem worse.

For example, a proposal is floating around that would have retirees remain in their former employers' plans and receive a capitated payment from Medicare. I have no problem with capitated payments, nor with providing beneficiaries with an additional health coverage option. But I do have a concern that we are already losing an average of 6% for every Medicare beneficiary that enrolls in an HMO. The percentage of retirees with employer-provided health insurance coverage has been declining dramatically -- from over 60% in 1985 to under 40% today. Why would employers now want to take on the whole liability of the over-65 population? I suspect because there are big bucks to be made. And as happened with HMOs, the bucks to be made are

not necessarily from efficient operation, but from being able to cherry-pick the healthiest beneficiaries.

A second and more extreme example is medical savings accounts. The potential for adverse selection posed by injecting an MSA option into Medicare is enormous.

A study just released by the American Academy of Actuaries found that, for the under-65 employer-covered population, the selection effect as a result of adding an MSA option to employees' health insurance choices could end-up increasing the standard, low-deductible premium by 60%. For the Medicare population, where high health care costs are even more concentrated in a small percentage of the pop-ulation, the adverse selection problem will be even greater.

These are only projections, though. MSAs today are a theoretical concept without foundation. The few insurers that offer any sizable number of MSA-like plans will not let me, or the American Academy of Actuaries, take a look at what they are actually offering.

Medicare is a social *insurance* program, not a social *experimentation* program. We should take extreme caution when using the Medicare population to prove or disprove some economist's latest theorem.

Providing Medicare beneficiaries a range of options is something I continue to favor. And as we know, there is no employer in the country today that provides the range of health insurance options to the range of Americans in the variety of locations as does the Medicare program. But every potential option we may provide beneficiaries is not necessarily a healthy one.

Just some words of caution as we work to make a better Medicare. Thank you.

Mr. MCCRERY [presiding]. Thank you, Mr. Stark.

We would like to call the first panel to the witness bench: Mr. Van Bell, Mr. Maher, Mr. Salter.

Gentlemen, thank you for joining us today. We have Richard J. Van Bell, president of John Deere Health Care, Inc.; Walter B. Maher, director of Federal relations for Chrysler Corp.; Charles G. Salter, director of employee benefits for GenCorp, Fairlawn, Ohio.

Thank you for joining us today, gentlemen, and any written statements that you have, if you would like to present those to the Committee, they will be included in the Committee in their entirety. We would ask you to summarize your testimony in about 5 minutes.

So, Mr. Van Bell, if you would start we would appreciate it.

STATEMENT OF RICHARD J. VAN BELL, PRESIDENT, JOHN DEERE HEALTH CARE, INC.

Mr. VAN BELL. I would like to thank the Chairman and other members of the House Ways and Means' Subcommittee on Health for the opportunity. My name is Richard Van Bell and I am president of John Deere Health Care, which is a wholly-owned subsidiary of Deere & Co., better known in the marketplace as John Deere.

Deere provides health care coverage to approximately 110,000 employees, retirees, and dependents. In 1994, Deere spent $222 million to provide coverage for this group. In this group there are approximately 17,000 retirees, of which 9,000 are Medicare eligible, and over half of this group elects to be covered through the company's managed care plans.

Over the last 3 years, 2,100 Deere retirees have reached age 65, of which 95 percent elected to remain in the company's managed care plans. Overall, John Deere Health Care provides managed health care services to over 300,000 enrollees through its two HMOs, Heritage National Health Plan and the John Deere Family Health Plan. Eighty percent of these enrollees are non-Deere commercial clients.

The John Deere Family Healthplan, a primary care staff model health center, was established through a strategic alliance with the world renowned Mayo Clinic, and with the endorsement and full support of the United Auto Workers.

Our success has been built on three basic principles: High quality health care is the most cost effective care; costs can be lowered when employers, providers, government, and managed care organizations create partnerships that utilize a market-based approach; patient satisfaction and education are of utmost importance.

Our overriding priority has been the development of high quality delivery systems. We focus our efforts on the primary care physician to coordinate the care. Working with Mayo physicians, we are implementing disease management strategies, a series of practice guidelines to best treat high frequency, high cost diseases. We are also deploying an electronic medical record which will provide our physicians an important tool to track all patient care and specifically these chronic diseases.

These tools, along with data, provide the physician greater control of care which we believe will enhance the quality of care. Em-

ployers, hospitals, physicians, and MCOs are responding to the need to manage cost while enhancing the quality of care.

Some examples: Deere health costs, which include supplemental costs for retirees, increased 2 percent in 1994. Deere costs equate to approximately $2,000 per covered person per year, which we believe is the only true method to measure cost. In 1994, we tripled the number of Iowa counties in which we served the Medicaid population. This program began in 1986 and now has 23,000 clients.

Our quality improvement program, such as the asthma disease management strategies, are being used with this population. We are encouraged by our recent success with the asthmatic population enrolled in our health centers. With overall success of the program, according to the Iowa officials, we are saving the State $500 per year per enrollee, and we voluntarily returned $3.5 million to the State last year.

These changes could not occur without patient satisfaction. Three years ago our enrollees rated our service the best in the country, according to a leading consumer magazine. In 1994, the Gallup organization researched our patients. Gallup compared us to 64 other health plans. Our patients scored us significantly higher than the national composite in key areas of patient satisfaction. Enrollee satisfaction in our staff model center was at 94 percent, or 6 percent higher than our IPA model. This suggests to us that we are able to offer choice, and yet see satisfaction levels above 90 percent in our most tightly managed care model. We believe we are adding value.

I would like to briefly speak to the issue of the Medicare insured group demonstration project we have been working on with Health Care Financing Administration, HCFA. Our involvement began when I chaired the OHMO National Industry Council in the late eighties. Former Secretary of Health and Human Services, Richard Schweiker, created the council to foster the development of HMOs.

The Medicare Insured Group, MIG, would be a 5-year demonstration project which would provide a savings to the Medicare Program by enrolling Deere retirees in our managed care programs. The post-65 retiree would continue to have a choice of plans but there would be incentives to move to the managed care programs. John Deere Health Care, through our health plans, would manage the care, paid for by Medicare, and we would also manage the supplemental benefits Deere provides this group.

While there have been many delays, we believe this concept can work and we are hopeful that the demonstration project can move forward. By utilizing some of the tools I have already mentioned, such as Disease Management Strategies, DMS, and Electronic Medical Record, EMR, we believe we can add value in managing the care and cost of this important population.

In closing, we believe that many of our programs can be made to work in the general Medicare population. Our experience with the Iowa Medicaid Program suggests it can work. Quality improvements in cost savings continue in that group. Current Deere employees, upon retirement and becoming eligible for Medicare, by and large, remain in our managed care programs. We also continue to see high levels of patient satisfaction.

With the emerging tools of care for physicians, DMS and EMR, we believe our managed care efforts are moving from the traditional component management of care to managing the continuum of care. This is the real value added.

We are confident after nearly 20 years of working to improve our managed care programs that they have proven their value in providing enhanced quality while managing cost. We believe the Medicare population will embrace managed care as they learn the value added, as have many Deere retirees. By encouraging choice within the Medicare population, we can build on one of our key principles: High quality health care is the most cost effective care.

Thank you.

[The prepared statement follows:]

TESTIMONY OF RICHARD J. VAN BELL
JOHN DEERE HEALTH CARE, INC.

I would like to thank the members of the House Ways and Means subcommittee on health for this opportunity. I am President of John Deere Health Care, which is a wholly-owned subsidiary of Deere & Company. Deere & Company, of course, is best known for manufacturing John Deere farm machinery.

Deere & Company currently employs approximately 34,000 individuals worldwide. Health care benefits are provided to these employees, 17,000 Deere retirees and the beneficiaries of both groups. In 1994, Deere & Company spent $222 million to provide health and accident coverage to employees and retirees.

Twenty years ago, the company decided the cost of health care services provided to its employees and retirees could be better managed and the quality of care could actually be enhanced. After successfully starting two small Health Maintenance Organizations for our own employees, we were approached by other employers that they too would like to use the same techniques to impact the quality and cost of their own health care benefits.

Today John Deere Health Care offers health management services and managed care programs to Deere & Company, other companies and government agencies in Illinois, Iowa, Wisconsin and Tennessee. We serve the needs of over 300,000 members through two subsidiaries - Heritage National Healthplan and John Deere Family Healthplan.

We have gained considerable experience with government programs and with the Medicare population. Of the 17,000 Deere retirees for whom we currently provide health care benefits, more than 9,000 are Medicare-eligible. Just over half of those individuals choose to be covered in our managed care programs. We have 2100 retirees who reached age 65 in the past three years. Of those in managed care, 95 percent of them choose to remain in our managed care programs.

In addition, we provide health care coverage to approximately 40,000 Medicaid recipients. More than half of those are enrolled in the state of Iowa. There we have gained considerable success in providing quality health care at lower costs for patients in this population. We hope to see similar success in the TennCare project in Tennessee.

We have traditionally offered our managed care products through an Independent Physician - Model HMO named Heritage National Healthplan. In the past two years, Deere has opened three staff model health centers and will open four more by the end of 1995. These health centers are managed as a primary care, staff-model HMO named John Deere Family Healthplan. The health centers were opened as part of a strategic alliance with the Mayo Clinic. We received the endorsement and full support of the United Auto Workers to open these centers.

The number of employers using our managed care services has grown from 290 just two years ago to over 700 today. Deere employees and retirees now represent about twenty percent of our total enrollment.

Our success has been built on three basic principles. We have applied these principles to other government programs with great success, and no doubt they could be applied to Medicare as well.

- We believe that high quality health care is the most cost effective care.
- We believe that costs can be lowered significantly when employers, providers, government and managed care companies create partnerships that utilize a market-based approach.
- We believe that patient satisfaction and education are of utmost importance.

High quality health care is the most cost effective care.

Our overriding priority has been on the development of high quality delivery systems. We have found that by emphasizing the quality of care, we can also lower costs. This quality control is obtained by focusing on the primary care physician. That physician can direct all of the care of an enrollee and the enrollee's family. Coordinating this activity helps the physician to improve the consistency of care given each patient.

We emphasize quality of care in many ways. Here are some examples:

- As we started our health centers, Deere & Company developed an alliance with the Mayo Clinic for the continuous improvement of Disease Management Strategies, a series of clinical practice guidelines used by physicians in the health centers. These important guidelines allow health care professionals to create the best treatment protocols for certain high frequency, high cost diseases. These guidelines help the physician to deliver consistently high quality care but do not mandate the treatment plan.

  We have three strategies already in use at our health centers. They include guidelines for asthma, diabetes and high blood pressure. A total of 11 have been designed and will be implemented.

  Other diseases targeted include heart disease, depression, chronic headaches, lower back pain, breast cancer, gallstones, abnormal uterine bleeding and abnormal Pap smear.

- We are now deploying an Electronic Medical Record system which allows our physicians to track all key aspects of the care given to a patient. The system assists the physician in coordinating the care of each patient. The use of technology allows physicians to identify chronic disease patterns and act to prevent health care problems. This technology provides a tool for more consistent care.

- In our staff model health centers, Deere & Company handles the management and administrative functions. This frees the physician to focus on patient care. We provide data about each physician's practice that can be used by the physician to improve the quality of care provided.

- In choosing physicians, we review more than a dozen indicators to assure that the physician will practice medicine with a program and patient philosophy consistent with our own.

The success we have experienced at Deere in managed care comes from our practical, day-to-day recognition that the highest quality health care is also the most cost effective health care.

Partnerships which take a market-based approach can impact cost.

Employers, hospitals, physicians, community alliances and managed care companies are responding to the need to control health care costs while not compromising quality of care. For instance, Deere health care costs increased by two percent in 1994 which includes the cost for retiree supplemental plans with a slightly older workforce. Our cost last year was approximately $2000 per covered individual. We believe this is the only meaningful way to measure this cost since a cost per family can vary significantly because of family size. We also know there currently is no meaningful data available nationally on a per covered person basis.

We have not removed choice to achieve these results for enrollees from Deere, other companies and in our government programs. Employers have told us they prefer to give employees a choice

in health care plans, to allow the individual employee to choose the health care plan best suited to their specific situation. This system works when pricing of the various plans is reflective of the real market situation. We believe partnerships create plans which allow the interests of patients and employers to be met.

Partnerships also work in government programs. In 1994, we tripled the number of Iowa counties where we serve the Medicaid population. In this program, government served as a catalyst for change. Because of concerns by the State of Iowa, private sector alternatives were sought and developed. We first became involved with this project in 1986. Today 23,000 Medicaid enrollees in Iowa receive health care coverage through our managed care program. The history of our project is as follows:

- When the State identified the need, we first worked with local providers to create a partnership that was committed to meeting the challenge.

- We believed in one concept then that we maintain today. All patients are part of the mainstream in our system. Our quality improvement initiatives are targeted to improve the care provided to all patients. Our managed care programs and services are used with all patient populations.

  As an example, this year we are targeting children with asthma with our Disease Management Strategies. Our intervention with these patients will aim to improve the child's health status. Children in our Iowa Medicaid population will be included in the project. We will most likely provide financial savings to the State of Iowa by ensuring that a consistent and proper treatment plan is in place for this chronic illness.

- Annually, the State of Iowa pays five percent less than they would outside our program. In addition, two years ago we voluntarily returned an additional $3.5 million to the State of Iowa. According to Iowa officials, our program is saving the state $500 per year per enrollee.

We also are gaining valuable experience in state-mandated reform by participating in the TennCare program in Tennessee. We currently have 17,000 enrollees in the plan and have put in place some of the same strategies used in our Iowa experience.

In addition, we have 10,000 members enrolled through a Medicare cost contract and are working on development of a Medicare Insured Group (MIG) demonstration project with the Health Care Financing Administration.

Our involvement with the MIG project started when I chaired the OHMO National Industry Council in the late 1980s. This council was created by Richard Schweiker, former Secretary of Health and Human Services. The Council met to enhance and encourage the development of the managed care industry. Through this council, Deere & Company, along with others, envisioned a program to encourage more post-65 retirees into managed care.

The five-year demonstration project would provide for a five percent savings to the Federal Medicare program for each enrolled participant in our managed care network. The post-65 retiree would continue to have a choice in plans. But we believe there would be strong incentives for the post-65 year old retirees to move to managed care programs.

This concept continues to be of interest to us and we are moving forward to put this demonstration project in place. We believe the MIG project will provide better value to the Medicare enrollee and allow us to work more effectively with the providers.

In all of this experience, I would underscore the importance of all patient care being delivered in the same manner. No group of patients should be treated differently than another.

Patient satisfaction and education is an important emphasis.

Change cannot occur if patient satisfaction is not maintained. Three years ago, our enrollees rated our services as the best in the country, according to research by a leading consumer magazine. This rating came after many of our enrollees had seen dramatic change, moving to managed care programs for the first time in their life. We managed this change with educational programs and open communication. When you introduce more choice to Medicare participants, we believe you must target patient education as a top priority.

In late 1994, we commissioned the Gallup Organization to do research with our patients. Gallup compared us to a national composite database of 64 other health care plans. Our patients score us significantly higher than the national composite in key areas of patient satisfaction. These include:

- Overall Satisfaction
- Satisfaction as compared to their previous plan
- Satisfaction with Customer Service
- Courtesy with Physician Office Staff
- Overall Quality of Physician Care
- Thoroughness of Physician
- Satisfaction with the time the physician spends with the patient

There is a significant finding in this research. Overall enrollee satisfaction in the staff model health centers was six percent higher than in our Independent Physician Model HMO. Both scores are very favorable. However, the 94 percent ranking in our staff model managed care program means that a population can be moved to a more tightly managed plan without decreasing patient satisfaction. We have focused on improving the primary care physician's relationship with patients in this model and it appears to be adding value from the patient's perspective.

We also believe strongly in education of all enrollees. We have developed many programs aimed at specific groups to improve their health care. We have a New Generations program for women who will soon be new mothers. In this program we have improved the rate of pregnant women who seek care in the first trimester. We have also had significant success with other educational programs targeted at diseases such as diabetes, cervical cancer and breast cancer.

Can these same principles be applied to Medicare?

We have focused on quality of care in all of our programs. We believe in partnership with all of the stakeholders in the health care industry. We know patient satisfaction should not be jeopardized. These principles draw more people into managed care programs, even when they are given a choice. We believe these same concepts can work in the Medicare population:

- Our experience with the Medicaid program in Iowa clearly suggests it can work. Quality improvements and cost savings continue in that program. As we develop new strategies to improve the quality of care, we are having an additional favorable impact on health care costs for that population.

- We can keep current employees in managed care programs as they become Medicare eligible. Deere retirees report high levels of satisfaction with their care and with the administration of the managed care programs.

- Education of patients can attract other retirees not now in managed care. Our retiree population continues to grow in our managed care programs. This education must be focused on the quality of care provided.

- Mainstreaming Medicare beneficiaries with other patient populations is clearly possible and beneficial. Managed care plans have proven their value in providing lower costs and higher quality. Managed care is, however, only one tool among an array to manage health care cost and enhance quality.

There are important considerations in introducing more choice into the Medicare program, especially when the choices will include managed care programs. Here are some final thoughts about our current strategy for the MIG project.

- The MIG does not contain any monetary inducements for retirees to enroll in one of the managed care programs. However, we have designed the project to encourage enrollment in the MIG.

- We will closely parallel our current options to enrollees. The Medicare eligible will be automatically enrolled in the MIG.

- We believe retirees who currently enjoy the benefits of managed care will want to enroll in the MIG project. Our provider panels, our facilities, our commitment to quality, our enrollee satisfaction and our benefit levels have served as inducements in the past and will continue to be attractive under the MIG.

- Retiree participation in HMOs has increased over time. This appears to be because of the growth in the participation of active employees. As our employees retire, they stay with the benefits and delivery systems to which they have grown accustomed. And as the Gallup Survey showed, they are very satisfied with their current plans.

Deere has traditionally supplemented the Medicare benefit to cover virtually all medical expenses, and provided it at little or no charge to retirees. Because of this, there are only subtle reasons to choose managed care Retirees have nevertheless chosen the HMO options. We believe this increasing success is based on their perception of the quality of care, the coverage for preventive measures and the freedom from paperwork.

Encouraging choice in the Medicare program is important. Designing the choices to encourage high quality, cost effective health care will be a foundation for success.

Mr. MCCRERY. Thank you, Mr. Van Bell.
Mr. Maher.

STATEMENT OF WALTER B. MAHER, DIRECTOR, FEDERAL RELATIONS, CHRYSLER CORP.

Mr. MAHER. Thank you, Mr. Chairman and Members of the Committee. My name is Walter Maher. I am director of Federal relations for Chrysler Corp., and we appreciate the opportunity to be here today to discuss this important issue.

Chrysler firmly believes that anyone sponsoring a health plan, whether an employer or a government, can achieve savings without sacrificing quality if those benefits are delivered by selective managed care plans as opposed to traditional fee-for-service indemnity plans. And as such, we commend the Committee for examining all the options that are available to increase substantially the number of Medicare beneficiaries enrolled in such plans.

Now, given the current low rate of enrollment of Medicare beneficiaries in managed care plans and the potential savings inherent in increasing that number, real opportunities exist to achieve Medicare savings and help reach balanced budget objectives.

Increases in Medicare managed care enrollment will also help strengthen the hand of employers as they seek to achieve greater efficiencies from the health care system. In short, working in tandem, the public and private sectors can bring about reduced health care costs for our country, help bring those costs more in line with the costs prevailing in other leading countries, and in the process enhance American living standards, American competitiveness, and free up funds to help our country meet its other pressing needs.

Prior to 1989, I was Chrysler's director of employee benefits. With the cooperation of the unions representing many of our employees, we had put into place a series of successful innovative managed care programs designed to reduce the cost of the health care programs covering our employees and our non-Medicare retirees. During the latter half of the eighties, we entered into a cooperative research project with Health Care Financing Administration, HCFA, to determine whether Medicare and employer retiree health costs could be controlled, enrollee satisfaction enhanced, while maintaining quality of care.

Based on the recommendations of Health Data Institute, which conducted the study for us, in 1989 we decided not to pursue a demonstration project at that time. We were in the relative infancy of this concept, the number of unknowns were legion, and the risks to any company sponsor were great. More specifically, the parties were unable to satisfactorily resolve questions concerning risk selection and other uncontrollable risks.

The issue of the demonstration project's administrative cost was a significant one. To achieve lower operating costs would require significant investments amortized over long periods and large enrollments, neither of which were ensured.

We were also unable to secure an agreement with HCFA to permit the demonstration project to use Medicare's favorable provider payment arrangements.

Finally, if additional benefits were to be provided to spur enrollment, the demonstration project would have to generate efficiencies

great enough to exceed the combined cost of the additional benefits, Medicare's 5-percent retention, and the additional cost of administration if it were to reduce the cost for the sponsor of the demonstration.

Now, to say the least, much has transpired since 1989 insofar as health care financing is concerned. One major change in today's environment is the reality of financial accounting standard 106 regarding retiree health expensing. Employers providing retiree health benefits are more than ever acutely sensitive to such costs. They now have an even greater incentive to reduce those costs, but they also have incentives to avoid taking on new risks and liabilities: Witness the decline in the number of employers providing retiree health coverage.

Nevertheless, for employers who continue to provide coverage, it is clear that both they and Medicare have an interest in reducing the cost of retiree health care. Now, whether this will translate into employer interest in entering into risk arrangements with HCFA will depend on a number of factors, not the least of which is the company's aversion to doing anything likely to increase its retiree health cost or risk.

Now, in this regard, forecasted Medicare cost escalation and Part A shortfalls during the post-2002 period, portend further Medicare cost reduction efforts which may deter employers from participating in a demonstration where they assume the risk. Now, while such cost reduction efforts will undoubtedly be required, we would hope the primary focus will be on assuring that providers of care are committed to a continuous quality improvement process eliminating all semblances of waste in the system. The goal should be to reduce the cost of health care for all payers, public and private, rather than shifting costs from the public to the private sector.

Despite all of this, opportunities do exist for employers and Medicare to work together to realize retiree health care savings. For example, many employers offering managed care options offer plans developed by Blue Cross/Blue Shield, commercial insurance companies, and well-recognized HMOs. These plans, in turn, contract with providers. HCFA could negotiate risk arrangements directly with the managed care plans covering Medicare benefits, while the employer could negotiate an arrangement with the plan covering employer-provided complimentary benefits; and, by doing that, meet the combined objectives of Medicare, the employer, and the beneficiaries share.

In conclusion, Mr. Chairman, reforming the Medicare Program to incorporate an extensive offering of managed care options available to the employee population is a long overdo means to reduce the rate of growth in Medicare spending. Both our Federal budget deficit and our high rate of national health spending pose a major threat to sustained economic growth in the future. While solving either or both problems will not solve all of our country's economic and social problems, they are interrelated and solving them will be essential if we are to offer future generations of Americans the opportunities we all have enjoyed.

Thank you.

[The prepared statement follows:]

TESTIMONY OF WALTER B. MAHER
CHRYSLER CORPORATION

Mr. Chairman and members of the Committee, my name is Walter B. Maher. I am the Director - Federal Relations for Chrysler Corporation. Thank you for inviting me to appear here today to discuss employers and the Medicare program, and specifically the provision of Medicare coverage to former employees.

Chrysler Corporation produces cars, trucks, minivans and sport-utility vehicles for customers in more than 100 countries. It has been in business for seventy years. We employ over 120,000 people worldwide, almost 100,000 of whom work in this country. Chrysler provides health benefits for its employees, retirees and dependents of both groups. In 1994, we spent over $800 million for this coverage.

Chrysler firmly believes that anyone sponsoring a health benefit plan, whether it be an employer or a government, can achieve savings, without sacrificing quality, if those benefits were delivered by selective managed care plans as opposed to traditional fee-for-service indemnity plans. As such, we commend this Committee for examining all options to increase substantially the number of Medicare beneficiaries enrolled in such plans.

We also believe that, as Congress sets about the essential task of balancing the federal budget by a date certain, it is most appropriate that action be taken to reduce the rate of growth of federal Medicare expenditures. Given the current low rate of enrollment of Medicare beneficiaries in managed care plans, and the potential savings inherent in increasing that number, real opportunities exist to achieve Medicare savings and help reach balanced budget objectives. Increases in Medicare managed care enrolment will also strengthen the hand of employers and other private sector health plan sponsors as they seek to achieve greater efficiencies from the health care system. In short, working in tandem, the public and private sectors can bring our country's health care costs more in line with costs prevailing in other leading countries, and in the process enhance American living standards, enhance America's competitiveness, and free up funds to help our country meet its other pressing needs.

Medicare Insured Group Feasibility Study

Prior to June of 1989, I was Chrysler's Director of Employee Benefits. While in that position, one of my responsibilities was managing Chrysler's health care plans. As is the case today, controlling health costs was of the highest priority to Chrysler. Due to the highly competitive nature of the global automotive marketplace, and the significantly lower health costs in all other auto-producing countries, controlling health costs is critical to our competitive success.

Prior to 1989, with the cooperation of the unions representing many of our employees, we put into place a series of innovative managed care programs designed to reduce the cost of the health care programs covering our employees and non-Medicare retirees. This included not only traditional HMO's and PPO's, but also PPO's designed specifically for certain coverages, such as mental health and substance abuse cases, as well as programs to reduce the cost of our fee-for-service indemnity plans. As a result of these efforts, Chrysler kept its rate of health cost growth well below that of business in general.

For retirees eligible for Medicare benefits, Chrysler provides coverage for services not covered by Medicare that are covered by our plan for active employees. During the latter half of the 1980's, as part of our overall effort to better manage health plan costs, Chrysler, in cooperation with the UAW, sought to develop a feasible strategy to provide cost effective care for Chrysler retirees eligible for Medicare benefits. It was hoped that it would be possible to demonstrate that a single, integrated Medicare Insured Group (MIG) program would work better than two separate Medicare and Chrysler complementary programs. Consistent with the framework provided by the Omnibus Budget Reconciliation Act of 1987, a cooperative research project was

undertaken with the Health Care Financing Administration (HCFA) to determine whether Medicare and employer retiree health costs could be controlled, enrollee satisfaction enhanced, while maintaining quality of care.

Following a lengthy analysis by Health Data Institute (HDI), in 1989 Chrysler and the UAW concurred with HDI's recommendation not to pursue a MIG demonstration at that time. Several matters contributed to this decision, not the least of which was that we were in the relative infancy of this concept, the number of unknowns were legion, and the risks to MIG sponsors were great.

More specifically, given that the demonstration was to be voluntary for retirees (i.e. the retiree could choose to opt in to the MIG program or retain traditional Medicare coverage), Chrysler and HCFA were unable to satisfactorily resolve questions concerning risk selection and other uncontrollable risks.

Further, the issue of MIG administrative costs was a significant one. The cost to Medicare to administer its fee-for-service plan is significantly less than the costs an employer must incur to administer a comprehensive managed care plan, even for a very large group. Not only were ongoing MIG administrative costs anticipated to be higher, but since Chrysler was not in the health insurance or HMO business, significant start-up administrative costs were projected. To achieve lower operating costs would require significant systems investments amortized over long periods and large enrollments, neither of which were assured. Chrysler and HCFA were also unable to resolve this issue.

Given Medicare's favorable provider payment arrangements, we sought to enable the MIG to have the same terms available to it. We were unable to secure such an agreement with HCFA.

Another issue we confronted was the fact that certain managed care initiatives, to the extent they impacted the number of participating providers, could impact MIG enrollment and risk selection. If benefits over and above those provided by the combined Medicare/Chrysler benefits were to be provided by the MIG to spur enrollment, Chrysler would have to bear the cost of such benefits with no assurance of offsetting savings. In this regard, it should be noted that Medicare was to retain 5% of the cost of an experience rated capitated payment. Accordingly, if additional benefits were to be provided, the MIG would have to generate efficiencies great enough to exceed the combined cost of the additional benefits, Medicare's 5% retention, and the additional costs of administration, if it were to reduce costs for the MIG sponsor.

There were also several uncertainties in 1989, including uncertainties about the then recently enacted Medicare catastrophic coverage law and how it might impact the MIG, and uncertainties about future Medicare cost containment initiatives, including the 1989 recommendation by the Physician Payment Review Commission to change the way Medicare reimbursed physicians.

Current Environment

To say the least, much has transpired since 1989 insofar as health care financing is concerned. Medicare has continued to tighten its provider reimbursement policies to the extent that, for a comparable MIG project to save money today, it must rely almost exclusively on utilization-related savings. Further, some progress has been made to achieve utilization reductions within indemnity plans, so some of the "low hanging fruit" has already been plucked. Nevertheless, managed care still presents savings opportunities for Medicare and for employers providing Medicare complementary benefits.

Another difference in today's environment compared with 1989 is the reality of FAS 106. Financial Accounting Standard 106, which went into effect in 1993, requires

companies providing retiree health benefits to accrue the cost of such benefits during the years employees provide services. Prior to FAS 106, the expense recognized for these benefits was based primarily on the cash expenditures for the period during which the benefits were provided. It is clear that FAS 106 sent a wake-up call to corporate America on the future cost of retiree health benefits. Employers providing retiree health benefits are, more than ever, acutely sensitive to such costs. They now have an even greater incentive to reduce these costs, as well as ample reason to avoid taking on new liabilities.

According to a 1994 study released by KMPG Peat Marwick, Retiree Health Benefits: The Uncertainty Continues, employers' offering of retiree health benefits continues to shrink, even among the largest firms. According to this study, "Corporate America is against the wall on retiree health coverage, and firms are taking dramatic measures in response." It goes on to say, however, that employers are not necessarily out of options:

> ".. there are considerable opportunities for decreasing the burden of retiree health coverage on a firm's balance sheet. Managed-care plans, flexible benefit plans, and defined contribution health plans are just a few of the ways employers may be able to significantly reduce their retiree medical liabilities while still providing some level of retiree health coverage."

It is clear, therefore, that both Medicare and employers have a shared interest in reducing the cost of retiree health care. However, whether this will translate into employer interest in entering into risk arrangements with HCFA will depend on a number of factors, not the least of which is a company's aversion to doing anything likely to increase its retiree health costs or its risk. In this regard, employers must take cognizance of the fact that, according to recent testimony earlier this month before the Senate Budget Committee by Henry J. Aaron , Director of Economic Studies, The Brookings Institution, budget projections indicate that while Medicare outlays, absent change, are scheduled to rise from $176B in 1995 to well over $300B in 2002, they are scheduled to rise further to over $400B by 2005. Likewise, trust fund projections for Medicare Part A indicate that while the cash flow deficit is expected to hit $50B in 2003, it will grow to $100B in 2008. Given such forecasts, continued Medicare cost reduction efforts will likely be required if the federal budget is to remain in balance without resorting to tax increases. This prospect may deter many employers from participating in a MIG like arrangement Further, as efforts continue to reduce Medicare outlays, a primary focus should be on assuring that providers of care are committed to a continuous quality improvement process, eliminating all semblances of waste in the system, and meeting best practice benchmarks. The goal should be to reduce the cost of health care for all payers, public and private, rather than shifting costs from the public to the private sector.

Alternatives

Notwithstanding the above, opportunities exist for employers and Medicare to work together to realize retiree health care savings. For example, many employers offering managed care options, offer plans developed by Blue Cross Blue Shield, commercial insurance companies, and well.recognized HMOs. These plans, in turn, contract with providers. While these managed care plans often incorporate benefit administration techniques developed in concert with the employer, HCFA could seek to negotiate a risk arrangement directly with the managed care plan covering Medicare benefits, while the employer could negotiate an arrangement with the plan covering employer provided complementary benefits. In this way, the retiree would be able to remain in the same health system, subject to the same or similar cost containment rules applicable during pre-Medicare years, free of the administrative hassle retirees coping with both Medicare and a former employer's claims processing procedures must endure, and both Medicare and the former employer could realize health care savings.

In this regard, it should be noted that it has been the existence of ERISA which has facilitated the growth and development of high quality, cost effective employer sponsored health plans, the very plans you seek to enlist to help control the rate of growth in Medicare outlays. For this reason, both the federal government and employers have a mutual interest in preventing the adoption of anti-managed care proposals.

In addition, to assure Medicare does realize savings from the expansion of managed care enrollment, it appears that, in addition to revising the program to provide a reason for a Medicare beneficiary to want to enroll in a managed care plan, Medicare must also develop a risk adjusting technique to guard against risk selection. Based on testimony this Committee received earlier this year from Bruce Vladeck, HCFA Administrator, the Adjusted Average Per Capita Cost (AAPCC) method HCFA uses to pay Medicare risk contractors (not MIGs), is not adjusted for the health status of the enrollee. As a result, managed care currently costs the Medicare program rather than achieving savings, as these plans appear to attract the healthier members of the Medicare population. While negative for Medicare, beneficiaries enrolled in some of these plans receive additional benefits at no cost to them (which often serve as the incentive for them to join the plan in the first case). If Medicare wishes to achieve savings and increase enrollment in managed care plans, this cannot continue.

Conclusion

Mr. Chairman, reforming the Medicare program to incorporate the extensive offering of managed care options available to the employed population is a long overdo means to reduce the rate of growth in Medicare spending. Efforts to achieve Medicare savings which rely mainly on constrained provider fees, and which ignore the savings opportunities presented by managed care, often end up shifting costs to private sector payers and doing little to reduce overall national health spending. Both our federal budget deficit and our high rate of national health spending pose a major threat to sustained economic growth in the future. While solving either or both problems will not solve all of our country's economic and social problems, they are interrelated, and solving them will be essential if we are to offer future generations of Americans the opportunities we have enjoyed.

Mr. MCCRERY. Thank you, Mr. Maher.
Mr. Salter.

STATEMENT OF CHARLES G. SALTER, DIRECTOR, EMPLOYEE BENEFITS, GENCORP, FAIRLAWN, OHIO

Mr. SALTER. Mr. Chairman and Members of the Subcommittee, my name is Charles G. Salter, director of employee benefits of GenCorp. I am also pleased to serve on the board of directors for the Association of Private Pension and Welfare Plans, an association I am sure each of you are familiar with, with their constructive and thoughtful assistance in legislative matters affecting pensions and health care.

GenCorp is a technology-based company in Fairlawn, Ohio, with positions in aerospace/defense, automotive and polymer product markets. We cover approximately 26,000 employees and dependents in our employee medical plans and approximately 21,000 retirees and dependents under various retiree medical programs.

As a representative of a plan sponsored by a self-insured employer and an employee benefits professional, my intent today is to encourage you in your further exploration of the ways in which employers can participate constructively in the Medicare Program.

Like many other emplyers, we are engaged in examining the feasibility of contracting with HMOs that have risk-sharing contracts with Medicare. Briefly stated, I wish to encourage you in the following specific areas:

Congress should encourage the expansion of managed care within the Medicare Program. Managed care should be positioned to enhance the quality of health care delivered to Medicare beneficiaries. Congress should seek to attract more HMOs to participate in the Medicare risk-sharing program. Congress should encourage the participation of employer groups in the HMO risk-sharing program.

First, the experience of employers like GenCorp indicates that the strategy of managing health care produces better results than the passive use of the unmanaged fee-for-service system. Working with health care providers and network managers, such as HMOs or insurers, employers have driven the employee group health marketplace in the direction of organized systems of care that focus on the course of a patient's treatment, the coordination of necessary care, and attention to the overall allocation of scarce resources. The extension of these advances to Medicare beneficiaries should be encouraged and expanded.

Many managed care concepts and innovations have been developed and honed in the marketplace for active employees. Requiring health care providers and managed care networks to be responsive to the needs of plan participants and the employer/payers has literally transformed the marketplace for private employer groups in the last 7 to 10 years. It is not merely an economic phenomenon. Most successful employer managed care programs are focused on improving the quality of health care delivery. Good financial results typically follow efficient delivery of quality health care services. This model has much to offer the Medicare population, particularly in the areas of disease management, wellness, care of chronic health conditions, and the continuity of care.

Next, one of the hallmarks of the movement of employer plans toward managed care has been a focus on improved quality in the health care system. Among the lessons we have learned in manufacturing, as well as in delivering health care benefits to our employees, is that illusive concepts such as health care quality can be reduced to identifiable elements. The relative presence or absence of these elements can serve as indicators of the quality of network management and ultimately the quality of health care delivery.

The coalescence of health providers, network managers, insurers, and other professionals around such benchmarking activities as the HEDIS, Health Plan Employer Data and Information Set, measurement tool and the collaborative efforts of employer-led initiatives like the Cleveland Health Quality Choice program are evidence of marketplace activity that is having success and positive impact on improving the quality of care and reducing cost.

Both, the government and the private sector have substantial financial obligations with regard to retiree medical coverage. Approximately 40 percent of all Americans receive their health care benefits from self-insured employer-sponsored plans. It is clear that both parties have a significant interest in seeing that quality improvement continues to be a hallmark of managed care as it is introduced to the Medicare population.

My message to you today, simply put, is that quality costs less. Incorrect diagnoses, improper treatments, unnecessary service, and the inappropriate setting for care are, by definition, not quality. The key is identifying a reasonable consensus view on quality indicators, communicating that view to managed care organizations, and then driving the change.

Today, less than 10 percent of Medicare beneficiaries are enrolled in managed care for the receipt of their benefits. Despite increased efforts by HCFA and the HMO community, the level of participation is far below the level of participation in the pre-65 population. At GenCorp, the figure in managed care is close to 80 percent.

I will leave it to the HMO community and managed care networks to identify technical factors that may need to be revisited in order to increase managed care enrollment under Medicare. Generally, however, I would call your attention to one significant characteristic of the current Medicare risk-sharing program.

Under the HMO risk-sharing program, HMOs contract with HCFA on a capitated basis to provide at least the full Medicare benefit package, usually along with additional supplemental benefits. This has led, however, to the development of an HMO Medicare product focused on individuals rather than on groups.

The individual nature of the product contributes to the labor intensive way in which HMOs must market, enroll, and administer their Medicare members. It also leads to the final suggestion I wish to offer to you today. Increased employer involvement in enrolling retirees in Medicare risk-sharing HMOs can help bring greater group related efficiencies, greater retiree acceptance as well.

Increased employer participation in the Medicare risk-sharing marketplace has several benefits to the beneficiaries, employers, and the government. Current and future Medicare beneficiaries will be more willing to enroll in Medicare risk-sharing HMOs if

their employers are actively involved in reviewing and monitoring those plans.

Employees are also able to negotiate and improve plan designs from risk-sharing HMOs by seeking supplemental benefits and improve pricing arrangements for employer groups. Experience with enrolling active employees in managed care has also taught employers what needs to be communicated to participants in order for their decisions to be well informed and for a managed care program to be successful.

At GenCorp, we are currently participating in an employer coalition lead by a national benefits consulting firm, Towers Perrin. This coalition of over 70 employers is exploring the offering of selected risk-sharing Medicare HMOs to over 1.5 million Medicare-eligible retirees. We recently completed the first phase of analysis in which we identified the areas where our retiree population, combined with others in the coalition, have a geographic match with current risk-sharing HMOs. The response of HMOs so far is encouraging. We are hoping to negotiate and approve meaningful supplemental benefits on favorable terms in addition to the required Medicare package.

We believe that employer involvement in the process will contribute to higher than average retiree enrollment and satisfaction with the selected HMOs involved. This is a developing example of the positive role that employers committed to the benefits of managed care can play in connection with the Medicare Program.

I thank you for the opportunity to testify today, and I would be pleased to respond to any questions you might have.

[The prepared statement follows:]

TESTIMONY OF CHARLES G. SALTER
GENCORP

Mr. Chairman and members of the Subcommittee, my name is Charles G. Salter, Director, Employee Benefits of GenCorp.

GenCorp is a technology-based company located in Fairlawn, Ohio, with strong positions in aerospace/defense, automotive and polymer product markets with net sales of $1.7 Billion in 1994. We cover approximately 26,000 employees and dependents in our employee medical plans and approximately 21,000 retirees and dependents under various retiree medical programs.

As a representative of a plan sponsored by a self-insured employer and an employee benefits professional, my intent today is to encourage you in your further exploration of the ways in which employers can participate constructively in the Medicare program. Like many other employers, we are engaged in examining the feasibility of contracting with HMOs that have risk sharing contracts with Medicare. Briefly stated, I wish to encourage you in the following specific areas:

- Encourage the expansion of managed care within the Medicare program.

The experience of employers like GenCorp indicates that the strategy of managing health care produces better results than the passive use of the unmanaged fee-for-service system. Working with health care providers and network managers, such as HMOs or insurers, employers have driven the employee group health marketplace in the direction of organized systems of care that focus on the course of a patient's treatment, the coordination of necessary care and attention to the overall allocation of scarce resources. The extension of these advances to Medicare beneficiaries should be encouraged and expanded.

Many managed care concepts and innovations have been developed and honed in the marketplace for active employee group health benefits. Requiring health care providers and managed care networks to be responsive to the needs of plan participants and the employer/payers has literally transformed the marketplace for private employer group health coverage in the last seven to ten years. This is not merely an economic phenomenon. Most successful employer managed care programs are focused on improving the quality of health care delivery; good financial results typically follow efficient delivery of quality health care services. This model has much to offer to the

Medicare population, particularly in the areas of disease management, wellness, the care of chronic health conditions and the continuity of care.

- Use managed care to enhance the quality of health care delivered to Medicare.

One of the hallmarks of the movement of employer plans toward managed care has been a focus on improved quality in the delivery of health care benefits. Among the lessons we have learned in manufacturing, as well as in delivering health care benefits to our employees, is that elusive concepts such as health care quality can be reduced to identifiable elements. The relative presence and/or absence of these elements can serve as indicators of the quality of network management and ultimately the quality of health care delivery. The coalescence of health providers, network managers, insurers and other professionals around such benchmarking activities as the HEDIS measurement tool and the collaborative efforts of employer-led initiatives like the "Cleveland Health Quality Choice" program are evidence of marketplace activity that is having success and positive impact on improving the quality of care and reducing cost.

Both the government and the private sector have substantial financial obligations with regard to retiree medical coverage. Approximately 40% of all Americans receive their health care benefits from self-insured, employer sponsored plans. It is clear that both parties have a significant interest in seeing that quality improvement continues to be a hallmark of managed care as it is introduced to the Medicare population. My message to you, simply put, is that quality costs less. Incorrect diagnoses, improper treatments, unnecessary services and inappropriate settings for care are, by definition, not quality. The key is identifying a reasonable, consensus view on quality indicators, communicating that view to managed care organizations and then driving the process in our roles as payer through continual quality improvements.

- Attract more HMOs in the Medicare risk sharing program.

Today, less than ten percent of Medicare beneficiaries are enrolled in managed care programs for the receipt of their Medicare benefits. Despite increased efforts by HCFA and the HMO community, this level of participation is far below the level of participation of the pre-65 population in managed care. Among active eligible employees, more than 50 percent are enrolled in some type of managed health care system. At GenCorp this figure is closer to 80%. The employers who moved in this direction, some of them many years ago now, have enjoyed the benefits along with the risks of being pioneers. In similar fashion -- that is, to drive marketplace change for Medicare beneficiaries -- I suggest you focus on those policy changes that will

continue to attract HMOs in all regions of the country into the risk sharing program.

I will leave it to the HMO community and managed care networks to identify those technical factors that may need to be revisited in order to increase managed care enrollment under Medicare. Generally, however, I would call your attention to one significant characteristic of the current Medicare risk sharing program. Under the HMO risk sharing program, HMOs contract with HCFA on a capitated basis to provide at least the full Medicare benefit package, usually along with additional supplemental benefits. This has led, however, to the development of an HMO Medicare product focused on individuals, rather than groups. The individual nature of this product contributes to the labor intensive way in which HMOs must market, enroll and administer their Medicare members. It also leads to the final suggestion I wish to offer you; increased employer involvement in enrolling retirees in Medicare risk sharing HMOs can help bring greater group-related efficiencies and greater retiree acceptance to this aspect of the Medicare program.

- Continue to encourage the participation of employer groups in the HMO risk sharing program.

Increased employer participation in the Medicare risk sharing marketplace can have several benefits for Medicare beneficiaries, employers and the government. Current and future Medicare beneficiaries will be more willing to enroll in Medicare risk sharing HMOs if their employers are actively involved in reviewing and monitoring these plans. No amount of HMO marketing and advertising can compete with the positive effect of a communication from the retiree's former employer introducing the managed care concept and the potential benefits of participating in a managed care network or HMO. As I indicated earlier, approximately 80% of our employees are already participating in managed care programs; therefore, continuation of managed care into retirement will be anticipated and considered the norm.

Employers also are able to negotiate improved plan designs from risk sharing HMOs by seeking supplemental benefits and improved pricing arrangements for employer groups. This existing flexibility in the risk sharing program is sometimes not even fully understood by HMOs that have risk sharing contracts with Medicare. As sophisticated purchasers of health services, employers involved in this market place can bring about product innovation by HMOs and greater value to retirees.

Experience with enrolling active employees in managed care programs has also taught employers what needs to be communicated to participants in order for their decisions to be well informed and for

a managed care program to be successful. Success in these programs is measured by participant understanding and acceptance, not by coercion. Employer involvement in enrolling retirees in risk sharing HMOs that the employer endorses can lead to lower disenrollment by retirees from risk sharing HMOs.

At GenCorp, we are currently participating in an employer coalition led by a national benefits consulting firm, Towers Perrin. This coalition of over 70 employers is exploring the offering of selected risk sharing Medicare HMOs to over 1.6 million Medicare-eligible retirees. We recently completed the first phase of analysis in which we identified the areas where our retiree population, combined with others in the coalition, have a geographic match with current risk sharing HMOs. The response of HMOs so far is encouraging; we are hoping to negotiate improved and meaningful supplemental benefits on favorable terms in addition to the required Medicare package. We believe employer involvement in this process will contribute to higher than average retiree enrollment and satisfaction with the selected HMOs involved. This is a developing example of the positive role that employers committed to the benefits of managed care can play in connection with the Medicare program.

Thank you for the opportunity to testify today. I would be pleased to respond to any questions you may have.

Mr. MCCRERY. Thank you, Mr. Salter, and thank all of you for your excellent testimony.

Now I am going to ask Mr. Ensign if he would like to inquire of the witnesses.

Mr. ENSIGN. Thank you, Mr. Chairman.

I want to explore some of these ideas you talked about. Mr. Van Bell, you talked about saving $500 per year. I think that all of you, through a lot of the innovations you have done through your companies and with some of the coalitions, have been able to bring the costs down in some cases, in some cases slowing the rate of growth similar to what we are talking about doing with the Medicare population.

In Mr. Stark's opening testimony, he talked about severe cuts in Medicare spending. I want to address that issue because I think it is a very important issue. The other day we had a person that was in charge of the University of California health care systems, and they talked about savings, over $650 per year per enrollee. Because of the innovations they had done, they actually had savings that much per year.

I asked the question, and I am asking you the same question, do you consider the savings through innovation, and all of you mentioned that you had improved quality and not decreased the level of satisfaction from your enrollees. Do you consider those cuts?

Mr. VAN BELL. I would certainly be happy to try to respond to the question. I don't believe that our retirees or the Medicaid eligible in the State of Iowa that are in our program would look upon our innovations as cuts. I believe that they would look upon them as enhancements to the quality of the care we provide.

In a number of initiatives surrounding our disease management strategies with the asthmatic population, we are beginning to see some real benefits through the education process, teaching these patients how to use peak flow meters and manage their own conditions so they are not needing to run to an emergency room at 3 o'clock in the morning. These kinds of innovations, we believe, are going to clearly enhance the quality of care.

People have told us that they feel they are in control and they are managing their care much more efficiently with the primary physician that they are now a part of, in a relationship.

Mr. ENSIGN. What Mr. Stark said this morning, though, you just cut their benefits because you are spending less money. You are saving money by not going to the emergency room. That is a cut. Just because you are giving them better care, that doesn't mean anything, I guess. That is a cut.

Mr. VAN BELL. Well, I can't really represent what was said earlier. I can only say what we are doing, and I look upon it as a way to improve the quality of care, and that is really one of my missions. If I am saving money in the process that can be used for other types of care or other services in this country, then that is a positive that flows from this activity.

Mr. ENSIGN. Mr. Stark also mentioned in his testimony about maybe these companies getting involved with the retirement population do not have the purest motives at heart when they are trying to get involved with this type population.

Could you, anybody on the panel, address some of the reasons that you would want to be involved with the retirement population, the Medicare population?

Mr. MAHER. I think the only reason a company would want to get involved is the same reason that the government wants to get involved, and that is to have a win-win situation. For that reason, a company is not likely to want to get involved if they think the deck is stacked against them and they are going to lose money, very clearly for the reasons in my testimony. I would submit that Medicare, likewise, should not enter into an arrangement if it would lose money.

I happen to believe that, as you go down this path, which makes an awful lot of sense in terms of trying to get more people in managed care plans, that the current methodology that is used to pay for these beneficiaries appears to be working against the government. The last thing you want to do is to worsen the budgetary situation.

So, I would encourage the Committee to look into how the government pays to make sure that it is a good deal for the government. The only way this is going to work is if it is a good deal for both parties, and, frankly, it can be.

Mr. ENSIGN. Well, not as far as the rhetoric up here is concerned. It is one or the other. I would agree with you. We need to change our paradigm. We need to change our mindset, similar to what business is doing in the United States with labor unions and management.

There are ways to have both parties win. I think the best way for us is to design programs where the Medicare population and the government both win.

Mr. VAN BELL. I would just add that in our health plans, on the boards of our health plans, labor is represented and has been represented for 15 years. So, we have an ongoing dialog with labor.

As we look at managing the costs of our parent company, that is one of our missions within John Deere Health Care. Our retirees are an important part of that, as I mentioned. We believe that it is important to manage all the supplemental benefits that we provide.

Beyond Medicare, we provide the pharmaceutical benefit, drug benefits, vision, hearing, dental. All of those are components of cost that we have to bear as a corporation, and we need to work on managing those costs and that is part of our responsibility.

Mr. ENSIGN. My time is up. Thank you, Mr. Chairman.

Mr. MCCRERY. Thank you, Mr. Ensign.

Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman. Let me thank all three of our witnesses, not only for their testimony, but for the ways in which you have managed your health care for your respective entities. Very impressive testimony and very impressive results.

One of the purposes for today's hearing is to explore the feasibility of looking to private employers to assume more of the responsibility in Medicare, if we were to look at your employees once they reach the age of Medicare eligibility, all remaining in your health care plans.

The Republican-passed budget in the House provides for an annual increase in Medicare over the next 7 years of 5.4 percent. Now, if you adjust that for the demographic changes that are anticipated, that would be approximately a 3.9 percent per capita increase over the next 7 years.

The question that I would like to focus on, would you be willing to assume the responsibility of all of your retirees who have reached the age of Medicare eligibility, and assume full responsibility for their health care costs with the Federal government paying to you the current per enrollee federal cost for Medicare, adjusted annually by 3.9 percent? Can that work?

One of the difficulties we have on optional plans is, we run into the problem of potential adverse selection or cherrypicking, however you want to refer to it, and there is a tendency for the more disabled seniors to stay in fee-for-service under Medicare and not to come into a managed care environment.

So, my question is, if the system were so designed that every person that is in your plan remains in your plan on reaching Medicare eligibility, and the Federal Government were to pay you that sum of money, is that a feasible alternative? Understanding, of course, that we would require that the benefit levels not be reduced or the cost to the seniors increased as one of the ways of bringing the plans into balance.

Who wants to tackle that? Are you willing to assume that responsibility?

Mr. MAHER. I will start. Mr. Cardin, there are a lot of employers, including our company for a sizable number of our retirees, that have already taken the step the Congress is trying to take, that is, by trying to limit our future liability for cost by just assuming that we are going to pay *x* dollars, perhaps inflated each year by some amount, and, in essence, the risk gets transferred, in this case to beneficiaries. For a lot of the reasons set forth in my testimony, I think that you will find a lot of apprehension in the employer community about the proposal that you mentioned.

Let me get to the larger question, and that is businesses in this country today, if they are going to succeed in a global economy must operate with a continuous improvement mentality, setting breakthrough objectives and then, hopefully, meeting them; and setting new breakthrough objectives. The objective should not be whether it is reducing the rate of growth or cutting Medicare costs, it is trying to get the job done as efficiently as possible.

Given all of the indicators of excess in the health care delivery system in this country, I am not prepared to say that 3.9 percent is not doable.

Mr. CARDIN. The question is would you be willing—how would you feel if legislation were crafted that required you to assume this responsibility without diminution of benefits to the seniors or without additional cost to the seniors, guaranteeing you the funds that I said? How would Chrysler feel about that? Would you support that legislation?

Mr. MAHER. Well, first off, I think you saw the attitude of the great bulk of the employer community in the last 2 years when the subject was taking on the risk for active employees on a mandated

basis. I suspect that if you are talking about, all right, we are going to therefore mandate everybody to take on not only——

Mr. CARDIN. I will do it voluntarily. Will you step forward and volunteer to take——

Mr. MAHER. I think my testimony makes clear all of the reasons why you would find a lot of apprehension in the employer community for the employer to assume that risk.

Mr. CARDIN. I understand that.

Mr. MAHER. I think I have set some alternatives here. There are people in the business called HMO plans who are in the business of assuming risk, and there is no reason why HCFA and employers cannot contract with them.

Mr. CARDIN. The difficulty is that unless you take the full group, you run into the——

Mr. MAHER. Selection problem.

Mr. CARDIN. The selection problem. We know that is one we have not been able to come up with a satisfactory solution for. Maybe, you all have the answer to that. We welcome your suggestions. We are still trying to figure out how to deal with selection.

The bottom line is this: Can the business community, which has been successful in dealing with health care by better educating your enrollees and developing better ways of offering additional choice to your employees, can you take on more of this responsibility, at a 3.9 percent annual growth, without diminution of the benefits or additional cost?

I think the answer is—and you were pretty direct—you would be pretty reluctant to accept that kind of responsibility.

I don't know if either of the other two witnesses want to comment or not.

Mr. VAN BELL. I would quickly add that I don't believe we know the answer to the question. There are so many variables when you look at our population versus, say, Chrysler's or anyone else, trying to understand how you would do it. We as an HMO are looking into seeking a risk contract as we speak. Some of the work we are doing with a MIG addresses——

Mr. CARDIN. That doesn't assume all your employees.

Mr. VAN BELL. Pardon?

Mr. CARDIN. That doesn't assume that everyone will join the risk contracts.

Mr. VAN BELL. No, I am talking about the commercial aspect of John Deere Health Care. The risk.

Mr. CARDIN. I'm sorry.

Mr. VAN BELL. There are so many variables that we would have to understand, plus the administrative activities. Seeking a risk contract, as I understand it, is probably a year's proposition at the very best. So, there are a lot of things that go into that decision, and it is very difficult. The variation from different parts of the country. It is so difficult to answer that question.

Mr. CARDIN. Thank you.

Mr. SALTER. I can say that at GenCorp we certainly believe this whole issue is a national issue; probably needs to be spread in some form over the economy as a whole.

What I think each one of us, independently, has said is that managed care has worked at our companies. If you have a level

playingfield, there is absolutely no reason why it cannot work nationally. When we talk about cuts, we are really talking about cuts in waste, cuts in inefficiency.

Our companies are not in the position to continue to invest in waste. Quite the opposite. We are trying to cut that. That, in turn, relates to improved service and improved quality, and so forth.

So, I believe what we are really saying is that quality costs less and the only way you get to quality is to begin to measure what you do. Right now we are not doing that in our health care delivery system.

Mr. MCCRERY. Thank you, gentlemen. Thank you, Mr. Cardin.

Since, Mr. Cardin's questions are always so penetrating and elicit such enlightening information, and because he has no help on his side today, I allowed him to go further than we normally would.

Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Let's just go over some Medicare facts in terms of the spending per senior citizen this year and in terms of medical benefits received. Currently, we are spending $4,800 per Medicare recipient. In year 2002, we are going to spend $6,400 per Medicare recipient in terms of medical benefits received. That is a $1,600 increase.

Listening to Mr. Stark speak, it would seem as if we are bringing an end to Medicare as we know it. These "Mediscare" tactics that have been promulgated by the liberals in this House is really disgusting, and we keep hearing it from our friends on the left. It doesn't help us get to a solution of the Medicare problem.

Clinton's own trustees, as you know, have stated that Medicare goes bankrupt in the year 2002. It is growing at a 10-percent growth rate. We are going to slow it down to 6 percent. But yet, to listen to Mr. Stark and others speak, innovative and novel ideas are not what we need at this time.

My question would be regarding the Democrats' big government experiment with health care last year that was soundly rejected by the American people. Where were each of your companies on this approach to solving health care last year? And then I have a follow-up.

Mr. VAN BELL. We followed the legislation throughout the process and we felt very strongly that the private sector held many of the solutions. We were very concerned about the creation of alliances and more government intervention with our programs.

We felt very strongly that we should continue to work to unleash the private sector in health care. We felt a number of the innovations that we had embarked on and invested in to improve the quality of care would probably not continue if we moved in that direction. So we were terribly concerned with the direction of legislation last year.

Mr. MAHER. Our company believes that the health cost in this country and the cost shifting that is inherent in this country will really never be fully resolved until you get all people in this country covered. As a result, there were many aspects of the Health Security Act, including the goal of getting everyone in this country covered that we supported.

To the extent the country decided that it wanted to continue with a public-private system as opposed to a fully tax supported system,

if we were going to rely on employers to provide coverage for people who worked, the great bulk of people do that, we did support the fact that all employers should be required in some way to contribute to the cost of health care in this country.

We supported reliance on competition in terms of health plan design as opposed to a fully rated regulated system. Because we think that competition, in terms of solving the cost problem, if it is competition versus full rate regulation, you are better to have some blend of both rather than having a fully rated regulated system. Because, clearly, the marketplace has shown that you can get efficiencies in the system. We are starting to see the introduction in some European countries experimenting with HMOs, and so forth, even within their budgeted systems.

We did support a requirement that all employers in some way participate in the system, because my company, for example, and the manufacturing sector in general, is paying about 28 percent additional in health costs because of cost shifting. A great deal of that is because people in our industry, in manufacturing and other large industries end up not only paying for their employees, but also spouses of their employees who have jobs elsewhere. It is just, in our sense, not a fair way of distributing costs.

Mr. CHRISTENSEN. Mr. Salter, also, I would like you to address whether your company has experimented with MSAs at all?

Mr. SALTER. No, we have not. I have a comment on that, though. I think it is interesting, I had a chance to explore the issue as far as allowing individuals through MSAs, for example, to purchase their own health care. It gets to the subject or the topic of innovation in health care.

It is interesting. It is not very innovative if you look at somebody who is selling an appliance in a store. They have a price tag, and they even have a consumer report that will rank all the quality. I think what we have said today is that we really would like to see the force of the markets unleashed at producing efficiencies in the system.

There is no consumer report on health care. Quality is assumed in the system. That is dangerous because we have already recognized we have measured some. There is a large variance in quality within even communities. Price is very difficult to obtain. Therefore, if you are purchasing based upon value, and value typically is some tradeoff between quality of a product and the cost of that product, that is not available in the health care system.

So, really, consumers today cannot go out there and, quote, shop for their health care. I think if we had something like that, it would perhaps go a ways toward helping with MSAs.

Mr. CHRISTENSEN. You are exactly right, and we had a panel yesterday, including, among others, Stuart Altman, who summed it up perfectly about the HCFA and the health care system delivery we have now for the Medicare. His quote was, we are talking about efficiency here. That, unfortunately, sums up our system.

Thank you, Mr. Chairman.

Mr. MCCRERY. Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman. Just a couple of questions, one specific and one a little broader.

Specifically about John Deere. Is this correct, that you give retirees the same health care coverage if they go outside the managed care arrangements?

Mr. VAN BELL. Their benefit offering provides that they have basically the same package. There would be some enhancements through our managed care program, effective case management, some education in preventive medicine, and things like that. They are very much the same plans.

Mr. HOUGHTON. OK. Now, the more general question really is, the difference between the approach that Chrysler and John Deere are taking as far as retirees.

If I understand it, Chrysler rejected the concept—working closer with HCFA—to be able to blend the Medicare and the non-Medicare expenses. It somehow did not work out. John Deere was willing to do that, assuming, of course, that the whole push would be more toward the managed care area, and you thought that that was a good sort of common denominator. Why the difference in the two approaches here?

Mr. VAN BELL. I will let Wally answer that and then I will try to respond, too.

Mr. MAHER. Two things. First, the time period. Our involvement was 1988 and 1989. In addition to the uncertainties that I mentioned in my oral testimony today, my written testimony talks about a lot of the other things on the table then. For example, at that time the Medicare Catastrophic Act had just passed. The question was how in the world is that going to impact our negotiations with HCFA? The Physician Payment Review Commission had just recommended to Congress a total overhaul in the way Medicare paid physicians, which was probably going to be implemented, and indeed was. How was that going to impact our arrangements? Probably the biggest factor is that we are not in the HMO business; John Deere is in the HMO business. They have been working on this project with HCFA for 5 years and will likely start it, as I understand it, next year, 1996.

Being in the health plan business eliminates from consideration a significant amount of the investment in administrative systems. In other words, to a certain extent there is some sunken cost already there in an ongoing HMO that we don't have, and we are in the car and truck business and not in the HMO business.

So, the question to our management at that time, do we want to make an additional investment in this type of system which, to make sense, would have to be amortized over a long period of time and over a large enrollment? The question: Are you going to be in this demonstration for a long enough period of time and get enough people in it to make it worthwhile? And those questions were just not satisfactorily resolved.

Mr. HOUGHTON. OK.

Mr. MAHER. Conceptually, what I think is important, is we continue to believe that both companies offering complimentary benefits and Medicare, both can gain if that Medicare beneficiary is enrolled in a good, efficient health plan. The question is: Who is going to bear that risk?

I think one suggestion we have is there are businesses out there in that business of managing health plan delivery. I suggest that,

in terms of accountability, it may be best to have the health plan, the accountable health plan, be the one bearing that risk. Indeed, that is the business that John Deere Health Care is in, to be an accountable health plan.

Mr. VAN BELL. There clearly are differences. First of all, we feel very strongly that health care is local. Our environments are very different, where Chrysler would be located and maybe where Deere is located with a number of its facilities. I also need to preface any remark by indicating it has been 5 years and that is not really a problem because of HCFA, it has been a combination of a lot of things that had to be dealt with.

We believe with health care being local that we can work with those providers very effectively. We know that most of our retirees domicile in the community in which they work when they retire. We have been in this business for about 20 years. We have a database of retiree costs, at least supplemental costs. The situation was significantly different looking at Chrysler and John Deere.

Now, there are applications, I am sure, very similar to ours in other parts of the country where a MIG might very well work.

Mr. HOUGHTON. Mr. Chairman, could I just ask one more quick question?

Gentlemen, since you are not willing to accept the succulent offer of Mr. Cardin here on the 3.9 percent, I must assume, therefore, that you are going to be able to control your costs over the next 5 years below that. Is that right?

Mr. VAN BELL. I don't know as anyone really knows what is going to happen with costs over the next 5 years. I know we will negotiate additional labor contracts in that period of time. I have no idea what might be envisioned in labor negotiations that might impact retiree costs. I have no idea what might happen at the State or Federal level. It is very, very difficult to try and forecast what those costs are.

What I try to do is to manage those costs as well as I possibly can with a quality thrust. Our whole effort, we really believe that enhancing the quality of care is going to reduce the cost of that care. Everything we do, our physicians that are on staff in our centers, our work with Mayo, all are directed to do that. We believe the payoff is in managing that cost. The peripherals out there, many things I cannot control.

Mr. HOUGHTON. Thank you, Mr. Chairman.

Mr. MCCRERY. Thank you, Mr. Houghton.

Mr. Van Bell, if you can, let us explore some of the negotiations that have been taking place with HCFA over the last several years. I am going to try to characterize the interests of HCFA and the interests of John Deere and you tell me if it is a proper characterization and then let us expound on it.

HCFA, I assume, is concerned that if they give you a capitated rate for folks in your HMO that you will get the low-cost employees into your HMO and the high-cost employees will stay in the fee-for-service and Medicare will have to reimburse them on a fee-for-service basis.

Your concern, I would assume, is that if you accept a capitated payment, you don't want to get all the high-risk patients in your

HMO under a capitated rate and have the better risk stay in fee-for-service.

Is that the tug and the pull that has been taking place?

Mr. VAN BELL. I don't know it is fair to characterize it as a tugging and pulling, but I would say that trying to understand what the rate ought to be is the question. We have been working with HCFA in very positive ways to try to determine what the appropriate rate is, looking at the Deere experience, looking at the county experience, looking at national experience.

We have engaged the help of Deloitte & Touche as we work through this and in attempting to come up with what is appropriate. Obviously, the MIG has a 5 percent savings right off the top, on whatever rate you establish for the beginning of the demonstration for the Medicare Program. There also is a cap on what we would be able to retain if, in fact, we do generate the savings that we believe are there through local involvement, local control.

I believe that the rate setting will be established. I think it is a question of making sure that we have the appropriate risk and reward relationship put together.

Mr. MCCRERY. And where are you right now?

Mr. VAN BELL. We are really in the final stages of reviewing where we are on rates. We have had some dialog in the last few weeks. We expect that we will be sitting down with HCFA very shortly.

Our goal would be to do that, to continue to visit with the UAW, United Auto Workers. We have brought them along as this process has evolved over the last several years. It has been in phases, if you will. Factfinding, rate setting, and education. Our goal would be that we would start that MIG sometime the end of this year or January 1, 1996. That is at least the objective set in place.

Again, I will assume that we can work through the rate-setting issues. I assume that we will have continued endorsement from the UAW to do the demonstration.

Mr. MCCRERY. Well, are you basing your assumptions on a normal or average group or are you trying to get more specific than that and analyzing who your participants are going to be?

Mr. VAN BELL. The work that we have been doing is a demonstration in one community where Deere has a major presence. It is in the quad city, Moline, where our corporate office is located. About 350,000 people reside in that community and we have a good concentration of retirees that live there.

We are trying to understand the experience of that population, which is data that HCFA has. We would only have supplemental data. What the county rates are versus national rates and trying to understand how the Deere population stacks up in there so we can set the rate that is appropriate and HCFA then in fact is incented with their 5 percent and we are incented to perform the kinds of things I mentioned earlier we are working to do.

Mr. MCCRERY. Will all of your retiree population participate?

Mr. VAN BELL. In that community they would be placed in the MIG, but could elect to opt out of that program if they so elect. It is my understanding that that is acceptable as to how we would do it.

We would have to go into an exhaustive education process. Keep in mind, a lot of our retirees already are in our managed care programs in that community.

Mr. MCCRERY. But if they have that option to get out of the HMO, isn't HCFA concerned that their high risk beneficiaries will opt out and go for the fee-for-service?

Mr. VAN BELL. I have not personally been in a discussion where that was mentioned. It may be that that is an issue that they will raise with us, I don't know.

Mr. MCCRERY. OK. One last question for Mr. Salter. If you want to entice your retirees to join a Medicare HMO, how would you do it?

Mr. SALTER. Well, probably the easiest way is an evolutionary approach. We have, for example, close to 65 or 70 percent of our active employees on the West Coast in HMOs now. Our biggest challenge, obviously, is the challenge of change, and it takes some time to get people used to the managed care concept.

I think any time that you run parallel systems where you are allowing essentially two delivery systems to operate side-by-side, one that allows, "total freedom of choice to go anywhere you want on a fee-for-service basis and another, managed care system that has restrictions on utilization, people with higher risk will tend to opt for the fee-for-service system."

The way we have expressed it at GenCorp, is that we are on a continuum of care and we are moving from fee-for-service toward full managed care. So, where GenCorp will ultimately spend its money is in the managed care environment. It will become, I believe, prohibitively expensive for employees and then, later, as retirees, to go into the fee-for-service system, if that is provided as a choice at all.

I think you do it in an evolutionary manner. In the short term your biggest problem is with change, changing purchasing behavior and having confidence that the care that is delivered in the new setting, the managed care setting, is equal to and, in fact, better than the care that can be obtained by self-referral.

Mr. MCCRERY. So, I am inferring that when you say if they choose to stay in fee-for-service it would become prohibitively expensive, that you are going to either reduce their benefits or increase their coinsurance if they choose to stay in that form of service?

Mr. SALTER. I believe that is necessary just as in other areas of our business. Remember part of my message here today is that the phenomena of having a price on an item with a quality indicator, is not unique in this country, it is only unique that it is absent in the health care delivery system.

Our company purchases a number of things on a wholesale basis. When we do that, we are also allowed to set higher specifications for the production of the services and products that we receive. So, what we are saying is that if the company has determined after a period of time that it can produce, it can purchase rather, a higher quality product at lower cost, it only makes sense, then, if someone chooses to continue to purchase retail, that the company charge the differential.

Mr. MCCRERY. So, the answer is yes.

Mr. SALTER. Yes.

Mr. VAN BELL. Mr. Chairman, one additional comment I would make. It may sound a little unusual, but it is really to our benefit if we can get the people with the greatest illnesses in our plan, because we then can more effectively manage that care and the supplemental benefits that we provide, the pharmaceutical, the drug costs, if you will.

So, it may sound a little unusual, but trying to encourage the sickest, if you will, into our managed care program would be beneficial to Deere in managing its supplemental cost.

Mr. MCCRERY. Thank you, gentlemen, for your comments. We appreciate your testimony.

We now call up the second panel. Matthew Stover, president and chief executive officer of NYNEX Information Resources Corp., and he is here on behalf of the National Association of Manufacturers and accompanied by Sharon Canner, vice president, human resources policy department, National Association of Manufacturers; James S. Ray, counsel, National Coordinating Committee for Multiemployer Plans, and he is accompanied by Judith Mazo, counsel.

Thank you for joining us today, and like the previous panel, any written prepared remarks that you have will be entered into the record and we would ask you to summarize your testimony in 5 minutes. When the yellow light comes on, you will have about 1 minute to conclude. When the red light comes on, if you would just attempt to reach a conclusion.

Mr. Stover.

STATEMENT OF MATTHEW STOVER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NYNEX INFORMATION RESOURCES CORP., ON BEHALF OF NATIONAL ASSOCIATION OF MANUFACTURERS, ACCOMPANIED BY SHARON CANNER, VICE PRESIDENT, HUMAN RESOURCES POLICY DEPARTMENT, NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. STOVER. Thank you, Mr. Chairman, Members of the Committee. I am Matthew Stover, president and chief executive officer of NYNEX Information Resources Corp., the information services subsidiary of NYNEX Corp. NYNEX employs 67,000 active individuals and we have 63,000 retirees, for all of whom we provide approximately $640 million in annual medical coverage. I am also a member of the board of directors of the National Association of Manufacturers and chair the NAM's employee benefits committee.

NAM would like to thank you and your colleagues for taking a leadership role in the Medicare debate. The NAM agrees the present Medicare system needs to be restructured and we are pleased to be given the opportunity to participate in your search for the best restructuring solutions.

Your concept of seamless coverage in which the Federal Government would make payments to employers who retain their Medicare-eligible retirees in their health plans is an innovative response to the crisis in the Medicare system. Employers would have the option to assume the risk of these retirees and manage their care with the same tools that we have been using to successfully manage the care of active workers.

In summarizing my written statement today, I would like to discuss the NAM's principles for Medicare reform, highlight several trends in employer-sponsored health coverage, and conclude by noting several specific concerns of beneficiaries, government, and employers.

The NAM urges this Committee to consider the following principles as it modifies Medicare: That any modification should: (1) provide incentives for greater use of managed care; (2) maintain quality health care for employees, retirees, and Medicare beneficiaries; (3) seek solutions that reduces escalation of medical costs for the Nation as a whole; (4) avoid initiatives that result in cost shifting; and finally, continue to pursue market approaches to ensure access to quality medical care for all Americans.

Consistent with these principles, the NAM board of directors adopted a resolution on Medicare and Medicaid in February of this year. Within that resolution, the NAM supports efforts to reduce our Nation's budget deficit, however, we believe that unilateral across-the-board reductions in the Medicare and Medicaid Programs should be avoided because they are likely to exacerbate cost shifting to the private sector and individuals. The challenge for business individuals and the government is to reduce the total cost of health care, both public and private.

Specifically, the NAM supports restructuring Medicare with an emphasis on greater use of quality managed care, which delivers higher value by encouraging more efficiency and the wiser use of services. Cost containment is important to all Americans and it is very important to many NAM companies that provide broad medical benefits and are forced to compete internationally with companies that do not incur similar expenses.

Consistent with this, the NAM commends you for proposing ways to restructure Medicare and for exploring opportunities to increase the use of managed care for Medicare beneficiaries. As you consider a role for employers in the Medicare system, it is important to note a few facts. While 97 percent of NAM members provide health coverage to active workers, only 61 percent of all working age Americans receive employment-based coverage. In addition, 52 percent of employers surveyed provide early retiree benefits, in 1992, down from 64 percent in 1987. So, there is a trend downward in the coverage of retirees.

According to the Health Care Financing Administration, 75 percent of Medicare beneficiaries have private insurance to supplement Medicare while 38 percent have employer-sponsored coverage. So, we see that employers are disengaging themselves from the retiree health system. In fact, between 1987 and 1992 it reduced from 57 percent down to 46 percent.

In considering the creation of a seamless health care option for Medicare beneficiaries, the benefits and costs of Medicare-eligible retirees, the Federal Government, and the employer community must be considered. Medicare-eligible retirees would benefit from greater access to quality managed care plans offered by former employers, particularly if this allowed them to remain in their current managed care plan. However, Medicare-eligible retirees may have some geographic difficulty gaining access to employer-sponsored plans because they may not be located where the retiree is living.

The Federal Government may overestimate savings from this concept, particularly if the only employers who choose to participate are the ones with, "healthier retirees." Greater savings would result from moving the less healthy Medicare populations into managed care arrangements, not the healthier ones. The solution to this issue may, unfortunately, not be found without more government regulation, looking at risk adjustor systems and also looking at increased government regulation and review to monitor the solvency of employer's health plans and the proper use of payments.

Employers will insist that the seamless coverage concept be voluntary for both the employer and the retiree. Clearly, any mandate to shifting cost from government to business would be unpopular and would not address the fundamental issue of reducing the overall rate in the growth of health care costs. It is of note that some employers already are trying to increase retiree participation in managed care plans by encouraging their retirees to join risk contract HMOs. These are HMOs that contract with HCFA to treat Medicare-eligible retirees.

NYNEX and seven other large employers are participating in Florida in a Medicare Risk Coalition which is designed for employers with large retiree populations in Florida. The employer members of the coalition, which began on January 1 of this year have approximately 27,000 Medicare-eligible retirees in Florida and we have contracted with four Florida HMOs to provide a voluntary conversion to managed care. So far, a few hundred of these retirees have elected to make the switch this year.

Let me conclude by saying again how pleased the NAM is that you and your colleagues are exploring ways to restructure and improve Medicare. The NAM commends your efforts. Our comments today are offered to be helpful and highlight issues that will need to be considered in developing a seamless coverage option. NAM agrees more retirees should be covered by cost-effective and quality managed care plans. Of course, there will be, as with any major restructuring of a system, technical issues that must be considered in the final approach, but the overall concept of employers and government working together to reduce waste and inefficiency in our Nation's health care system is one with which the NAM very much agrees. Thank you.

[The prepared statement follows:]

TESTIMONY OF MATTHEW STOVER
NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. Chairman and members of the Subcommittee, I am Matthew J. Stover, President and Chief Executive Officer of NYNEX Information Resources Corporation, an information service company which is a subsidiary of NYNEX Corporation. NYNEX has 67,000 employees and 63,000 retirees worldwide. I am also a member of the National Association of Manufacturers Board of Directors and I chair NAM's Employee Benefits Committee. I am testifying today on behalf of the NAM. I am accompanied by Sharon Canner, Vice President of NAM's Human Resources Policy Department.

The NAM would like to thank you and your colleagues, Mr. Chairman, for taking a leadership role in the Medicare debate. The April 3 report of the Board of Trustees of the Federal Hospital Insurance Trust Fund concerns us all. As you know, the Trustees essentially told you that Medicare Part A, if left unchanged, would be insolvent by 2002. The NAM agrees that the present Medicare system needs to be restructured and we are pleased to be given the opportunity to participate in the debate.

Your concept of "seamless coverage," in which the federal government would make payments to employers who retain their Medicare-eligible retirees in their health plans is an innovative response to the crisis in the Medicare system. Employers would assume the risk of these retirees and manage their care with the same tools employers have been using to successfully manage the care of their active workers. The NAM urges this committee to consider the following principles as it modifies Medicare:

- Provide incentives for greater use of managed care;
- Maintain quality health care for employees, retirees and Medicare beneficiaries;
- Seek solutions that reduce the escalation of medical costs as a whole;
- Avoid initiatives that result in cost-shifting;
- Continue to pursue market approaches to ensure access to quality medical care for all Americans.

Today, I would like to discuss the following matters with you. First, I will provide a general background on employers and retiree health coverage. I will then discuss the NAM principles for Medicare reform. I will conclude with a discussion of the issues that will concern Medicare beneficiaries, the federal government and employers should the Congress move forward to develop the seamless coverage concept.

I. Background - Employers and Retiree Health Coverage

A. Early Retiree Coverage. Many employees retire before they are eligible for Medicare. To understand how Medicare might be integrated with employer-provided coverage, it is important to examine health care coverage for this group of retirees.

In 1992, slightly over half -- 52 percent of employers surveyed by the benefits consulting firm A. Foster Higgins, provided health care benefits to their retirees under age 65. This figure was down from 64 percent in 1987. Manufacturers, according to the Employee Benefits Research Institute (EBRI), provided the bulk of this coverage with approximately 64 percent (in 1991) of manufacturers making health insurance available to retirees aged 51 to 61.

Firm size is the major predictor in determining if a firm provides retiree health benefits. A 1993 survey, reported by EBRI in its most recent Databook on Employees Benefits, showed that in firms of 10 to 49 employees, only 8 percent provided health insurance coverage to retirees under age 65. By contrast, in firms of 20,000 or more employees, 84 percent provided health insurance coverage to such early retirees. Given these statistics, it seems likely that larger employers would be the employers most interested in participating in a seamless coverage system. Most firms (68 percent) that provided health coverage for retirees under 65 require that the retiree pay the entire premium. Only eleven percent of responding firms shared the cost with the early retiree.

B. Medicare-Eligible Retirees. Medicare is the primary payer of benefits for retirees aged 65 and over. Employer benefits are secondary. In 1993, 10 percent of employers surveyed by A. Foster Higgins provided health insurance to their retirees aged 65 and older. Only 22 percent of those employers paid the entire cost of this coverage. The most common type of coverage was a Medicare coordination of benefits (COB) plan. Under the COB method, the private plan pays the difference between the Medicare payments and the total charge, as long as that difference is less than the total amount the private plan would

have paid in the absence of Medicare.

In 1991, the Health Care Financing Administration (HCFA) found that approximately 75 percent of Medicare beneficiaries had some form of private insurance to supplement Medicare. Approximately 38 percent supplement Medicare with employer-sponsored private insurance.

It is important to note that the number of Medicare beneficiaries with employer-sponsored supplemental coverage declines with age. The 1991 Medicare beneficiary survey showed that employer-sponsored coverage is at its highest among beneficiaries ages 65 - 69 (41.5 percent). The number drops steadily until reaching a low point of 15.5 percent covered under employer-sponsored plans for beneficiaries 85 or older.

This trend is troubling. We are here today to discuss the potential role for employers in the Medicare system. At the same time, employers are disengaging themselves from the retiree health care system. As the number of Medicare beneficiaries with employer-sponsored health coverage continues to decline, due to forced reductions by many large employers and business decisions to reduce retiree benefits, creating a role for employers in the Medicare system will be more challenging.

C. Managed Care and Employer Health Care Costs. Many employers have found managed care to be a crucial component in their efforts to control their health care costs and provide quality, cost-effective health care to their employees. More than 90 million Americans are now enrolled in some form of managed care. In fact, HMO enrollment alone has nearly doubled since 1986 to 50 million people in 1994. The Congressional Budget Office reports that the most effective HMO's -- group and staff model HMO's -- can reduce employers' health care costs by 22 percent compared to typical indemnity plans. In contrast, approximately 8 percent of Medicare beneficiaries -- 2.3 million -- were enrolled in HMO's as of December 1994.

II. NAM Principles

In February 1995, the NAM Board of Directors approved a resolution on Medicare and Medicaid. The NAM supports efforts to reduce our nation's budget deficit; however, unilateral across-the-board reductions in the Medicare and Medicaid programs should be avoided because they are likely to exacerbate the cost-shifting to the private sector and individuals. The challenge is for government, business, and individuals working together to reduce the total costs of health care, both public and private.

Specifically, the NAM supports restructuring Medicare with an emphasis on greater use of quality managed care, which delivers higher value by encouraging more efficiency and wiser use of services. Strategies to accomplish this goal should include reducing barriers to managed care, promoting innovation, and fostering competition among program providers.

Given our Board's resolution, we commend you, Mr. Chairman, for proposing ways to restructure Medicare and for exploring opportunities to increase the use of managed care for Medicare beneficiaries. Current health care expenditures by the government, businesses and individuals cannot be sustained. The United States devotes a much larger portion of its GNP to health expenditures than do other industrialized nations. The NAM supports a reduction in the rate of growth in overall health care costs for all payers. Cost-effective purchasing and management of care will be critical. At the same time, any solution must maintain quality health care for employees, retirees and Medicare beneficiaries. The solution should not shift costs. It is in the nation's best interest if the solution reduces the rate of growth in all health care spending without resorting to cost-shifting.

Further, as background, long-standing NAM policy suggests the following guidelines: Public programs (Medicare and Medicaid) should be structured to distribute the burdens equitably between the public and private sector and among consumers, payers, and health care providers. Cost-conscious consumer behavior should be encouraged through greater cost-sharing and other incentives. Cost-conscious provider behavior should be encouraged through measures such as prospective payment systems and at-risk arrangements.

III. Issues to Consider in Creating a Seamless Coverage System

In considering the creation of a seamless health care system for Medicare beneficiaries, the benefits and costs to Medicare-eligible retirees, the federal government and the employer community should all be considered.

A. Considerations for Medicare-Eligible Retirees. Medicare-eligible retirees

would benefit from greater access to quality managed care plans offered by their former employers, particularly if this allowed them to remain in their current managed care plan. They could remain with the same doctors they had before they became Medicare-eligible, and they would be familiar with the plan's procedures.

Medicare-eligible retirees may have some difficulty gaining access to employer-sponsored managed care plans. First, to make educated decisions about their health care, employees need to be adequately informed of their options. Providing this information to retirees may place an increased administrative burden on the former employer. There may also be geographic issues to consider. The former employer's managed care plan may not be located where the retiree now lives. In this situation, remaining with the former employer's managed care plan would not be a viable option.

Retirees who are "snowbirds" -- that is, they live in one, usually warm place for some or all of the winter and elsewhere for the rest of the year -- often cannot enroll in "closed panel" HMO's. This model HMO does not cover the cost of care outside the HMO. Using a provider outside the network is prohibited. These individuals could enroll in their employer-sponsored open panel HMO's, which permit visits to a provider outside the HMO, but the cost of using a non-network provider may be prohibitive.

B. Considerations for the Federal Government. If the former employer who successfully manages the Medicare-eligible retirees' care is allowed to retain any savings, employers with healthier retiree populations are more likely to be attracted to this seamless coverage concept. These employers could expect to successfully manage their retiree's care. This trend will leave the higher-cost retirees in traditional Medicare plans. As a result, the federal government would save less than anticipated because greater savings would result from moving the less healthy Medicare populations into managed care arrangements, not the healthier ones.

The solution to this favorable selection issue may unfortunately be more government regulation, which runs counter to the expressed philosophy of many members of Congress and the NAM. The solution may be a risk adjustor that incorporates some measure of health status. Such a system would pay employers accurately for the risk that their retirees represent, thereby bringing government costs down. However, implementing such a risk adjustment may be prohibitively expensive and administratively burdensome for many employers and their health plans. As a result, it may fall on the government to bear the cost of a risk adjustment system.

Another factor to consider is that Medicare enjoys lower administrative costs, as a percentage of total spending, in administering fee-for-service payment than the private sector does in administering managed care plans. According to HCFA, in 1988, the administrative costs of the Medicare program were 2 percent of total program costs, but were 5.5 percent for the large group market -- firms with more than 50 employees. Employers who provide expanded coverage to their retirees may require additional funding to cover their higher administrative costs.

Increased government regulation and bureaucracy may be needed to monitor the solvency of an employer's health plan and the proper use of payment from the government to the employer. This raises both a jurisdictional and a cost-benefit issue. Under the Employee Retirement Income Security Act (ERISA), the Department of Labor has general oversight of how private employee benefits plans are administered, but the Health Care Financing Administration (HCFA) administers Medicare. No matter which agency monitors such a process, regulations would be needed to protect Medicare beneficiaries whose former employers stopped providing health benefits or became insolvent. Monitoring the transactions and solvency of private plans, although necessary, would create additional government regulations and costs. The costs and benefits of this additional regulation would need to be further analyzed.

C. Considerations for Employers

1. Seamless Coverage Must Be Voluntary. The concept of seamless coverage raises a number of issues for employers. First, a seamless coverage system should be voluntary for both the employer and the retiree. Since 1974, the Employee Retirement Income Security Act (ERISA) has given employers the ability to structure their benefit packages according to the needs of their employees and retirees. The voluntary ERISA-system has been crucial to the ability of employers to find innovative and creative ways to provide cost-effective, quality health care benefits. Clearly, any mandate or shift in costs

from government to business would be unpopular and would not address the fundamental issue of reducing the overall rate of growth in health care costs.

It would be administratively difficult for self-insured employers to accept payments directly from the government for the provision of health care benefits. A more attractive arrangement from the perspective of employers may be for the government payments to go directly to the managed care plan, which would then bear the risk.

2. FAS 106. Another issue to consider is Financial Accounting Standard 106 (FAS 106), which went into effect for most companies in 1993. This standard requires companies that sponsor retiree health plans to record unfunded liabilities for future expenditures on their balance sheets. The standard increases balance sheet liabilities for corporations that have large retiree populations and/or generous health benefit plans. To the extent that any payment did not adequately compensate employers for their retirees' health care costs, the FAS 106 rule would make these employers appear to be less attractive investments and adversely affect their competitiveness.

3. Continued Budget Cutting. The environment of government downsizing and deficit reduction may make many employers leery of participating in this concept of seamless coverage. Congress may decide to reduce payments to employers in future years. Such a reduction would leave employers with a costly and unsustainable burden as more of their employees become Medicare-eligible. This would induce fear among employers who have volunteered to participate and may lead to many leaving the program. In fact, anticipation of the budget cuts that are being considered by Congress may be enough to discourage many employers from participating in this new seamless system in the first place.

4. Employers and Risk-Contract HMO's. Some employers are already trying to increase retiree participation in managed care plans by encouraging their retirees to join risk-contract HMO's. These HMO's which contract with HCFA to treat Medicare-eligible retirees usually have a special expertise with Medicare beneficiaries. Under Medicare risk contracts, an HMO receives 95 per cent of the average per capita rate reimbursed under conventional Medicare coverage for each of its Medicare members, and it must absorb any losses if its costs to provide care to those members exceed that rate. The few employers that have successfully led more of their retirees to enroll in risk-contract HMO's have lowered their supplemental premiums and often provided their retirees with more comprehensive coverage, all within the construct of existing law.

For example, NYNEX and seven other large employers are participating in the Florida Medicare Risk Coalition, which is designed for employers with large retiree populations in Florida. The employer members of the Coalition, which began January 1st of this year, together have 27,000 Medicare-eligible retirees in Florida.

The Coalition contracted with four Florida HMO's to promote a voluntary conversion to managed care. So far, only a few hundred of the retirees have made the switch. For each retiree that has switched, his or her former employer will save from $500 to $2,000, depending on how much the employer had been spending on supplemental coverage. If the government redesigns the HMO payment formula in the risk program, it too could save money from the current Medicare risk contract program.

IV. Conclusion

Mr. Chairman, let me conclude by again saying how pleased the NAM is that you and your colleagues are focused on the Medicare system and exploring ways to restructure the program. The NAM commends you for your efforts. Our comments today are offered to be helpful and highlight issues that will need to be considered when developing a seamless coverage system.

The growth in the rate of health care expenditures cannot be sustained, particularly in our public programs. Restructuring of the Medicare system needs to be a top priority for this Congress, particularly in light of the Trustee's report on the looming crisis.

The NAM agrees that more retirees should be covered by cost-effective and quality managed care plans. There will be, as with any major restructuring of a system, technical issues that must be considered but the overall concept of employers and the government working together to reduce waste and inefficiency in our nation's health care system is one the NAM very much agrees with.

Again, NAM urges this Subcommittee to consider the following principles as it

reforms Medicare:

- Provide incentives for greater use of managed care;
- Maintain quality health care for employees, retirees and Medicare beneficiaries;
- Seek solutions that reduce the escalation of medical costs as a whole;
- Avoid initiatives that result in cost-shifting;
- Continue to pursue market approaches to ensure access to quality medical care for all Americans

We look forward to working with you in the months ahead and congratulate you on your vision in seeking innovative ways to remedy the Medicare crisis. Mr. Chairman, I would be happy to answer your questions or those of any other member of this subcommittee.

Mr. MCCRERY. Thank you, Mr. Stover.
Mr. Ray.

STATEMENT OF JAMES S. RAY, COUNSEL, NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS, ACCOMPANIED BY JUDITH F. MAZO, COUNSEL

Mr. RAY. Thank you, Mr. Chairman. I am accompanied by Judy Mazo, who is also a member of the NCCMP's professional staff, and by Jack Curran, the NCCMP's long-time legislative director. On behalf of our chairman, Bob Georgine, let me express our appreciation for the opportunity to participate in this discussion.

For 20 years now, the NCCMP has been representing the interests of the more than 10 million workers and families who obtain their health coverage through joint labor-management multiemployer plans established by collective bargaining under the Taft-Hartley Act of 1947. I should note, Mr. Chairman, that our population of plan participants and beneficiaries is defined by coverage under a collective bargaining agreement and not by health status. So, there is no cherrypicking with regard to our plans.

Mr. Chairman, the multiemployer plan community is interested in exploring cost-effective means by which Medicare-eligible employees, retirees, and their spouses, covered by our health and welfare plans, can look to those plans for both their Medicare benefits and other health, disability, and death benefits that our plans may provide. We believe that arrangements for multiemployer plans to deliver such seamless coverage, as workers move through active employment into retirement, can be worthwhile for all parties: Medicare beneficiaries, multiemployer plans, and taxpayers alike.

We would appreciate the further opportunity to submit to the Subcommittee at a later date a proposal for such "one-stop shopping" for multiemployer plan participants and beneficiaries.

In developing a proposal, we are guided by a fundamental principle: They must be designed to help, not hurt, our plan participants. This means Medicare-eligible participants and beneficiaries must be assured of coverage at least as good as what the current Medicare Program delivers, and the program must not imperil the plan's ability to continue providing other participants with good health coverage at a moderate cost. We believe that this is doable under certain conditions.

Financing is the key, however, both for the government and for our plans. In managing multiemployer plans, the trustees are not running a business in which they are free to take big risks in the hope of achieving big gains. They are nothing more and nothing less than fiduciaries of a fund that must be administered in a way that maximizes the benefits of those it covers.

Because Medicare has provided the lion's share of health coverage for the over 65 population for so long, multiemployer plans, like other private sector payers, do not have reliable independent bases of experience from which to estimate the potential cost of following that age group back into their basic coverage.

Initially, a fair amount of trial and error will be needed to cost out these programs. To attract multiemployer plans to such voluntary arrangements, various concerns relating mostly to financial risk will have to be addressed. Among those are, number one, the

pricing. How much will Medicare pay to the plan? To what extent, if any, do cost sharings or do cost savings from favorable experience have to be shared with the government?

Design. To what extent will plan trustees have flexibility to design the benefit package and delivery system for Medicare eligibles as well as our other participants?

And regulation. To what extent will plans be required to comply with Medicare regulations on top of ERISA's regulatory scheme?

We believe that there is much to be gained for all parties, Medicare eligibles, multiemployer plans and their participants as a whole, and the Medicare Program itself, if an arrangement that satisfactorily addresses these concerns can be designed.

Mr. Chairman, we thank you, and Judy and I are prepared to answer any questions you may have.

[The prepared statement follows:]

TESTIMONY OF NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS (NCCMP) AS PRESENTED BY JAMES S. RAY AND JUDITH F. MAZO

Mr. Chairman and Members of the Subcommittee:

On behalf of the National Coordinating Committee for Multiemployer Plans (NCCMP), its affiliates, and its Chairman, Robert A. Georgine, we are pleased to have this opportunity to share with you the interest of the multiemployer plan community in exploring cost-effective means by which Medicare-eligible employees, retirees and their spouses who are covered by multiemployer health and welfare plans can look to those multiemployer plans for both their Medicare benefits and any other coverage -- supplemental, for retirees, or primary for active workers -- that the health and welfare plan provides. We believe that arrangements for the multiemployer plans to deliver that kind of "seamless" coverage can be worthwhile for the beneficiaries, the plans and the U.S. taxpayers. We would appreciate the further opportunity to submit to the Subcommittee at a later date a more detailed proposal for such "one stop shopping." In considering the specifics, we have a fundamental guiding principle: its must be designed to help, not hurt, our plan participants. This means that Medicare-eligible participants and beneficiaries must be assured of coverage at least as good as what the current Medicare program offers, and the program must not imperil the plans' ability to continue providing the other participants with good health coverage at moderate cost. We believe this to be do-able.

To assist you in understanding the perspective from which we approach this question, let us first describe the NCCMP, the nature of multiemployer plans, and the concerns of multiemployer plans and the millions of families they cover with regard to the current health care system.

The NCCMP

The NCCMP is a non-partisan, non-profit organization of multiemployer pension, health and welfare plans and their labor-management sponsors. The NCCMP was established in 1975 to represent the legislative, regulatory, and legal interests of the multiemployer plan community -- a community composed of thousands of plans, more than ten million American workers and their families, and tens of thousands of labor-management sponsors.

The national, regional and local benefit plans affiliated with the NCCMP cover workers in a variety of industries including building and construction, food and commercial, transportation, service, clothing, textiles, bakery and confectionery, entertainment, and maritime.

Since the enactment of the Employee Retirement Income Security Act of 1974 (ERISA), the NCCMP has provided guidance to Congress, the Labor Department, the Internal Revenue Service, the Pension Benefit Guaranty Corporation, other government agencies, and the courts on a wide variety of legislative, regulatory and legal issues of concern to the multiemployer plan community. The organization's contributions to the development of employee benefits law with regard to multiemployer plans has been publicly recognized on many occasions by Congress, by administrative agencies, and by the Supreme Court.

The retirement, health, and income security of millions of Americans depends upon the continued existence and well-being of multiemployer plans -- an express legislative finding of Congress itself.[1/]

The Nature of Multiemployer Health & Welfare Plans

Among the proudest achievements of collective bargaining is the decades-old nationwide system of joint labor-management multiemployer health and welfare plans that provide more than ten million Americans workers and their families with medical,

---

1/ *See Multiemployer Pension Plan Amendments Act of 1990, Public Law 96-364, Section 3(a).*

hospital, sickness, death, disability, and related benefits.[2/] Workers covered by multiemployer plans are employed throughout the Nation in industries as diverse as building and construction, retail, food, clothing, textiles, transportation, service, mining, entertainment, hotel and restaurant, and maritime.

But for multiemployer plans, most of these millions of Americans would be uninsured and at risk for financial ruin in the event of a serious illness. The seasonal, intermittent, and mobile employment patterns that characterize these industries would prevent the workers from obtaining health benefits coverage absent a central pooled fund through which portable coverage is provided to workers as they move from one participating employer to another. In addition, most employers in these industries are small and would not maintain their own employee health plans, particularly for transient or short-term workers.

For example, a building tradesman may be employed by a particular employer for only a day, a week, a month or a few months to work on a specific project, and then move on to work on another employer's project, and thereafter another, etc. Between jobs, he or she might be off work for a day, a week, a month, or longer. A building tradesman might work for scores of different employers over his or her working life, with periods of unemployment between jobs. Most construction employers would not maintain their own employee health plans, particularly for transient workers, if they did not participate in our multiemployer plans. In fact, very few non-union contractors maintain health plans for their employees. The non-union segment of the building and construction industry is among the worst of all industries in terms of health care coverage. In contrast, virtually all union workers who are employed on jobs covered by collective bargaining agreements have health care coverage for themselves and their dependents.

For several decades now, our multiemployer health and welfare plans have been accommodating these employment patterns by providing a central fund through which portable coverage is provided to workers as they move from one participating employer to another. In effect, all of the participating employers -- scores, hundreds, and even thousands of employers -- are treated as a single employer for purposes of providing health and welfare benefits coverage to workers and their families.

Multiemployer health and welfare plans are financed, in reality, by covered workers through their labor. Collective bargaining agreements typically require signatory employers to contribute to a particular health and welfare plan at a set dollars-and-cents rate for each hour worked by a covered worker. While the law

---

2/ *A multiemployer health and welfare plan, often referred as a "Taft-Hartley plan," is:*

- *a trust fund established through labor-management collective bargaining and pursuant to the Labor Management Relations ("Taft-Hartley") Act of 1947 by one or more labor unions and more than one employer of the union-represented workers;*
- *administered by a joint board of trustees with equal labor and management representation;*
- *providing medical, hospitalization, and other health-related benefits, as well as death, disability and sickness benefits, to covered workers and their dependents; and*
- *financed by employer contributions which are collectively-bargained between the sponsoring union(s) and the participating employers.*

These structural requirements are imposed by Section 302(c)(5) of the Taft-Hartley Act [29 U.S.C. §186(c)(5)]. Multiemployer health and welfare plans are also regulated by the Employee Retirement Income Security Act (ERISA) as employer welfare benefit plans. A multiemployer plan is not a "multiple employer welfare arrangement" or a "MEWA" within the meaning of ERISA.

considers these to be "employer contributions," the reality is that the employer's contributions are substitute wages for labor received. Instead of putting this money into the worker's paycheck, the employer pays it to the health and welfare plan to finance benefits coverage for the worker and his family. Covered workers are well aware of the cost of health care coverage; they pay the cost by accepting employer contributions in lieu of cash wages. They know that they are paying the full cost of their health care coverage. They do not need a new law or tax to motivate them to hold down health care costs to the extent possible.

For example, the nature of collective bargaining in the building and construction industry is that the total compensation package cost is negotiated with the employers, and the workers, through their union, decide how to allocate the total hourly rate among cash wages, pensions, health and welfare, apprenticeship and training, and other beneficial programs. An increase in the contribution rate for the health and welfare plan means less in wages, or less in pension plan contributions, or less in contributions to another benefit plan. This process makes the workers very sensitive to increases in the cost of health care coverage.

From the plan's perspective, financing depends upon the level of covered work, as well as the collectively-bargained contribution rate. That is, the plan generally receives employer contributions only for hours worked in employment covered by a collective bargaining agreement. If the level of covered work declines, plan income declines. The per hour contribution rate set by the collective bargaining agreements usually cannot be increased unless and until the labor-management parties negotiate a new or modified agreement. A multiemployer plan cannot simply reach into the corporate treasury of an employer, in contrast to single-employer corporate plans.

Over the years, the labor-management boards of trustees of our plans, with professional assistance, have designed health and welfare programs that balance the benefit needs and wants of the covered workers with the financing that can be provided by the collectively-bargained contributions. To balance these factors, the trustees have developed various eligibility rules, benefit packages, and operational practices tailored to their particular circumstances. For example, plans have developed various systems for continuing coverage during gaps in employment and into retirement. These systems include "hours-bank" arrangements under which a worker's hours of covered employment are "banked" and used to pay for benefit eligibility during periods of unemployment. Other systems use eligibility periods during which a worker's covered employment builds credit towards benefit eligibility in a future period (e.g., covered employment in the first quarter earns the worker benefit eligibility for claims incurred in the second quarter).

By pooling the contributions of many employers into a central fund, multiemployer health and welfare plans enjoy economies of scale in administration as well as enhanced purchasing power in dealing with health care providers and insurers. Multiemployer plans are prototype purchasing cooperatives. Many of our plans are self-funded. Many others insure some or all of their benefits with commercial carriers or other health insurers. Some of our plans have in-house administration, although most use professional third-party administrators who answer to the plan's labor-management board of trustees.

Participating employers are advantaged in that they are required to do little other than submit their periodic contributions to the plan with verifying information. The employers need not become involved in plan administration or plan design. These functions are the responsibility of the plan's labor-management board of trustees and the professionals they hire.

These financial advantages are even greater for the many multiemployer plans that are multi-state in coverage. Many multiemployer health and welfare plans cover workers, dependents, and/or retirees in multiple States. Some multiemployer plans are national in coverage. Fortunately, because of federal preemption under the Employee Retirement Income Security Act (ERISA), most of our multi-state plans are not subject to regulation by the States; although ERISA preemption is being dangerously diluted by recent court decisions, some of which have narrowly construed ERISA to allow State taxes relating to plans, and some of which have read ERISA too broadly to strike down State laws that Congress intended to preserve. The cost and operation of multiemployer plans, if not their very existence, would be adversely affected if the plans were subject to multiple, inconsistent regulation by the States in addition to Federal regulation. Indeed, even intra-state plans would be adversely impacted if the State could regulate and tax them. Every dollar spent by a plan on regulatory compliance and administration is a worker's dollar, and a dollar that cannot be returned to covered workers in the form of benefits.

Among the unique characteristics of multiemployer plans is the involvement of the covered workers in their health coverage. The plan's financing is the subject of collective bargaining between the workers' union and their employers. And, the design and operation of the plan is, by law, controlled by a board of trustees, half of whom represent the covered workers. As mentioned above, the workers' influence is reflected in the benefit packages provided by plans, which are typically custom-designed to meet the needs and wishes of the workers, within the confines of what the particular plan can afford with the collectively-bargained contributions generated by the covered workers' labor.

Many multiemployer plans provide health benefits coverage to retirees and pay all or a substantial portion of the cost from contributions generated by the active workers' labor. This retiree health coverage reflects the reality that many covered workers are engaged in heavy physical labor that wears down their bodies and drives them from the workforce earlier. These members have earned a secure retirement without fear of financial catastrophe if they become ill or are injured without health benefits coverage.

Beyond health benefits coverage, multiemployer health and welfare plans provide an array of other valuable employee benefits such as disability, sickness, and death benefits. But for multiemployer plans, most covered workers and families would not have access to such benefits for all the same reasons that health benefits coverage is effectively available only through multiemployer plans.

Problems With The Current Health Care System

Our system of multiemployer health and welfare plans is a proud achievement in self-reliance and labor-management cooperation. We are most reluctant to invite additional government regulation that would unnecessarily disturb our successful system by injecting more costs. But, there are forces in the current health care system that are beyond our control and threaten the security of our participants' health and welfare coverage. Only action by the Federal Government can effectively address these forces.

Inflation in the cost of health care and insurance has cut severely into wages. Labor-management bargainers have had to shift increasing amounts of wages into health and welfare contributions to offset cost increases. In many cases, cash wages have been frozen, with negotiated increases being redirected into the health and welfare plans to keep them adequately funded. In some areas, pension plan contribution rates have been reduced by the bargaining parties, and the "savings" rechanneled to the health and welfare plans. Many health and welfare plan boards of trustees have been

compelled by cost pressures to cutback benefits, tighten eligibility rules, and increase out-of-pocket payments by covered workers. Workers are less secure about their coverage, especially if they have been unemployed for a period, as many have.

The economic recession in some industries, like the building and construction industry, itself is a product, in part, of health care cost inflation. As health care costs consume ever-increasing portions of government budgets and private sector resources, less money is available for investment in public and private building and construction projects. This means fewer jobs for our covered workers and less income for our health and welfare plans.

While we have struggled with these pressures to maintain responsible health coverage for covered workers, our non-union competition has gained an unfair competitive advantage. Non-union employers have found a way to shift the cost of medical treatment for their employees and families onto the backs of our health and welfare plans and covered workers; a way to cut their costs and increase ours.

Most non-union employers against whom our employers compete do not provide health plan coverage for their employees or their employees' families. If the employer provides any, it is inadequate coverage. This social irresponsibility gives the non-union employer an immediate cost advantage over responsible union employers who contribute to our multiemployer health and welfare plans.

This unfair competitive advantage is multiplied when the employer's uninsured worker or his family needs medical treatment. Lacking insurance coverage, they have no regular doctor, but rather go to hospital emergency rooms for treatment of minor and major ailments; the most expensive place to get treatment. And, when the worker is unable to pay for the treatment, the cost is passed onto our multiemployer health and welfare plans in the form of higher hospital bills, higher insurance premiums, or State uncompensated care taxes and assessments.

In other words, our covered workers are being compelled by the current system to pay twice for health care: once for themselves and their families, and a second time for the non-union workers who take our jobs and their families. Government statistics show that the vast majority of the millions of uninsured Americans are workers or dependents of workers. The cost of health care for these millions -- and for millions more who are underinsured -- is being unfairly shifted to employers and workers who do maintain adequate health plans, penalizing us for being socially responsible.

Government -- at the State, as well as the Federal, level -- is a major player in the cost-shifting game that unfairly inflates the cost of health care and health plan coverage. Concern about State regulation and taxation increasing the cost of maintaining a multiemployer plan is at the core of our longstanding support for ERISA preemption of State and local laws relating to employee health, welfare and pension plans. As recently observed by the United States Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 63 U.S.L.W. 4372 (April 26, 1995), the

> "basic thrust of the [ERISA] preemption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.
> ...
>
> [Congress intended] to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of

> complying with conflicting directives among States or between States and the Federal Government to prevent the potential for conflict in substantive law requiring the tailoring of plans and employee conduct to the peculiarities of the law of each jurisdiction..."

63 U.S.L.W. at 4375.

Despite this recognition of the essential protective purposes of ERISA preemption, the Supreme Court created a large loophole in these protections by its decision in the *Travelers* case. The Court ruled that ERISA does not preempt New York State's law requiring hospitals to impose surcharges (amounting to up to 24%) on the bills of patients covered by commercially-insured health plans, even though the State law exempts from those surcharges patients who are insured by a Blue Cross/Blue Shield plan and certain other patients. The imposition of such surcharges on self-funded health plans is at issue in the case on remand to the lower courts.

The *Travelers* decision appears to have cleared the way for States to impose discriminatory surcharges -- taxes, really -- on hospital and other provider bills to shift the cost of uncompensated care for uninsured workers to insured workers, and to control such fundamental plan decisions as whether to insure (and, if so, with what insurer) or whether to self-fund benefits. The impact of the *Travelers* decision will be to drive up the cost of health care even further as States seize on health plans as a source of public revenues and as a dumping ground for the cost of care provided to uninsured persons in the State.

State officials do not want the political heat created by general tax increases to pay for charity health care for uninsured workers and families. So, they impose hidden taxes on workers who do have health plan coverage -- an approach that discourages health plan coverage and exacerbates the uninsured and cost-shifting problems.

The *Travelers* loophole was preceded by another Court-made loophole in the protections which ERISA preemption was designed to provide. In *Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985)*, the Supreme Court ruled that ERISA does not preempt States from dictating what benefits must be included in every health insurance policy, including policies sold to ERISA-covered plans. In effect, States can -- and do, extensively -- mandate the benefits and services to be provided by any insured health plan. Hundreds of State laws so mandating health benefits and services have been enacted under the authority of the *Metropolitan Life* reading of ERISA preemption. And, in response, many multiemployer plans and employers alike have dropped insurance coverage and undertaken to self-fund benefits to avoid the costs and governmental control imposed by mandated benefit laws. The *Travelers* decision may provide States with the means for retaliating against these plans and employers -- through taxation; indeed, discriminatory taxation.

The Federal Government, too, plays a major role in the cost-shifting aspects of health care cost inflation. Changes in the Medicare and Medicaid programs often have an indirect, but predictable and costly, impact on multiemployer health and welfare plans. Congress has a record of achieving savings in these public programs by shifting a portion of their costs to private sector plans like ours. Reimbursement rates for hospitals and doctors who treat Medicare and Medicaid patients have been reduced by congress with the realization that these care providers tend to recoup such reductions by raising their rates for private, insured patients -- workers with multiemployer plan coverage. Another example of cutting public program costs at the expense of private health plans is the Medicare Secondary Payor program that requires private plans,

including multiemployer health plans, to provide primary coverage for Medicare eligible workers.

This government cost-shifting is particularly troubling because it taxes only those of us who have health insurance or other health plan coverage. And, this tax discourages health plan coverage, driving more people into the ranks of the uninsured whose health care costs, too, are shifted to the shrinking pool of persons with health plan coverage. This effect is directly opposite of the direction in which national policy should be traveling. Clearly, Medicare and Medicaid costs need to be contained, but not through taxation of only persons with health plan coverage. A fairer means of financing-- that also reaches those employers who do not provide health plan coverage for employees -- needs to be found.

In short, our workers and their families are generally pleased with their health and welfare plans; plans which have been custom-designed for them and which they control through collective bargaining and through the plans' boards of labor-management trustees. But, health care cost inflation and cost-shifting beyond our control is undermining the plans and our workers' standard of living, while placing them at an unfair competitive disadvantage.

Retiree Benefits and Medicare

As mentioned earlier, the majority of multiemployer health and welfare plans provide some coverage for participants who are retired and drawing retirement benefits from a related multiemployer pension plan. Practice varies by industry, geographic area, and plan size. Most often, this coverage applies to all retirees (and their dependents) -- under age 65 as well as Medicare eligibles. Some plans limit coverage to early retirees as a bridge between coverage as an active worker and Medicare eligibility. Coverage for Medicare eligibles is designed to supplement Medicare coverage.

Retiree coverage is usually financed (subsidized) at least partially by the collectively bargained contributions generated by the labor of active workers. Employers are not required to contribute to multiemployer plans on behalf of retirees, but only for the work performed by active workers covered by a collective bargaining agreement. However, a portion of these contributions is used by the plan to finance coverage for retirees.

In addition, most plans require a retiree to make a contribution (self-pay) towards the cost of his or her coverage as a condition of maintaining the coverage. Of course, coverage is voluntary for retirees.

Inasmuch as retiree coverage is subsidized by current collectively-bargained contributions, declines in contribution-generating work by active workers creates financial pressures on retirees' coverage -- as well as on actives' coverage. Cutbacks in retiree coverage or increases in retiree contributions may result from reductions in covered work. Such necessary changes are harder on early retirees who are not yet eligible for Medicare.

Multiemployer plans would much prefer to expand retiree coverage -- if they could work it out financially. There is a strong feeling of commitment and loyalty to long-service members, and a desire to maintain their affiliation with the union that sponsors the plan. There is a sense that they have earned health coverage in their retirement years because contributions made during their work careers helped to fund coverage for earlier retirees.

Financing is the key, however. Multiemployer plan trustees must maintain a proper balance between the beneficial needs and wants of all participants, on the one hand, and the available funding to backup benefit promises on the other hand.

An arrangement under which the Medicare program provides funding to a multiemployer plan for Medicare-eligibles' benefits may provide the means for more plans to maintain and expand retiree coverage. Such an arrangement would give retirees the advantage of a "one-stop shop" for all of their health care benefits -- a shop with which they are familiar and which is familiar to them, and which may also be providing them with life insurance and other types of benefits. Most importantly, of course, a retiree's or older worker's multiemployer plan is an organization over which the covered population, through their union representatives on the board of trustees, have an equal say in plan management, and which, under the joint stewardship of the labor and management trustees, is dedicated exclusively to serving the interests of its participants and beneficiaries. Coverage could be seamless as the individual moves from active employment into retirement. Savings from efficiencies could be used to fund early retiree coverage, and to ease the pressure on active workers to generate contributions to finance retiree coverage.

Financing is, of course, a key concern, both to the government and to the plans. In managing multiemployer plans, the trustees are not running a business in which they are free to take big risks in the hope of achieving big gains. They are nothing more, and nothing less, than fiduciaries of a fund that must be administered in a way that maximizes the benefits of those it covers. Because Medicare has provided the lion's share of health coverage for the over-65 population for so long, multiemployer plans -- like other private sector payors -- do not have a reliable independent base of experience from which to estimate the potential cost of folding that age group back into their basic coverage. Initially, a fair amount of trial and error will be needed to cost out these programs and, as noted, plan trustees do not have much room for error!

To attract multiemployer plans to such a voluntary arrangement, various concerns (mostly relating to financial risk) will have to be addressed, including:

- Pricing -- How much will Medicare pay the plan? Will the amount vary by location and demographics of the eligible group? On what basis will Medicare's payments to the plans increase? To what extent, if any, do cost-savings from favorable experience have to be shared with the government? To what extent, if any, will Medicare provide guarantees against plan losses?

- Design -- To what extent will plan trustees have flexibility to design the benefit package and delivery systems for Medicare eligibles as well as other participants? To what extent can the plan link Medicare benefits and supplemental benefits? Will plans be free to cutback benefits if Medicare benefits are cutback? Could a plan use Medicare funding to finance early retiree coverage?

- Regulation -- To what extent will plans be required to comply with Medicare regulations on top of ERISA's regulatory scheme? Does the plan gain Medicare law protections (e.g., limit on physician charges)? How, if at all, would the Medicare Secondary Payor program apply with respect to the plan's active workers who are Medicare eligible?

We believe that there is much to be gained for all parties -- Medicare eligibles, multiemployer plans and their participants as a whole, and the Medicare program -- if an arrangement that satisfactorily addresses all of these concerns can be designed.

Thank you.

Mr. MCCRERY. Thank you very much for your testimony.

We have a vote on the floor, and since I am the only one who has not voted, I am going to recess the Subcommittee for just a few minutes. If you will just stay where you are, someone will be back to open the Subcommittee for questions. Thank you.

The Subcommittee is in recess.

[Brief Recess.]

Mr. ENSIGN. It is just us.

Mr. RAY. Is it something we said, Mr. Chairman?

Mr. ENSIGN. I happened to be the only one left walking over here.

Let's start off by talking a little bit about one of the problems associated with Medicare costs. Most of the medical expenses are expended in the last months of a person's life; and the problem there is that a lot of the expense is not for the benefit of the patient. I mean, when a lot of the care is given, it is totally hopeless care. The chances of the outcome being positive are virtually nil; and we know a lot of that money and services that could be going to help healthy patients is not there because the resources are taken up by those kinds of situations.

If employers were involved with the Medicare population, how would you foresee—because hospice care is something that is done so well in this country, and sometimes it is the best thing that people would choose for themselves if they had the capacity to make that decision for themselves. A lot of times these patients are on life support systems, or they do not have the ability to make those kinds of decisions for themselves.

How would you design a system that would, allow for or encourage people to set up living wills, or whatever it is, so that at that point we aren't spending the bulk of the health care dollars in this country on patients that, first of all, wouldn't want it spent on themselves?

Mr. STOVER. You know, there are a couple of ways to approach that question; and one way verges on the theological, and I am not going to take that approach.

I think the other one is to really look at the experience we have had over the last few years and say, it is more an issue of how do we give people more choices. I think a lot of the outcomes from a standard way of dealing with people toward the end of their lives has been, well, there has been one system and there has been one set of expectations and that is sort of what the overall health care system has allowed.

When you speak of hospices, I think what we have seen over the last—you want to say 4, 5, 6 years, is there have been more HMOs, as there have been more alternative ways of looking at how medical care can be delivered, and then you get some different answers. It really gets down to individuals having a choice in how they would like to manage things and becoming more involved in defining for themselves what they view value to be in terms of their medical care. That is not always a price issue, and it is not always a "how many tests can you run" issue, but a sort of "how do you feel about the care that you are receiving," "how does that relate, not just to you, but the involvement of your family members and where they are living" and so on and so forth.

So, I think that, clearly, if we have some more flexibility for people to select some options——

Mr. ENSIGN. When would they select those options, when they are signing up for their particular plan, or on an annual basis?

Mr. STOVER. I think this is—really, when it comes to medical care, it needs to be a lifelong education process. I think that is something that a lot of us as employers or certainly with group plans do a lot of education; and increasingly, we are providing background on medical care so people can make informed choices on a much better basis instead of just having, some faith as you go into it that the system is going to take care of me.

Ms. MAZO. Of course, we are all working on a program, so we can identify what is the last month of a person's life. Until that time—another feature, by the way, this is an equal problem from the point of view of employer-funded plans at the beginning of life, a major cost is enabling families to make decisions about damaged babies and how far they go.

I think one of the things that a fund that has been involved with the person following them all along—and the John Deere people and the Chrysler people talked about this—is when you get into individualized, major case management, which is delivered by an institution that the person and the family trust, it can help the choices that have to be made at the ultimate point. Choices and advice are given at an early point, but finally someone has to decide, yes, this is what we believe is hopeless. This is what we believe is not true life.

There always has to be an individual decision, and when it is coming under the guidance and through a payer who has a personal involvement in the way—the way a union does, the way an employer does with the person and their family, I think it may be a little more credible and a little more useful than when it is just coming from the government or from an insurance company.

Mr. ENSIGN. We—obviously, are in a situation where we don't have a choice about Medicare going on as it has in the past because of the findings of the trustee report. Do we think that the Taft-Hartley plans may be one of the answers to more efficiently delivering health care to the elderly than the Medicare Programs?

Ms. MAZO. Not all of them but some might be. I have to say that the Taft-Hartley plans are not as far advanced, in general, as the major corporations represented by NAM in their sophisticated use of managed care, but they are moving in that direction; and they capture a population which can't be captured by the large corporations, and so they provide a useful supplement.

Just as business is in a position to do it now, I think the Taft-Hartley plans, in fact, perhaps given the added incentive of the opportunity to maintain the connection with their retirees—in a sense this option might also be an incentive to move them along generally down the managed care path.

Mr. STOVER. I might just add to that, I think what we are finding in common is both the issues of portability and continuity that we come back to. The Taft-Hartley plans allow them some continuity. If we had more portability vis-a-vis the other kind of private plans that are tied to a specific employer now, that would also help ensure more continuity, which we think is a positive.

Mr. RAY. Mr. Chairman, if I could underscore that comment, one of the unique parts of our Taft-Hartley plans is, we do have portability, by definition, with a group of employers who are signatories to collective bargaining agreements. You get seamless coverage as you move from job to job with different employers who are bound by the collective bargaining agreement to contribute.

Mr. ENSIGN. One of the other aspects I would like to explore just a little bit, and that is when you are getting into a situation of assuming too much risk, the risk where you are getting the patient populations that are going to jump on board and potentially bankrupt your company; the Medicare population as a whole obviously is a very large population. It can be spread out over a very large population.

How do you avoid the cherrypicking, but also avoiding the potential massive risk if you get a higher percentage of AIDS cases or diabetic cases or whatever; to stop cherrypicking results when you have a system set up in its totality that has incentives and disincentives to do things that would otherwise make the system work?

I think the earlier panelists have talked about the issue of quality as being very important, and if we set up options in which people can select quality care in a number of different ways, so that there is not a perception that the value for me as an individual for getting medical care from this provider is less than it is going to be over here, then you are not going to drive to cherrypick situations like that.

So, I think that it is not an either/or, employers or the government—let's look at how we set up something with the flexibility so that positive outcomes can come from individuals either way.

Ms. MAZO. You obviously have put your finger on the hardest question and that is why I think it has to evolve over a period of time. We are also not cherry picking because we are working with a population we know that we have been taking care of up until age 65. Often their health traits and the problems of their family are—they may be sort of linked to the industry in which they have been working.

Just as we can begin to get a sense of what the costs are going to be once people reach age 55 and 60 from what the costs have been when they were 35 and 40 and 45, over—I can't say that the first 3 years of this program we are going to have excellent predictors. Within some period of time we will begin, and we will be building on a base of knowing how they have been operating up until this date.

Mr. ENSIGN. I would like to thank the panel very much for your excellent testimony and call the next panel forward.

We have Tom Erhart, vice president, human resources for RCI Corp. from Brighton, Michigan; Peter Ferrara, senior fellow, National Center for Policy Analysis; Jane Orient, a medical doctor, executive director of the Association of American Physicians and Surgeons, Inc.

Mr. Erhart, why don't you proceed. You have 5 minutes. When there is 1 minute to go, the amber light will appear; and if you could keep your remarks around 5 minutes, we would appreciate it. Thank you.

STATEMENT OF TOM ERHART, VICE PRESIDENT, HUMAN RESOURCES, RCI CO., BRIGHTON, MICHIGAN

Mr. ERHART. Thank you. I am Tom Erhart, vice president, human resources, for RCI, an automotive specialty manufacturer in Brighton, Mich. I would like to relate to you the terrific experiences our company and employees have enjoyed with medical savings accounts, MSAs.

One year ago we replaced our traditional employee insurance program, which offered a very high level of benefits and was fully company paid, with the medical account program. MSAs are an extremely cost-effective way to offer health care benefits to employees because they put the consumer, the employee, back in the process.

Employees are free to choose where they want to go for their medical care. They make choices based on the quality of care provided and the cost of such care. Even though employees have a higher level of benefits with the MSA than our previous health program, our annual health benefit costs were reduced from $4,800 to $4,200 per employee, a 14.3 percent savings. For a business with 200 employees, this amounts to an annual savings of $120,000 per year; and we don't even anticipate a premium increase for the second year of our program.

The MSA program at RCI works very simply. An employee with dependents receives an MSA of 1,700, a single employee receives 1,200. This MSA is provided by the company. RCI then purchases a health insurance policy with a $2,000 deductible for employees with dependents and $1,500 for single employees.

This insurance policy pays 100 percent of all covered medical expenses after the deductible is met, no employee copay. Employees' maximum amount of out-of-pocket expense is $300 per year, the difference between the MSA and the deductible, and employees only have this out-of-pocket expense after their MSA is expended.

At the end of the year, employees receive any money remaining in their MSA or carry over to next year's MSA. Since there is currently no tax advantage to rolling the remaining money over, most employees elect to take the cash option. This is an incentive to be conscientious consumers of health care.

Our employees use only one MSA health I.D. card to pay for all their medical, prescription, dental and vision expenses. We find that our employees shop around for their health care needs; and what better way to control costs than through free enterprise? A managed care system is an added feature that our employees may choose to utilize to lower their medical expenditures.

Our employees are proud to point out that they have saved money by comparing costs. They often save $50 to more than several hundred dollars on routine procedures. One employee even bragged that he saved $2.59 on a prescription by comparing costs.

After the first year of our MSA Program, nearly 75 percent of our employees received money back and the average amounted annually to over $1,000 per employee. Employees are enthused and excited about MSAs because they have the freedom to go to the provider they would like. They have the opportunity to receive a significant amount of money back at year end or build up a pool of money in their MSA to pay for health care, retirement, or when they are out of work. They can control how their health care dollars

are spent, and MSAs provide employees with the financial incentive to stay healthy.

Our company is pleased with MSAs because we are able to offer an increased level of benefits and are reducing costs at the same time. By putting the consumer back in the loop, health care expenses are kept to a minimum. Paperwork is significantly reduced. Payments are not subject to the scrutiny of reasonable and customary determination, preexisting conditions and other administratively burdensome reviews. I know of no other program that presents such a win-win situation for both employer and employee.

Companies from across the country call me daily to seek information about MSAs and how well they work. Workers—I should say organizations—such as Crown Northrop, Quaker Oats, Danville, Ohio schools, United Mine Workers of America now provide MSAs and hundreds of others are considering the program.

At RCI we envision a great future for MSAs. If the Federal Government authorizes medical savings accounts and grants them tax deductible status, these programs will thrive. MSAs would be offered by a greater number of insurance companies, allowing for more competition, better pricing, greater portability and more widespread savings on the part of employees for their future health care needs. Paperwork expenses would be slashed drastically because employees and retirees could use their MSA card like a universally accepted credit card. The MSA credit card-type system will reduce paperwork costs from 30 cents of every dollar to 6 cents of every dollar spent on health care.

MSAs would be a natural replacement for Medicare. Individuals accumulate their MSA nest egg through the years and, by age 65, could have $200,000 or more, assuming an average accumulation of $1,000 a year since age 21 at a 6 percent interest rate. That individual could then purchase a super MSA from an insurance company with a $200,000 deductible for the remainder of their life at a very economical rate.

The challenge in acceptance of medical savings accounts nationally is merely getting the public to understand the concept and advantages of a program and for the government to implement MSAs. I envision the education process to explain what MSA means as being no different than the evolution of HMO. Ten years ago that was an unknown. Today HMO is a household word, and that is the kind of growth and potential we could expect to see from MSAs.

Based on my firsthand experience with medical savings accounts at RCI and exhaustive research on health care alternatives, I can tell you that MSAs work. I strongly believe not another health insurance program offered compares with the MSA concept. MSAs can and should play a major role in reducing health care costs nationally. If the Federal Government authorizes tax deductible status for MSAs, we will see them flourish. Now is the time to expand MSAs as the choice for providing health care to all Americans.

Thank you.

[The prepared statement follows:]

TESTIMONY OF TOM ERHART
RCI, BRIGHTON, MICHIGAN

Medical Savings Accounts at RCI

I would like to relate to you the terrific experiences our Company, RCI and its employees have enjoyed with Medical Savings Accounts (MSA's)

RCI is an automotive specialty manufacturer located in Brighton, Michigan. One year ago we replaced our employees traditional health insurance program which offered a very high level of benefits and was fully Company paid, with a Medical Savings Account program. MSA's are an extremely cost effective way to offer health care benefits to employees because they put the consumer, the employee, back in the process. Employees are free to choose where they want to go for their medical care. They make choices based on the quality of care provided and the cost of such care. Eventhough employees have a higher level of benefits with the MSA than our previous health insurance program, our annual health benefit costs were reduced from $4800 to $4200 per employee, a 14.3% savings. For a business with 200 employees, this amounts to an annual savings of $120,000 per year! We do not even anticipate a premium increase for the 2nd year of our program.

The MSA program at RCI works very simply. An employee with dependents receives a MSA of $1700 and a single employee receives $1200. This MSA is provided to employees by the Company. RCI then purchases a health insurance policy with a $2000 deductible for employees with dependents and a $1500 deductible for single employees. This insurance policy pays 100% of all covered medical expenses after the deductible is met - no employee copay! Employees maximum out-of-pocket expenses $300 per year, the difference between the Medical Savings Account and the deductible. Employees only have out-of-pocket expenses after their MSA is expended.

CLAIM EXAMPLES

(Assume a $1700 MSA and $2000 Annual Deductible)

Annual Medical Claims less than MSA amount	
MSA	$1700
Medical Expenses (doctor visits, prescriptions, x-rays, hospital charges)	-$ 500
MSA payout at year-end	$1200
Annual Medical Claims greater than MSA amount	
Medical Expenses (doctor visits, prescriptions, x-rays, hospital charges)	$5000
Paid from MSA	-$1700
Employee out of pocket expenses	-$ 300
Paid by Health Insurance	$3000

At the end of the year, employees receive any money remaining in their MSA or carry it over to next year's MSA. This is the incentive to be conscientious consumers of health care. Employees have a direct role in seeing that their health care dollars are spent wisely. This also provides employees the incentive to take care of their health and utilize preventative health care to avoid costlier procedures.

Employees use only one MSA health ID card to pay for all of their medical, prescription, dental and vision expenses.

We find that our employees shop around for their health care needs and what better way to control costs than through free enterprise? A managed care system, PPOM, is an added feature our employees may choose to utilize to lower their medical expenditures.

Our employees are proud to point out that they have saved money by comparing costs. They often save $50 to several hundred dollars to routine procedures, and one employee even bragged that he saved $2.59 on a prescription by comparing costs.

After the first year of our MSA program, **nearly 75% of our employees received money back, and the average amount returned annually is over $1000 per employee**. Since there is currently no tax advantage to rolling the remaining money over to next year's MSA, most employees elect to take the cash option. Since the average employee only spends approximately $1000 on health care annually, the majority of employees will have a surplus in their MSA.

Employees are enthused and excited about MSA'a because:

- They have the freedom to go to any doctor, hospital or pharmacy they would like.
- They have the opportunity to receive a significant amount of money back at year-end.
- They control has the health care dollars are spent.
- They can build up a pool of money in their MSA to pay for health care at retirement or when they are out of work.
- MSA's provide employees with a financial incentive to stay healthy.

RCI is pleased with MSA's because:

- We were able to increase the level of benefits to employees while reducing our health insurance by nearly 15%.
- Putting the consumer back into the loop keeps health care expenses to a minimum.
- Paperwork is significantly reduced - Since 75% of our employees don't spend more that the amount in their MSA, these payments are not subject to the scrutiny of reasonable and customary determination, pre-existing conditions and other administratively cumbersome reviews. The expenses are simply paid out of the MSA!
- Future premium increases will be reduced because the premium base is lower with the higher deductible.

I know of no other program that presents such a **win/win** situation for employer and employee!

Companies from around the country call me daily to seek information about the Medical Savings Account concept and how well it works. Numerous organizations including Crown Northrop, Quaker Oats, Danville, Ohio Schools, United Mine Workers of America and Forbes Magazine now provide MSA's to their employees and hundreds of others are considering the program.

Our Vision for MSA's

At RCI we envision a great future for MSA's. If the Federal government authorizes Medical Savings Accounts and grants them tax deductible status, these programs will thrive. MSA's would be offered by a greater number of insurance companies allowing for more competition, better pricing, greater portability and more widespread savings on the part of employees for their future health care needs. Participants will accumulate large nest eggs in their MSA to be used for health care upon retirement.

I envision a dramatic reduction in health care expenses nationally with MSA's, mainly because the consumer is involved in cost control. Additionally, administrative/paperwork expenses would be slashed drastically because employees and retirees could use their MSA card like a universally accepted credit card. Use of the MSA "credit card system" will reduce paper work costs from $.30 of every dollar spent on health care to $.06 of every dollar.

Providers would be paid on a monthly basis, with the insurance company merely debiting their account and sending them one statement. Participants would also only receive one consolidated statement from the insurance company showing their activity for the month.

MSA's will also help eliminate the very costly government programs of Medicare and Medicaid Concerning Medicaid, the government would give an individual on welfare an MSA voucher which could be taken to an insurance company of his or her choice to get an MSA/insurance policy. If that individual has money coming to them at the end of the year, it will be held until they find a job, providing them with another financial incentive to seek work.

Eventually MSA's would be a natural replacement for Medicare. Individuals accumulate their MSA nest egg through the years and by age 65 could have $200,000, assuming an average of $1000 is accumulated per year since age 21 at 6% interest. That individual could then purchase a "super MSA" from an insurance company with a $200,000 deductible for the remainder of their life at a very economical rate.

The major challenge to implementing Medical Savings Accounts nationally and gaining acceptance from employees, employers and Medicare/Medicaid participants is merely getting the public to understand the concept and advantages of such a program and having the government implement MSA's. This can be readily addressed. I envision the education process to explain what MSA means as being no different than the evolution of the HMO. Ten years ago it was an unknown, today HMO is a household word. That's the kind of growth and potential we can

expect to see from MSA's.

Conclusion

Based on my first-hand experience with the Medical Savings Accounts at RCI and exhaustive research on health care alternatives, I tell you that MSA's work! I strongly believe there is not another health insurance program offered that compares to the MSA concept when it comes to providing a high level of employees benefits, employee satisfaction, cost control, freedom of choice, and administrative efficiency.

MSA's can and should play a major role in reducing health care costs and improving health care delivery nationally. It's time to expand MSA's as the choice for providing health to all Americans. If the Federal government authorizes tax deductible status for MSA's, we will see them flourish for employees, employers, individuals, Medicare and Medicaid.

Chairman THOMAS [presiding]. Thank you very much, Mr. Erhart.

Mr. Ferrara.

STATEMENT OF PETER J. FERRARA, SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS

Mr. FERRARA. Thank you, Mr. Chairman. My name is Peter Ferrara, and I am a senior fellow at the National Center for Policy Analysis.

We all know why we are here. We are here because the Medicare Program is not only going bankrupt; it is finally collapsing in a most disastrous manner. President Clinton's own trustee's report shows, if you study carefully the data that is published, that in order to pay all the promised benefits by the time today's young workers retire, under current policies if the benefits are not changed, you would require at least tripling the payroll tax under Medicare, increasing the deductibles paid by the elderly under Medicare to the equivalent of $4,000 per year per elderly couple and you would still be running a deficit of $250 billion in the Medicare Program in today's 1995 dollars, which is bigger than the entire Federal deficit.

I would submit to you that this effectively is Mr. Stark's plan, Mr. Gephardt's plan, Mr. Clinton's plan, the plan of anyone who says they are not going to make any changes in Medicare benefits. Their plan is to triple the payroll taxes, raise the deductible premium to $4,000 per couple and run a deficit in the Medicare system bigger than the entire deficit. That is what is going to happen according to President Clinton's own report if changes aren't made.

I am here today to present a proposal which—to address this problem, which I think can address it in a very appealing way. The proposal I am presenting that is advanced by my organization, the National Center for Policy Analysis, has broad support from many other groups that many of you worked with in the past, including the Cato Institute, the United Seniors Association, the Seniors Coalition, the National Taxpayers Union. Citizens For a Sound Economy is helping me with this and many other groups you all have worked with in the past.

Let me try to explain how this works. The broad concept is encaptured by medical choice. Elderly recipients under Medicare would have the freedom to withdraw their share of funds of Medicare from Medicare each year and use it to buy anything in the private sector that they want. They could buy an HMO, coverage from an HMO. They could buy coverage from a current or former employer plan. They could buy traditional insurance, but also they could buy a medical savings account to receive their coverage. The amounts they could withdraw from Medicare would be risk adjusted, based on age, geographic location, health status, so those who are relatively younger and healthier would take less if they left for the private sector. Those who were older and sicker would take more and the system would be protected from any adverse problems because people are just taking the share of funds that are represented by the risk that they present.

This proposal is designed to meet the budget targets, without question. The amounts that people withdraw from Medicare each—

have the right to withdraw from Medicare each year would be targeted to grow no faster than the budget target, whether it is 5 or 6 percent or whatever. So, everyone who exercises this option and leaves Medicare for the private sector would take an amount each year that grows no faster than the budget target.

In addition, we are advocating that for people who stay in Medicare that an automatic up front deductible be added to the Medicare benefit structure each year of sufficient magnitude so the rest of Medicare does not grow faster than the budget target of 5 or 6 percent or whatever it is.

So, here you have a plan that is guaranteed to meet your budget targets regardless of any other factor.

Now what is intriguing about this, from our perspective, is the medical savings account option, because that will enable people to meet these budget targets while still getting better benefits than even Medicare offers them today. Let me explain how that would work.

We have had actuaries estimate this for us and what they have indicated is that if you take the amount of funds that can be withdrawn from Medicare through this program each year, the amount the elderly are already spending out of pocket for medical expenses and for health care, private supplemental health insurance, the amount they are already spending on average, there is enough in that pool to buy an insurance policy covering all expenses above a deductible of $3,000 to $4,000 and still put $3,000 to $4,000 in an account; and they could use the funds in that account to pay for medical expenses below the deductible of $3,000 or $4,000. So, they are entirely covered by either insurance or savings in the medical savings account. Whatever they don't spend by the end of the year, they could then withdraw and use for any purpose.

I think that is very important to protect that freedom of control. That provides the most powerful incentive because now people have the money; it is their money. They now have great incentives to control costs, like you have heard from the prior witness. In fact, what is fascinating about this—and this was a perfect example, employers across the country are already adopting these medical savings accounts. They are achieving bigger reductions in their cost increases than is targeted in the House budget from Medicare. They were doing more than reducing growth from 10 to 5 percent. They are often reducing growth from 15 percent down to zero percent and even less.

What that shows is that, with the MSA option, people can achieve the targeted cost reductions while still maintaining their benefits. Under this medical savings account structure that I have defined, they have better benefits than under Medicare. They have unlimited catastrophic coverage for all expenses over the coverage, over $4,000. They have a cap on out-of-pocket expenses. If they have the MSA, they only have to pay up to the deductible and also they get money from Medicare in that account to help pay those expenses below the deductible. All they have to pay out of pocket is the difference.

Actuaries have estimated for us that would be about $1,900 a year today. So, in other words, the MSA option is offering people a cap on out-of-pocket expenses they don't have under Medicare,

unlimited catastrophic coverage, yet while achieving the budget targets.

So, let me just make one more point. I heard Mr. Stark present what I have to insist is a very uninformed presentation of what medical savings accounts are. Under our proposal, anyone from these private sector options would have to accept everybody from Medicare that wanted to join. You could not just come in and say, we will only take a few healthy people; you have to accept everybody who would come.

My estimate of the number of people—ultimately, the potential for MSAs is—I will put my number out; it is 90 percent, I estimate, is where the people—based on how people are choosing MSAs in the private sector.

The last thing I want to say is, let me suggest to you that you should not be in the business of, increasing managed care enrollment in Medicare or reducing costs by greater use of managed care or emphasizing managed care over anything else. There must be a level playingfield. All the options should be out there, and the emphasis should be on freedom of choice; and I think in terms of appealing to the grass-roots who are—try to support what you are doing here, MSAs, which really appeal to the idea of greater power of the people, what we are really doing here by this proposal is taking control of the program, and the funds, away from just the government, the doctors and the hospitals that control it today and shifting the power back to the people, to the elderly recipients themselves.

Thank you very much.

[The prepared statement follows:]

TESTIMONY OF PETER J. FERRARA
NATIONAL CENTER FOR POLICY ANALYSIS

The government's own latest annual report for Medicare established beyond contention that the program must be fundamentally reformed. As has been widely noted, the report indicates that Medicare will likely run short of funds to pay promised benefits within 7 years, by 2002. But what has not been as clearly reported is how big the financial gap becomes. Without change, paying all promised benefits to today's young workers would require:

- Tripling the current total Medicare payroll tax of 2.9%;
- Increasing the annual Medicare premiums paid by the elderly relative to income to the equivalent of almost $4,000 per elderly couple per year in today's terms;
- And still running an annual deficit in the program of over $250 billion in constant 1995 dollars, larger than the entire federal deficit today.

For those who say they oppose any change in Medicare benefits, this effectively is their reform program for Medicare.

And all of this is just under the so-called intermediate projections in the report. Under the so-called pessimistic projections, which many top experts think are more realistic or at least more prudent, the problem is much worse.

This financial disaster will occur even though Medicare is already effectively rationing health care for the elderly to reduce costs. Medicare pays doctors and hospitals only about 70% of the costs of the services provided under the program. This is leading to lower quality care and reduced access to care for many patients. In addition, Medicare pays the same fees, regardless of the quality of care provided. This encourages lower quality, less expensive care. The Medicare payment system also allows hospitals to make more net income by discharging patients earlier, regardless of health condition. Evidence suggests that resulting premature discharges have harmed some patients.

Medicare is also slow to approve new medical technologies, leaving the elderly without the latest and best treatments and care. For example, Cochlear implants are far superior to previous technology for treating some types of hearing loss. But the elderly under Medicare are stuck with hearing aids because Medicare doesn't pay for the more costly implants.

All of this is apart from the problems of the general federal budget, and the need to reduce the total federal deficit. But unlike Social Security, Medicare is already running deficits contributing to the federal deficit. This year, Medicare alone will add over $50 billion to the federal deficit, about one-fourth of the total deficit. By 2000, Medicare will be increasing the federal deficit by over $100 billion in today's dollars. By 2010, Medicare alone will be running a deficit almost as large as the entire federal deficit today. And, again, this is all just under the intermediate projections. Clearly, we cannot bring the total federal deficit under control without controlling these deficits under Medicare.

Indeed, by the year 2000 Medicare alone will constitute 13% of the entire federal budget. If Medicare is exempted from spending restraint along with Social Security, interest on the national debt (which is constitutionally protected), and the defense budget as proposed by Clinton (which has already been cut sharply), then about two-thirds of the total budget in that year would be shielded from spending reductions. The rest of the government would then have to be cut by one-third to balance the budget.

But how can Medicare spending be restrained? Fortunately, a Medicare reform plan with true popular appeal that would accomplish this has already been developed by free market and conservative organizations, led by the National Center for Policy Analysis in Dallas. This proposal was designed so that it would be assured of achieving the cost control targets for Medicare included in the budget resolution adopted last week by the House. That resolution calls for reducing the annual rate of growth of Medicare from 10% to 5%.

Under the proposal, the elderly would each be free to withdraw their share of Medicare spending each year and use it to purchase private coverage of their choice instead, including an MSA option, HMO plans, employer plans, or traditional insurance. The share each retiree could withdraw from Medicare would be risk rated to reflect the retiree's age, geographic location and

health status. Consequently, those who are older and sicker would receive more from Medicare to purchase private coverage. Those who are younger and healthier would receive less, reflecting the lower amounts they would be charged for such coverage. This would prevent adverse selection problems, since retirees who leave the program would only take the share of funds that actuarially reflects their own risks.

The key is that these amounts that could be withdrawn from Medicare each year would be restricted to grow by no more than 5% per year. So for those who chose the private options, Medicare spending would grow no faster than the budget targets.

Another provision would ensure that for anyone who chose to stay in Medicare, spending would also grow no faster than budget targets. An upfront deductible would be added to the Medicare benefit structure. The deductible would be set at whatever amount necessary each year to ensure that the rest of the program for those staying in the current system would not grow faster than 5% per year.

Consequently, Medicare overall would be assured of growing no faster than 5% per year, meeting the budget targets.

The MSA Option

The MSA option in the above reform plan would enable the elderly to get even better benefits and health care than under the current Medicare system, while staying within the budget targets. That is because the powerful incentives of the MSAs would control costs while other features of the MSA option would actually improve benefits and the quality of care.

Under the MSA option, the retiree would use part of the funds from Medicare to purchase insurance covering all expenses over a high deductible, say $3,000 - $4,000 per year. The remaining funds would be saved in the MSA and used to pay medical expenses below the deductible. The retiree could then withdraw any remaining MSA funds at the end of the year and use them for any purpose.

Health insurance actuaries have estimated for the NCPA that the amounts the elderly could withdraw from Medicare, plus the amounts they are already paying out-of-pocket for health care and supplemental Medigap insurance, would be enough to pay for the insurance and put $3,000 - $4,000 in the MSA for expenses below the deductible.[1]

Under this structure, the elderly choosing the MSA option would effectively be spending their own money on health expenses below $3,000 - $4,000 per year. This would make them fully cost conscious consumers of health care for such expenses. They would consequently seek to avoid unnecessary or overly costly care, or any care where the costs exceed the benefits. Perhaps more importantly, because of this new consumer cost concern, doctors and hospitals would compete to reduce costs to attract consumers trying to preserve their funds.

Several studies show that for those who used the MSAs, these incentives would quite likely produce savings more than sufficient to hold costs within the 5% per year growth rate targeted under the budget for Medicare:

- The prestigious Rand Corporation conducted a rigorous scientific study of the health expenditures of 2,500 families from 1974 to 1982. The families were each provided with one of four different insurance plans, ranging from a zero deductible and all health expenses paid, to 5% of the first $1,000 in expenses paid, and 100% after that. The families with no deductible incurred 53% more in hospital expenses, and consumed 63% more in doctors' visits, drugs, and other health services, than the families with the highest deductible. Yet, the study also found no difference between these families in health outcomes.[2]

- Overall, these Rand studies indicate that families today with a deductible of about $3,000 would consume 30% less health care than families with no deductible — with no adverse effects on health.

---

[1] See Peter J. Ferrara and John C. Goodman, "Medical Savings Accounts for Medicare," Brief Analysis No. 160, National Center for Policy Analysis, Dallas, Texas, April 17, 1995.

[2] Joseph Newhouse, et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine*, December 17, 1981.

- The Congressional Budget Office estimates that Medicare enrollees with private Medigap insurance shielding them from Medicare deductibles and co-payments use about 24% more services than those who do not have such coverage and face the cost-saving incentives of these deductibles and co-payments.[3]

  A 1992 study by the National Center for Policy Analysis estimated that if the public generally switched from traditional third party insurance to MSAs, the resulting cost control incentives and competition would reduce health spending by about 30%.[4]

- Another study by the health consulting firm of Milliman and Robertson estimated that the cost control incentives and competition created by MSAs, if generally adopted in the private sector, would reduce national health care spending by $600 billion over 5 years.[5]

- A recent Cato Institute study estimated that if MSAs were generally adopted, leaving traditional third party payment insurance to cover 25% of total health costs, the cost incentives and competition created by MSAs would reduce health costs by about 40% per year.[6]

- Another Cato Institute study examined the experience of employers across the country who were already adopting MSAs. The resulting cost-savings for those employers would be more than enough in the case of Medicare to hold program costs within targeted growth limits. Indeed, cost-growth for almost all of these employers was zero or even negative.[7]

Such cost savings would result for the elderly who used MSAs for their Medicare coverage, enabling them to obtain their benefits within the growth-capped payments they could withdraw from Medicare.[8]

Indeed, such an MSA structure would offer improved benefits and quality for the elderly:

- The MSA catastrophic insurance would provide unlimited coverage for all expenses over the deductible, unlike Medicare benefits, which are limited in duration and do not provide full catastrophic coverage.

- The above MSA model would cap all annual out-of-pocket expenses, unlike Medicare, which does not cap out-of-pocket payments. Indeed, the estimates from the actuaries indicate that the MSA could cap out-of-pocket contributions and expenses from the elderly at less than $2,000 per year.

- Through the MSA, the elderly could avoid the increasing rationing under Medicare, which is reducing the quality of their care and their access to care.[9]

This proposal achieves the targeted cost controls for Medicare, essentially by giving the elderly direct control over the program's funds. Retirees can consequently profit by wise use of those funds. By avoiding unnecessary expenses, they can each pay themselves a large rebate each year under the MSA option. When they get sick, this reform would also allow them to escape the increasing rationing of health care under Medicare. Instead, they would be free to choose the doctors, hospitals, treatments, and benefits they want. Moreover, the MSA actually offers better benefits than Medicare. These and other benefits of the reform for the elderly would make the necessary reductions in program expenditures politically possible.

---

[3] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," Washington, D.C., February, 1995, p. 287.
[4] John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," NCPA Policy Report No. 168, National Center for Policy Analysis, Dallas, Texas, January, 1992.
[5] Litow, Milliman and Robertson, "Financial Impact of Medical Savings Accounts on Health Care Spending in the Federal Budget," Council for Affordable Health Insurance, October, 1993.
[6] Stan Liebowitz, "Why Health Care Costs Too Much," Cato Institute, Washington, D.C., Policy Analysis No. 211, June 13, 1994.
[7] Peter J. Ferrara, "More Than a Theory: Medical Savings Accounts at Work," Cato Institute, Washington, D.C. Policy Analysis No. 220, March 14, 1995.
[8] Note, however, that even if such savings were somehow not fully achieved, that would not affect whether the necessary budget savings were achieved, as those savings would result from the 5% growth cap on the funds that could be withdrawn from Medicare in any event. The only result would be that the withdrawn Medicare funds would buy less in private benefits than otherwise.
[9] See Peter J. Ferrara and John C. Goodman, "Medical Savings Accounts for Medicare," Brief Analysis No. 160, National Center for Policy Analysis, Dallas, Texas, April 17, 1995.

Other Reform Features

Other features of the reform proposal would include the following:

- The private plans offered as an alternative to Medicare would have to cover the same medical services and treatments as Medicare.

- The private plans would have to accept anyone from Medicare for coverage to participate in the system.

- Those who chose a private plan could go back to Medicare after one year, but not before. The could switch to another private plan that would accept them at any time, but those plans again would not be required to accept them from another plan.

Chairman THOMAS. Thank you very much, Mr. Ferrara.
Dr. Orient.

STATEMENT OF JANE M. ORIENT, M.D., EXECUTIVE DIRECTOR, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

Dr. ORIENT. Mr. Thomas, I am executive director of the Association of American Physicians and Surgeons. Our association thanks you for the opportunity to participate in this discussion.

We will not claim to have a plan to save Medicare, because it is a serious offense to lie to Congress. The fact is that the handwriting is on the wall. You can read it for yourselves in the 1995 Report of the Medicare Trustees. Medicare has been weighed in the balance and found wanting. Next year, it will be wanting about $30 billion. The gap between income and expenditures will increase progressively, and the HI, Health Insurance, Trust Fund will be exhausted long before baby boomers retire.

In 1967, Frederick Exner, a former secretary of our association, wrote, "Medicare can never be sound. The projected tax increases when the plan was adopted should be enough to scare us even though they failed to scare the Congress; but actually they will provide only a fraction of what the expenses are sure to be." In 1966, the maximum Medicare HI tax was only $46.20 a year.

The truth is that Medicare was built on an unsound foundation and straddles a major fault. The foundation is crumbling and the building is about to be hit by a major earthquake: the demographic dislocation of baby boomer retirement.

The structure cannot be fixed by remodeling the executive suite and hiring a new management team. If all Medicare patients were forced into HMOs, the structure would still collapse and the private sector would be blamed. Medicare HMOs would also help to destroy the rest of the medical system. In the appendix to our written testimony, physician's assistant Jim Morris, from his position as an insider selling HMO products, describes the deception and the rationing forced on employers, patients and physicians.

Medicare is a pyramid scheme founded on deceit. Seniors think that they have paid for their benefits, but in reality current workers are paying for them and, in addition, must bear the brunt of the cost-shifting and price inflation caused by Medicare.

It is time to admit that we cannot repair the Medicare building and to shift our attention to the people who are trapped inside.

Medicare traps patients and those who care for them into government dependency. We must immediately allow people who are able to do so to escape from Medicare. This will help to unload the stresses on the system.

To unstop the safety valve provided by the private market, we should encourage private contracting outside the system for which no Medicare claim is filed.

We must also repeal price controls and allow balance billing so that the marketplace can compensate when Medicare reimbursements do not cover the cost.

The long-term solution is to phase out taxpayer-financed medical insurance for retirees. This requires fixing the problem in the rest of the medical system.

What Congress must do and can do without cost to the Federal Treasury is to reform the basic inequity in the Federal Tax Code.

The Tax Code should not punish Americans for paying for medical care at the time of service or for buying individually owned, portable, true insurance. Because of the Tax Code, most Americans prepay for medical care through tax-favored employer-owned arrangements which arrangements cannot even be transferred to a different job much less into retirement. It diverts a large fraction of the medical dollar to the pockets of middlemen and leads to inflated prices and overutilization.

Medical savings accounts and individually owned catastrophic insurance should receive the same tax treatment as employer-owned comprehensive coverage, which is really a tax-free substitute for wages. Medical savings accounts allow patients to benefit from their cost-saving decisions because when patients are spending their own money, they consider costs, and this type of market pressure tends to drive down the price paid per service rendered. Companies that have tried medical savings accounts have found that their medical costs have actually decreased.

In contrast, managed care can, at best, claim to contain expenditures by reducing both quality and quantity of services. The patient bears the cost of rationing, inconvenience, poorer care and loss of choice, but receives none of the benefits of savings.

Patients own their medical savings accounts; managed care companies own patients.

Medicare is socialized medicine. We must replace socialism with free enterprise. Because free enterprise works, all Congress needs to do is to remove the impediments, the most important of which is that Americans have to earn about twice as many dollars after taxes to wrest control of their medical care from employers and third parties.

The long-term cure for American medicine, including Medicare, is tax equity. The short-term symptomatic treatment for Medicare is, let the people go.

The Medicare experiment provides one more demonstration that socialism doesn't work. We have no choice but to replace this failed and unjust system. If we act promptly, we can ease the transition to free enterprise and minimize the pain for those who are trapped in this misguided social engineering project.

You have heard about the financial foundations of the system. Let me say one word about the moral foundations. Free enterprise is morally right; socialism is morally wrong. Money given in Medicare benefits is first taken from those who earned it. That—in the words of a former Congressman named David Crockett—money is not yours to give.

[The prepared statement and attachments follow:]

TESTIMONY
of the

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC

to the Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Presented by: Jane M. Orient, M.D.
Executive Director

May 25, 1995

The Association of American Physicians and Surgeons thanks you for the invitation to participate in this discussion. We cannot, however, in good faith, propose a plan to save Medicare. That's because we understand it is a serious offense to lie to Congress.

The fact is that the handwriting is on the wall. You can look at the figures yourselves, or you can read the 1995 report of the Medicare Trustees. Medicare has been weighed in the balance and found wanting. Next year, it will be wanting around $30 billion. The gap between income and expenditures will increase progressively, and the trust fund will be exhausted long before the baby boomers retire.

In 1967, Frederick B. Exner, M.D., a former Secretary of the Association of American Physicians and Surgeons wrote: "Medicare can never be sound...The projected tax increases when the plan was adopted should be enough to scare us even though they failed to scare the Congress; but actually they will provide only a fraction of what the expenses are sure to be." [In 1966, the maximum Medicare HI tax was only $46.20 per year.]

The truth is that Medicare was built on an unsound foundation and straddles a major fault. The foundation is crumbling, and the building is about to be hit by a major earthquake: the demographic dislocation of baby boomer retirement.

The structure cannot be fixed by remodeling the executive suite and hiring a new management team. If all Medicare patients were forced into HMOs, the structure would still collapse, and the private sector would be blamed. Medicare HMOs would also help to destroy the rest of the medical system. The reasons are graphically described by physician's assistant Jim Morris in the appendix to our written testimony. From his position as an insider, selling HMO product, he describes the deceptions and rationing forced on employers, patients and physicians alike.

The dreadful truth is that Medicare is a pyramid scheme founded on deceit. Seniors think they have paid for their benefits. In reality, current workers are paying for them, and in addition, must bear the brunt of the cost-shifting and price inflation caused by Medicare.

It is time to admit that we cannot repair the Medicare building and shift our attention to the people trapped inside. Medicare traps patients and those who care for them into government dependency.

We must immediately allow people who are able to do so to escape from Medicare. This will unload the stresses on the system to some extent, to the benefit of those who remain trapped.

The first step, which would actually save money for the Federal Treasury, is to unplug the safety valve provided by the private market:

> (1) **Encourage private contracting outside the system.** For such services, no Medicare claim is filed.
>
> (2) **Repeal price controls.** This means to allow balance billing so that the marketplace can compensate for Medicare reimbursements that do not cover costs.

The long-term solution is to phase out taxpayer-financed medical insurance for retirees. This requires fixing the problem in the rest of the medical system.

What Congress must do, and can do without cost to the Treasury, is to reform a basic inequity in the federal tax code.

The tax code should not punish Americans for paying for medical care at the time of service or for buying individually owned, portable insurance. Because of the tax code, most Americans prepay for medical care through employer-owned insurance. Such insurance cannot even be transferred to a different job, much less into retirement. It diverts a large fraction of the medical dollar to the pockets of middlemen and leads to inflated prices and overutilization.

Medical savings accounts and individually owned catastrophic insurance should receive the same tax treatment as employer-owned comprehensive coverage, which is really a tax-free substitute for a wage increase.

Medical savings accounts allow patients to benefit from cost-saving decisions. Because patients are spending their own money, they consider costs in their decisions. This type of market pressure tends to drive down the price paid per service rendered. Companies that have tried medical savings accounts have found that their medical costs have actually decreased.

In contrast, "managed care" can at best claim to "contain" expenditures by reducing the quality and quantity of services. The patient bears the costs of rationing (inconvenience, poorer care, and loss of choice) but receives none of benefits of saving.

Patients own their medical savings accounts. Managed care companies own patients.

Medicare is socialized medicine. We must replace socialism with free enterprise. Because free enterprise works, all Congress needs to do is to remove the impediments. The most important impediment is that Americans have to earn about twice as many dollars, after taxes, to wrest control of their medical care away from their employers and third parties.

The two word description of the long-term cure for American medicine, including Medicare, is "tax equity."

The three-word description for the short-term symptomatic treatment for Medicare is: "let people go."

The Medicare experiment provides one more demonstration that socialism doesn't work. We have no choice but to replace this failed and unjust system.

If we act promptly we can ease the transition to free enterprise, and minimize the pain for those who are trapped in this misguided social engineering project.

SPEECH

Presented by

Jim Morris

to the

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC

Regional Conference in Boise, Idaho

May 6, 1995

I'd like to start with a little history about myself: I have been a physician's assistant for about 20 years. For part of that time I was in the military, which obviously has the worst type of socialized medicine. I took care of runny noses and sore throats at all hours of the day and night. I was awakened one morning about 2:00 a.m. for a gentleman who presented to the Naval Emergency Center for acne. So, as all cases, I got up and saw him and suggested that he take some tetracycline and so forth.

Then I said, "I have a question for you."

"What's that?" he responded.

"Have you ever heard of terminal acne?" I asked.

"No, is this terminal?"

"Wake me up at 2:00 o'clock again and it will be."

One of my past positions was as part of an HMO team. I was one of those people that went out and sold the program to companies, to doctors, to hospitals. This was a real eye opener. I'd like to tell you the methods we used to sell HMOs.

First, we were instructed in how to talk to employers. The first thing you talk to employers about is reduced cost. We told them that their employees were paying $320.00 a month for insurance for their families and that we could do it for $90.00 a month. When employees went to the doctor, it would only cost a $10 copayment.

Well, we just happened to forget to tell the employers that since it only cost them $10.00 to go to the doctor, they'd probably go more often, losing more time on the job. The other thing is that we forgot to tell them that people were going to snap the program up, and after that they would be ours.

If I came to any of you and told you the bottom line was that instead of $320.00 a month to take care of your wife and two kids, it's only going to cost you $90.00 a month, which program would you sign for? Of course, the program looks great on paper.

We talked to the employers about how they could sell the program to the employees so that the company could save money. We'd help.

Usually we would go into plants that made wood products or were involved in agriculture. It's very easy to sell to their employees. They're working for minimum wage or not

much more. They are also young. They have had no experience in the health-care market. They sign up, and the company says we'll provide health care. They didn't care what kind of plan, as long as they knew they had health care for their family. They went from paycheck to paycheck. Their educational level was low, they had no economic background, they weren't inclined to ask questions, and we certainly didn't tell them anything they didn't want to know.

From the managed-care company's standpoint, the more people we could sign up, the better. Every person enrolled means more revenue generated. So we went in and sold this program as quickly as we could. Some of you may have long dissertations with your insurance man or with your attorney. Our average appointment with a management team was one hour.

We wanted to present everything and get out of there before they had time to ask any questions. And as long as a CEO was looking at the bottom line, it was a go. We probably sold between 85 and 90% of the plans we approached.

I look back on that and I think I resembled a used-car salesman. This runs great, looks good, here it is, take the keys, gimmie $100.00, it's yours, your outta here. The problem is, I didn't tell you that it's probably only going to get you about three blocks down the road, you're lucky.

When we sold to physicians, our point was to join now or somebody else would. We said we've only got slots for four family practice docs in our list of physicians here so you know if you don't sign, Dr. Jones down here will and of course if he signs and you don't and you have patient that all work for John Doe company over here, he gets all of those patients automatically. It doesn't make any difference whether they want to go to him or not, that's where they are going to go if they want their services paid for.

We preyed upon poorly educated employees. If they were hesitant at all, we'd go out on the factory floor as we were walking out and say "Wait a minute, if you're really not sure this is a plan for you, let's ask this guy over here running this mill." We'd pull the guy off the mill and say, "Listen young man, how much do you pay for health insurance for your family? How would you like to pay 1/3 of that? Oh, and you pay 20% on top of that? Oh, well, how would you like to pay $10.00?"

Now, you only have to hit one man on the floor or possibly two, and the word would go through that company. There is a health insurance plan available that is only going to cost one third of what people are paying now and $10.00 a visit. The plan is sold. They will not dare turn your plan down because they will have a revolt from the employees if they do.

We gave people limited information concerning the panel of physicians. People would ask, "Well, is my doctor on the panel? Could I go see my family doctor?"

"Well, we are currently negotiating with a number of physicians to join our panel and actually we are talking to Dr. Jones, your physician, and he has shown some interest."

I hadn't even been to see the man yet. That's the way the system works. Don't answer any question up front, and don't answer them straight. Make a quick sale to the employer, and do it by selling it to the employees first, if necessary.

Then I changed jobs. I went from selling HMOs to working in a private office in which the physician I worked with signed up for a number of HMOs. He got caught in the crunch: "If you don't sign, the doctor down the street will. You've got 4000 patients, we own 1200 of those, can you afford that loss in income with three kids in college?" Those were the types of things that were told to the physicians. When the physician I worked for refused to sign up for an HMO, we lost 300 patients overnight. That's a pretty good chunk out of a single physician family practice group. That's a significant cut in income.

Now, what happens when you do sign up for an HMO and the other doctors don't? You get all their patients. Then you have more patients than you can handle. People can't get in to be seen. We started losing patients because they couldn't get appointments. We had patients that had been members of that practice for eight and nine years who were now seeking physicians further and further out of town because they could call and be seen that week. Our patient load got to the point that we were scheduling patients two and three months in advance.

Another selling point for doctors is the capitation. The idea is to get 300 patients on your panel, knowing that only 5% of the population is really ill. Well, I'm not sure who has worked in family practice, but let me explain what actually happens. If you tell 400 patients that they can come to the doctor and be seen for $10.00 or less, you can bet that a good portion of those are going to show up-far more than 5%. It makes it harder and harder for the sick patient to get in to be seen. So they start going outside the system. What happens if they go outside the system? They don't have any insurance.

"Well, that was on page 42 in the fine print that said that if you didn't see your family physician first, then you have to pay for the service out of pocket."

"You mean you didn't call us and ask? Oh, well I'm sorry that's on page 43, it says call this 800 number" (which of course is always busy).

If a patient goes outside the system and to a (please pardon the terminology) doc-in-the-box, and he says, "Well, look, you've got this bad heart murmur and you should go see the cardiologist," the patient generally makes an appointment to see the cardiologist. But he wasn't referred by his family practice doc, and he has no coverage. So now he's faced with a bill for $1200 - $1500, and no coverage.

We had patients go through this. We had a doc-in-the-box next door, two doors down from our office. We had people go in there. They would walk into our office, and our receptionist would say "I'm sorry Mrs. Jones, our next opening is next Thursday."

"Well, I'm sorry, but I need to see somebody today."

The patient could walk right out in the parking lot and see the sign that says "M.D. on duty" and walk in. She doesn't know any better, she doesn't care at that point, not until the bills start rolling in. And the insurance company doesn't care, the HMO doesn't care. They say, "I'm sorry-you didn't follow the guidelines, and we're not paying for anything." And they don't. The next thing you know, I have to see Mrs. Jones in the office with chest pain because she just got this $1200 bill from the cardiologist. She thought she had insurance, so she called the insurance company, but they refused to pay. She's down to her last $5 fixed May, 1995, income after she pays her rent and her groceries.

One of the other problems we had was with patients who had to travel a long distance. One of the HMOs we signed up for was in Reno. We worked in Gardnerville, Nevada, which is about 65 miles south. We were one of the first family practice docs to sign up with this HMO, so we had people driving 65 miles for their routine office care when there were obviously a large number of family practice doctors in an area like Reno or Sparks that were more than willing to see them.

Many of these patients were elderly. Some were sick children who cried for 65 miles on their way to see us. If the patient wanted to see somebody other than the family doctor on the panel, or wanted to go to the ER, he had to get prior approval. Try to get approval after 5:00 at night or on a weekend. It doesn't happen. Any number of HMOs, including the one that I was involved with, had five or six operators on during the day, but only one operator at night and on

weekends. That 800 number would ring incessantly. I have even called it myself and let it ring 60 times and not had an answer. That's what happens to your patients.

Now, what about transporting a patient by ambulance? Suppose Mrs. Jones calls you says "My husband fell down the stairs, and I think he broke his hip." You can't just say, "Okay, we'll call the ambulance, and we will see him in the emergency room." They have to call and get that approval for that ambulance, and you have to be sure they have done it. And many HMO's don't cover ambulance transportation, so it's an out of pocket expense.

Specialists care. Now we get down to what gets into the physicians pocket. Your capitated, you've got 400 patients in your panel, your capitated at $5.00 a piece and so you've got this set income that's going to come in, $2000.00. Okay now, we forgot to tell you though that we are going to keep 10% of that off the top for a catastrophic fund, that's in case somebody has to have a bypass or something like that. So, we are going to withhold that amount of money.

This is a true story. You go in to see your physician, I had an 18 year old girl who came in with acute onset of a heart murmur and chest pain. She came in, I said "look we ought to send you to see the cardiologist". Well, we had to call and get approval to send her to the cardiologist. Not a major problem with this one HMO, worked pretty well. The only problem was that we paid for the cardiologist, it comes out of our capitation fund.

I was lucky, the doctor I worked with didn't look at dollars, he looked at patients, he took care of her, he sent her.

There were other doctors I know that worked in the same area that did not refer patients because they had to pay for it. If you have somebody that does not have a life threatening condition, we had a 35 year old female with new onset seizures who we attempted to refer. We had to try, according to the HMO panel, at least three anti-seizure medications before she could be referred to a neurologist. They would not pay for an EEG, they would not pay for a neurosurgeons evaluation or neurology evaluation until she had been tried on at least three clinical drugs.

And then you run into the panel. If you have a patient (the same May, 1995 lady with the seizures) who we did try three drugs on and then we attempted to get an EEG because it was "expensive" and that is determined by each individual HMO (how costly a test is) it has to go before the approval panel. You have to submit a form to go to the panel.

Well, if you're lucky, the panel meets weekly. Unfortunately, ours met monthly to begin with, because it was small. So you submit a consultation form to the panel with the clinical information on it and request permission to send this lady to an out-of-panel neurologist and have an EEG done.

Unfortunately, on the panel you have one physician (who we were lucky was an internist, who was fairly well versed), you have an accountant and you have a CEO or CFO of the HMO. Well, he doesn't care. She's not related to him and he is not married to her, so, as far as he is concerned that's another body and he is looking at expenses. So, each person has a vote on whether or not that person gets that test done.

You have an accountant and a CEO that votes no and an M.D. that votes yes. Even in good conscious this guy is losing. It happened three times before we got this lady transferred. These are honest stories on a stack of bibles people - I swear.

Again, strict criteria for patient care, you have to meet certain criteria before you can transfer a patient. I worked in a cardiology group for awhile at a large hospital in Nevada. It was near the State line. We used to get patients over from a large HMO out of Sacramento. They would come over, they'd had an angiogram done. They did have chest pain, they had been

admitted to their hospital to their HMO facility and evaluated. Their chest pain was calmed down, they were doing fairly well on their nitrates, they went ahead and did an angiogram.

One gentleman in particular had two 75% lesions and one 70% lesion and was 76 years old. His HMO said, "Gee, we don't do anything under 80% lesions for starters and secondly we don't do anybody over 70 either". Well it doesn't make any difference if this gentleman chronologically looked like he was 60 and not 75 or 76, but "we just don't do those lesions, so, you know, sorry".

It's kind of like socialized medicine in Canada. These people would come over to our area, Reno, and they would check in the Emergency Room to see how busy things were, go across the street to the park and run up and down in the park in three piece suits until they had chest pain and then walk back across the street and get admitted in the emergency room.

Since they crossed the State line, they were out of their service area, they could be admitted on an emergent basis and treated as necessary without prior approval. I've seen it more than once. I can give you three names. I mean, this is not, out of the ordinary, this is common. It's common practice.

When you talk to people that are trying to sell HMO's to physicians, the first thing they sell the physician is, especially on a capitation program, is that this is a get rich quick scheme, as I eluded to earlier "we are going to sign up 400 patients for you because this guy down the street won't sign up with us and we are going to capitate you at $5.00 to $10.00 to $12.00 a piece, whatever it takes to get you to sign up. So -you are going to get this 2, 3, 4, $6000.00 a month no matter if you only see one of these people off this panel." Well again, since it only costs them $10.00 to come in, you are going to see a lot more than 1 or 2%. We signed up a 400 patient panel, we averaged 120 of those people a month.

The people that get rich off HMO's is the management. As the Wall Street Journal stuff was demonstrated recently, those are the people taking home the money, not the physicians in the street. Initially you think you are going to get paid for doing little or nothing - doesn't work - you get beat into the ground.

You are no longer a patient advocate. You start having to protect yourself. You start having to protect your income because you've got kids in college. You've got a house to pay for and all at once, you're not thinking about the patients well-being, you start thinking about your pocketbook and as Dr. Goltry alluded, that is the wrong direction to head.

Patients lose their choice. If you send a patient to a cardiologist or to a neurologist and you have a neurologist assigned on the panel who you really have some doubts about. Well, maybe he's not quite as aggressive as you would like and so forth, doesn't make any difference, if he is on the panel that's where your patient goes - once you get approval.

It happens many times. The problem you run into is that you may have 20 family practice docs on a panel and one neurologist. Even though there are five or six in town, there is only one on the panel. So, again, try and get a patient in.

It was not uncommon to call for cardiology or neurology services and find out that it was a three to six month wait to get an appointment and then that's an initial evaluation appointment - that's not for any services. Then they have to turn around and reschedule again three months later to get in to be seen for their follow-ups. It happens commonly. You get in medicine by proxies.

I alluded to panel choices. The panel decides what's going to happen to your patient, not you. As Dr. Goltry said, I am a physician assistant, I work with M.D.'s, D.O.'s and so I turn my choices over to the physician to make the ultimate choice in how the patient is treated and where they go, I assist in that care. But, I was trained basically to take care of the patient the best way I

know how and to use all of the knowledge that I have and I have been at this for 20 years. So, for me to turn around and fill out a form to send and let two financial people and one doctor decide what's going to happen to the patient goes against my better well-being and it definitely causes some ulcers.

There is some question in HMO panel programs now where a panel decides on medical care as to whether or not you are open for litigation. Whether you have not exercised your medical knowledge to the best care of that patient. There are two cases pending in California, that I am aware of, where a doctor is being sued because he did not refer a patient because the panel told him he couldn't.

Referral fund, as I allluded to earlier. A certain percent of your capitation goes back into referral fund. Again, this is dependent upon the contract you sign, but the ones I was exposed to this is what happened. That money then comes out of that referral fund, if you send a patient to a cardiologist, or so-forth for further care. Dependent upon whether or not that care exceeds that fund, it may or may not come out of your capitation fees.

So, instead of us getting a $3000.00 a month check, it was common for us to get $1500.00 or $1700.00 from the HMO because we spent more than what we were supposed to spend for specialty care. Again, the doctor I worked with was more concerned about his patients than his checkbook. There is something called a catastrophic fund. That is a certain percentage of your income that goes into a fund to cover those patients that need a bypass or that have to have chemotherapy or a transplant, etc.

What happens to those doctors involved in the HMO when there is no money left. What happens if you happen to be in that unlucky group that has three five vessel bypasses and a kidney transplant that year? There is no money left.

The question is, who is responsible? The physician I worked with in Nevada had a case where we just happened to be the unlucky people. We were involved with a group of family practitioners that grossly exceeded our funding because we have two five vessel bypasses out of our group and a renal transplant and so did a couple of the other physicians. That doctor ended up paying, even though he signed out of the HMO, even though he quit, because those expenses were incurred while he was still a member. He ended up paying for five years after that because those expenses he was liable for.

If any of you really contemplate joining an HMO, read your contract very carefully. There is something in there about how long you are liable for expenses and also how long for patient liability. If you are de-selected, if you should be so lucky if you happen to make the error of signing up, and find out whether or not you are still liable for expenses, even though you have been de-selected, how long the contract period goes.

I have worked in family practice and in a cardiology group which were both HMO involved. I have been involved with four HMO groups as a provider and one HMO corporation and it is the worst thing that I have ever done in my life. As Dr. Goltry alluded to, it's perverse, it's inhuman, it takes away physician choice, it takes away patient choice and it ruins what we were all taught to do.

AAPS news
The Voice for Private Physicians
ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Volume 51, No. 6 June 1995

CAN MEDICARE BE SAVED?

Speaker Gingrich is setting the agenda, and Medicare is at the top for the next few months. With great political astuteness, Gingrich lobbed the ball into Bill Clinton's court. With equal savvy and lightning speed, Clinton slammed it back.

They both know where the "third rail in American politics" is, and neither wants to touch it. What politician could survive the credit for bringing down the federal building of Medicare, the great shining showcase of the Welfare State and government-funded medicine?

On the other hand, everyone wants credit for saving Medicare—including physicians. And something must be done.

If a building is in trouble, one needs to send in men in hard hats to examine the foundations.

Let's set aside the various Reports, Plans, Bills, Opinion Surveys, and Trial Balloons—and take a hard look at the foundations of Medicare. Here are the rock-solid indisputable facts that every American needs to know:

- **Medicare Part A is built on a first-dollar tax on wages.** Out of every dollar an American earns, 2.9 cents goes to Medicare Part A. No one may lawfully earn money to buy milk for the children, a train ticket to work, or insurance for himself, without paying that tax first. Americans who earn $20,000 pay $580; those who earn $200,000 pay $5800 to Medicare Part A.
- **Medicare Part *B* premiums are about 75 percent subsidized by general tax funds.** Uninsured working Americans are paying part of the premiums of wealthy retirees.
- **The tax is not enough; bankruptcy is inevitable.** Receipts from the payroll tax already fall about $22 billion short of covering current Part A outlays.
- **The tax *cannot* be increased enough to keep politicians' promises.** Increased longevity plus decreased fertility yields a demographic bomb. By 2040, the Medicare payroll tax *alone* would consume between 10.6 and 20.26 percent of all wages to maintain present benefits. Long before tax rates rise that high, capital and labor will move to places where they can earn a decent return. If forced to remain, their productivity will be minimal.

The dreadful truth is that Medicare is a pyramid scheme founded on deceit. It is like a poorly constructed building that straddles a major fault.

The answer to the question in the title is simply "No, Medicare in its present form cannot be saved." That is simply a fact, not a wish or a statement of political philosophy.

The next question is what to do about it. One approach is to deny the magnitude of the problem and offer a palatable nostrum. Appealing but dangerous "solutions" include changes in the top management along with schemes that paper over the cracks with price controls.

Those in power know that they cannot repair the problem, but they hope to postpone the day of reckoning so that it does not occur on their watch. Or they simply wish to delegate the responsibility so that someone else will be blamed for the debacle. "Private" entities, namely "managed" care, are popular candidates. Let them skim a fat share of gross receipts from the top for playing the heavy and taking the heat.

"Managed care" may be called a "market-based" or "private" solution, but those terms are in Orwellian Newspeak. As documents of the Clinton Health Care Task Force acknowledge, enterprises that exercise powers belonging to government, or that are under pervasive government control, are private only in name or form. Medicare HMOs are funded by the government and act as an arm of the government. But their failure will be construed as a failure of the marketplace and as a reason for frank government takeover.

Another approach is to call for the outright, immediate repeal of Medicare. This would be about as irresponsible as dynamiting an unsound building while people are inside.

The humane and rational approach is to shift our attention from saving the building to saving the people who are trapped in it.

The first step is to avoid further damage from loading on additional costly regulations. The second is to unload the counterproductive stresses that already exist (the Clinical Laboratory Improvement Act, restrictions on balance billing, claims filing when no reimbursement is expected, etc.). Next is to protect as well as possible the most vulnerable patients who cannot find assistance outside the system. Most important is to evacuate in an orderly manner those who are willing and able to leave—and simultaneously to allow the development of sound structures to replace the failed Medicare system.

Persuading people that they *should* leave a heavily subsidized program will not be easy—especially when they themselves have been taxed to provide the subsidy. Persuading young persons that they should not enter is somewhat easier. Finding the means for them to do so, given present levels of taxation, is the difficult part.

Under politics as usual, Congress will study plans to remodel the top floor. The health-care management interests will try to block the front exits, while fashioning policy that must inevitably hasten departures via the morgue.

Meanwhile, the real support for the structure is crumbling—the support of workers. Their ability to produce is drained by taxes and regulations, and their anger grows as they see the legacy that awaits them.

The choices are stark: we can tell the truth and rescue the people—or we can lie and do nothing to mitigate the inevitable collapse.

Chairman THOMAS. Thank you very much, Doctor.

If it was not said previously, any written statements that you have will be made a part of the record, without objection; and if you will entertain some questions, I will call first on the gentleman from Louisiana, Mr. McCrery. He is someone who is very interested in medical savings accounts.

Mr. MCCRERY. Thank you, Mr. Chairman. You are right, I am very interested in medical savings accounts.

Chairman THOMAS. Not that the others of us aren't. You just show exceeding interest.

Mr. MCCRERY. Well, I wouldn't say so, but I think appropriate——

Chairman THOMAS. Appropriate.

Mr. MCCRERY [continuing]. Interest. In fact, a bill that I introduced last year would have done, I think—well, wouldn't have done exactly what Mr. Ferrara recommended, but it—in fact would have gone further because it would have given tax-favored status only to medical savings accounts, high deductible options and managed care arrangements so that the traditional, first-dollar-type insurance policy would no longer be tax favored. That is how radical I am in trying to shift the population into some arrangement that, in fact, does encourage personal responsibility and involvement of the patient in his own care. That was only for the non-Medicare population.

Today we are talking about the Medicare population, which is, I must admit, a different situation, and it is one that I have not given a whole lot of thought to, frankly, until now. I am interested in the observations of all of you with regard to the Medicare population.

Is it not true that the Medicare population is far different from the rest of the population in terms of their likely medical needs? It seems to me that we must analyze the effect of medical savings accounts on that population separate from the rest of the population because of those differences.

I gather you disagree with that. Tell me, if you do disagree with that, why it is not true.

Mr. FERRARA. Well, I—the elderly have higher average costs, but in other respects, I think it is the same. The higher average costs, that just reflects the price of coverage. That is—and it seems to me that is—all the actuarial principles and all the market principles and everything else is the same. It is just that you have a somewhat higher incidence and you need somewhat more funds to cover the actuarial risk.

That is accounted for in everything I said. Medicare is already paying for that. So, the money—there is already money in the system to cover that.

The elderly are already paying for a lot of out-of-pocket expense. A lot of them are buying additional insurance out of pocket. The actuaries have looked at this and indicated to us that for what Medicare is already spending and what the elderly are already spending, you can fund the medical savings account that would produce all these benefits I described.

Mr. MCCRERY. Yes. It is your opinion that the effect on total expenditures would be the same as the effect on the non-Medicare population?

Mr. FERRARA. Yes. I think if you look at the cost distribution, as a matter of fact, under Medicare, you will find that most people—say, you had a deductible of $4,000 in the medical savings account, the great majority of people would not go above that every year—and HCFA has these numbers; if you look at that distribution, I bet it is on the order of 80 percent probably never go above that—and you would have the same incentive effect that you have got with the non-Medicare population. People are spending their own money; they don't want to waste it.

There is another factor that comes into play here that people often overlook. Because the people are concerned about not wasting money, the doctors and the hospitals for the first time really compete on cost. Today, they don't compete on cost because the patient is not choosing them on the basis of cost; the patient is choosing them only on the basis of quality. The patient doesn't care about cost because Medicare or the insurance company is paying for it.

When the patient starts choosing on the basis of cost as well as quality, they will compete on cost as well as quality; they will come up with ways to tell the patient, here is how you can do it for less.

Mr. MCCRERY. You think that principle holds true with the Medicare population?

Mr. FERRARA. Yes.

Mr. MCCRERY. Dr. Orient, have you thought about this difference between the Medicare population, the non-Medicare population and the effect of MSAs on each?

Dr. ORIENT. Well, the Medicare population is an artificial distinction caused by the existence of the government-funded program past the age of 65. Otherwise, they are human beings and they have a continuum of needs as younger people do.

Mr. MCCRERY. But they are elderly folks. When they are over the age of 65, they do have, on average, greater demands for health care; is that not correct?

Dr. ORIENT. Yes, that is correct. Mr. Ferrara, I think, has addressed that question.

Mr. MCCRERY. So, it is not an artificial distinction exactly. It is obviously an arbitrary distinction at 65, but it is not an artificial distinction, it is a real distinction. I am just curious, have you given any thought to the effect of medical savings accounts on the population, the universe of people above 65? Would it be the same? Would it act the same as those under 65? Is it more dangerous because of the greater health care demands?

Dr. ORIENT. I think clearly it would work the same way; and people over the age of 65, they are adults, they are capable of making prudent decisions about their medical care and, in fact, they do take cost into consideration when they know that there will be an out-of-pocket cost that they themselves have to pay.

Yet they also are extremely interested in their health, and I think they make wise decisions and it has been shown, certainly in younger population with MSAs that they may, in fact, tend to obtain more preventive care when it is their own money they are spending, or saving if they get the care at a propitious time.

Mr. MCCRERY. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you Mr. McCrery.

The gentleman from Nevada, Mr. Ensign.

Mr. ENSIGN. Thank you, Mr. Chairman.

First of all, I would like to compliment whoever your employer is, Mr. Erhart. He has just done a terrific job on this, his foresight and forward thinking on choosing this option for your employees.

I would like to address Mr. Ferrara, first; you mentioned the risk assessment. Who would do the risk assessment? How often would that be done? And I guess whoever would do it, are they capable of doing that?

Mr. FERRARA. Well, this would be—HCFA would determine how much there—each individual is going to withdraw.

Mr. ENSIGN. I was afraid you were going to say HCFA, but go ahead.

Mr. FERRARA. They would do it on the basis of a few objective factors. I am not expecting them to examine each elderly person and give them a number. They have a lot of data about distributional cost by age, distributional cost by geography, and they would look at a few objective factors for health status, whether the person is—a cancer patient or a heart patient would have a different risk profile than someone who doesn't have cancer or hasn't had a heart attack in the past year or something like that—disabled. There are a few other major things. They could advise us as to the—as to the factors to be considered.

Last year it was suggested by the Clinton administration that they could—they were going to risk-adjust every health plan in America. So, they seem to think that they had some technology to be able to do that.

Now, this is different, because then, that proposal—because here the government is paying for it already, it is a matter of how much the government is going to pay in each circumstance. So, it doesn't involve the same complications as the one they were proposing last year. By their own implication, by what they were proposing to do last year, they were suggesting that they could have the technology to do this.

It doesn't need to be precise, down to the *n*th percentile. If you do some risk adjustment to get relatively close, then you will avoid the adverse selection problem.

People say, what if all the healthy people leave? If this is done right, then that wouldn't present the same risk. It wouldn't present a problem because they would take money that reflects their risk and enough would be left for the people who are remaining in Medicare.

Mr. ENSIGN. The other problem that I have—because the concept sounds great. As a practicing veterinarian, we operate basically with medical savings accounts because we operate in a free market where people are paying out of their pocket, and that is the concept that you are trying to bring in here, bringing the consumer back into the marketplace.

Veterinary medicine is incredibly competitive. We do well. We still make a decent living, but our costs have been way below inflation for 20 to 30 years, providing better and better service every year. I support the concept.

I do have another concern that a lot of the costs are consumed in the last few months of a person's life. It is difficult to determine when those last few months are going to be, but, Dr. Orient, I am sure you would agree there are times when you have a very high probability that what we are doing here is useless treatment, and if the person was able to make that decision, would probably deny the treatment in a lot of those cases. How do we, with these medical savings accounts as an option, develop systems where people are empowered to make those decisions prospectively about those last few months of their lives.

Mr. FERRARA. We have some ideas to try and address that aspect of the problem, but they are not really in this—in this proposal we are offering you today and how to basically extend the medical savings concept to more catastrophic illnesses. They reflect the idea that insurance will pay a certain percentage or a certain amount of cost, and you determine if you want to spend more or if you want to pay less.

It gets to be—it is a pretty complex thing, and we really haven't advanced that. There are ways to try to address that, but what I want to submit to you is the medical savings account, the way it is designed, is getting big cost reductions that are more than big enough to do the job that you have got before you now, when you are talking about reducing the rate of growth from 10 percent to 5 percent. Even without this more advanced version that we are still exploring to try and address the problem you are talking about, where employers have been adopting this, they are getting cost reductions reducing 15-percent growth to zero-percent growth or cutting the cost by 20 or 25 percent.

I think the emphasis should be, let's get these cost savings that are on the table and achieve what we can. That will is very large and addresses the immediate problem.

Let me say one more thing about the risk adjustment. The same kind of concept was advanced in the report that the Committee, led by Mr. Shays, released at the time the House Budget Committee report was released. They have a report on Medicare. Representative Miller, Representative Largent, Representative Shays—there was a fourth one in there—they had a system: age, demographic location, disability and ERD status. They had a way of approaching this.

So, I would submit, with a few objective factors, you can get a workable system that gets you close enough so that it will function; and then any—when you are dealing with large numbers of people, some of them will cost far more than were risk assessed, most of them will cost less, and on average you get enough numbers that it will work out for both Medicare and the insurers.

Mr. ENSIGN. My time is up, I see.

Thank you, Mr. Chairman.

Chairman THOMAS. You are welcome.

The gentleman from Nebraska, Mr. Christensen.

Mr. CHRISTENSEN. Thank you, Mr. Chairman. Thank you for this panel. I am also a strong supporter of MSAs. Dr. John Goodman, with the NCPA, has been out there in the forefront for some time leading the discussion on this, and now this year they are in al-

most everybody's plan in one form or another. I would like to see them as part of the solution.

I want to thank Mr. Erhart for being here. I am not surprised that your company is using MSAs in leading the innovative decisionmaking process here with health care reform. As most of the people in this room know, RCI is one of the leading companies in terms of producing police cruisers and electric car batteries for the 21st century.

This is a company owned by our colleague, Richard Chrysler, who has been on the forefront; and Dick, I want to thank you. I appreciate your leading the charge in this area.

Dick was kind enough to present all of us with our own medical savings account card, and I think it is a process that we need to look at very closely. Michigan has done something with your innovative Governor up there to help the process along with MSAs and maybe, Mr. Erhart, could explain what Michigan and Governor Engler have done that we might try on a national basis.

Mr. ERHART. Yes, thank you.

Michigan has authorized medical savings accounts to be tax deductible, and it has helped very much, although it is just a part of the puzzle. We feel that, more importantly, if we can do the same thing at the Federal level it will have much greater impact.

Now, at the State level, for businesses or individuals that have medical savings accounts established, the funds that they pay out for medical benefits from these medical savings account programs are tax deductible and, in fact, if they—if the individual chooses to roll over their remaining MSA at the end of the year, then those funds remain tax deductible. I think because of that, in the long run that is where we feel the role of Medicare would be satisfied, because the individual over the years would build up this large nest egg of funds.

That is how we would address—we would call it the super MSA, for example, and as I mentioned, the individual would be able to purchase this high deductible insurance program, a high deductible insurance policy that would protect them and it would be extremely economical if they built up $100,000, $200,000 or more throughout the years. We feel that that would handle the Medicare issue and the various cost concerns that are being brought up today.

Mr. CHRISTENSEN. You came to that $200,000 in your written testimony figure by an employee entering the market at age 21, at 6 percent interest, putting $1,000 away in their medical savings account over their working life?

Mr. ERHART. Yes. That is based on our experience and what we have seen with our employees in the relatively short time that we have had the program, but we feel that is very representative of what will be accomplished in the future.

Mr. CHRISTENSEN. So, your employees have been able to put money away, you found. You found your costs have been reduced. Do you really believe that we could transfer this type of innovative thinking into the Medicare field?

I mean, I know that my colleague from Louisiana, who I agree with on almost everything, didn't mean to infer that people still aren't cost conscious at age 65, because I truly believe they are very cost conscious and very careful in how they spend their dollars

and they want to save as much as anybody at age 65. Wouldn't a program like this be able to be transferred to solving a lot of our problems in the Medicare arena?

Mr. ERHART. There is no question about it. In addition to Medicare, Medicaid, the Medicaid Programs could also be addressed with the government giving Medicaid recipients who are on welfare a voucher where they would actually go out and purchase an MSA policy from an insurer of their choice; and in fact at the end of the year, if those Medicaid recipients are still not at work, then they would not be entitled to the Medicare—or the MSA balance that might be in there. We see it as possibly another way to encourage people to go back to work, another financial incentive where they wouldn't have access to their remaining MSA funds until they had a job.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Chairman THOMAS. The gentlewoman from Connecticut, Mrs. Johnson.

Mrs. JOHNSON. Thank you. I appreciate the good testimony of the panel on a subject that is really very important to all of us. I do have a concern about the application of this approach to the senior population and let me describe it. There has been some discussion in other sessions of structuring the medical savings account approach to take into account my concern, but I do want to share it with you.

The average income among American seniors is $25,000 but, the median income is just under $18,000. I can't tell you how many seniors have come to me with anguish in their faces because they have gone to the doctor, but they can't afford the prescription. We have a lot of seniors who use going to the doctor as a substitute for care, because what the doctor tells them to do they can't afford to do.

Now, they are making the choice, day in and day out often, not to buy medication that they know will get them well because they have to buy food. If you take any public employee in Connecticut who is retired on a municipal pension or a teacher's pension before the time when those pensions also had Social Security, these people are living on extremely small incomes.

Now, this kind of person could be lured into a medical savings account very easily and they would use that money as a salary expander. They would not use it for health care; they couldn't afford to. The big thing in Medicare now for those who have tried to micromanage from this Committee, the big frustration is that it doesn't cover prevention. It doesn't cover the very services that could lower our costs overall, and improve the quality of health care for seniors. I worry about making this available without some strings attached that in order to be eligible you have to have paid for a basic physical or something like that; or if prescription medications are prescribed by your doctor, you must demonstrate that you actually bought them and took them. I mean, at some point you have to be accountable for spending this money in a way that is prohealth, not just an income expander. This is an aspect of the medical savings account in terms of its application to the senior population that troubles me.

I wonder if you have given that any thought, and have you any proposed solutions?

Mr. FERRARA. Well, Congresswoman, let me suggest that the proposal, the way I described it, addresses this concern in the most powerful way and that all other micromanagement is not necessary.

Look, if the person only has an option to take out of Medicare the funds that will buy an insurance policy covering everything over $4,000, and then $2,100 is put in their funds, which is—in their MSA, which is what actuaries are telling me could be done, basically that $2,100 could be used for prescription drugs, can be used for medical—for checkups, for preventive care.

You are addressing their problem. You are having people who are saying I am going to the doctor, he is prescribing these drugs, I can't afford to pay for them.

Mrs. JOHNSON. The problem is, Mr. Ferrara, if you allow them to withdraw at the end of the year what is left, you are not doing that. If they preserve that money, then the next year they get that and they can use it for whatever they want.

Mr. FERRARA. Right, but listen—I am sorry, what I am trying to say is, if you give people a savings account of $2,100 that they can use to buy prescription drugs, you are giving them a big advantage over the current system. They will then have the money available.

Now, as—but apart from that, you have to leave them the freedom of choice to make their own decisions. The government should not be telling them, you have to use it for this or you have to use it for that. They make their own decisions about their own priorities; and you are going—if you limit what they can use the funds on, you will undermine the incentive to control cost, because——

Mrs. JOHNSON. I think you are missing my point. If the government is going to actually give people money for the purposes of health, we have some responsibility to see that that money is used for health. If a senior uses that money for other than health purposes, just because they are on a very low income and they are desperate, then they get sick, they will go to the hospital and we will take care of them.

Now, since the taxpayer ultimately has the obligation to pick up the cost—and we do, we are a humane society; we are not going to turn them away because they spent their medical savings account on something else. So, I don't think you can take quite as casually as you are taking the fact that people might choose to spend the medical savings dollars in other ways and, particularly, refuse to spend it in health prevention ways that would minimize their costs in the future.

Then, the other thing, the numbers that you use, $4,000 catastrophic and we are going to give them $2,100, that means they are exposed to a $1,900 expenditure. For a person on a $7,000 or $8,000 income—and there are lots of them out there; any public school retiree in Connecticut who is about 70 is retired on $500 a month; that is what they are retired on—and no Social Security.

My understanding is—well, you say that is not right. I have had a teacher stand there and say my husband taught Latin in the local high school all those years. Maybe they couldn't.

Mr. FERRARA. It is a better benefit than under Medicare. They are better off with that proposal than they have got under Medicare, because you have got a cap on out-of-pocket expenses here of $1,900. On Medicare now, there is no cap on out-of-pocket expenses.

Mrs. JOHNSON. What do you spend down to Medicaid?

Mr. FERRARA. Apart from Medicaid, this is a better benefit structure than you have under Medicare on the cap of $1,900. Under Medicare there is no cap. According to AARP, the average person is spending about that much in out-of-pocket expenses already.

You have a better benefit structure under the MSA than you have under Medicare because you are giving them a cap on out-of-pocket expenses and unlimited catastrophic under $4,000, and a lot of people are paying out of pocket today to get those benefits from medigap insurance. You are offering them a better benefit package with the MSA and an opportunity to actually benefit if they use those funds wisely.

Let me suggest that what you are offering people by letting them spend the money on what they want at the end of the year is a reward for saving both the government and themselves health costs.

Mrs. JOHNSON. I don't differ with you that it is a better benefit structure if you are going to max out. I do differ with you that it is necessarily a better benefit structure under some circumstances; but my primary concern is that there is an obligation on the part of the Federal Government, if we provide subsidies, to see that the subsidies create the behavior that we are requesting, and the behavior that we are requesting is that you spend the money on health and you do it in a way that minimizes cost.

Mr. FERRARA. But the whole purpose——

Mrs. JOHNSON. I think you have to take into account in a medical savings approach some obligation on the part of the medical savings accountholder to assure that they take certain health care actions that we know are necessary to prevention.

Mr. ERHART. I believe your concern could be easily addressed merely by restricting the MSA expenditures for health care expenses only. I wouldn't see any problem with that. The money remaining in the person's account at year end is still theirs, but they must leave it there to pay for medical expenses in future years; and I think that handles that approach.

Mrs. JOHNSON. That would go toward the $1,900 exposure next year.

Mr. FERRARA. Excuse me, as a matter of economic analysis, that won't work. If you can only spend it on health care, that won't work. It gives you no incentive to save on health care. As a matter of economic analysis, that doesn't work.

If you want to do this the way—as a matter of sound economic analysis, you must allow an even playingfield choice between health care and nonhealth care. That is the choice as a matter of economic analysis you want to allow because what—what happens now is people are overspending on health care because they are not taking advantage of cost. They are not weighing cost against benefits.

To get the full weighing of cost against benefits, you have to allow them the freedom of choice to spend it on health care, as unlimited as possible at the end of the year. Any way you restrict that, you are undermining the economic incentive to try to weigh costs against benefits. You are reducing the rewards they get for not spending money on health care.

The whole idea behind MSAs is to give people incentives not to spend money on health care, and it is not to give people more money to spend on health care.

Mrs. JOHNSON. I do understand the economic analysis, Mr. Ferrara, but my time has expired so I can't pursue this any further.

Chairman THOMAS. Thank you.

I believe Mr. McCrery wants to speak but before he does, Mr. Ferrara, one of the things that we do around here is look at economics in terms of not only real-world context but also, in terms of a political-reality context. I understand your argument about weighing health care costs versus other uses for the money. I found out a long time ago that one of the first things you have to do around here is get a program started before you have a program. I was on the floor, not able to be with this Subcommittee for a portion of the time, as we were in the process of moving toward a conference committee with the Senate on Medicare Select. You cannot imagine what was said on the floor on such a modest little program.

Your example that you just gave would allow me, unfortunately, in a political context to say what Mr. Ferrara wants to do with the taxpayers' money, with the Medicare Program is to give the senior the choice between an RV or necessary medical attention. We know that is a phony argument. That, in essence, is what you are setting up in terms of an open-ended MSA account to be expended for whatever purpose someone wishes to expend that money for in an attempt to equate, in a pure economic sense, health care costs.

I found out a long time ago that you don't legislate in a vacuum and you do have to legislate in political reality. So, one of the things that we will be looking for as a Committee moving forward is a medical savings account program which not only creates an option or a choice for an individual from other structured programs, but has a modicum of a chance to pass. We have to deal with political realities as well as all other things being equal economic reality.

So, I guess what I am politely trying to say to you is that your colloquy with my colleague from Connecticut, although it may score points in terms of an academic argument over economics does not advance our cause of finding a politically salable approach to medical savings accounts.

So, we are going to have to examine Mr. Erhart's comment very carefully about saying if you do carry over money, what you are in essence doing is moving toward self-insuring yourself by the accumulation of funds in an MSA to be spent only for medical purposes; and that may very well be the best world that we can reach, because to do otherwise would be not to have any medical savings account option, and I believe that the former is a better choice than the latter.

Mr. FERRARA. May I address that?

Chairman THOMAS. Sure.

Mr. FERRARA. Let me make this suggestion as to political realities.

Surely it will be more politically appealing to say to people they can take the remaining funds at the end of the year and spend it on whatever they want, rather than say to them, you can take the funds and only spend it on these few things that the government says you can spend it on. So, the——

Chairman THOMAS. I understand your argument. I have carried it out in a number of different forums. That may be appealing in one context; it is a political anathema in another context.

All I am saying is that the vigorousness with which you argue your position, I understand it, but it may not be a possibility of creating a system, one step that allows you to spend it only for medical purposes.

And, for example, one of the questions that I was going to ask Mr. Erhart is, what happens if someone accumulates and rolls over the surplus funds in their MSA and does it year after year after year; and if one is as healthy as a horse and never expends their money from their MSA and they then die in an automobile accident or otherwise, is that money theirs? Does it go into their estate?

Mr. ERHART. That is how I would envision it, yes. It would go into their estate, possibly it could be used for their beneficiary's health care, it could be designated for that use only; or I think that is something that could be explored further.

Chairman THOMAS. OK, Mr. Ferrara, there is an area that we can work on. You and I will work together to try not to have an intergenerational requirement on a carryover on MSA to be spent only for medical purposes, so we can break this chain at least on the generational level and we may then be able to bring it back from that generational level.

What we are doing is trying to simply respond to you in a shorthand way the concerns that we might have about a theoretical approach which would be granted in a theoretical environment. Unfortunately—perhaps fortunately—we do not operate in a theoretical environment.

The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Ferrara, let me try to clarify what we are talking about here in terms of the availability of money in an MSA for expenditure by the holder of the MSA. You are saying that the person would get how much in cash?

Mr. FERRARA. What I have seen from actuaries estimating this, you can—one thing you could do is buy a policy covering all expenses over $4,000 and have about $2,100 left——

Mr. MCCRERY. How much cash would they get?

Mr. FERRARA. I don't know. It is either looking at the amount you withdraw from Medicare, on average, but what they are telling me is, the amount they can get out of Medicare would be enough to pay for a policy covering everything over $4,000 and put about $2,100 in the account each year.

Mr. MCCRERY. $2,100 in cash?

Mr. FERRARA. Each year.

Mr. MCCRERY. To use for common, everyday health expenditures?

Mr. FERRARA. Right.

Mr. MCCRERY. Do they get that cash in hand or is it in an account somewhere that they draw on, or how do you envision this?

Mr. FERRARA. Say they want to do this with XYZ Insurance Co. The account and the insurance—it goes to the insurance company. For the first year, they can only use it on health expenses. So, if they have a health expense, they send the form to the account and they will pay them back for it. What we would do is have that health expense be as broad as medical expenses are defined under the Internal Revenue Code.

Mr. MCCRERY. You would not allow those folks to spend that cash on nonhealth care expenses in the initial year.

Mr. FERRARA. Right. Right.

Mr. MCCRERY. OK. I think Mrs. Johnson may have been thinking that they are able to spend that money on going to the movies and whatever during that year.

Mr. FERRARA. Right.

Mr. MCCRERY. You don't envision that?

Mr. FERRARA. No, no, no, no.

Mr. MCCRERY. You are saying at the end of the year, if they have any money left, then they can spend it on going to the movies or whatever they want, because they get another $2,100.

The mechanics, though, we would have to figure out, because if you give somebody cash——

Mr. FERRARA. You don't give them cash. The insurance company holds it until the end of the year. At the end of the year, you would say give me a rebate on the remaining funds.

Mr. MCCRERY. So, you are with us there. We would have to figure that out.

I disagree with Mr. Thomas' analysis of the politics of this. In the old Congress, I think he may have been right; in the new Congress, I think there is a distinctly different flavor of philosophy that might lend itself to passing something like this. It depends upon the intelligence of the individual, and the individual operating in his own self-interest rather than some government plan that directs the individual in certain ways.

So, I disagree with him, but as a compromise, what we might consider is allowing the individual to get any money over and above the amount of the deductible, or the out-of-pocket cap, as long as that individual has sufficient money in his account to cover the deductible. He could use any excess at the end of the year. That might be a compromise that would help.

Mr. FERRARA. I think that would work. I think it is important—it is very important not to say you can only spend it on health care. It is not going to work. It would be worse than doing nothing.

Mr. MCCRERY. I am in total agreement with you there, except with the under 65-year-old group. Frankly, I think it is possible to tell them you must keep any excess in that account until you reach age 59 1/2, or whatever. At such time you can then withdraw it for any other purposes. Until that age you would have to spend it on health care only and it would accumulate, tax free, in that account, like an IRA, individual retirement account.

For the elderly, for folks over 65, I agree with you. I think you have to let them spend it at the end of the year. Maybe we could work a compromise that would satisfy Mr. Thomas' socialistic leanings and the realities of the new Congress at the same time.

Dr. ORIENT. It is interesting that you object to the senior citizen being able to buy an RV, but no one objects to the HMO pocketing the profits.

Mr. MCCRERY. I don't object. You are talking to Mr. Thomas.

Chairman THOMAS. Obviously, I am not going to advance a third party argument anymore. I was trying to offer options in terms of political realities.

I also find it somewhat interesting, Mr. McCrery, that you do fall back on the usual IRA argument, where it has to be included for a specified reason to spend out only, otherwise there are various penalties, loss of interest, time-certain amounts, which are the old-fashioned IRAs.

When you talk about a medical savings account, I think most people would examine that and say that it is an account to be used for a particular purpose, and you named it a medical savings account for that purpose, when, in fact, it is not a medical savings account, as you have described it, except for the first year, which you are now going to require them to keep it for a medical savings account. After that, I don't know exactly what it is, since you can spend the money for anything you want.

We will have to get into the Tax Code and what that means and how it is reported. It gets a bit more complicated if, in fact, you are going to create a one-way street one year and a two-way street the next year; and somebody gets married to someone else who has a new MSA, which is a one-way street MSA the first year and they exhaust their money. Can they borrow it? I am just trying to get practical when you get in the real world with people who live real lives. We have been dealing in a very neat, singular economic world about a theoretical discussion.

It is more complicated than we are currently making it out to be. Not so complicated that it is not a very attractive alternative to any other program out there right now.

Mr. MCCRERY. For those of us, Mr. Chairman, who have thought about this for a long time, there are answers to all those objections. In fact, I agree with Mr. Ferrara, that when you put those kinds of economic interests in play, you are going to get the desired result; that individuals operating in their own self-interests will accomplish the desired results.

Chairman THOMAS. I have no doubt that there are answers to questions, whether they are good answers.

Mr. MCCRERY. Oh, yes.

Chairman THOMAS. Sufficient answers.

Mr. MCCRERY. Yes.

Chairman THOMAS. The gentleman from Nebraska.

Mr. CHRISTENSEN. Mr. Ferrara, I agree with your economic analysis as far as incentives go. As a free market believer I think that is the correct way to go.

Mr. Erhart, you suggest that the money should stay within the medical savings account for medical purposes only and not be used for other purposes. Would you tend to agree or disagree, then, with

Mr. Ferrara's analysis that that would take away the incentive, or what is your perspective on that?

Why or why not would it not take away the incentive to keep it within the health care purchasing only?

Mr. ERHART. Well, I would tend to believe that it would not take away the incentive to still be a conscientious consumer of health care. Because the end idea is to have this built as a nest egg, as an account for future health care. And, again, we are aiming at a long-term solution for Medicare. I think that people would see that, certainly, that it is going to benefit them in the long run in the same way that they are putting money into IRAs these days to be able to prepare for the future.

If they know that that is the way that their Medicare is paid for, that their long-term health care needs are met is by accumulating this amount, I think there would still be that incentive to save and for this program to be effective and successful.

Mr. CHRISTENSEN. Have you experienced any of your employees' foregoing preventive measures to put money in their own pocket that should have gone through the preventive measures, that ended up with a long-term illness or a catastrophic health care situation that could have been prevented earlier because of your plan?

Mr. ERHART. We have experienced exactly the opposite of that. I have had a number of employees approach me and say that they are going for a routine physical exam; they have not gone for one in years because their traditional insurance program does not pay for preventive health care. So, I have experienced exactly the opposite of that.

Mr. CHRISTENSEN. Do you think that would be true of the Medicare population? Do you think preventive health care would also take place there like you have experienced in your company?

Mr. ERHART. Absolutely. Especially through the years, as this thing builds, and as people become more familiar with the concept of it and how it works, that is how they are brought up through the system, and I think that it would definitely be the case.

Mr. CHRISTENSEN. What about my penny pinching, conservative, frugal mom who does not go to the doctor for a sniffle or a cold and ends up deathly ill. Can't you foresee something like that happening with the senior citizens?

I am playing devil's advocate to some degree, because, believe me, my colleague from California, when he comes in here he is not for profit or he is not for any good innovative new ideas, like he said earlier. He is content with letting the system go bankrupt. We are going to try to fix it and come up with a system that is better for everybody.

I am just trying to think through all the arguments that we will see here later as we get closer to a decision on this.

Where do you see this, Dr. Orient?

Dr. ORIENT. I think physicians sometimes present to you an exaggerated sense of their powers. It is perfectly rational for a senior citizen or anybody not to go to the doctor when they have a cold. There is nothing I can do to cure their cold or keep it from turning into pneumonia.

Really, these preventive measures, in most instances, do not save money for society. They are good for the individual because they

help to prevent you from getting a serious illness, but not because they save money. Most senior citizens really are quite sensible and prudent. They didn't live to be 65 years of age by not taking care of their health.

Mr. CHRISTENSEN. You are with the physicians and surgeons. I have heard some people in Omaha talk about the fact that the specialists are not happy with a managed care approach to solving Medicare because they are going to see the gatekeeper theory; the primary care physician lock them out of seeing that patient that they need to see.

A lot of specialists have complained to me they don't want to go to a managed care solution with Medicare. Do you see that with your membership or have you experienced that personally?

Dr. ORIENT. Well, forget about what the specialists feel about it. Think about the patients. The patients are being locked out of seeing a physician who can solve their problem for them, and they are given the runaround and have to go to committees and go to the primary doctor who cannot help them over and over again as a means of rationing.——

Mr. CHRISTENSEN. So, you think there is some truth to that.

Dr. ORIENT. Oh, I think there is. I think you should look at it from the patient's perspective. They are the ones who are being deprived of the services that they could benefit from.

Mr. CHRISTENSEN. OK. Thank you, Mr. Chairman.

Chairman THOMAS. Mr. Erhart, I am a new employee. I have just received my medical savings account card. There is some writing on the front that I am not completely familiar with, and I turn the card over and there is the well-known fine print on the back side. Explain to me what the fine print means.

On the front side there is a PPOM, and there is Claims Pro. The fine print says, see certificate for exclusions and other terms of coverage. Managed care services program requirements. Medical precertification is required at least 7 days prior to admissions, surgery, or home health care.

Now, PPOM is the Preferred Provider Organization of Michigan. Do you have a contract with them? The company has a contract with them?

Mr. ERHART. Yes, that is correct. I appreciate your bringing that issue up because that is one of the features of our program that we have integrated into the MSA merely as an option, where if employees do choose to go to one of the PPOM providers, they are assured of a negotiated rate that is very, very competitive.

Chairman THOMAS. Because you do have a non-PPOM provider contact point on the back of the card as well. So, the employee has a choice to go into a preferred provider structure or stay outside of it?

Mr. ERHART. That is correct.

Chairman THOMAS. Are you familiar with International Paper's program? I sat in the other night with the Speaker discussing it with them just very roughly. International Paper examines the doctors in the area and develops a fee schedule that they believe is an appropriate one. They provide a lot of background information on the doctors, their degrees, number of years they have practiced, the number of times they perform certain procedures, and so forth.

They then tell the employee that they will pay 100 percent of what they believe to be an appropriate fee, if they would go out and tell the doctor that, well, this is what we believe is the appropriate fee.

They used to have a health care benefit where the employee would pay 20 percent, and if they worked hard they would save the company 80 percent and they would save themselves 20 percent. By talking about, in essence, a voucher of 100 percent, the employee feels a little more strongly about negotiating that price, since they don't pay anything if they are able to get it at that price.

The company then spends about a half an hour with the employee on a video talking about how you are supposed to discuss this with the doctor and the rest. It is basically using the company as an information base to empower the employee to get a good price.

Do you do anything working with the employee to empower them a little bit about information, beyond I guess what the normal employer would do in terms of informing employees; that would kind of give you an argument as to the fact that the company is assisting them in getting the best possible price with their medical savings account moneys?

Mr. ERHART. Well, certainly. I have conversations with employees on a formal and informal level on an ongoing basis, and really, that is what the MSA is all about, is educating people to know how to be wise and conscientious consumers; how to shop for the best medical care, both from a quality and cost standpoint. We see that as the concept becomes more widespread and well-known, that that education process is going to become even easier.

Chairman THOMAS. Obviously, you now have empowered every single employee to go out there and get the best deal possible. Some people will, frankly, do a better job than others. Do you have any kind of a clearinghouse for information, so that someone who is looking for a lead, or does not feel they have gotten a good price, and can get a feel for what others have gotten?

Do people tend to brag about the fact that they got a good price on something? Is there a way to disseminate that information among employees that would make all of them better shoppers?

Mr. ERHART. Well, people do brag about the fact that they have achieved a cost savings. There is no question about that.

As far as a clearinghouse, that is not something we have established at this point, but it is an excellent suggestion that I think would be very worthwhile.

Chairman THOMAS. I just think the key is sharing information. When someone has had a real world experience, that kind of information needs to get around.

Mr. Ferrara, in your testimony you talked about risk——

Mr. FERRARA. Yes, sir.

Chairman THOMAS [continuing]. Adjusting and MSA. There was some discussion there but I don't completely understand this. I have two people, two males, widowers, same age, next door to each other, both former steelworkers, one has a very serious health problem, the other one does not.

Now, we are going to give the one who has a serious health problem more money; is that how we are going to risk adjust on individuals?

Mr. FERRARA. Let me explain how that would work. It is not just the MSA that is risk adjusted, it is the whole private option. In other words, what we are proposing is people each get to take a share out of Medicare each year. They have the freedom to choose that and buy anything in the private sector they want: HMOs, MSAs or anything. That share they get to take is what is risk adjusted.

In other words, if you are younger and healthier, there is less you take to go and buy either an HMO, an insurance policy, or an MSA. If you are older and sicker, you get to take more because it will cost you more anyway to go out and buy and pay for that. Then this helps to avoid any adverse selection problem, because people are taking with them the money that reflects the risk that they are taking with them.

Chairman THOMAS. So, basically, it is going to be distributed to each according to their need?

Mr. FERRARA. According to their risk, is how I would put it. Distributing to each according to their risk.

Chairman THOMAS. But risk is, in essence, need; isn't it? The risk of what?

Mr. FERRARA. Of health expenses.

Chairman THOMAS. Of health expenses. Health expenses for two people if they are different, one needs more money than the other; that is why you are risk adjusting.

Mr. FERRARA. But risk may not be the same as need in all circumstances, and it really is risk that you are adjusting for here. The key thing is this avoids the adverse selection.

Chairman THOMAS. So, to each according to their risk?

Mr. FERRARA. Yes.

Chairman THOMAS. From each—it is a payroll tax, right? So, people who make more will pay more into it?

Mr. FERRARA. During their working years, yes. During their working years.

Chairman THOMAS. From each, according to their ability, in terms of making money. Then it will be distributed to each according to their risk, which is need.

Mr. FERRARA. That is what Medicare is doing today. This is Jane Orient's point.

Chairman THOMAS. I can think of all the people filing out there. Somebody probably recalls the phrase from each according to their ability, to each according to their need.

Mr. FERRARA. But that is what Medicare does today.

Chairman THOMAS. That is what you are proposing in your concept.

Mr. FERRARA. Well, no, that is what Medicare does today; it takes from each according to their tax payments and gives to each according to their need. It pays them for the health expenses that they need.

So, we are devising a program that is within the Medicare context. Of course, it addresses those issues, and that enables you to say to your elderly constituents, we are still fulfilling the function that you are looking to fulfill with Medicare.

Chairman THOMAS. I am just saying that I may lose the battle with my friend from Louisiana not on a socialist argument but on

a political argument about letting seniors spend their money, but I think you are going to have a very difficult time on a political argument telling two seniors that one is going to get a whole lot more money on a risk-related basis than someone else.

That may be the case today, but when you strip it from all of the various levels of discussion and you simply say *y* gets this and *x* gets this, plus a factor on the risk selection, once again it is relatively easy to conceptualize and create a structure which seems to be equitable, but to take that and attempt to put it into political reality is a much, much more difficult thing to do.

So, when you just sit there and say we are going to take the MSA and MSA is going to be risk adjusted——

Mr. FERRARA. Well, it is not the MSA that is risk adjusted. It is the voucher amount that you would draw from Medicare.

The reason why I think that this would not be a political problem is because the amount each is withdrawing is reflecting what they would have to pay to buy coverage in the private sector. A person who has a serious illness has to pay a lot more to buy this coverage than a person who does not have an illness. So, that is why I think that this would be seen as equitable and that they would not create——

Chairman THOMAS. Would the illness be treated differently and in a different expense in a different health care structure?

Mr. FERRARA. Would it be treated differently? I don't think so. The point is, if you are dealing with one person who does not have the illness and one person who does, the person who does not have the illness can buy insurance a lot more economically than the person who does have the illness. So, what I was suggesting——

Chairman THOMAS. But if the person who has the illness, and it is going to cost more for in a fee-for-service program than it would, for example, in an HMO program, shouldn't we have the right to say you should go to where it is the cheapest to get the service?

Mr. FERRARA. He can go to an HMO under my proposal, if that is what he wants. He can go to anything he wants. He can take the risk-adjusted voucher out of Medicare; he can go to a current employer plan, a former——

Chairman THOMAS. Is the risk adjusted to the lowest possible health plan cost out there?

Mr. FERRARA. No, no, no, it reflects the costs that are going to be incurred by the plan that takes him. So, that it is an actuarial estimate based on his expected health costs, and you look at factors like——

Chairman THOMAS. So, one plan will take him for $3,000 and another plan will take him for $4,000. Which is the amount that should be paid?

Mr. FERRARA. You don't pick the amount based on what the plan charges. You pick the amount that he takes in his vouchers based on his expected health costs. He then takes the voucher amount and sees what can I buy on the market. An HMO will come along and say, we can take that and give you better benefits. The MSA says, we can take that and give you an MSA and you can withdraw the money at the end of the year. A former employer may say, we have another bargain.

He goes out and looks to see what he can get for that, whatever it is, $5,000, $6,000 or $7,000 he has taken out of Medicare and he looks to see what is the best deal he can get from all of those alternatives.

Chairman THOMAS. I have to walk through a couple of models as we move forward on this.

Dr. Orient, on your first page, I am trying to remember the exact language, I will paraphrase it, but you are not a fan of HMOs.

Dr. ORIENT. No, sir.

Chairman THOMAS. In fact, they are undermining, I think was the word. If we are urging, especially with MSAs, if we are urging a free market of choice in this structure, should we, based upon your belief in terms of HMOs, allow those as a choice for people to select? Should they continue to exist?

Dr. ORIENT. I have no objection to them being a choice, but I think that any of the advantages that were given to them, such as subsidies on startup or requirements that employers must offer an HMO if they offer any other kind of insurance, that those should be eliminated and we should truly have a level playingfield.

Chairman THOMAS. Good, that helps in terms of the direction you are going on the HMO. I have no problem with eliminating subsidies that create advantages for one particular model over another, including examining current antitrust laws which were built for the 19th century production of things and not necessarily the delivery of services, where perhaps communication would produce a better product rather than lack of communication among professionals.

So, I am interested in a broad-based removal of subsidies to any kind of a structure. I am sure I will run into my political realities in pursuing that one as well.

I want to thank the panel very much. Obviously, some folks have thought very much about integrating this kind of a concept into our health care system, including the seniors, which, on first blush, frankly, a lot of people are taken aback when you talk about a medical savings account for seniors, given the profile the gentleman from Louisiana discussed, which might be slightly higher for seniors, that you are arguing is not necessarily so.

Mr. Erhart, I want to thank you for giving us an example of a real world opportunity. I noticed in your testimony a number of other companies are inquiring about your structure. Do you have an organization or an association of companies that are sharing information about medical savings accounts or is this so new you are just finding each other now?

Mr. ERHART. It has been very informal up to this point.

Chairman THOMAS. My assumption is, since there is an association for every possible existing relationship, that by next year we will have a medical savings account employers association.

I am looking forward to the experiences, especially on a geographic basis, on a regional basis, since we have found a lot of differences in terms of health care practices across the country. It will be interesting to see how this integrates either in terms of a preferred provider structure or other operations in other parts of the country.

It is an idea I think that is exciting. It is something new. It does do what I think most of us believe is the real answer, and that is get the consumer directly involved in the decisionmaking process in health care. They are ultimately the solution.

I want to thank you folks for your presentation today.

Any questions from the other members on the panel? Thank you very much and the Subcommittee stands adjourned.

[Whereupon, at 1 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Potential Role for Employers, Associations,
and Medical Savings Accounts in the Medicare Program Hearing

Written Testimony for the Record
Submitted by the
American Academy of Actuaries'
Medicare Work Group

June 8, 1995

The American Academy of Actuaries provides technical actuarial expertise to public policy makers and maintains the actuarial profession's standards of qualification, practice, and conduct. Academy members include actuaries from all practice specialties: health, life, pensions, and property/casualty.

Academy committees and work groups offer expert testimony, provide technical information, comment on proposed legislation, and work closely with federal and state officials on insurance-related issues. The Academy's Department of Public Policy coordinates the work of committees and work groups with the needs of public policy makers.

This testimony is intended to be an objective analysis of issues surrounding Medicare and medical savings accounts. It is not intended to favor one position over another.

GROWTH IN MEDICARE HEALTH CARE COSTS

The financial problems of the Medicare program are, at this point, so large that there will have to be substantial changes made in the program in order to preserve Medicare for future generations of beneficiaries. According to the *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, to place income and expenditures in balance even over the next 25 years will require either an immediate 30 percent reduction in expenditures, an immediate 44 percent increase in the Hospital Insurance (HI) tax rate, or some combination of both.

To achieve such reductions in Medicare costs in the least detrimental way, innovative ways to reduce program costs will need to be put into place. These innovations will need to deal with the two factors which, in combination, are driving up health care costs in the Medicare

program as well as in the private sector: fee-for-service medicine and third-party payments. Increasing Medicare coinsurance and deductibles is an attempt to deal with the third-party payment factor. Introducing capitated services, such as those called for in the Medicare Risk Program, is one method of dealing with the fee-for-service medicine factor. To date, the federal government has done very little to deal with the factor of third-party payments to control health care costs. Its efforts at producing savings through capitated managed care have not been fully successful.

High deductible plans represent a way to deal with the issue of third-party payments. Direct payments by patients for a portion of the cost of their health care services are a proven method of creating behavioral changes among both providers and patients, resulting in substantial reductions in health care costs.

When patients and providers perceive that they are spending other people's money, they do not concern themselves with either the price or the quantity of services provided. Even the relatively modest cost-sharing provisions of the Medicare program have a substantial impact on the utilization of health care services by Medicare beneficiaries. Research conducted by the Health Care Financing Administration's Office of the Actuary on the Medicare Current Beneficiary Survey found that, even when controlled for self-reported health status, Medicare beneficiaries who did not have Medigap plans, and who were thus fully subject to Medicare's cost sharing provisions, have significantly lower overall health expenditures.[1]

Table 1 indicates the differences in health care spending between Medicare beneficiaries without Medigap plans and those with employer-sponsored Medigap plans. Individuals who are fully subject to Medicare cost sharing (i.e., they are not covered by an employer-sponsored Medigap plan) cost the Medicare program substantially less than individuals who are not fully subject to Medicare cost sharing.

Table 1

Medicare Spending Per Beneficiary for Aged 65 and Older Population, based on Self-Reported Health Status and Coverage by an Employer-Sponsored Medigap Plan

Health Status	Medicare Only	Employer-Sponsored Medigap Plan	Ratio
Excellent	$705	$1,217	172.6%
Very Good	$905	$1,490	164.6%
Good	$1,713	$2,347	137.0%
Fair	$2,462	$3,236	131.4%
Poor	$4,684	$6,477	138.3%

Source: Health Care Financing Review.

[1]Approximately 80 percent of Medicare beneficiaries have either Medigap plans or Medicaid to cover Medicare coinsurance and deductibles.

Additionally, research shows that not only are health care costs higher because of third-party payments, but health care costs increase faster because of third-party payments. A forthcoming *Health Affairs* article, co-authored by Mark Freeland, Ph.D. and Al Pedron, Ph.D., shows that the acceleration in the rate of growth in health care expenditures in the United States has been highly correlated with the shift toward third-party payments. This research shows roughly that every ten percentage point shift from out-of-pocket payments to third-party payments results in an increase in the annual rate of growth in health care costs of about 2 percentage points, and this accelerated rate of growth persists for about ten years. This is an important finding because it provides the potential key to reducing the rapid growth of health care costs in the United States.

POTENTIAL ROLE FOR MEDICAL SAVINGS ACCOUNTS

Medical savings accounts (MSAs) could play an important role in facilitating the introduction of high-deductible plans into the Medicare program and reducing Medicare outlays substantially.

Illustrative Example

A plan could be developed that would require Supplementary Medical Insurance (SMI) enrollees who volunteered to switch to a high-deductible plan (with a $1,200 deductible) and who volunteered to forego the purchase of Medigap policies, to pay a $4.00 monthly SMI premium, compared with the current monthly payment of $46.10. They would be allowed to deposit their $505.20 annual premium savings in an MSA tax free. Money withdrawn from the MSA for expenditures other than health expenditures would be taxed as Social Security income. If all SMI enrollees joined this plan, ensuring no favorable selection, the savings to the government in the SMI program could be $5 billion in the first year alone, according to estimates by HCFA's Office of the Actuary. All of these savings would arise from behavioral changes alone, rather than merely shifting costs to beneficiaries or reducing payments to providers.

Potential Impact of Risk Segmentation

Risk segmentation is an important factor that would need to be considered if an MSA with a high-deductible "true" catastrophic plan (including Medicare HI benefits) were offered as an optional Medicare benefit plan. Risk segmentation can be generally defined as a situation where beneficiaries of differing health status systematically choose to enroll in different plan options. It is very important to give careful actuarial attention to plan design and to the administration of enrollment and disenrollment in the options in order to

minimize the impact of risk segmentation. Ignoring risk segmentation could lead to higher overall federal government costs—not substantial cost savings.

Individuals' Ability to Meet High-Deductible Requirements

In deciding whether to introduce high-deductible plans for Medicare beneficiaries, an important policy consideration is whether beneficiaries choosing the high-deductible plan would make provisions to ensure that they have adequate financial resources to meet the deductible requirement. Some policy makers might want to require beneficiaries wanting to enroll in the high-deductible plan to prove that they have adequate financial resources to meet the deductible. Other policy makers might feel that this would be unwarranted interference with beneficiaries' freedom of choice.

CONCLUSION

If the above factors are thoughtfully considered, and MSAs are carefully implemented, they may provide powerful incentives for potentially containing costs in the Medicare program. Members of the Academy's Medicare Work Group are available to discuss these and related issues.

WRITTEN STATEMENT OF
AMERICAN SOCIETY OF ASSOCIATION EXECUTIVES
1575 Eye Street, N.W., Washington, D.C. 20005
Telephone: (202) 626-2703

ASAE is pleased to have this opportunity to present testimony before the Subcommittee on Health of the House Ways and Means Committee regarding the importance of association plans in health care reform.

ASAE is a professional society of over 22,000 association executives representing more than 10,700 national, state, and local associations. Most of our members work for associations with less than 10 employees. ASAE's members represent tax exempt organizations, mostly under Internal Revenue Code Sections 501(c)(6) and 501(c)(3).

I. INTRODUCTION

The future of association sponsored health plans is in serious doubt, as our nation debates health care reform. Many proposals for a single payor system, or a managed care system with exclusive health purchasing alliances or cooperatives may deny a role for plans which associations now offer or operate for their members.

Associations have for many years sponsored employer group health plans as viable mechanisms for pooling risks along functional and industry lines. Associations have also increased the market leverage and buying power of small employers as consumers of health care services.

The association plans were generated by, and composed of, employers which participate directly in the decision-making process and management of their association health plans.

For more than fifty-five years, association-sponsored health plans have been providing millions of people with an effective way to protect themselves and their families against financial catastrophe. Association plans have enabled these millions of citizens to have access to quality, affordable health care, which was often denied to them through the available market. Today, thousands of U.S. trade and professional employer associations provide health coverage benefit programs to industry groups representing millions of employees and their dependents.

In an October 1992 survey of *Nation's Business* readers, 13% of the respondents polled reported they purchase their health plans through industry associations (90% of the respondents were employers with less than 100 employees).

According to a national survey of trade and professional associations conducted by ASAE and William F. Morneau & Associates, 779 of 6,300 associations reported health premiums paid in 1991 of $6.2 billion. This amount is larger than the total annual health care premium income

reported by Prudential, the largest health insurance carrier in the U.S. In addition, of the 779 associations surveyed, more than 1.9 million lives were covered.

Extrapolated against all associations in ASAE, this data suggests that ASAE member associations may be directly involved in the collection of approximately $21 billion in annual health care premiums – more than the ten largest insurance companies collectively generate in premiums. When examining lives covered, the extrapolation would mean that at least 10 million lives are covered by association plans.

Under the current U.S. health care system, association plans provide significant health care coverage to a substantial number of small employers throughout the nation and in a large cross-section of U.S. industries. Many of these small employers are located in rural areas which are underserved by managed care providers. These employers have sought and received the buying power and protection of qualified association plans which provide access to quality, affordable health care. The ASAE survey uncovered three significant facets of association-sponsored plans:

- Of those associations offering plans, the average penetration of membership (percentage of members participating in the association health plan) is a significant 27%. This is a clearly important member service at these associations.

- 49% of associations with plans have a trust agreement in place. This is a strong indication of the sophistication level of such plans and the degree of effort that is being made to closely manage the programs.

- The vast majority of plans (86%) are funded on a fully-insured basis. This runs counter to the common stereotype of the underfunded MEWA about to go bankrupt and leave thousands of policyholders with unpaid claims.

The importance of the widespread geographic coverage of association health plans can be seen from a study supported by a grant from the Federal Agency for Health Care Policy and Research, which concluded that "reform of the U.S. health care system through expansion of governmental managed competition is feasible in large metropolitan areas. But, smaller metropolitan areas and rural areas would require alternative forms of organization and regulations..." "A substantial number of people live in areas that fall outside" the realm of managed competition, said Richard Krfonic, an assistant professor of Community and Family Medicine at the University of California at San Diego.

In 19 states, the majority of the population lives in areas of less than 180,000 persons, where hospital services must be extensively shared. In 42 states, 20% or more of the population lives in such areas. And, while 23 states and the District of Columbia have at least one metropolitan area large enough to support three HMOs, the study found, in only 10 states do the majority of people live in such areas. Association plans are active in all of these areas currently, which demonstrates their viability and market orientation.

Association plans also have extensive experience in:

- designing special plans to meet the financial needs of their members.
- pooling health risks within organized industry groups.
- gathering employee data.
- collecting and disseminating information on health care quality, cost and resource allocation.
- communicating with members and employees.
- administering of benefit programs.

All Americans should have equal access to high quality, cost-effective health care through health plans offered under a competitive market system. Employers within the U.S. employment-based system should have the flexibility and freedom to select the most effective organizational mechanisms available for delivering health services. Association plans have proven for years to be such a vehicle.

Let's consider association plans in light of the various "reform" proposals. Associations are uniquely structured to be a part of a new or revised health care delivery system. That is because they are already structured to represent their members in other areas. They possess the infrastructure, administrative mechanisms and experience to unify employers and employees into effective consumers of health services.

Employers who join purchasing groups or cooperatives organized by associations can offer employees access to high quality private health coverage at lower costs, and with an expanded number of options.

Associations already offer a wide variety of approved health plans and managed care arrangements (insured arrangements, Blue Cross/Blue Shields, HMOs, self-insured) to employers and employees. Associations can also distribute information, provide price data, and offer qualitative comparisons between health plans.

Associations also develop common statistical databases by major industry and professional groupings. This assists such plans in administering for claims, premium contributions and utilization of health care services.

In summary, qualified and functioning industry-based associations have been successfully providing comprehensive health benefit programs, as well as many other services, to their members for more than fifty years. The administrative systems, expertise in negotiation, data collection and communication are all in place and operational today, not in some theoretical planning scenario.

II. CONSUMER ACCOUNTABILITY & ASSOCIATION HEALTH PLANS

A primary reason why health care spending is out of control is that most of the time, when we enter the medical marketplace as patients, we are spending someone else's money. Economic studies – and common sense – confirm that we are less likely to be prudent, careful shoppers if someone else is paying the bill. Association plans have been dealing with these concerns since health care costs started spiraling in the 1970's. Plan design, member education and provider

involvement have been put to work to hold down health care costs. Most importantly, both employers and their employees have been able to choose between different options.

Member identity with their association, and member control of programs help educate the participants as to the costs and choices in health care, much more so than in traditional insurance coverages.

Association plans are not a "third-party" phenomenon. Members realize that association plans are, in reality, their own money and that "wellness" activities, as well as careful health care purchasing save them money directly.

III. STUDY TRACES HISTORY AND EXTENT OF ASSOCIATION INSURANCE PLANS

Some association executives mistakenly believe that association sponsorship of insurance programs is a new phenomenon. In actuality, many such programs have been in existence for over 55 years. The most successful association-sponsored programs are those that have continually undergone change to adapt to evolving insurance and association management trends.

The health insurance industry has been in a "hard" market for many years. Member difficulty in obtaining appropriate health insurance coverages has led many associations to adopt sponsored health insurance programs.

More than 90% of the respondents indicated "member service" as the primary reason they initiated programs.

Life and health programs appear to be generally attractive to associations with large individual memberships and/or memberships comprising a large number of companies or firms, each of which has only a few employees. The increasingly difficult health insurance marketplace has made the sponsorship of health insurance coverages particularly attractive in recent years.

Those associations reporting life or health programs offered the following coverages:

•medical insurance,	81.7%
•vision care,	8.0%
•prescription plans,	8.6%
•dental care,	30.8%
•accidental death/disab.	25.7%
•basic life,	61.7%
•short-term disability,	29.7%
•long-term disability,	32.1%
•supplemental life,	8.0%
•supplemental AD&D,	7.4%

In looking at the variety of benefit plans associations offer, it is apparent that, if empowered and encouraged by federal legislation, even more expanded programs could be offered.

Approximately 85% of those associations sponsoring insurance programs for their memberships have formal, written agreements with insurance carriers, agents, or brokers.

These agreements can guarantee the association's right to continuing and complete information on the program, including loss statistics, premium income, insurer profit and expenses, and member participation, from participating insurers.

Much of this specific information, needed to design benefit plans and respond to members' needs, would not be available to employers from a governmentally operated health purchasing alliance or cooperative. Currently, association plans use this information to assist their members.

ASAE and the Aon Specialty Group's Risk Management Services consulting unit, Washington D.C. are producing the ***1993 Association Insurance Program Guide and Survey Report.*** This publication contains how-to instructions for implementing and managing a successful program, as well as statistics from our broad survey (conducted in fall 1992) of ASAE members.

IV. EXAMPLES OF ASSOCIATION SPONSORED PLANS, AND HOW THEY BENEFIT EMPLOYEES.

A. Taft-Hartley and Multi-Employer Plans.

There are thousands of Taft-Hartley multi-employer health plans covering more than eight million workers and dependents in industries as diverse as building and construction, clothing, textiles, transportation, services, retail, maritime, food, hotel and restaurant, mining, entertainment, and light manufacturing. Anywhere from two to 2,000 or more separate employers may contribute to a single plan.

These plans provide continuous health benefits coverage to workers as they change employment from one contributing employer to another. This portability or "seamless" coverage is essential for workers in mobile, seasonal industries like building and construction, entertainment, longshoremen and agriculture. Without a central plan covering all of his or her work for multiple employers, such a worker would not have health benefits coverage.

These multi-employer plans enjoy economies of scale in administration, and combined purchasing power, not available to individual or small employers. Participating employers are required to do little other than submit their periodic contributions to the plan with verifying information. All of the plan design and administrative functions are generally performed by the plan trustees with professional assistance. This eliminates any need for a participating employer to maintain its own plan administration work force.

Over the decades of their existence, these multiple employer plans have developed eligibility rules, benefit packages, and financing and collection methods tailored to meet the employment patterns, needs and practices of their particular industries.

These plans have developed industry-specific systems for maximizing coverage, given the employment patterns of the industry and the financing needs of the plan.

Many of these plans cover employers in different states. State-by-state regulation, with its threat of multiple, inconsistent rules, would adversely affect their efficient and economical operation. ERISA's preemption provisions are intended to protect these plans from such conflicting requirements.

These plans, operated by elected officers from industries and unions, are politically and directly accountable for how the plan is operating and how much it costs.

For the associations and unions which sponsor these multiple employer health and welfare plans, these plans are a proud achievement which provide health and income security benefits that would otherwise be unavailable to their members. The contributing employers function as a single employer through these plans for purposes of furnishing benefits and negotiating with health care providers. They are as concerned about the covered workers and as innovative as any single employer, if not more so, since there is more worker involvement in the design, operation and financing of these plans than in any single employer plan.

If any of the health care reform proposals finally adopted allow large employers to opt out of the purchasing system, these plans should be given the same opportunity under the same conditions.

B. Coca-Cola Bottlers' Association

Founded in 1914, the Coca-Cola Bottlers' Association has operated a voluntary group health insurance program since 1937. Smaller bottlers are pooled in a group, and larger participating employers are experience rated and participate in some of the risk of medical claims.

The program now covers approximately 13,000 employees and 26,000 dependents. Approximately 93 cents of every premium dollar goes to the payment of claims. This efficiency is well above that of most insurance company or health maintenance organization plans. The association's plan includes life insurance benefits which help keep costs of medical coverage down.

The average cost per employee for the benefit plans is $2,600, well below the national average of almost $4,000 per employee per year for conventionally insured plans, or even most self-funded plans.

The association also offers an Ergonomics Program which allows employees to be assessed for their physical ability to perform necessary work-related physical tasks, and helping to avoid on-the-job injuries.

The association also provides access to HMO's, PPO's, utilization review, pharmaceutical review, individual care management, and a wellness program to improve health of their members' employees. Additionally, the association is able to negotiate performance guarantees in areas such as claims turn around time, accuracy of claims payments, and customer service.

C. Eastern Material Dealers Association

From its humble beginnings in 1949, the Eastern Group Trust has developed the reputation for consistently good service, fair dealing, and funding stability within the scope of medical care plans.

Primarily organized to respond to the short-term disability income responsibilities under New Jersey statutes, the Group Insurance Trust has expanded its variety of coverages to include group term life, accidental death and dismemberment, weekly disability income, long-term disability income, six medical plans and a dental plan.

The major objectives of the Group Insurance Trust have been to use plan designs that are easily understood by participating employees and to provide as much stability in funding as can be obtained in a rapidly inflating market place of medical care. The program is run as an "experience rated contract" with State Mutual, with surplus funding available for reallocation to reduce future premiums paid by employers and employees.

Directed by a seven-member Board of Trustees, elected by plan participants pursuant to the requirements of Section 501(c)(9) of the Internal Revenue Code, the Group Insurance Trust is managed by staff employees. This staff is responsible for sales, installation, certificate and identification card issuance, billing and collection of premiums, payment of claims and providing Trustee and insurance carrier reports.

Approximately 230 employers participate in providing innovative plans which provide $11 million per year in benefits to the industry's employees.

D. Western Agriculture

Agriculture in the Western U.S., particularly California and Arizona, is highly seasonal, with fruit, grape and vegetable production supplying over half of the entire U.S. consumers' needs, as well as providing major exports which assist the nation's international balance of trade.

Traditional insurance carriers, and all current HMO organizations, declined in the past to provide medical coverage for the 350,000 employees of this vital industry, due to their seasonal employment, wage levels, and predominantly Spanish-speaking language needs.

Four major farm organizations provide virtually all of the health benefits for these seasonal employees, using association designed and operated programs. Self funding is a critical component of these benefit plans, due to the reluctance of the usual insurance market to offer coverages.

The largest of these programs, Western Growers Association, provides benefits to 18,000 employees, offering free choice of medical provider as well as managed care plans.

Grouping the buying power of its 2,000 participating members, Western Growers has been able to negotiate discounts from hospitals which saved 46% on billed charges on 1992, and saving over $4 million dollars for farm employers and their employees. The association's plans average 20% discounts in contracting doctor's fees and elimination of "usual and customary" problems

for patients using contracting physicians. WGA has contracted for 9% below-wholesale drug costs for its medical plans.

The association also operates a licensed and admitted workers' compensation company in Arizona and California, and has integrated on-the-job and off-the-job medical benefits for over 10 years, preventing "double-dipping" and making the coordination of benefits easy.

The association offers flexible benefit plans, which have been very well received by seasonal farm workers. It also offers services by medical providers in Mexico for those workers near the U.S. border, and for those workers with families in Mexico.

These are but a few examples of the thousands of association-sponsored medical plans offered by nonprofit member associations of ASAE.

V. ASAE POSITION

Congress and the Administration has recognized the need for employers and individuals to join together in pooling their buying power. Association plans have been doing just that for over 55 years, and can provide a major service to our nation by being allowed to continue.

Association health plans would welcome many of the insurance reforms currently proposed such as portability, open enrollments, and limitations on preexisting conditions.

ASAE supports the basic goals of health care reform, which would provide quality, affordable, accessible health care for all Americans. ASAE further believes that association health care plans possess many years of proven experience in the delivery of benefits through purchasing coalitions. As such, association health care plans can lead the way to the reform goals of providing the efficient delivery of quality health care to more citizens.

May 23, 1995

Sir:

It has come to my attention that Congress will be debating the issue of medical savings accounts. I'm writing to make known my belief in and support of medical savings accounts -- provided that they are voluntary and tax-free.

I believe such accounts would be a step towards restoring a free market in health care. As with all other commodities the free market works to bring prices down while at the same time improving the overall quality of products and services. This is what the American people need.

Sincerely,

Craig K. Barber
321 Gonzalez Dr.
San Francisco, CA 94132
(415) 587-9083

MICHAEL J. BLAIR

22216 Victory Boulevard #C-303 Woodland Hills, CA 91367-1807

VIA FEDERAL EXPRESS

Wednesday, May 24, 1995

Philip Moseley
Majority Chief of Staff
House Committee on Ways and Means
1102 Longworth Office Building
Independence and New Jersey Avenues SE
Washington, DC 20515

Dear Mr. Moseley:

I wish to enter a written statement into the printed record of the upcoming hearings on Medical Savings Accounts. My statement takes the form of this letter and the pamphlet *Health Care is Not a Right.* Six copies of each are enclosed. Please acknowledge in writing.

Your committee's hearings will no doubt deal with the practical and legal aspects of Medical Savings Accounts. My plea is that you openly discuss the moral aspects, too. Where does morality fit in? The pamphlet will explain.

In brief, when proponents speak of the "right" to health care, there is no escaping the conclusion that some citizens must therefore provide that health care to others. For when someone has a right to a service, someone else must provide it, correct? Otherwise, the "right" is being violated. "Must" in this context means "without choice." Thus, the claimant controls the services of the provider because the provider must give those services on demand.

There is even an American precedent for such a relationship. At one time, a person (A) was entitled to any and all services provided by another person (B). The law was so specific that in fact, A owned B. The institution was slavery. Shakespeare wrote, "A rose by any other name, would smell as sweet." Similarly, slavery by any other name, would be as wrong.

My guiding principle is that **there is no dichotomy between the moral and the practical.** Giving citizens personal control of their own health care spending—and giving doctors personal control of their own lives—is not only what is more efficient; it is also what is right.

Very truly yours,

Michael J. Blair

/mjb
Enclosures

HEALTH CARE IS NOT A RIGHT

by

LEONARD PEIKOFF

This talk was delivered under the auspices of
Americans for Free Choice in Medicine
at a Town Hall Meeting on Health Care
Red Lion Hotel, Costa Mesa, California
December 11, 1993

LEONARD PEIKOFF is a philosopher and the foremost interpreter of the philosophy of Ayn Rand. He has taught philosophy at Hunter College, Long Island University, and New York University. He is the author of *Objectivism: The Philosophy of Ayn Rand,* the definitive statement of Ayn Rand's philosophic system. Dr. Peikoff's speech, "The Forgotten Man of Socialized Medicine: The Doctor," was presented to the Congress of Neurological Surgeons in 1988 and to other physicians' groups throughout the United States and Canada. A transcript of the talk was published in *Clinical Neurosurgery,* Vol. 36.

Good morning, ladies and gentlemen:

Most people who oppose socialized medicine do so on the grounds that it is moral and well-intentioned, but impractical; i.e., it is a noble idea—which just somehow does not work. I do not agree that socialized medicine is moral and well-intentioned, but impractical. Of course, it *is* impractical—it does *not* work—but I hold that it is impractical *because* it is immoral. This is not a case of noble in theory but a failure in practice; it is a case of vicious in theory and *therefore* a disaster in practice. So I'm going to leave it to other speakers to concentrate on the practical flaws in the Clinton health plan. I want to focus on the moral issue at stake. So long as people believe that socialized medicine is a noble plan, there is no way to fight it. You cannot stop a noble plan—not if it really is noble. The only way you can defeat it is to unmask it—to show that it is the very opposite of noble. Then, at least, you have a fighting chance.

What is morality in this context? The American concept of it is officially stated in the Declaration of Independence. It upholds man's unalienable, individual *rights*. The term "rights," note, is a moral (not just a political) term; it tells us that a certain course of behavior is right, sanctioned, proper, a prerogative to be respected by others, not interfered with—and that anyone who violates a man's rights is: wrong, morally wrong, unsanctioned, evil.

Now, our only rights, the American viewpoint continues, are the rights to life, liberty, property, and the pursuit of happiness. That's all. According to the Founding Fathers, we are not born with the right to a trip to Disneyland, or a meal at McDonald's, or a kidney dialysis (nor with the 18th-century equivalent of these things). We have certain specific rights—and only these.

Why *only* these? Observe that all legitimate rights have one thing in common: they are rights to action, not to rewards from other people. The American rights impose no obligations on other people, merely the negative obligation to leave you alone. The system guarantees you the chance to work for what you want—not to be given it without effort by somebody else.

The right to life, e.g., does not mean that your neighbors have to feed and clothe you; it means you have the right to earn your food and clothes yourself, if necessary by a hard struggle, and that no one can forcibly stop your struggle for these things or steal them from you if and when you have achieved them. In other words: you have the right to act, and to keep the results of your actions, the products you make, to keep them or trade them with others, if you wish. But you have no right to the actions or products of others, except on terms to which they voluntarily agree.

To take one more example: the right to the pursuit of happiness is precisely that: the right to the *pursuit*—to a certain type of action on your part and its result—not to any guarantee that other people will make you happy—or even try to do so. Otherwise, there would be no liberty in the country: if your mere desire for something, anything, imposes a duty on other people to satisfy you, then they have no choice in their lives, no say in what they do, they have no liberty, they cannot pursue *their* happiness. Your "right" to happiness at their expense means that they become rightless serfs, i.e., your slaves. Your right to *anything* at others' expense means that they become rightless.

That is why the U.S. system defines rights as it does, strictly as the rights to action. This was the approach that made the U.S. the first truly free country in all world history—and, soon afterwards, as a result, the greatest country in history, the richest and the most powerful. It became the most powerful because its view of rights made it the most moral. It was the country of individualism and personal independence.

Today, however, we are seeing the rise of principled *immorality* in this country. We are seeing a total abandonment by the intellectuals and the politicians of the moral principles on which the U.S. was founded. We are seeing the complete destruction of the concept of rights. The original American idea has been virtually wiped out, ignored as if it had never existed. The rule now is for politicians to ignore and violate men's actual rights, while arguing about a whole list of rights never dreamed of in this country's founding documents—rights which require no earning, no effort, no action at all on the part of the recipient.

You are entitled to something, the politicians say, simply because it exists and you want or need it—period. You are entitled to be given it by the government. Where does the government get it from? What does the government have to do to private citizens—to their individual rights—to their *real* rights—in order to carry out the promise of showering free services on the people?

The answers are obvious. The newfangled rights wipe out real rights—and turn the people who actually create the goods and services involved into servants of the state. The Russians tried this exact system for many decades. Unfortunately, we have not learned from their experience. Yet the meaning of socialism (this is the right name for Clinton's medical plan) is clearly evident in any field at all—you don't need to think of health care as a special case; it is just as apparent if the government were to proclaim a universal right to food, or to a vacation, or to a haircut. I mean: a right in the new sense: not that you are free to earn these things by your own effort and trade, but that you have a moral claim to be given these things free of charge, with no action on your part, simply as handouts from a benevolent government.

How would these alleged new rights be fulfilled? Take the simplest case: you are born with a moral right to hair care, let us say, provided by a loving government free of charge to all who want or need it. What would happen under such a moral theory?

Haircuts are free, like the air we breathe, so some people show up every day for an expensive new styling, the government pays out more and more, barbers revel in their huge new incomes, and the profession starts to grow ravenously, bald men start to come in droves for free hair implantations, a school of fancy, specialized eyebrow pluckers develops—it's all free, the government pays. The dishonest barbers are having a field day, of course—but so are the honest ones; they are working and spending like mad, trying to give every customer his heart's desire, which is a millionaire's worth of special hair care and services—the government starts to scream, the budget is out of control. Suddenly directives erupt: we must limit the number of barbers, we must limit the time spent

on haircuts, we must limit the permissible type of hair styles; bureaucrats begin to split hairs about how many hairs a barber should be allowed to split. A new computerized office of records filled with inspectors and red tape shoots up; some barbers, it seems, are still getting too rich, they must be getting more than their fair share of the national hair, so barbers have to start applying for Certificates of Need in order to buy razors, while peer review boards are established to assess every stylist's work, both the dishonest and the overly honest alike, to make sure no one is too bad or too good or too busy or too unbusy. Etc. In the end, there are lines of wretched customers waiting for their chance to be routinely scalped by bored, hogtied haircutters some of whom remember dreamily the old days when somehow everything was so much better.

Do you think the situation would be improved by having haircare cooperatives organized by the government?—having them engage in managed competition, managed by the government, in order to buy haircut insurance from companies controlled by the government?

If this is what would happen under government-managed hair care, what else can possibly happen—it is already starting to happen—under the idea of *health* care as a right? Health care in the modern world is a complex, scientific, technological service. How can anybody be born with a right to such a thing?

Under the American system you have a right to health care if you can pay for it, i.e., if you can earn it by your own action and effort. But nobody has the right to the services of any professional individual or group simply because he wants them and desperately needs them. The very fact that he needs these services so desperately is the proof that he had better respect the freedom, the integrity, and the rights of the people who provide them.

You have a right to work, not to rob others of the fruits of their work, not to turn others into sacrificial, rightless animals laboring to fulfill your needs.

Some of you may ask here: But can people afford health care on their own? Even leaving aside the present government-inflated medical prices,

the answer is: Certainly people can afford it. Where do you think the money is coming from *right now* to pay for it all—where does the government gets its fabled unlimited money? Government is not a productive organization; it has no source of wealth other than confiscation of the citizens' wealth, through taxation, deficit financing or the like.

But, you may say, isn't it the "rich" who are really paying the costs of medical care now—the rich, not the broad bulk of the people? As has been proved time and again, there are not enough rich anywhere to make a dent in the government's costs; it is the vast middle class in the U.S. that is the only source of the kind of money that national programs like government health care require. A simple example of this is the fact that the Clinton Administration's new program rests squarely on the backs not of Big Business, but of small businessmen who are struggling in today's economy merely to stay alive and in existence. Under any socialized program, it is the "little people" who do most of the paying for it—under the senseless pretext that "the people" can't afford such and such, so the government must take over. If the people of a country *truly* couldn't afford a certain service—as e.g., in Somalia—neither, for that very reason, could any government in that country afford it, either.

Some people can't afford medical care in the U. S. But they are necessarily a small minority in a free or even semi-free country. If they were the majority, the country would be an utter bankrupt and could not even think of a national medical program. As to this small minority, in a free country they have to rely solely on private, voluntary charity. Yes, charity, the kindness of the doctors or of the better off—charity, not right, i.e., not their right to the lives or work of others. And such charity, I may say, was always forthcoming in the past in America. The advocates of Medicaid and Medicare under LBJ did not claim that the poor or the old in the '60's got bad care; they claimed that it was an affront for anyone to have to depend on charity.

But the fact is: You don't abolish charity by calling it something else. If a person is getting health care *for nothing*, simply because he is breathing, he is still getting charity, whether or not President Clinton calls it a

"right." To call it a right when the recipient did not earn it is merely to compound the evil. It is charity still—though now extorted by criminal tactics of force, while hiding under a dishonest name.

As with any good or service that is provided by some specific group of men, if you try to make its possession by all a right, you thereby enslave the providers of the service, wreck the service, and end up depriving the very consumers you are supposed to be helping. To call "medical care" a right will merely enslave the doctors and thus destroy the quality of medical care in this country, as socialized medicine has done around the world, wherever it has been tried, including Canada (I was born in Canada and I know a bit about that system first hand).

I would like to clarify the point about socialized medicine enslaving the doctors. Let me quote here from an article I wrote a few years ago: "Medicine: The Death of a Profession." [*The Voice of Reason: Essays in Objectivist Thought*, NAL Books, © 1988 by the Estate of Ayn Rand and Leonard Peikoff.]

"In medicine, above all, the mind must be left free. Medical treatment involves countless variables and options that must be taken into account, weighed, and summed up by the doctor's mind and subconscious. Your life depends on the private, inner essence of the doctor's function: it depends on the input that enters his brain, and on the processing such input receives from him. What is being thrust now into the equation? It is not only objective medical facts any longer. Today, in one form or another, the following also has to enter that brain: 'The DRG administrator [in effect, the hospital or HMO man trying to control costs] will raise hell if I operate, but the malpractice attorney will have a field day if I don't—and my rival down the street, who heads the local PRO [Peer Review Organization], favors a CAT scan in these cases, I can't afford to antagonize him, but the CON boys disagree and they won't authorize a CAT scanner for our hospital—and besides the FDA prohibits the drug I should be prescribing, even though it is widely used in Europe, and the IRS might not allow the patient a tax deduction for it, anyhow, and I can't get a specialist's advice because the latest Medicare rules

prohibit a consultation with this diagnosis, and maybe I shouldn't even take this patient, he's so sick—after all, some doctors are manipulating their slate of patients, they accept only the healthiest ones, so their average costs are coming in lower than mine, and it looks bad for my staff privileges.' Would you like your case to be treated this way—by a doctor who takes into account your objective medical needs *and* the contradictory, unintelligible demands of some ninety different state and Federal government agencies? If you were a doctor could you comply with all of it? Could you plan or work around or deal with the unknowable? But how could you not? Those agencies are real and they are rapidly gaining total power over you and your mind and your patients. In this kind of nightmare world, if and when it takes hold fully, thought is helpless; no one can decide by rational means what to do. A doctor either obeys the loudest authority—*or* he tries to sneak by unnoticed, bootlegging some good health care occasionally *or*, as so many are doing now, he simply gives up and quits the field."

The Clinton plan will finish off quality medicine in this country—because it will finish off the medical profession. It will deliver the doctors bound hands and feet to the mercies of the bureaucracy.

The only hope—for the doctors, for their patients, for all of us—is for the doctors to assert a *moral* principle. I mean: to assert their own personal individual rights—their real rights in this issue—their right to their lives, their liberty, their property, *their* pursuit of happiness. The Declaration of Independence applies to the medical profession too. We must reject the idea that doctors are slaves destined to serve others at the behest of the state.

I'd like to conclude with a sentence from Ayn Rand. Doctors, she wrote, are not servants of their patients. They are "traders, like everyone else in a free society, and they should bear that title proudly, considering the crucial importance of the services they offer."

The battle against the Clinton plan, in my opinion, depends on the doctors speaking out against the plan—but not only on practical grounds—rather, first of all, on *moral* grounds. The doctors must defend them-

selves and their own interests as a matter of solemn justice, upholding a moral principle, the first moral principle: self-preservation. If they can do it, all of us will still have a chance. I hope it is not already too late. Thank you.

Chuck Braman
76 Carmine St., #3-D
New York, NY 10014-4346

May 23, 1995

Mr. Phillip Moseley
Majority Chief of Staff
House Committee Ways and Means
1102 Longworth House Office Building, (LHOB)
Washington, DC 20515

Dear Mr. Moseley:

I would like to let all of my representatives in Washington know that I strongly favor the idea of tax-free medical savings accounts, like IRAs; voluntary, tax-free, no compromises! For a summary of the reasons why I favor a fully free market in medical care, please see the enclosed 7 page summary of "The Real Right to Medical Care vs. Socialized Medicine."

Sincerely

Chuck Braman

THE REAL RIGHT TO MEDICAL CARE VS. SOCIALIZED MEDICINE
(Summary of George Reisman article by Chuck Braman)

The Medical Crisis and the Need for Radical Procapitalist Reform

For decades the cost of health care, unlike the cost of other economic goods, has risen relative to prices in general and to people's incomes. The cost of health care is now so high that a radical reform is necessary. The current type of reform being advanced by the Clinton administration, however, is an anachronism. It is, to be exact, the enactment of a full system of socialized medicine, a system based on the mistaken and discredited tenets of Marxism, which will aim to reduce the cost of our partially socialized medical system by means of its full socialization accompanied by price controls and rationing. In contrast, the real reform necessary to reduce the cost of health care would be one based on opposite premises, i.e. one based on the tenets of capitalism, tenets which in this century have reached their fullest development in the political philosophy of Ayn Rand, and in the economic theory of Ludwig von Mises. The radical reform necessary is based on the movement *away* from government interference and *toward* individual freedom.

The Right to Medical Care and the Causes of the Medical Crisis

The root cause of the runaway cost of medical care is philosophical. The cause is the current perversion of the concept of rights, a perversion which underlies the laws which have been passed, the consequences of which are responsible for the current crisis.

The correct concept of rights is based on the individual's right to life, which right includes the right to take the actions necessary for sustaining one's life. Rather than being a claim to goods to be provided by others, it is an injunction against the whole rest of society to leave one free so that one may produce the values which one's life requires. Such a right can only be violated by the initiation of physical force, so that under such a concept of rights the initiation of physical force is abolished, and cooperation among people is achieved through voluntary trade rather than the forced transfer of wealth from one person to another. On a social and economic level, in a division-of-labor society, this right, the right to life, is exercised by selling one's goods or labor (what one produces) for money to buy another's goods and labor (what another produces). Applied to medical care, this means that the right to medical care is the right to all the medical care one can buy from willing providers. Such a right is exactly what is currently violated by medical licensing legislation and all regulations and legislations that artificially raise the cost of medicine, because all represent different forms of the government initiating, or threatening to initiate, physical force against producers and traders who themselves have not initiated physical force, and thus physically restricting their right to produce and trade.

In contrast to the concept of rights described above, which Dr. Reisman refers to as "the rational concept of rights," is the concept of rights put forward

by the Clinton administration, which Dr. Reisman calls "the need-based concept of rights." It is, in simplest essence, based the premise that wealth is something that appears more or less causelessly—as opposed to being produced by the effort of individual people who by that fact retain a right to such property—and that the fact of any one person possessing a need for such wealth gives him a right to it.

There were three cornerstones in the history of medical care in the United States which have lead to the application of this premise in order to pass laws which produced the runaway medical costs we face today. They were (1) the government imposition of medical licensing laws starting in the nineteenth century, (2) the government imposition of wage and price controls during World War II, and (3) the government imposition of the Medicare and Medicaid programs during the 1960's.

Medical licensing increases the costs of medical care by lowering the supply of medical providers. Historically, it has been supported by doctors because it is a means of increasing their wages by virtue of creating a monopoly. As to the extent that is has actually raised the standards by which medicine is practiced (which is limited, since the qualifications imposed by licensing are largely arbitrary), it is through the means of reducing the number of options available to consumers. This is because instead of the market offering a full range of skilled practitioners offering various services at various prices, it essentially must now offer only a higher range of skilled practitioners offering this same range of services at a higher range of prices to fewer people. As a result, it primarily victimizes the poor, thereby playing into the hands of those who advocate socialized medicine.

The second step towards socialized medicine in the U.S. resulted from a string of events following the government imposition of wage and price controls during World War II. It occurred because the government made a single exception to its prohibition of wage increases during this period by allowing employers to pay for tax-free medical insurance for their employees. Because this was the only possible means of increasing wages (and therefore the only possible means of competing for employees), and because the individual employee's alternative to this insurance was taxed by the government, the scope of coverage offered by this form of insurance, as opposed to the traditional private insurance offered up to that point, was artificially encouraged to be made comprehensive rather than to being limited to providing only for emergencies. (In current dollars this form of comprehensive insurance costs the equivalent of $5000/year per family, whereas in current dollars the cost of coverage limited to medical emergencies costs about $2000/year per family.) Following World War II, coercive labor unions made such insurance a standard part of their contracts. The effects resulting from such employer-provided comprehensive insurance are (1) a psychological mindset among employees, akin to that which exists in socialist countries, that medical care is a right of employees that can be provided essentially for free, and (2) an economic situation, akin to that which exists under socialism, whereby all costs are borne collectively by a group rather than by individual people.

Most significantly, the collectivization of costs resulting from such a system is the leading cause of the continuous rise in medical costs since

W.W.II. This is because if one's expenses for any commodity are covered by a huge anonymous group rather than by that individual, the individual has no incentive to contain his spending. When all the individuals within such a group are mutually relieved of responsibility, the result is a form of mutual plunder. Every individual within the group ends up spending more than he would have as an individual because he is able to pass along almost all of his costs to the others, while all the other individuals in the group similarly increase their spending because they are able to do the same. Thus, the amount of spending by each individual within the group increases much more so than it would if each individual was directly responsible for his own costs. In addition to this absolute increase in individual spending, it is the combined increased demand on a limited supply that leads to radically rising prices.

This increase in the prices of medical services resulting from the collectivization of costs following W.W.II led to the third major step towards socialized medicine in the U.S., the imposition of the Medicare and Medicaid programs in the 1960s. These programs were instituted to make the increasingly expensive medical care more affordable to the poor and the elderly. However, since such programs represent an even further collectivization of costs than collectivized insurance, drawing their funding as they do from the entire body of taxpayers rather than from a smaller body of insurance holders, they have lead to the pricing of medical care beyond the reach of the uninsured middle class. As a result, their implementation has lead to the current call for complete socialized medicine.

Ironically, of course, the problems that socialized medicine is supposed to solve are all problems stemming from the previous steps the government has taken towards socializing medicine. Specifically, there have been several consequences following from the concept of a need-based right to medical care and the collectivization of costs to finance it which have acted to raise the price of medical care.

First, of course, is the increase in prices which necessarily follows when one is able to bid on a limited supply of goods and then pass the expense off to an anonymous group. Such bidding on government-supplied goods leads inevitably to government-imposed price controls and rationing as the only possible means of controlling costs, followed thereafter by the government's further refusal to allow anyone to bid the price up any further even using their own money.

Second is an increased demand for medical care, in the form of increased visits and increased services.

Third is the recent phenomenon of irrational standards for malpractice and radically increased malpractice awards. This follows from the notion that if medical care is a right, then a right to medical care as such means a right to the best medical care available. As a result, providing a patient with anything less than the best, most expensive medical care comes to constitute malpractice, whether or not the doctor is being compensated to provide such care. Fear of malpractice lawsuits has lead to the new phenomenon of doctors practicing "defensive medicine," i.e. conducting medically unnecessary tests to provide a record for their defense in the event of a lawsuit. Defensive

medicine is estimated to account for more than one-third of the total cost of health care in the U.S. today.

Fourth is an intense demand created for prohibitively expensive new technology. Traditionally in medicine, as well as in any other field, new technology does not raise costs; initial buyers, who must pay out of their own pocket, are few, allowing the item to slowly develop a market as experience is gained in producing it, during which time its cost falls while its quality improves. Since costs for medical technology are collectivized, however, new, prohibitively expensive technology, which individuals would not be able to afford if they had to pay out of their own pockets, is demanded universally as a matter of right.

Fifth, prices are collectively bid up on patented drugs which need not fear competition, while at the same time prohibitions against price discrimination prevent lower-priced versions of the same drugs from serving the market of the uninsured. (In addition, of course, FDA regulations greatly increase the development time of drugs and further inflate their prices.)

Sixth, lack of profit and loss incentives causes wasteful spending on expensive equipment. The government responds to such wastefulness by such means as requiring a "certificate of need" before it will authorize such expenditures. As a result, expenditures often end up being restricted on necessary as well as unnecessary equipment.

Seventh, government-imposed cost-controls on public patients leads to cost-shifting to private patients, which becomes necessary in order for physicians and hospitals to make up their losses. (Such cost controls include categorizing treatments into "diagnostic related groups," (DRGs)—categories for which the government pays a flat fee, no matter what the actual cost of the treatment, which could be more or less than the fee according to the individual circumstances.)

Eighth, the bureaucratic controls imposed by the government in order to contain the costs increase costs by increasing paperwork and administrative costs.

Finally, government safety, environmental, and labor regulations increase the cost of medical care, probably even more so than in other fields, because of the separation of the buyer from the seller, which buyer is therefore less likely to be aware of and to protest such interference.

Most ironically, and above all, the need-based right to health care and the collectivization of costs required to pay for it eliminates the real, rational right to care in the instances where those who would be able to afford to buy medical care now cannot do so.

The Clinton Plan

The original, rational right to medical care, the right to buy the medical care one needs from willing providers, has become almost impossible to exercise now. Under the Clinton plan it would be made completely illegal. The "Health Security Preliminary Plan Summary" imposes criminal penalties "for the payment of bribes or gratuities to influence the delivery of health services and coverage." Under the Clinton plan dependence on the government would be made absolute, as everyone would be compelled to join a government-approved insurance plan.

Clinton's plan envisions a "National Health Board" that would decide what kind of care would be provided by what methods. Regional alliances would tax away the employee-financed health insurance premiums from medical payroll taxes imposed on small companies to pay HMO-styled insurance companies. (Large corporations of 5000 employees or more would be allowed to constitute themselves as "corporate alliances" and pay these insurance companies directly.) The managed competition referred to by Clinton, which is essentially a form of government-controlled monopoly, refers to the choice, to be made by the regional alliances, of which insurance companies are to be allowed to compete in which markets. Consumers would then choose among these remaining companies. All these insurance companies would offer uniform benefits and operate under the guidance of the NHB.

As the 37 million new, presently uninsured individuals are brought under socialized medicine, demand for health care would increase correspondingly, and yet at the same time Clinton plans to cut current medical spending by $200 billion or more. The only possible outcome of this situation would be shortages and rationing. More expensive procedures would be performed less, fee-for-service practitioners would be controlled and monitored, and the patient's choice of doctors would essentially be lost because the demand for their time will so greatly exceed their supply. The physician's new protection against malpractice lawsuits, irrespective of the outcome on the patient, will be his adherence to "Practice Guidelines," bureaucratic rule books provided by the government detailing minimum standards of treatment.

Areas of medical care likely to suffer would include medical technology (which bureaucrats would not be likely to encourage), and new drugs, whose profitability Clinton is already fighting to restrict. In addition, if the practice of other countries which have instituted socialized medicine is any indication, cutbacks for the aged would be likely, because they demand extensive care and have few years left as voters.

The reduction in administration costs promised by Clinton would essentially represent a reduction in service, and would itself be offset by the new administration costs for the 37 million new individuals who would be joining the system.

Under such a system, the profit motive would be turned against itself because the source of profit under a flat fee system derives from the withholding of care. When combined with the fact that the patient is prohibited from offering his own money to pay for his own care, the result is that the doctor's self-interest becomes set against the patient's self-interest. As under Communism, security is lost because the right to buy what one needs is lost. In place of the individual's calculations of self-interest are the government's considerations of such things as the level of its spending for medical care in relation to its gross national product.

The Free Market Solution

The free market solution to the crisis of rising medical costs is the restoration of the rational right to medical care: the complete removal of government interference between the buyers and sellers of medical care and

the complete removal of all government interference which makes medical care more expensive than it otherwise would be.

Under the free market, the cost of medical care would be determined by the prevailing supply of talent, the state of capital accumulation, the state of technology, the profit motive and the freedom to compete for patients, and the ability to practice price discrimination.

The elimination of licensing would result in the greatest possible supply of talent, while at the same time broadening the range of services offered. The lower end of the market could be served to a large degree by nurses, pharmacists or paramedics providing the particular services in which they are qualified but currently prohibited from performing. To the extent certification is desired, it would be provided by professional degrees, and by certificates which could be provided by private organizations.

In a free market, medical insurance limited to providing for catastrophic illnesses would out-compete collectivized insurance because it would be so much less expensive. Such limited insurance would include an annual deductible in excess of all routine medical expenses, thereby leaving the individual incentives to control cost. Always, the operative standard in a private system would be the benefits to the individual patient's life, as judged by the patient himself by considering potential medical treatments in relation to his other needs.

Toward a Free Market in Medical Care

Of course, the simplest solution to establish a free market in medicine would be to abolish all government intervention in medicine in one stroke. Since such a solution is unlikely to be enacted, however, a gradual solution is the best alternative, provided that it uses as its standard the eventual goal of the complete abolition of government intervention from medicine.

The focus of such a solution would be on the plight of the uninsured, and would approach cost reduction from two mutually reinforcing sides: the elimination of the artificial increase in demand for medical care, achieved by income tax reform and Medicare reform, and the elimination of the artificial increase in costs of medical care, achieved by the liberalization of licensing laws and the reduction of hospital costs.

As an income tax reform, employees should be given a choice between employer-financed medical insurance (which is currently not taxed), and an equivalent tax-free increase to their annual income, which, matching the current cost of employer-financed medical insurance, would average around $5000 per family. Such a choice would create a strong incentive for individuals to purchase less expensive insurance with a high deductible, which would be limited to covering catastrophic illnesses, and which at current market prices would cost about $2000 annually per family. The difference in the costs of these two kinds of insurance could be used to pay the deductible in the event such a need arises.

As a second reform, wealthy Medicare patients could be made to pay a substantial deductible before their coverage would begin and a copayment of costs beyond some maximum limit. Such a measure would not be unreasonable, as the amount of money those eligible for Medicare have paid

into the program since it was inaugurated is substantially less than is typically drawn out.

Alternately, those over 65 should be given a choice of signing away their rights to Medicare and social security in exchange for exemption from all taxes (excluding sales taxes) such as personal, interest and dividend, and estate and gift taxes. Besides increasing personal freedom and personal revenues, such a measure would result in increases in government revenues, since government spending would be reduced, while people who otherwise would have been encouraged to retire would be encouraged to work and save (as well as pay sales taxes), which saving would act to increase capital accumulation and ultimately production.

As a measure to eliminate artificial increases in costs, licensing laws could be liberalized by the method of allowing those holding higher medical licenses to extend the benefit of their licenses to those holding lesser medical licenses, whom they could also train if they deemed such training necessary. As a secondary benefit, such a measure would also act to increase the incomes of all those involved by virtue of opening up a market previously not served.

As a second measure to eliminate artificial increases in costs, hospitals and the uninsured should be exempted from all government regulations and interference from such agencies as the DHHS, SSA, NLRB, EPA, OSHA, etc., and by granting them the right to agree to mutually binding standards of malpractice. Further savings could be realized by allowing physicians to open new hospitals serving such patients, by allowing existing hospitals to practice price discrimination toward such patients, and finally, by creating a Deregulation Agency, whose purpose and powers would be limited to repealing existing regulations.

The above represent strategies which should be used to oppose the Clinton plan. If, however, the Clinton plan is enacted into law, a different, two tiered strategy should be applied. First, there should be a call for legislation introducing the unrestricted right to practice medicine outside of the government's control for those who value that right. Then, after this is achieved, there should begin a fight to end all remaining socialized medicine on behalf of those who do not wish to be forced involuntarily to pay for the health care of others.

Such a fight on behalf of freedom in health care is what is needed immediately as part of the larger fight on behalf of freedom, individualism, and capitalism.

May 22, 1995

Phillip Moseley
Majority Chief of Staff
House Committee Way and Means
1102 Longworth House Office Bldg (LHOB)
Washington DC 20515

Please have this read into today's Congressional Record.

I (and many people who are not writing) favor **Medical Savings** Accounts. Like IRAs, these MSAs would be a fair way to solve the health crisis in a way that is fair to everybody -- gradually phasing out medicare. Contrary to popular belief, health care is not a right.

These MSAs should be voluntary, and tax-free.

Thank you.

Sincerely,
Ann Ciccolella

3710-A Meredith St.
Austin TX 78703

Coalition of Mental Health Professionals and Consumers, Inc.
P. O. Box 438, Commack, NY 11725 Phone/Fax: 516-424-5232

Testimony
Karen Shore, Ph.D., Executive Director
1966 Ashley Place, Westbury, NY 11590
516-997-3390

A) Introduction:

I am submitting testimony on behalf of the Coalition's approximately 1250 members. The Coalition is a national, grass-roots organization, made up of clinicians from all mental health disciplines and consumers of mental health care, their family members, and their advocates. The Coalition is working with approximately 24 regional "affiliated groups" that have no legal tie to the Coalition, though some have taken out memberships. Thus, I am not officially testifying for these groups, but do want the Subcommittee to know that several of these groups are state or regional Coalitions (MA, NY, NJ, PA, DE, MD, NC, GA, TN, IL, OH, CO, CA, WA, MO) that have been inspired by our Coalition or that formed prior to our forming (November, 1992), have similar goals, and are attempting to work together. Each of these groups may have dozens, hundreds, or thousands of members.

I am testifying because of plans to increase the number of Medicare beneficiaries to be enrolled in HMO's and other forms of managed care. The Coalition formed specifically because of the decline in quality of mental health treatment brought by managed care organizations (MCO's). MCO's also have a strong impact on the ability of professionals to deliver proper care. The problems of managed care have the most impact on beneficiaries who need treatment, as opposed to those who are generally healthy. Thus, a larger percentage of the Medicare population covered by MCO's than of the general MCO population will experience these problems, as our elderly generally require more treatment than does the general population.

In this testimony, I will outline the problems we have seen in delivery of services under MCO's in the private sector and will offer recommendations. We cannot assume that Medicare beneficiaries will receive better care under MCO's than those in the private sector.

B) Problems with Managed Mental Health Care for Consumers and Providers:

1. Citizens lose the right to freely choose clinicians and treatment facilities.

a) MCO's increasingly limit their provider list to providers who demonstrate a willingness to perform short-term treatment, whether or not it is truly appropriate, and on their willingness to do so without complaint. Thus, the pool of providers available to the consumer may exclude those who would perform or advocate for quality care.

b) Primary care providers often must act as gatekeepers and may limit access to psychiatrists and to psychotherapists. Often, there are financial penalties if primary care providers make "too many" referrals. Corporate profits are often more important than the consumer and treatment. Primary care physicians are asked to do "counseling," but do not have the training to do real psychotherapy.

c) MCO panel limitations often cause the consumer to travel a great distance for their care, which could be especially burdensome for the elderly, and may prevent needed care.

d) Consumers may have to change clinicians often as plans drop providers and merge with other MCO's, or as the consumer changes health plan. Continuity of care and the building of trust in the clinician are impeded. Continuity of care and trust may be particularly important for the elderly, who often are more in need of ongoing treatment than the general population.

e) Clinicians are impeded in their ability to make the best referral possible due to panel restrictions preventing them from referring "out-of-network."

f) Generally, psychiatrists and other doctoral-level clinicians, and even master's level clinicians, may be prevented from performing psychotherapy by MCO's, as MCO's often search for the "cheapest" clinicians. One MCO reportedly has begun using bachelor's level counselors rather than professionally trained master's and doctoral level professionals. When beneficiaries cannot receive reimbursement for treatment by clinicians with advanced training, quality of care is compromised.

g) Patients hospitalized in a non-network hospital in an emergency may be forcibly transferred to a network hospital before they are well, impeding recovery and possibly increasing symptoms.

h) Even if the MCO offers out-of-network benefits (Point-of-Service Option), consumers with limited incomes may be unable to access out-of-network providers, as they are financially penalized for doing so. This may affect the elderly in large proportions due to the large percentage on limited incomes.

2. Patients lose the right to make their own treatment decisions.

a) The MCO may pre-determine that all or most patients are to receive brief hospitalizations and brief, crisis-focused psychotherapy, regardless of patients need. This is based on decisions about money, not treatment and consumer need.

b) The MCO often requires reports from the treating clinician and then takes over treatment decisions. The patient and his/her clinician may be powerless to decide the course of treatment. The sense of powerlessness and the prevention of access to proper treatment may increase a patient's symptoms, especially depression and anxiety. Hospitalization or intensive psychotherapy for a particular patient may be declared "not medically necessary," even though the standards of practice in the professions would clearly show the need for treatment.

c) What is "medically necessary" varies from one MCO to another, as it generally has more to do with costs than with care.

d) Many MCO's will only authorize three or four psychotherapy sessions at a time, leaving the beneficiary and provider unable to know how long their work will be able to continue. Anxiety often rises before each "approval" and session time is often spent on discussing the MCO, rather than on the problem for which the patient sought treatment.

e) Some MCO's deny funds for psychotherapy if the patient refuses medication. This is because medication may produce a fast relief of symptoms, even though it may actually fail to correct the actual problem. This then allows the MCO to discharge the patient without investing much money. In general, there is concern that too many of our elderly are already over-medicated. Often, they are considered too old to make changes and not good candidates for psychotherapy, which is not necessarily true. This puts the elderly at increased risk of over-medication. Further, there is a bias among some physicians and scientists toward medication and away from "talk therapies," but this may reflect little more than an honest bias and the difficulty of forcing "talk therapy" into the molds of empirical science. Patients may have a strong need to talk out their problems, yet their voices do not count under managed care.

3. Consumers lose the right to privacy under managed care.

Because reports must be submitted to the MCO by the provider in order for the MCO to determine whether or not continuing care is "necessary," information that should not leave the treatment room must be given to the MCO, which may store it in their data banks. Psychotherapy patients often require privacy over information involving personal problems. Many consumers are not at all comfortable allowing such information to be divulged, but may have to sacrifice reimbursement if they withhold this information. Under Medicare, psychotherapy providers are not permitted to treat beneficiaries outside the plan. Thus, those requiring privacy or those with paranoid conditions may be forced to forego needed treatment due to inappropriate cost-containment techniques that may be suited to "industry," but not to human services.

4. MCO's may be grossly under-treating consumers of mental health care due to cost-containment. Because it is illegal for psychotherapists to provide treatment for Medicare beneficiaries outside of Medicare, those consumers who need treatment beyond what the MCO dictates may be prevented from legally obtaining needed services.

a) Many MCO's provide a grossly inadequate model of "short-term therapy," "solution-oriented therapy," "crisis intervention," or "stabilization," or they may state that they only treat the "acute phase" of a problem, refusing to pay for proper treatment for "chronic" or "ongoing" problems. This is a standard that would never be tolerated in medical care, and should not be tolerated in mental health care. Examples of MCO literature stating these limits can be provided to the reader.

b) Many patients need time to build trust in the clinician and to tell their story. Patience and understanding from the clinician are as necessary as advice. The clinician needs to spend enough time with the patient in order to know if the problem goes deeper than the surface "presenting problem." These things are too often impossible under managed care.

c) MCO's are misusing research data by not speaking to the limits of the research in order to support their bias toward short-term treatment.

d) Even though the literature in many MCO plans may state that beneficiaries may have "up to 20 sessions" in a year, often times the companies' reviewers are told never to allow more than a few sessions (see vignettes), or providers are warned that if they average more than a few sessions per patient, they will be ejected from the panel or refused further referrals. Thus, the provider may be too afraid to give the consumer the treatment that is needed.

e) A recent Harvard study (James Hegarty, MD, at McLean Hospital, Boston, as reported in *Newsday*, "Study: Managed-Care Squeezes Hospital Stay," 5/24/95) showed that there has been a dramatic increase in re-hospitalizations of psychiatric patients under managed care due to premature discharges. The average length of stay (LOS) at McLean in 1989 was 45 days. By 1994, due to managed care, the average LOS was 15 days. There was a concomitant increase in the number of people readmitted within a month, from 0% in 1989 to 21% in 1994, and an increase in patients who were minimally improved or worse at discharge than at admission, from 4% to 18%.

f) The industry is ignoring 100 years of development in the field of psychotherapy and is creating standards for treatment that are *substandard*.

5. Many managed care provider contracts contain "non-disparagement clauses," prohibiting the provider from saying anything negative about the managed care company to the patient or anyone else, often preventing providers from making the consumer aware that he/she is not receiving proper care.

Consumers are prevented from accessing professionals who follow their ethics and refuse to sign such agreements, as these providers will not be included on the MCO's panel. Also, this can mean that if a panel provider believes that the MCO's recommendations would be harmful to the patient, the provider may not tell this to the beneficiary. The consumer should have the right to know his/her provider's opinions of treatment decisions made by the MCO, especially if the provider believes that the MCO's decision is not in the patient's best interests. Also, these clauses prevent managed care abuses from reaching the press and legislators.

6. Patients may find that they must fight for benefits when they are ill, when their energy should be spent on getting well.

Patients never know whether or not their treatment will be covered until they become ill. Since providers may be at risk if they advocate for the consumer, this leaves consumers often having to spend their energy on advocating for themselves when needed treatment is being denied. Patients who do not have the ability, self-confidence, or energy to advocate for themselves may be seriously under-treated. Often, mental health patients are too derpressed, anxious, or too humiliated by their problems to advocate for themselves. With providers being at risk for unemployment if they advocate for their patients, there may be no one left to advocate for the elderly patient, especially if family is uninvolved or lives far away.

7. Under managed care, many providers fear doing what is right for the patient, putting the consumer at risk.

Since the MCO's now decide which providers will be able to continue working, many have been frightened into silence. Many feel too powerless to protest poor treatment of consumers to the MCO, the press, or to their legislators. When New York State's Assembly held hearings on managed care in January, 1994, several providers told me they were too afraid of being identified by the MCO's to testify. Their fear was that they would be ejected from the networks, refused referrals, or that their patients would be refused future sessions. These very real threats put the consumer at risk, especially in mental health, where patients usually do not advocate for themselves, and especially with the elderly patient, who may not be able to advocate for him/herself.

8. Quality and quantity of care will always be a problem under managed care and any form of capitation, as *there is an inherent conflict of interest when an entity that is supposed to offer care, be it an MCO or an individual provider, keeps whatever money is not spent on treatment.* This is especially destructive when mental health is under-capitalized.

a) MCO's keep money that is not spent on treatment. Corporate profits are soaring while beneficiaries are prohibited from receiving care for chronic and ongoing problems and are being discharged from hospitals prematurely.

b) Even capitated contracts that are made between employers and providers directly, bypassing MCO's, are problematic. One California therapist told me that she was called by a capitated plan and told that she would receive approximately $235 for each patient they send her. Obviously, if she performs one session only, she does very well. She still does well if she performs only two. Obviously, if the patient requires 10 sessions, she is receiving poor wages (with no benefits) for someone with a doctorate or even a master's degree. If the patient requires 40, 50, or more sessions, it becomes ludicrous. Thus, there is a strong incentive to under-treat, and clinicians may simply not be able to afford to

treat patients properly due to under-capitation. It is the bias of the corporations that people should only require 1-3 sessions. This is not reality.

c) It is true that under the fee-for-service system, there was some incentive to over-treat the patient. However, not all providers over-treated, as wise clinicians knew that they would receive future referrals from patients whom they treated appropriately. Also, under a fee-for-service system, if a consumer feels that he/she is not being treated properly, he/she can easily leave that clinician and find another. Further, a system of appropriate co-payments, when used by the insurers, encouraged consumers to be cost- and utilization-conscious.

9. Despite claims that managed care and managed competition comprise a "free market solution," there is no free market for the patient, the actual consumer of health care.

a) Managed competition is really about the elimination of competition. As consolidation continues, only a few large insurers will remain.

b) In several areas, the industry already controls 90% of the market. Where managed care squeezes out fee-for-service plans, *there is no competition for managed care itself.* A lack of competition always bodes poorly for quality.

c) A free market for the patient would mean that the patient is the one who would determine what care is needed, determine the value of that care, and choose freely from all who are qualified to provide that care. Managed care does not allow the patient these liberties. As managed care becomes an arrangement between employers or governments and the insurer, and the "consumer" becomes the employer or government, for they pay the premiums, the "free market" exists between the MCO and the payor. Under managed care, the MCO determines who will receive what kind of treatment, for how long, and who can deliver it. The true consumers of care, the patients, as well as the body of professionals who could administer care, are kept out of the "marketplace."

d) The managed care industry controls both supply and demand in regard to health care services. MCO's have declared that there is an over-supply of mental health professionals. This is predicated, however, on the industry's assumption that only brief forms of crisis-oriented therapy are needed, and that few people need treatment. This is not based upon true demand, which would be based upon the citizens' requests for care. Although fee-for-service is a "subsidized" market, it is still based on a more true supply and demand than under managed care. Under a fee-for-service system which had, in recent years, seen extremely high co-payments for psychotherapy, the demand for services was far greater than what is allowed under managed care. There will soon be a drastic shortage of mental health professionals and other providers, for the number will be based on what the managed care industry "needs," not upon what our citizens need. This will affect our entire society.

C) Recommendations:

1. Allow Medicare beneficiaries to choose among a variety of health plans, including fee-for-service plans, Medical Savings Accounts, MCO's, and any other type of health plan that currently exists or is yet to be devised.

a) Medical Savings Accounts (MSA) are attempts to return the rights of the "free market" to the actual consumers of health care. Incentives are provided that make the consumer cost- and utilization-conscious. Up to the catastrophic limit of the MSA, the consumer retains the right to choice of provider, the right to privacy, and the right to make his/her own treatment decisions.

b) There are some problems with MSA's, however:

i) Beyond the catastrophic limit, the consumer retains freedom of choice, but loses privacy and the right to make his/her own treatment decisions, as treatment may be subject to utilization review. However, because there are no panels, and MCO's can't threaten the providers with unemployment, providers are free to advocate for patients.

ii) The standard MSA contract written by the Golden Rule Insurance Company, has a limit on mental health services of $10,000 per year per individual. This is generally adequate for a patient requiring only psychotherapy, but not for one requiring a day treatment program or hospitalization.

iii) There is some concern that MSA's will not be appropriate for those who are unable to be responsible for their funds. This may affect some of the elderly. It may be necessary to arrange for a relative to make MSA decisions or, when there is no such relative close by, for a consumer case manager (not a case manager contracted by the insurer) to do so.

c) Some MSA plans are combined with MCO's. Again, this penalizes consumers for using out-of-network clinicians, which limits their choice of providers, especially for those with a limited income.

2. Return control over health care to the citizen:

a) Phase out employer involvement in health care. It no longer works. For employees, premium money actually belongs to the employee, for it is taken from his/her wages. Return this money to the employee so that employed citizens can purchase, own, and control their own health care plans. Under Medicare, and for citizens with limited incomes, beneficiaries should be expected to pay a portion of their premiums, based on their incomes, with government paying the balance.

b) Return the three basic rights consumers have lost under managed care (choice, privacy, and decision-making). Employees lost these rights because we now expect employers to pay for insurance, and because employers needed to cut costs once the patient became separated from the consequences of their decisions under the fee-for-service system. Citizens have been separated from the fact that it is their money to begin with, and the greater the separation, the less care they take with that money.

c) In order to protect their freedom, citizens must be financially responsible for their care to whatever extent they can afford to be so.

i) Medicare beneficiaries with adequate incomes would buy their own plans, or at least pay for a portion of their premiums. Government would pay that portion of the premium which is unaffordable for the Medicare beneficiary or other citizens.

ii) Benefit design must create incentives for patients to be cost- and utilization-conscious, without restricting access to care and other freedoms.

d) Individual mandates might be considered. Car insurance is required of all who drive, not just of all who have accidents. Why can't health insurance be required of all who live, not just those who get sick? While we might wish to protect the freedom of the citizen NOT to be insured, all citizens must then pay for emergency care and follow-up treatment when an uninsured individual requires treatment he/she cannot afford out-of-pocket.

3. Protect quality care and consumer freedoms by encouraging citizens to buy and own their own insurance plans. Allow a 100% tax deduction for all citizens buying their own health care plans.

All citizens deserve the tax break now given to employers, especially those who are self-employed or unemployed, which may include a large number of Medicare beneficiaries. Also, it is important for a government to encourage people to take care of themselves, so they will be less dependent upon the government for services. The more health insurance coverage one owns, the less dependent one will be on the government for care.

4. Guarantee portability of health care plans.

5. Prohibit "pre-existing condition" barriers to treatment.

6. Guarantee all citizens in MCO's access to "Point-of-Service" options:

Unfettered access to specialists is crucial for those who are ill.

7. Guarantee the right of all citizens, including Medicare beneficiaries, to "contract privately" with providers of their choice.

In the case that a health plan denies reimbursement for a particular service, the citizen must still be allowed to purchase health care he/she believes is necessary. The MCO might be making incorrect decisions. Medicare beneficiaries cannot currently purchase psychotherapy except from Medicare providers. If Medicare comes under managed care, beneficiaries will also frequently be denied more than a handful of psychotherapy sessions, as is already happening to the general population. Most MCO's are only allowing "crisis" care, and are prohibiting true forms of psychotherapy. We cannot make it *illegal* for Medicare beneficiaries, or anyone else, to obtain genuine psychotherapy.

8. Allow the States to regulate the managed care industry.

a) With a true "free market" system, in which the citizen has the ability to make his/her own health care decisions while being given incentives to be cost-conscious, there will be less need for regulation than there is under managed care.

b) Managed care plans frequently short-change the patient, and often prevent providers from advocating for patients and from delivering the best care they know how to

provide. It is imperative that the federal government allow the States to regulate this industry. ERISA laws were not intended for health care. They were intended for pension plans. If employer involvement were phased out, employers would not object to state regulation of health insurance plans.

9. Allow states the flexibility to experiment with a variety of health care plans.
   a) Encourage the States and regions to develop insurance plans that involve "freedom with responsibility." MSA's attempt to do this.
   b) There are many ideas yet to be devised and written down (e.g., see "Managed Cooperation," item F, below). Please do not lock Americans into any particular form of system, as this will prevent better ideas from being formulated and implemented.

D) Summary:

There are many problems that have already occurred in the private sector under managed care. These problems generally involve the loss of consumer freedoms to make their own treatment decisions, in private, with their chosen clinician. In mental health, the industry has changed the "standards of care" to substandard care.

In general, we urge Congress to institute some insurance reform and to allow the States to regulate the managed care industry. We urge Congress to increase choice of plan for Medicare beneficiaries and others, and to pass legislation that enables the development and implementation of programs that offer alternatives to managed care and managed competition, especially those that re-institute a true free market for the actual consumers of care. We support plans which retain consumer freedom while containing costs by providing incentives for consumers to be cost- and utilization-conscious, thus expecting some financial responsibility from the consumer, according to the financial means of the consumer.

E) **Vignettes from Managed Mental Health Care** - see pages 7 & 8.

F) **"Managed Cooperation:" A Medical/Mental Health Care Plan** - see pages 9 & 10.

These pages contain ideas ("Managed Cooperation") designed by the Coalition. Many of these ideas could be helpful in designing systems of cost-containment that put the consumer of care back in charge of his/her own treatment.

Original Vignettes (#1)
Managed Mental Health Care
(Revised 12/18/93)

The following vignettes are summaries of managed care (MC) cases. Decisions about who can be in treatment, how long treatment can continue, what type of treatment patients can have, and who can provide it, are being made by the MC companies. While they state they are basing decisions on "medical necessity," the companies cannot be free of a need to themselves be profitable. Unfortunately, the cases below are not atypical.

1. Ten year-old "Susie" was involved in a tragic and frightening accident. She and one parent escaped, but the other parent and her sibling died. "Susie" became mute, and began drawing pictures of a little girl with a noose around her neck. The surviving parent brought "Susie" to their HMO. "Susie" began therapy, but her pictures became increasingly darker (a symbolic indication of deepening depression and increasing suicidal risk). After the ninth session, the parent found "Susie" about to make a suicide attempt. This was reported to the therapist (who had not yet earned a master's degree) at the 10th session. This HMO therapist concluded treatment with the 10th session, stating that "Susie" "should be" finished. "Susie" was still mute and suicidal. Fortunately, the parent had some money available to pay for therapy without insurance coverage. The parent asked a friend for a referral outside the HMO and found a psychiatrist who offered a reduced fee. "Susie" was seen three times/week for 18 months. It took 12 months before "Susie" began to speak again.

2. "Mary," a depressed woman with several physical problems related to her emotional disorder, was denied therapy after 8 visits, even though her policy allowed up to 20 visits. The therapist (licensed) strongly recommended further treatment, but the reviewer (not licensed) refused authorization, saying that he had been instructed not to approve any outpatient treatment beyond 8 sessions regardless of the diagnosis or provider recommendation. "Mary" was too depressed to appeal. Within a month, she was hospitalized for severe gastric distress and required surgery. The therapist believes this was caused by inadequately treated depression.

3. "Jane," a depressed and suicidal woman, had finally left her physically abusive husband. She called her MC company for permission to begin therapy and for a referral. The request was refused. The reason given was that "domestic violence is a social problem, not a psychological problem."

4. "Sean," an adolescent boy, asked to be in therapy. His mother called the MC company for permission for him to begin therapy and for a referral. "Sean" stated he would not be comfortable seeing a male therapist. No list of network therapists is published, so the mother could not find an appropriate referral herself. The company agent refused to offer the name of a female therapist, though there were many in the network in that area. Despite many protests by the mother, the agent gave only names of male therapists, stating: "Listen, if you're sick, it doesn't matter who you see. And if you don't take the names I gave you, I can't help you anymore."

5. "Rosa," a young mother with 3 young children, cuts her wrists. Her HMO approved only 8 sessions. The therapist believes her symptom is due to feelings of anger at the responsibilities of motherhood. As the oldest of 9 children herself, "Rosa" had been over-burdened with responsibility as a child, for her own mother was unable to care for the children. Without appropriate treatment, "Rosa" will not likely understand the reasons for her distress. She will likely continue to cut her wrists, possibly escalating to serious cuts. The potential for child abuse is also present should "Rosa" begin directing her anger outward instead of toward herself.

6. "Henry," a middle-aged man with a childhood history of being severely humiliated, requested treatment due to interpersonal problems, including difficulty trusting others. "Henry" refused to return to treatment when the therapist was required to submit a detailed report about him and his therapy. The therapist finally convinced him to return and they spent much time discussing what the therapist should write. The report was written and more sessions were authorized, but "Henry" never returned for treatment. When the therapist called him, "Henry" said that the experience of having to divulge information to the company was too humiliating for him.

7. "Steven" experienced increasing depression, panic attacks, and phobic anxiety that prevented him from working. His psychiatrist provided psychotherapy and medication. There was a brief admission to a local hospital for a suicide attempt. After a year of treatment, "Steven's" insurance was changed to a MC company. The psychiatrist joined the network to be able to continue the treatment. The treatment resistant depression and severe anxiety showed some improvement, but the MC company said "Steven" was a "chronic" patient who wasn't showing enough improvement. The psychiatrist had to plead for more sessions. "Steven" did show more improvement. Later, a new anti-depressant helped lift "Steven's" mood and eliminated almost all panic attacks. However, "Steven" then began manifesting increasing manic symptomatology, including spending sprees. Restarting Lithium, which had been helpful in the past, now led to an organic brain syndrome. To be hospitalized under his MC plan, "Steven" would have had to enter the MC company's "anchor" hospital, which was not in his community, and would have been required to change psychiatrists. "Steven" refused to change psychiatrists and thus refused the hospitalization, though he would have agreed to a local hospitalization with his own psychiatrist. The organic symptoms decreased, but the manic symptoms remained. However, the psychiatrist did not feel "Steven" qualified for an involuntary hospitalization. "Steven" endured a full month of manic symptoms, infuding spending sprees. The cost to "Steven" was great in terms of financial, interpersonal and emotional effects before the manic symptoms remitted with outpatient treatment.

8. "Barbara" was in individual and group therapy before a MC company took over her insurance. She had been sexually abused by her grandfather in many horrifying ways between the ages of 5 and 12. She was also abused by a neighbor at age 12. Marital sex was accompanied by terrifying flashbacks of the abuse. The therapist was told by a reviewer to "hurry it along." Unfortunately, the symptoms had worsened because "Barbara" was given a new assignment at work which required her to work with men about the same age as her grandfather. Also, she had recently undergone her first gynecological exam, which left her psychologically disorganized for several weeks. The reviewer, a psychiatrist, asked if "Barbara" was suicidal. When the therapist said she was not, the reviewer disallowed further group treatment, stating she was just "following company policy." Group treatment, in addition to individual treatment, is often extremely important for sexual abuse survivors.

9. "Linda" was in treatment for about 1 1/2 years before a MC company took over. "Linda" was unable to tolerate anti-anxiety medication, but did respond to psychotherapy. Toward the end of the second year, "Linda" witnessed her 22 year-old daughter being hit by a car, leaving her a quadriplegic. "Linda's" symptoms increased dramatically. She was likely manifesting signs of Post Traumatic Stress Disorder. The therapist called the reviewer for permission to continue treatment. The therapist was told: "Well, doctor, let me tell you something. We are going to cut you off - be prepared - its coming down the pike soon!"

10. "Allison" had been sexually abused by two of her brothers for several years during childhood. She was raped as an adolescent, and battered throughout her first marriage. She was in group and individual therapy. Group therapy was later denied by the MC company. When the therapist, a recognized expert in treatment of sexual abuse, told the reviewer that the literature speaks to the importance of individual and group therapy for optimal treatment, the reviewer said: "Listen, we are not interested in providing optimal treatment. We are interested only in providing that which is absolutely medically necessary."

11. "Bill" is usually in control of his anger, but when he loses his temper, he threatens his pregnant wife with a loaded gun. His therapist was encouraged to complete the work in 8-12 sessions. Although the reviewer agreed this was a "long-term" case, he stated that it is not the company's policy to provide long-term treatment.

12. "Jennifer," in her late 30's, noticed pain in one breast, though she found no lump on self-examination. Her HMO doctor also found no lump. "Jennifer," suspecting a problem, asked for mammography. The doctor, who also acted as "gatekeeper," stated that the HMO does not pay for mammography for women under 50 unless there is a physical finding upon examination. With this refusal, "Jennifer" had a mammogram outside her HMO at her own expense. The test showed breast cancer. She decided to sue the HMO. Distressed by the cancer and the refusal of the HMO to provide the services she deemed necessary, "Jennifer" requested psychotherapy to deal with the stress. The HMO refused to authorize psychotherapy for her.

MANAGED COOPERATION

A Medical/Mental Health Care Plan

An Idea for the future

(revised 2/14/95)

---

1. The success of a health care plan will depend on the value system upon which it is based. Cooperation seeks solutions that enhance and are fair to all parties involved.

2. Managed Cooperation optimally balances patient choice and freedom with responsiblility, instills provider responsibility to the patient, and engenders cost- and utilization-consciousness in patients and providers.

3. Managed Cooperation can be written in both single and multiple payer versions.

4. Benefit design would encourage patients and providers to be conscious of costs. When little or no co-payment is expected at the time of service, patients may not be motivated to question a provider's fees or suggested procedures. External controls (gatekeepers, case managers, and utilization reviewers) may then be called upon to do this, reducing patient control over their care. It is important, therefore, for patients to be financially responsible for their care at the time of service to the extent that out-of-pocket expenses are significant enough to the patient that the patient questions providers about fees and recommendations, but not to the point where out-of-pocket costs are burdensome and present a barrier to treatment for those with limited incomes. Sliding scales for premiums, fees and co-payments, deductibles, and catastrophic limits are all possibilities under Managed Cooperation.

5. We suggest a gradual phase-out of employer involvement in health care. When employers buy coverage, they may, understandably, seek to control the care given, limiting the freedom of citizens to make their own treatment decisions, in privacy, with their chosen clinicians. Since the money used by employers to buy insurance really comes out of the employees' income, we encourage a return of this money to employees in the form of income so that they may buy and own their own policies. This returns control over health care choices and decisions to the individual citizen. The possibility of an individual mandate might be considered.

6. Managed Cooperation relies upon regional cooperation. Cost-containment procedures as described below would be carried out by Regional Boards made up of consumer advocates, professionals, government representatives, and insurers (if a multiple payer plan is used).

7. Annually or every other year, Regional Boards would recommend fee ranges and insurance reimbursement levels for each procedure and send this information to consumers, clinicians, and insurers (the government if single payer systems are used or to insurance companies if a multiple payer system is used). Insurers would set dollar amounts for each procedure's reimbursement. Providers would set fees, preferably on a sliding scale, starting with a fee minimally above the reimbursement, up to a reasonable "full fee." The co-payment would be the difference between the reimbursement and the fee for the patient's income level, and could be legally waived if necessary. Clinicians would provide current and prospective patients with their fee schedule

upon request. The intention is to provide true discounts for those with limited incomes. The Board's recommended fee ranges would protect wealthier patients from being over-charged. High-priced clinicians would have to be able to justify their fees to patients. Caps on fees and the mandatory use of sliding scale fees could be instituted if a voluntary sliding scale did not adequately control fees. Sliding scales might be able to be used for hospital expenses if the percentage share for costs was graduated according to income (e.g., citizens earning $30,000 might only pay 5% of hospital bills up to a catastrophic limit appropriate for their income, while those earning $300,000 might pay 50% of all bills up to an affordable catastrophic limit.

Under this system: a) the insurer's liability is limited by the fixed reimbursement, b) patients and providers, due to a co-payment scaled to the patient's income, become cost- and utilization-conscious, c) patients could "comparison shop" and have freedom of choice, and d) practitioners would be guaranteed at least a minimum payment for each procedure (the fixed reimbursement), yet would retain some independence to compete in a truly free market based upon training, talent, reputation in the community, and fees.

8. Regional Boards could regulate purchases of expensive machinery; perform outcome studies; focus on fraud and incompetence, rather than micromanagement; and settle disputes between patients, providers, and insurers.

9. Government support for building hospital-based and free-standing primary care centers would reduce emergency room visits and encourage primary care use.

10. Outpatient psychotherapy would cover individual, group, and marital/couple/family treatment, as allowing children, adults, or families to remain in distress is harmful and costly to our country. Coverage for 40-50 sessions/year is recommended, as: a) 85% of patients use less than 26 sessions, even with liberal benefits and no UR (utilization review), b) liberal outpatient benefits reduce inpatient costs and, thus, overall mental health costs, and c) preventing the 15% of patients who need long-term psychotherapy from receiving it may increase society's costs and harm patients and their families. UR can be used to provide additional sessions beyond the annual limit for those who demonstrate strong psychological and/or medical need AND financial need. UR would not intrude on session content or personal information. Inpatient treatment would require UR, but at reasonable intervals. Medication management would be given the same status as any medical visit. Partial hospitalization, half-way houses, and group homes would be supported to reduce inpatient costs and the costs to society of inadequately treated mental health needs. There would be no limit to inpatient care for the seriously mentally ill (schizophrenia, bipolar disorder, major depression, severe borderline personality disorder, etc.), but appropriate UR would be utilized. Patient education would be developed to explain mental health problems, different forms of treatment and psychotherapy, and the educational requirements of different types of clinicians.

11. UR, or at least denials of benefits, would be done by licensed, practicing professionals who are independent of the insurer, and who have training comparable to that of the treating clinician. UR would focus only on those procedures known to be over-utilized.

12. Incentives in the form of partial premium rebates could be used to encourage patients to refrain from submitting smaller claims.

13. Claims procedures would be simplified and standardized, and claims could be submitted either by patients or providers.

May 22, 1995

Mr. Phillip Moseley
Majority Chief of Staff
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Mr. Moseley,

I am strongly in favor of passing a bill to institute MEDICAL SAVINGS ACCOUNTS. It is the only way to take responsibility for myself and provide for my medical future. It's voluntary, tax free and it gives me the right to choose what kind of health care I want and when.

Remember---- HEALTH CARE IS NOT A RIGHT!!!

Sincerely,

Kathleen Conn

Kathleen Conn
1548 Middle Rd.
E. Greenwich, RI 02818

TESTIMONY OF CONSORTIUM FOR CITIZENS WITH DISABILITIES

The Consortium for Citizens with Disabilities (CCD) is a working coalition of over a 100 national consumer, service provider, and professional organizations, which advocate on behalf of persons with disabilities and their families. Since 1973, CCD has advocated for federal legislation, regulations, and funding to benefit people with disabilities. Fifty of the these organizations comprise the CCD Health Task Force, which works to enact comprehensive health care legislation that will meet the needs of persons with disabilities and chronic illnesses, and their families. This testimony is presented on behalf of the Task Force.

People with disabilities include individuals with physical and mental impairments, conditions or disorders, and people with acute or chronic illnesses, which impair their ability to function. Lack of adequate and affordable health care coverage is a critical issue for many persons with disabilities and chronic illnesses, who have experienced first hand the myriad problems with the current system of private insurance. In particular, they are subjected to the many discriminatory practices of the health insurance industry, which either refuses to insure them outright, or will only issue a policy with a pre-existing condition exclusion.

The Importance of Medicare for People with Disabilities & Chronic Illnesses

Millions of people of all ages with disabilities and chronic illnesses depend on Medicare for health care coverage. The Consortium for Citizens with Disabilities (CCD) Health Task Force has major concerns that the deep spending cuts to the Medicare program being considered by Congress will have a significant negative impact on beneficiaries, particularly people with disabilities. We are also concerned that encouraging Medicare beneficiaries to join managed care programs will limit their choice of providers, and will not achieve the proposed savings since many of these managed care entities will seek primarily to enroll lower risk beneficiaries. Additionally, we believe that the use of vouchers by Medicare recipients would lead to adverse selection and would undermine the social insurance basis of the Medicare program.

Who is Covered?

In 1994, approximately 4.2 million adults under age 65 with disabilities were enrolled in Medicare.

People with disabilities under age 65 who meet the eligibility criteria for the Social Security Disability Income (SSDI) Program can qualify for Medicare health care coverage after a two year waiting period. SSDI is a social insurance program paid for by Social Security taxes of workers and their employers. Eligibility for disability benefits is based on the number of years worked, and the amount of the benefit is based on a person's earnings.

Examples of individuals who are eligible for Medicare through the SSDI program include:

- A 30 year old man who sustained a spinal cord injury in a car accident;
- a 45 year old woman with multiple sclerosis; and
- a 52 year old man with Alzheimers Disease.

People with severe disabilities who have limited work histories, but who were disabled prior to age 22, may also be eligible for SSDI on the basis of their parents' work history. For example, a 35 year old man with severe mental retardation who has never held a job and who is dependent on his parents, can receive SSDI benefits both while his parents are alive and after they are deceased.

People who are eligible for SSDI may return to work. If they are covered under a large group health plan (i.e., for 100 employees or more), Medicare is the secondary payer for health care expenses. A large group health plan cannot treat any individual it covers differently simply because they have a disability and have Medicare coverage. If the person with a disability is not covered by his or her employer's plan, Medicare is the primary payer and the employer may not provide or subsidize supplemental coverage, except for items and services not covered by Medicare.

What is Covered?

Medicare is the largest single purchaser of hospital care, physician services, and rehabilitation services. While people with disabilities require access to the full range of health services, rehabilitation services are of particular importance. The range of inpatient and outpatient rehabilitation services covered by Medicare includes physical therapy, occupational therapy, speech therapy, recreational therapy, durable medical equipment, and orthotics and prosthetics.

These services may be provided in a number of locations, including:

- rehabilitation hospitals or units in general hospitals;
- skilled nursing facilities;
- comprehensive outpatient rehabilitation facilities;
- rehabilitation agencies;
- private offices; and
- patient's homes through the services of a home care agency.

Medicare is the single largest payer of medical rehabilitation services in the United States, accounting for an average of 40% of revenues in rehabilitation hospitals and more than 50% in rehabilitation units in hospitals.

Issues and Concerns

Potential Reductions in Medicare Services

The House and Senate Budget Resolutions propose between $256 and $282 billion in Medicare cuts over the next 7 years. Currently, Medicare does not cover important services such as outpatient prescription drugs and most preventive and screening services. As a result, many Medicare beneficiaries -- even those with Medigap policies -- have high out-of-pocket expenses. For those without Medigap policies, including many individuals on SSDI, out-of-pocket expenses are even higher. Further budget cuts in Medicare will result in benefit cuts and increases in out-of-pocket payments.

Low Reimbursement Rates and Cost-Shifting to Private Payers

According to the Physician Payment Review Commission, Medicare pays physicians approximately 70% of their charges. Health care providers and hospitals have traditionally shifted the shortfall in Medicare payments onto private health insurance payers. Deep cuts in Medicare funding will further exacerbate this problem. The Medicare program has already been cut significantly -- nearly $200 billion since 1980, and most recently, by $56 billion in 1993. Singling out Medicare for additional spending reductions will likely result in continued cost-shifting to businesses and privately insured individuals as hospitals and physicians try to recoup lost revenues.

Difficulty in Finding Physicians who will Accept Medicare Patients

As managed care plans have increased their share of the health insurance marketplace, they have been able to negotiate lower rates from health care providers who are less able to shift costs to private payers. Further reductions in Medicare reimbursement rates would put additional financial pressure on providers. As a result, fewer doctors and other health care practitioners may be willing to provide care to Medicare beneficiaries.

The magnitude of these recent cuts has already had a negative affect on many Medicare beneficiaries, who are having difficulties finding physicians willing to treat them. People with disabilities and chronic illnesses develop long-term relationships with particular providers to help maintain their optimal health status. Medicare funding cuts which force providers to discontinue providing services to these vulnerable individuals may have serious effects on the quality of their health care and their health status.

Recommendations

Given the pending insolvency of the Medicare Part A Trust Fund, and the escalating costs of the Part B program, the CCD Health Task Force recognizes that the financing problems in the Medicare program must be resolved. However, any action taken by Congress to address these problems must not jeopardize the Medicare program's guarantee of affordable health insurance protection for people over 65 and adults with disabilities. In particular, we are concerned that spending cuts not reduce necessary health services or lead to increased deductibles and copayments for Medicare beneficiaries.

We believe it is inadvisable to cut Medicare further or to restructure the program without simultaneously addressing the larger systemic problems in the U.S. health care system. Medicare's problems are symptomatic of the general failure of the U.S. to guarantee affordable health insurance protection for all individuals. Attempting to fix Medicare's problems alone could lead to unintended negative consequences, not only for Medicare beneficiaries, but for the health system generally.

MEDICAL SAVINGS ACCOUNTS

Many Members of Congress believe that Medical Savings Accounts (MSAs) have the potential to reduce health care costs and increase the number of Americans with insurance. There have been suggestions that MSAs be implemented not only in the private sector but in the Medicare program as well.

The Consortium for Citizens with Disabilities Health Task Force has major concerns with the emphasis presently being placed on Medical Savings Accounts as a solution to our health system's problems of access and affordability. The use of MSAs is not only untested, but also has the very strong potential for making comprehensive health insurance less affordable for persons with disabilities and serious chronic illnesses. *Because of our many concerns, which are discussed below, and in the absence of other reforms, the CCD Health Task Force does not support the establishment of MSAs as either an incremental reform or as a solution to the health care problems facing millions of uninsured and underinsured individuals in the U.S.*

Supporters of MSAs state that:

- MSAs will allow the marketplace, not the government to address the cost and access issue. By giving responsibility for paying for health care to consumers, it is assumed that MSAs will reduce unnecessary health care expenditures because individuals who are spending their own money will be more prudent purchasers. It is also assumed that the lower cost of catastrophic health insurance will lead more employers to offer health insurance.

- MSAs will lead to lower administrative costs because insurance companies will only be involved with claims higher than the deductible amount.

However, MSAs are untested, and it is not clear that they will either lower costs or improve access to services.

What are MSAs and How do they Work?

Medical Savings Accounts are tax-exempt savings accounts modeled on Individual Retirement Accounts that employed individuals can use to pay for health-related expenditures. State MSA laws generally create incentives for people to set up these accounts by exempting from state taxes the money contributed to these accounts. MSAs work like this:

- Employers can purchase a standard health insurance plan with a low deductible ($250 - $500 annually per person) or a catastrophic health insurance plan with a high deductible ($3000-$5000 annually per person). Because most people will not have health care costs higher than several thousand dollars, the premiums for high deductible catastrophic health insurance plans are much lower than for plans with low deductibles.

- An employer sets up a MSA for employees who want to participate in this type of plan and deposits, in pre-tax dollars, an amount equal to the difference between the cost of a standard low deductible plan and a catastrophic high deductible plan. The self-employed can also set up a MSA.

- Employees can use the money in their individual account for health care expenses. When the high deductible is met, the insurance company then pays the bills. If money is left in the account at the end of the year, it can be withdrawn and used for other purposes or carried over with accrued interest into the next year.

The CCD has several major concerns about MSAs:

- The catastrophic health plans that are purchased in conjunction with MSAs can impose pre-existing condition limitations and can refuse to cover persons with certain health conditions or disabilities.

- Catastrophic health plans with high deductibles often do not provide the comprehensive coverage needed by persons with serious illnesses or conditions. Some of these plans have lifetime or per condition limits of only $100,000.

- The American Academy of Actuaries has estimated that persons with high health expenses will experience major increases in out-of-pocket costs with MSAs. MSAs may also increase out-of-pocket costs if the amount employers contribute to the MSA is not sufficient to cover the annual catastrophic deductible. Additionally, the combined cost to the employer of an MSA contribution and the catastrophic heath plan premium may not be less than the cost of a standard health plan.

- If large numbers of individuals choose MSAs plus catastrophic health plans, the health insurance market will be further segmented, reducing the size of the population pool needed to spread risk adequately.

- MSAs will likely lead to adverse selection because they will be utilized primarily by younger, healthier people who do not anticipate a need for health care. Persons who anticipate health care expenditures, those who need comprehensive coverage, and those who are older and at higher risk for needing health care are likely to remain in standard low deductible health insurance plans. Individuals with MSAs could also change to a low-deductible plan when they become sick or anticipate medical bills (e.g., childbirth expenses), thus exacerbating the problem of adverse selection.

- Adverse selection will lead to higher premiums for persons in standard, low deductible health insurance plans. It has been estimated that if MSAs are widely adopted, the cost of a standard, low deductible health insurance policy would rise by as much as 26%. Increases of this magnitude will make comprehensive, low deductible insurance unaffordable both for employers and individuals who want to purchase these policies.

- There is no evidence that MSAs will make consumers more cost conscious when they are seriously ill. Physicians -- not consumers -- determine what treatment is needed. If surgery is recommended, consumers don't look for the cheapest surgeon, they look for the best surgeon.

- Some individuals may forgo preventive and early intervention services if they are allowed to use money left in their MSAs at the end of the year for personal expenses other than health care. This concern also raises the question of whether it is appropriate to allow pre-tax dollars to be used for non-health expenses.

- It is likely that catastrophic health plans will restrict the type of health care expenditures that will count towards the deductible. For example, if an individual spends $3000 on mental health services, there is no guarantee that all of these expenses will be counted towards the deductible, particularly if the insurance has limited coverage for these services.

- A majority of Americans are enrolled in some form of managed health care plan. It is unclear whether MSAs can be coordinated with these plans. Those opposed to managed care view MSAs as a means to maintain the market for indemnity insurance and fee-for-service health care delivery.

- Experience with MSAs is very limited. It is not clear whether they will result in savings. Some analysts predict that any potential system cost savings will be eliminated by the additional costs required to administer MSAs.

Most importantly, the CCD Health Task Force believes that allowing employers and the self-employed the option of establishing tax deductible MSAs in conjunction with high deductible catastrophic insurance coverage is not the solution to our nation's health system problems because:

- MSAs do not address the need for insurance by millions of working Americans whose employers will not contribute to the cost of health insurance; and

- MSAs do not address the need for insurance by millions of low-income individuals who are self-employed or unemployed and who cannot afford to buy health insurance.

Should you require additional information regarding this document or the CCD Health Task Force position, please contact one of the three CCD Co-Chairs listed below.

Janet O'Keeffe
American Psychological Association
202-336-5934

Peter Thomas
Amputee Coalition of America
202-466-6550

Kathy McGinley
The Arc (Association for Retarded Citizens)
202-785-3388

To: Mr. Phillip Moseley
Majority Chief of Staff
House Committee Ways and Means
1102 Longworth House Office Bldg (LHOB)
Washington, DC 20515

May 22nd, 1995

From: Thomas Fahrner
1174 Fremont St
Santa Clara, CA 95050-4816

Re: Medical Savings Account

Mr. Moseley,

I strongly support the idea of voluntary tax free medical savings accounts. I urge you to support the passage of such medical savings account legislation. I think it is a step in the right direction. It moves us closer to a system in which each person is responsible for their own medical care.

Sincerely,

Thomas Fahrner

Thomas Fahrner
h (408) 246-4976
w (408) 946-2304

Mark A. Hurt, MD
36 Four Seasons Ctr, Ste 334
Chesterfield, MO 63017-3103

Tel (314) 434.4878
FAX (314) 434.3890

Electronic Mail Addresses:
MarkHurt@aol.com

May 23, 1995

Mr. Phillip Moseley
Majority Chief of Staff
House Committee Ways and Means
1102 Longworth House Office Building, (LHOB)
Washington, DC 20515

RE: Medical Savings Accounts

Dear Mr. Moseley:

It is my understanding that the debate on the question of medical savings accounts (MSA's) is going to happen soon. I would like my statement of support for MSA's read into the *Congressional Record* for consideration by the Congress. I will call you at (202) 225.3625 on May 25 to follow up.

~~~~~~~~~~

Health care costs are a major concern of Americans today. No one, whether he is for, against, or undecided on the moral-political issue of individual rights or one's "right" to health care, considers health care costs a debatable issue; everyone acknowledges that costs are going up almost exponentially. Furthermore, the driving force behind health care costs is acknowledged almost universally: costs are related directly to the supply and demand of goods and services. The reason that health care costs are so high today is because there is a constant high demand for all types of health care that must be filled by relatively few, highly skilled, highly regulated (by government) providers, and paid for directly or indirectly by the government. The net result: costs that are ever increasing.

In recent years, there have been attempts to curtail the rising costs of health care, principally through managed care vehicles in the private sector, supported by the implicit and explicit threats of even *more* government regulation. With the Republican Contract with America and its aftermath, there has been a movement by the Congress to apply similar managed care methods to Medicare and Medicaid. This alone is not a rational solution to the problem. One cannot advocate, in good conscience, the use of government force to make people pay into a system all their lives and then suddenly invoke managed care tactics to make it difficult, if not impossible for them to obtain medical care, presumably that they have already paid for. Thus, medical savings accounts should be available to all
~~~~~~~~~~

Americans in order to bridge the transition from Medicare/Medicaid systems to a system financed by individuals without using the government as a third party payer. The MSA is a mechanism to phase out government interference into the medical markets.

The MSA is a financial vehicle that is ethically sound, in contrast to Medicare, Medicaid and the government's regulatory control of the private insurance industry. The MSA restores the political and economic power of an individual to retain property he has already earned: his money. An MSA, like an IRA, allows a person to accumulate, tax free, a certain annual amount of money for the purpose of paying for his health care as well as saving for his future. It offers him the incentive of using accrued money to pay for his medical bills out of pocket or, in the case of a medical crisis, it sets the economic stage favorable for the development of a market for individual, high deductible, catastrophic medical insurance.

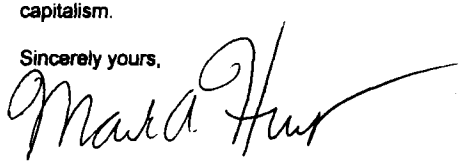
For those older individuals who have already paid into the Medicare/Medicaid system for many years, they could receive whatever benefits of the system as it exists but, in addition, could also begin sequestering their future earnings into an MSA for any future medical needs.

An MSA gives younger individuals an opportunity to take charge of their own health care before their money is removed and funneled into a third party payer system such as Medicare. Over the course of such an individual's life, he would be able to accumulate far more than any Medicare/Medicaid system could ever offer him -- *without the bureaucracy.* More fundamentally, he could save his money under a system of political freedom and voluntary action, rather than the current system of involuntary monetary expropriation via taxation by the government.

Mr. Moseley, I implore you and the Congress to consider seriously the moral and medical implications of MSA's for the future all Americans. It is morally right that a person in this country be able to retain that which he has earned. Happily, what is moral is also practical. When people spend their own money in seeking goods or services, they have a powerful personal incentive to search for the best services available at the lowest price, which ultimately will decrease the overall cost of providing health care to patients.

Health care that is "purchased" at the price of individual rights and political freedom is slavery. In reforming our health care system, we must reclaim America's philosophical foundation, which is individual liberty and its corresponding political-economic system: capitalism.

Sincerely yours,



Mark A. Hurt, MD

P. Michael Hutchins
911 North Road
Carlisle, MA 01741

22MAY95

Mr. Phillip Moseley
Majority Chief of Staff
House Committee Ways and Means
1102 Longworth House Office Building, (LHOB)
Washington, DC 20515

Mr. Moseley:

The institution of medical savings accounts would be an important step towards giving back some control over their future to the people who are the heart and engine of this country (those who produce the wealth that they need to live).

No medical system can work, long term, that is built upon a foundational structure that puts primary emphasis on entities other than the beneficiary paying for medical care. Before our wonderful, unequalled medical system is destroyed, please work to establish at least this tiny island of sanity.

Sincerely,

P Michael Hutchins

P. Michael Hutchins

May 22, 1995

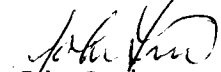
Mr. Phillip Moseley
Majority Chief of Staff
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Mr. Moseley,

I am strongly in favor of passing a bill to institute MEDICAL SAVINGS ACCOUNTS. It is the only way to take responsibility for myself and provide for my medical future. It's voluntary, tax free and it gives me the right to choose what kind of health care I want and when.

Remember---- HEALTH CARE IS NOT A RIGHT!!!

Sincerely,



John Lewis
1548 Middle Rd.
E. Greenwich, RI 02818

May 21, 1995

Larry Salzman
7500 Parkway Dr. #304
La Mesa, CA 91942

Mr. Phillip Mosley
Majority Chief of Staff
House Ways & Means Commitee
1102 LHOB
Washington, DC 20515

Dear Mr. Mosley,

As an American I have a strong interest in the future of freedom for our nation. As such, the recent debate concerning the adoption of socialized medicine is of grave concern to me. Fortunately, reason has temporarily prevailed on this issue. The real problems with our medical system which gave rise to President Clinton's ill-conceived solution, however, still exist. Costs have skyrocketed, many Americans do not have access to medical care and worse, doctors have come increasingly under control of onerous regulation - replacing the sanctity of their scientific judgment with the edicts of beauracrats and hospital administrators.

The above looms ominous in my desire for reliable, affordable, innovative medical care for me, my family and others I care for. I believe that freedom breeds prosperity and that prosperity is the prerequisite of innovation, affordability and reliability - in medicine as in all other human endeavors. The solution to our medical woes, therefore, must begin with the extension of freedom to this vital human need. Tax-Free Savings Accounts for individuals wishing to provide for their own medical expenses is a healthy first step toward extending freedom for medical consumers and providers. Please seriously consider the adoption of this modest first step into a free medical marketplace as you deliberate over how to solve the real problems with the medical system in the United States.

Sincerely,

Larry Salzman

Henry L. Solomon
77 Seventh Avenue – Apt 16V
New York, New York 10011
212-243-3364

May 23, 1995

Mr. Phillip Moseley
Majority Chief of Staff
House Committee Ways and Means
1102 Longworth House Office Buildings (LHOB)
Washington, DC 20515

Dear Mr. Moseley,

I would like to express my full support for Tax Free Voluntary Medical Savings Accounts as an important step forward in getting ~~the~~ government out of the business of making potentially life and death medical decisions on behalf of free citizens who should be left free to use their own independent judgement to lead their own lives, and seek their own happiness as befits a free people

Sincerely,
Henry C. Solomon

○