Approved March 16, 1992
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 ~~a.m.~~/p.m. on March 4, 1992 in room 123 S of the Capitol.

All members were present except:
Representative Sebelius - Excused
Representative Welshimer - Excused
Representative Cornfield - Excused
Committee staff present:
Mr. Fred Carman, Revisor
Mrs. Emalene Correll, Research
Mr. Chris Courtwright, Research
Mrs. Nikki Feuerborn, Secretary

Conferees appearing before the committee:
Rep. Walker Hendrix
Rep. Wanda Fuller
Rep. Robert Miller
Mr. Jim Schwartz, Kansas Employer Coalition on Health
Mr. George Goebel, Capitol City Task Force of the AARP
Mr. Brad Smoot, BC/BS and KS Association of Health Maintenance Organizations

Hearing on HB 3026 - Universal health care access act.

Mrs. Emalene Correll gave the staff review for this proposed comprehensive, statewide health insurance coverage for residents of the state.

Representative Walker Hendrix, an author of the bill, spoke as a proponent of this health care reform bill. At least 500,000 persons in Kansas have no health insurance and many times do not pay for their treatment thus causing rising care costs. By the year 2000, it is estimated that our national annual health care costs will rise to $1.5 trillion. This plan provides for cost containment through the regulation of health insurance premiums and the encouragement of managed care. The plan provides a "pay or play" concept. This basically allows employers and individuals the opportunity to provide health care coverage or contribute to the Kansas health services trust fund. There is a tax component if you are an employer that does not have health care coverage. There is also a tax imposed on individuals who do not have health care coverage. The employer and the employee are called upon to make relatively equal contributions. The bill provides for small group coverage and community ratings. Individuals who do not have insurance will receive vouchers to purchase health care insurance from the carrier of their choice. (See Attachment 1).

The committee questioned the advisability of a 24 month residency requirement being long enough for eligibility for enrollment. It was also asked if rejection by an insurance company would be a prerequisite for being accepted into the program. It was suggested that an actual residence address be required rather than the use of a P.O. Box number.

Representative Wanda Fuller, co-author of the bill, appeared before the committee. She gave shocking facts regarding costs of individual health care and the total amounts spent in the United States. The 37 million Americans without medical insurance cause delayed and neglected access to needed care, as well as leading to uncompensated services by providers and an undesirable level of cost shifting to paying patients. More and more working Americans earn too much money to qualify for Medicaid but too little to afford care. She cited inadequacies of Medicaid and Medicare. Partial blame for exorbitant health care costs was placed on corporate America because the cost has been a tax write-off. She urged favorable consideration of **HB 3026** in order to provide access to health care services to all residents of Kansas who are not covered by medical and health insurance. (See Attachment 2).

Representative Robert Miller urged the passage of this proposed legislation.

Mr. Jim Schwartz, consulting director of the Kansas Employer Coalition on Health, Inc., testified on behalf of **HB 3026.** This bill assures that every Kansas, regardless of economic status, will be insured against large health-care costs. It also limits the cost of health care purchased through private insurance. One of the precepts of this bill is to make use of what is good in the current system and to achieve the goals of access and cost containment with a minimum of government regulation. Simply by restraining increases in insurance rates, the bill creates a budget for health care purchased by insurance. **HB 3026** supplies an environment where the primary function of insurance companies is to supervise, organize and help coordinate the sprawling health-care industry into real systems. (See Attachment 3).

During committee questions of Mr. Schwartz, it was determined that access to this program could be cost prohibitive through language used in the bill.

Mr. George Goebel, chairman of the Capitol City Task Force of the American Association of Retired Persons, spoke on behalf of the bill. For a universal access health care program to be affordable, the program must have strict cost controls, malpractice reforms, and elimination of waste and duplication. It should assure access to the full range of prevention, prescription drug, acute and long-term care benefits. (See Attachment 4).

Mr. Brad Smoot, Kansas Association of Health Maintenance Organization and Blue Cross/Blue Shield, endorsed the concept of the bill.

The hearing will be continued at a date to be announced later.

The meeting adjourned at 5:10 p.m.

GUEST LIST

COMMITTEE: House Insurance DATE: 3-4-92

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Dick Brock	Topeka	Ins Dept.
Meyer L Goldman	Kansas City	Humana Health Plans
Brad Smoot	Topeka	BCBS / KHMO Assn
Bill Pitsenberger	Topeka	Blue Cross & Blue Shield of Ks
Priscilla Marsh	Leawood	League of Women Voters
Patricia Martin	Kansas City	" "
Joe Furjanic	Topeka	K.C.A
[illegible]	McAlester	Alliance Ins Co
[illegible]	Hutchinson	Alliance Ins Cos
Terry Leatherman	Topeka	KCCI
David Hanson	Topeka	Ks Life Assoc.
Larry Magill	Topeka	IIAK
Lee Wright	Overland Park	Farmers Ins.
Bill Sneed	Topeka	HIAA / State Farm

STATE OF KANSAS

WALKER HENDRIX
REPRESENTATIVE, 10TH DISTRICT
FRANKLIN COUNTY
121 W. 3RD
P.O. BOX 787
OTTAWA, KANSAS 66067
(913) 242-8568

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: ENERGY AND NATURAL RESOURCES
LEGISLATIVE, JUDICIAL AND
CONGRESSIONAL APPORTIONMENT
LOCAL GOVERNMENT
PENSIONS, INVESTMENTS AND BENEFITS

HEALTH CARE REFORM
(H.B. 3026)

I know of no issue that can create as much conversation and emotion than health care. At my local forums, if there were no time constraints, we could talk endlessly about health care and its cost. Whether you are the single working mother who is frightened by not having or not being able to afford health coverage, whether you are the small employer who cannot get group coverage, whether you are the medicare recepient that agonizes over the cost of prescription drugs or whether you are the self-insured major company with HMO's and PPO's, the issue of health care dominates discussions. We, as public policymakers, cannot afford the luxury of burying our heads in the sand about this issue. We must respond to the needs of our people by pulling up our britches and sucking in our guts. We need to deliver on the health care issue.

It is estimated that over 500,000 individuals do not have health care coverage in Kansas. These uninsured people have caused health costs to go up because their treatment at emergency rooms and elsewhere goes uncompensated. Other factors have impacted costs as well. It is predicted that health care costs in the United States will increase by 14 percent during 1992. It is estimated that health care costs will rise an average of 12 to 13 percent a year. Government statistics indicate that hospital care will jump almost 11 percent in 1992 to $313 billion and physician services will increase by 11 percent to $155 billion.

Major reform is necessary to hault skyrocketing health care costs. Health care has gotten too expensive. We, as a nation, will spend over $700 billion on health care this year. By the year 2000, it is estimated that our annual health care costs will rise to $1.5 trillion. From 1989 to 1990, health care costs per employee have increased from $2,748 to $3,217 on the average.

H. B. 3026 is not a new concept. The ideas embodied in the bill were endorsed by the Hayden and Finney task forces. The ideas incorporated in the bill should be enacted without delay. The time for intellectual discussion is over. In order to fully implement this plan, an ERISA waiver must be obtained. The universal access provisions, therefore, are not self-effectuating and considerable work will be required to obtain the waiver. This bill will put into motion the effort to make universal health care in Kansas a reality.

House Ins.
3-4-92
Attachment 1

I have borrowed liberally from the concepts and ideas that have been devloped by Jim Schwartz at the Kansas Employer Coalition on Health, Inc. His input and development have been invaluable. The plan provides for cost containment through the regulation of health insurance premiums and the encouragement of managed care. The plan provides a "pay or play" concept. This basically allows employers and individuals the opportunity to provide health care coverage or contribute to the Kansas health services trust fund. There is a tax component if you are an employer that does not provide health care coverage. There is also a tax imposed on individuals who do not have health care coverage. The employer and the employee are called upon to make relatively equal contributions. Because health care insurance has traditionally been provided at the place of employment, the focus for providing health care coverage is still within the traditional group approach.

The bill provides for small group coverage and community ratings. Individuals who do not have insurance will receive vouchers to purchase health care insurance from the carrier of their choice.

By providing for universal access, health care for all Kansans will be compensated. Through the regulation of insurance premium rates, costs will be contained. The plan will not displace any of the traditional sectors of health care industry. It will require providers and carriers to be more efficient. The alternative to acting now and utilizing the traditional forms of health care service is some centralized governmental health care plan. I hope that this development does not take place. I ask for your consideration and favorable passage.

TESTIMONY ON HB 3026 before the HOUSE INSURANCE COMMITTEE on Wednesday, March 4, 1992, by Representative Wanda Fuller, 87th District

There are two kinds of prices in America today: regular prices and health-care prices. The first kind seems to follow some sensible laws of supply and demand. But America's medical bills are something else. They flow from a surreal world where science has lost connection with reality, where bureaucracy and paperwork have no limit, where a half-hour tonsillectomy costs what an average worker earns in three weeks. The prices, like the system that issues them, are out of control.

Examples:

* Annual dose of human growth hormone for a child with a severe deficiency; $20,000.
* Coronary bypass surgery for a 50-year old man: $49,000.
* Cost of a Bufferin tablet for a patient in a psychiatric hospital: $3.75.
* Price of a modified radical mastectomy: $7,900.
* One day's intensive care for a crack baby: $2,000.
* A 50-minute session with an elite psychotherapist: $160.
* Delivery of a baby by Caesarean section: $7,500.

Americans spend $23,000 a second on medical care, more than $2 billion a day, $733 billion a year. That is nearly twice what they spent seven years ago, including annual increases of 10% during the past two years.

Unchecked, the U.S. medical bill will more than double in the next 10 years, to $1.6 trillion, crowding out spending for other urgent needs.

The present methods of funding and providing health care throughout most of the United States (including Kansas) have allowed or contributed to the emergence of several serious problems:

Health care costs have increased at an alarming rate throughtout the 1980s, far outstripping the overall inflation rate and doubling approximately every 6 years (WASHINGTON POST, January 8, 1989).

<u>500,000 Kansans* (21%) and over 37 million Americans are without any medical insurance.</u> Besides causing delayed and neglected access to needed care, such lack of coverage leads to uncompensated services by providers and an undesirable level of cost shifting to paying patients.

House Insurance
Attachment 2
3-4-92

About 1 out of 9 American working families has no health insurance at all. Most of the un-insured are the families of workers in small firms that do not offer such coverage. Among the uninsured are an estimated 8 million American children growing up without adequate medical and dental care.

Medicaid is supposed to insure those who cannot pay for coverage. However, hard-pressed states have found it increasingly difficult to pay for the program (they put up 68% of the total money), and they have tightened eligibility standards. As a result, more and more working Americans earn too much money to qualify but too little to afford care.

Medicaid doesn't do a very good job because the rules governing the delivery of care are unrealistic and wasteful, often requiring hospitalization, for example, where out-patient treatment would suffice. Moreover, many doctors refuse to treat Medicaid patients because of rock-bottom reimbursement and the snarl of bureaucratic rules.

The $110 billion Medicare program - which started out 26 years ago with a budget of $5 billion - was designed to provide decent care for the elderly. But the program gives the same benefits to those who are well-off as to the elderly poor. Though the elderly do pay some of the costs - and staunchly resist bearing more of them - nearly 90% of Medicare funds come from payroll taxes on workers. As a result, the burden falls partly on laborers who have no health insurance of their own and may have trouble making ends meet.

The burden on younger Americans to pay for Medicare is growing more onerous as the U.S. population ages, bringing with it the responsibility of caring for millions of elderly with enormously expensive medical needs. There are now about seven Americans under the age of 65 for every person over that threshold, compared with 11 to 1 in 1960. One of those younger Americans is unemployed, and two are children. That leaves about four workers to support each elderly American. And one of those doesn't even have his own health insurance.

Taxpayers, even those who have no insurance, spend an estimated $84 billion a year to subsidize medical care for mostly middle-and upper-class Americans. That is because companies can write off every dollar they spend on health care as a business expense, which may help explain why corporate America did so little to contain the costs until they got out of hand. At the same time, employees who enjoy generous benefits plans pay no taxes

on the thousands of dollars in health-care coverage that their companies provide for them.

<u>The 500,000 Kansans without any medical insurance need our help now!!!!</u>

Major changes in the health care system can no longer be put on hold. Further analysis will neither change the facts nor diminish the problems.

HB 3026, creating the Kansas universal health care access act, will provide access to health care services to all residents of the state who are <u>not</u> covered by medical and health insurance.

I urge you to give favorable consideration to HB 3026.

References:

TIME/NOVEMBER 25, 1991 Nation Condition: Critical by Janice Castro

JAMA The Journal of the American Medical Association, May 15, 1991, Volume 265 Reform of U.S. Health Care System - Kansas Employer Coalition on Health, Task Force on Long-term Solutions

* Kansas Commission on Access to Services for the Medically Indigent and Homeless. Report and Recommendations on Access to Services for the Medically Indigent and Homeless. Topeka, Kan: Kansas Dept. of Legislative Reserarch; 1989:4.

Kansas Employer Coalition on Health, Inc.
1271 S.W. Harrison • Topeka, Kansas 66612 • (913) 233-0351

Testimony to House Insurance Committee on HB 3026

(universal access and cost containment)

by James P. Schwartz Jr.
Consulting Director
March 4, 1992

I am Jim Schwartz, consulting director for the Kansas Employer Coalition on Health. The Coalition is 100 employers across Kansas who share concerns about the cost-effectiveness of health care for our 350,000 Kansas employees and dependents.

We realize as well as any group that the health-care system is in crisis and in need of fundamental restructuring. The problem of spiraling costs has been our central concern since our founding in 1983. The kindred problem of large numbers of uninsureds has been a focus since 1987. In 1990, after years of careful study, we published a paper outlining a reform strategy. For that effort we received a national award. Last year our paper was published in the Journal of the American Medical Association and presented before the National Press Club in Washington, DC. Our strategy has been praised as politically moderate, balanced and do-able.

HB 3026 is fashioned very closely after this coalition's strategy. To be sure, not all coalition members will support this bill. It's likely that few employers would endorse every element. Still, the general feeling of our leadership is that the bill, as a whole, represents a big step in the right direction.

What would the bill do? Two things, basically. First, it assures that every Kansan, regardless of economic status, will be insured against large health-care costs. Second, it limits the cost of health care purchased through private insurance. As important as *what* it does is *how* it does it. One of the precepts of this bill is to make use of what's good in the current system. Another precept is to achieve the goals of access and cost containment with a minimum of government regulation. We think those two precepts distinguish this legislation from others, like SB 553, which would accomplish the same ends with much more radical means.

House Ins.
3-4-92
Attachment 3

Though ambitious, this bill offers a politically moderate approach by building on the tradition of employer-sponsored insurance. If we were going to build a system from scratch, given what we know today, we probably would steer clear of linking health insurance to the workplace. But we're not starting from scratch. The relationships between labor and management concerning health care are deep. So are relationships between employers, insurers, and providers. Rather than try to tear up all those roots, we believe the best approach is to work within the system that has served the vast majority of Kansans quite well for a long time. HB 3026 builds on the tradition of employer sponsorship by requiring all Kansas employers to contribute to the cost of health insurance. They can do that either by sponsoring coverage directly or by paying on a sliding scale to a fund. That fund would subsidize private insurance for all uninsureds. An equal obligation would fall to individuals, to either participate in a health plan or pay an income-related tax. That tax would fund placement of those individuals into private plans. A voucher system would allow a degree of selection among qualifying plans. A 2% "brother's keeper" tax on all plans would make up the shortfall due to sliding scales.

Employers who don't presently sponsor plans may resist having to contribute. In a sense, those employers have been taking a free ride on the generosity of responsible companies who do provide coverage. When uninsured patients receive treatment, those costs are generally shifted to insured patients. This hidden tax is no longer supportable. We need a system that handles subsidization in an above-board, accountable way. We need a system that spreads the cost of care broadly, so no individual or group bears a disproportionate load. The alternative to requiring employer contribution is to place the full load on individuals. That's not how we generally fund social programs in this country. For good reasons we usually require a sharing of cost between individuals and companies. That's the approach taken by HB 3026.

This bill is called the "Kansas Universal Health Care Access Act." A better name would be the "Kansas Universal Health Care Access *and Cost Containment Act*." Besides a universal access component, the bill contains a brilliant cost-containment methodology. It's brilliant for its simplicity, its small role for government, its impetus for managed care, and its positive implications for quality. Simply by restraining increases in insurance rates, the bill creates a budget for health care purchased by insurance. Rate regulation is a small role for government compared to the alternative of having government micro-manage the health industry through complex fee schedules. That's what Medicare does now. I'd hope

that our experience with Medicare would help us avoid recreating that degree of public jurisdiction. Instead of micro-managing the system at the provider level, HB 3026 applies its budget upstream in the funding process, at the insurance level. The necessary response by insurers would be to form joint ventures with providers for highly integrated networks of managed care. Most insurers could not accomplish this. But some could. We believe that having a few choices among health plans is preferable to having a single state-run plan.

The cost-containment provisions in the bill will be tough for traditional insurers to abide. Insurers that simply act as conduits of funds, perennially passing along higher costs in the form of rate increases, should fear this bill. Their clients, though, have grown tired of such lack of added value to the system. That's one reason why so many employers have gone to self insurance or managed care plans. What we need, and what 3026 supplies, is an environment where the primary function of insurance companies is to supervise, organize, and help coordinate the sprawling health-care industry into real systems. Those systems, operating on a limited budget, will have to make the tough decisions about how many MRIs are needed in a community, how much doctors are paid, what procedures are most effective for an illness, and whether we really need a new wing on the hospital. Those choices must be made — either by a government agency or by organized systems competing for quality, price and service. We vastly prefer the latter, operating within a light-handed regulatory framework.

HB 3026 is exceptional for its balance. Every party gives up something but gets something in return. For individuals, the plusses are universal coverage, choice of plan, and a sliding scale for low income. The minuses are premium sharing and copayments. For employers the plusses are cost containment and more uniformity of rates. The minuses are the pay-or-play mandate and loss of experience rating. For health-care providers the plus is that every patient is a paying patient. The minuses are oversight by managed care and limits on funding. For insurers the plusses are that there is a meaningful role for them and that the number of covered lives will be increased. The minuses are capped rates and consolidation. For government the plusses are universal access, continuity with the existing system, equity among consumers, and simplicity of cost containment. The minus is the pain that accompanies change.

Some opponents of this kind of reform believe that less ambitious measures are required. They point to small group insurance reforms, as in SB 561, as the answer. Let's be clear about the distinction. SB 561 will do little to reduce the number of uninsureds. Nor will it

affect overall health-care costs. All it does is level the playing field somewhat. That's important, and HB 3026 includes those provisions as well. But if our aim is to assure access and cost containment, we have to do more.

Some opponents of comprehensive reform claim that managed care, alone or coupled with small group reform, is the answer. Managed care is part of the answer, and 3026 contains powerful incentives for accelerating that trend. But managed care doesn't expand access. And it has never approached its potential for savings in the absence of an overall health-care budget. HB 3026 supplies that budget.

Like any major legislation that is newly arrived, HB 3026 poses questions on many levels. On the technical level, it must be demonstrated that the funding is adequate. It must be shown that the phase-in requirements are appropriate. Enforcement provisions must be clarified. On a broad level, we need agreement on whether Kansas should wait for federal initiatives in health system reform — or whether we should proceed with a state initiative. It must be noted that special obstacles exist on the state level that are not as problematic on the national level. Some examples are problems relating to eligibility, out-of-state care, conflicting federal laws, and threat of boycotts by providers, insurers or employers.

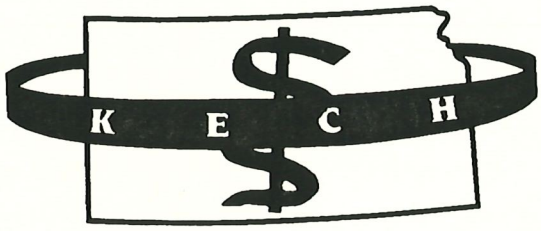
It will take time to digest all the implications of this bill. But since the public is demanding solutions , it's not too soon to give this bill serious study. In my judgement, the 403 Commission will conclude similarly to the Hayden and Finney task forces: that comprehensive health reform is necessary and that a politically moderate approach is advisable. It is also likely that if President Bush is re-elected, the job of revamping the system will devolve to the states. If those events transpire, Kansas will be in a better position to respond if we have worked hard on this bill.

Virtually all of us agree on the goals of universal access at a controlled and widely distributed cost. HB 3026 provides a way to achieve those goals with a reliable role for all current players and a balance of responsibility between the public and private sectors. It deserves an honorable welcome into the realm of public debate.

A Framework for Reform of the U.S. Healthcare Financing and Delivery System

by the
Kansas Employer Coalition on Health, Inc.

January 1992



Kansas Employer Coalition
on Health, Inc.
1271 Harrison
Topeka, Kansas 66612
James P. Schwartz Jr.,
Consulting Director
913-233-0351

Page 5 of 3

Preface

There comes a time in the debate of any major issue when the call to action sounds louder than one's fears. The debate on healthcare costs and access is rapidly reaching that point.

Concerned that government might react to that call with a reflexive solution that most employers could find unpalatable, the Kansas Employer Coalition on Health resolved to provide thoughtful, grassroots leadership toward a fair and feasible solution.

The Kansas Employer Coalition on Health is a statewide, not-for-profit membership organization of over 100 corporations, including business, insurance, healthcare providers, professional associations, labor, and municipal groups. Through coalition membership, those companies share experience, information and concern about the value and affordability of employee healthcare.

Setting aside prospects for narrow, temporary gain, the coalition's Board of Directors supports a comprehensive restructuring of the healthcare system on a state or national level. That restructuring should, we believe, assure access to basic health services for every American and involve a broadly distributed cost that is explicitly limited.

After much deliberation, including review of a membership opinion survey, a majority of the board of directors has endorsed the principles and general strategies contained in this document. No one, including this Board, agrees with every detail in this document, yet it was the feeling of the majority that this strategy offers a blueprint for an effective middle ground between the status quo and national health insurance. We feel strongly that measures such as these ought to be tried before attempting to solve the crisis at the expense of any single party, be it government, business, insurance, healthcare providers or individuals. This framework describes a balanced role for all these parties. Accommodation is required of each. In return, each is rewarded with equitable access, incentives for quality care, and long-term financial stability.

To our knowledge, this strategy is the first by a business/health coalition to set forth concrete recommendations for cost containment and universal access. What's more, it may be the first healthcare reform paper by any source to enjoy the endorsement of a broad-based, grassroots organization.

This Board hopes that policy makers will appreciate the appropriateness of the proposal and accept this contribution to the national debate on the future of U.S. healthcare.

For the Kansas Employer Coalition on Health, Inc.

Gary Bahr

Gary Bahr, Chairman
July 1990

Long-Term Solutions Task Force

Melissa Levy Hungerford
Vice-President
Kansas Hospital Association

John Knack
Senior Vice-President, External Affairs
BlueCross/Blue Shield of Kansas

Thomas M. Palace
Executive Vice-President
Savings League Services, Inc.

Thomas Plumberg
Manager, Compensation and Benefits
Hill's Pet Products

Walter D. Rogers
Chairman
Family Health Plan

James Slover, R.N.
President
Healthcheck, Inc.

Staff: James Schwartz

A Framework for Reform of the U.S. Healthcare Financing and Delivery System

by the

Kansas Employer Coalition on Health, Inc.

January 1992

Abstract:

A task force of Kansas business/health coalition members has prepared recommendations for alleviating the most pressing problems associated with the funding and delivery of healthcare in the United States.

Those problems, which the authors consider interrelated, include rising costs, inequitable access, and variable quality. The recommendations constitute a comprehensive approach to restructuring the system on a state or federal level, yet build on existing institutions and systems to a large extent.

Recommendations are offered for 1) universal health insurance coverage through employer-based plans and a publicly sponsored plan, 2) regulation of insurance rate increases by a formula closely tracking the Consumer Price Index, 3) patient participation in a portion of insurance and treatment costs, 4) insurance industry reforms, and 5) governmental monitoring of quality and support for medical research into preferred methods of treatment.

Although not every coalition member supports every recommendation, the board of directors of the Kansas Employer Coalition on Health, Inc., in July 1990, endorsed the principles and general strategies contained in this document .

Background:

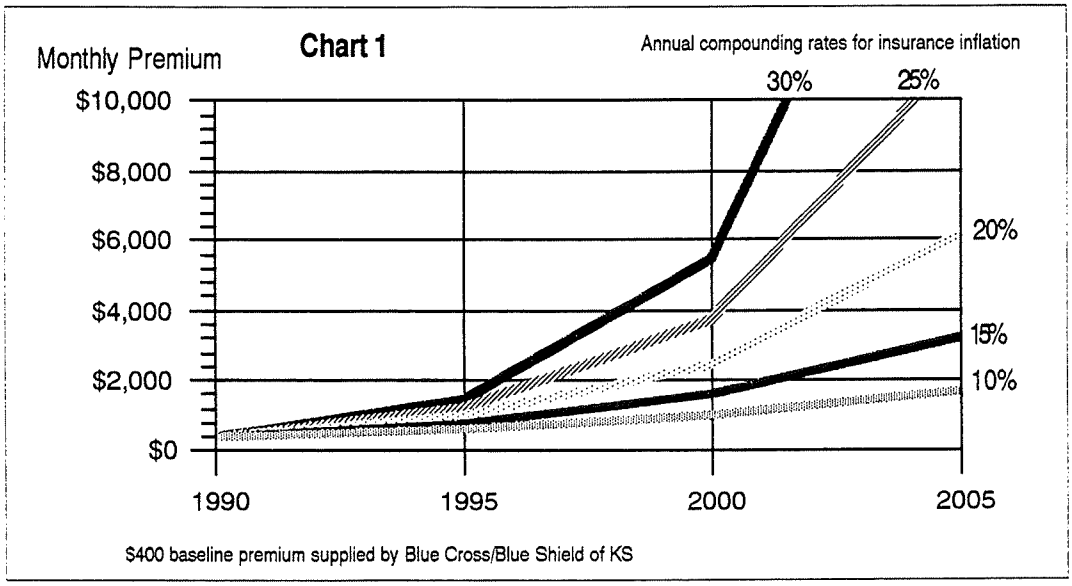
Representing 100 businesses, insurers, providers and other employers throughout Kansas, the Kansas Employer Coalition on Health is the state's primary voice for employers in matters of health policy.

In 1987 the coalition's board resolved to supply private-sector leadership to solving the problem of large numbers of uninsured Americans. When an internal committee presented a universal-access model, the board returned it to the committee with instructions to include provisions for cost containment. In July 1990 the board endorsed the principles and general strategies of the framework that follows.

The present methods of funding and delivering healthcare throughout most of the United States (including Kansas) have allowed or contributed to the emergence of several serious problems:

1) Healthcare costs have increased at an alarming rate throughout the 1980's, far outstripping the overall inflation rate and doubling approximately every six years.

2) As many as 500,000 Kansans[1] (21%) and over 30 million Americans[2] are without any insurance against the cost of medical care. Besides causing delayed and neglected access to needed



Effects of Insurance Inflation Factors on Monthly Family Premiums

care, such lack of coverage leads to uncompensated services by providers and an undesirable level of cost-shifting to paying patients.

3) Morbidity and mortality statistics for the United States are unenviable compared to those of other developed countries, despite this country's leading role in healthcare spending.

Healthcare observers generally concede that market forces of the 1980's have failed to deal successfully and permanently with the problems of cost, access and quality (table 1).

Recognizing the need for private sector leadership the Kansas Employer Coalition on Health asked its Governmental Affairs Committee to seek long-term solutions.

That committee formed a Long-Term Solutions Task Force in April 1989, represented by two members each from business, insurance, and providers, with assistance from KECH staff.

The group began by identifying the major problems facing healthcare purchasers today. The problems of cost, access, quality and demand were explored in considerable detail. The group placed particular attention on the question of why supply-and-demand economic forces had failed to control healthcare costs. Many answers to that question emerged, including 1) separation of payer and vendor by virtue of insurance, 2) ability of some patients to receive treatment without paying, 3) provider-created demand for services (providers influence the amount of care dispensed), 4) commonplace attitudes among patients that only the best care is acceptable and that more care is better care, 5) lack of data for consumers on prices and quality of services, 6) lack of rational consumerism on the part of sick and frightened patients, and 7) a common consumer view of responsibility for health as lying with the system rather than with personal lifestyles and health habits.

The group explored domestic proposals for reform, as well as a number of foreign systems: Canadian, western European and Pacific rim. Because of cultural differences between these countries and the United States, none of these systems appeared directly applicable to this country.

A consensus emerged within the group that the problems of cost, access and quality are interrelated. Further, the group came to view the prospects for long-term solutions as more favorable within the context of a comprehensive restructuring of the system. Simply expanding the current system and amplifying present cost-containment techniques would likely prove inadequate. The committee felt that comprehensive reform could succeed on a state level but that a national initiative would be preferable. The advantages of a national approach include smoother handling of state border discrepancies, multi-state logistics for employers, and conflicting federal laws.

The group reached agreement that lasting solutions must include making difficult choices. Those choices must reflect priorities for funding societal needs, including housing, education, defense, transportation, and retirement security, to name only a few. Given that funding available for healthcare is finite, some rational method must be devised to assure that healthcare resources are applied so as to render the best possible health outcomes for the dollar—for the citizenry as a whole. Such a choice carries with it the result that not all possible services will be funded; services of marginal value would have to be sacrificed in favor of those that give more benefit for the expense.

The committee recognized that the funding relationships in the present system carry a heavy burden of administrative complexity. In addition, the diffusion of purchasing authority dilutes clout necessary to control costs.

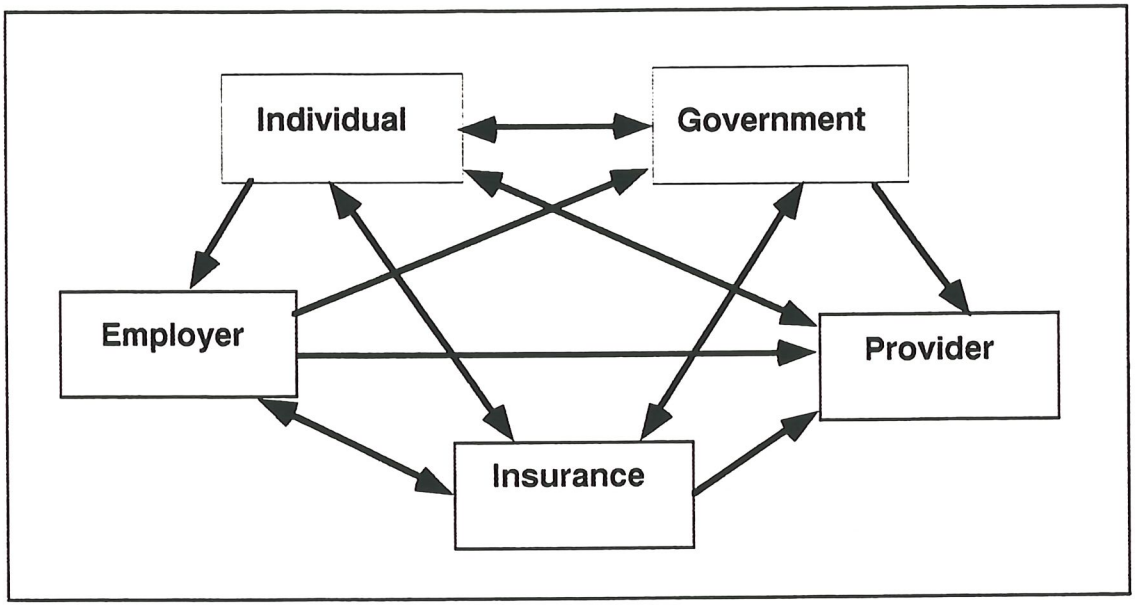
The group came to recognize that a healthcare system involving a single payer has advantages in terms of administrative streamlining and clout for controlling costs. At the same time, it was acknowledged that since the single payer would likely be government, any proposal for such a system would have to contend with a deep skepticism in U.S. society about government's ability to operate such a sensitive system.

Determined to begin with an approach that minimizes the role of government and yet achieves reform of the system, the committee agreed that an evolutionary approach—building on existing foundations—is desirable, possible and, in all

Table 1

Why have competitive forces failed to control costs?

- separation of payer and vendor by virtue of insurance;
- ability of some patients to receive treatment without paying;
- provider-created demand for services (providers influence the amount of care dispensed);
- commonplace attitudes among patients that only the best care is acceptable and that more care is better care;
- lack of usable data for consumers on prices and quality of services;
- a lack of rational consumerism on the part of sick and frightened patients;
- a common consumer view of responsibility for health as lying with the system rather than with personal lifestyles and health habits.



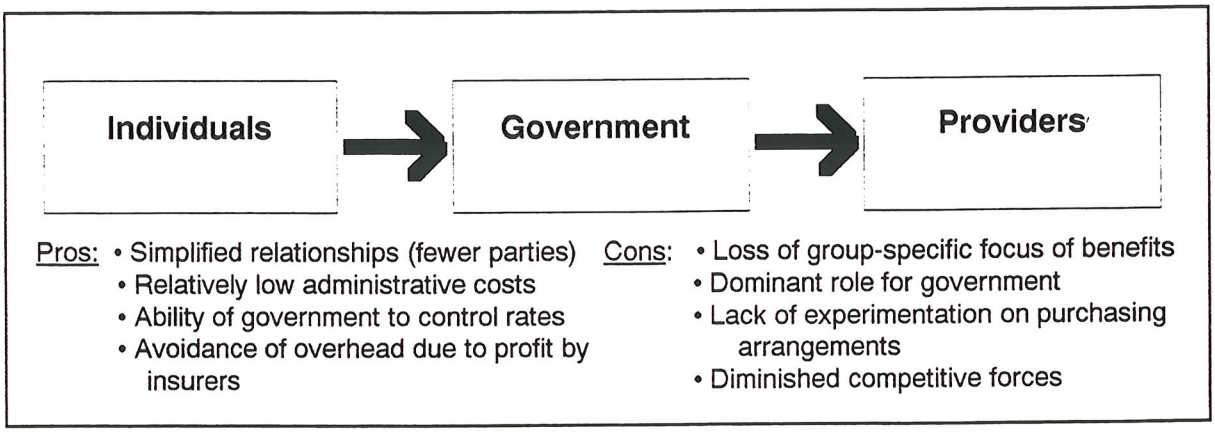
Flow of funds in the "pluralistic" US healthcare system

likelihood, politically necessary. The goal became to envision new relationships among existing parties such that 1) competitive forces operate to trim and energize the system and 2) governmental activities supplement competition by defining limits and assuring equity.

If, however, reform involving multiple payers fails to contain costs, then a single-payer system involving a stronger governmental role will likely be required.

After many months of discussion, the group concurred on a set of principles for action. Those principles, tempered by recognition of some political realities, societal constraints, and a spirit of give and take, led to the formation of a set of recommendations for restructuring the state or national healthcare funding and delivery systems.

The recommendations, while subject to modification, form a cohesive structure that one may best appreciate in its entirety.



Flow of Funds in a Typical Single-Payer Health Insurance System

Page 11 of 3

Principles

1. **Each citizen or citizen's family has a responsibility to secure financial protection against major healthcare costs and so should participate in a comprehensive plan of health insurance.**

2. **Each citizen has a responsibility, means permitting, to share in the cost of his or her insurance plan.**

3. **Each citizen has a responsibility, means permitting, to share in the cost of every episode of care.**

4. **Because healthcare is fundamental to the productivity, independence and well-being of the citizenry, the public has a responsibility to assure that basic healthcare is available to its members, regardless of economic status.**

5. **The insurance system should spread the risks for medical expenses across the widest practical base, thus assuring that no individual or group bears a disproportionate exposure.**

6. **Proposals for system reform should build upon current structures to a maximum extent consistent with achieving control of costs, access and quality.**

7. **Proposals for system reform should minimize reliance on regulatory controls, consistent with goals for costs, access and quality.**

Recommendations and Rationale

1) Establish a system in which each citizen or citizen's family not eligible for Medicare subscribes either to his or her employer's health plan or, by default, to a publicly sponsored plan.

The American public perceives healthcare as fundamental to the productivity, independence, and well-being of the citizenry. It follows that, to secure such a basic good, the public bears a responsibility to assure access to a reasonable level of healthcare for all its members, regardless of economic status. Those who minimize the responsibility of society to individuals in this regard still tend to concede the value to society of providing basic treatment in order to prevent expensive emergency care.

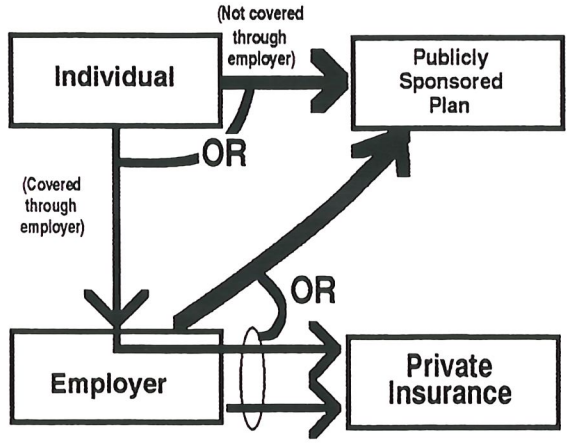
For these reasons, a key tenet of this framework is to enroll each citizen in a broad plan of health insurance coverage. Each individual or family would be expected to show evidence of health insurance (perhaps accompanying a tax return). Failure to do so would trigger a tax to help support a publicly sponsored plan, in which that person would be enrolled by default.

Individuals and dependents who have access to a qualifying employer-sponsored plan would be required by law to enroll in one such plan.

In order to apply cost containment (discussed below) across a broad range of medical services, the coverage must have corresponding breath. Failing to make the coverage broad simply invites continued escalation of costs for uncovered services. Thus it is recommended that the minimum breadth of coverage be similar to that of the HMO Act or Medicare.

One may well question the appropriateness and utility of having employers sponsor health plans. From a practical standpoint, however, an evolutionary approach to achieving universal coverage seems advisable, building upon existing employer-insurance relationships. Thus it is recommended that employers have an option either to provide coverage or to pay a tax to help support a publicly sponsored plan.

Individuals would be required to help support their plan participation through either premium sharing (in the case of employer-sponsored plans) or taxation (in the case of the publicly sponsored plan).



Notes:

- Individuals eligible for employer plan enroll in that plan. Others default to the Publicly Sponsored Plan and pay tax to support it, means permitting, .
- Individuals in employer plan pay some contribution to premium.
- Employers that offer insurance contribute to premium. Others pay tax to support public plan.

Flow of funds between Individuals, Employers and Insurance

Page 13 of 3

Currently, many uninsured individuals could afford to pay some fraction of the cost of insurance. Instead, under the present system, their large medical expenses must be shifted to the insured population. Thus by requiring individual participation (means permitting) in the cost of insurance, costs would more equitably be spread among those who are able to bear them. Moreover, a requirement for individual premium sharing would make patients more cognizant of costs and, presumably, wiser purchasers of care.

Detailed funding schemes that satisfy these requirements have been articulated by the National Leadership Commission on Health Care[3]; Enthoven and Kronick[4]; and The Pepper Commission[5].

The operation of the publicly sponsored plan could be contracted to private carriers or to private fiscal intermediaries for administrative services. Failing successful private management, the plan could be administered directly by government. In any case, state Medicaid programs could be folded into the public plan.

Taxes on individuals for the publicly sponsored plan would reflect income (and perhaps asset) level, probably with some realistic cap on taxable amount.

In all likelihood, existing forces will maintain a strong commitment by employers to providing coverage. Those forces include the need to attract labor by offering a contribution to insurance premiums, as well as tax deductibility of those contributions. In addition, employers would be free to offer private, supplemental insurance for conditions not covered in the basic plan.

2) Establish a mechanism by which the state (or the federal government) determines a single maximum annual percentage of premium increase (or taxation increase in the case of the publicly sponsored plan) for all health insurance plans.

The concept of a budget is fundamental to healthcare cost containment[6]. An expeditious way to achieve a budget without inviting government to assign roles and apportion resources is to require the state or federal government to determine a single maximum annual percentage of premium increase (or taxation increase in the case of the publicly sponsored plan) for all health insurance plans.

Government would determine the rate by a formula closely tracking some measure of general inflation, possibly the Consumer Price Index. The reason for not limiting the increases strictly to the CPI is that some latitude may be needed 1) to fund general medical research and research on protocols (see recommendation #3, below), 2) to fund improved technology, and 3) to reflect changes in the injury and illness patterns of society.

A separate pool made up of all carriers could be created to fund widespread catastrophes or unpredictable epidemics. That pool, similar to current "guarantee funds," would also protect against insolvency on the part of individual insurers.

This requirement for limiting increases in insurance rates establishes, in essence, a budget for the system. Experience has taught that when the healthcare system is constrained in a particular direction, it tends to bulge out in another direction. Thus, by establishing a budget for the entire system, expansion of the system may be controlled.

The effect of limiting rate increases would be to place insurers at risk for increasing costs. Thus insurers would have a powerful incentive to control costs. A natural reaction by insurers would be to form tightly integrated managed-care alliances with providers in order to share the financial risk with those providers. Insurers and their provider allies would have a strong incentive to apply careful cost/benefit judgments to such matters as capital expansion, preference among treatment locations and modalities, length of confinement, and selection of materials and subcontractors. Providers

who fail to help the plan stay within budget would be less attractive to plan sponsors.

Incentives for insurers to profit by downgrading quality of care would bee offset by public dissemination of quality comparisons among providers (see recommendation # 3, below) and by competition for market share between the networks.

Most likely, such rate regulation would force a consolidation of the health insurance industry from hundreds to a small number that can develop the capability to manage costs. Indeed, insurers may eventually become the financing and marketing arms of the delivery system.
Implementing this requirement on a national scale would preclude insurers from boycotting individual states. The challenge to insurers would thus be to find an efficient niche within a consolidated market. Failing that, the likely alternative would be a highly regulated single-payer system.

Given a fair chance, rate regulation may be expected to reduce the administrative overhead associated with the present, fragmented system. In addition, this strategy creates incentives to apply provider compensation methods that reward cost-effective behavior. For example, fee-for-service plans would likely give way to plans that pay providers by salary, per patient or per case. Where fees are paid, fee schedules and expenditure targets would be employed.

A politically attractive aspect of this strategy is that it encourages desirable economic changes simply by limiting the pot of funds available for care. The market will then attend to realignment, without need for sweeping government intervention.

3) Quality of healthcare services will be assured through government monitoring and establishment of publicly sponsored research on medical protocols.

When cost containment is discussed, providers often warn of the possibility that quality will suffer. To guard against deteriorating quality, it is recommended that government monitor the quality of medical services and make reports available to the public. In addition, a portion of the taxes on employers, insurers and individuals should be earmarked for research on medical protocols. The reason for this last item is the wide variation in practice styles, unsupported by evidence of differing effectiveness or outcomes[7]. Research on protocols would help clarify some of the "gray areas" in medicine and raise some of the art to the level of science.

4) Re-establish "community rating" as a basis for determining premiums.

The health insurance industry began with the concept that costs should be spread among many people, so that no individual would risk financial devastation from healthcare expenses. Early insurance plans charged the same rate for all groups within a given community. This practice became known as "community rating."

Eventually some groups discovered that through good fortune their members were unusually healthy and so needed less care than those of other groups. They found carriers who would rate them according to their exceptionally low-cost experience. Having lost these low-cost members, the remaining plans quickly found their costs per beneficiary much higher and so needed to raise premiums.

This trend of splitting the healthy from the unhealthy has continued until the cost of insurance for some less-healthy groups has become unaffordable. Even seemingly innocuous practices such as rating groups by age and sex may effectively shift costs toward the most needy. The offering of multiple options within groups has further aggravated this situation. Worse yet, some groups have resorted to questionable practices like excluding seriously ill members from the plan to keep costs in line.

If one accepts the premise that the public has a responsibility to assure its members a reasonable level of care, regardless of economic status, then it follows that systemic reform must restore the practice of well people shouldering the financial burden imposed on the ill and aged. Experience rating, by contrast, tends to shift costs to the ill, injured and aging — often the people least able to cope with such demands.

Thus it is recommended that insurers be required to adopt community rating, meaning a single set of rates based only on dependent status and the broadest practical geographic basis.

In order to maintain incentives for promoting healthy lifestyles among plan members, allowance would be made for rate adjustment by lifestyle characteristics, e.g., not smoking, use of safety belts, maintenance of safe blood pressure. Determining the proper extent of these adjustments will require further analysis.

To fully realize the system-wide benefits of community rating, the ability of individual companies to splinter off from the community and pay only for preferred risks would have to be minimized. Thus it is contemplated that self-insured plans might best be gradually phased out. This sacrifice on the part of self-insured firms is intended to be offset by savings from the cost-containment scheme in recommendation #2, above.

5) Adopt a policy that all health care plans must, within capacity limits, accept any applying employer group or association of employer groups.

Some groups presently encounter an extreme form of experience rating: not by premium levels, but by exclusion at any price. There is currently much financial pressure on insurers to "skim" the healthiest risks from the available population. Thus it is commonplace for insurers to refuse to write coverage for groups with high claims histories—or to cancel groups that develop such records. The effect of such practices is to segregate the ill from the able, which benefits the able at the expense of the unfortunate. For the same reasons presented for recommendation #4 above, it is recommended that insurers be required to accept any employer-based group (or association of employer groups) that applies.

6) Adopt a policy that each patient or patient's family, means permitting, shall pay some fee for every episode of care, up to some out-of-pocket maximum.

It is generally agreed that efforts to contain the overall costs of healthcare must address demand by individuals. The first Rand Corporation study[8] showed that medical services perceived as "free" tend to be utilized at a greater rate than those that bear some cost to the recipient. Thus it is recommended that each patient, means permitting, pay some fraction of the cost of each episode of care. An annual limit could be placed on the amount of this expense.

7) Establish ancillary activities by government.

To provide a context for reform, government should provide leadership to develop healthcare policy — on a national, regional and state level.

Since prevention is the best medicine and education is the key to prevention, government should provide improved health education services to the public.

Because of the requirement in this framework for every citizen to carry coverage, some entity (probably government) must establish what constitutes coverage. That is, government must establish a minimum level of benefits that meets the intent of the law.

The proposed approach is expected to provide strong incentives for providers to participate. If, however, lack of participation becomes a problem,

then some regulation may be contemplated to require reimbursement through plan sponsors.
Because of the pressures for medical inflation caused by malpractice litigation, it is recommended that government take strong measures to reform the tort system in a more cost-conscious direction.

Because the recommended provisions are, compared to other reform strategies, friendly to existing arrangements, government should inform the public that if the approach fails, it will implement a single-payer system.

Conclusions:
The above recommendations are intended to constitute a politically moderate approach, with roles and tradeoffs for all current actors. Competitive forces are supported by leaving the primary funding and delivery systems in the private sector and by establishing an overall budget. Regulation is invoked to bring about universality of coverage, explicit containment of costs, and preservation of quality.

Although these elements are certainly amenable to modification, they are deemed by the authors to be hung in fair and delicate balance. Modifications will necessarily alter the balance of tradeoffs and the likelihood of acceptance by various groups. Likewise, the recommendations are presented not as a sundry assortment of fixes, but rather as a cohesive structure with value greater than the sum of its parts.

References:

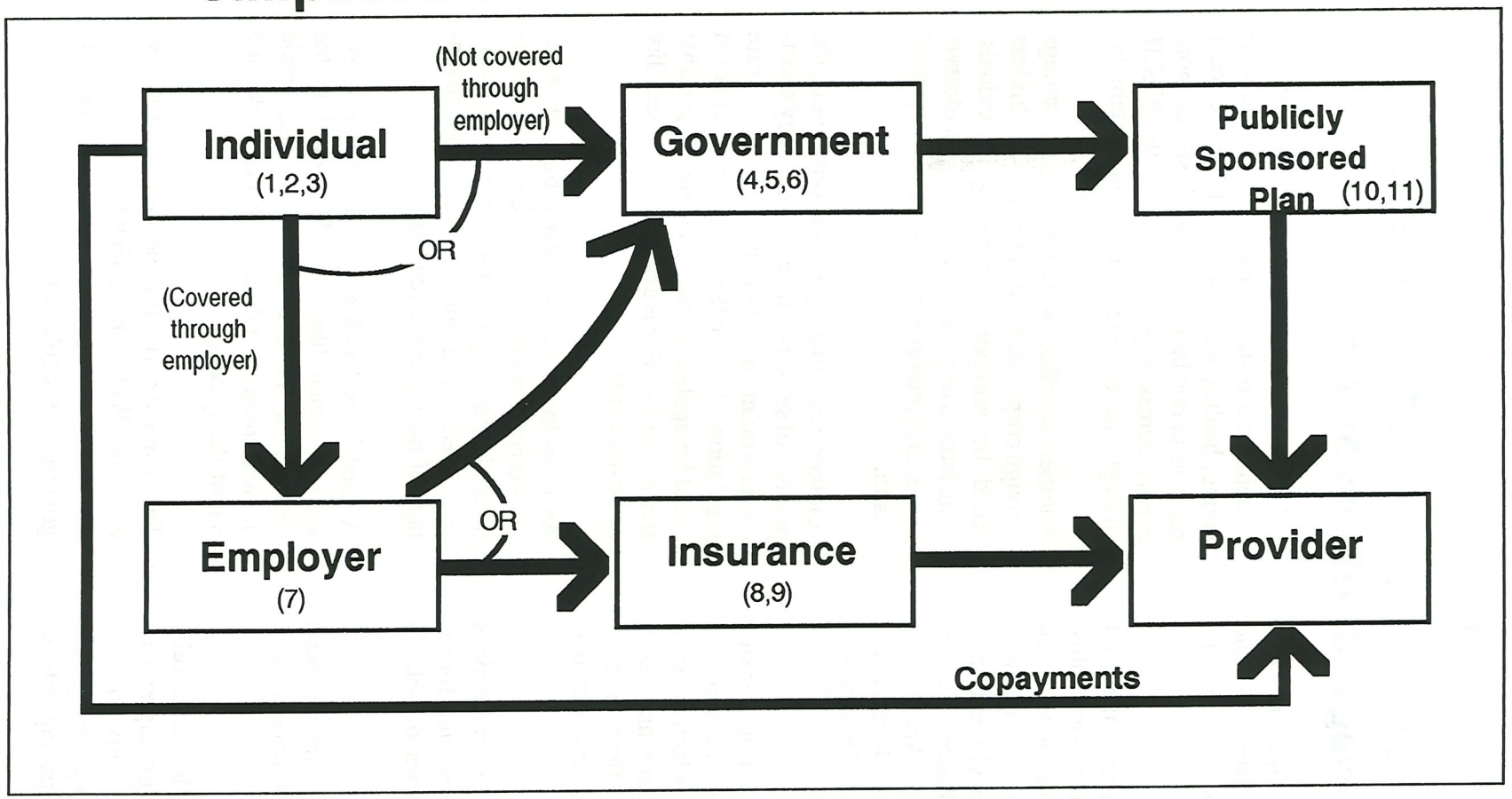
[1] Kansas Commission on Access to Services for the Medically Indigent and Homeless: *Report and Recommendations on Access to Services for the Medically Indigent and Homeless.* Topeka, KS: Kansas Dept of Legislative Research; 1989: 4.
[2] Moyer, ME: A Revised Look at the Number of Uninsured Americans. Health Affairs, Summer 1989, pp 102-110.
[3] National Leadership Commission on Health Care. *For the Health of a Nation.* Ann Arbor, MI: Health Administration Press; 1989.
[4] Enthoven A, Kronick R: A Consumer-Choice Health Plan for the 1990's. *New England Journal of Medicine.* 1989; 320, No. 1.
[5] U.S. Bipartisan Commission on Comprehensive Health Care. *A Call for Action.* Washington, DC: The Pepper Commission on Comprehensive Health Care; 1990.
[6] Brown LD, McLaughlin C: Constraining Costs at the Community Level, *Health Affairs*, Winter 1990, pp 5-28.
[7] Wennberg J, Gittelsohn A: Variations in Medical Care among Small Areas. *Scientific American*, 246, 1982, pp 120-133.
[8] Duan N, Keeler EB, Leibowitz A, Marquis MS. Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment. *American Economic Review*, June 1987, pp 251-277.

The Kansas Employer Coalition on Health, Inc. welcomes comment on this document. Please address all remarks to

James Schwartz, Consulting Director
Kansas Employer Coalition on Health, Inc.
1271 Harrison
Topeka, KS 66612
913-233-0351

Page 1743

Simplified Overview of the Flow of Funds



1) Mandatory coverage through either an employer-sponsored plan or a publicly sponsored plan.
2) Out-of-pocket payment for each episode of care, according to ability to pay.
3) Payment of some portion of premium for employer's plan — or payment of tax toward publicly sponsored plan.
4) Regulation of maximum allowable premium increases.
5) Quality monitoring and support for protocol research.
6) Reform of tort system.
7) Option to provide coverage or pay tax toward publicly sponsored plan.
8) Required "community rating."
9) Required acceptance of any applying employer group.
10) Because of sliding scale and worse risk for this group, subsidy will be required through tax or else surcharge on other insurance.
11) Operation could be be any of several means, e.g. contracted administration, contracted inclusion in carriers' lines, or direct government operation.

Questions and Answers

for

KECH Framework for Reform of the U.S. Healthcare Financing and Delivery System

Q: The strategy calls for limits on insurance rate increases. Will insurance companies be able to curb costs enough to survive such constraints?

A: Even in the present system, time is running out on insurers' window of opportunity to control costs. If insurance companies cannot curb costs in the near future, they may be replaced by a single-payer system. The KECH framework offers insurers a last chance to effectively address the cost problem. And it gives them every incentive to do so. Only those that can control costs will survive. There would likely be a shake-out.

The framework's prescription for insurer survival under rate regulation is for them to form joint ventures with providers, in which financial risk is shared. These joint ventures may result in some insurers becoming, in effect, the marketing and financial arms of provider networks.

Q: Will employers accept the recommendations for adopting "community rating" and for removing some of the advantages of self-insurance?

A: Seen narrowly and in the short term, no. Seen in the context of long-term cost containment, yes.

The present health system suffers dreadfully from decline of the insurance principle: wide spreading of risk. To reinstate this principle equitably, steps must be taken to prevent groups from isolating themselves and paying only for preferred risks.

All parties will need to make some sacrifices to achieve a better system. Employers with young, healthy workforces will experience a short-term rate increase as risk is spread more evenly across a population. In the KECH strategy, the reward is long-run price stability.

Another sacrifice would be direct savings through corporate health promotion. This loss could be mitigated by rating individuals' contribution to premium according to lifestyle habits, thus preserving incentives for improved health.

Another factor that argues for constraining the practice of self-insurance is the strategy's cost-containment mechanism: insurance rate regulation. It is unclear how rate regulation could be applied to self-insureds. A possible step in that direction is a cap on tax deductibility of health benefits.

As a way to achieve equity among plans without outright banning of self-insurance, self-insured plans might be allowed to pay a surtax calculated to neutralize the economic advantage of having preferred risks.

A final consideration is that a single-payer system, which likely would prevail in the absence of the one described here, would likewise prohibit individual groups' selecting out of the system.

Q: The plan calls for an important role for government. Will such a policy be palatable to a society that values market principles over government regulation?

A: The KECH strategy also favors market prin-

ciples over government regulation. By placing insurers (and by extension, providers) at risk for keeping costs within budget, a powerful incentive is created to apply "managed care" techniques. Those techniques are competitive in nature, boosting efficiency and energizing the system.

At the same time, the paper acknowledges historical limitations of competitive approaches in an arena broadly perceived as a "public good." The strategy favors *private* implementation of a "publicly sponsored pool" to insure those not covered through employer-sponsored plans. The plan also recommends a tax mechanism as an efficient means for collecting money necessary to fund the public pool. Government would set limits on increases in insurance rates. Government would also articulate a public policy on health and catalyze several problem-solving efforts. All these roles for government are best viewed as collaborative with private efforts.

Government already plays a strong role in health care. The intent of the KECH paper is to fashion that role into one that augments market forces.

Popular proposals for comprehensive reform of the US healthcare system generally involve a rather more active government role than that suggested here. The KECH framework assures a vital role for all current players: individuals, employers, providers, insurers and government. The failure of a pluralistic system such as this would likely lead to even more government intrusion.

Q: Will business support the requirement to either provide coverage or pay a tax to fund a public pool?

A: Increasingly, businesses that now provide benefits recognize the hidden subsidy they bear: the shifted medical costs of uninsured workers. Those firms respect the fairness of policy that would spread the cost of care more broadly.

On the other hand, any struggling business will balk at a new expense. Those that currently provide no health benefits have the most to lose from a redistribution of responsibility that involves everyone. Those firms need to recognize that in a reformed system, no party will be allowed to opt out of responsibility to shoulder costs. This is true for all major societal support systems: social security, unemployment compensation, etc. As medical care has gained such stature in the minds of the public, so must its costs be borne by all.

The "play or pay" model envisioned here, as compared with a simple employer mandate, softens the impact on firms employing low-income workers by allowing them the option to pay a payroll tax that reflects those wages.

The voluntary system of employer-sponsored health insurance has left too many gaps. The nation must decide whether employers will be full partners in the provision of health benefits or no partner at all. The KECH plan favors building on the well-established institution of employer sponsorship—and enlarges on that principle by closing the gaps.

Q: If the proposed cost-containment provisions are adopted, will the belt tightening lead to rationing of healthcare services?

A: If "rationing" is taken to mean long lines of patients waiting for essential services, the answer is no. The funding level of the US healthcare system is high enough to assure that essential services are abundantly available.

The answer is yes, however, if "rationing" is taken to mean a rational allocation of services, prioritized on the basis of efficacy, efficiency, quality of outcomes, and ethical consensus. No system can provide all the health care that might ideally be made available. The system presented here employs competition between (a reduced number of) organized systems of care, in order to challenge each to offer a mix of services that optimizes value for purchasers.

An implication of the cost-containment provi-

sion is that a strong incentive will be created to reduce waste. Duplication of services within an area will come under close scrutiny. So will policy for hospital admissions, doctor visits, hospital expansion, as well as protocol for diagnostic tests, surgery, and every other source of "fat" in the system.

Q: Will the "publicly sponsored plan" require an additional subsidy beyond the taxes mentioned in the paper?

A: Yes. The paper recommends that the publicly sponsored plan be funded by individuals on a sliding scale and by employers on a "play or pay" basis. The sliding scale implies, however, a degree of incomplete funding that must be subsidized. Additionally, employer participation in the public pool is apt to be favored by employers of low-income workers; thus the taxes on those firms will tend to be less than full fare. Because of these shortfalls, it will be necessary for the public plan to be subsidized by a supplemental tax.

A number universal health care proposals that retain an employer role address this need by stipulating a smaller, secondary "brother's keeper" tax on individuals and companies that are insured privately. While the KECH framework stops short of endorsing any one of these specific mechanisms, the authors contemplate some variation of same.

Combined costs of operating the public *and* private plans will be contained by rate regulation. Therefore, aside from some start-up costs, the ultimate cost of the total US healthcare system would increase roughly in step with overall inflation.

Q. The recommendations call for patient copayments for services. Are those copayments intended to apply to all services?

A. Yes. These authors acknowledge that collection of copayments carries an administrative burden. That burden is considered supportable, though, by virtue of the utilization-dampening effect. In addition, copayments will reduce the need to fund care through the tax system, thus adding to the strategy's chances for political acceptance.

Further, the principle of simplicity suggests that the policy for applying copayments be as uniform as possible.

Q. Does this strategy include limits on tax deductibility for employer-sponsored plans?

A. No. One of the concerns about mixed public/private approaches (like this one) is that the private tier might collapse and dump employees into the public plan. Tax deductibility of employers' health costs is an important incentive to retaining a strong private-sector role.

The chief intent of limits on tax deductibility is to discourage continued enrichment of benefits. The present trend in benefit design, however, even in the absence of such regulation, is already toward leaner coverage. Besides, the recommended limits on premium prices will essentially achieve the intent of the tax modification.

Q. Is this strategy suited better to state or national adoption?

A. National. Although the strategy could, in principle, be employed on a state level, more obstacles lie there. First, individuals or groups living near state borders and feeling either attracted or repelled by the plan would tend to relocate across the border. These relocations would be disruptive, expensive and inclined to maintain present disparities. Second, since the strategy creates pressure on insurers, there is a risk with state-level implementation that insurers might boycott the state. Third, since the plan involves all employer groups (including those presently self-insured), federal ERISA exemptions for self-insureds would impede state-level implementation.

TESTIMONY on House Bill No. 3026

Date: March 4, 1992

Mr. Chairman and Members of the Committee:

My name is George Goebel. I am chairman of the Capitol City Task Force of the American Association of Retired Persons. We appreciate the opportunity to testify on House Bill 3026.

AARP members, like the rest of the American public, are calling for action on the problem of health care in our nation. To respond to the concern, the Association's volunteer National Legislative Council has recommended to the Board of Directors a proposal that will both inform members and provide them the opportunity for input during the coming year. That proposal is now being circulated to AARP chapters nationwide.

To the extent that House Bill 3026 contributes to the state and national discussions of one of this country's most serious problems, access to health care, we applaud the initiative of its authors.

The AARP believes that, for a universal access health care program to be affordable, the program must have strict cost controls, malpractice reforms, and elimination of waste and duplication. It should assure access to the full range of preventive, prescription drug, acute and long-term care benefits.

It probably would not be helpful for us to comment on individual sections of this bill at this time. If committee members would like to have copies of the AARP draft Health Care Reform Proposal, I will be pleased to provide them.

Thank you.

Human Res.
Attachment 4
3-4-92