

Ending Separate and Unequal Health Care

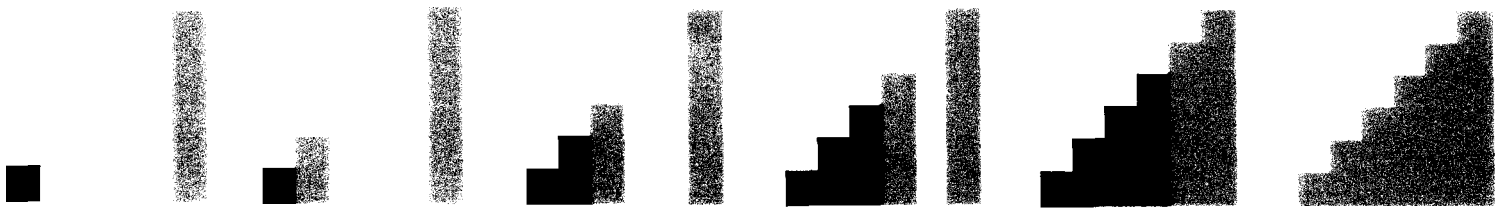
***Proposals of the
American Society of
Internal Medicine***

APRIL 1990



american society of internal medicine

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ASIM Policies for Ending Separate and Unequal Health Care

EXPANDING EMPLOYER-BASED HEALTH INSURANCE

1. Require employers to offer employees a basic package of health insurance benefits.
2. Provide special assistance to small businesses to make the cost of offering health insurance more affordable:
 - Allow for an appropriate phase-in of the requirement;
 - Designate regional insurers and establish risk pools;
 - Allow businesses to substitute an “actuarially equivalent” plan for the required standard benefit package;
 - Provide a federal subsidy in hardship cases;
 - Preempt state laws that mandate minimum benefits; and
 - Permit full tax deductions for the costs of health insurance premiums.
3. Reform the market for health insurance by prohibiting experience rating and preexisting condition exclusions and by establishing special rules for marketing to small groups. Once market reforms are implemented, along with expansion of Medicaid and a mandate that employers provide health insurance coverage to their employees, all individuals should be required to offer evidence of having obtained insurance coverage.
4. Provide tax incentives for individuals to set aside funds to pay for health expenses in order to supplement financing from employer-based health insurance and public programs.

IMPROVING AND EXPANDING PUBLIC FINANCING

1. Convert Medicaid from a welfare program to a source of funding for all individuals, regardless of income, who are unable to obtain employer-based health insurance:
 - Mandate national uniform eligibility standards;
 - Require individuals with incomes above the poverty level to contribute to the cost of coverage (through premiums, deductibles, and copayments) under the public plan, with the level contribution and cost-sharing varying on a sliding scale based on income.
(As an alternative to revamping Medicaid, a new federal-state program could be established to accomplish the same purposes.)
2. Mandate a defined set of basic benefits for the Medicaid program.
3. Reform physician payment under the Medicaid program to ensure adequate incentives for physician participation and to introduce proper incentives into the system.
4. Increase federal government funding for the expanded Medicaid program to reduce the financial burden on the states.



PROVIDING COVERAGE FOR LONG-TERM CARE

1. Encourage the availability of private long-term care insurance:
 - Apply the same tax status to long-term care products as now exists for accidental death and dismemberment insurance and health insurance;
 - Allow the deductibility of insurance reserves and related investment earnings and permit the inclusion of long-term care coverage in cafeteria plans;
 - Offer tax credits for the purchase of long-term care coverage; and
 - Eliminate restrictions on the prefunding of retiree health benefits and long-term care insurance.
2. Provide a sliding subsidy to enable low-income beneficiaries (e.g., those with incomes up to twice the poverty level) to purchase private long-term care insurance.
3. Provide for federal and state regulations that enhance consumer protections in the long-term care market. These regulations should:
 - Assure appropriate standards of coverage;
 - Promote establishment of guidelines for proper disclosure;
 - Provide protections against sales abuses;
 - Regulate renewal and cancellation;
 - Assure requirements for sufficient reserves; and
 - Develop benefit/premium ratios.
4. Provide an asset protection program for individuals who purchase long-term care policies as an incentive to purchase private long-term care insurance.
5. Establish a new Medicare benefit to assist individuals in paying for long-term care. The program should:
 - Provide for adequate cost sharing by individuals;
 - Protect against depleting personal assets; and
 - Have premium contributions on a sliding-scale basis.



HEALTH CARE COSTS AND OTHER BARRIERS TO ACCESS

1. In order to assure that money spent on medical care is spent wisely and effectively, the medical profession, with the cooperation of government and other payers, should:
 - Place high priority on studying the outcomes of different medical interventions and
 - Develop practice guidelines to modify physician behavior and provide a basis for setting payment criteria.
2. Eliminate administrative hassles that impede access to care.
3. Institute reforms in the medical liability system.
4. Require some level of patient cost-sharing in all insurance plans.

Achieving **Equal** Access To **Health Care**

America has two separate and unequal health care systems—one that provides access to a basic level of health insurance coverage and one that does not. It is time to provide *all* Americans with equal access to adequate health insurance protection.

Most Americans are fortunate to be under a system that allows them to obtain affordable health insurance through their employer. By providing access to insurance coverage, and by sharing the cost between the employer and the employee, the employer-based system of health insurance coverage provides most Americans with protection from the catastrophic costs of major illnesses. They are able to obtain the latest treatments and technology without fear of impoverishment. They are able to choose their own physicians and hospitals. They have access to regular, comprehensive medical care. The system is not perfect, but employer-based health insurance accomplishes its major purpose: assuring that no American need delay seeking care because of fear of financial catastrophe.

But there is a sizable minority of Americans estimates range between 30 million and 37 million, or about 15 percent of the population¹—that receives its care (if able to obtain it at all) in a completely different world. For them, there is no health insurance protection. A major illness can mean personal bankruptcy. Even minor illnesses can represent an intolerably high expense. Delays in obtaining care are common. Access to preventive care is virtually unknown. And, when they do get so sick that they need professional care, that care usually comes from chronically underfunded public clinics or hospital emergency rooms—or from physicians who donated some \$6 billion in charitable care in 1989.²

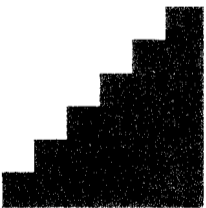
Others have health insurance—but it is inadequate for the task. Lack of coverage for the

catastrophic illnesses expenses and inadequate benefits for preventive and primary care services place too many Americans—the underinsured—at risk. Americans who have coverage under welfare-type public programs, such as Medicaid, find that chronic underfunding of those programs creates insurmountable barriers to care. As many as 20 million Americans have inadequate health insurance coverage.³

Even those Americans who now receive comprehensive coverage through their employer are at risk. Unemployment can lead to loss of coverage. An illness followed by a change in jobs can make it impossible to obtain coverage for that illness, since most insurers refuse to provide coverage for “pre-existing” health problems. As the cost of providing insurance escalates, more and more businesses are contemplating dropping or limiting their health benefits. Even those fortunate to have good comprehensive insurance through their jobs still live with the fear and uncertainty of joining the ranks of the uninsured.

The American Society of Internal Medicine (ASIM), representing physicians nationwide who are specialists in adult medical care, believes that we can no longer accept two separate and unequal health care systems. A comprehensive solution that gives all Americans equal access to a basic level of health insurance is within our grasp. Such a solution should preserve the strengths of our present system while closing its gaps; spread the burden of financing care equitably throughout society; and ask businesses, government, patients and physicians to all do their share.

This paper outlines ASIM’s proposal for putting an end to separate and unequal access to basic medical care. Since any realistic solution must be based on an understanding



of why some Americans do not have access to the same type of protection available to most of their neighbors, this paper begins by looking at who are the uninsured and underinsured. It then presents a series of recommendations for comprehensive long-term reform, including a comparison of ASIM's recommendations with other proposals, such as the U.S. Bipartisan Commission on Comprehensive Health Care (better known as the Pepper Commission) report and the Basic Health Benefits for All Americans Act, and an assessment of each recommendation's impact on cost and access.

Who Are the Uninsured and Underinsured?

Several recent studies have looked at the characteristics of those who constitute the ranks of the insured and underinsured, and how they differ from other Americans. Several findings are especially important in crafting a workable solution:

- **Most of the uninsured-80 percent of those Americans without health insurance-have jobs or are dependents of those who work.**⁴ In fact, 14 percent of American workers have no health insurance.⁵
- **By comparison, a large majority of Americans are insured through their places of employment.** Only a small minority of Americans under the age of 65 are covered through publicly funded programs. According to the Congressional Research Service, 64.8 percent of all Americans under the age of 65 are insured through the workplace, 17.7 percent are insured through individually purchased insurance or through publicly funded programs, and 17.5 percent are uninsured.⁶ Experts estimate that 85 percent of all workers and their families receive job-based health insurance.⁷
- **Of the uninsured who are the primary source of financial support for their families, 60 percent work full-time.'**
- **Many, but not all, of the uninsured are poor.** One third have annual incomes that fall under the U.S. poverty level (\$10,989 for a family of four and \$5,469 for an individual); 19 percent have incomes that fall between 100-150 percent of the poverty level; 14 percent have incomes that fall between 150-200 percent of the poverty level; and one third **have** incomes that are

at least twice the U.S. poverty level.⁹ Still, low-wage earners are as likely to be uninsured as unemployed individuals.¹⁰

- **Most of the working uninsured are employed by small businesses. One-third of the uninsured are employed by businesses with fewer than 10 employees and another 25 percent are employed by firms employing between 10 to 100 people."**
- **Still, most businesses-including most small businesses-offer coverage to their employees. Nine out of 10 businesses with more than 25 employees already cover their workers. Almost half (46 percent) of the smallest businesses—those with fewer than 10 employees—offered health insurance to their employees. Almost 80 percent of firms employing between 10 and 24 workers provided health insurance to their workers.**¹²
- **Medicaid, ostensibly the major source of coverage for the poor, actually finances care for only 42 percent of people whose incomes are below the U.S. poverty level.**¹³ The low income eligibility standards set by many states make it impossible for many poor Americans to qualify for the program.
- **Virtually every American lacks adequate protection for long-term care. The extraordinary costs of intensive long-term care make most people vulnerable to financial catastrophe. Medicaid, the major source of public financing for long-term care, requires people to deplete their own resources in order to qualify. Although Congress recently enacted legislation to reduce spousal impoverishment, Medicaid still poses too great a risk to personal assets.**

Directions for National Health Policy

These findings suggest several important directions that should guide national policy to end separate and unequal coverage.

First, a logical national strategy should be directed toward making it possible for uninsured workers to obtain job-based insurance. The common assumption that the typical uninsured person is unemployed and without any financial resources, or is someone who works only part-time, is a myth. Most uninsured persons are no different from their neighbors with health insurance. They work full-time or are dependents of full-time

workers. The only difference is that their employers are unable or unwilling to offer health insurance.

Second, since most businesses—large and small—do a good job of offering health insurance to their employees, an effective national strategy should be directed toward the minority of businesses that do not now offer health insurance. This means asking those businesses that can afford to offer coverage, but now refuse to do so, to accept the same level of responsibility to their employees, as do most firms. It also means finding a way to make insurance premiums affordable for those small businesses that now cannot afford to provide health benefits to their employees.

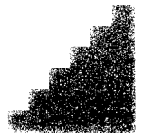
Third, Medicaid needs to be restructured so that it is no longer a “welfare” program for some of the poor, but a program that can provide coverage to any person—regardless of income—who cannot obtain insurance through his or her employer.

Fourth, for the majority of Americans who now have access to health insurance, im-

provements in the current employer-based system—rather than a complete shift away from job-based insurance—makes sense. Such improvements should protect these individuals from underinsurance or from losing their coverage because of a change in career or employment status or the onset of illness. But it defies logic to toss out entirely a system—which works well for most Americans and can be made better with modest improvements—for a new and untried approach. The goal instead should be to bring as many Americans as possible into the employer-based system—not to replace it.

Fifth, since rising costs threaten the ability of employers and government to provide adequate funding for health benefits, it is important to institute measures that make health insurance premiums more affordable and that direct expenditures on health only toward those services that are of benefit to patients.

ASIM’s specific recommendations for a national policy that reflect these directions is presented on the following pages.



Expanding Employer-Based Health Insurance

1 ■ All employers should be required to offer to their employees a basic package of health insurance benefits.

Impact on the Problem

The most effective approach to reaching most of the uninsured is to require those businesses that do not now offer health insurance to do so, with provisions to assist small businesses and to make premiums more affordable as outlined under the following recommendations. In October 1988, the ASIM House of Delegates—representing democratically elected state leaders of internal medicine and its subspecialties—became the first medical organization to call for a mandate that employers offer health insurance coverage. The Society subsequently endorsed the Basic Health Benefits for All Americans Act, introduced by Sen. Ted Kennedy (D-Mass.) and Rep. Henry Waxman (D-Calif.). Although this bill reportedly is being revised, the original version provides a useful model of a plan that is consistent with ASTM's recommendations. However, Congress should have flexibility to consider a variety of proposed implementation strategies to achieve the goals identified in this paper.

The Basic Health Benefits Act would require all employers to offer health insurance benefits to all workers who are employed more than 17.5 hours per week. A basic package of health benefits would be mandated by the bill. The Congressional Budget Office (CBO) projects that the bill's employer mandate would result in most of the previously uninsured's having access to health insurance. According to the CBO, 23 million out of 37 million uninsured—or almost two thirds of the uninsured—would then be covered through their employer.¹⁴

Recently, the Pepper Commission released a comprehensive plan for assuring access that

contains a similar approach for expanding job-based health insurance coverage. All businesses with more than 100 employees would be required to provide private health insurance (that included defined minimum benefits) or to contribute to a public plan for all employees and nonworking dependents. Smaller businesses also would be required to offer private insurance or to pay into a public plan, unless they voluntarily provided health insurance coverage within a specified period of time to at least 80 percent of their employees. If an insufficient number of employees of small businesses were not voluntarily covered within five years (defined as 80 percent of all workers and their dependents in firms with fewer than 25 employees), all businesses would be required to either provide insurance or pay into a public plan. The end result would be the same as the Basic Health Benefits Act: Virtually all working Americans and their dependents would have access to health insurance through their employer.

Both the Pepper Commission proposal and the Basic Health Benefits Act call for requiring employers to subsidize at least 80 percent of the cost of health insurance premiums, thus minimizing any undue economic burden on working Americans.

Cost Impact

There is no question that mandating employer-based health insurance would be effective in substantially reducing the numbers of the uninsured, and because of the specified benefits requirements, the underinsured. But some have questioned whether the cost of such a requirement is too high for many businesses.

The evidence suggests, however, that the actual net cost to most businesses is not inappropriately high. The total value of the insurance that would be purchased by

businesses under the Basic Health Benefits Act is estimated to be \$33 billion. The net cost would be \$18 billion as a result of eliminating uncompensated charitable care costs that currently are passed on to businesses in the form of higher premiums, plus the addition of other provisions in the bill that would result in savings to businesses. The average hourly cost of an indemnity plan that meets the bill's requirements is estimated at 80 cents for a full-time worker, of which the employer would pay 64 cents. A managed care plan would cost employers 54 cents per hour. Put another way, the costs of the bill's employer mandate would represent four-tenths of 1 percent of total wages.¹⁶ The Pepper Commission estimates the cost to employers of its requirement at \$20 billion.¹⁶

For many businesses—those that are now providing health insurance to their employees—costs actually would be lower, since they are now indirectly subsidizing, through higher premiums, the health care expenses of their competitors' uninsured employees. All employers would benefit from the insurance reforms discussed later in this report.

And for those employers who can now well afford to provide health benefits to their employees, but who refuse to do so, the proposed mandate simply asks them to pay their fair share. Although most of the working uninsured are employed by small businesses that have a legitimate concern about costs, one-quarter of uninsured workers are employed by firms with 1,000 or more employees.¹⁷ As noted earlier, most small businesses—including half of those with fewer than 10 employees now provide health benefits. Those businesses would stand to gain under a more equitable sharing of costs.

Nor would the economy suffer significant damage. Several studies, which take into account jobs that will be gained in the health care sector, found no net job loss as a result of the Basic Health Benefits for Americans Act. Still other studies, which did not take into account offsetting gains, found a small increase in unemployment (one-tenth of 1 percent or less over a three-year period).¹⁸

Most importantly, these costs must be compared to the far greater human and economic costs of denying millions of adult Americans and their children access to health insurance.

Requiring employers to offer health insurance coverage enjoys extraordinarily broad public

support. Two recent polls found that approximately three out of four Americans felt that employers should be required to provide health insurance. The same level of support was found in all regions of the country and among all political ideologies.¹⁹ In addition to ASIM, at least 21 other medical associations have endorsed mandatory employer-provided health insurance. The American Hospital Association and a number of other organizations representing health providers, consumers and labor also have endorsed this approach as part of a comprehensive strategy to expand access. Several business leaders also have endorsed the concept.

Most of the opposition to an employer mandate have come from small businesses, which understandably are concerned about the impact of this requirement on their economic viability. However, both the proposed Basic Health Benefits Act and the Pepper Commission report include measures to assist small businesses and to reform the market for health insurance to lower premium costs.

2. Provide special assistance to small businesses to make the cost of offering health insurance more affordable. Specifically, allow for an appropriate phase-in of the requirement, designate regional insurers and establish risk pools, allow businesses to substitute an “actuarially equivalent” plan for the required standard benefit package, provide a federal subsidy in hardship cases, preempt state laws that mandate minimum benefits, and permit full tax deductions for the costs of health insurance premiums.

Impact on the Problem

Both the Basic Health Benefits Act and the Pepper Commission proposal recognize the potential adverse impact on some small businesses of any requirement that employers provide private health insurance to their employees. After all, the cost of such insurance is the primary reason that some small businesses are unable to offer such health benefits. The Congressional Research Service estimates that health insurance premiums for small employers average 10 to 15 percent higher than for large employers.²⁰

The Basic Health Benefits Act would directly help small businesses in several ways. Many businesses that now offer good health insurance coverage would not have to upgrade their plans as long as their benefits packages are actuarially equivalent (i.e., the employer's dollar contribution to the plan is equal to what would be the case if they offered the specified benefits). New businesses with fewer than 10 employees would be required to offer only a low-cost catastrophic plan in the first two years. Full coverage of businesses with fewer than five employees would be phased in over five years.

Companion legislation would allow 100 percent tax deductibility of the cost of self-employed and unincorporated business' contribution, instead of the current 25 percent limit. All small businesses that currently insure their workers and those who would be required to start offering health insurance would benefit from a system of regional insurers. Under the regional insurance program, small businesses would be offered the economy of scale, group purchasing power, and reduced sales and administrative costs previously available only to larger businesses. The Small Business Administration reports that 17 percent of very small employers (one to nine employees), 3 percent of small employers (10 to 25 employees) and 22 percent of employers with 25 to 50 workers cite the unavailability of group coverage as a reason for not offering health insurance.²¹

Finally, the bill provides a direct federal subsidy for small businesses that spend more than 5 percent of gross revenues on premiums. Seventy-five percent of the cost in excess of this ceiling would be paid by the federal government. A similar subsidy program has been in effect in the state of Hawaii, which has required employers to offer health insurance for the past 10 years. In those 10 years, however, only four businesses applied for a subsidy due to hardship.²²

The Pepper Commission report provides an even more extensive program of assistance to small businesses. The employer requirement would not begin for large employers until the third year of the plan; businesses of 25 to 100 employees would not be subject to the requirement until the fourth year, and businesses with fewer than 25 employees would have five years to comply. Small businesses that voluntarily insure 80 percent of their employees would be exempt. The option of contributing to a public fund, rather than purchasing private insurance, also gives small

employers greater choices in how to cover their employees, although ASIM strongly believes that the contribution to the public fund must be set at a level to encourage provision of private insurance to the greatest extent possible.

Under the Pepper Commission plan, firms with fewer than 25 employees and average payrolls below \$18,000 would be eligible to receive a 40 percent tax credit/subsidy for the cost of health insurance. Employees of these firms with family incomes up to twice the poverty level would receive a subsidy.

In addition, the plan calls for the creation of a voluntary reinsurance mechanism through which insurers could spread the risk of insuring high-risk persons or groups. ASIM believes that this approach could be taken a step further, by legislatively mandating state risk pools to make coverage available at standard group rates to high-risk individuals. This would enhance the ability of small businesses to purchase coverage at a more affordable rate than might be available on the private market.

Both the Basic Health Benefits Act and the Pepper Commission would preempt state laws that require insurers to offer a specified package of minimum or basic benefits. By substituting federally determined basic benefits, employers would be protected from state governments mandating benefit expansions that drive up the costs of premiums.

Cost Impact

The Basic Health Benefits Act would save small businesses that currently provide health insurance an estimated \$4.8 billion, because they would have the opportunity to participate in the regional insurance program and offer managed care programs. The regional insurance program would reduce premiums to small businesses by 10 percent as a result of savings on sales and administrative costs, and the availability of managed care options would save an additional 15 percent, for a total premium reduction of 25 percent.²³ The cost to the federal government of the subsidy program would be about \$200 million in the first year but would rise to \$600 million by the fourth year.²⁴

Small businesses and their employees would receive annual subsidies costing the federal government \$8.4 billion as proposed in the Pepper Commission report. The 100 percent tax deductibility for self-employed individu-

als and unincorporated firms, if it had been implemented in 1988, would have resulted in an estimated reduction in federal revenue of \$500 million in 1988, \$900 million in 1989, and \$1.3 billion in 1990, which represents an equivalent amount of tax savings to small businesses.²⁵

3. Reform the market for health insurance by prohibiting experience rating and pre-existing condition exclusions and establishing special rules for marketing to small groups. Once market reforms are implemented, along with expansion of Medicaid and a mandate that employers provide health insurance coverage to their employees, all individuals should be required to offer evidence of having obtained insurance coverage.

Impact on the Problem

Both the Pepper Commission report and the Basic Health Benefits Act attack practices in the insurance industry that now drive up costs, particularly to small businesses, and leave too many Americans at risk for losing health insurance coverage due to illness.

Prohibiting exclusions for pre-existing conditions, as both plans would do, would close one of the major gaps in our present insurance system. Currently uninsured individuals who become ill and then try to purchase insurance on their own, or who otherwise would become eligible for job-based health insurance, no longer could have benefits for their illness denied by insurers. Currently insured individuals who change jobs (and insurance plans) also could no longer be denied coverage for a preexisting condition. The Office of Technology Assessment estimates that 20 percent of all Americans who apply for commercial health insurance face pre-existing condition limitations resulting either in increased premiums or exclusions from coverage.²⁶ Since prohibiting pre-existing condition exclusions could result in individuals declining to obtain health insurance until they are ill, the Pepper Commission appropriately would require all individuals to document that they have obtained coverage either through a private or public plan. Once the availability of insurance is guaranteed, no one would be permitted to simply decline to obtain coverage.

The current practice of experience rating—basing premiums on the characteristics and claims experience of the particular group being insured—drives up costs for small businesses. Small businesses can be subject to huge premium increases if only a few of their employees are viewed as “high risk,” or if several of their employees take advantage of their health benefits during a particular year. The Pepper Commission proposal would outlaw the practice. Instead, insurers would set rates based on the characteristics of the entire community (community rating), meaning that all employers would have their premiums established on the same terms.

The Pepper Commission report also directly confronts many of the other barriers that small businesses must face in obtaining affordable coverage. Insurers would be required to guarantee acceptance of all groups wishing to purchase insurance. Rates could not be increased selectively for any group in a plan. Enrollment would be for a specified minimum period. Both the Pepper Commission and the Basic Health Benefits Act would require insurers to offer small businesses managed care plans if such plans are available to large employers.

Cost Impact

Replacing experience rating with community rating would substantially lower premium costs for small businesses, although precise estimates of the impact are not available.

4. Provide tax incentives for individuals to set aside funds to pay for health expenses in order to supplement financing from employer-based health insurance and public programs.

Impact on the Problem

Allowing individuals to set aside tax deductible funds each year to help pay for future health care expenses would provide an important source of supplemental financing for health care. Similar in concept to Individual Retirement Accounts (IRAs), individuals would be given an incentive to save money to help pay for their health care expenses. Interest earned on the account also would be tax free. Savings and interest income would be taxable only upon withdrawal to supplement benefits under private and public health insurance programs.

Neither the Basic Health Benefits Act nor the Pepper Commission report includes a recommendation for “Health IRAs,” although the Pepper Commission calls for inclusion of long-term care policies in employer cafeteria plans, which would enable employees to set aside pretax dollars to buy long-term care insurance.

ASIM believes that “Health IRAs” should be viewed as a supplement to requiring employers to provide health benefits and expanding public programs, not as an alternative to those policies. Although some have advocated “Health IRAs” as the primary source of financing for medical care, ASIM believes that without an expansion in employer-based health insurance and substantial improvements in public programs, Health IRAs by themselves would leave too many Americans without adequate coverage. It is not clear how many Americans would choose to set aside funds to pay for future medical care expenses, even with favorable tax treatment. Moreover, low wage earners, who are more likely to be uninsured, are less likely to contribute to a Health IRA. For these reasons,

ASIM advocates the inclusion of Health IRAs only as a way for some individuals to supplement coverage by insurers and the public sector.

Cost Impact

Depending on the number of individuals who take advantage of this option, some loss in federal tax revenues is likely. The Joint Tax Committee estimates that a bill by Rep. French Slaughter (R-Va.) to create Health IRAs would have resulted in loss of federal revenue in 1988 of \$2.5 billion, \$6.8 billion in 1989, \$7.2 billion in 1990, and \$7.9 billion in 1992.²⁷ By providing an individual source of financing for health care, however, some savings to businesses and government might be expected. Because of the potential adverse impact on federal revenues, however, ASIM believes that making federal funds available for the other recommendations in this plan of action (e.g. expansion of public programs, as described in the next section) should take priority over establishing Health IRAs. Health IRAs could be added as resources become available.

Improving and Expanding Public Financing

- 1. Convert Medicaid from a welfare program to a source of funding for all individuals, regardless of income, who are unable to obtain employer-based health insurance. Specifically, national uniform eligibility standards should be mandated. Individuals with incomes above the poverty level should be required to contribute to the cost of coverage (through premiums, deductibles and copayments) under the public plan, with the level of contribution and cost-sharing varying on a sliding scale based on income. As an alternative to revamping Medicaid, a new federal-state program could be established to accomplish the same purposes.**

Impact on the Problem

Even with a mandate that employers provide health insurance coverage and with the insurance reforms described earlier, there will still be individuals who otherwise would be without health insurance coverage. Unemployed, self-employed and part-time (those who work less than 17.5 hours per week) individuals and their dependents could still be without access to health insurance. Without expansion of Medicaid or creation of a comparable public program to provide coverage for all of the remaining uninsured, approximately 14 million of the uninsured still would not have access to health insurance.²⁸

There is widespread agreement on the need to reform the current Medicaid program or to replace it with a new one, so that public funding for medical care no longer is linked to AFDC (Aid for Families With Dependent

Children) or other welfare programs. With fewer than half of all individuals below the poverty level now eligible for Medicaid, the program-as currently structured-is clearly inadequate to the task of providing coverage for the poor, let alone serving as a vehicle to provide access for uninsured individuals with incomes above the poverty level.

The Basic Health Benefits Act would correct this fundamental flaw by establishing uniform eligibility standards for Medicaid or another comparable program. The first phase of the public program (implemented simultaneously with the employer requirement) would cover all uninsured children of families whose incomes are below the poverty level and pregnant women whose incomes fall between the poverty line and 85 percent above that line. This would expand coverage to 4 million unemployed persons.²⁹

The second phase of the program, which would be implemented in 1996, calls for providing coverage for all uninsured adults with incomes up to 85 percent above the poverty line. An estimated 5.7 million more Americans would now be covered.³⁰

The third phase, to be implemented by the end of the decade, would cover all of the remaining uninsured.

Copayments, deductibles and premiums for nonworking individuals and dependents between the poverty line and up to 85 percent above the poverty level could be imposed, at state option. Copayments and deductibles for those with incomes beyond 85 percent above the poverty level would be equal to those required under the employer-based plan. Federal premium subsidies and limits on premiums would be mandated based on gross income. The Pepper Commission advocates a similar approach. In the first year, all uninsured pregnant women and

children up to age 6 would be eligible to enroll in a new federal-state public plan that would replace Medicaid, if they are from nonworking families or in the families of workers whose employers do not provide coverage.

In the second year, the plan would be available to all uninsured children up to age 18. Costs would be subsidized, according to ability to pay, at least for those with family incomes up to double the poverty level. More individuals initially would fall under a public plan with the Pepper Commission proposal than the Basic Health Benefits Act. This is primarily because the proposed Pepper Commission expansion of the public program would take place prior to the requirement that employers provide health insurance. Also, the income eligibility standards under the commission's plan are higher (100 percent above the poverty line compared to just 85 percent above the line under the Basic Health Benefits Act) after the second year. In years three, four and five, businesses (depending on size) would be required to provide health insurance, meet voluntary coverage goals, or contribute toward the public plan to cover their employees and dependents. Within five years, all individuals would be covered either through their employer or under the public plan.

The Pepper Commission approach, by giving employers the option of providing coverage for their workers through the public program, also is likely to end up with a larger proportion of individuals insured under the public program instead of private insurance than would be the case under the Basic Health Benefits Act. As explained earlier, if Congress decides to give employers this option, ASIM believes it is essential that a sufficient monetary incentive exists to encourage employers to insure their workers through private insurance to the maximum extent possible.

Support for establishing national uniform eligibility standards for Medicaid has also come from the Health Policy Agenda for the American People (HPA) Ad Hoc Committee on Medicaid Reform, chaired by the Hon. James Tallon, majority leader of the New York State Assembly. The committee included representatives of the medical profession, insurers and consumers. The HPA recommended that eligibility for Medicaid be set at no less than the U.S. poverty level. The HPA committee recommendation assumed inclusion of all currently uninsured individuals below the poverty level in Medicaid. Since an employer mandate was outside the charge of the HPA

committee, it did not address how many of these individuals could instead be covered through the workplace. Extending current Medicaid benefits to the uninsured poor would cover 10.9 million individuals.³¹

Although ASIM strongly believes that a comprehensive solution to the access problem requires expansion of Medicaid along with an employer mandate, the Society believes that the most critical need is to provide coverage for our poorest citizens. Therefore, ASIM would support enactment of the HPA recommendation to expand coverage to all individuals below the U.S. poverty level as an interim step toward a comprehensive plan involving expansion of employer-based health insurance. The Omnibus Budget Reconciliation Act of 1989 took an important step toward including all poorer Americans in Medicaid by mandating coverage for all pregnant women, infants and children in families that are 33 percent above the poverty level, with the income limit rising in future years.

Cost Impact

The federal cost of the public portion of the Basic Health Benefits Act (which includes the standardized benefits package described below) is estimated to increase from \$1.7 billion in the first year to \$3.5 billion in the fourth year. The final phase of the plan is estimated to cost another \$1.7 billion, for a total cost of \$5.2 billion annually.³²

The federal cost of the public portion of the Pepper Commission (including the standard benefits package and improvements in provider reimbursement) is projected to be \$3.4 billion in the first year, about \$10.1 billion to \$13.4 billion in the second year, \$3.5 billion in year three, \$2.8 billion in year four, and \$11.8 billion in year five, for a total net federal cost of \$31.8 billion. Elimination of the federal subsidy to small firms with low wage earners would save \$8.4 billion in year seven, for a total net cost to the federal government of \$23.4 billion annually.³³

Expansion of current Medicaid benefits to all those below the U.S. poverty level, in the absence of an employer mandate, would cost federal and state governments \$9.05 billion. Some of those costs would be offset from savings in paying for uncompensated care, with a total net cost of \$7.75 billion.³⁴ Benefits expansions proposed by the HPA would cost considerably more than just expanding access to current benefits.

2. Mandate a defined set of basic benefits for the Medicaid program.

Impact on the Problem

The Pepper Commission, the Basic Health Benefits Act and the Health Policy Agenda report all agree on the need to improve and standardize benefits under Medicaid or a comparable new program.

The Basic Health Benefits Act would require all states to offer the same basic benefits as those mandated under private, employer-based health insurance, including medically necessary hospital care, physician care, diagnostic tests, prenatal care, well-baby care and a limited mental health benefit.

Under the Pepper Commission plan, a new federal-state program would be created to offer basic services, including hospital and surgical services, physician services, diagnostic tests, limited mental health benefits, preventive services (prenatal care, well-child care, mammograms and Pap smears, colorectal and prostate cancer screening procedures, and other preventive services that evidence shows are effective relative to cost), and early periodic screening and treatment services for children.

The HPA offers the most ambitious list of benefit expansions. In addition to the benefits proposed under the other two plans, it would include institutional care for the elderly and the disabled, dental services, family planning services, and home health and personal care services.

In order to protect those most at risk under the current system, ASIM believes that it would be appropriate to mandate expansions of Medicaid's benefit structure as an interim step toward a more comprehensive solution requiring an employer mandate.

Cost Impact

The costs of the Basic Health Benefits Act and the Pepper Commission proposed standard benefits were included in the earlier cost estimates.

The HPA benefit package, in the absence of an employer mandate, would increase Medicaid spending (federal and state) by between \$6.5 billion (for a "median" package) to \$21.5 billion (for a comprehensive package), in addition to the \$9 billion to expand eligibility.³⁵ Since the HPA package is the

most expensive of the proposals, it might make sense to begin with a more basic benefits package, such as proposed in the other two plans, and then augment the package further as funds become available.

3. Reform physician payment under the Medicaid program to ensure adequate incentives for physician participation and to introduce proper incentives into the system.

Impact on the Problem

Low levels of reimbursement under most state Medicaid programs have created significant barriers to access to care. Access to primary care services (internal medicine, pediatrics, family practice and obstetrics) that historically have been paid disproportionately less than other services, has been particularly impeded. Moreover, payments for services vary widely among states. Maximum payments for brief follow-up office visits ranged from \$6 in New Hampshire to \$28.41 in Alaska.³⁶

All three of the major proposals for Medicaid reform address this inequity. The Pepper Commission would model future reimbursement under its new federal-state program on the Medicare physician payment reform legislation enacted by Congress in 1989. Beginning in 1992, Medicare will reimburse for all physician services based on a resource-based relative value scale (RBRVS), which will substantially improve payments for undervalued primary care—*or* evaluation and management—services. By narrowing the historic gap in compensation between evaluation and management services and surgical and technological procedures, more appropriate incentives would be introduced into the system. The Pepper Commission would also immediately mandate improvements in reimbursement for obstetrical and pediatric care.

ASIM supports the Pepper Commission proposal to base future reimbursement under Medicaid (or a comparable new program) on the Medicare RBRVS fee schedule, provided that this is clarified to state that reimbursement under the state program would be no less than would be paid under the Medicare RBRVS fee schedule for a comparable service, states would have the flexibility to further increase payments for services where particular access problems exist, and other Medicare

rules (such as volume performance standards and limits on balance billing for higher income individuals) would not be mandated.

The Basic Health Benefits Act simply requires states to offer payment rates at levels adequate to insure access. The Health Policy Agenda similarly recommends that Medicaid expansion would include policies and incentives to encourage provider participation. The HPA cites a Congressional Research Service estimate that shows raising the level of Medicaid payments to physicians would increase by 13.6 million the number of visits to physician offices, a clear indication of the importance of improved reimbursement in eliminating barriers to care.³⁷

The Physician Payment Review Commission, an independent body of physicians, economists, consumers, business and health professionals established to advise Congress on reform of physician payment under Medicare, and now Medicaid, reviewed several studies on the effects of fee levels on access. The commission reports that “practically every study has reached the same conclusion: Higher Medicaid fees result in greater physician participation in the program.”³⁸

Cost Impact

The cost of applying the Medicare rules of payment to the Pepper Commission’s proposed federal-state public program were estimated to cost \$4 billion annually at full implementation.³⁹

There is no specific information available on the potential costs of improved reimbursement as called for by the Basic Health Benefits Act.

The HPA estimates that if states reimbursed physicians at Medicare levels and hospitals at incurred costs, costs would rise an additional \$4.4 billion to \$5.5 billion, of which \$1.5 billion would represent increased spending on physician services.⁴⁰ The Physician Payment Review Commission cited one study, however, that found that every 1 percent increase in fees was associated with a 0.5 percent increase in Medicaid expenditures. One of the reasons that the relationship was less than one-to-one was that there was an inverse relationship between the number of recipients of outpatient care and Medicaid fees, indicating the apparent substitutability between outpatient and office services. In other words, higher expenditures on office visits might be partially offset by fewer visits to more expen-

sive hospital outpatient departments or emergency rooms.⁴¹

4. To reduce the financial burden on the states, increase the federal government’s funding for the expanded Medicaid program.

Impact on the Problem

The HPA specifically has called for the federal government to bear a greater burden of the fiscal impact of eligibility expansion. The Pepper Commission agrees: It calls for the fully phased-in public plan to be financed and administered primarily by the federal government. States would continue to contribute the same amount that they currently spend on Medicaid to the new program. The Basic Health Benefits Act would match eligible state expenditures for the program at Medicaid matching rates, which suggests that the Act would not significantly alter the share of the costs of the program borne by federal and state governments.

ASIM believes that it is essential that the federal government pay the largest portion of the proposed Medicaid expansions. Uniform benefits and eligibility would financially strap poorer states with more limited resources. Many of the states that now have more restrictive benefits, eligibility and reimbursement simply are unable to afford program expansions. A federal mandate that all states enhance their programs to meet national guidelines makes sense only if the federal government is willing to finance largely those expansions. Opposition of the nation’s governors to further federal mandates to improve Medicaid would be muted if the federal government were to provide its fair share.

Cost Estimates

The estimates of increased federal costs and savings to states depend on how large a portion of program expenditures the federal government would pick up. More detailed projections are not now available.

Providing Coverage for Long-Term Care

1. ■ **Encourage the availability of private long-term care insurance by: applying the same tax status to long-term care products as now exists for accidental death and dismemberment insurance and health insurance, allowing the deductibility of insurance reserves and related investment earnings, permitting the inclusion of long-term care coverage in cafeteria plans, offering tax credits for the purchase of long-term care coverage, and eliminating restrictions on the prefunding of retiree health benefits and long-term care insurance.**

Impact on the Problem

Currently, the market for long-term care insurance is hindered by inequitable tax treatment. Allowing tax deductions of long-term care insurance premiums paid by employers and tax benefits for insurance companies-allowing them to accumulate interest on collected premiums-would help stimulate the long-term care insurance market place. Changes in the tax code to accomplish these purposes were proposed as part of the Long-Term Care Assistance Act, introduced in 1988 by Sen. George Mitchell (D-Maine). The bill also allowed for inclusion of long-term care policies in employer cafeteria plans, in order to enable employees to purchase these plans with pretax dollars. The proposed changes in the tax code were endorsed by the Pepper Commission as well. The Long-Term Care Assistance Act reportedly is being redrafted prior to its reintroduction.

Prefunding of long-term care insurance, through Health IRAs or other mechanisms, would help reduce the economic burden on the next generation.

Cost Impact

Little data is available on how the proposed changes in the tax code would affect the cost of long-term care insurance. One estimate suggested that premiums could be as much as 11 percent lower for insurance purchased at age 65 if long-term care insurance reserves were treated the same as life insurance reserves.⁴²

The Pepper Commission estimates that \$6.7 billion in lost federal revenue in fiscal 1990 would result from its proposals to change the tax code to encourage long-term care insurance.⁴³

2. ■ **Provide a sliding subsidy to enable low-income beneficiaries (e.g., those with incomes up to twice the poverty level or less) to purchase private long-term care insurance.**

ASIM supports a bill introduced in 1989 by Rep. Barbara Kennelly (D-Conn.) to provide federal subsidies to help low-income individuals purchase private long-term care insurance. This would extend assistance to those individuals who would not benefit from tax credits, as would middle- and upper-income groups. Although it is unclear how many lower-income Americans would take advantage of the subsidy, ASIM believes that it is important to establish the principle that individuals with lower incomes should not be excluded from the long-term care market.

Cost Impact

No data is currently available on the cost of the proposed federal subsidy to low-income persons.

3. Provide for federal and state regulations that enhance consumer protections in the long-term care market. These regulations should assure appropriate standards of coverage, the establishment of guidelines for proper disclosure, protections against sales abuses, regulation of renewal and cancellation, requirements for sufficient reserves, and development of benefit/premium ratios.

Impact on the Problem

Any proposal to stimulate the availability of long-term care insurance must protect consumers from the deceptive and fraudulent practices that all too often have accompanied marketing of Medicare supplemental insurance (or Medigap) policies. Without such protection, individuals are at risk for purchasing inadequate insurance, paying excessive premiums or purchasing duplicate coverage.

The Pepper Commission agrees with the need for states to regulate long-term care insurance by using federal or stricter standards. The commission recommends that the federal government encourage states to strengthen civil penalties for misrepresentation, sales knowingly made of duplicative insurance or sales of unapproved policies by mail.

Cost Impact

No data is available on the costs to state authorities or the insurance industry associated with promulgating and complying with stricter regulatory standards.

4. As an incentive to purchase private long-term care insurance, provide an asset protection program for individuals who purchase long-term care policies.

Impact on the Problem

Rep. Kennelly's proposal would provide a strong incentive for individuals to purchase long-term care policies as a way of protecting themselves from future impoverishment. Under her plan, an individual's assets would be protected up to the dollar value of the benefits provided by the insurance. Once the individual's unprotected assets are used, he

or she would become eligible to receive long-term care benefits under the Medicaid program. For example, if an individual with \$50,000 in assets purchased a long-term care policy with \$50,000 in long-term care benefits, the individual would be able to maintain those assets and still qualify for Medicaid coverage after the private policy's benefits were exhausted.

Cost Impact

No estimates are available on the cost of this proposal.

5. Establish a new Medicare benefit to assist individuals in paying for long-term care. The program should provide for adequate cost sharing by individuals, protection against depleting personal assets and premium contributions on a sliding scale basis.

The Long-Term Care Assistance Act, as proposed by Sen. Mitchell in 1988, would provide for Medicare coverage of long-term care after an individual paid for the first two years of chronic nursing home care. Medicare would pay 70 percent of costs for an unlimited time in a nursing home after the first two years. Home health care benefits would be expanded to include benefits of up to \$2,000 a year with a 50 percent copayment. The new benefit would enable individuals caring for a Medicare beneficiary **at home to hire someone** to relieve them when needed. The new benefit would be financed partly by premiums that would increase with beneficiary income.

The Pepper Commission proposes an even more ambitious plan. Rather than paying benefits after the beneficiary **has** financed CARE out-of-pocket for a defined time period, the commission would pay for the entire cost of the first three months of skilled and custodial nursing home care, except for a modest copayment. During the first three months, all income and assets would be protected. After the first three months, individuals must contribute their income toward the cost of care minus a personal needs and housing allowance. Individuals would contribute non-housing assets above \$30,000 for single persons and \$60,000 for married persons. The commission also proposes a separate social insurance program for home and community-based care.

ASIM believes that either approach is consistent with the principles of asset protection, cost-sharing and varying contributions by income. More debate is needed on whether or not the beneficiary should be required to pay more out-of-pocket up front, compared with having the federal government finance the first few months in a nursing home. The Pepper Commission's rationale for this proposal is that most Americans who need long-term care are in and out within three months.

Given the huge costs of financing long-term care, Congress will need to carefully consider what is a realistic level of federal support. ASIM also believes that although providing benefits for long-term care is an appropriate national objective, the highest priority must go toward providing access to care for the

more than 30 million Americans without any health insurance coverage. Consequently, if limited resources dictate a choice between implementing that portion of our program calling for Medicaid expansion and an employer mandate, or that portion calling for the creation of a long-term care benefit, priority must go toward the former. Long-term care benefits could be added as funds become available.

Cost Impact

The Pepper Commission long-term care proposal is estimated to cost \$42.8 billion.”

The Long-Term Care Assistance Act, as initially proposed in 1988, was estimated to cost between \$16 billion and \$18 billion.⁴⁵



Advantages of **ASIM's** Access Plan Over Alternative Approaches

he common thread running through ASIM's proposals on access and long-term care is one calling for the private sector and government to share the costs of expanding access to care. We believe that the way most Americans now get coverage for medical care—through employer-based health insurance—has worked well and must be preserved, albeit with some substantial improvements. The objective must be to bring as many Americans as possible into that system—not replace it.

Some have advocated that this country move toward a single-payer system. Although the specifics of single payer proposals vary, they have one element in common: The federal and/or state governments would finance coverage for all Americans. Some of the plans would do away with private insurance. Others would have the government issue vouchers to purchase private insurance, or would contract with private insurers to administer the program. Some would administer the plan largely at the federal level; others would give primary responsibility to the states. Proponents of a single-payer system tend to look toward the Canadian system as a model.

Whatever variation of a single-payer system is proposed, however, there are significant drawbacks compared to ASIM's proposed mix of public and private funding sources. Specifically:

- 1. By giving one entity-government-an exclusive monopoly over financing care, patients would be limited to receiving care only under that system.**

Under the current pluralistic system, if patients or employers do not like the service they receive from a particular insurer or feel that payments or benefits under the plan are

inadequate or do not care for restrictions the plan places on access to physicians and hospitals, they can simply purchase coverage by another plan. But if the government-financed program is the only practical choice available to patients, they cannot just “fire” the government and select another plan. Only the very wealthy would have the resources to opt out entirely from the system. Even if a single-payer plan contemplates a role for private insurers, the fact that the government still pays all the bills would result in the same inherent restriction on choice. If patients do not like medicine financed and controlled by the government, simply finding another insurance plan that operates within that system does not really offer the only choice that matters: the freedom to obtain coverage through another financing source.

- 2. A single-payer system would limit competition.**

It is ironic that at a time when more competition is being introduced into virtually all segments of society, proponents of a single-payer system propose to give a monopoly to a plan operated and financed by the government. Most Americans would agree that consumers benefit when government programs are forced to compete with private sector alternatives. Consumers, for example, benefit when the U.S. Postal Service is forced to compete with private delivery services. But in a far more important arena—the health of Americans—some are calling for a government monopoly. That just doesn't make sense.

- 3. If the government pays the entire health care bill, the care available to individuals would be at risk to the annual budgetary battles over competing priorities.**

If the government accepts the enormous responsibility of another massive entitlement program, medical care would be at risk to competing budget priorities. Congress would need to balance funding for medical care against such other priorities as defense spending, deficit reduction, education and aid to farmers. Given that the new single-payer program would immediately become one of the largest spending programs, it would be a natural target for spending cuts to pay for other national priorities--or to reduce the deficit. Medicare, which has been cut by more than \$35 billion during the past nine years, is one example of the pressure to cut costs that would be placed on the new program.

4. A single-payer system places too much control over patient care in the hands of governmental agencies.

After promising to pay for the health care bills of all Americans, Congress immediately would be under pressure to cut costs. This would inevitably lead to efforts to restrict benefits for needed services, to penalize financially physicians and hospitals that provide patients with the care they need and to limit access to new technology. The government also would have a reason to impose even more administrative barriers that are designed to make it difficult for physicians to order and patients to obtain benefits for needed services. As the only payment source, the government essentially could impose its will on who receives care and under what circumstances. Multiple funding sources, as ASIM proposes, protect the public from too much power being concentrated in any single payer.

5. It is fiscally irresponsible to propose a single-payer system at a time when the U.S. has a massive budget deficit.

One proposal for a single-payer system recently introduced in Congress is estimated to cost more than \$250 billion. Obligating the federal government to a massive entitlement

program, at a time when there already is a huge federal deficit, is irresponsible. Public opinion polls show that of those who favored federally funded National Health Insurance, 90 percent would be unwilling to pay even \$500 a year in additional taxes to finance a new national health program.⁴⁶ It is unrealistic to expect Congress to approve a plan that will exacerbate the deficit and impose a large tax burden on workers.

6. By holding out for a single-payer system, proponents of this approach risk blocking any action on expanding access.

In the late 1970s, an opportunity to reach agreement on a moderate approach to expand access was lost because of the insistence of some that only a single-payer national health insurance program would be acceptable. Pushing a single-payer system now risks reopening that divisive debate, with the same outcome expected. Given the growing consensus for requiring employers to offer health insurance and expanding public programs to fill the remaining gaps, it is counterproductive to reintroduce the debate over a single-payer system. This time around, many of the groups and individuals that were in conflict with each other in the past have codicled around the approach recommended by the Pepper Commission. Let's build on that consensus, not undermine it.

An employer mandate coupled with expansion of public programs also offers advantages over alternatives that rely solely on tax breaks and the marketplace to encourage employers to offer health insurance. Tax breaks alone will not be a sufficient incentive for employers to provide health insurance. Some have proposed asking individuals to finance their own basic care, with insurance paying only for catastrophic expenses. But this approach could hinder access to services that patients would be required to pay for out-of-pocket, such as routine medical care and preventive services.



Health Care Costs and Other Barriers to Access

comprehensive plan to end separate and unequal access to care must address more than expanding the availability of health insurance coverage but also other barriers to access. Those barriers include the cost of medical care, inequitable reimbursement systems, excessive medical liability costs, and administrative and review requirements that impede access to appropriate services. ASIM offers the following specific proposals to address these barriers. More information on the rationale behind each of these recommendations is available from ASIM.

1. **In order to assure that money spent on medical care is spent wisely and effectively, the medical profession, with the cooperation of government and other payers, should place high priority on studying the outcomes of different medical interventions and developing practice guidelines to modify physician behavior and to provide a basis for setting payment criteria.**

Outcomes research and the development of practice guidelines must be at the core of any effort to address the cost of medical care. By providing a scientific basis for physicians to decide what works and what does not work in treating patients, the uncertainties of medical practice that drive increases in the volume of services can be substantially reduced. Physicians would have a basis for not providing certain services that, based on the best scientific evaluation available, are ineffective or not as effective as alternative treatments. The creation by Congress in 1989 of the new Agency for Health Care Policy and Research can provide a focal point and financial resources to support this effort.

ASIM is involved with a partnership with the American Medical Association and other specialty societies to promote the development of practice guidelines.

Development of practice guidelines is a more effective approach to moderating costs than attempting to set arbitrary limits or targets on expenditures, since it gets to the heart of the relationship that largely determines the cost of care—the decisions that a physician makes on behalf of his or her patients—instead of attempting to impose overall limits on resources. ASIM is pleased that the Pepper Commission endorses the role of practice guidelines in addressing cost increases.

Once practice guidelines are widely available, however, medical care costs are likely to continue to increase due to the aging population, advances in diagnosing and treating patients, and new diseases. Practice guidelines provide payers with a reasonable certainty, however, that money is being spent only on those services shown to be effective. Further attempts to restrain costs will require a basic societal decision on whether and how resources for medical care should be limited, even though this may require limiting coverage for some services shown to be effective.

Caution must be exercised in imposing other cost-containment strategies that could, in fact, hinder access, by forcing or rewarding physicians for withholding needed services, by lowering payments to the point where physicians cannot afford to treat patients for the payment allowed (as is already the case with Medicaid in most states), or by setting up unnecessary administrative barriers to paying benefits for appropriate care. Moreover, the more than 30 million Americans without health insurance should not be held hostage while the country tries to find an

answer to the extraordinarily difficult problem of expanding access while controlling costs.

2. Eliminate administrative hassles that impede access to care.

The “hassle factors” associated with medical practice pose a direct threat to access.

There is a growing consensus that the current methodologies instituted by payers to review utilization and appropriateness of care are overly intrusive and are not working well for patients, physicians or payers. Criteria for review is of questionable scientific validity and is typically developed with minimal professional input. Bad criteria can result in payments for needed services being denied, while inappropriate services escape scrutiny. Emphasis on sanctions and payment denials—rather than education—undermines physician support for medical review and is ultimately less effective in modifying behavior. Those physicians who practice responsible, cost-effective medicine are subject to the same intrusive review requirements as physicians with more questionable practice patterns. Claim-by-claim review often results in denials of payments for appropriate services that later are reversed on appeal. But the hassle of fighting for payment for each claim can discourage physicians and beneficiaries from pursuing payment for needed services. The barriers to paying for covered services imposed by many payers have appropriately been characterized by one author as “rationing by inconvenience.”⁴⁷

Other administrative burdens—excessive paperwork and record-keeping requirements, overly complicated rules of payment, duplicative and contradictory rules of different payers, and constantly changing requirements—also are contributing to the problem.

Since the hassles of medical practice today hit office-based physicians the hardest, it is

perhaps not surprising that fewer physicians are entering specialties such as internal medicine, and more and more physicians are expressing a desire to retire early or accept administrative positions outside of direct patient care.⁴⁸ Some physicians have become so frustrated with the red tape of Medicare and Medicaid that they are likely to be reluctant to see patients covered by those programs, even if reimbursement is made more equitable.

For these reasons, any comprehensive plan to improve access must include measures to reduce the hassle factor of medical practice and to replace the present irrational, overlapping and complex system with a simplified, more fair and more effective alternative. ASIM will be releasing a comprehensive plan to reduce the “hassle factor” in the near future.

3. Institute reforms in the medical liability system.

ASTM is pleased that the Pepper Commission recognizes the role of medical liability reform in reducing medical care expenditures. We strongly support tort reform and limits on contingency fees and punitive damages as part of any effort to bring the costs of medical liability under control.

4. Require some level of patient cost-sharing in all insurance plans.

Requiring individuals to pay some share of the cost of services, through deductibles and copayments, provides an incentive for patients and physicians to use services judiciously. Varying cost-sharing by income would protect those who cannot afford significant out-of-pocket contributions, while still maintaining adequate protection over excess utilization.



Financing of Access and Long-Term Care Proposals

Many critics have chided the Pepper Commission for not identifying specific financing mechanisms to pay for its recommended programs. Similar criticisms can be leveled at the Basic Health Benefits Act and the recommendations in this paper.

ASIM recognizes that implementation of the recommendations in this paper will carry a large price tag. But we believe the price of neglecting those without adequate access to care is even higher. Criticism of the Pepper Commission and other similar proposals for not identifying specific funding measures is unfounded. The Commission has identified what it will cost to carry out its plan. Throughout this paper, ASIM has attempted to identify as well the potential costs of implementing our recommendations.

The issue is not the specific funding mechanisms needed to pay for the proposed expansions, but instead, whether this country agrees with the urgency of getting the job done. If there is a consensus that expanding access to care is an important national priority, then Congress can arrive at the right combination of tax increases and reallocation of spending priorities to pay for the needed expansions. But no one can argue that expanding access to Americans who now receive care under a separate and unequal system will not cost money. It is expensive, but it is well worth it.

One of the advantages of ASIM's proposal is that it asks business, government, taxpayers and patients to share the costs of expanding access to care rather than asking only one segment of society to pay the whole bill. It also is appropriate for Congress to sort through the various plans that are consistent with the recommendations in this report—particularly the Pepper Commission, the Basic Health Benefits Act and the Health Policy Agenda proposals—and decide which combination of specific changes proposed in each is most effective at expanding access at a realistic cost. Finally, setting some priorities for expansion is appropriate. ASIM believes that if limited resources preclude implementation of this entire plan at this time, making immediate interim improvements in the Medicaid program, followed by implementation of the employer mandate and a complete overhaul of Medicaid, must take initial priority over other recommendations in this paper.

But in our view, it is unconscionable for the administration and Congress to delay any longer on moving forward to end separate and unequal health care.

Let's get the job done-now.

Key Access Proposals in Suggested Order of Priority For Resource Allocation

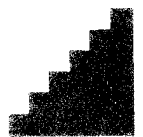
1. Make interim improvements in Medicaid eligibility, benefits and reimbursement to expand access for the poor and near-poor.

2. Require all employers to provide health insurance to their employees, institute reforms in the market for health insurance, and implement programs to provide special assistance to small businesses to reduce the cost of providing such insurance.

3. Implement measures to expand availability of private long-term care insurance.

4. Establish new federal benefits for long-term care.

5. Establish "Health IRAs" as a supplemental source of financing for medical and long-term care expenses.



Available Annual Cost Estimates For Key **ASIM** Access Proposals

(In billions of dollars)

	<u>Public</u>	<u>Employers</u>
Expand Medicaid eligibility, benefits and reimbursement (without concurrent employer mandate)	\$ 20 -36.05	
Expand Medicaid eligibility, benefits and reimbursement (with concurrent employer mandate)	5.2 - 23.4	
Require employers to provide health insurance		
• Mandate that all employers provide basic benefit package		\$ 18-33
• Provide subsidy to small business	0.6 - 8.4	(0.6 - 8.4)*
• Provide 100% tax deductibility for health insurance purchases by self-employed and unincorporated	1.3	(1.3)'
• Establish regional insurance program		(4.8)*
Create new federal benefit for long-term care	16 - 42.8	
Enact legislation to establish "Health IRAs"	7.9	

* Figures in parentheses indicate savings.

Sources: Health Policy Agenda for the American People; Pepper Commission Findings, Objectives and Recommendations; Report and Background Information on the Basic Health Benefits for All Americans Act; and Congressional Budget Office Estimates on Long-Term Care Assistance Act of 1988 and "Health IRAs." See text and endnotes for details on assumptions underlying cost estimates.

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