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A PUBLICATION OF DELAWARE BAR FOUNDATION

Volume 13 Number 1 $3.00 Spring 1995

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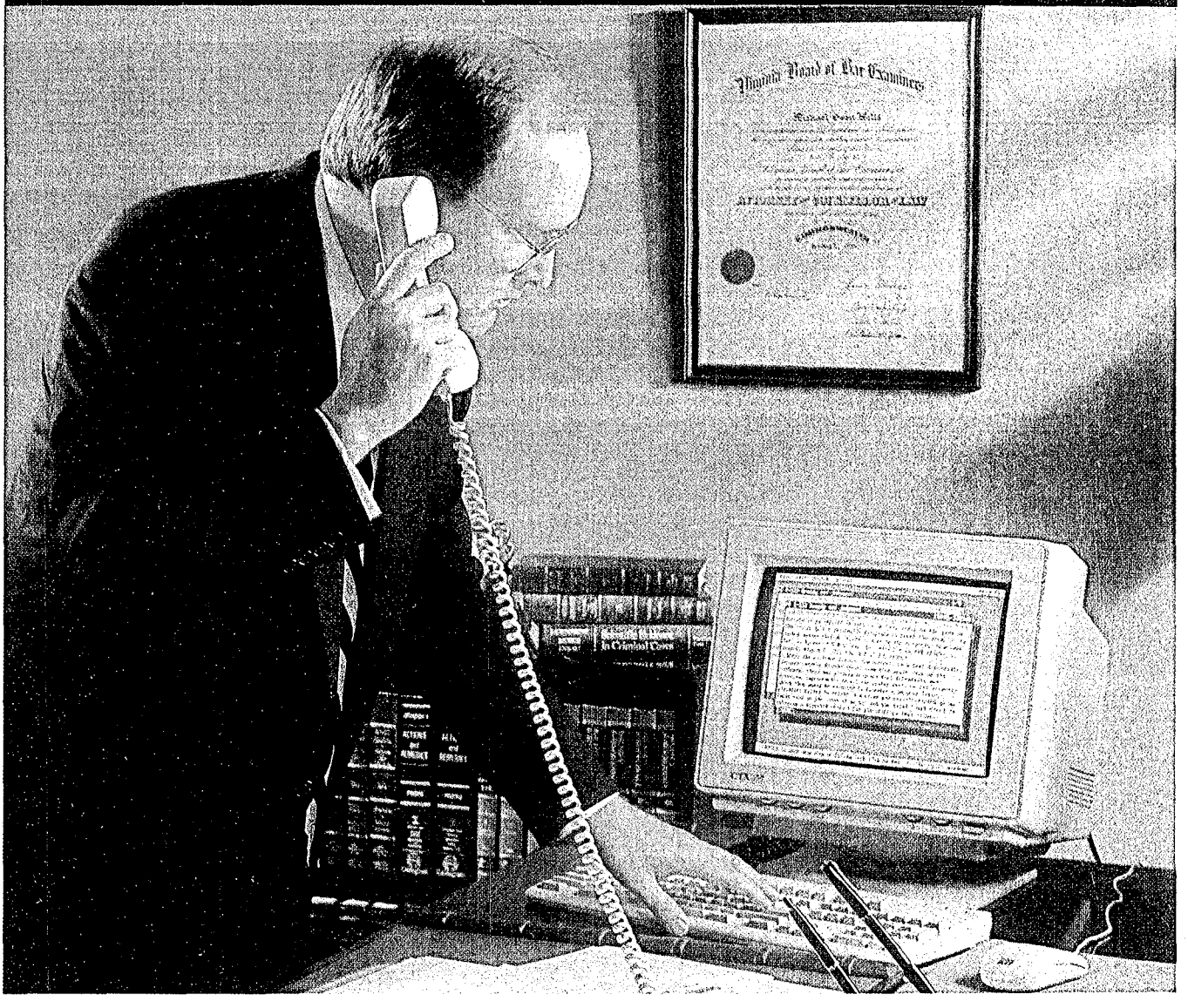

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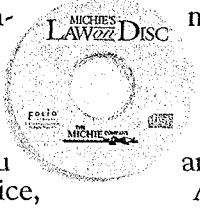

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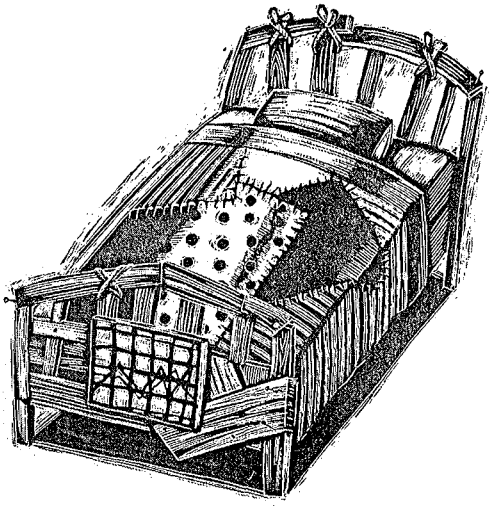
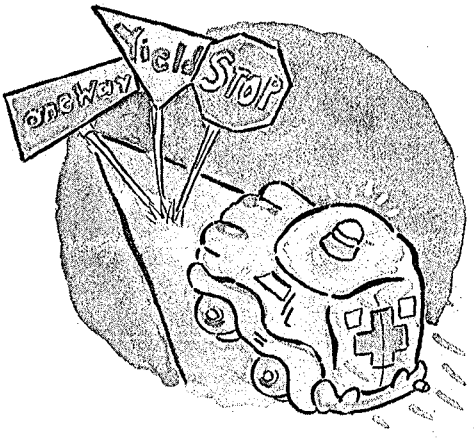
Contents



17



30

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EDITOR'S NOTE

Health care is the Rubik's cube of public policy, and this edition of The Delaware Lawyer undertakes a sixsided review of that issue. But the complexity and diversity of the health care debate blurs the relative simplicity of the problem. Our society is increasingly unable to afford escalating health care costs, and that fact inevitably is forcing profound changes in medical insurance, medical practice and the availability of health care. Our six authors in this edition examine this problem from somewhat differing, but always challenging, perspectives.

William E. Kirk, III, general counsel of Blue Cross and Blue Shield of Delaware, challenges us to face the "pain" of health care reform and acknowledge that "... in the near term, we will simply have to accept a lesser brand of care for all or some of our population, or we will have to spend more money." Bruce W. Karrh, a physician and a vice president of the DuPont Company, explains that employers, overburdened with health care expenses, have learned that "they can bring about significant costs controls through the use of managed care and other innovations ... and they are unlikely to roll back the clock."

Dr. Stephen R. Permut, an attorney and a physician who is a past president of the Medical Society of Delaware, reports that in Delaware $1.67 is charged to cover $1.00 of costs in order to subsidize care for un/underinsured patients. Without universal coverage, employers or medical payers "with negotiating clout" will force the costs of care for un/underinsured patients to "small employers and individuals," causing premiums for such groups to increase and "pricing many of them out of affordable health insurance" (absent local or national reforms suggested by Dr. Permut). Paula K. Roy, Executive Director of the Delaware Health Care Commission, explains that Delaware "stands at a critical crossroads which brings both challenges and opportunities," and she outlines a number of steps the Commission will be studying to meet this challenge, including the "evaluation of medical liability issues and current tort law."

Dr. Thomas J. Maxwell, a practicing physician and the current President of The Medical Society of Delaware, addresses the challenges which physicians face in dealing with health care reform being imposed by the private sector. He explains that "for patients and physicians alike, Health Reform currently means Managed Care" and optimistically predicts that "[w]e are on the verge of developing a health care system that will be a model for the rest of the world." Finally, John Hawley Lopez, a polished writer and experienced political observer, explains how the Clinton Plan failed politically and what the prognosis is for less comprehensive reforms, admonishing that the basic rule of reformers (like physicians) should be "do no harm."

From these six articles one thing is for certain. Whatever happens, you will be affected by the health care revolution.

— David McBride

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DELAWARE LAWYER
A publication of Delaware Bar Foundation
Volume 13, Number 1
1225 King Street
Wilmington, Delaware 19801

Editorial inquiries should be directed to:

DELAWARE LAWYER
Attention: Chairman, Board of Editors
c/o Suburban Marketing Associates, Inc.
Three Christina Centre
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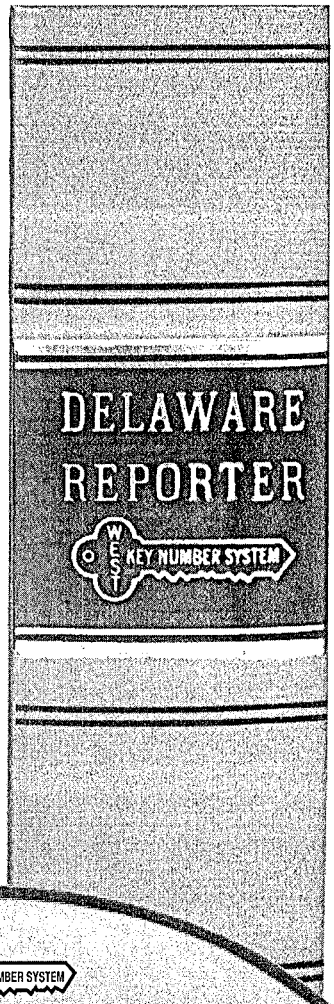

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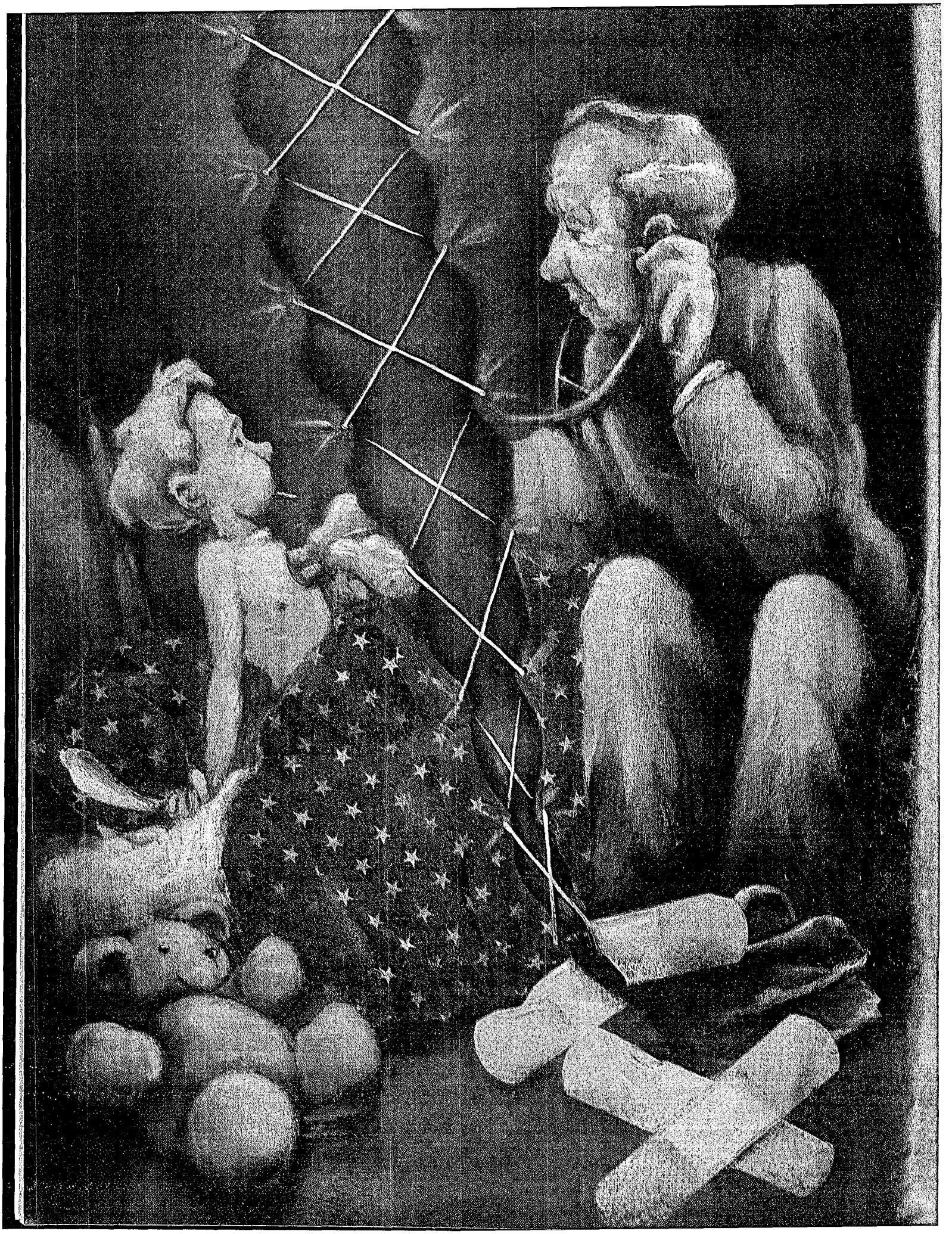


FACING THE INEVITABLE:

by William E. Kirk, III

The 1992 election of President Clinton heralded a widespread expectation that the United States would quickly adopt major reforms to its health care system, leading to universal coverage well before the end of the century. In anticipation of such reform, many states including Delaware began to make plans for their state systems to be ready to integrate into the new federal framework. Two years later, the Clinton Health Security Act is comatose if not dead, and the political landscape seems to have been hit by an earthquake, leading to Republican control of both Houses of Congress for the first time in 40 years. Even its supporters recognize that not only is comprehensive health reform stalled at the federal level, but it is likely that the President's plan was a big part of the Democratic electoral disaster, which will have a chilling effect on future legislative efforts for major change. To some, the question of how a plan that seemed to have such momentum could have come to such a grinding halt is puzzling if not downright sinister. Some attribute it to advertising and lobbying by insurers and others opposed to change, and there is no question that these activities played a part.[1] But there were other, more basic reasons.

This article will set forth the proposition that the present standoff in the health care debate was inevitable, because "we" have never been able to agree on a definitive answer to the most fundamental question of all in the health care discussion. Our society has not yet truly decided whether health care is a *right*, which should be guaranteed to all our citizens as a basic entitlement, or is simply a service that is bought and sold in a marketplace that includes health insurance. And in the absence of such a decision, health care remains presumed to be a market item rather than a universal entitlement, notwithstanding the widespread and fervent wish that it were otherwise.

The Pain of Health Care Reform

Those who argue that health care should be a right make a number of compelling points. One is that the United States already spends upward of 14% of its Gross Domestic Product on health care, as much or more than any other nation, and yet despite this massive spending we do not cover all our citizens. They point out that except for South Africa, the U.S. is the only industrialized nation that does not guarantee health care to all its citizens. They note that we guarantee elementary and secondary education to all our citizens,[2] and will even provide attorneys to those accused of crimes. They are quick to cite the health care coverage provided to Members of Congress, and to question whether the lawmakers deserve a better deal than ordinary citizens. Even opponents of the President's plan generally took pains to state that universal coverage was a worthy goal.

But the problem that simply refuses to go away is that of health care's cost, and this seems to be at the heart of all but the most ideological opposition to the "health care is a right" viewpoint. It is widely believed that the voters will not tolerate a general tax increase sufficient

ILLUSTRATION BY MIKE WOHNOUTKA

to fund universal coverage, and the 1994 election results seem to bear this out.

I Feel Your Pain (But I Don't Want to Talk About It)

When President Clinton was a candidate in 1992, he shied away from addressing the cost of universal coverage (perhaps for the same reason that former President Bush came to regret his "read my lips" recantation). Clinton promised universal coverage, better benefits, and a private sector approach, all the while controlling costs sufficiently to reduce the federal deficit by reducing federal outlays for health care. He indicated that this could be achieved largely through eliminating waste, and imposing an employer mandate to pay for most of their employees' coverage. The theory was that this would not be unduly burdensome because the premiums would be lowered dramatically.

The difficult truth that he avoided saying would have been something like: universal coverage will take a gut-wrenching dose of painful medicine for the whole country, but we need to do it sooner or later and I'm prepared to take the heat and lead us to do it sooner. He should have acknowledged that the medicine includes cost controls and other necessary elements that will reduce the use of services and eventually lead to reduced choices of providers. Candidate Clinton should have acknowledged the pain that would be felt in the small business sector by the employer mandate to pay for coverage, and after the election he and his team should have addressed this more directly.

Instead, the selling of the Clinton plan put a heavy emphasis on criticizing the health insurance industry and reciting some of the ills that have plagued it. The anecdotes of hard-working middle-class people getting sick and losing their coverage made for good drama, but they ignored the reality that there was already much insurance underwriting reform taking place at the state level to address this.[3] There seemed to be few stories about hard-working farm laborers or dishwashers or office cleaners whose employers simply never had been able to afford to provide health benefits. For political and public relations reasons, the Administration needed to convince middle class voters to support their plan out of concern that anyone could lose their existing coverage if reform did not occur. But for similar reasons, it was probably expedient to avoid emphasizing the creation of an expensive new entitlement program to benefit people who did not already have coverage, i.e. the approximately 37 million uninsured Americans. Any realistic discussion of that program would have involved acknowledging the necessary redistribution of wealth (in the form of taxes or employer mandates) to pay for it.

In what could be viewed as a case where the proof did not support the pleadings, the Administration and its supporters proposed a solution in the form of a major national program centered on employer mandates to achieve universal coverage, but as their chief evidence they cited the middle class problems that called out for insurance underwriting reform. In the end, this was perhaps not surprising, given the political difficulties a major new entitlement program created for a President who had run as a New Democrat, who had promised a middle class tax cut and deficit reduction, and who was elected by only 43% of the voters.

When insurance buyers are resourceful, they are willing supporters of cherry-picking, as long as they believe that they are the cherries.

The Law of Averages Meets the Law of the Jungle

One reason why market forces seem to be at odds with the goal of universal coverage is this: a relatively small number of people account for a large percentage of health care expenditures. In a given population, 20% of the people will generate 80% of the health care expenses; 5% of the people account for 50% of the dollars. If an insurer or other payer can avoid having to cover its full share of the users of health care services, it will realize a dramatic downward leveraging effect on its expenses. There are a number of underwriting techniques that can be used to accomplish this, which are appropriately and collectively termed "cherry picking." Many of the states have begun to restrict these practices, particularly in the small employer market, usually by adopting one or more Model Acts which have been developed by the National Association of Insurance Commissioners (NAIC).

For instance, some reform proposals restrict health insurers' ability to vary the rates charged to groups or individuals according to their claims experience, their health status or their demographic characteristics. The most far-reaching of such proposals mandate so-called community rating. It is a popular misconception that this means all carriers in a geographic area are required to charge common rates. But the most widely accepted technical meaning of the term is that each carrier is required to pool all its insureds' claim experience and charge all its customers the same rate for like coverage.

Sometimes modified community rating is permitted, in which carriers may vary the rates for like coverage according to the insured group's demographics, or its geographic location, or its industry classification, but not its claims experience or its current health status. A less restrictive possibility is to allow carriers to vary the rates charged in order to reflect health status or claims experience, but to limit the range of the variations.[4] Keeping in mind that a small number of people generate the bulk of the dollar expenditures, it may make good business sense for a carrier to use a wide spread between the rates charged to its highest risk customers and its lowest risk customers. In states where the practice is not restricted, some carriers charge "sick" groups up to ten times the rate they charge to healthy groups for identical coverage. This leads to the sickest groups dropping their coverage because they cannot afford it, and as a result the carrier has to pay fewer claims. Using such techniques, a carrier can make very high profits even when charging seemingly low rates, because it does not take much income to be profitable if there is no payout.

At first glance, it appears that the thrust of laws restricting these techniques is to curtail carriers in their pursuit of profits; some of the reform rhetoric has centered on this, at both state and Federal levels. But efforts to restrict cherry-picking can also have significant negative impacts on insurance *buyers.* If a carrier is precluded from vary-

ing the rates among its customers according to their risk characteristics, then it must average them across its customer base. Obviously, this has the effect of raising the rates charged to the better risk groups in order to lower the rates for the worst. Some would argue that this subsidization should be inherent in the very nature of insurance. But that is easier said than accepted by an employer whose rates go up in response to a community rating requirement. It has been reported that such reforms in New York and New Jersey recently led to rate increases of 50% and more for some insureds.

In the face of such increases, it would not be surprising to find some employers and employees dropping coverage, particularly those who are in good health. Even if coverage is not dropped outright, healthy groups and individuals may downgrade their benefits to include only catastrophic coverage with high deductibles, or even choose products such as income replacement in the event of illness, policies which pay a per-day amount for inpatient hospital stays, or specific disease coverage such as cancer. While certainly better than no coverage, these products are a form of underinsurance which expose the policyholders to significant added risk and also increase the likelihood of cost-shifting due to uncompensated or under-compensated care.[5]

Another popular reform in recent years has been restricting carriers' use of pre-existing condition clauses, which typically take the form of requiring a waiting period before benefits will be paid on account of conditions which existed when coverage became effective. Viewed from the perspective that health care is a right, such clauses appear to be bureaucratic avoidance of obligation, somewhat akin to the cliché about banks: that they will only lend money to people who don't need loans. It has been argued that these clauses hurt the economy by locking workers into jobs for fear of gaps in coverage if they move. But from the marketplace perspective, such clauses make perfect sense: insurers do not want to take on risks from people who are obtaining coverage in the face of known losses. It would hardly be expected that an insurer would issue a life policy to someone at or beyond death's door, or a homeowner's policy to a beachfront dweller as a hurricane approaches.

Most reform efforts acknowledge

this, and merely limit but do not forbid the use of these clauses. Some require that a new carrier give credit toward its waiting period for time insured under equivalent coverage with another carrier, on the theory that if a person already had insurance, they are not likely to be trying to beat the system by waiting to buy insurance until it is needed.

When insurance buyers are resourceful, they are willing supporters of cherry-picking, as long as they believe that they are the cherries. This was brought home to me a few years ago in the offices of the Delaware State Bar Association. One of the members had experienced difficulties with increasing rates for his own small law firm, and he requested that the Association support legislative efforts to require community rating. I attended an Executive Committee meeting at which this was discussed, and then-President Jack Schmutz asked me if it would be feasible to set up a pool or cooperative for the Bar Association so that its risks could be spread across a broad base. I informally (and to be honest, somewhat rhetorically) polled the attorneys sitting around the table, most of whom were in firms or companies that had their own self-funded or experience-rated plans, and none of them seemed interested in giving up that arrangement to go into a larger pool.

Attorneys are well positioned to take advantage of opportunities to obtain group-specific coverage on favorable terms when their health permits, while seeking the safety of a larger pool when that is more advantageous. Shortly after joining Blue Cross in 1980, I spoke to an acquaintance at a fairly large law firm, one which had switched away from my company to a competitor a few years before. Thinking that a few months at the company qualified me to try to do some selling, I gently chided this lawyer for not lobbying to get his firm to come back to "the best", since it was in the interests of the attorneys and employees to have good coverage. I was surprised, to say the least, when this attorney matter-of-factly stated that Blue Cross certainly was "the best", and the attorney was glad to be covered there. As it turned out, the lawyer was also an officer in a small family-run business, and in those days of a more relaxed approach to underwriting, had managed to be covered through the business while the law firm saved money by using another carrier, without the responsibility for the claims of this lawyer's family.

When underwriting rules are designed for groups of workers in standard forms of business organization, (i.e. corporations and partnerships) it can be tempting for the owners to try to gain an advantage by the use of non-standard forms. Arrangements such as professional corporations within partnerships have been used to provide benefits to the owners that are superior to those provided to the staff, especially if the owners or their dependents have health problems but are unwilling to pay for the best level of benefits for all of their employees. Such forms of organization also make it possible to separate members who have health problems from the rest of the group so that it can get a better rate.

Whether used by insurers or insurance buyers, the techniques just described frustrate the classic insurance principle of spreading risk across a broad base, but they also illustrate that in a free market economy, where ingenuity is normally rewarded, there are strong incentives to treat health care as an ordinary market-based service.

The Unique Role of Health Insurance

One important reason for the current impasse and the failure to determine that health care is a right lies in the very phenomenon discussed at the beginning of the previous section on cherry-picking. Because only a small portion of the population generates a large portion of the health expenditures, then the majority of the population could accurately believe that it is subsidizing the unhealthy minority, and might resist efforts to increase that subsidy (through taxes or otherwise) by explicitly recognizing health care as an entitlement.

As previously noted, cross-subsidization to spread risk is often considered inherent in the very nature of insurance, so it might be somewhat surprising that resentment of and resistance to it could be a motivating factor in our society's difficulty in moving to embrace universal coverage. Yet some other types of insurance have produced analogous thinking.

Automobile insurers take great care in classifying drivers and vehicles according to perceived risk factors. Few would take issue with the widespread practice of reflecting a driver's moving violations or accidents in the premiums, since these factors seem to be very relevant to the future risk. The same could be said for completion of a defensive driving class, or possibly a teenage driver's academic record. A driver's age, gender, marital status and address may well seem less directly relevant, at least to the general public, and in the case of the first two factors, they are things over which the driver has no control.

Yet casualty insurance actuaries and underwriters find them relevant, and our society in general seems content to defer to their judgment. There has been little or no public outcry for insurance reform to smooth out automobile insurance rates, on the theory that driving is a right rather than a privilege.[6] Moreover, the accurate classification of risk seems to bring praise, not criticism, to insurers writing coverage for life, disability income replacement, workers' compensation, fire and theft, errors and omissions, directors and officers, professional liability, and perhaps others.[7]

Those Americans who are covered by a reasonably good health plan get essentially the same care as the wealthiest individuals in this country or in the world.

Health insurance has a special aura because it has, to a large extent, filled much of the role taken by governmentally-provided or required health coverage in other societies. Most countries made early decisions to require employers to provide workers' compensation for industrial accidents, as did the United States. Other common forms of social insurance include old age, disability and unemployment benefits, and the United States gradually adopted each of these. But where other countries adopted various national programs to ensure the provision of medical care, the United States did not. There were a number of efforts made to adopt a national health insurance plan for the United States earlier in this century. One of these efforts was made by President Truman, who attempted to pass it with a Congress that had changed to Republican control in 1946 following the Democratic New Deal years.[8] Each of these efforts failed, while private health insurance continued to grow. (Medicare and Medicaid were adopted to fill needs that were not met by private health insurance.) Through its tax policies, its labor laws, and otherwise, the government has encouraged this growth.[9]

Those Americans who are covered by a reasonably good health insurance plan can get essentially the same care as the wealthiest individuals in this country or in the world. That can be said of very few other marketplace goods and services. We do not expect that people of moderate means can live in any home they choose. We do not expect that most people will eat all their meals out at luxury restaurants. We do not expect that the men and women who work at the Chrysler or General Motors plants will drive a Jaguar or Rolls Royce — even leaving product loyalty aside. Yet the plant worker's child can go to the A.I. DuPont Institute for an orthopedic operation, or to Johns Hopkins University Hospital or even the Mayo Clinic.[10]

As a result, insurance has made many if not most middle class Americans into the "haves", at least insofar as health care is concerned. Much of this was brought about through collective bargaining, and ironically the unions were among the opponents of some earlier efforts to bring about national health care plans. (This was because some leaders such as Samuel Gompers wanted to obtain such coverage through the bargaining process; in recent times, unions have generally favored a national health plan.) With the "haves" being the roughly 85% of Americans who have health coverage, and the "have nots" the other 15%, it is not surprising that the former group is reluctant to give up (or see major change in) what it has in order to make things better for the others. A common refrain during the debate over the Health Security Act was essentially this: if only 15% of the population has the problem, why not deal with that and not ruin what works well for the rest of us. This line of thought finds its ancestry at least as far back as Truman's time, when various proposals were made involving voluntary private insurance for upper-income people and expanded Social Security or other government assistance would be provided to lower-income individuals. But it leads to a two-tiered health care system, which many find undesirable from an egalitarian standpoint.

Prospects for Congressional Action

The failure of the Clinton health plan in 1994 has prompted much speculation that there will be Republican-led efforts in the current Congress to pass some type of incremental health care reform bill. Before the 1994 election, there was probably a bipartisan consensus in favor of insurance underwriting reforms, including prohibitions on health-related cancellations, limits on the use of pre-existing condition clauses (sometimes referred to as portability of health benefits), and possibly for some type of community rating.

However, in his television address to the nation early in 1994, President Clinton held up his pen and said he would veto any measure that fell short of his goal of universal coverage, although he did indicate some flexibility in the timetable for achieving it. If the Administration takes a hard line in favor of universal coverage, and conservative opponents balk at even so much as insurance underwriting reforms, then the prospects for any meaningful action are poor. But Senators Dole and Gramm have Presidential ambitions of their own, and the GOP leadership will probably want to demonstrate to the nation that it is capable of leading and not just of resisting. Therefore it appears reasonably likely that some type of insurance underwriting reform will pass in this Congress.

Another major area for possible action by Congress is that of permitting states to have more leeway in designing their own health care systems, including universal coverage. One of the chief obstacles to comprehensive reform at the state level is the 20-year old federal law known as ERISA. The Employee Retirement Income Security Act of 1974 was originally designed to protect pensions, but in a series of court decisions, that law has been held to pre-empt state laws attempting to have an impact on many kinds of employee benefit plans. In general, ERISA does not pre-empt state laws regulating insurance, but the courts have ruled that if the underlying financial arrangement does not constitute true insurance, then there will be pre-emption even if an insurance company is involved. By moving to self-insure their benefit plans, employers and unions have been able to avoid a variety of state laws mandating that certain health benefits be covered. There is a strong trend in this direction, and it has been estimated that over half of the total number of employees in the country are under self-funded arrangements. As a percentage of the employees who actually have coverage, an even higher portion (as many as 60 or 70% in some states, including Delaware) have it under such arrangements.

The United States Supreme Court has agreed to review the Second Circuit decision pre-empting several New York state laws which impose surcharges on hospital bills in order to raise funds to assist the uninsured. Similar laws have also been struck down in New Jersey and Connecticut. The Supreme Court's decision may clarify the law in this area, but if it upholds the Second Circuit, it will be up to the new Congress to change the law so as to permit more state flexibility. Many large employers and some unions will oppose this, because they prefer to design their own plans for the benefit of their own members, without having to follow substantive and procedural requirements that vary from state to state.

In the near term, we will simply have to accept a lesser brand of care for some or all of our population, or we will have to spend more money.

As is discussed elsewhere in this issue, the Delaware Health Care Commission recognized this problem in its report to the Governor in 1994, and its recommendations were made with the knowledge that in the absence of changes to ERISA, Delaware would be very limited in its ability to require large employers to participate in paying for coverage for the uninsured. Because of the large number of employees whose coverage is self-insured, this is a very significant limitation. The prospects for Congressional action on this subject are uncertain at best.

A Range of Unappealing Choices

The kinds of insurance underwriting reform described above are a step in the right direction. They will ease the uncertainties for the majority of the population that now has health coverage. But they will not begin to solve the problem of getting coverage to low-income workers and their dependents. And ERISA reform, if Congress would pass it, simply shifts the scene of the painful debates over choices from Washington to the states.

True comprehensive reform, i.e. universal coverage, can only take place in one of three ways, or some combination:

(1) By establishing a two-tiered system (i.e. government and private) for those unable (financially or otherwise) to obtain mandatory private insurance, perhaps by expanding Medicaid eligibility and controlling its costs through tightly managed care;

(2) By putting everyone in a controlled system that spends less (or slightly more); or

(3) By spending much more money, either in the form of taxes or an employer mandate.

The Clinton Administration appears unlikely to accept the first, and it is not clear that the public would support it in any case. But if the other alternatives are not acceptable, this approach has the advantage of taking nothing away from the majority of Americans who are already covered. Some increased taxes would probably be needed; Medicaid expenditures have been increasing much faster than the rate of health care inflation. And it would be necessary to compel everyone to be covered privately or through the government program; for those currently without coverage who perceive themselves to be healthy, this may appear to be an unwarranted governmental infringement.

The second approach was part of the Clinton plan, with its regional health alliances and their expenditure targets. It is not clear whether it was this aspect or the employer mandate that was more damaging to the plan's public support. But it involves a majority of the population giving up at least part of something that they have now. It has been pointed out that this is already happening, since private insurance is moving in the direction of managed care and cost controls. But the 1994 election seemed to show a clear preference for the government's role to be reduced, not enlarged, and there is a growing resistance to the managed care techniques, even in the private insurance sector.

The third approach may be the least popular of all. There is no chance that

the new Congress will adopt the kind of major taxes necessary to fund such an expansion of health coverage. Indeed, such a program has rarely if ever been proposed by a President or Congressional leader of either party.

The employer mandate in the Clinton plan galvanized the nation's small businesses, and it was their opposition, especially as represented by the National Federation of Independent Businesses, that contributed more than any other interests to the plan's defeat. The merits of the mandate question are best left to another day, but the dimensions of the problem can be suggested with a couple of figures. Workers making minimum wage earn less than $10,000 per year, and even a basic plan of coverage costs at least $2,000 per year per worker, and more for family coverage. (Depending on what underwriting techniques are permitted, premiums may be lower for young, healthy employees, but as was seen above, that has the effect of raising them for the older and sicker ones.) And unless employers are required to pay the full cost of coverage, which even the Clinton plan did not do, then employees will also have to be required to pay their share of the costs; this would add many employees to the ranks of those feeling aggrieved by the mandate. There simply does not seem to be enough available wealth within that part of the small business sector to achieve universal coverage without a significant effect on jobs.[11]

If universal coverage is achieved, there may be some eventual savings realized, particularly if people who defer care due to lack of coverage will seek it earlier, when dealing with their problems is less costly. But in the near term, we will simply have to accept a lesser brand of care for all or some of our population, or we will have to spend more money. A final option of course is to leave the status quo, while making modest changes to increase security for those already having coverage. It is sometimes pointed out that lack of coverage does not necessarily equate to lack of care, particularly in a state like Delaware, where all the hospitals are of the not-for-profit, community-oriented type, and where the Nemours Foundation, the Medical Society and others have made commendable moves to render care to those who do not have coverage. But while it may be true that few if any of those lacking coverage are forced to do without care altogether, it is undeniable that Delaware has some serious inadequacies,

not the least of which is its high infant mortality rate. Perhaps by the next century we will find the political will to decide, in the words of Candidate Clinton, that indeed "we can do better."

William E. Kirk, III is Vice President, General Counsel and Corporate Secretary of Blue Cross and Blue Shield of Delaware, where he began work in 1980 after serving as a Deputy Attorney General for the State of Delaware. He is responsible for the Company's government affairs as well as its legal matters, and during his career there he has been actively involved in health care legislation in Dover. He served from 1991-1993 on the Insurance Reform Committee of the Delaware Health Care Commission, and has been a member of the Commission's Cost Containment Committee from 1993 to the present. His article on competition and deregulation in the health field appeared in the Winter, 1985 issue of Delaware Lawyer. His articles on Delaware's corporate history and its antitrust law have been published in the Delaware Journal of Corporate Law, the Corporation Law Journal, ad the Corporate Practice Commentator.

Footnotes

1 The "Harry and Louise" commercials, sponsored by the Health Insurance Association of America (with which Blue Cross and Blue Shield is not affiliated), were evidently quite effective with the public and troublesome to the proponents of the Clinton plan. It was reported that the President and the First Lady themselves took part in a skit spoofing the ads.

2 After the 1994 election passage of Proposition 187 in California, restricting access to education and health care for illegal aliens, it is clear that American generosity does not always extend to non-citizens. Interestingly, in the same election, Californians easily rejected Proposition 186, which called for a single-payer state-controlled health care system. (As early as 1918, California voters had rejected a referendum proposing a state health coverage plan.)

3 Such reforms were also being proposed in more modest Congressional bills. One such bill had nearly been passed during President Bush's term.

4 This is what Delaware did in 1992, following the lead of the NAIC Model Act on rating reforms in the small employer market. See 18 Delaware Code Section 7205.

5 In Delaware, hospitals must charge about $1.60 in order to collect $1, because they deliver so much uncompensated and undercompensated care. The Federal government causes the largest part of the problem, due to its inadequate reimbursements under Medicare and Medicaid.In 1993, Federal spending on these programs represented 31.7 percent of all health care expenditures in the U.S.

6 To be sure, there have been a number of successful efforts to ban gender as a factor, and,on occasion a bill is introduced in Delaware to limit automobile insurers' use of drivers' accidents or convictions.

7 Gender as a risk factor has also been somewhat controversial in these lines, as have geographic factors which appear to be "red-lining."

8 President Clinton now finds himself in an analogous situation. Truman ran against the "do-nothing Congress" in 1948, the year of the famous upset win over Thomas Dewey.

9 The reasons for the failures of reform efforts and the growth of insurance are discussed by Paul Starr in his brilliant and classic book, The Social Transformation of American Medicine (1982). Starr notes the effect that the growth of health insurance played in dampening agitation for a government program. It is interesting to speculate whether Starr,who served on the White House Task Force that produced the Health Security Act, advised the Administration on the reasons for the previous failures and suggested strategies for avoiding them.

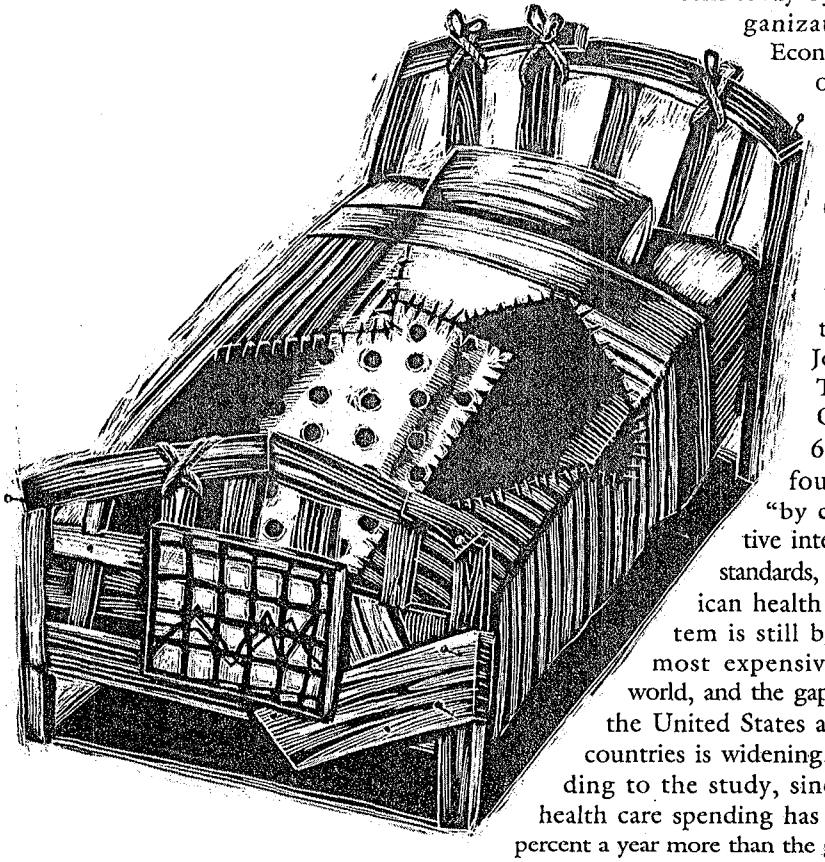
10 This assumes that the benefit plan permits a choice of institution. Increasingly, that is not the case; in 1993, traditional fee-for-service plans accounted for only half of all health coverages. The rest ere HMOs, PPOs (preferred provider organizations) and others which may restrict patient choices of health care providers. The societal and legislative response to this would be a subject for another complete article. For example, House Bill 616 in the 137th General Assembly would have required health insurers to include in their preferred networks at least one Delaware-based provider of every health service they cover. This would preclude an arrangement requiring insureds to go out of state, for instance for heart surgery, if the service is offered in Delaware. The bill was introduced but did not see action before the session ended.

11 A 1994 survey of Delaware businesses conducted by the University of Delaware and commissioned by the New Castle Chamber of Commerce reveals overwhelming small business opposition to an employer mandate. ◆

BRUCE W. KARRH

Health Care Reform in the United States

What is it about the health care system in the United States that makes it such a popular target for reform, especially since many regard it as the best in the world?



A recent study by the Organization for Economic Cooperation and Development (OECD), as reported in the Wilmington News Journal on Thursday, October 6, 1994, found that "by comparative international standards, the American health care system is still by far the most expensive in the world, and the gap between the United States and other countries is widening." According to the study, since 1980, health care spending has grown 4 percent a year more than the growth in consumer prices in the U.S.

In 1992, health care consumed about 14 percent of the U.S. Gross Domestic Product (GDP). That health care consumed that much of the GDP may not in itself be bad, but for any one industry to consume a disproportionate share of the GDP prevents money from being spent on other societal needs, such as education, transportation or rebuilding parts of the nation's infrastructure.

Reforming the U.S. health care system is essential to any significant attempts to reform the welfare system. With more than 37 million Americans without health insurance, many of them indigent, universal health care has to precede welfare reform efforts.

Health care in the U.S. has simply become too costly, too impersonal and too complex. Too many people do not have health insurance. This lack of insurance does not mean that those who are uninsured do not receive care when they need it. Rather, it means that they may get the care they need from an expensive, inappropriate and not cost-effective facility, such as a hospital emergency room for a non-emergency condition. Through cost-shifting, much of the cost of this care received by the uninsured is shifted to those who are already paying for their care.

Inspite of the demise of legislative health care reform, efforts undertaken by the private sector are increasingly successful. Employers as well as states have learned that they can bring about significant cost controls through use of managed care and other innovations in the health care delivery system, and they are very unlikely to roll back the clock. Health care providers also are looking at innovative ways they can restructure their organizations and participate in private health care reform efforts. Among these are cooperative agreements between hospitals and their physician staffs, creating systems called variously Physician Hospital Organizations (PHOs) or Integrated Service Organizations (ISOs).

For many reasons, most large employers have supported some form of comprehensive reform. Many of the costs for health care rendered to the uninsured and to recipients of Medicare and

Illustration by Juliette Borda

Medicaid are being shifted to those who are already paying for their care, whether by insurance or out of their own pockets. For example, data provided by Blue Cross of Delaware show that, for every dollar's worth of care a paying Delawarean receives from a hospital, there is an additional charge of more than 60 cents tacked on by cost shifting for uncompensated care. Employers currently providing benefits hope that reform will more equitably distribute the financing of health care across all segments of society.

What are the causes of the dramatic increases in health care costs both in Delaware and in the rest of the nation? There are many, each one contributing significantly to the increases.

Most observers agree there is considerable waste and inefficiency in the U.S. health care delivery system. It is estimated that this waste and inefficiency, plus unnecessary care, add about 20 percent to the cost of health care in this country.

There also are too many specialist physicians and too few primary care providers, contributing to a lack of care management. As patients in need of care, we refer ourselves to the specialists we believe we need to see, without the benefit of a primary care provider (PCP) directing or managing our care. We make medical choices without the guidance that a PCP can give. This practice has evolved over the last 25 years as more specialist physicians and fewer PCPs have come out of training. Prior to this evolution, the general practitioner was the care manager for his or her patients, directing them to what he or she perceived to be in the best interest of the patient.

Malpractice litigation, or the threat of such litigation, leads to what is known as "defensive medicine." While there are studies that suggest that fear of lawsuits does not significantly increase costs, it is perceived as being the cause of physicians ordering too many tests and procedures, and thus must be addressed in some way.

There have also been studies reporting that more than 50 percent of the health care a person receives over a lifetime is received in the last 6 months of life. Such a statistic points out a need to take a long, careful look at the decisions that need to be made and the ethical issues that are raised. For example, how much of the health care dollar should be spent in keeping a person alive for just a few more days or weeks? Should costly technologies be used for patients with conditions that are invariably fatal in a short time? These questions can only be answered by our society as a whole, not by health care practitioners, and so far our society has not stepped up to this responsibility.

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Another cause of the excessive costs of health care in the U.S. is that each health insurance company has its own unique requirements and reporting forms which are usually incompatible with the requirements and forms of other insurance companies. This variability imposes additional recordkeeping requirements on providers, thereby increasing administrative costs.

The technological innovations of the last 20 years, largely energized by space age technology, have created many wonderful capabilities. We have become dependent on these medical technologies, both as patients and providers. However, the unwarranted and inappropriate uses of technology further serve to drive up costs.

There also is significant duplication of technological capability among geographically close health care providers. Each hospital wants its own CAT scanner or magnetic resonance imaging (MRI) capability. Once purchased, it is to a hospital's financial advantage to keep this expensive equipment fully utilized, even if the indications for using the technology in some cases may not be clear.

In addition, the U.S. has a problem with an uneven distribution of physicians. The larger cities generally have sufficient numbers of health care providers, except perhaps in the lower socioeconomic city centers. People in rural areas, however, generally have to travel long distances to receive care. Society needs to explore this imbalance of access and develop innovative ways to correct it.

As excessive costs from all of these reasons pile up, they are passed on to the patient, or to the entity that is paying for the patient's care, driving up health care costs without improving the quality of the care being received.

As providers of a significant proportion of the health care insurance in the U. S., employers have seen their costs steadily increase from year to year, usually at rates two or three times the annual increases in the consumer price index (CPI). In some cases, employee health care has become the single largest cost a manager will incur over which he or she cannot exercise any control. That fact, coupled with changes which were made in Financial Accounting Standards Board (FASB) Rule 106, requiring employers to begin to account for future retiree health care costs, was a significant force which drove most employers to support health care reform. These two factors also drove employers to begin to make changes in the health care benefits they offered to employees and retirees. The purpose of the changes was to bring a more market-oriented approach to the health care delivery system in order to gain control of the costs and the annual cost increases and to minimize the amount of equity reduction a company had to take to comply with revised FASB Rule 106.

Employers operating in more than one state favor national rather than state-by-state reform to preserve their ability to offer employees uniform benefits and to avoid needless administrative costs of several different health care plans. A single health care plan not only reduces administrative costs but also makes it possible to have equitable benefits packages for employees working and living in many different states, which is a sensitive employee relations issue.

The task we face in health care reform is devising a way to improve the cost-effectiveness of the care we receive without causing deterioration of the quality. This was the challenge faced by Congress as they tried to address health care reform, and it continues to be an issue facing state legislators and governors. Private employers and individuals have not been exempt from facing this issue either.

Many different reform proposals surfaced during the national legislative debate on health care reform. The most visible and most discussed of these was the proposal of the Clinton Administration (1), developed by a task force led by the First Lady herself. The Clinton plan totally revamped the health care delivery system. It failed largely because it was so grandiose, which made it difficult to understand and more likely to create new government bureaucracies. The Clinton plan, however, would have accomplished at least one of the two critical needs that were outlined by the President—achieve universal coverage. The President's other critical requirement was to hold down costs, and there is a difference of opinion whether the Administration's plan would have accomplished that objective.

The Clinton plan had its advantages. Among these were that it relied on managed care to hold down costs, had a standard benefit package and standard forms, was focused on prevention, built universal coverage by expanding on the existing employer-based system of health insurance and had some desirable income tax provisions. In addition to the shortcomings noted above, however, the Clinton plan also had questionable financing mechanisms, did not adequately address malpractice issues and allowed considerable individual state flexibility, much to the detriment of multistate health insurance plans. Public and Congressional sentiment turned against the Clinton plan as its specifics became clearer.

Probably the next most discussed plan was one called the Cooper-Grandy proposal, offered by Congressman Cooper (D-Tenn.) and Congressman Grandy (R-Iowa). (2). This plan was patterned on the concept of "managed competition," advanced by a group of health policy experts referred to as the Jackson Hole Group. It was a minimally regulatory plan that built on the existing employer-based system, had a provision for a standard benefit package, was prevention focused, used outcomes data and patient satisfaction indices to guide

future improvements, included Medicaid and malpractice reform, would reduce system administrative expenses and was free market focused. Areas where it fell short, however, were that it did not require employers to provide health insurance to their employees, it omitted Medicare entirely and it had inadequate tax provisions. This proposal received some favorable, short-lived attention when it was endorsed by the prestigious business leadership group, The Business Roundtable, but that favor soon died.

Both leaderships, Republican and Democrat, in both the Senate and the House offered proposals when it became obvious in the latter stages of the 103rd Congress that neither the Clinton plan nor the Cooper-Grandy proposal could win sufficient support for passage. None of these proposals received serious attention.(3),(4),(5),(6).

A bipartisan group in the Senate, calling themselves the Mainstream Coalition and led by Senator Breaux (D-La.) and Senator Chafee (R- R.I.), developed a bill designed to appeal to both sides of the aisle, and to all who were interested in health care reform (7). Its advantages were that it had acceptable financing, would expand to some extent on the employment-based health care insurance system by requiring employers to offer, but not pay for, health care insurance and it limited individual state flexibility. Its major disadvantages were its lack of a mandate, and hence the unlikelihood that it would achieve universal coverage, inadequate tax provisions and a provision that could undercut efforts to control costs by implementing managed care.

On the House side, Congressman Rowland (D-Ga.) and Congressman Bilirakis (R-Fla.) also developed a bipartisan proposal (8). This was largely an insurance reform proposal that was never put into the legislative process. Its advantages were that it limited individual state flexibility, preempted state laws that would hamper efforts to implement managed care within the state and had significant health insurance and medical malpractice reforms. Its drawbacks were that there were no cost containment provisions, no mandates and shaky financing provisions. It also had the potential to create an unstable insurance market because of bad risk selection provisions.

Both the Senate Mainstream Bill and the Rowland-Bilirakis proposal lost political support over the Congressional Labor Day recess and never became viable proposals for Congressional consideration after that.

Although Congress failed to enact a comprehensive health care reform law, they did accomplish a lot toward getting needed reforms into the health care delivery system. Most state governments began to look at what could be done on a state level to get some needed reforms. Most employers also used the opportunity created by the attention being given to health care to make changes in their employee/retiree health insurance plans.

Legislation which has been adopted in some states, such as "any willing provider" statutes or "pharmacy access laws," are referred to as "anti-managed care" provisions. If a plan is required to take all providers, as these laws require, the plan cannot deliver the agreed volume to the providers who are willing to discount. This will serve to drive health care costs up.

Many employer-provided health care systems have begun to move away from traditional indemnity health insurance programs. Under an indemnity program, the employer either insured the health risks of its employees/retirees and was experience-rated each year or was self-insured, paying the actual health care costs incurred by the plan's beneficiaries.

Employers, especially the larger ones, have begun to move their beneficiaries into one or more of the various forms of managed care. The term "managed care" is used to describe collectively a group of several different mechanisms permitting access to health care while also allowing and, in fact, encouraging some control. A Health Maintenance Organization (HMO) is one form of managed care. There are at least two different types of HMOs, the staff model where the providers are employed by the HMO and provide care from a common office and the Independent Practice Association (IPA) model, where the providers practice from their own individual offices but combine some of their administrative needs.

Another managed care model which has been gaining favor in recent years, especially among employer-sponsored plans, is the Point of Service (POS) concept. In a POS plan, the patient has more flexibility and choice than in the traditional HMO. Each time the patient needs care, he or she can decide whether to go to a provider who is in a "network" and has agreed to treat patients for a reduced fee in return for a volume of patients, or to go to the provider of the patient's choice. The difference is that the patient will generally pay more out of pocket for going to the provider of his or her choice. POS allows freedom of choice, something which we all cherish, but at some additional personal expense.

Networks of providers set up under managed care plans can include not only physicians but also hospitals, pharmacies, laboratories, X-ray facilities and other providers. In these networks are providers who have agreed to offer discount fees or prices in return for the patient volume that can be directed to them. This is why legislation which has been adopted in some states, such as "any willing provider" statutes or "pharmacy access laws," are referred to as "anti-managed care" provisions. If a plan is required to take all providers, as these laws require, the plan cannot deliver the agreed volume to the providers who are willing to discount. This will serve to drive health care costs up. Several independent studies, one by the Wyatt Company (9) and a more recent one by Atkinson & Associates (10), have shown that "any willing provider" laws can defeat the cost savings that can be achieved with managed care programs. The Federal Trade Commission has expressed this same view in several letters to various state legislators inquiring about the effects of such legislation.

Many groups of smaller employers

we can expect much more activity by individual states.

State action will likely focus on gaining control over all the health plans operating in the state. To do so will require waivers from the provisions of the Employee Retirement Income Security Act (ERISA). For a long time, states have wanted to tax the self-insured health coverage plans that enjoy ERISA preemption. This preemption has resulted in lost revenue opportunities for the states that they sorely want and now, with Medicaid shortfalls, sorely need. Waivers from ERISA preemption will operate to the detriment of large employer plans operating in multiple states. A battle between employers and states can be expected.

ERISA allows employers operating self-insured health plans in many states, to operate consistent plans in all the states, without local benefit mandates creating imbalances in health care coverage between employee groups in different states. Consistent plans are advantageous for at least three major reasons: (1) they allow the employer to provide uniform employee benefits regardless of where the employee may be assigned; (2) they enhance the employer's ability to transfer employees between states without sudden changes in benefits; and (3) they enable the employer to avoid nonproductive administrative costs. Also, the individual states cannot tax plans that are ERISA exempt, which provides a savings to employers and a loss of revenue to the states.

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Both leaderships, Republi can and Democrat, in bot the Senate and the Hous offered proposals when i became obvious in the latte stages of the 103rd Congres that neither the Clinton pla nor the Cooper-Grandy pro- posal could win sufficient sup- port for passage. None of these proposals received seri- ous attention.(3),(4),(5),(6).

A bipartisan group in the Senate, calling themselves the Mainstream Coalition and led by Senator Breaux (D-La.) and Senator Chafee (R- R.I.), developed a bill designed to appeal to both sides of the aisle, and to all who were inter- ested in health care reform (7). Its advantages were that it had acceptable financing, would expand to some extent on the employment-based health care insurance system by requiring employers to offer, but not pay for, health care insurance and it limited individual state flexibility. Its major disadvantages were its lack of a mandate, and hence the unlikelihood that it would achieve universal coverage, inad- equate tax provisions and a provision that could undercut efforts to control costs by implementing managed care.

On the House side, Congressman Rowland (D-Ga.) and Congressman Bilirakis (R-Fla.) also developed a bipartisan proposal (8). This was largely an insurance reform proposal that was never put into the legislative process. Its advantages were that it limited individual state flexibility, preempted state laws that would hamper efforts to implement managed care within the state and had significant health insurance and medical malpractice reforms. Its drawbacks were that there were no cost containment provisions, no mandates and shaky financing provisions. It also had the potential to delivery system. Most state governments began to look at what could be done on a state level to get some needed reforms. Most employers also used the opportunity created by the attention being given to health care to make changes in their employee/retiree health insurance plans.

Many employer-provided health care systems have begun to move away from traditional indemnity health insurance programs. Under an indemnity program, the employer either insured the health risks of its employees/retirees and was experience-rated each year or was self-insured, paying the actual health care costs incurred by the plan's beneficiaries.

Employers, especially the larger ones, have begun to move their beneficiaries into one or more of the various forms of managed care. The term "managed care" is used to describe collectively a group of several different mechanisms permitting access to health care while also allowing and, in fact, encouraging some control. A Health Maintenance and has agreed to treat patients for a reduced fee in return for a volume of patients, or to go to the provider of the patient's choice. The difference is that the patient will generally pay more out of pocket for going to the provider of his or her choice. POS allows freedom of choice, something which we all cherish, but at some additional personal expense.

Networks of providers set up under managed care plans can include not only physicians but also hospitals, pharmacies, laboratories, X-ray facilities and other providers. In these networks are providers who have agreed to offer discount fees or prices in return for the patient volume that can be directed to them. This is why legislation which has been adopted in some states, such as "any willing provider" statutes or "pharmacy access laws," are referred to as "anti-managed care" provisions. If a plan is required to take all providers, as these laws require, the plan cannot deliver the agreed volume to the providers who are willing to discount. This will serve to drive health care costs up. Several independent studies, one by the Wyatt Company (9) and a more recent one by Atkinson & Associates (10), have shown that "any willing provider" laws can defeat the cost savings that can be achieved with managed care programs. The Federal Trade Commission has expressed this same view in several letters to various state legislators inquiring about the effects of such legislation.

Many groups of smaller employers

macy access laws," are referred to as "anti-managed care" provisions. If a plan is required to take all providers, as these laws require, the plan cannot deliver the agreed volume to the providers who are willing to discount. This will serve to drive health care costs up.

have banded together to develop purchasing cooperatives which then have enough purchasing power to negotiate favorable rates with insurers and health care providers. Many of these are under the auspices of Chambers of Commerce. In some states, the state has encouraged voluntary alliances, usually with some state-provided support, to accomplish the same result.

With federal efforts at reform essentially abandoned for this year and this Congress, what is likely to happen now? The Republican takeover of both houses of Congress in the recent election makes it difficult to predict the future of health care reform. Since the Republicans control both houses of Congress, comprehensive reform is unlikely but there may be opportunities for minor reform. Regardless of what happens in Congress, we can expect much more activity by individual states.

State action will likely focus on gaining control over all the health plans operating in the state. To do so will require waivers from the provisions of the Employee Retirement Income Security Act (ERISA). For a long time, states have wanted to tax the self-insured health coverage plans that enjoy ERISA preemption. This preemption has resulted in lost revenue opportunities for the states that they sorely want and now, with Medicaid shortfalls, sorely need. Waivers from ERISA preemption will operate to the detriment of large employer plans operating in multiple states. A battle between employers and states can be expected.

ERISA allows employers operating self-insured health plans in many states, to operate consistent plans in all the states, without local benefit mandates creating imbalances in health care coverage between employee groups in different states. Consistent plans are advantageous for at least three major reasons: (1) they allow the employer to provide uniform employee benefits regardless of where the employee may be assigned; (2) they enhance the employer's ability to transfer employees between states without sudden changes in benefits; and (3) they enable the employer to avoid nonproductive administrative costs. Also, the individual states cannot tax plans that are ERISA exempt, which provides a savings to employers and a loss of revenue to the states.

State health care reforms will also look at using managed care programs for Medicaid recipients to try to reduce the

cost of this increasingly expensive program for which the states have to pay about half the cost.

States will also consider medical liability (malpractice) and insurance reforms as ways to reduce the costs of health care delivered within the state. There will be considerable political pressure from powerful constituency groups for state legislators and governors to enact "any willing provider" laws.

One only needs to keep up with published reports to recognize that now is an exciting time to be involved in state health care reform. The issues will continue to evolve and, as we gain experience, we will be more successful no matter what happens on a national level. We have to be smart enough to preserve the good aspects of the American health care system but change those that prevent it from reaching its full potential. Hopefully, we can do it.

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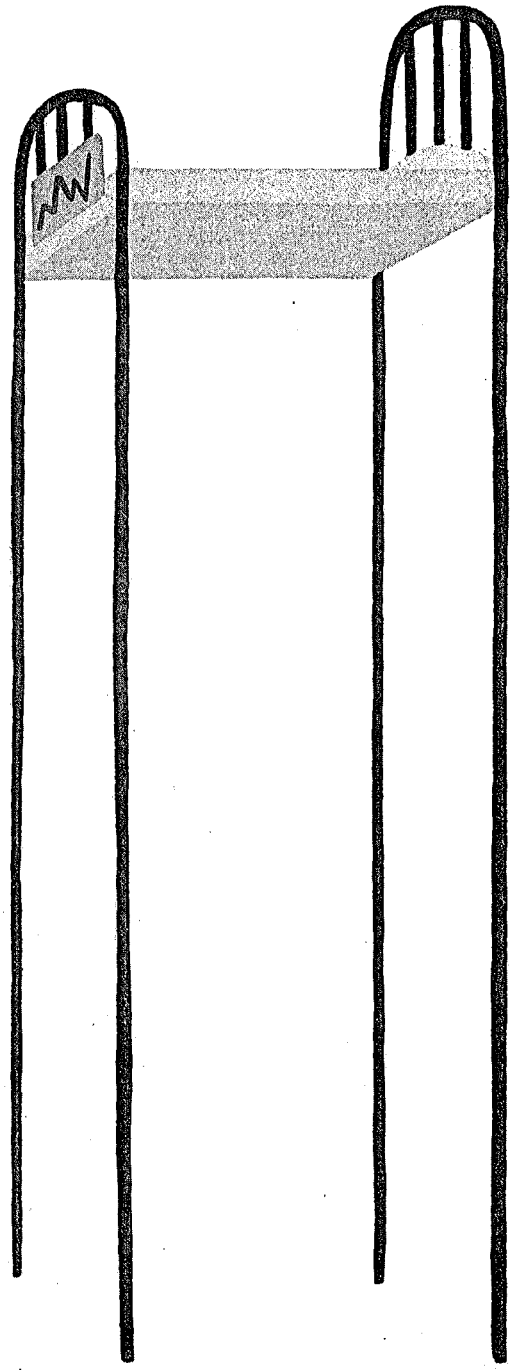
6. Affordable Health Care Now Act, sponsored by Congressman Michel and Senator Lott.
7. Senate Mainstream Coalition Bill, sponsored by Senators Breaux and Chaffee.
8. The Health Reform Consensus Act, sponsored by Congressmen Rowland and Bilirakis.
9. Cost Analysis of State Legislative Mandates on Six Managed, Health Care Practices, The Wyatt Company, June 7, 1991.
10. The Cost Impact of "Any Willing Provider Legislation," Atkinson & Company, June 27, 1994.

Bruce W. Karrh has had opportunities to look at health care delivery from almost every perspective: as a military physician: a practicing physician in a rural community in his native Alabama; a member of Delaware's initial Health Care Cost Management Commission; a member of Delaware's certificate of need agency, the Health Care Resources Management Council; a member of the Delaware Indigent Health Care Task Force, which explored ways to provide health care coverage to the state's indigent; a chairperson of its Health Care Cost Containment Committee; currently a member of the Board of Trustees of two major teaching hospitals and one medical school; and also as the person responsible for recently transforming the health care benefit of a major US employer, the DuPont Company. He has also testified in a hearing by a subcommittee of the US House of Representatives which was considering the Clinton health care plan. ◆

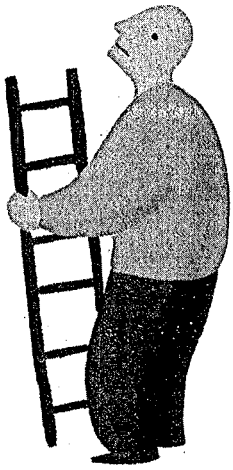
STEPHEN R. PERMUT, M.D., J.D.

Health Care Reform in Delaware in the Wake of Federal Inaction



During the Spring and Summer of 1993, the Association of Delaware Hospitals (ADH) and the Medical Society of Delaware (MSD) worked, at first independently, and then jointly, on the development of a Healthcare Reform Plan (the Plan) for the State of Delaware. This plan contained many of the elements of the Clinton Healthcare Plan, while avoiding much of the bureaucracy that was included in the more than 1,300 pages of legislation developed by the Clinton Administration.

The foundation of the Plan contained the elements shown on Table 1. A review of those elements demonstrates just how necessary healthcare reform legislation at the national level is. Were Delaware to adopt the major elements of the ADH/MSD Plan without surrounding states similarly adopting such elements, the State of Delaware and its employers would be placed at a significant economic disadvantage. This would result in a decline in the economic climate of the State and with it the health status of Delawareans. Thus, in the wake of federal inaction we are left with the question of what Delaware can do to advance the cause of healthcare reform.



The primary healthcare concern in Delaware is the rising cost of health insurance premiums. Here, rising healthcare costs is a far more critical problem than that of healthcare access. Every Delawarean ultimately has access to necessary healthcare services through hospital emergency rooms, but due to lack of insurance coverage, many Delawareans, (approximately 15%) do not avail themselves of office-based or ambulatory care services by primary physicians in advance of emergency circumstances. Were these patients to receive preventive care and early intervention, their problems could be managed at a much lower cost. But absent health insurance coverage, much of the State's population (nearly 90,000 Delawareans) obtain their only care on a crisis basis through hospital emergency rooms. Much of the costs (both hospital and physician) of the care of these uninsured patients goes uncompensated and must be absorbed by the providers.

In addition to the costs that healthcare providers must absorb due to the non-paying uninsured, the federal health insurance programs, Medicare and Medicaid, grossly undercompensate hospitals and physicians, and this combination of non-payment and underpayments results in the phenomenon of cost shifting. This phenomenon basically results in these non-payments and the underpayments being passed onto or shifted to patients with private insurance, resulting

Illustration by Dan Yaccarino

in higher insurance premiums in the State.

Delaware has one of the highest percentages of cost shifting in the Nation with approximately 67% of healthcare costs in the State shifted to private insurers. (E.g. $1.67 must be charged to cover $1.00 of cost incurred by insured patients.) More than half of this cost shift is due to the underpayments by the Medicare and Medicaid programs. In attempting to develop a healthcare reform strategy for Delaware, our healthcare cost crisis is further compounded by the fact that 70% of the Delawareans with private insurance are covered by ERISA (Employment Retirement Income Security Act) exempt, self-insured plans. Because these self-insured plans fall under the jurisdiction of federal law, they are not subject to the State insurance laws. Hence, in Delaware, half of the cost shift and 70% of the patients with health insurance cannot be brought into a healthcare reform plan that is developed solely at the State level.

As has been widely publicized, healthcare reform is occurring at a rapid pace across the country and in Delaware through the growth of managed care organizations. However, the actions by these organizations, as well as continued federal cuts in the Medicare Program, are actually worsening the health status of the State. This is so because the managed care organizations are "cutting their own deals," transferring patients requiring high cost procedures out of State, and micro-managing individual cases, all in an attempt to get the most value for their healthcare dollars, while avoiding their fair share of the necessary cost shift for un/underinsured patients. At the same time medicare cuts are continuing to worsen the cost-shift. Ultimately, cost shifting will be insufficient to provide for the healthcare needs of un/underinsured patients and necessary care will be restricted resulting in a worsening of Delaware's health status.

It cannot be denied that attempting to build value (i.e., obtaining effective services at a competitive price) into our healthcare system is an important goal. However, without universal coverage, as employers/payers with negotiating clout do get value for their healthcare dollars, the cost of care for un/underinsured will be shifted to those payers/employers without such clout, e.g., those insuring small employers and individuals. This results in higher health insurance premiums for these groups, pricing many of them out of affordable health insurance, thus, increasing the number of uninsured and further increasing the cost shift.

So much for gloom and doom. What can we do in Delaware until the United States Congress decides to act on the healthcare financing crisis that exists in our country? The Association of Delaware Hospitals and the Medical Society of Delaware have come together to establish a list of State level reforms that we believe will not economically jeopardize the State, but will establish a structure for healthcare reform that can be built upon once appropriate federal legislation is passed. Those elements are listed in Table 2, and are described in some detail, below.

TABLE 1

KEY ELEMENTS OF ADH/MSD HEALTHCARE REFORM PLAN, 1993

- Universal Coverage
- Employer/Employee Mandate
- Medicaid Expansion
- Medicare/Medicaid Mainstreaming
- Standard Benefits Package
- Insurance Market Reforms-Community Rating, Elimination of Pre-Existing Condition Clauses
- Incorporations of Worker's Compensation and Auto Insurance Medical Benefits into the Health Insurance System
- Administrative Simplication Through a Uniform Electronic Intermediary
- Medical Liability Reform
- Anti-trust Reform
- Taxation of Benefit Rich Plans
- Increased Taxes on Alcohol and Tobacco
- Incentives for Prevention and Healthy Lifestyles
- Promotion of Improved Efficiency in the Healthcare System

The first element is universal access to health insurance coverage. This would require all employers in the State to offer health insurance to their employees and their dependents, although it would not mandate that employers pay all or even any portion of the premiums for that insurance. This would create some minimal additional costs to employers, since they would be required to provide an administrative role in these offerings. However, mandating the availability of health insurance to the families of all employed persons might significantly reduce the percentage of uninsured individuals, since about 80% of insured individuals live in a household in which one of the people is employed.

Both the State government and health insurers offering coverage in Delaware also have a role to play in the process of providing universal access to health insurance. Health insurers would be required to provide an annual open enrollment period to any unemployed individuals above 185% of the poverty level regardless of health status, to purchase health insurance at community rate premiums. These community rate premiums could be adjusted only for age, gender, and geography, and they would be discounted for healthy lifestyles. The State government would be required to expand the Medicaid Program to provide coverage to all Delawareans at or below the 185% of the poverty line.

To further encourage individuals to take advantage of the availability and affordibility of health insurance that the above reforms creating universal access would provide, the State should provide tax credits for employees and individuals who pay more that 20 % of their health insurance premiums.

Another key element would be the establishment of statewide insurance market reforms by eliminating pre-existing condition exclusions, waiting periods and redlining by employer or industry and prohibiting cancellations or non-renewal of coverage for "medical reasons". Portability of coverage would be

provided to employees so that, if they change jobs, they would be able to obtain health insurance at their new place of employment within the State.

The next key element is the expansion of private sector initiatives, such as the Claymont Community Health Service, the Nemours Program for children and the elderly, the Medical Society of Delaware's Voluntary Initiative Program, Nanticoke Hospital's Managed Care Project, and the Health Care Consortium, which have been developed over the past several years. Among the best known of these is the Claymont Community Health Service, where the Medical Society of Delaware working with the Claymont Community Center has created a low cost health service open to anyone who needs primary health care and appropriate referrals. Such private sector initiatives provide low cost access at times other than crisis situations for those Delawareans who would not be covered by Medicaid, or who cannot afford to purchase health insurance through the mechanisms described above. An expansion of existing initiatives along with the development of new projects can play an important role in achieving more readily available access to pre-emergency services for the uninsured, while incremental reforms are tested and universal coverage is awaited.

The next series of reforms have to do with the management of healthcare costs in the State. The first of these is medical liability reform and these would include: 1) the establishment of mandatory and biding arbitration for medical malpractice suits with access to the courts only on an abuse of discretion standard; 2) a requirement that the patient or the patient's attorney provide an affidavit of merit from a qualified medical expert at the time a medical malpractice suit is filed. This would assure that those medical malpractice suits which are filed have substance, so that physicians' time and physicians' malpractice money is not wasted defending suits patently non-meritous; 3) the elimination of joint and several liability, so that when liability is assessed, it would be assessed in proportion to the amount of negligence of a given provider, and a provider with slight negligence would not face payment of a major portion of a malpractice award; 4) creating a presumption that providers have met the standard of care, if they have followed well recognized practice guidelines; and 5) capping non-economic damages in medical malpractice cases. All

of these reforms to the medical liability system would help reduce healthcare costs, in that they would provide a climate in which healthcare providers would feel less pressure to practice defensive medicine through the ordering of marginally necessary tests or hospitalizations, solely for the purpose of creating a record to assist them in defending a malpractice suit, should one arise.

The next set of reforms suggested by ADH/MSD deal with the streamlining of the administration of healthcare benefits by establishing a uniform statewide electronic intermediary and healthcare data base. This would require that the State develop a statewide computer system compatible with that utilized by the Federal Medicare Program; that all health insurers and providers in the State be required to utilize this system; that a single set of forms, policies, procedures, and codes be used for claims processing, confirmation of eligibility and benefits, and for collection of healthcare statistics. This would result in less paperwork for patients and providers alike in the submission and payment of health insurance claims. It would also create a data base through which effective outcome studies could be conducted, so that healthcare professionals could understand better which elements of practice are effective in alleviating, curing or preventing disease and which interventions are not effective.

An additional suggestion for reform at the State level which is being advanced by the Medical Society of Delaware is the adoption of the Model Patient Protection Act that was developed by the American Medical Association. This act would serve to protect patients, physicians and hospitals alike as "private healthcare reform" proceeds through the growth of managed care organizations. The Patient Protection Act would serve to protect the choices of patients in their selection of physicians and hospitals by requiring that all managed care organizations at a minimum accept and process the applications of any physicians and hospitals who wish to participate in their plans. This Act would further serve to require that managed care organizations provide the reasons for rejecting, terminating or failing to renew the contracts or applications of hospitals and physicians, who desire to participate with them. It would provide a level of due process to any physician or hospital who is being terminated from a managed care organization, by requiring these organizations to provide a hearing to any physician or hospital, who is being terminated or non-renewed (deselected) by a managed care organization. This legislation would give the managed care plans an opportunity to select from the broadest possible base of providers, thus, giving their patients a wider range of choices and allowing more patients to continue with their existing physicians and to be admitted and receive services from their hospital of choice.

The final two reform elements have to do with the changes in the way the federal government deals with Delaware in the healthcare insurance arena. As mentioned above, Delaware has one of the highest percentages of cost shifting in the United States, and this is because of the basis under which Medicare reimburses Delaware physicians and, in particular, Delaware hospitals. Medicare underpays Delaware hospitals by approximately 18%. This is in comparison to the State of Maryland, where healthcare providers are

TABLE 2

KEY ELEMENTS OF HEALTH CARE REFORM TO BE ESTABLISHED AT THE STATE LEVEL PENDING LEGISLATION AT THE NATIONAL LEVEL, ADH/MSD, FALL, 1994

- UNIVERSAL ACCESS
  - All employers must make health insurance available to their employees and their dependents
  - All health insurers licensed in the State must have an annual open enrollment period when any individual can purchase health insurance from them at community rate premiums
  - Expansion of Medicaid to all Delawareans at or below 185% of the poverty level
- STATE INCOME TAX CREDITS FOR INDIVIDUALS PURCHASING HEALTH INSURANCE
- INSURANCE MARKET REFORMS
  - Elimination of pre-existing condition exclusions
  - Elimination of waiting periods
  - Elimination of Medical Underwriting
  - Prohibition on Cancellation or non-renewal for medical reasons
  - Tightening of rate bands in the small group health insurance market to move towards true community rate premiums with adjustments only for age, gender, geography and healthy lifestyles
  - The establishment of portability of all health insurance contracts written in the State.
- EXPANSION OF PRIVATE SECTOR INITIATIVES SUCH AS THE CLAYMONT HEALTH SERVICE, AI CLINICS, HEALTHCARE CONSORTIUM, TINY STEPS, NANTICOKE HOSPITAL'S MANAGED CARE PROJECT, VIP
- MEDICAL LIABILITY REFORM
  - Mandatory and binding arbitration
  - Certificate of Merit
  - Elimination of joint and several liability
  - Utilization of practice guidelines as proof of standard of care
  - Caps on non-economic damages
- Development of a Statewide Uniform Electronic Intermediary
- PATIENT PROTECTION ACT TO ALLOW PATIENTS A CHOICE OF PROVIDERS AND FAIR DEALING BY MANAGED CARE COMPANIES WITH PROVIDERS
- APPLICATION FOR A MEDICARE WAIVER OR RE-BASING OF MEDICARE PAYMENT LEVEL FOR DELAWARE
- APPLICATION FOR AN ERISA WAIVER

actually paid 104% of their costs by Medicare, because the State of Maryland has for the past twenty years had a Medicare waiver. A Medicare waiver allows an individual State to establish an alternative mechanism for compensating providers under the Medicare Program. In Maryland, their waiver allows an "all payer" method of reimbursement of hospitals. Under this system, the State of Maryland regulates hospital charges and sets a single payment level for each hospital that must be paid by all third party payors. As one interim method of improving the cost shifting situation in Delaware, it is proposed that the State either seek to have the basis under which hospitals are reimbursed, re-based. The federal government may be unaware that Delaware hospitals receive no State or local support for the uncompensated care that they render. If this were taken into account, the Medicare levels of reimbursement could be raised, resulting in payments to Delaware physicians and hospitals, in particular, that are more equitable.

The final suggestion, again, would require federal intervention and would require a waiver from the health insurance impact of ERISA (Employee Retirement Security Act). Since Delaware has such a high proportion (70%) of its employees receiving health insurance benefits through ERISA exempt, self-insured plans, it is very difficult for healthcare reform at the State level to have a significant impact on employer based health insurance. By obtaining a waiver of the ERISA provisions for health insurance for the State of Delaware, this inequity could be corrected to a significant degree.

In summary, in an ideal world, an ideal healthcare reform bill would have been passed by the United States Congress during its most recent session. However, in the absence of such legislation, there are many actions that can be taken to position the State of Delaware for a time when healthcare reform at the national level does occur. Furthermore, implementation of the incremental recommendations listed above, at the State-level, could serve in the interim to reduce the amount of cost shifting in the State and to improve the access of Delawareans to healthcare at appropriate times and in appropriate places.

Dr. Permut is past president of the Medical Society of Delaware. He is a graduate of Temple University School of Medicine and Widener University Law School. ◆

PAULA K. ROY

Reforming Health Care Financing and Delivery

A Public Policy View

The extent to which federal action can be expected is unclear, and the focus on reform has shifted firmly to the states. With the benefit of having thought about the implications of reform, Delaware is better prepared to take on the task. With a new Chairman and two new members, the Commission is ready for the job.

The Delaware Health Care Commission has been at work for the past four years looking for commonsense and creative ways to improve the structure, financing and delivery of health care in Delaware. In 1990 the task seemed monumental, and it looked as though the federal government would offer little in the way of help. By 1993 the Commission made a dramatic turn in order to prepare for what seemed like imminent federal health care reform. Now the extent to which federal action can be expected is unclear, and focus on reform efforts has shifted firmly to the states. With the benefit of having thought about the implications of reform, Delaware is better prepared to take on the task of moving ahead. The Delaware Health Care Commission stands at a critical crossroads which brings both challenges and opportunities. With a new chairman and two new members, the Commission is ready for the job, but mindful of the need to proceed thoughtfully, innovatively and in partnership with the citizens who will be impacted by its decisions.

History and Background

When the General Assembly created the Delaware Health Care Commission in June, 1990, it was one of several steps taken following a report issued by the Commission's predecessor, the Indigent Health Care Task Force. At the core of the Task Force recommendations was the realization that the uninsured do in fact receive care in Delaware, because hospitals do not turn them away. The question is not whether people go without health care; rather the question is whether they receive cost-efficient, appropriate care, and whether the practice of shifting the costs of providing that care to the majority of Delawareans who do pay is the most sensible means of financing it.

Estimates vary, but most agree that at least an additional 60 cents is added to each dollar of health care in Delaware to pay for the uninsured. In short, the 604,000 insured Delawareans are paying for the 95,000 who are not through inflated hospital charges and insurance premiums. Providing a cost-efficient means of getting the uninsured into appropriate care continues to rest at the heart of the Commission's work, and the complications which arise from trying to solve that problem continue to challenge the Commission. As members of Congress discovered, identifying the problem is far easier than constructing a workable solution.

Composition and Mission

The Delaware Health Care Commission was designed to embody the public/private efforts which have traditionally spelled success for problem solving in Delaware. The ten members operate in largely a volunteer capacity. Six of the members, including the Chairman, Edward J. Bennett, are private citizens. The remaining four are ex-officio - Secretary of Health and Social Services, Secretary of Finance, Secretary of Services for Children, Youth & Their Families and Insurance Commissioner. The Chairman and four members are appointed by the Governor; one is appointed by the Speaker of the House and one by the President Pro Tempore of the Senate. Hence the Commission composition strikes a balance between executive and legislative branches of government and the public and private sectors.

The Commission's plan issued in May, 1994 offered a vision of universal health care based on a managed competition model. It built on the strengths of the employment based system of accessing care and looked to a system which placed greater emphasis on primary/ preventive care and managed care. The cost containment benefits of these strategies would be complemented by tightening the states certificate of need law, reducing administrative costs and developing measures to address medical liability issues. Recognizing the need for reliable, consistent data to evaluate reform efforts, the plan calls for a statewide health data system.

The Commission anticipated implementation of this plan under three scenarios: (1) federal reform occurs and the state will take action to comply; (2)

federal reform does not occur, but states are given flexibility to pursue reform on their own and (3) no federal reform occurs and states are not given flexibility to proceed.

Looking Ahead

Clearly no large scale federal reform has occurred or is likely to occur. While states are enjoying some flexibility to implement innovative Medicaid programs, they are not likely to gain flexibility under ERISA. The State is moving aggressively to obtain the necessary waiver to implement a managed care program for all Medicaid enrollees, and plans to use the cost savings to expand eligibility to all adults under poverty.

But taking up the challenge of state-based reform will require members of the Delaware Health Care Commission to understand two additional complex forces: ERISA and the sweeping reforms already taking place each day in the private sector.

ERISA - Employee Retirement Income Security Act - is a federal law enacted to guarantee uniformity of employee pension plans. The advantage of ERISA in this regard is that large, multi-state corporations can use one uniform method of administering employee pension plans, rather than multiple state laws. Otherwise a corporation would face potentially complicated and conflicting methods of managing pension plans. ERISA makes life easier for these companies and guarantees uniformity of benefits for their employees. However, a small pre-emption clause in the act has a paralyzing effect on states which are serious about state-based health reform. The long arm of ERISA reaches into employee benefit plans, which the courts have interpreted to mean health plans as well. The same act allows companies to self-insure. That is, they assume the financial responsibility of paying for employees health care, but they are also completely exempt from any state based action or regulation. What corporate America sees as an administrative dream is the bane of serious-minded state health reformers. In Delaware it is estimated that as much as sixty to seventy percent of the state's workforce is employed by ERISA-exempt companies, posing substantial questions about just how much impact major reforms would have.

In the meantime sweeping changes are taking place in the private sector. Arguably, reform is already occurring around us each day, and the Commission needs to understand the nature of these changes, the incentives causing them and their impact on employers, employees and providers. The private sector has moved swiftly toward managed care, and organizations are becoming more vertically integrated. With increased emphasis on primary, preventive health care, more professionals are asking for authority to expand the scope of their practices.

In the last session of the General Assembly ten to twelve bills were introduced which impacted the state's health care financing and delivery system in some small way. Since they were addressed while the Commission was finalizing its own blueprint, they were enacted outside of a contextual relationship to each other and with no overall framework for reform. Yet each had the effect of reforming the system.

States, like Delaware, are enjoying some flexibility to implement innovative Medicaid programs. But taking up the challenge of state-based reform will require members of the Delaware Health Care Commission to understand two additional complex forces: ERISA and the sweeping reforms already taking place each day in the private sector.

Second order issues arising from the move to managed care were also evident last year. Cost savings benefits of managed care potentially stand in the way of personal choices, and most certainly toughens competition among providers. Pharmacists were successful in gaining passage of any willing provider legislation, although limited to two years. Whether this will give rise to a new wave of similar bills is unclear at this point. Hence, while Commissioners are in the throes of studying ERISA and learning about the changes already occurring in the private sector, legislators will be struggling with second order reform issues.

In the meantime the Commission will proceed on three significant projects in 1995:

- Evaluation of medical liability issues and current tort law,
- Development of a strategic plan on the collection, analysis and dissemination of health data, and
- Evaluation of the effectiveness of certificate of need as a cost containment tool.

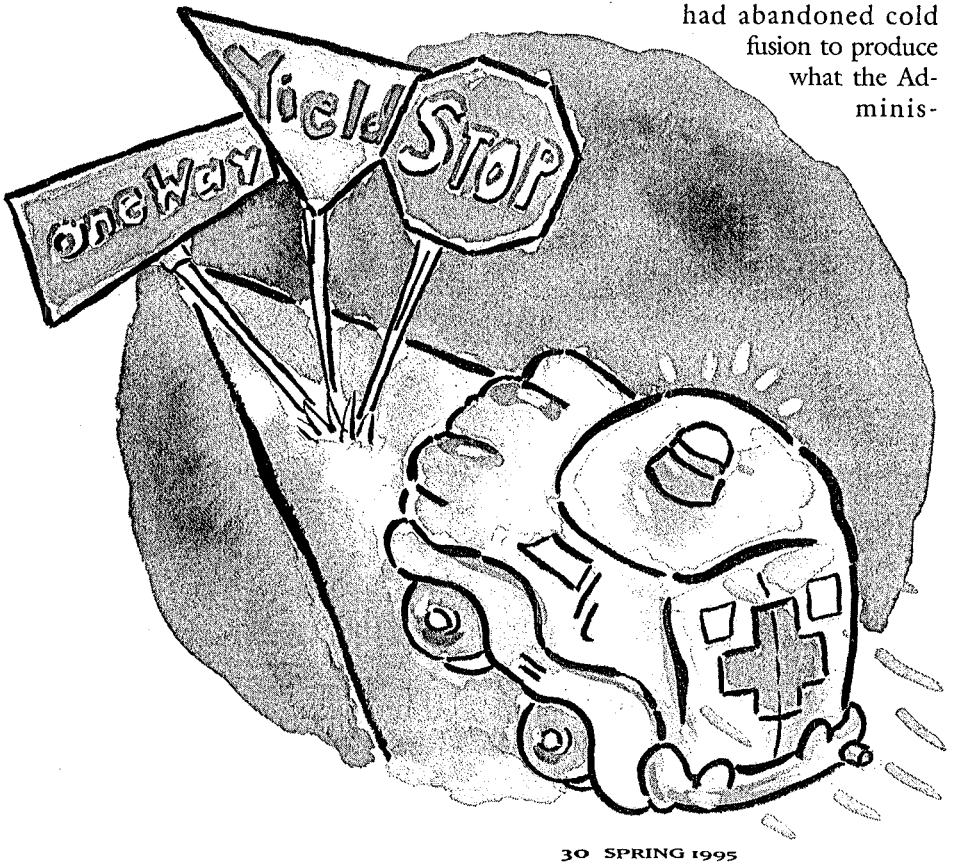
A January strategic planning session will allow Commissioners to evaluate the impact of previous activities, the changing nature of the health care and political environment and assess its performance to date. A full report on the Commission's path forward will be highlighted in the next issue of the Delaware Lawyer, including the results of on-going studies of the state's medical liability system and tort law.

Paula K. Roy is Executive Director of the Delaware Health Care Commission. Her range of state government health policy experience dates back five years to the Commission's predecessor, the Indigent Health Care Task Force. She has served state government in a variety of roles, including Manager of Community Affairs for the Department of Finance and Special Assistant to former Governor Pierre S. duPont IV. In the private sector she has served as Director of Government Relations for the Delaware State Chamber of Commerce and Executive Director of the Delaware Retail Association. ◆

JOHN HAWLEY LOPEZ

The Lessons of Defeat

Although the images of the 1991 campaign that unseated an incumbent Republican president are already misting about the edges, it is instructive to recall to what two themes the pundits attributed Clinton's success. One was: "It's the economy, stupid!" and the other was health care reform. The plastic insurance card, waved on high and promised by candidate Clinton to every American as a right, served to symbolize health care reform. At the President's insistence, Hillary Rodham Clinton, took charge of the health care reform effort and closeted herself for eleven months with more than five hundred consultants organized by Ira Magaziner, who had abandoned cold fusion to produce what the Administration promised would be a total restructuring of American health care. It was to cover every citizen with portable, privately administered, health care insurance. The enterprise was to be financed through savings from bloated federal medical "entitlement" programs that had passed defense spending as budget busting line items.



Originally promised in the first one hundred days of the Clinton Administration, the health care bill arrived about two hundred days late and was dead on arrival. A task force of the magnitude that had been assembled could not keep everyone inside the tent as the group moved from the general managed care principles of the Jackson Hole Group to legislative specifics. Delays and leaks from the task force gave potential opponents the opportunity to refine alternatives, plan strategy and raise war chests. Perhaps the fatal error was simple hubris. Hopeful that a year after the election, public response would remain as enthusiastic as when the plastic card was first unsheathed by James Carvill for Harris Wofford's first Pennsylvania Senate campaign, the White House made health care reform a partisan issue. This was a stretch for a president elected with 43% of the popular vote. It froze out potential Republican allies and gave a sharper edge to the critiques being crafted by armies of consultants across the country. In the end, despite substantial Democrat majorities in the House and Senate, the Democrat leadership conceded that they could not pass the Clinton bill, or any other reform legislation, in 1994.

With control of both houses of Congress in jeopardy, and the public mood clearly hostile to grand reform projects, Donna E. Shalala, Health and

Illustration by Kevin Plottner

Human Services Secretary, announced on October 20, 1994, that the Clinton Administration had received the message that the public did not want it to take on the whole health care system. The foundation of the Clinton Administration plan — requiring all employers to pay health care premiums for their employees — had gone from brilliant idea to dead issue in just one year. Shalala added, "The public was against a government-run health care plan ... and in that context," she said, the public viewed the employer mandate "as a proxy for a government-run" system.

The White House has put health care reform in the hands of its top economic and domestic policy aides, Robert E. Rubin and Carol H. Rasco, and has reduced the role of Ira Magaziner, former chief architect. Congress had already listened to the polls, suffered lobbying from every interest involved, read their mail and determined to punt the issue. In the meantime, they hoped passionately that they would be on the receiving end of that punt in the next Congress.

How did we get to the point where health care makes up one seventh of the national economy, produces services and products that are acknowledged to be the world's best and yet reflects a system that is in deep trouble? In Delaware, for example, direct hospital employment accounts for 12,000 jobs and constitutes a significant factor in the state's economy. Such a massive industry affects so many constituencies on a national scale that it is not surprising that problems have been building for a long time without radical solutions being attempted.

Our modern health care delivery and payment system was born out of economic mobilization during World War II. Wage and price controls limited the inducements that could be offered to attract labor, but at the same time virtually unlimited production was demanded. A loophole was found in Office of Price Administration regulations that allowed firms to offer free health care for workers and their families as part of labor contracts. This benefit continued in the post-war period in the main industrial, trade and government union contracts. As availability of health "insurance" became more widespread in the 1950s with the expansion of MD/Hospital owned Blue Cross and Blue Shield plans, health care insurance became a popular employment benefit at nominal cost to employers. This was partly the result of the favorable tax treatment given to health insurance as a pre-tax expense for employers. Individuals and part-time workers did not enjoy the same benefit. Thus the seeds were planted for the "job-lock" that affects many today whose state of health keeps them from leaving their current employer for fear of being unable to qualify for coverage under a new plan.

The first heart transplant in 1967 signaled the beginning of the explosion of medical technology which continued through the 1960's, 70's and 80's. High-tech intensive care units today blur the line between life and death. Every month a tinier premature infant is kept alive for a longer period of time at staggering cost while elsewhere families agonize over whether or when to detach a terminal relative from artificial life support. Since these same intensive care units represent an income stream of tens of thousands of dollars per day, substantial economic interests complicate what are already desperate ethical dilemmas. In the recent past, such expenses were referred by the providers to third party payers, nominally insurers, who paid and passed the costs back to the community in higher premiums spread over a broad cross section of policy holders or "self insuring" companies.

Even today, the second question normally posed by a patient remains: "Is it covered?" not, "How much will it cost?"

For decades this system worked well enough for all within the system. The Faustian bargain made by the providers when they set up the community rated pre-payment plans that became known as health insurance only began to become apparent when efforts were made to allocate expenses for care administered to those not participating in the system. Until fairly recently, community hospitals would sit down at the end of the year and pass over their uncovered expenses to the constituencies whose representatives sat on their boards: local insurers, major employers and local government. Such a system put no premium on cost control by the providers or the patients. Quite the contrary. Even today, in the twilight of the old system, the second question normally posed by a patient about a recommended procedure remains: "Is it covered?" not, "How much will it cost?"

"Costs" and "Charges" mean different things in the health care arena, especially the Delaware health care arena, than they do in other contexts. Here there has been a shifting of costs from those that could not or would not pay to those who would accept the bill. As long as this payer was Blue Cross or the DuPont Company or some other deep pocket with a social conscience, all was well, and those who benefited accepted the generosity of those who subsidized them as their due. Several things have happened in Delaware and other states in recent years that have irretrievably altered the health care economy. In earlier times, there was an implicit social contract that the young and the healthy would subsidize the pre-payment of the health care expenses of the old and the ill. This system, known as "community rating," in essence charged the same rate to all who sought health insurance. The system worked pretty well, with occasional end-of-year subsidies to make up any shortfall being contributed by the large, public spirited companies represented on both the Blue Cross and hospital boards.

Several developments in recent times have undermined this arrangement. One was the explosion in high tech medicine and its attendant cost. Another was the advent of insurers who saw profit in selecting and insuring the best risks (undercutting "community rates" for these "cherry picked" clients), which left a pool of increasingly "bad," more expensive risks over which to spread the community rate. ERISA provided an overwhelming incentive for larger corporations to self-insure and thereby save premium costs (especially when their universe of risk was better than the general population). This accelerated the deterioration of the quality and efficiency of the community rated group by removing large numbers of easy to administer, relatively healthy subscribers and the solvent enterprises

that had paid their premiums. Aggravating all these trends, global competition arrived at the very moment that the other strictures were beginning to pinch. With the young, healthy and triple A-rated financial population fleeing their group health plans, the former community raters were now forced to "underwrite," i.e., to charge premiums based on individual risk prospects rather than community rating. This accelerated the flight of the young and healthy, who often decided to go without insurance, thereby adding "and foolish" to the foregoing description. The remaining risk pool began to resemble an insurance group of last resort with high rates and no recourse. Blue Cross companies in many states were forced into insolvency or deep into their reserves to survive from year to year.

In Delaware this situation is further aggravated by the fact that there is no publicly supported hospital system for general patient populations. Delaware's hospitals have generally given uncompensated care as required and simply added that cost to the charges of those who were expected to pay. This is one reason that Delaware rates for a variety of procedures are considerably higher than those of neighboring states. These neighboring states are beginning to do, vis-a'-vis hospitals, what the cherry picking insurance companies did previously to the Blue Cross companies. Out-of-state institutions are aggressively marketing their services to corporate payers and insurance carriers by offering package prices for procedures such as coronary by-pass operations that undercut Delaware hospital charges by as much as 40 percent. Naturally, these rates only apply to patients whose bills would in the normal course of events be paid. These downward pressures on charges also can apply to entire population segments when a hospital like Jefferson or Johns Hopkins skims off the "best" cases (those with the highest likelihood of being paid), leaving local institutions with even more costs to shift among a population with even less ability to pay. Rather than letting its employees who reside in Delaware use local hospitals at higher cost, Perdue now sends its self-insured cases to Peninsula General Hospital in Salisbury, Maryland.

What the foregoing means is that, barring federal dispensation from ERISA, and few are prepared to ask for it, Delaware is not in a position to do much more than experiment in small ways at the margins of health care reform. Both Governor Castle and Governor Carper have understood these limitations very well. The program of primary care for children that they have instituted with the assistance of the Nemours Foundation is the type of response to the problem that Delaware is best equipped to make. Other initiatives designed to reduce infant mortality in Delaware are being funded by the Delaware Health Care Commission, but it is too early to assess their impact.

America's health care system is a quirky, complex, organic creation. Subjecting it to any radical procedures should be inhibited by the basic rule of medicine, "First, do no harm."

The 1994 mid-term elections were in part a plebiscite on the Clinton health care plan and only the most obtuse will fail to acknowledge the voters' rejection of big government programs. The new landscape of political reality dictates that any health care reform will proceed via Republican moderates while making the necessary obeisance to fiscal conservatives. Congressman Castle, who is a key leader of the House moderates, is likely to push for less controversial items such as extending Delaware style access to health care for children nationwide. Reform from this Congress will be incremental, solving obvious problems but preserving the basic structure of a system that delivers the best medical research and care in the world. It will eschew the intrusive aspects of the various Democrat plans that failed to make it out of committees last year. It will attempt to expand access to health insurance coverage. The closest analogies to the mandates of the Clinton plan are likely to be requirements for employers to offer, but not necessarily pay for, basic insurance plans to their employees, and requirements for insurers to offer health plans to all companies that employ from 2 to 50 workers. Any Republican plan will undoubtedly involve the "Medisave Account" or medical IRA endorsed by both Congressman Castle and Senator Roth. Variations on this theme will permit individuals to control their own health care spending through tax deductible contributions to personal family accounts where the interest will accumulate tax free. Another easy and quick adjustment for the self-employed is to allow 100 percent deductibility for health insurance costs, up from the current 25 percent which is due to lapse shortly. Any comprehensive legislation will try to deal with the problem of the uninsured by increasing the number of rural and community health centers serving low income families. Most health care economists are optimistic that access to primary care will reduce the current high costs of acute care provided to the indigent via emergency facilities.

After the traumatic debates of the past year, aggravated by the shrill propaganda from all sides, the American public will demand reassurance that there is health care security on the way. "Job lock" remains a real problem as well as an even greater perceived problem. Some form of guaranteed access or portability of insurance for employees will appear in legislative proposals, as will extension of coverage to pre-existing conditions. Private long-term health care coverage for older Americans will be granted the same tax benefits as other insurance on the theory that every part of the problem that can be handled by the private sector will benefit the public in general. In the same manner, penalty-free withdrawals from IRAs, 401(k) plans or life insurance will be permitted when the object is the purchase of long-term care insurance.

Controlling the explosive growth of health care costs, has taken on a less urgent aspect lately since the double digit increases of the past several years has slowed dramatically. Relatively straightforward measures that will be manageable for Congress and the health care industry include malpractice reform aimed at reducing the practice of defensive medicine reputed to cost between $7 and $12 billion per year. A cap on non-economic damage awards is also in the cards, largely because the trial bar does not have the same clout with the new Congress as it had with the old. Other reforms expected include limitations on attorney fees in medical malpractice actions and alternative dispute

resolution procedures that bypass the courts. Finally, antitrust relief will be forthcoming for the medical providers. This will allow them to share facilities and equipment in the hope of reducing costs and redundant high tech installations that must be used to retire debt, whether needed or not.

Some states will be in a better position than Delaware to profit from increased flexibility in the administration of state level health care experiments. Most will be able to apply managed care plans to their Medicaid populations. Some will apply federal Medicaid waivers to implement and pay for innovative health care reform plans.

Other lessons learned from the Clinton experience include the maxim, "retain maximum patient choice" by allowing families to continue to choose their own health care providers. Perhaps the most useful federal initiative would be to finally adopt a single standard claim form for all insurers, which will work if it reflects the best industry experience rather than some model imposed by its bureaucrat author.

The most important lesson for the Republican Congress to learn is not to overreach. America's health care system is a quirky, complex, organic creation. Subjecting it to any radical procedures should be inhibited by the basic rule of medicine, "First, do no harm." Once bills are crafted, there will be the nearly irresistible impulse to make them comprehensive and universal. This very same impulse was fatal for the Democrats and should be strenuously resisted. A fair amount of messy experimentation can be expected at least until the mechanisms that drive the system are better understood than is the case today. In the meantime, not too much reliance should be placed on the hope that prevention and healthier lifestyles will produce any significant cost savings. The best route is for the federal government to nibble about the edges of the problem and experiment with restoring some degree of market discipline to the medical inflation situation. Otherwise, the law of unintended consequences will take its toll on the Republicans as it did upon the Democrats in the last election.

John H. Lopez is the founder and former executive director of the Delaware Public Policy Institute. An attorney, he retired with 27 years of federal service in Asia, Europe, Africa and Latin America. ◆

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continued from page 40

methods to provide medical care, although cost saving *per se* was not the genesis of this prototype Managed Care entity. Kaiser-Permanente is a classic example of a vertically integrated, closed panel, staff model HMO. This simply means that for a set fee, the Managed Care Organization (MCO) provides a member with all medical services through a single organization. All the physicians providing these services are employees of this organization, and all medical services needed are provided within the 'walls' of this system.

Managed care is largely driven by large employers who purchase health insurance for their employees. Through this mechanism, they have become the payors for a large portion of health care. Medical care costs have escalated rapidly over the past twenty years. This has occurred in response to rapid advances in medical science, the 'aging' population and the not surprising increased demand for these modern miracles. Consequently, employers watched health insurance premiums evolve into the largest single contributor to overhead. As this component of overhead exceeded similar costs for foreign manufacturers, American industry became less competitive internationally. Further stimulating the need to control costs was a change in corporate accounting rules. These new rules required publicly held companies to account for estimated future health care costs of retirees, on current balance sheets. These estimated future liabilities depressed share values, sending a second wake-up call to corporate boards and CFOs. Presidents since FDR have raised the issue of national health care, but not until corporate America took up the cause did things begin to happen.

Recognizing this need to reduce health care costs, insurers and managed care entrepreneurs saw an opportunity. They formed cost savings entities that were different from the staff models like Kaiser-Permanente. These early models of managed care operated simply by finding doctors and hospitals willing to discount their usual fees, in return for a promised higher volume of patients. As these new managed care companies grew, they learned how to shift more and more of the financial risk to providers (primarily physicians, hospitals and commercial laboratories). This shift of risk moved these new MCOs from the traditional role of risk buffering insurance companies, to true intermediaries. As the amount of financial risk transferred to providers increases, the "value added" service of traditional insurance decreases. One would expect that less "value added" would mean less profit for managed care companies versus traditional insurers, but the opposite has been the case. Profits in managed care can be enormous. Contrast Kaiser-Permanente's "Medical Loss Ratio" of 95 percent (95 percent of the premium dollar is spent on medical care for members), with US Healthcare's MLR of 68.9 percent! This difference is what allowed US Healthcare (one of the largest MCO's with 1.7 million members) to earn a net profit of $105 million in a recent quarter. US Healthcare covers just 0.6 percent of our population. Playing with the numbers, using US Healthcare's profit margins, there is a potential $60 plus billion net profit in managed care each year. Current growth in managed care is driven by two engines, the corporate need to control health care costs and the enormous profit potential in the managed care business. This is the climate for Delaware physicians and hospitals. The present environment is a mixture of "managing care" and "managing profits."

While Health System Reform at the Federal level is in limbo, Health Care Reform is very much alive... For patients and physicians alike, Health Reform currently means Managed Care.

The **"How"** of managed care combines insurance underwriting and marketing techniques, with various methods of delivering medical care. At one end of the marketing spectrum, it is very profitable to enroll healthy, young populations. Known as "cherry picking," these policies can be written with premiums below community rates. With healthy patients, even a discounted rate is extremely profitable. To exaggerate — insuring just employees of health and fitness clubs is likely to be wildly profitable, even with discounted premiums. Contrast this with the high cost of insuring members of roofing and insulating unions, who have higher rates of smoking and exposure to asbestos. Even the Medicare population may be victims of cherry picking. A local physician tells a story he heard while working on his Masters Degree in Public Health. It seems one HMO was having singular financial success with a full-risk Medicare contract; they were very profitable. Other HMOs in similar areas were having problems or even going bankrupt with Medicare contracts. It turned out, the enrollment office was a third floor walk-up. A simple, but effective means of selecting the healthier medicare member.

Removing the healthy members of a community pool via "cherry picking" increases the premiums of those remaining in traditional insurance. This is a problem which must be addressed by Health *System* Reform. A similar escalation in premiums will occur, if we have insurance market reforms that guarantee availability, without some form of an employer (or other) mandate, to carry insurance. In this situation, young healthy people will see no advantage to purchase health insurance — until they are sick. The premium cost goes up for the "sicker" population who remain, which will cause more people to opt out, driving premiums even higher — an unsustainable cost spiral.

Medical care can be delivered by any number of acronyms — HMOs, IPAs, PPOs, etc. For the purposes of this article, I will use the acronym "MCO," for Managed Care Organization, a generic terms for the entities that sell "managed care."

Health Maintenance Organizations may be "staff model," where the MCO owns the outpatient sites (sometimes the hospitals), and hires salaried physicians. Alternatively, an HMO can contract with community physicians and hospitals to provide care to HMO enrollees. These panels of physicians may be

Independent Practice Associations or Preferred Provider Organizations, and may be open or closed to new physicians. The MCO may also contract with providers outside the community for specialized services, either not available in the community or at a lower cost.

One might assume that staff model, closed panel HMOs would be the most successful model. The ability to closely control utilization with salaried physicians should have a significant advantage over loosely controlled IPAs. In older models such as the Geisinger Clinic, Kaiser-Permanente and others, this is generally true. Locally, the one attempt to build an insurer run staff model HMO has not had much success.

In models such as IPAs and PPOs, where the providers own and manage the sites of care (physicians' offices and hospitals), MCOs have two main forms of reimbursement: a discounted fee-for-service and capitation arrangements. Fee-for-service is the traditional form of reimbursement. In current managed care form, the MCO pays most of the provider charge for each service, with the patient responsible for a small part, termed "co-pay." In a capitated arrangement, a physician is paid a fixed amount monthly for every patient for whom the doctor is obligated to provide care. These monies are determined actuarially, and are paid whether or not the patient uses physician services. Capitation can cover specialty care as well as primary care, and is almost always used for laboratory and radiology services. In these IPA/PPO models, MCOs attempt to control costs in various fashions. For the most part these methods are a form of micro-management, not considered an enlightened management technique. Methods may include:

Pre-authorization: This form of utilization review occurs before care is rendered. A physician or staff member must call an "800" number and ask permission to: (a) send the patient for diagnostic studies; (b) see a specialist; (c) perform a procedure or surgery; (d) admit the patient to the hospital, etc. This prior review (often done by non-medical personnel) rarely results in denial. Medicare has eliminated most preauthorization as an ineffective tool. MCOs in Delaware continue to use this frustrating time consuming and expensive procedure. Physicians and patients carry this cost of micro-management.

Concurrent review: During a hospital stay, an MCO employee will call the physician for updates and plans of action. This technique can range from minor a annoyance every three days, to a daily hassle, a source of physician frustration and anger. Unfortunately, this also remains a staple of managed care policies.

Retrospective review: This amounts to a post-treatment review to determine whether care was appropriate. This technique, used to deny payment, is infrequently used by MCOs and has also been abandoned by Medicare. The teeth in all these utilization review techniques is denial of payment. If a service is denied, often the hospital, as well as the doctor, is not paid. At times, even the patient may then be responsible for part of the bill. Retrospective review is potentially a triple threat for a doctor who provides care, is denied payment and then has the hospital and a patient angry with him or her.

Incentives/Disincentives: There are two basic variations. There is a "risk withhold" form. This involves the MCO withholding a percentage (usually 10 to 20 percent) of an already discounted fee. This withhold is to be returned at the end of the year if the provider, and/or the plan, meets certain targets. The catches: (a) physicians are often not told what the targets are, or how the calculations are done; (b) the withhold reimbursement doesn't come until six or seven months into the next year; (c) if you leave the plan, you forfeit the withhold, meaning at a minimum, you lose 6 to 7 months of withhold.

On the incentive side, there are various forms of bonuses. Some are calculated in the same "black box" that risk withhold calculations are. This means you may receive a bonus, but not really know how it was calculated. Some of the better defined bonus plans use various financial "risk pools" for utilization of specialists, testing and hospitalization. The doctor's bonus depends on how much is left in each pool at the end of the year. These bonuses create an incentive for potential under-utilization rather than efficient utilization, which is a slippery slope for any physician. A developing form of incentive plan pays bonuses based on meeting certain "quality" screens. This method is intuitively more desirable.

Controlled access: This is generally thought of as a "gate keeper" model. All care is channeled through a primary care physician, usually a family practitioner, an internist or a pediatrician. This reduces "self-referral" to specialists. There are medical and financial advantages to this model, but it is not the only means of cost-effective delivery.

Utilization Review has driven down physician income by increasing overhead expenses. The profession has been slow to understand the true cost of this administrative burden. When managed care is a single digit percentage of a practice, the expense is negligible. As managed care patients make up a larger portion of a practice, the increased overhead becomes significant, but is often unrecognized or underappreciated. Virtually all doctors I talk with know they are working harder than ever. However, they are earning less (in inflation adjusted dollars, if not in actual dollars) than five or ten years ago. Overhead has increased far more rapidly than reimbursement. This observation is true for both primary care and procedure based practices.

The other half of the income equation, **reimbursement,** has frequently declined even as overhead increased. Again, physicians have been caught napping. With only a few patients in managed care, fee reductions were hardly noticed. However, with more patients in discounted fee arrangements, and the loss of other sources of office income such as lab tests and procedures, the drop in the

By digging in their heels, and hoping to preserve some form of the status quo, physicians and hospitals have allowed insurers to shape the future of heath care —— so far. This will change.

fee schedules became more significant. Another problem for solo and small group physicians is figuring out the relationship between their usual fees and captitated fees. Typical fee reduction in primary care range from 12.4 percent for a "routine" office visit, to 36 percent for a complete history and physical. However, in terms of take-home pay, these percentages must be adjusted for overhead, which runs 50 to 60 percent in primary care. This means a 15 percent fee reduction results in a 30 percent drop in take-home income. If an additional 15 percent is "risk withhold," a further 30 percent decrease in income occurs, until the withhold is returned (if and when).

Quality: As local markets mature and become saturated with MCOs, premiums among companies become similar. MCOs must then compete for business based on "quality." Ideally, quality is the most desirable parameter of medical care. However, the difficulty in measuring quality may be similar to defining pornography in legal terms. "We know quality when we see it," but we do not have the tools to accurately describe and measure what we see.

This evolving quest for quality translates into yet another problem, one with potentially devastating effects for a given physician. At this time "Quality" measurements are clumsy and indirect. Current methods include checking: HCFA — for Medicare or Medicaid sanctions; state Medical Boards — for any license restrictions; hospitals — for any disciplinary actions or loss of privileges; malpractice carriers — for coverage and prior claims; the National Practitioner Data Bank — for records of any settlements not found earlier. Physicians can be eliminated under "Quality Screens" if they are not Board Certified, or have chosen not to have hospital privileges. Failing a plans' quality screen often means exclusion from a new plan, or "deselection" from an existing plan. Exclusion from plans in a highly saturated area means you better move if you expect to earn a living as a doctor. More plans are using national services such as Equifax for these "quality" checks. Anyone who has experienced foul-ups on a credit check can appreciate how unnerving this development is.

Termination without cause: The reservation of a right to terminate a provider member is a common provision in many MCO contracts. One probable use of this clause is to allow an MCO to exclude those physicians who are expensive to the system through high utilization. This is reasonable when the physician is "gaming the system" for his own profit. However, this approach may not allow for physicians with sicker patients, or those who feel they are not doing the best for their patients until they have explored every reasonable avenue. This elimination of high utilizers is "economic credentialling," an undesirable relative of credentialling by education and training.

"Termination, exclusion, deselection" are terms so alien, we physicians often ignore these words in MCO contracts. Certainly a risky form of denial. The AMA has estimated that if the entire country functioned with the same doctor/patient ratio as Kaiser-Permanente, we would need about 320,000 physicians. There are close to 700,000 MDs/DOs in the U.S. today, a sobering thought for a physician who thought he or she had a job for life.

To quickly summarize: Managed Care Organizations are simultaneously decreasing reimbursement, increasing overhead, increasing the 'hassle factor,'

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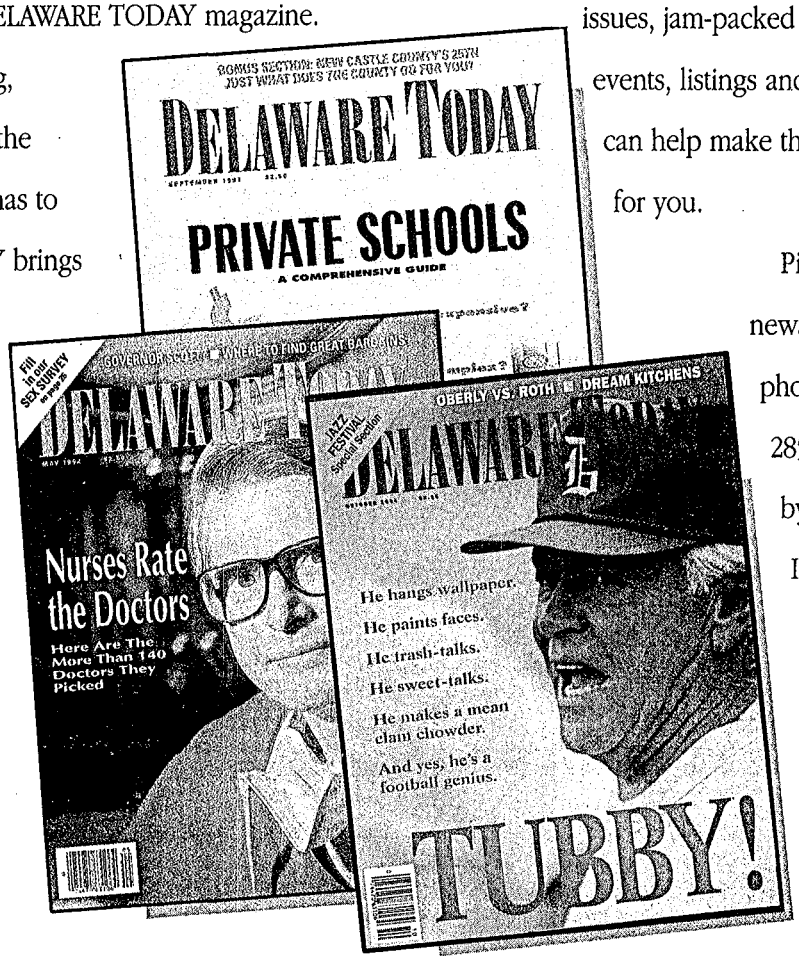

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subjecting the physician to crude measures of outcome analysis and financial credentialling, and ultimately threatening his/her ability to earn a living. This is, of course, a personal view of pressures that managed care has imposed on physicians.

As difficult as the current situation is, more unsettling is wondering what will happen next. Where does it lead? I have presented a gloomy scenario for physicians today, but personally I am optimistic for the future.

Managed Care evolves through distinct generations, at varying speeds, in different parts of the country. First-generation plans generally have modest discounted fee-for-service arrangements involving a small percentage of a community. Second and third generations enroll a higher percentage of the local population and the financial and medical controls become more structured. A fourth-generation plan might look like that found in the Twin Cities. There, 70+ percent of the population is enrolled in two or three plans providing cradle-to-grave care.

Does this mean Delaware will look like Minneapolis-St. Paul in a few years? No. There are forces at play that suggest we won't. It cannot be overemphasized how rapidly ideas and systems are evolving. A sophisticated, fourth-generation mechanical calculator was obsolete the minute crude, first-generation integrated circuits were printed on a silicon chip. A system that works in St. Paul today will not be desirable in Delaware in five years. Another key point: local forces shape health care. What works in a retirement area of Florida may not work in a farming community or the inner cities or Silicon Valley. Local providers and institutions know their communities, and need to design and be involved in health plans for their own unique situations. Furthermore, physicians and hospitals are learning from the experiences of colleagues who have gone through this process earlier.

Existing models were built by entities with financial capital, i.e., the insurance companies and entrepreneurs. Hospitals and physicians may own the 'bricks and mortar' and the intellectual capital, but have not taken advantage of these resources. By digging in their heels, and hoping to preserve some form of the status quo, physicians and hospitals have allowed insurers to shape the future of health care — so far. This will change.

Change will occur for several reasons. After spending 11 to 15 years in training, doctors have more at stake in health care reform than money. Physicians seem to go through stages when dealing with managed care. First is denial and disbelief: "It won't happen here" or "I'll survive without it." Second is shock: "I can't believe so many patients left my practice." Third, false hope: "I'll be OK, I'm a good doctor," or "If I don't make waves, they'll leave me alone."

These initial reactions are not productive. But an angry determination is beginning to replace these ineffective responses. Properly channeled anger is a positive force. As more physicians understand their options, there will be positive changes in health delivery.

As physicians and hospitals are forced to take on greater financial risk and become more cost-effective, they are realizing they have less to learn about the insurance business than insurers have to learn about medical care delivery. There has been a mistaken belief that just because a company sells health insurance, they actually know something about health care delivery. The surprisingly awkward attempt at managed care by many MCOs is making this ever more clear to physicians. Formation of MCOs owned and operated by physicians will continue at an increased rate, and pro-

vide needed balance to systems created by insurers and entrepreneurs.

Information technology will have a dramatic impact, allowing healthcare to be rationalized, rather than rationed. Changes will occure that cannot even be anticipated today. Changes that will make medical care both more cost effective, and more nearly universal. Ideally, technology should make the support structures of medical care invisible to patient and physician, and the doctor/patient interaction more focused and satisfying than it is today.

Without de-emphasizing the dislocations and stresses that change will entail, the result for patients and physicians will be superior medical care. We are on the verge of developing a health care system that will be a model for the rest of the world. Formation of large group practices will continue, solo and small groups will coalesce and decrease in numbers. However, these small groups are not doomed. Information technology will allow the efficiencies of large groups to extend to small practices. Medicine is a service industry, and more efficient dissemination of data will permit formation of various niches for physicians. Uniformity of practice and data collection can be vastly improved by such technology, and enable small groups to survive. Physician groups will assume more financial risk, providing care for groups of consumers at a contracted amount. In contrast to the current definition of "risk bearing" given by MCOs today, quality care and well-managed risk will enable cost-effective physicians to share in the profits inherent in a "risk/reward" equation. With tens of billions of dollars at stake, competition will be brutal. Like it or not, if we are to be patient advocates, physicians must actively participate in this evolution.

A few comments on 'System' Reform may be in order here. The competition between entities delivering care is heating up, and the profit motive, properly monitored, will lead to far more cost-effective delivery. It is desirable that we learn how to deliver cost-effective care in the private sector before we politicize the process and lock ourselves into unchangeable positions. The issue of "personal responsibility" should be worked out in the crucible of the marketplace before we attempt universal application. We also need to let the marketplace determine future physician numbers in terms of specialists. We overshot the mark in the seventies when medical school enrollments were doubled at the government's encouragement, and subspecialty training was subsidized by research and training grants from the NIH. Government attempts to control the numbers of specialists versus primary care physicians would be a bureaucratic waste of time and money.

Cost-effective delivery of the right amount of care, at the right time and in the right place, is the goal of managing health care. Management of medical care delivery is one arm of health care reform, and as such, physicians and hospitals should, and will, embrace managed care.

* * *

Originally from Havertown, in suburban Philadelphia, Dr. Maxwell received his undergraduate degree from the University of Delaware, and his M.D. degree from Jefferson Medical College. He holds several patents originating from work done at the DuPont company before attending medical school. Professional activities include the immediate past presidencies of the Delaware Society of Internal Medicine, and the Medical Society of Delaware. He and his wife Linda, and their sons, Hunter and Spencer, live in Brandywine Hills. ◆

THOMAS J. MAXWELL, M.D.

Health Reform/Managed Care

A View From a Doctor's Office

I practice full time, primary care internal medicine. Like my peers, I am trying to understand and cope with changes in the delivery and financing of health care. My experience includes two years as a full-time ER physician and fourteen years in solo and small-group primary care practice. Our group of eight includes General Internists, Family Practitioners and Pediatricians. We participate in most managed care plans in Delaware. These include fee-for-service, and capitated plans.

While addressing the question of how managed care affects physicians in private practice, it will be helpful to put this query into perspective with other important questions. **What** is Managed Care? **Why *did it evolve?*** **How** does it work? **Where** does it lead?

It may be helpful to characterize the total process as Health *Care System* Reform and subdivide this into: Health *Care* Reform and Health *Systems* Reform. We can then artificially differentiate *System* Reform, dealing with public policy and legislation, from *Care* Reform, which addresses actual mechanisms of medical care delivery.

While Health *System* Reform at the Federal level is in limbo, Health *Care* Reform is very much alive. Practically speaking, for patients and physicians alike, Health Reform currently means **Managed Care**. Managed Care is a private sector initiative, fostered initially by the need for cost control. It is logical and desirable that the cost containment and quality improvement methods integral to Managed Care, evolve and develop in the private sector. Only after proving their value, should we transfer these methods to the public sector.

The AMA defines Managed Care as: "A system or techniques that affect access to, and control payment for, health care services." Techniques can include: (a) prior, concurrent or retrospective utilization reviews (in an attempt to decide if the services were appropriate); (b) incentives and disincentives; (c) controlled access.

Managed Care probably originated in the 1950s with the Kaiser industrial complex in California and Hawaii. Kaiser was a multi-faceted industrial empire employing thousands. Kaiser-Permanente developed as a closed system to provide health care to company employees. In order to keep costs down they looked for efficient

continued on page 34

Illustration by Paul Anderson

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