

1 MOB-97-P, September 1996 to support the **concept** contained in the document titled "Individually  
2 Selected and Individually Owned Health Insurance System", and to take the concept to the House of  
3 Delegates at the 1996 Annual Meeting.

## 4 5 **COLORADO MEDICAL SOCIETY**

### 6 7 **Individually Selected and Individually Owned** 8 **Health Insurance System**

#### 9 10 **CONCEPT PAPER Introduction**

11 Health care has become a political issue due to the fact that there exists an imbalance between the desire  
12 of people to consume health care and their ability to pay for it. This imbalance has given rise to the  
13 dependency on the third-party payer system for health care. Less and less of personal medical costs are  
14 paid by the individual, and more is paid by insurance. In 1960, individuals paid 49% of their health care  
15 costs, while government programs paid 24% and insurance companies paid 22%. Contrast this with the  
16 18% individuals paid, 44% the government paid, and 34% insurance companies paid in 1993. With less  
17 personal exposure to cost, patients have had little incentive to restrict consumption of health care.

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19 Such consumption at the expense of "someone else", combined with the cost shifting that has occurred  
20 with government programs such as Medicare and Medicaid, has caused unsustainable health insurance  
21 cost increases. Since the overwhelming majority of people obtain health insurance through their place of  
22 employment, the financial impact of providing such insurance has weighed heavily on the employer. The  
23 employer's answer has been to seek lower cost insurance from the insurance industry. Such less costly  
24 plans have shifted employers and their employees from higher cost indemnity plans into lower cost  
25 managed care plans, often HMOs. Such managed care plans have been able to control costs better than  
26 indemnity plans, in part, by limiting both the patient's choice of providers and the patient's direct access to  
27 specialty care. For the healthier segment of the population who consumes little care, such restrictions to  
28 obtain lower costs are accepted. To the 20% or more of the population with chronic or more complicated  
29 illnesses, such restrictions affect the ability to access the desired care and often affect the quality of the  
30 patient's life. Often, the employee is offered little or no choice of health plans by their employer. Too  
31 frequently, the employer changes the employee health plan every one or two years in order to find more  
32 economical plans. Such changes in health plans may lead to an increasing uninsured population  
33 comprised of those workers with pre-existing medical conditions who then find themselves uninsurable.

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35 Here lies the problem. The employer tries to manage the cost of providing health insurance to employees,  
36 while the employee may not be able to choose the health care delivery system and providers which they  
37 desire. Often times, the employee has so little involvement in the system that they do not respond to  
38 normal market forces. The accountability in the system is aligned from the health plan to the employer,  
39 often driven solely on the basis of cost, with little, if any, accountability between the health plan and the  
40 patient. Globally, market forces have slowed the rise in cost of health insurance, but often in a way  
41 undesirable to the patients.

42 The Colorado Medical Society and the American Medical Association believe that there will be greater  
43 value and efficiency to involve patients more directly in their own health care. Several models exist  
44 currently in both the public sector (the Federal Employees Health Benefit Plan "FEHBP") and the private  
45 sector (e.g., Quaker Oats). By making patients into true "health care consumers" market forces can better  
46 help restrain prices and improve the quality of care delivered. Such has been the experience in the  
47 FEHBP where the annual rate of rise in health insurance premiums during the last 15 years has been  
48 almost half the national average. In such a system, individuals would select the delivery system and  
49 health plan which best meets their need and the needs of their family, not necessarily the employer's.  
50 They would participate in important personal decisions such as choosing premium structures, deductible  
51 and co-pay levels. This system parallels the Medichoice program passed by Congress as part of the

1 Medicare transformation bill. In such a system, cost, quality, and access would determine the winners.  
2 Accountability for policy decisions on the part of the health plan would be determined by the free open  
3 market. Issues of exorbitant profits and excessive executive compensation by HMOs, restrictions on  
4 patient access to needed services, and excessive administrative hassle would be resolved by market  
5 forces. "Any willing provider" and physician fairness issues would disappear.  
6

7 The Congress is acting to provide additional delivery options, from which a patient can choose, including  
8 medical savings accounts and provider sponsored networks. Unfortunately, many consumers will be  
9 unable to access these innovative mechanisms due to the fact that their employers do not choose to  
10 provide these choices. This innovative way of giving individual choice of health plan provides such an  
11 enabling mechanism and furthers competition in the marketplace, thereby helping to control costs.  
12 Additionally, the establishment of a medical savings account early in the productive life of an individual  
13 would provide a mechanism through which that individual could plan for their long-term care and end of  
14 life medical needs. Currently, such costs are either passed on to the patient's family or society. In a way  
15 similar to the planning process used to fund college education and retirement needs, individuals could  
16 begin to plan for their currently uncovered end of life medical needs.  
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18 The main obstacle to implementing such a system is the current tax treatment of employer and employee  
19 paid health insurance benefits. If an employer provides a health insurance benefit to employees, that  
20 employer contribution is tax deductible to the employer provided it is used to purchase an employer-  
21 sponsored health insurance plan. No additional payroll taxes are added to such employer contributions.  
22 Unfortunately, employee contributions to such employer-sponsored health insurance plans are only tax  
23 exempt if they, along with other health care expenditures, exceed 7.5% of the employee's adjusted gross  
24 income. If the employer were to give the employee the same dollar benefit to purchase health insurance  
25 away from the place of employment, additional employer payroll taxes would accrue, and the employee  
26 would similarly pay payroll taxes, federal and state income taxes on such amounts. Therefore, little  
27 incentive exists today for either the employer or employee to want to purchase their health insurance  
28 away from the place of employment.

29 Our model perpetuates the system of voluntary tax deductible contributions made by employers and  
30 employees to fund private health insurance. The employee would have the option of selecting from the  
31 health plan(s) offered at the place of employment, or requesting from their employer a health care  
32 voucher of equal amount with which the employee could purchase health insurance away from the place  
33 of employment accessing an unlimited number of health care delivery systems and health plans.  
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35 Patients would have the option of staying in an employer-sponsored plan; accessing health plans  
36 sponsored by church, clubs, business groups, and other organizations; establishing a medical saving  
37 account; utilizing a Physician Sponsored Network (PSN); joining a voluntary health insurance purchasing  
38 alliance; or accessing an expanded and more competitive individual health insurance market.  
39 Accountability would be reestablished between the health plan and the patient. Market forces would  
40 encourage health plans to change policies in order to attract new subscribers and retain current members.  
41 The ability of the individual to leave their employer-sponsored group health insurance plan and  
42 participate in any of the individually selected options has been facilitated by the recent passage of the  
43 Kassenbaum-Kennedy Bill which places limitations on pre-existing illness exclusions.  
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#### 45 **The Legislation**

46 The legislation would provide the employer the same tax treatment for voluntary payment of health  
47 insurance premiums both when the employer provides the health insurance plan to employees and when  
48 the employer gives employees the same dollar contribution or payment equivalent to the same relative  
49 percentage of the employee's health insurance premium to purchase individually selected and individually  
50 owned health insurance. Provisions would have to be included to allow individual employees to "opt out"  
51 of group plans without jeopardizing the ability of the group to continue their employer selected group

1 coverage. Specifically, there would have to be a limitation on the requirement for absolute employee  
2 numbers or percentages to issue group coverage. Employees should be limited to changing health  
3 insurance plans no more than once every 12 months. Such legislation alone would provide the  
4 mechanism for implementation and would be budget neutral.

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6 The most direct method to facilitate implementation of the proposal would be to provide for equal tax  
7 treatment for the costs of health insurance purchased by employers, employees, and those individuals who  
8 are self-employed. Congress would have to set a "cap" on the annual levels of deductibility to limit the  
9 cost of the program. All contributions above that level would be taxable. Our estimate for the cost of  
10 providing such tax deductibility to all three groups is \$24 billion annually, less currently, with the phased-  
11 in increases in deductibility for health insurance premiums paid by self-employed individuals (Public Law  
12 104-191). Two approaches could be taken to fund that cost:

- 13 • outright appropriation which would increase the total Congressional budget by \$24 billion  
14 annually; or
- 15 • reduction of the level of employer deductibility of contributions made for employee health  
16 insurance and redistribution of the taxes so generated to provide a similar level of deductibility  
17 to employees and self-employed. It is estimated that establishment of a 75% deductibility level  
18 would provide such a budget neutral level. Such limitation of employer deductibility would  
19 increase employer cost for providing health insurance and therefore, might lead to fewer  
20 employers providing health insurance to their employees.

21 Provision of significant deductibility for employees and self-insureds should increase the number of  
22 workers purchasing health insurance, thereby allowing more individuals access to care earlier in their  
23 illness in a more cost effective clinical setting which could offset part of the \$24 billion annual cost.

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25 Safeguards would have to be established, such as a health care voucher system, to ensure that  
26 contributions made to an employee for the purchase of individually selected and individually owned  
27 health insurance are used for that purpose. To ensure that the health insurance plan purchased by the  
28 individual was sufficient to provide a basic level of health care and did not increase the potential for the  
29 individual to become part of the medically indigent populations, a limited number of ground rules would  
30 need to be included: minimum benefit requirements including catastrophic protection; fiscal solvency of  
31 the plan; promotion of consumer information; and protection of the consumers from fraud. Additional  
32 requirements for the individual health insurance market, including guaranteed issue, guaranteed  
33 renewability, and rate reform, would be required to make the individual market a viable consumer option.

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35 In order to limit cost shifting and permit the greatest degree of open market competition, this new federal  
36 law should not allow ERISA pre-emption.

### 37 38 **How This Proposal Affects The Players In Health Care**

#### 39 40 **The Patient (Public)**

##### 41 42 **Support**

43 Patients would benefit by this plan in affording them more choice of product design. The individual  
44 would be able to pick the plan and delivery system that works best for their individual and family needs.  
45 Individuals, frequently for the first time, would have to take cost into consideration when choosing their  
46 health plan. They would become consumers of health care. Such individual attention to the cost and  
47 services provided has the potential for controlling costs in a profound way. The individual would have a  
48 greater incentive to verify charges and negotiate fees. By allowing the individual to choose the health  
49 plan they would be able to continue in valued ongoing doctor-patient relationships by determining in  
50 which plan their providers participate. Choice of hospital would similarly be possible.

1 **Opposition**

2 Some might think that individuals are not prepared to choose from a variety of plans and delivery  
3 systems. Such has not been the experience of the FEHBP where everyone from manual laborers to  
4 Senators have benefited from the plan. Consumer services to assist individuals in plan selection would  
5 undoubtedly come forth, such as consumer guides and computer assisted matching services. Open  
6 advertising by competing plans would assist provision of plan specific information. Consumers currently  
7 are able to make selections for a variety of other products in the marketplace such as home, life, and auto  
8 insurance, and in purchasing durable goods.  
9 Unions may want to continue to negotiate their health benefits themselves without outside interference.  
10 Patients may lose the ability to have a single group rate as they have in group coverage at work. Such  
11 could potentially increase individual cost if insurance is purchased away from employment.

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13 **The Employer**

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15 **Support**

16 The employer would benefit through improved employee morale, and not needing to offer a plan at work  
17 in order to provide a health insurance benefit to employees. The cost of administering employer-  
18 sponsored health plans could be significantly reduced. There would be little need for a large  
19 administrative staff to operate the employer-sponsored plan. The FEHBP has been able to administer  
20 their program for 1% of the total cost of the plan.

21  
22 **Opposition**

23 Employers may have concern that by giving up the ability to negotiate the rate of their employee health  
24 plan, costs will rise. If significant numbers of employees leave an employer-sponsored plan, with a  
25 smaller group size the premium could rise. Conversely, the experience of the FEHBP has been that such  
26 open selection fosters competition between plans and helps to control costs. This is even more significant  
27 when one considers that pre-existing illness exclusions do not apply in the FEHBP whereas such  
28 exclusions are common in other employer provided health insurance, especially in the small employer  
29 market. Employers might have concern that if too many employees leave employer-sponsored plans, the  
30 rates for such plans would rise. Such a possibility exists, but with individual access to options other than  
31 employer-sponsored plans, competition in the marketplace should help deter price increases.

32  
33 Some large employers and employer coalitions have begun developing accountability standards for health  
34 plans. Such standards and accountability procedures could continue for employer-sponsored plans, and  
35 that information could also be made available to assist individuals with plan selection. Additionally,  
36 National Committee on Quality Assurance (NCQA) accreditation has served as a benchmark for quality  
37 in the HMO industry and could provide an additional level of public accountability.

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39 **The Insurance Industry**

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41 **Support**

42 Insurers would benefit through expanded markets. Innovation in pricing and services could produce  
43 additional sales.

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45 **Opposition**

46 Insurers would no longer be able to buy large groups of covered lives simply on the basis of cost.  
47 Additional accountability would be demanded by the patient who could individually switch plans if not  
48 satisfied with health plan policies and performance. Insurers who now have the market cornered might be  
49 adverse to the increased accountability such a proposal would force upon them. Insurers would face  
50 additional marketing costs needing to market to both groups and individuals, but such is the market with  
51 Medicare HMOs, which sell directly to the patient.

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**The Provider (Physician, Hospital, Home Health Services, Etc.)**

**Support**

Such a system would open access to providers who have been excluded by selective contracting by health plans. This would increase competition in all local markets. Providers would be able to attract additional business through quality, cost, and access. It would significantly foster continuous quality improvement (CQI). Additionally, issues such as "any willing provider" and other anti-managed care issues would disappear. Patients would be able to determine plans with which their providers participate, and thereby continue valued long term relationships, such as between patient and physician, by purchasing such health plans.

**Opposition**

Inasmuch as patients would become health care consumers in certain health care delivery systems, providers would have to begin discussing price and become more accountable for charges than they currently are.

**The Government**

**Support**

By providing similar choice to the rest of the public, in addition to Medicare and FEHBP recipients, a single level of health care choice could be provided. Conceptually, such an approach could also be used for the Medicaid program. With the elimination of pre-existing illness exclusions and the opening up of the individual market, access for the uninsured would be improved. Government could utilize this system to purchase health insurance with public assistance funding for segments of the uninsured population. By making the individual more accountable for their decisions in consuming health care services, financial restraint should produce cost savings from the demand side of health care economics. Additionally, requests from providers to further regulate the HMO industry would markedly decrease by allowing market forces to modify the policies of these companies.

**The Insurance Broker Industry**

**Support**

This change would open up new markets to brokers. They could become a significant resource for individuals in selecting a delivery system and health plan.

**Opposition**

Safeguards would have to be established to prevent fraud and abuse in this industry.