**Statement on Behalf of Group Health Association of America, Inc.**
**Presented by Samuel Havens**
**Chairman of the Board**
**Senior Vice President, The Prudential Insurance Company of America, Inc.**

**Before the Subcommittee on Health and the Environment**
**Of the House Energy and Commerce Committee**
**U.S. House of Representatives**
**November 8, 1993**

Mr. Chairman and members of the Subcommittee, I am Samuel Havens, Senior Vice President of The Prudential Insurance Company of America, Inc., and Chairman of the Board of Group Health Association of America, Inc. (GHAA). I am here today on behalf of GHAA which represents 347 health maintenance organizations whose 32 million enrollees account for about 75 percent of the total national HMO enrollment.

GHAA supports the goals of health care reform, and we are pleased that HMOs are being given a central place in the health care reform debate. It is our conviction that expansion of well-structured, fiscally-sound managed care options can play a major role in providing comprehensive, high quality health care at an affordable cost to all Americans. However, we are concerned that these goals could be undermined by the use of global budgets and price controls to constrain health care costs.

We want to emphasize that while much of the impetus for reform comes from the need to reduce the inordinately high rate of increase in overall health care costs, an even greater emphasis on assuring appropriate care and on maintaining and continuously improving the quality of care will be necessary if reform efforts are to succeed. HMOs meet both of these objectives by combining the financing and delivery of health care.

We are convinced that the cost of health care can be contained over the long term only by changing the structure of the current system to promote competition on the basis of both quality and cost effectiveness. It is on this basis that HMOs have achieved their success.

While maintaining their focus on the continuous improvement of the quality of care that they provide, HMOs have become increasingly popular with employers due to their ability to control costs. Not coincidentally, where HMO penetration is highest, more significant moderation of cost increases has been seen. Studies such as those by James C. Robinson published in the Journal of the American Medical Association on November 20, 1991, ("HMO Market Penetration and Hospital Cost Inflation in California, JAMA 266(19): 2791-2723] and W. Pete Welch published by The Urban Institute in March, 1991, ["HMO Market Share and Its Effect on Local Medicare Costs] have found that the greater the HMO penetration and hospital competition for HMO and PPO business, the lower the rate of increase in health care costs overall.

KPMG Peat Marwick recently reported a significant departure from years of double digit increases in the rate of overall premium growth: 8 percent in 1992-93 down from 11 percent in

1991-92. As a primary reason for this decrease, the firm cites the growing maturity, of managed care and utilization management, which it credits with changing the environment in which physicians and other providers deliver care. If enrollment in HMOs and other managed care options increases under health care reform as many anticipate, the positive impact of HMO practice patterns and quality assurance initiatives will grow accordingly.

Consumer satisfaction with HMOs has been demonstrated by their impressive growth over the past decade. Membership has increased from 10 million enrollees in 1982 to 41 million enrollees in 1992. A recent consumer satisfaction survey conducted by National Research Corporation of Lincoln, NE, and reported in the December 14, 1992, issue of Modern Healthcare magazine showed that HMOs enrollees are, on average, more satisfied with their health plans than consumers with PPO or indemnity coverage.

Studies of quality, such as that which appeared in the Annals of Internal Medicine in September, 1991, [Steven Udvarhelyi, et al, "Comparison of the Quality, of Ambulatory Care for Fee-for-Service and Prepaid Patients," Annals of Internal Medicine 115(5):394-4003 have shown consistently that quality of care in HMOs is equal to or better than that in the fee-for-service sector. Because HMOs care for an enrolled population, they have the capability to systematically enhance quality through internal quality improvement systems. Their access to detailed information on services provided allows HMOs to analyze the care and implement appropriate guidelines to improve outcomes. Further, drawing upon this information, HMOs in partnership with private sector employers are now in the forefront of efforts to develop performance measures and provide better and more useful information to consumers through projects such as the development of HEDIS 2.0, which contains over sixty standardized health plan performance measures related to quality, enrollee access and satisfaction, utilization and financial data and is designed to provide standardized information on the quality and performance of HMOs and similar managed care systems.

All of the major quality enhancement initiatives recommended in the Administration's proposal — practice guidelines, outcomes measurement and increased emphasis on preventive care — are a traditional part of an HMO. These initiatives contribute to cost effectiveness and quality of care by eliminating or drastically decreasing unnecessary services and by providing for more appropriate care at early stages of illness and for access to preventive care.

Premium Caps/Capital

Regulatory cost containment initiatives can thwart the future development of HMOs and other systems that integrate the financing and delivery of health care. A major concern for HMOs is the negative impact of premium caps on the ability of health plans to raise capital. Many health plans will require large infusions of new investment capital if they are to meet the needs of the proposed universal health security system. While facility-based group and staff model HMOs have the most obvious capital needs, expansion of IPA and network model plans requires substantial capital as well. The former have a greater proportion of their assets in property and equipment since they are more likely to own their own medical buildings and equipment. The latter must make a substantial investment to create the administrative infrastructure and sophisticated management information systems (MIS) necessary to their success. In addition, we

anticipate that health plans will be required to expend substantial resources to meet new national data requirements. Health plans should be free to build into their rates adequate allowances to support anticipated capital needs and to maintain the fiscal strength to attract needed capital. The limitations imposed by premium caps will divorce rate setting from these important needs.

Premium Caps/Efficient Plans

Premium caps present an additional problem for managed care plans. HMOs, which have already eliminated some of the waste from their health care delivery systems, will find it much harder to meet arbitrary premium caps than less efficient plans who are likely to have more flexibility in adjusting their premiums, because they have more waste to eliminate.

Indeed, the achievement of high quality with ever greater efficiency is a constant challenge and would become even more so in an environment with cost controls. HMOs have achieved cost savings by improving the coordination and appropriateness of care, negotiating favorable rates with hospitals and providers, and avoiding unnecessary hospitalizations. As discussed in a recent article by Jack A. Meyer and Ingrid Tillmann in Managed Care Quarterly, HMOs and other managed care entities have become dedicated to continuous quality improvement and are reducing inappropriate practice variation; improving management of high cost patients and conditions, sometimes through expanded packages of services which are expected to yield long-term savings; and examining patterns of care in relation to health outcomes and continually feeding back information to providers.

Experience with Cost Controls

Experience to date with all forms of regulatory cost controls, whether simple or complex in design (as in the unit price controls under the Nixon administration or the DRG and RBRVS mechanisms of the current Medicare program), suggests that they are at best crude instruments with which to contain costs, and at worst they may be explicitly counterproductive. It is our concern that such controls and the shape they may take will negatively impact the plans that are the foundation of a reformed health care system.

Global Budgets

The Administration's proposal calls for the National Health Board to establish a “national per capita baseline premium target” which is based upon a determination of the total expenditures in 1993 for services covered under the comprehensive benefit package. Regional alliance premium caps are built upon this foundation with annual indexing to bring the rate of growth in premiums down to the rate of growth in the CPI by 1999. Many noted economists have argued that the link to the CPI is unrealistic and unattainable.

The baseline premium target does not incorporate all of the increased costs, which must be borne by health plans under the Administration's proposed legislation. For example:

- health plans in a regional alliance may be assessed up to 2 percent of the total premiums paid by those enrolled through the alliance to cover outstanding liabilities in the event of a health plan insolvency;

- health plans will continue to bear the impact of cost shifting because of shortfalls in payments on behalf of Medicaid beneficiaries, the cap on subsidies available to low-wage and small businesses, and because they are prohibited from disenrolling members for nonpayment of premiums;

- health plans may be required to expend substantial resources to meet national data requirements; and

- since the point of service coverage which must be offered by plans offering the "low cost sharing schedule" differs substantially from current HMO point of service offerings — which generally provide for a deductible and higher cost sharing for out-of-plan use — it remains unclear whether premiums for this option will be high enough to cover the combination of in-plan and out-of-plan utilization.

An additional design problem with the baseline target amount is that it institutionalizes current geographic variations in health expenditures. High cost areas in which a significant cost factor may be overutilization will remain relatively high cost areas. Low cost areas, such as medically underserved rural areas, will not be given sufficient room for growth in premiums to improve accessibility to needed care.

In conclusion, the most troublesome problem with premium caps is that they will inevitably serve as a serious impediment to the primary goal of health care reform — the alteration of marketplace incentives to bring about the delivery of high quality, affordable health care. While the establishment of targets against which the success of reform can be measured may be useful, the imposition of caps from the outset may mean that a market-based system is never put to a true test of its effectiveness.

The innovation in the private sector that has been sparked by the prospect of health care reform and that is distinguished by a dual emphasis on quality and cost effectiveness deserves encouragement. Physicians and hospitals are forming new alliances; providers are increasingly affiliating with managed care organizations; many employers have become sophisticated purchasers of health benefits; both consumers and purchasers are actively seeking better information on which to base their coverage choices; and HMO growth is continuing at an impressive pace.

It is critical to the success of health care reform that marketplace innovation and the demonstrated success of HMOs in achieving the central goals of reform, delivery of comprehensive, high quality, affordable health care services to all Americans, be encouraged. We look forward to working with you as action on reform legislation proceeds.